

2024 AMA Medical Student Section (MSS) Annual Meeting Chicago, IL June 6-7

Policy Materials

If you do not have the link to the MSS I-23 Assembly Microbrick and/or are not part of the A-24 Business Groupme and your Region Groupme. Please email amamedstudents@gmail.com.

Resolution 004 - Supporting Community Physician and Paramedic Partnerships
Resolution 008 - Routine Provision of Information Concerning Insulin Cost-Reduction Programs
Resolution 015 - Support of Collective Bargaining
Resolution 020 - Support for Early Detection and Intervention of Juvenile Depression
Resolution 021 - Physician-led and Rural Access to Emergency Care
Resolution 022 - Opposition to Capital Punishment
Resolution 023 - Improving IPV Screening for People with Disabilities
Resolution 102 - Radiation Exposure Compensation Coverage
Resolution 105 - Native American Medical Debt
Resolution 108 - ACA Subsidies for Undocumented Immigrants
Resolution 109 - Tribal Dialysis Access
Resolution 115 - Corrections to The Medicare Part C Payment Structure
Resolution 203 - Access to Healthcare for Transgender and Gender Diverse Incarcerated People
Resolution 205 - Support for Doula Care Programs
Resolution 207 - Repatriation of American Indian, Alaska Native, and Native Hawaiian Remains
Resolution 210 - Opposition to the Deceptive Relocation of Migrants and Asylum Seekers
Resolution 211 - SSI Savings Penalty Elimination
Resolution 213 - Undocumented Worker Protections
Resolution 223 - Increased Transparency in Psychotropic Drug Administration in Prisons

Resolution 308 - Expanding Medical Education Access and Support for First-Generation Students

Resolution 311 - Parity for DO and MD graduating seniors through reporting total number of DO and MD applicants interviewed and ranked by each residency program

Resolution 313 - Opposition to Medical School Admissions Preference for Children of Donors and Faculty

Resolution 315 - Removing Headshot Requirements from Medical School, Residency, and Fellowship Applications

Resolution 321 - Humanism in Anatomical Medical Education

Resolution 402 - Studying the Effects of Plant-Based Meat

Resolution 403 - Improving Child Disciplinary Education for Caregivers

Resolution 404 - Support for Standardized Periodic Hearing Screenings in Primary Schools

Resolution 419 - Equity in Celiac Disease and Food Allergies Research and Resources

Resolution 422 - Protecting the Healthcare Supply Chain from the Impacts of Climate Change

Resolution 423 - Preventing Heat Related Illness with Appropriate Heat Response Standards

Resolution 425 - Support of Universal School Meals for School Age Children

Resolution 427 - AMA Study on Plastic Pollution Reduction

Resolution 601 - Advisory Committee on Tribal Affairs

Late Resolution 001 - MSS Endorsements in the AMA House of Delegates

Section reports

GC Report A - Sunset Report

GC Report C - Biennial Review of Organizations Seated in the AMA-MSS Assembly

GC Report D - MSS Abortion, Contraception, & Sex Education Position Consolidation

GC Report E - MSS Employment & Educational Leave Positions Review & Consolidation

GC Report F - MSS Firearm Positions Consolidation

GC Report G - Consolidation of Positions Relating to MSS Governance

GC Report H - MSS Alcohol-Related Positions Consolidation

GC Report I - Guidelines for Official Observers in the AMA-MSS Assembly

GC Report J - Use of Inclusive Language in AMA Policy

ATF Report - Archives Task Force Report

SCTF Report - Standing Committee Task Force Report

Delegate Report A - MSS Policy Process and HOD Resolution Queue

MSS CEQM WIM LGBTQ+ Report A - Coverage for Care Provided After Sexual Assault

MSS CEQM COLA Report A - Opposing Private Equity Acquisitions of Healthcare Practices

MSS CME CDA Report A - Studying Effects of Online Education on Medical Education Outcomes During COVID-19 Pandemic

MSS LGBTQ+ CHIT Report A - Improving Usability of Electronic Health Records for Transgender and Gender Diverse Patients

MSS MIC CSI CAIA Report A - Increasing Access to Medical

Interpreters in Research and Support for Increased Diversity in Genetic Research

MSS WIM COLA LGBTQ+ Report A - "Addressing Gender-Based Disparities on Health-Related Consumer Goods (The Pink Tax)"

Informational reports

GC Report B - MSSAI Report

Delegate Report B – Policy Proceedings of the Interim 2023 House of Delegates Meeting

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 004
(A-24)

Introduced by: Muhammad Zulfiqar, University of Virginia; Yashna Thakker, Sam Houston State University; Taya Smith, Western Michigan University Homer Stryker MD School of Medicine

Subject: Supporting Community Physician and Paramedic Partnerships

Sponsored by: Region 2, Region 4, Asian Pacific American Medical Student Association (APAMSA), Association of Native American Medical Students (ANAMS)

Referred to: MSS Reference Committee
(Caitlin Blaukovitch and Shaminy Manoranjithan, Co-Chairs)

- 1 Whereas, rural patients tend to have poorer health and a harder time accessing healthcare
2 compared to urban patients¹;
3
- 4 Whereas, among the multifactorial reasons for rural health disparities, geographical distance to
5 care providers is often a barrier limiting patient access to care²; and
6
- 7 Whereas, limited access to primary care in rural areas often leads to emergency department
8 overcrowding, resulting in increased rates of mortality and morbidity^{3,4}; and
9
- 10 Whereas, the advent of community paramedicine expands the ability of primary care physicians
11 to reach patients in rural areas, overcoming geographical barriers by utilizing paramedics as
12 physician extenders⁵; and
13
- 14 Whereas, community paramedicine programs send paramedics to the homes of patients who
15 have recently received care in an emergency department to assist with remote patient
16 monitoring, video support, connecting patients with PCPs and/or clinical specialists, scheduling
17 appointments, deploying transportation, pharmacy consults, and medication reviews^{5,6}; and
18
- 19 Whereas, implementation of a community paramedicine program in rural Ontario led to a 24%
20 reduction in 911 calls, 20% reduction in emergency department visits, and 55% reduction in
21 hospital admissions following emergency department visits after one year⁷; and
22
- 23 Whereas, in one study, patients who received a post-hospital community paramedic intervention
24 had fewer hospital readmissions, reduced emergency department usage, and savings up to
25 \$410,428 in addition to higher rates of quality of life^{8,9}; and
26
- 27 Whereas, data from a community paramedicine program established by Abbeville County
28 Emergency Management Services showed a 58.7% decrease in emergency department
29 utilization over a four year period¹⁰; and
30

1 Whereas, American College of Emergency physicians reported the implementation of
2 community paramedicine alongside telehealth resulted in lower median ED length of stay (11.9
3 hours vs 30 hours) and lower inpatient admission rates (9.7% to 24.7%)¹¹; and
4

5 Whereas, community paramedicine programs are funded through a variety of mechanisms like
6 government grants, cost-sharing with partner sites such as hospitals or assisted living facilities,
7 the Emergency Triage, Treat, and Transport model by the Centers for Medicare and Medicaid
8 services, and by some state Medicaid agencies including Arizona, Georgia, Minnesota, Nevada,
9 and Wyoming^{12,13}; therefore be it

10
11 RESOLVED, that our American Medical Association support efforts to establish and expand
12 physician-led community paramedicine programs; and be it further

13
14 RESOLVED, that our AMA support legislation, regulation, and other efforts to require all health
15 payers to cover community paramedicine services.

Fiscal Note: TBD

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RELEVANT [AMA POLICY](#)

Emergency Department Boarding and Crowding H-130.940

Our AMA:

1. congratulates the American College of Emergency Physicians for developing and promulgating solutions to the problem of emergency department boarding and crowding;
2. supports collaboration between organized medical staff and emergency department staff to reduce emergency department boarding and crowding;
3. supports dissemination of best practices in reducing emergency department boarding and crowding;
4. continues to encourage entities engaged in measuring emergency department performance (e.g., payers, licensing bodies, health systems) to use evidence-based, clinical performance measures that enable clinical quality improvement and capture variation such as those developed by the profession through the Physician Consortium for Performance Improvement;
5. continues to support physician and hospital use and reporting of emergency medicine performance measures developed by the Physician Consortium for Performance Improvement; and
6. continues to support the harmonization of individual physician, team-based, and facility emergency medicine performance metrics so there is consistency in evaluation, methodology, and limited burden associated with measurement. [CMS Rep. 3, A-09; Reaffirmed: CMS Rep. 01, A-19; Reaffirmed: BOT Rep. 16, A-19]

Incentives to Encourage Efficient Use of Emergency Departments H-130.931

Our AMA will support: (1) continued monitoring, by the Centers for Medicare & Medicaid Services and other stakeholders, of strategies and best practices for reducing non-emergency emergency department (ED) use among Medicaid/Children's Health Insurance Program (CHIP) enrollees, including frequent ED users; and (2) state efforts to encourage appropriate emergency department (ED) use among Medicaid/CHIP enrollees that are consistent with the standards and safeguards outlined in AMA policy on ED services. [CMS Rep. 1, I-22]

Access to and Quality of Rural Health Care H-465.997

Our AMA believes that solutions to access problems in rural areas should be developed through the efforts of voluntary local health planning groups, coordinated at the regional or state level by a similar voluntary health planning entity. Regional or statewide coordination of local efforts will not only help to remedy a particular community's problems, but will also help to avoid and, if necessary, resolve existing duplication of health care resources. (2) In addition to local solutions, our AMA believes that on a national level, the implementation of Association policy for providing the uninsured and underinsured with adequate protection against health care expense would be an effective way to help maintain and improve access to care for residents of economically depressed rural areas who lack adequate health insurance coverage. Efforts to place National Health Service Corps physicians in underserved areas of the country should also be continued. [CMS Rep. G, A-87; Modified: Sunset Report, I-97; Reaffirmation A-01; Reaffirmed: CMS Rep. 7, A-11; Reaffirmed: CMS Rep. 1, A-21]

RELEVANT [MSS POLICY](#)

130.004 MSS Decreasing Emergency Department Overcrowding

- (1) AMA-MSS supports legislation that addresses the issue of emergency department overcrowding and patient boarding.
- (2) AMA-MSS will ask the AMA to work with state and federal governments, including agencies such as the Centers for Medicare and Medicaid Services and the U.S. Office of Preparedness and Emergency Operations, to develop guidelines and increase incentives for hospitals to reduce emergency department overcrowding. (MSS Sub Res 2 Adopted in Lieu of MSS Res 2 and MSS Res 7, I-08) (CMS Rep 3, A-09,

Adopted in Lieu of AMA Res 719, A-09 [H-130.940]) (Reaffirmed: MSS GC Rep A, I-14) (Reaffirmed: MSS GC Rep A, I-19)

200.018MSS Incorporating Community Health Workers into the U.S. Health Care System That our AMA-MSS Digest of Policy Actions/ 119 AMA (1) encourages the incorporation of community health workers into the U.S. health care system and support legislation that integrates community health workers into care delivery models especially in communities of economically disadvantaged, rural, and minority populations; and (2) supports appropriate stakeholders to define community health workers in order to define their required level of training and scope of practice and to legitimize their role as health care providers. (MSS Res 4, A-14) (AMA Res 805, I-14 Referred) (Reaffirmed: MSS GC Rep A, I-19)

160.040MSS Supporting Research into the Use of Mobile Integrated Health Care and Community Paramedicine in Addressing the Primary Care Shortage

AMA-MSS will study mobile medical units as a means of delivering healthcare to underserved communities. (MSS Res 28, I-18)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 008
(A-24)

Introduced by: Andrew Bell, Harvard Medical School; Suraj Joshi, Tufts University School of Medicine; Soneet Kapadia, Long School of Medicine at San Antonio; Bethany Brumbaugh, Harvard Medical School; Lily Rajaei, Loyola University Stritch School of Medicine; Megi Maci, Loyola University Stritch School of Medicine; Jenny Marie Jobe, University of New England College of Osteopathic Medicine; Brooke Taylor, University of South Carolina School of Medicine, Greenville

Subject: Routine Provision of Information Concerning Insulin Cost-Reduction Programs

Sponsored by:

Referred to: MSS Reference Committee
(Caitlin Blaukovitch and Shaminy Manoranjithan, Co-Chairs)

- 1 Whereas, insulin affordability continues to pose one of the most pressing public health
2 challenges in pharmaceutical and drug policy of our time;¹⁻³ and
3
- 4 Whereas, the prevalence of diabetes varies widely with respect to social determinants of health,
5 including race, ethnicity, socioeconomic status, education, housing status, and others;⁴ and
6
- 7 Whereas, health literacy is directly associated with socioeconomic status, and the individuals in
8 the most need of pharmaceutical cost-reduction strategies may be the least able to make use of
9 them;⁵⁻⁷ and
10
- 11 Whereas, individuals with low health literacy demonstrate lower levels of comprehension
12 regarding the need for each of their prescribed medications, the risks of not following their
13 medication plan, and the factors influencing the cost paid by consumers upon receipt of
14 medication; and health literacy is correlated with improved glycemic control by individuals with
15 diabetes;⁷ and
16
- 17 Whereas, for patients with Type 1 Diabetes Mellitus (T1D) and Insulin-Dependent Type 2
18 Diabetes Mellitus (T2D), there exists no other comparable alternative therapy for prolonging life
19 and reducing morbidity;⁸ and
20
- 21 Whereas, the state of being without insulin constitutes an imminent risk of death especially for
22 patients with T1D, which places considerable psychological stress on these patients;⁹ and
23
- 24 Whereas, 14% of individuals who use insulin in the US spend at least 40% of their post-
25 subsistence income on insulin, an amount that is considered to be “catastrophic”;^{10,11} and
26
- 27 Whereas, the Inflation Reduction Act of 2022 (IRA) incorporated reforms to Medicare, including
28 an out-of-pocket price cap of \$35 for insulin products covered under Medicare Part D for
29 patients enrolled in Medicare plans¹²; and

1 Whereas, since the IRA was passed, insulin fills have increased for patients enrolled in
2 Medicare plans¹³; and the cost-reduction methods implemented under the IRA have been
3 projected to generate savings in excess of \$700 million annually¹⁴; and
4

5 Whereas, despite the above, as many as 48% of patients using insulin in the United States are
6 not covered by Medicare plans and are ineligible for the benefits provided by the IRA;¹⁵ and
7

8 Whereas, several pharmaceutical companies, including the largest three manufacturers of
9 insulin products used to treat diabetes in the United States - Eli Lilly, Novo Nordisk, and Sanofi -
10 have introduced private, voluntary cost-reduction programs, including out of pocket spending
11 caps, for patients who cannot afford their insulin or who are underinsured or uninsured; and
12

13 Whereas, there is heterogeneity in the terms and conditions of cost-reduction programs
14 administered by different private companies, and these details may not be readily available to
15 patients as they make decisions regarding payment for their medications; and
16

17 Whereas, a consensus report of the American Diabetes Association, the Association of
18 Diabetes Care & Education Specialists, the Academy of Nutrition and Dietetics, the American
19 Academy of Family Physicians, the American Academy of PAs, the American Association of
20 Nurse Practitioners, and the American Pharmacists Association recommends that education of
21 patients regarding their medical treatment and managing their diabetes be given “1) at
22 diagnosis, 2) annually and/or when not meeting treatment targets, 3) when complicating factors
23 develop, and 4) when transitions in life and care occur;”¹⁶ and
24

25 Whereas, the fragmented nature of care for patients with diabetes, who often receive care in
26 multiple treatment settings, including primary care, urgent care, and specialty clinics, highlights
27 the need for coordination among all medical specialties regarding the routine distribution of
28 insulin cost reduction information to patients;¹⁷ and
29

30 Whereas, abundant evidence suggests that patients’ memory for medical information conveyed
31 during the clinic visit is a limiting factor for their ability to act on information obtained during the
32 clinical encounter, and that assessment of patients’ health literacy and patient education by
33 physicians caring for diabetic patients correlates with improved glycemic control;^{5,18} and
34

35 Whereas, interventions providing actionable information for individuals without medical training
36 have demonstrated effectiveness at improving medication adherence and health outcomes,
37 especially for individuals with low health literacy;^{19,20} and
38

39 Whereas, prior policy, including H-100.964, encourages physicians to “counsel their patients
40 about their prescription medicines and when appropriate, to supplement with written
41 information”, but does not extend the recommendation to include information concerning cost
42 reduction;²¹ and
43

44 Whereas, prior policy, including H-100.964 and H-110.997, encourages physicians to
45 “supplement medical judgments with cost considerations” when making decisions about which
46 drugs to prescribe, and to “consider prescribing the least expensive drug product”, but makes no
47 recommendations concerning the provision of cost reduction information for patients *after* a
48 medication is prescribed or when there are no alternative treatments;^{21,22} and
49

50 Whereas, prior policy, including H-110.997, “encourages expanded third party coverage of
51 prescription pharmaceuticals as cost effective and necessary medical therapies” but does not

1 delineate how and how often physicians should communicate information about drug costs to
2 their patients;²² and

3
4 Whereas, prior policy, including H-110.991, establishes that our AMA “will pursue legislation
5 requiring pharmacies, pharmacy benefit managers and health plans to inform patients of the
6 actual cash price as well as the formulary price of any medication prior to the purchase of the
7 medication” and “advocate for increased transparency through access to meaningful and
8 relevant information about medication price and out-of-pocket costs”, but this policy limits its
9 consideration to price transparency by pharmacies, pharmacy benefit managers and health
10 plans rather than the final price paid by consumers;²³ therefore be it

11
12 RESOLVED, that our American Medical Association support the implementation of routine
13 physician-to-patient education (in the form of printed and/or digital information) regarding cost-
14 reduction program options for insulin therapy: 1) at diagnosis, 2) annually and/or when not
15 meeting treatment targets, 3) when complicating factors develop, and 4) when transitions in life
16 and care occur; and be it further

17
18 RESOLVED, that our AMA support efforts by specialty societies and other relevant stakeholders
19 to create a standardized informational resource that is: 1) written in plain language, 2) available
20 in printed or digital format, and 3) available in several languages, such that patients can make
21 informed decisions regarding private cost-reduction programs for insulin products.

Fiscal Note: TBD

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RELEVANT [AMA POLICY](#)

Insulin Affordability H-110.984

Our AMA will: (1) encourage the Federal Trade Commission (FTC) and the Department of Justice to investigate insulin pricing and market competition and take enforcement actions as appropriate; (2) support initiatives, including those by national medical specialty societies, that provide physician education regarding the cost-effectiveness of insulin therapies; and (3) support state and national efforts to limit the ultimate expenses incurred by insured patients for prescribed insulin. [CMS Rep. 07, A-18; Modified: Res. 118, A-22; Reaffirmed: Res. 113, A-23]

Drug Issues in Health System Reform H-100.964

Our AMA:

(1) Consistent with AMA Policy H-165.925, supports coverage of prescription drugs, including insulin, in the AMA standard benefits package.

(6a) Encourages physicians to counsel their patients about their prescription medicines and when appropriate, to supplement with written information; and supports the physician's role as the "learned intermediary" about prescription drugs.

(6b) Encourages physicians to incorporate medication reviews, including discussions about drug interactions and side effects, as part of routine office-based practice, which may include the use of medication cards to facilitate this process. Medication cards should be regarded as a supplement, and not a replacement, for other information provided by the physician to the patient via oral counseling and, as appropriate, other written information. [BOT Rep. 53, A-94; Reaffirmed by Sub. Res. 501, A-95; Reaffirmed by CSA Rep. 3, A-97; Amended: CSA Rep. 2, I-98; Renumbered: CMS Rep. 7, I-05; Reaffirmation A-10; Reaffirmed in lieu of Res. 201, I-11; Modified: CMS Rep. 1, A-21]

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. [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]

Price of Medicine H-110.991

Our AMA:

- (1) advocates that pharmacies be required to list the full retail price of the prescription on the receipt along with the co-pay that is required in order to better inform our patients of the price of their medications;
- (2) will pursue legislation requiring pharmacies, pharmacy benefit managers and health plans to inform patients of the actual cash price as well as the formulary price of any medication prior to the purchase of the medication;
- (3) opposes provisions in pharmacies' contracts with pharmacy benefit managers that prohibit pharmacists from disclosing that a patient's co-pay is higher than the drug's cash price;
- (4) will disseminate model state legislation to promote drug price and cost transparency and to prohibit "clawbacks";
- (5) supports physician education regarding drug price and cost transparency, manufacturers' pricing practices, and challenges patients may encounter at the pharmacy point-of-sale; and
- (6) work with relevant organizations to advocate for increased transparency through access to meaningful and relevant information about medication price and out-of-pocket costs for prescription medications sold at both retail and mail order/online pharmacies, including but not limited to Medicare's drug-pricing dashboard. [CMS Rep. 6, A-03; Appended: Res. 107, A-07; Reaffirmed in lieu of: Res. 207, A-17; Appended: Alt. Res. 806, I-17; Reaffirmed: BOT Rep. 14, A-18; Appended: CMS Rep. 07, A-18; Reaffirmation: A-19; Appended: Res. 126, A-19]

Patient-Reported Outcomes in Gender Confirmation Surgery H-460.893

Our AMA supports:

- (1) initiatives and research developed by specialty societies and other relevant stakeholders to establish standardized protocols for patient selection, surgical management, and preoperative and postoperative care for transgender patients undergoing gender confirmation surgeries; and (2) implementation of standardized tools, such as questionnaires, developed by specialty societies and other relevant stakeholders to evaluate outcomes of gender confirmation surgeries. [Res. 004, A-18]

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 015
(A-24)

Introduced by: Eli Schantz, Sydney Clark, Wade Catt, Alison Blodgett; Indiana University School of Medicine

Subject: Support of Collective Bargaining

Sponsored by: Region 2, Region 4, Region 5, Region 6, Asian Pacific American Medical Student Association (APAMSA)

Referred to: MSS Reference Committee
(Caitlin Blaukovitch and Shaminy Manoranjithan, Co-Chairs)

1 Whereas, a rapidly growing number of physicians are members of bargaining units, with
2 approximately 70,000 physicians currently being members of such units, marking an increase of
3 nearly 30% from a decade ago¹; and
4

5 Whereas, the fraction of physicians employed by health systems and other corporate entities
6 reached 52.1% and 21.8% respectively in 2022, encompassing an estimated 74% of practicing
7 physicians²; and
8

9 Whereas, increased unionization of corporate physicians, coupled with the potential of strikes,
10 may force corporate ownership to remove barriers to quality patient care including challenges
11 with staffing, documentation burden, and access to specialty referrals³; and
12

13 Whereas, recent unionization efforts by residents have led to improvements in benefits, working
14 conditions (including work hours, break times, and both physical and mental demands), wages,
15 and more beneficial agreements surrounding grievances and arbitration⁴; and
16

17 Whereas, the argument that physician strikes harm patients does not hold up to scrutiny, as a
18 recent review demonstrated that physician strikes do not have "any significant impact on in-
19 patient patient mortality."⁵; and
20

21 Whereas, 530.017MSS, the only labor relations policy of the AMA-MSS, not only references a
22 *Code of Medical Ethics* opinion that no longer exists, but also restricts the collective action of
23 physicians and medical trainees to national bargaining units established by the AMA, of which
24 there are none; and
25

26 Whereas, Opinion 1.2.10 of the *Code of Medical Ethics* places extreme restrictions on collective
27 action, as it (i) requires collective action to be non-disruptive and (ii) prevents collective action
28 through bargaining units which also represent individuals outside of healthcare; and
29

30 Whereas, Opinion 1.2.10 of the *Code of Medical Ethics* has explicitly been interpreted, by AMA
31 Policy H-383.998, to forbid certain forms of collective action for resident physicians; and
32

1 Whereas, the AMA and AMA-MSS have commissioned many studies over the years with
 2 respect to the risks, benefits, and other considerations of collective bargaining (i.e.
 3 310.034MSS, D-383.977, H-405.946, D-383.98) with little significant change in the current state
 4 of policy; and

5
 6 Whereas, AMA Policy H-285.995, H-385.973, H-385.976, and H-385.946 focus on the ability of
 7 physicians to negotiate with managed care plans, payers, and the government, but neglect to
 8 discuss negotiations with employers or private equity; and

9
 10 Whereas, the Council on Ethical and Judicial Affairs (CEJA) is due to report back on H-405.946
 11 at A-24, providing an opportunity for the MSS to offer the perspective of medical students on
 12 collective bargaining and our own potential membership in said bargaining units; therefore be it

13
 14 RESOLVED, that our AMA-MSS rescind 530.017MSS from the policy digest; and be it further

15
 16 RESOLVED, that our AMA-MSS support the right of physicians and medical trainees to
 17 collectively bargain, including via disruptive means, and support efforts to remove national,
 18 state, and local restrictions on strike action on physicians and medical trainees; and be it further

19
 20 RESOLVED, that our AMA-MSS support the development and implementation of collective
 21 bargaining units and the membership of physicians and medical trainees in said units at a
 22 national, state, and local level.

Fiscal Note: TBD

Date Received: 03/31/2024

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RELEVANT [AMA POLICY](#)

Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or Unionization H-405.946

Our American Medical Association will: (1) reevaluate the various efforts to achieve collective actions and/or unionization for physicians nationally; and (2) request CEJA to review the advisory restricting collective action in section 1.2.10 of its Code of Medical Ethics to allow for more flexibility on the part of physicians who have exhausted other non-disruptive methods for reform. [Res. 016, A-23]

Code of Medical Ethics Opinion 1.2.10: Political Action by Physicians

Physicians who participate in advocacy activities should:

- (a) Ensure that the health of patients is not jeopardized and that patient care is not compromised.
- (a) 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 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.
- (b) Avoid forming workplace alliances, such as unions, with workers who do not share physicians' primary and overriding commitment to patients.
- (c) 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.

Managed Care - Policy and Initiatives H-285.995

- (1) All "hold harmless" clauses in managed care contracts should be explicitly identified as such. Our AMA urges physicians to consult with legal counsel prior to contracting with a managed care entity to prevent the imposition of unfair liability upon the physician. Our AMA will develop model state legislation to prohibit "hold harmless" clauses in managed care contracts and encourages state medical societies to pursue such legislation.
- (2) Our AMA will continue to advocate strongly to Congress, the Department of Justice, and the Federal Trade Commission the need for changes in relevant antitrust laws to allow physicians and physician organizations to form bargaining groups to engage in group negotiations with managed care plans.
- (3) Our AMA will continue to advocate strongly and refine further, as appropriate, the managed care provisions contained in Health Access America.
- (4) Our AMA will support, and pursue an active role in, the development of national managed care and utilization review standards.
- (5) Our AMA will support, and pursue an active role in, the creation of a national managed care/utilization review accrediting or certifying process when acceptable national standards are developed.
- (6) Our AMA extends Policy 340.928 to managed care programs so that such programs make available to physicians under review the identities and credentials of the physician reviewers.
- (7) Our AMA reaffirms the portion of its existing model state legislation that calls for certain elements of utilization review to be defined as the practice of medicine.
- (8) Our AMA reaffirms its policy that payers be liable for harm resulting from the results of any review decisions. [BOT Rep. MM, I-92; Reaffirmed: BOT Rep. I-93-25; Reaffirmed by Res. 725, A-95; Reaffirmed by BOT Rep. 12, I-95; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmation I-96; Reaffirmation A-97; Reaffirmation I-98; Reaffirmation A-99; Reaffirmation A-00; Reaffirmation I-04; Reaffirmation A-05; Reaffirmed: BOT Rep. 10, I-05; Reaffirmation A-06; Reaffirmation A-08; Reaffirmation I-08; Reaffirmed: Sub. Res. 728, A-10; Reaffirmation I-10; Reaffirmed: Sub. Res. 222, I-10; Reaffirmed: Res. 215, A-11; Reaffirmed in lieu of Res. 235, A-11; BOT action in response to referred for decision Res. 235, A-11; Reaffirmed: BOT action in response to referred for decision Res. 201, I-12; Reaffirmed: CMS Rep. 04, A-18]

Investigation into Residents, Fellows and Physician Unions D-383.977

Our AMA will study the risks and benefits of collective bargaining for physicians and physicians-in-training in today's healthcare environment. [Res. 606, A-19]

Employee Associations and Collective Bargaining for Physicians D-383.981

Our AMA will study and report back on physician unionization in the United States. [Res. 601, I-14; Reaffirmed: Res. 206, A-19]

Collective Bargaining: Antitrust Immunity D-383.983

Our AMA will: (1) continue to pursue an antitrust advocacy strategy, in collaboration with the medical specialty stakeholders in the Antitrust Steering Committee, to urge the Department of Justice and Federal Trade Commission to amend the "Statements of Antitrust Enforcement Policy in Health Care" (or tacitly approve expansion of the Statements) and adopt new policy statements regarding market concentration that are consistent with AMA policy; and (2) execute a federal legislative strategy. [BOT Action in

response to referred for decision Res. 209, A-07 and Res. 232, A-07; Reaffirmed: Res. 215, A-11; Reaffirmed: Res. 206, A-19]

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

Our AMA will: (1) pursue the elimination of or physician exemption from anti-trust provisions that serve as a barrier to negotiating adequate physician payment; (2) work to establish tools to enable physicians to consolidate in a manner to insure a viable governance structure and equitable distribution of equity, as well as pursuing the elimination of anti-trust provisions that inhibited collective bargaining; and (3) find and improve business models for physicians to improve their ability to maintain a viable economic environment to support community access to high quality comprehensive healthcare. [Res. 229, A-12; Reaffirmed: Res. 206, A-19]

AMA's Aggressive Pursuit of Antitrust Reform D-383.990

Our AMA will: (1) place a high priority on the level of support provided to AMA's Public and Private Sector Advocacy Units, which are key to successfully addressing the problems physicians face as a result of the current application of federal antitrust laws;

(2) through its private and public sector advocacy efforts, continue to aggressively advocate for a level playing field for negotiations between physicians and health insurers by aggressively pursuing legislative relief at the federal level and providing support to state medical society efforts to pass legislation based on the "state action doctrine";

(3) continue to advocate to the Federal Trade Commission and Department of Justice for more flexible and fair treatment of physicians under the antitrust laws and for greater scrutiny of insurers;

(4) continue to develop and publish objective evidence of the dominance of health insurers through its comprehensive study, Competition in Health Insurance: Comprehensive Study of US Markets, and other appropriate means;

(5) identify consequences of the concentration of market power by health plans to enlist a Senate sponsor for a bill allowing collective negotiation by physicians; and

(6) develop practical educational resources to help its member physicians better understand and use the currently available, effective modalities by which physician groups may legally negotiate contracts with insurers and health plans. [Res. 908, I-03; Reaffirmation, A-05; Reaffirmed: BOT Rep. 10, I-05; Reaffirmation A-06; Reaffirmation A-08; Reaffirmed: BOT Rep. 09, A-18; Reaffirmed: Res. 206, A-19]

Resident Physicians, Unions and Organized Labor H-383.998

Our AMA strongly advocates for the separation of academic issues from terms of employment in determining negotiable items for labor organizations representing resident physicians and that those organizations should adhere to the AMA's Principles of Medical Ethics which prohibits such organizations or any of its members from engaging in any strike by the withholding of essential medical services from patients. [CME Rep. 7, A-00; Reaffirmed: CME Rep. 2, A-10; Modified: Speakers Rep. 01, A-17; Reaffirmed: BOT Rep. 13, A-19]

Collective Negotiations H-385.973

It is the policy of the AMA to seek amendments to the National Labor Relations Act and other appropriate federal antitrust laws to allow physicians to negotiate collectively with payers who have market power. [Res. 95, A-90; Reaffirmed by BOT Rep. 33, A-96; Reaffirmation A-97; Reaffirmation I-98; Reaffirmation A-00; Reaffirmation I-00; Reaffirmation A-01; Reaffirmation A-04; Reaffirmation A-05; Reaffirmation A-06; Reaffirmation A-08; Reaffirmation I-10; Reaffirmed: Res. 215, A-11; Reaffirmed: BOT action in response to referred for decision Res. 201, I-12; Reaffirmed: Res. 206, A-19]

Physician Collective Bargaining H-385.976

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

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

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

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

(5) Our AMA supports obtaining for the profession the ability to fully negotiate with the government about important issues involving reimbursement and patient care. [BOT Rep. P, I-88; Modified: Sunset Report, I-98; Reaffirmation A-00; Reaffirmation I-00; Reaffirmation A-01; Reaffirmation I-03; Reaffirmation A-04; Reaffirmed in lieu of Res. 105, A-04; Reaffirmation A-05; Reaffirmation A-06; Reaffirmation A-08; Reaffirmed: BOT Rep. 17, A-09; Reaffirmation I-10; Reaffirmed: Sub. Res. 222, I-10; Reaffirmed: Res. 215, A-11; Reaffirmed: BOT action in response to referred for decision Res. 201, I-12; Reaffirmed: Res. 206, A-19]

Collective Bargaining for Physicians H-385.946

The AMA will seek means to remove restrictions for physicians to form collective bargaining units in order to negotiate reasonable payments for medical services and to compete in the current managed care environment; and will include the drafting of appropriate legislation. [Res. 239, A-97; Reaffirmation I-98; Reaffirmation A-01; Reaffirmation A-05; Reaffirmation A-06; Reaffirmation A-08; Reaffirmation I-10; Reaffirmed: Res. 206, A-19]

9.4.4 Physicians with Disruptive Behavior

The importance of respect among all health professionals as a means of ensuring good patient care is foundational to ethics. Physicians have a responsibility to address situations in which individual physicians behave disruptively, that is, speak or act in ways that may negatively affect patient care, including conduct that interferes with the individual's ability to work with other members of the health care team, or for others to work with the physician. Disruptive behavior is different from criticism offered in good faith with the aim of improving patient care and from collective action on the part of physicians. Physicians must not submit false or malicious reports of disruptive behavior. Physicians who have leadership roles in a health care institution must be sensitive to the unintended effects institutional structures, policies, and practices may have on patient care and professional staff. As members of the medical staff, physicians should develop and adopt policies or bylaw provisions that:

- (a) Establish a body authorized to receive, review, and act on reports of disruptive behavior, such as a medical staff wellness committee. Members must be required to disclose relevant conflicts of interest and to recuse themselves from a hearing.
- (b) Establish procedural safeguards that protect due process.
- (c) Clearly state principal objectives in terms that ensure high standards of patient care, and promote a professional practice and work environment.
- (d) Clearly describe the behaviors or types of behavior that will prompt intervention.
- (e) Provide a channel for reporting and appropriately recording instances of disruptive behavior. A single incident may not warrant action, but individual reports may help identify a pattern that requires intervention.
- (f) Establish a process to review or verify reports of disruptive behavior.
- (g) Establish a process to notify a physician that his or her behavior has been reported as disruptive, and provide opportunity for the physician to respond to the report.
- (h) Provide for monitoring and assessing whether a physician's disruptive conduct improves after intervention.
- (i) Provide for evaluative and corrective actions that are commensurate with the behavior, such as self-correction and structured rehabilitation. Suspending the individual's responsibilities or privileges should be a mechanism of final resort.
- (j) Identify who will be involved in the various stages of the process, from reviewing reports to notifying physicians and monitoring conduct after intervention.
- (k) Provide clear guidelines for protecting confidentiality.
- (l) Ensure that individuals who report instances of disruptive behavior are appropriately protected.

Issued: 2016

RELEVANT [MSS POLICY](#)**Creation of a National Labor Organization for Physicians 530.017MSS**

AMA-MSS (1) supports the development and implementation by the AMA of a national bargaining unit under the National Labor Relations Act, consistent with our AMA Principles of Medical Ethics (Opinion 9.025), for employed physicians in professional practice, in order to retain the physician's role as the patient advocate, (2) vigorously supports national and state antitrust relief that permits collective bargaining between self-employed physicians and health plans/insurers/hospitals and others under the National Labor Relations Act, and (3) supports the development and implementation by the AMA of a national labor organization under the National Labor Relations Act consistent with our AMA Principles of Medical Ethics (Opinion 9.025) specifically for resident and fellow physicians. (MSS Amended Rep C, A-99) (Reaffirmed: MSS GC Report A, I-04) (Reaffirmed: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)

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) (Reaffirmed: MSS GC Report A, I-21)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 020
(A-24)

Introduced by: Zackary Tareky, Kentucky College of Osteopathic Medicine; Kloie D. Nutt,
Kentucky College of Osteopathic Medicine

Subject: Support for Early Detection and Intervention of Juvenile Depression

Sponsored by:

Referred to: MSS Reference Committee
(Caitlin Blaukovitch and Shaminy Manoranjithan, Co-Chairs)

1 Whereas, in a randomized clinical trial in 2021, mental health screening in school helped
2 increase the likelihood of identifying students with major depressive disorder and getting them
3 proper treatment⁴; and
4

5 Whereas, administration of the Patient Health Questionnaire-9 in school systems has been
6 shown to substantially aid in screening youth for depression and initiating treatment⁵; and
7

8 Whereas, empowering school professionals with the tools to complete random screenings could
9 promote early intervention to treat depression in adolescents and is a step forward in preventing
10 possible worse outcomes³⁻⁴; therefore be it
11

12 RESOLVED, that our American Medical Association amend Policy H-60.937, "Youth and Young
13 Adult Suicide in the United States," as follows;
14

15 "Youth and Young Adult Suicide in the United States," H-60.937

16 1. Our American Medical Association recognizes child, youth and
17 young adult suicide as a serious health concern in the US.

18 2. Our AMA encourages the development and dissemination of
19 educational resources and tools for physicians, especially those
20 more likely to encounter child, youth or young adult patients,
21 addressing effective suicide prevention, including screening tools,
22 methods to identify risk factors and acuity, safety planning, and
23 appropriate follow-up care including treatment and linkages to
24 appropriate counseling resources.

25 3. Our AMA supports collaboration with federal agencies, relevant
26 state and specialty societies, schools, public health agencies,
27 community organizations, and other stakeholders to enhance
28 awareness of the increase in child, youth and young adult suicide
29 and to promote protective factors, raise awareness of risk factors,
30 support evidence-based prevention strategies and interventions,
31 encourage awareness of community mental health resources, and
32 improve care for children, youth and young adults at risk of suicide.

33 4. Our AMA encourages efforts to provide children, youth and
34 young adults better and more equitable access to treatment and

- 1 care for depression, substance use disorder, and other disorders
2 that contribute to suicide risk.
- 3 5. Our AMA encourages continued research to better understand
4 suicide risk and effective prevention efforts in children, youth and
5 young adults, especially in higher risk sub-populations such as
6 those with a history of childhood trauma and adversity, Black,
7 LGBTQ+, Hispanic/Latinx, Indigenous/Native Alaskan youth and
8 young adult populations, and children in the welfare system.
- 9 6. Our AMA supports the development of novel technologies and
10 therapeutics, along with improved utilization of existing medications
11 to address acute suicidality and underlying risk factors in children,
12 youth and young adults.
- 13 7. Our AMA supports research to identify evidence-based universal
14 and targeted suicide prevention programs for implementation in
15 middle schools and high schools.
- 16 8. Our AMA will publicly call attention to the escalating crisis in
17 children, youth and young adult mental health in this country in the
18 wake of the Covid-19 pandemic.
- 19 9. Our AMA will advocate at the state and national level for policies
20 by young adults mental, emotional, and behavioral health.
- 21 10. Our AMA will advocate for comprehensive system of care
22 including prevention, management, and crisis care to address
23 mental and behavioral health needs for children, youth, and young
24 adults.
- 25 11. Our AMA will advocate for a comprehensive approach to the
26 youth, and young adult mental and behavioral health crisis when
27 such initiatives and opportunities are consistent with AMA policy.
- 28 12. Our AMA will recommend the use of the PHQ-9 in public
29 schools to identify those who may be impacted by Depression or
30 other mental illness.
- 31 13. Our AMA will provide access to a list of mental health providers
32 and/or ways to access regional mental health providers to public
33 schools, for recommended distribution by the school to any student
34 who tests positive on the PHQ-9.

Fiscal Note: TBD

Date Received: 03/31/2024

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RELEVANT [AMA POLICY](#)

Screening and Brief Interventions For Alcohol Problems H-30.942

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

Awareness, Diagnosis and Treatment of Depression and other Mental Illnesses H-345.984

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; Reaffirmed: Res. 425, A-22]

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 021
(A-24)

Introduced by: Nicholas Bohannon, University of Nebraska College of Medicine; Jared Buteau, University of South Carolina School of Medicine – Greenville; Brooke Taylor, University of South Carolina School of Medicine – Greenville; Amber Shirley, Lincoln Memorial University DeBusk COM – Harrogate; Sham Manoranjithan, University of Missouri - Columbia School of Medicine; Sherry Cheng, University of South Carolina School of Medicine Greenville; Kaye Dandrea, University of New England College of Osteopathic Medicine; Danielle Dircks, University of Nebraska College of Medicine; Wyatt Lanik, University of Nebraska College of Medicine; Keegan Schuchart, University of Nebraska College of Medicine

Subject: Support for Early Detection and Intervention of Juvenile Depression

Sponsored by: Region 2

Referred to: MSS Reference Committee
(Caitlin Blaukovitch and Shaminy Manoranjithan, Co-Chairs)

-
- 1 Whereas, emergency medicine-trained physicians are uniquely equipped to stabilize acutely ill
2 or injured patients regardless of age, gender, or etiology of their pathology¹; and
3
- 4 Whereas, in areas with an ample presence of emergency medicine-trained physicians, there are
5 improved outcomes in the treatment of many illnesses such as cardiac arrest, substance use
6 disorder, cerebrovascular events, geriatric care, psychiatric emergency care, and early
7 analgesia²; and
8
- 9 Whereas, physician-led care in emergency settings is associated with lower costs and better
10 outcomes compared to nurse practitioners, especially when dealing with complex patients^{3,4};
11 and
12
- 13 Whereas, physician-led care supported patient flow and safety within the emergency
14 department with early assessments, treatments, and investigations⁵; and
15
- 16 Whereas, physician-led team triage demonstrated numerous improvements in the efficiency and
17 quality of care in the emergency department⁶; and
18
- 19 Whereas, more than 80% of adult patients prefer to be treated by a physician as their ailment or
20 injury becomes more severe (i.e. chest pain, stroke, MVA)⁷; and
21
- 22 Whereas, nearly three-fourths of adults (72%) would be very or somewhat concerned if a
23 doctor/physician was unavailable to oversee their diagnosing and treatment in a medical
24 emergency⁸; and
25
- 26 Whereas, critical access hospitals (CAHs) are, by the Centers for Medicare & Medicaid Services
27 (CMS) certification requirements, hospitals greater than 35 miles from the next nearest hospital

1 with no more than 25 inpatient beds and are required to provide 24-hour emergency care 7 days
2 a week⁹; and

3
4 Whereas, despite CAHs being funded via a cost-based reimbursement from CMS, which is
5 often greater than standard CMS reimbursement rates for non-CAH facilities, CAHs have fewer
6 financial and human capital resources as compared to their suburban and urban counterparts¹⁰;
7 and

8
9 Whereas, roughly 92 percent of emergency medicine-trained physicians practice in urban areas,
10 with only 8% practicing in rural communities, down from 10% in 2008¹¹; and

11
12 Whereas, a U.S survey showed that 1,031 rural hospital CEOs reported that physician
13 specialists are lacking in rural settings with 75.4% of the rural CEOs reporting physician
14 shortages¹²; and

15
16 Whereas, emergency medical services coverage in rural regions is sparse, often due to higher
17 cost-per-transport per patient, causing increased patient mortality due to increased transport
18 times¹³; and

19
20 Whereas, rural hospital closures primarily stem from inadequate payments and
21 reimbursements, alongside patients' inability to afford treatment, as most affected hospitals
22 experienced substantial losses without sufficient alternative income sources¹⁴; and

23
24 Whereas, rural areas have lower population densities, causing rural hospitals to face challenges
25 in maintaining patient volumes, leading to difficulty covering fixed-operating costs and hindering
26 participation in performance measurement and quality improvement activities, as well as
27 strongly limiting potential involvement in innovative payment models¹⁵; and

28
29 Whereas, Medicare cuts substantially affect rural hospitals because they face lower
30 reimbursement rates from Medicare Advantage plans, which have increased enrollment in rural
31 areas by 48% between 2019 and 2023¹⁶; and

32
33 Whereas, Medicare Advantage plans offer less reimbursement than traditional Medicare,
34 compounded by the exclusion of certain revenue-generating services, leading to difficulties in
35 obtaining payment due to prior authorization requirements and contributing to existing financial
36 strains¹⁶; and

37
38 Whereas, from 2010 to 2020, the median cost per patient day at CAHs rose, on average, by
39 12% in comparison to just 5% at non-CAHs¹⁷; and

40
41 Whereas, CAHs had a higher average cost per patient day of \$6,140 compared to non-CAHs,
42 which had a mean cost per patient day of \$4,710¹⁷; and

43
44 Whereas, our American Medical Association (AMA) House of Delegates (HOD) referred
45 Resolution 207 for study at the Interim 2023 (I-23) meeting with a report due back at the Interim
46 2024 (I-24) meeting of HOD¹⁸; and

47
48 Whereas, resolution 207 proposes "...real-time, on-site presence of a physician, and on-site
49 supervision of non-physician practitioners... by a licensed physician with training and
50 experience in emergency medical care whose primary duty is dedicated to patients seeking
51 emergency medical care..."¹⁸; therefore be it

1 RESOLVED, that our AMA-MSS support access to emergency medical care led by Emergency
 2 Medicine-trained physicians, where possible, with appropriate exceptions for rural and critical
 3 access health systems where their employment is likely to further compromise the systems'
 4 financial viability; and be it further

5
 6 RESOLVED, that our AMA-MSS support physician-led emergency medical care with
 7 appropriate supervision for non-physician healthcare providers, which should include on-site or
 8 immediately available physician consultation.

Fiscal Note: TBD

Date Received: 03/31/2024

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RELEVANT [AMA POLICY](#)

AMA Support for States in Their Development of Legislation to Support Physician-Led, Team Based Care [D-35.982](#)

1. Our AMA will continue to assist states in opposing legislation that would allow for the independent practice of certified registered nurse practitioners; 2. Our AMA will assist state medical societies and specialty organizations that seek to enact legislation that would define the valued role of mid-level and other health care professionals within a physician-led team based model structured to efficiently deliver optimal quality patient care and to assure patient safety; 3. Our AMA will actively oppose health care teams that are not physician-led. [Res. 240, A-13, Reaffirmation A-15]

Rural Health [H-465.989](#)

It is the policy of the AMA that: (1) the AMA closely monitor the impact of balance billing restrictions mandated by the Budget Reconciliation legislation on reimbursement levels and access to care in rural areas, and take action as needed to moderate that impact; (2) the AMA closely monitor implementation of the legislation establishing essential access community hospitals and rural primary care hospitals, to ensure that this program is implemented in a manner conducive to high quality of patient care and consistent with Association policy concerning the functions and supervision of physician assistants and nurse practitioners; (3) state medical associations be encouraged to monitor similarly and to influence any legislation or regulations governing the development and operation of such limited service rural hospital facilities in their own jurisdictions; and (4) the AMA establish liaison with the American Hospital Association, Congress and the Centers for Medicare & Medicaid Services regarding any further development of essential access community hospitals and rural primary care hospitals grants. [CMS Rep. K, A-90, Modified: Sunset Report, I-00, Reaffirmed: BOT Rep. 6, A-10, Reaffirmed: CMS Rep. 3, A-15]

Access to Physician Services in Rural Health Clinics [H-465.984](#)

Our AMA strongly encourages CMS and appropriate state departments of health to review the Rural Health Clinic Program eligibility and certification requirements to ensure that independent (e.g., physician) and provider-based (e.g., hospital) facilities are certified as Rural Health Clinics only in those areas that truly do not have appropriate access to physician services. [Sub. Res. 717, I-91, Reaffirmed: Sunset Report, I-01, Reaffirmed: CMS Rep. 7, A-11, Reaffirmed: CMS Rep. 1, A-21]

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 022
(A-24)

Introduced by: Matthew Linz, Rutgers New Jersey Medical School; Rasa Valiauga, Loyola University of Chicago Stritch School of Medicine; Catriona Hong, Thea Anderson, University of Connecticut School of Medicine; Jara Alvarez, Indiana University School of Medicine; Chandana Kulkarni, Anne Marion Burnett School of Medicine (TCUSOM); Tucker Shelton, Medical University of South Carolina; Samantha Barr, University of Wisconsin School of Medicine & Public Health; Shaminy Manoranjithan, University of Missouri Columbia School of Medicine; Nicole Charland, David Geffen School of Medicine at UCLA; Wyatt Lanik, University of Nebraska College of Medicine

Subject: Opposition to Capital Punishment

Sponsored by: Region 2, Region 3, Region 4, Region 5, Region 6, Region 7, Asian Pacific American Medical Student Association (APAMSA)

Referred to: MSS Reference Committee
(Caitlin Blaukovitch and Shaminy Manoranjithan, Co-Chairs)

1 Whereas, the principle of medicine “to help and do no harm” is related to beneficence, which
2 speaks to the obligation of the physician to act for the benefit of the patient and remove
3 conditions that will cause harm, and nonmaleficence, which is concerned with weighing the
4 benefits and burdens of medical interventions and proceeding with the best choice for the
5 patient that minimizes harm and suffering;¹ and
6

7 Whereas, capital punishment is defined by the United States Bureau of Justice Statistics as “the
8 process of sentencing convicted offenders to death for the most serious crimes (capital crimes)
9 and carrying out that sentence” where the specific offenses are “defined by statute and are
10 prescribed by Congress or any state legislature”;² and
11

12 Whereas, forms of capital punishment used in the United States include electrocution, lethal
13 injection, and firing squad;^{3,4} and
14

15 Whereas, the number of people executed in the United States varies per year, with 24
16 individuals in 5 states (Texas, Oklahoma, Missouri, Alabama, and Florida) executed in 2023;^{2,5}
17 and
18

19 Whereas, capital punishment has life-preserving alternatives that are more cost-effective such
20 as life imprisonment without parole;⁶⁻¹⁰ and
21

22 Whereas, twenty-three states have abolished capital punishment and have not demonstrated
23 significant changes in crime rates or murders, challenging the argument that capital punishment
24 acts as an effective deterrent to serious crimes;¹¹⁻¹⁷ and
25

26 Whereas, in response to drug shortages, manufacturing changes, cost-related issues, and
27 manufacturer reluctance to sell drugs for execution, prisons have been introducing novel forms

1 of capital punishment including nitrogen hypoxia and midazolam administration in lieu of
2 phenobarbital in addition to procuring drugs for lethal injection from illegal and untraceable
3 sources;¹⁸⁻²⁰ and
4

5 Whereas, current methods of capital punishment used in the United States have been
6 associated with severe distress, in addition to the inherent harm caused by the act of capital
7 punishment itself;²¹⁻²³ and
8

9 Whereas, there have been hundreds of failed executions in the United States in the past
10 century, including several recent high-profile cases like Clayton Lockett, Joe Nathan James, Jr.,
11 Alan Eugene Miller, and Kenneth Eugene Smith, where errors prolonged the execution process
12 and further exacerbated the pain and distress of the prisoner;²⁴⁻²⁸ and
13

14 Whereas, nitrogen hypoxia is opposed as a use of euthanasia by the American Veterinary
15 Medical Association, as it is known to cause distress in nonhuman animals;²⁹ and
16

17 Whereas, the threshold for an acceptable amount of suffering in humans is widely considered to
18 be lower than for suffering in nonhuman animals;³⁰ and
19

20 Whereas, in 2018 the AMA filed an amicus curiae brief related to the Supreme Court case
21 *Bucklew v. Precythe* explicitly stating that it “opposes physician assistance in capital
22 punishment”;³¹ and
23

24 Whereas, the AMA Code of Medical Ethics Section 9.7.3 Capital Punishment states clearly that
25 physicians must not participate in any form of capital punishment and currently characterizes
26 physicians as “a profession dedicated to preserving life when there is hope of doing so”; and
27

28 Whereas, current AMA policy H-140.896 “Moratorium on Capital Punishment” states that our
29 AMA currently does not take a position on capital punishment, which contradicts the AMA Code
30 of Medical Ethics, given feasible, life-preserving alternatives to capital punishment such as life
31 imprisonment without parole; therefore be it
32

33 RESOLVED, that our American Medical Association oppose all forms of capital punishment.

Fiscal Note: TBD

Date Received: 03/31/2024

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RELEVANT [AMA POLICY](#)

H-140.896 Moratorium on Capital Punishment

Our AMA: (1) does not take a position on capital punishment; and (2) urges appropriate legislative and legal authorities to continue to implement changes in the system of administration of capital punishment, if used at all, and to promote its fair and impartial administration in accordance with basic requirements of

due process. [Sub. Res. 8, A-01; Reaffirmation A-04; Reaffirmation A-07; Reaffirmed: CEJA Rep. 04, A-17]

Code of Medical Ethics 9.7.3 Capital Punishment

Debate over capital punishment has occurred for centuries and remains a volatile social, political, and legal issue. An individual's opinion on capital punishment is the personal moral decision of the individual. However, as a member of a profession dedicated to preserving life when there is hope of doing so, a physician must not participate in a legally authorized execution.[...] Issued: 2016

H-140.950 Physician Participation in Capital Punishment

Evaluations of Prisoner Competence to be Executed; Treatment to Restore Competence to be Executed: Our AMA endorses the following: (1) Physician participation in evaluations of a prisoner's competence to be executed is ethical only when certain safeguards are in place. A physician can render a medical opinion regarding competency which should be merely one aspect of the information taken into account by the ultimate decision maker, a role that legally should be assumed by a judge or hearing officer. Prisoners' rights to due process at the competency hearings should be carefully observed.

(2) When a condemned prisoner has been declared incompetent to be executed, physicians should not treat the prisoner to restore competence unless a commutation order is issued before treatment begins.

(3) If the incompetent prisoner is undergoing extreme suffering as a result of psychosis or any other illness, medical intervention intended to mitigate the level of suffering is ethically permissible. It will not always be easy to distinguish these situations from treatment for the purpose of restoring the prisoner's competence, and in particular, to determine when treatment initiated to reduce suffering should be stopped. However, there is no alternative at this time other than to rely upon the treating physician to exercise judgment in deciding when and to what extent treatment is necessary to reduce extreme suffering. The cumulative experience of physicians applying these principles over time may lead to future refinements.

Treatment should be provided in a properly-secured, general medical or psychiatric facility, not in a cell block. The task of re-evaluating the prisoner's competence to be executed should be performed by an independent physician examiner.

(4) Given the ethical conflicts involved, no physician, even if employed by the state, should be compelled to participate in the process of establishing a prisoner's competence to be executed if such activity is contrary to the physician's personal beliefs. Similarly, physicians who would prefer not to be involved with treatment of an incompetent, condemned prisoner should be excused or permitted to transfer care of the prisoner to another physician. [CEJA Rep. 6, A-95; Reaffirmation A-04; Reaffirmed: CEJA Rep. 8, A-14; Reaffirmed in lieu of Res. 7, A-14; Reaffirmed in lieu of: CCB A-14]

H-430.978 Improving Care to Lower the Rate of Recidivism

Our American Medical Association will advocate and encourage (1) federal, state, and local legislators and officials to increase access to community mental health facilities, community drug rehabilitation facilities, appropriate clinical care, and social support services (e.g., housing, transportation, employment, etc.) to meet the needs of indigent, homeless, and released previously incarcerated persons; and (2) federal, state, and local legislators and officials to advocate prompt reinstatement in governmental medical programs and insurance for those being released from incarceration facilities. [Res. 244, A-23]

H-140.898 Medical Profession Opposition to Physician Participation in Execution

Our AMA strongly reaffirms its opposition to physician participation in execution. [Res. 10, A-02; Reaffirmation A-04; Reaffirmed: CEJA Rep. 8, A-14]

D-140.991 Continuing Efforts to Exclude Physicians from State Executions Protocols

Our AMA will remind all state medical societies to review their state execution statutes to ensure that physician participation is not required. [Res. 3, A-00Reaffirmed: CEJA Rep. 6, A-10Reaffirmed: CEJA Rep. 01, A-20]

H-140.963 Secrecy and Physician Participation in State Executions

The AMA opposes any and all attempts either in state laws or in rules and regulations that seek to enable or require physician participation in legal executions and/or which protect from disclosure the identity of

physicians participating or performing direct or ancillary functions in an execution. [Res. 6, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmation A-04; Reaffirmed: CEJA Rep. 8, A-14]

RELEVANT MSS POLICY

270.035MSS Opposition to Capital Punishment

AMA-MSS opposes all forms of capital punishment. (MSS Res 34, A-17) (Reaffirmed: MSS GC Report A, A-23)

440.120MSS Reducing Burden of Incarceration on Public Health

AMA-MSS will ask that our AMA (1) support efforts to reduce the negative health impacts of incarceration, such as (a) implementation and incentivization of adequate funding and resources towards indigent defense systems; (b) implementation of practices that promote access to stable employment and laws that ensure employment non-discrimination for workers with previous non-felony criminal records; (c) housing support for formerly incarcerated people, including programs that facilitate access to immediate housing after release from carceral settings; and (2) partner with the American Public Health Association and other stakeholders to urge Congress, the Department of Justice, and the Department of Health & Human Services to minimize the negative health effects of incarceration by supporting programs that facilitate employment and housing opportunities for formerly incarcerated individuals as well as research into alternatives to incarceration. (MSS COLA CGPH Rep A, A-22)

440.126MSS A Public Health-Centered Criminal Justice System

AMA-MSS will ask the AMA to support legislation that reduces the negative health impacts of incarceration by: 1. advocating for decreasing the magnitude of penalties, including the length of prison sentences, to create a criminal justice model focused on citizen safety and improved public health outcomes and rehabilitative practices rather than retribution, 2. advocating for legislation and regulations that reduce the number of people placed in prison conditions, such as preventing people who were formerly incarcerated from being sent back to prison without justifiable cause, and 3. supporting the continual review of sentences for people at various time points of their sentence to enable early release of people who are incarcerated but unlikely to pose a risk to society; and be it further and (1) recognize the inefficacy of mandatory minimums and three-strike rules and the negative consequences of resultant longer prison sentences to the health of incarcerated individuals, and (2) support legislation that reduces or eliminates mandatory minimums and three-strike rules. (MSS Res. 058, A-23)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 023
(A-24)

Introduced by: Priya Gupta, Aaron Kiel, Christian Tallo, Jessica MacIntyre, Stephanie Humen, University of Connecticut School of Medicine

Subject: Improving IPV Screening for People with Disabilities

Sponsored by: American Medical Women's Association Medical Student Division (AMWA MSD)

Referred to: MSS Reference Committee
(Caitlin Blaukovitch and Shaminy Manoranjithan, Co-Chairs)

1 Whereas, intimate partner violence (IPV) is defined as abuse or aggression by an intimate
2 partner, including physical and sexual violence, psychological aggression, emotional abuse, and
3 stalking^{1,2}; and
4

5 Whereas, people with disabilities experience many forms of IPV at higher rates than the general
6 population, with nearly double the lifetime risk of IPV^{3,4}; and
7

8 Whereas, it has been estimated that up to 54-80% of women with disabilities experienced IPV
9 with a lifetime prevalence between 26-90%²; and
10

11 Whereas, 21% of women with a disability experience psychological violence, 7% experience
12 physical violence, and about 7% experience some form of sexual violence²; and
13

14 Whereas, physician implicit bias leads to people with disabilities receiving inadequate
15 counseling and screenings related to sexual health, which may lead to a discrepancy in
16 screening for IPV⁵; and
17

18 Whereas, despite professional organizations recommending routine IPV screening, only 15% of
19 women with disabilities are asked by healthcare providers if they have experienced abuse⁴; and
20

21 Whereas, traditional IPV screening tools are only 80% as accurate at identifying IPV in people
22 with physical disabilities as disability-specific IPV screening tools, such as the Abuse
23 Assessment Screen-Disability (AAS-D)⁶; and
24

25 Whereas, proper screening of IPV in people with disabilities with disability-specific screening
26 tools such as the AAS-D could help improve identification, guide treatment, and allow for the
27 incorporation of trauma-informed care⁶; and
28

29 Whereas, studying recent IPV data, unique IPV-related issues faced by people with disabilities,
30 and currently available screening tools for IPV in people with disabilities may raise awareness
31 about the challenges faced by people with disabilities and guide efforts to better screen for and
32 address IPV in this population⁴; therefore be it
33

- 1 RESOLVED, that our American Medical Association study the prevalence of IPV in people with
 2 disabilities, currently available screening tools for IPV in people with disabilities, and the unique
 3 IPV-related issues faced by people with disabilities; and be it further
 4
- 5 RESOLVED, that our AMA promote research into the validation, development, and
 6 implementation of improved evidence-based IPV screening that addresses the specific forms of
 7 abuse faced by people with disabilities; and be it further
 8
- 9 RESOLVED, that our AMA support efforts to educate physicians regarding the importance of
 10 regular IPV screening for patients with disabilities using an evidence-based and validated
 11 disability-specific screening tool.

Fiscal Note: TBD

Date Received: 03/31/2024

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RELEVANT [AMA POLICY](#)

Family and Intimate Partner Violence H-515.965

(1) Our AMA believes that all forms of family and intimate partner violence (IPV) are major public health issues and urges the profession, both individually and collectively, to work with other interested parties to prevent such violence and to address the needs of survivors. Physicians have a major role in lessening the prevalence, scope and severity of child maltreatment, intimate partner violence, and elder abuse, all of which fall under the rubric of family violence. To support physicians in practice, our AMA will continue to campaign against family violence and remains open to working with all interested parties to address violence in US society. [...] (3) The prevalence of family violence is sufficiently high and its ongoing character is such that physicians, particularly physicians providing primary care, will encounter survivors on a regular basis. Persons in clinical settings are more likely to have experienced intimate partner and family violence than non-clinical populations. Thus, to improve clinical services as well as the public health, our AMA encourages physicians to: (a) Routinely inquire about the family violence histories of their patients as this knowledge is essential for effective diagnosis and care; [CSA Rep. 7, I-00; Reaffirmed: CSAPH Rep. 2, I-09; Modified: CSAPH Rep. 01, A-19]

Improving Screening and Treatment Guidelines for Intimate Partner Violence (IPV) Against Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and Other Individuals (LGBTQ) D-515.980

Our AMA will: 1. [...] (4) encourage research on intimate partner violence in the LGBTQ community to include studies on the prevalence, the accuracy of screening tools, effectiveness of early detection and interventions, as well as the benefits and harms of screening; and (5) encourage the dissemination of research to educate physicians and the community regarding the prevalence of IPV in the LGBTQ population, the accuracy of screening tools, effectiveness of early detection and interventions, as well as the benefits and harms of screening. (Modify HOD policy) 2. Our AMA encourages research on intimate partner violence in the LGBTQ community to include studies on the prevalence, the accuracy of screening tools, effectiveness of early detection and interventions, as well as the benefits and harms of screening. [Res. 903, I-17; Modified: CSAPH Rep. 01, I-18]

Medical Care of Persons with Disabilities H-90.968

1. Our AMA encourages: (a) clinicians to learn and appreciate variable presentations of complex functioning profiles in all persons with disabilities including but not limited to physical, sensory, developmental, intellectual, learning, and psychiatric disabilities and chronic illnesses; [...] (d) education of physicians on how to provide and/or advocate for developmentally appropriate and accessible medical, social and living support for patients with disabilities so as to improve health outcomes; [...] 3. Our AMA entreats health care professionals, parents, and others participating in decision-making to be guided by the following principles: [...] Our AMA advocates for the highest quality medical care for persons with profound disabilities; [CCB/CLRPD Rep. 3, A-14; Appended: Res. 306, A-14; Appended: Res. 315, A-17; Appended: Res. 304, A-18; Reaffirmed in lieu of the 1st Resolved: Res. 304, A-18; Modified: Res. 428, A-22]

RELEVANT [MSS POLICY](#)

Improving Screening and Treatment Guidelines for Domestic Violence Against Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and Other Individuals 65.023MSS

AMA-MSS (1) supports the promotion of crisis resources for LGBTQ+ patients that cater to the specific needs of LGBTQ+ victims of domestic violence; and (2) recognizes 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. (MSS Res. 10, A-17) (Amended: MSS GC Report A, A-23)

Expanding Access to Screening Tools for Social Determinants of Health 160.033MSS

AMA-MSS will ask that our AMA (1) provide access to evidence-based screening tools for evaluating and addressing social determinants of health in their physician resources; (2) support the continued integration of evidence-based screening tools evaluating social determinants of health into the electronic medical record and electronic health record; and (3) support fair compensation for the use of evidence-based social determinants of health screening tools and interventions in clinical settings. (MSS Res 03, I-16) (AMA Res 711, A-17 Referred) (Reaffirmed: MSS GC Report A, I-21)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 102
(A-24)

Introduced by: Alec Calac, UC San Diego School of Medicine, Linsey Golding, Kirk Kerkorian School of Medicine at UNLV, Lois Suh, Kirk Kerkorian School of Medicine at UNLV, Manasvi Khullar, Touro University California College of Osteopathic Medicine; Michael Shukis, University of Cincinnati College of Medicine; Anna Klunk, Philadelphia College of Osteopathic Medicine, Brianna Baldwin, University of Virginia School of Medicine, Muhammad Zulfiqar, University of Virginia; Hailey Baker, University of Minnesota Medical School; Jared Boyce, University of Wisconsin School of Medicine and Public Health

Subject: Radiation Exposure Compensation Coverage

Sponsored by: Region 2, Region 5, Region 6, Association of Native American Medical Students (ANAMS)

Referred to: MSS Reference Committee
(Caitlin Blaukovitch and Shaminy Manoranjithan, Co-Chairs)

1 Whereas, between 1945 and 1962, the United States conducted close to 200 atmospheric
2 nuclear weapons development tests requiring uranium mining and processing, involving the
3 efforts of tens of thousands of workers¹; and
4

5 Whereas, although nuclear testing and manufacturing was performed in supposedly remote
6 areas, many individuals lived in close proximity such as those who lived 12 miles downwind of
7 the Trinity test site or those who lived near open steel drums of radioactive waste in St. Louis,
8 Missouri²⁻³; and
9

10 Whereas, the adverse health effects from ionizing radiation exposure include cardiovascular
11 disease, thyroid cancer, and leukemia¹³, and children and fetuses exposed at the time are
12 particularly at risk⁴; and
13

14 Whereas, the 1945 Trinity Nuclear Test contaminated drinking water and food sources in the
15 surrounding areas, including milk products, beef, fruits, and vegetables along with contamination
16 occurring during nuclear waste disposal in other areas⁵⁻⁶; and
17

18 Whereas, after the conclusion of these activities, lawsuits were filed against the United States,
19 claiming a failure to warn about exposures to known radiation hazards, including contamination
20 of groundwater¹; and
21

22 Whereas, Congress passed the Radiation Exposure Compensation Act (“the Act” or “RECA”) in
23 1990 to provide monetary compensation to individuals who developed serious illnesses, such as
24 cancer, presumed to be a result of exposure to chronic radiation from atmospheric nuclear tests,
25 environmental contamination, or employment in the uranium processing and mining industries⁷⁻⁸;
26 and

1 Whereas, RECA originally only covered individuals who were downwind of the above-ground
2 testing done in Nevada and defined “affected areas” as certain counties and geographic regions
3 in the states of Nevada, Arizona, and Utah⁹; and
4

5 Whereas, RECA originally only covered uranium workers that worked at mines in Colorado, New
6 Mexico, Arizona, Wyoming, or Utah¹⁰; and
7

8 Whereas, there remain geographic areas, such as Colorado, Idaho, Missouri, Montana, Guam,
9 and certain parts of New Mexico including where the Trinity Test was performed, where
10 individuals affected by radiation exposure are not covered by RECA^{2,11}; and
11

12 Whereas, although the RECA Extension Act was approved by the president in June 2022,
13 establishing a deadline of June 2024 for claim submissions, limitations still persist within RECA,
14 most notably, the non-recognition of areas like the Tularosa Basin and downwind regions in New
15 Mexico, as well as other geographic areas like St. Louis, MO^{1,6,12-13}; and
16

17 Whereas, the legacy of nuclear weapons development continues to adversely impact members
18 of 24 federally-recognized tribal nations in the Southwest, who have either assisted with mining
19 or have had their groundwater contaminated with uranium and other heavy metals^{1,14-16}; and
20

21 Whereas, RECA’s downwind affected area covers land within multiple federally designated
22 American Indian reservations, including the Navajo, Hopi, and White Mountain Apache
23 reservations⁷; and
24

25 Whereas, over 54,000 RECA claims have been filed and approximately \$2.6 billion has been
26 awarded in connection with 40,258 approved claims through December 31, 2022, which reflects
27 only a 75 percent approval rate⁷; and
28

29 Whereas, as of December 31, 2022, the Program has received 7,704 claims from members of
30 tribal nations, representing 24 federally-recognized tribal nations and of those claims, 5,310
31 have been granted, totaling more than \$362.5 million in awards⁷; and
32

33 Whereas, RECA’s fiscal needs have yet to decrease with the estimated funds required for fiscal
34 year 2024 at \$80 million, an increase of \$30 million from FY2023⁷; and
35

36 Whereas, RECA is part of a large network of agencies that underscore the federal government’s
37 commitment to radiation compensation for affected individuals, such as the Veterans
38 administration (“VA”), The Nuclear Test Personnel Review (“NTPR”), The National Radiation
39 Exposure Screening and Education Program (“RESEP”), and The Energy Employees
40 Occupational Illness Compensation Program Act (“EEOICPA”)¹; and
41

42 Whereas, the United States Senate recently passed the Radiation Exposure Compensation
43 Reauthorization Act, which extends the period of claims filing and the geographic areas eligible
44 for compensation, shortly after these provisions were removed from the National Defense
45 Authorization Act, representing a timely moment AMA action¹⁷; therefore be it
46

47 RESOLVED, that our American Medical Association support continued authorization of federal
48 radiation exposure compensation programs and expanded program eligibility to downwind
49 individuals, communities, and tribes affected by the ongoing environmental harms of historic
50 atomic weapons testing, including, but not limited to, residents of areas affected by the test of

- 1 the first atomic bomb in New Mexico and uranium miners employed between 1942 through
2 1990.

Fiscal Note: TBD

Date Received: 03/31/2024

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RELEVANT AMA POLICY

Navajo Birth Cohort Study D-460.969

Our AMA recognizes the public health importance of the Navajo Birth Cohort Study for our Native American population and other populations exposed to uranium. [Res. 932, I-14]

Risks of Nuclear Energy and Low-Level Ionizing Radiation H-455.994

Our AMA supports the following policy on nuclear energy and low-level ionizing radiation: (1) Usefulness of Nuclear Energy: Energy produced by nuclear reactors makes an important contribution to the generation of electricity in the US at present, and it will continue to do so in the foreseeable future. Investigation and research should continue in order to develop improved safety and efficiency of nuclear reactors, and to explore the potential of competing methods for generating electricity. The research should include attention to occupational and public health hazards as well as to the environmental problems of

waste disposal and atmospheric pollution. [CSA Rep. A, A-81 Reaffirmed: CLRPD Rep. F, I-91 Reaffirmed: Sunset Report, I-01 Reaffirmed: CSAPH Rep. 1, A-11 Appended: CSAPH Rep. 4, A-13 Modified: CSAPH Rep. 8, A-23]

Environmental Protection and Safety in Federal Facilities H-135.985

The AMA urges physicians to contribute to the solution of environmental problems by serving as knowledgeable and concerned consultants to environmental, radiation, and public health protection agencies of state and local governments. [BOT Rep. T, I-87 Reaffirmed: Sunset Report, I-97 Reaffirmed: CSAPH Rep. 3, A-07 Reaffirmed: CSAPH Rep. 01, A-17]

Improving Health Care of American Indians H-350.976

Our AMA recommends that:(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 Reaffirmed: BOT Rep. 09, A-23]

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. [Res. 233, A-13 Appended: Res. 229, A-14 Appended: Res. 812, I-23]

RELEVANT MSS POLICY

Strongly Advocate for Federal Funding for Indian Health Services 270.026MSS

AMA-MSS (1) supports increased federal funding for Indian Health Service programs that directly influence medical student education opportunities; (2) supports AMA advocacy that all of the facilities that serve American Indian and Alaska Native populations under the Indian Health Service be adequately funded to fulfill their mission and their obligations to patients and providers; and (3) supports the AMA partnering with recognized American Indian health advocacy organizations like the National Indian Health Board, the National Congress of American Indians, and the Association of American Indian Physicians to advocate for increased funding for Indian Health Services in Congress.
(MSS Res 27, A-13) (Reaffirmed: MSS GC Rep A, I-19)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 105
(A-24)

Introduced by: Alec Calac, UC San Diego School of Medicine; Melody Brown-Clark, Northwestern University Feinberg School of Medicine; Michael Shukis, University of Cincinnati College of Medicine; Anna Klunk, Philadelphia College of Osteopathic Medicine; Annesha Datta, Rutgers Robert Wood Johnson Medical School; Donald Bourne, University of Pittsburgh School of Medicine

Subject: Native American Medical Debt

Sponsored by: Region 2, Region 4, Region 5, Region 6, Association of Native American Medical Students (ANAMS)

Referred to: MSS Reference Committee
(Caitlin Blaukovitch and Shaminy Manoranjithan, Co-Chairs)

1 Whereas, the Indian Health Service (IHS) operates a Purchased and Referred Care (PRC)
2 program to pay for health care services for American Indian and Alaska Native (AI/AN) patients
3 provided at non-IHS facilities¹; and
4

5 Whereas, limited PRC funding often results in payment requests for medically necessary
6 services being denied or deferred till the subsequent fiscal year, which leaves IHS patients to
7 pay out-of-pocket for healthcare services²; and
8

9 Whereas, management of the PRC program has resulted in bills and reimbursements either
10 going unpaid or being paid late, which, in many cases, results in IHS beneficiaries being
11 referred by private health providers to collection agencies or AI/AN beneficiaries paying PRC
12 bills out-of-pocket to avoid adverse impact on their credit²; and
13

14 Whereas, since 2016, IHS records show that it has declined to pay or reimburse medical bills for
15 more than 500,000 patients through PRC, saddling them with more than \$2 billion in active
16 medical debt²⁻³; and
17

18 Whereas, medical debt-related collection adversely impacts AI/AN patients' credit scores, which
19 results in higher interest rates for mortgages and consumer loans and, in some cases, the
20 inability to obtain credit or financing altogether⁴; and
21

22 Whereas, medical debt has been linked to increased financial vulnerability across multiple axes,
23 including increased likelihood of forgoing needed medical treatment due to cost, using high-risk
24 short-term loans, and facing costly financial penalties such as overdraft and late payment fees⁵;
25 and
26

27 Whereas, the 2018 National Financial Capability Study's survey data to examine household
28 medical debt and cost avoidance behaviors found that AI/AN patients are more likely to have
29 medical debt and skip filling prescriptions due to costs than their non-Hispanic White
30 counterparts⁶; and

1 Whereas, in 2018, Congress enacted into law, the Protecting Veterans Credit Act of 2017,
2 which amended the Fair Credit Reporting Act to, among other things, establish a process that
3 requires credit reporting agencies to remove information on veterans' credit reports that relates
4 to debts or collections activity for medical bills that should have been paid by the Department of
5 Veterans Affairs⁷; and
6

7 Whereas, unlike the process established for users of the Department of Veterans Affairs' health
8 system in the Protecting Veterans Credit Act of 2017, no comparable process exists for users of
9 the IHS system to require credit reporting agencies to remove debts or collections activity on
10 their credit reports for bills that the IHS should have but did not pay⁷⁻⁸; and
11

12 Whereas, in March 2024, U.S. Representative Dusty Johnson and Rep. Kim Schrier introduced
13 two bipartisan bills to hold the IHS accountable for disregarding health care bills owed to
14 physicians and to protect Native Americans' credit from wrongfully charged medical bills owed
15 by IHS through PRC claims⁸; and
16

17 Whereas, while the AMA supports the exclusion of medical debt that has been paid or fully
18 settled (H-373.996), this is different than the established protections for veterans and the
19 proposed protections for Native Americans with current IHS-related medical debts; therefore be
20 it
21

22 RESOLVED, that our American Medical Association support federal legislation requiring credit
23 reporting agencies to remove information on the credit reports of Indian Health Service (IHS)
24 beneficiaries that relate to debts or collections activities for medical services that should have
25 been paid by the IHS.

Fiscal Note: TBD

Date Received: 03/31/2024

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RELEVANT [AMA POLICY](#)

Indian Health Service H-350.977

The policy of the AMA is to support efforts in Congress to enable the Indian Health Service to meet its obligation to bring American Indian health up to the general population level. The AMA specifically

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

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

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

(4) Medical Societies: In those states where Indian Health Service facilities are located, and in counties containing or adjacent to Service facilities, that the appropriate medical societies should explore the possibility of increased formal liaison with local Indian Health Service physicians. Increased support from organized medicine for improvement of health care provided under their direction, including professional consultation and involvement in society activities should be pursued.

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

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

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

RELEVANT MSS POLICY

270.026MSS Strongly Advocate for Federal Funding for Indian Health Services

AMA-MSS (1) supports increased federal funding for Indian Health Service programs that directly influence medical student education opportunities; (2) supports AMA advocacy that all of the facilities that serve American Indian and Alaska Native populations under the Indian Health Service be adequately funded to fulfill their mission and their obligations to patients and providers; and (3) supports the AMA partnering with recognized American Indian health advocacy organizations like the National Indian Health Board, the National Congress of American Indians, and the Association of American Indian Physicians to advocate for increased funding for Indian Health Services in Congress. (MSS Res 27, A-13) (Reaffirmed: MSS GC Rep A, I-19)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 108
(A-24)

Introduced by: Ryan Englander, University of Connecticut School of Medicine; Justin Magrath, Tulane University School of Medicine; Nicholas Wilson, Morehouse School of Medicine; Austin Eason, University of Florida College of Medicine; Jara Alvarez-Del-Pino, Indiana University School of Medicine; Jared Boyce, University of Wisconsin School of Medicine and Public Health; Vignesh Senthilkumar, University of Virginia School of Medicine

Subject: ACA Subsidies for Undocumented Immigrants

Sponsored by: Region 2, Region 3, Region 4, Region 5, Region 6, Region 7

Referred to: MSS Reference Committee
(Caitlin Blaukovitch and Shaminy Manoranjithan, Co-Chairs)

1 Whereas, the uninsurance rate among undocumented immigrants is approximately 50%
2 compared to 7.7% for US residents, meaning that approximately 5 million undocumented
3 immigrants are uninsured in the United States^{1,2}; and
4

5 Whereas, this high uninsurance rate leads to reduced access to care, an increased likelihood of
6 foregoing necessary medical care due to cost, and poorer health outcomes¹⁻⁵; and
7

8 Whereas, expanding health insurance coverage to undocumented immigrants improves access
9 to care and health outcomes^{6,7}; and
10

11 Whereas, undocumented immigrants may file federal taxes through the use of an Individual
12 Taxpayer Identification Number (ITIN), which is a tax processing number issued by the IRS to
13 individuals who owe federal taxes (ex., payroll taxes) but are not eligible for a Social Security
14 Number, meaning that undocumented immigrants collectively pay billions into the tax system^{8,9};
15 and
16

17 Whereas, because the incomes of many undocumented immigrants are reported to the federal
18 government through ITIN's, undocumented immigrants may be ineligible for means-tested
19 insurance programs like Medicaid based on their income, even if their state permits
20 undocumented immigrants to enroll in Medicaid^{1,10,11}; and
21

22 Whereas, undocumented immigrants are currently prohibited from purchasing insurance
23 through the Affordable Care Act (ACA) marketplaces¹²; and
24

25 Whereas, AMA Policy H-165.823, "Options to Maximize Coverage under the AMA Proposal for
26 Reform", states that our AMA "supports extending eligibility to purchase Affordable Care Act
27 (ACA) marketplace coverage to undocumented immigrants and Deferred Action for Childhood
28 Arrivals (DACA) recipients" but does not support extending access to premium tax credits and
29 and cost-sharing reductions to these populations, and does not address state-based programs
30 to provide coverage options for undocumented immigrants; and
31

1 Whereas, insurance plans on the ACA marketplaces are unaffordable for most individuals in the
2 absence of premium tax credit and cost-sharing reduction subsidies¹³⁻¹⁵; and

3
4 Whereas, in order to fully realize the benefits of extending eligibility to purchase plans on the
5 ACA marketplaces, undocumented immigrants would also need to be made eligible to receive
6 premium tax credits and cost-sharing reductions, but are currently prohibited from receiving
7 these subsidies¹²; and

8
9 Whereas, states including Colorado and Washington have implemented programs to provide
10 state subsidies for undocumented immigrants to purchase health insurance on state exchanges,
11 leading to 11,000 immigrants enrolling in subsidized coverage in Colorado in 2024¹⁸; and

12
13 Whereas, pending legislation in states and in Congress would expand ACA premium tax credit
14 and cost sharing reduction eligibility to undocumented immigrants in addition to allowing them to
15 purchase coverage through the ACA marketplaces^{19,20}; and

16
17 Whereas, the AMA “advocates for the removal of eligibility criteria based on immigration status
18 from Medicaid and CHIP” (D-440.911) and should similarly support removing this criteria for
19 premium tax credits and cost-sharing reductions; therefore be it

20
21 **RESOLVED**, that our American Medical Association support providing subsidies for
22 undocumented immigrants to purchase health insurance, including by extending eligibility
23 for premium tax credits and cost-sharing reductions on the Affordable Care Act (ACA)
24 marketplaces.

Fiscal Note: TBD

Date Received: 03/31/2024

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RELEVANT AMA POLICY

Options to Maximize Coverage under the AMA Proposal for Reform H-165.823

1. That our AMA advocate for a pluralistic health care system, which may include a public option, that focuses on increasing equity and access, is cost-conscious, and reduces burden on physicians.
2. Our AMA will advocate that any public option to expand health insurance coverage must meet the following standards:
 - a. The primary goals of establishing a public option are to maximize patient choice of health plan and maximize health plan marketplace competition.
 - b. Eligibility for premium tax credit and cost-sharing assistance to purchase the public option is restricted to individuals without access to affordable employer-sponsored coverage that meets standards for minimum value of benefits.
 - c. Physician payments under the public option are established through meaningful negotiations and contracts. Physician payments under the public option must be higher than prevailing Medicare rates and at rates sufficient to sustain the costs of medical practice.
 - d. Physicians have the freedom to choose whether to participate in the public option. Public option proposals should not require provider participation and/or tie physician participation in Medicare, Medicaid and/or any commercial product to participation in the public option.
 - e. The public option is financially self-sustaining and has uniform solvency requirements.
 - f. The public option does not receive advantageous government subsidies in comparison to those provided to other health plans.
 - g. The public option shall be made available to uninsured individuals who fall into the “coverage gap” in states that do not expand Medicaid – having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credits – at no or nominal cost.
3. Our AMA supports states and/or the federal government pursuing auto-enrollment in health insurance coverage that meets the following standards:
 - a. Individuals must provide consent to the applicable state and/or federal entities to share their health insurance status and tax data with the entity with the authority to make coverage determinations.
 - b. Individuals should only be auto-enrolled in health insurance coverage if they are eligible for coverage options that would be of no cost to them after the application of any subsidies. Candidates for auto-enrollment would, therefore, include individuals eligible for Medicaid/Children’s Health Insurance Program (CHIP) or zero-premium marketplace coverage.
 - c. Individuals should have the opportunity to opt out from health insurance coverage into which they are auto-enrolled.
 - d. Individuals should not be penalized if they are auto-enrolled into coverage for which they are not eligible or remain uninsured despite believing they were enrolled in health insurance coverage via auto-enrollment.
 - e. Individuals eligible for zero-premium marketplace coverage should be randomly assigned among the zero-premium plans with the highest actuarial values.

f. Health plans should be incentivized to offer pre-deductible coverage including physician services in their bronze and silver plans, to maximize the value of zero-premium plans to plan enrollees.

g. Individuals enrolled in a zero-premium bronze plan who are eligible for cost-sharing reductions should be notified of the cost-sharing advantages of enrolling in silver plans.

h. There should be targeted outreach and streamlined enrollment mechanisms promoting health insurance enrollment, which could include raising awareness of the availability of premium tax credits and cost-sharing reductions, and establishing a special enrollment period.

4. Our AMA: (a) will advocate that any federal approach to cover uninsured individuals who fall into the "coverage gap" in states that do not expand Medicaid--having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credit eligibility--make health insurance coverage available to uninsured individuals who fall into the coverage gap at no or nominal cost, with significant cost-sharing protections; (b) will advocate that any federal approach to cover uninsured individuals who fall into the coverage gap provide states that have already implemented Medicaid expansions with additional incentives to maintain their expansions; (c) supports extending eligibility to purchase Affordable Care Act (ACA) marketplace coverage to undocumented immigrants and Deferred Action for Childhood Arrivals (DACA) recipients, with the guarantee that health plans and ACA marketplaces will not collect and/or report data regarding enrollee immigration status; and (d) recognizes the potential for state and local initiatives to provide coverage to immigrants without regard to immigration status. [CMS Rep. 1, I-20; Appended: CMS Rep. 3, I-21; Reaffirmation: A-22; Reaffirmed: CMS Rep. 3, A-22; Reaffirmed: Res. 122, A-22; Modified: Res. 813, I-22]

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 109
(A-24)

Introduced by: Alec Calac, UC San Diego School of Medicine, Brianna Irons, UC San Diego School of Medicine; Hailey Baker, University of Minnesota Medical School; Anna Klunk, Philadelphia College of Osteopathic Medicine, Olivia Spaulding, Howard University College of Medicine

Subject: Tribal Dialysis Access

Sponsored by: Region 2, Region 4, Association of Native American Medical Students (ANAMS)

Referred to: MSS Reference Committee
(TBA, Chair)

1 Whereas, as of 2021, the incidence and prevalence of end-stage renal failure remains higher
2 among American Indian and Alaska Native (AI/AN) communities relative to the non-Hispanic
3 white population¹; and
4
5 Whereas, compared to other racial and ethnic groups, AI/AN end-stage renal disease patients
6 had the lowest percentage with a kidney transplant (19.4%) and the highest percentage
7 receiving in-center hemodialysis (71.1%)¹; and
8
9 Whereas, in response to a 2011 Congressional inquiry, the Department of Health and Human
10 Services Office of Inspector General (HHS-OIG) found that less than five percent of Indian
11 Health Service (IHS) and Tribal Health Programs (20 of 506) offered on-site HD services³; and
12
13 Whereas, the HHS-OIG concluded its 2011 Congressional inquiry by asking the IHS to offer a
14 plan, agency expertise and technical assistance, and funding opportunities to assist Tribes in
15 expanding local dialysis services, which has yet to be acted on³; and
16
17 Whereas, in 2022, the Centers for Medicare and Medicaid Services reported that only five IHS
18 and Tribal Health Programs were certified as dialysis centers, a 75% decrease in just over a
19 decade⁴; and
20
21 Whereas, rural areas, including AI/AN reservations, face significant disparities in dialysis care
22 compared to urban areas due to limited access to dialysis facilities, longer travel distances, and
23 a shortage of physician specialists and allied healthcare professionals^{3,5}; and
24
25 Whereas, a 2023 study reported that from 2001 to 2015, the odds of a more than 10-mile
26 increase in one-way travel distance to a dialysis center were four-fold higher in small-town areas
27 and five-fold higher in rural areas relative to metropolitan areas⁶; and
28
29 Whereas, distance and the need for transportation to dialysis are known barriers that impact
30 adherence to dialysis that can lead to missed appointments and unnecessary
31 hospitalizations^{7,8,9}; and
32

1 Whereas, researchers have identified that relationality, having family and community close by, is
2 positively impacts AI/AN patients in need of dialysis care, rather than spending significant time
3 away from their communities in non-IHS facilities¹⁰; and
4

5 Whereas, innovative solutions to improve local dialysis access, such as mobile unit dialysis,
6 have proven benefits including improving social and emotional well-being for Indigenous
7 patients who have otherwise suffered from being separated from their families and required
8 relocation to access dialysis care^{11,12}; and
9

10 Whereas, strategies to address physician and allied health professions shortages among
11 healthcare facilities, including dialysis facilities in rural areas and reservations, include reform of
12 loan repayment programs, such as the IHS loan repayment program in which qualified
13 healthcare professionals can receive up to \$50,000 for educational loans in exchange for a two-
14 year service commitment to IHS^{13,14}; and
15

16 Whereas, a bipartisan group of legislators is seeking to reform the IHS loan repayment program
17 to allow also allow part-time, rather than full-time service at IHS facilities (mirroring service
18 commitments for the National Health Service Corps loan repayment program), creating greater
19 flexibility for prospective physicians^{15,16}; and
20

21 Whereas, Medicare and Medicaid are important sources of third-party revenue for IHS facilities,
22 allowing for Tribes and the IHS to stretch limited fiscal resources^{17,18,19,20}; and
23

24 Whereas, Tribal elders and those with chronic ailments often face difficulty enrolling in public
25 programs like Medicare, citing difficulties with technology and poor health literacy^{21,22,23}; and
26

27 Whereas, Insurance and general health system navigator programs have demonstrated great
28 outcomes and cost-effectiveness in enrolling patients in programs like Medicare and Medicaid,
29 which can offset a significant amount of dialysis-related costs to IHS and Tribal Health
30 Programs²⁴; and
31

32 Whereas, The U.S. Centers for Medicare and Medicaid Services does not assist the IHS and
33 Tribal Health Programs to enroll patients in public insurance options despite funding navigator
34 programs in state partnership marketplaces^{25,26}; therefore be it
35

36 RESOLVED, that our American Medical Association ask the Indian Health Service to offer a
37 plan, agency expertise and technical assistance, and health-facilities funding to assist Tribes in
38 expanding local dialysis services; and be it further
39

40 RESOLVED, that our AMA support reform of the IHS Loan Repayment Program to be eligible
41 for repayment with a part-time, rather than full-time employment commitment to IHS and Tribal
42 Health Programs; and be it further
43

44 RESOLVED, that our AMA support a nationwide AI/AN Medicare and Medicaid enrollment
45 campaign coordinated by CMS and the IHS that funds insurance navigator programs at Tribal
46 Health Programs.

Fiscal Note: TBD

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RELEVANT AMA POLICY

Improving Rural Health H-465.994

1. Our AMA (a) supports continued and intensified efforts to develop and implement proposals for improving rural health care and public health, (b) urges physicians practicing in rural areas to be actively involved in these efforts, and (c) advocates widely publicizing AMA's policies and proposals for improving rural health care and public health to the profession, other concerned groups, and the public.

2. Our AMA will work with other entities and organizations interested in public health to:

- Encourage more research to identify the unique needs and models for delivering public health and health care services in rural communities.
- Identify and disseminate concrete examples of administrative leadership and funding structures that support and optimize local, community-based rural public health.
- Develop an actionable advocacy plan to positively impact local, community-based rural public health including but not limited to the development of rural public health networks, training of current and future rural physicians and public health professionals in core public health techniques and novel funding mechanisms to support public health initiatives that are led and managed by local public health authorities.
- Advocate for adequate and sustained funding for public health staffing and programs.

[Sub. Res. 72, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CEJA Rep. 06, A-18; Appended: Res. 433, A-19; Modified: CSAPH Rep. 2, A-22; Reaffirmed: CMS Rep. 09, A-23; Reaffirmed: Res. 724, A-23]

Indian Health Service H-350.977

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

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

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

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

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

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

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

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

Patient Navigation Programs H-373.994

1. Our AMA recognizes the increasing use of patient navigator and patient advocacy services to help improve access to care and help patients manage complex aspects of the health care system. In order to ensure that patient navigator services enhance the delivery of high-quality patient care, our AMA supports the following guidelines for patient navigator programs:

a) The primary role of a patient navigator should be to foster patient empowerment, and to provide patients with information that enhances their ability to make appropriate health care choices and to receive medical care with an enhanced sense of confidence about risks, benefits, and responsibilities.

b) Patient navigator programs should establish procedures to ensure direct communication between the navigator and the patient's medical team.

c) Patient navigators should refrain from any activity that could be construed as clinical in nature, including interpreting test results or medical symptoms, offering second opinions, or making treatment recommendations. Patient navigators should provide a supportive role for patients and, when necessary, help them understand medical information provided by physicians and other members of their medical care team.

d) Patient navigators should fully disclose relevant training, experience, and credentials, in order to help patients understand the scope of services the navigator is qualified to provide.

e) Patient navigators should fully disclose potential conflicts of interest to those whom they serve, including employment arrangements.

2. Our AMA will work with the American College of Surgeons and other entities and organizations to ensure that patient navigators are free of bias, do not have any role in directing referrals, do not usurp the physician's role in and responsibility for patient education or treatment planning, and act under the direction of the physician or physicians primarily responsible for each patient's care.

3. Policy provisions for patient navigators are also relevant for community health workers and other non-clinical public health workers. [CMS Rep. 7, I-11; Appended: CMS Rep. 7, I-15]

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 115
(A-24)

Introduced by: Austin Eason, University of Florida, College of Medicine; Justin Magrath,
Tulane School of Medicine; Bo Peng, Mayank Kotadia, Patrick Haley,
University of Florida, College of Medicine

Subject: Corrections to The Medicare Part C Payment Structure

Sponsored by: Region 3, Region 4

Referred to: MSS Reference Committee
(Caitlin Blaukovitch and Shaminy Manoranjithan, Co-Chairs)

1 Whereas, Medicare Part C, also known as Medicare Advantage, provides the benefits of
2 Medicare parts A and B, and potentially additional benefits, through a private insurance
3 company; and
4

5 Whereas, the number of Medicare patients on a Part C plan has increased from 11 million in
6 2010 to 31 million in 2023, now accounting for more than half of all Medicare beneficiaries¹; and
7

8 Whereas, Medicare Part C has a myriad of problems including smaller networks, increased prior
9 authorization, and lower physician compensation than Traditional Medicare²⁻⁶; and
10

11 Whereas, one proposed benefit of Medicare Part C is that it could ideally utilize market
12 competition to reduce costs, however, Medicare Part C has never spent less than Traditional
13 Medicare including spending 109% of Traditional Medicare per patient in 2023⁷; and
14

15 Whereas, these unrealized cost savings reflect problems in the Medicare Part C payment
16 structure, which consists of three primary components: risk adjustment, benchmarks and
17 bidding, and quality bonuses¹³; and
18

19 Whereas, due to the increased payment rate received for sicker patients, insurance companies
20 are incentivized to give Medicare Part C patients more diagnoses, leading the average risk
21 score given to patients in a Medicare Part C plan to be nearly 16.2% higher than if those
22 patients were to be enrolled in Traditional Medicare, with the gap increasing annually⁸; and
23

24 Whereas, recognizing this discrepancy in risk scores between patients on Medicare Part C and
25 Traditional Medicare, Congress passed a statutory coding risk adjustment of 5.9% that reduces
26 the risk score given to patients under Medicare Part C in an attempt to correct the resulting
27 overpayments⁹; and
28

29 Whereas, the risk score adjustment fails to correct the underlying problem with the Medicare
30 Part C payment structure and creates inequity between Medicare Part C plans which code less
31 intensely than others, which results in punishing those plans whose coding patterns are more
32 similar to traditional Medicare; and
33

1 Whereas, the Medicare Payment Advisory Commission (MedPAC) has made several
2 recommendations on how to correct issues regarding overpayment to Medicare Part C plans¹²;
3 and
4

5 Whereas, one MedPAC recommendation is to use two years of diagnostic data instead of one
6 when determining a risk adjustment model and payment for both Medicare Part C and
7 Traditional Medicare¹²; and
8

9 Whereas, another strategy to reduce risk adjustment based overpayments is to prevent
10 diagnoses identified from a chart review or health risk assessment from being included in this
11 score as proposed by the No UPCODE Act¹⁰; and
12

13 Whereas, a proposed adjustment is for the differences in coding patterns between Medicare
14 Part C plans to be evaluated and publicly published by the CMS to promote transparency of fair
15 and adequate risk adjustment which include adjustment on the level of individual contracts as
16 phrased in the No UPCODE Act¹⁰; and
17

18 Whereas, benchmark payment rates are set based on the amount spent on patients in
19 Traditional Medicare within that area, with the benchmark for areas with the lowest spending is
20 set at 115% of Traditional Medicare¹³; and
21

22 Whereas, this high benchmark rate in low spending areas leads to overpayment of Medicare
23 Part C plans and prevents cost savings¹³; and
24

25 Whereas, MedPAC believes “a better Medicare Part C benchmark policy would rebalance
26 benchmarks by allowing the Medicare program to capture some MA efficiencies” and has
27 proposed specific recommendations to accomplish this goal including altering benchmarks to
28 include data from both national and local fee for service payments while eliminating the current
29 quartile system¹¹; and
30

31 Whereas, quality bonuses are given to Medicare Part C plans according to a star-rating system
32 that is based off of 46 different factors which include measures related to clinical outcomes,
33 patient experience, and administrative performance¹¹; and
34

35 Whereas, Medicare Part C plans may rate highly but still have average clinical outcomes which
36 reflects the high propensity of administrative performance measures when determining a plans
37 rating¹¹; and
38

39 Whereas, the current star-rating system for distributing quality bonuses to programs does not
40 reflect the extent of network coverage, inappropriate denials of care related to prior-
41 authorizations, or account for geographic differences in care within a plan, especially for
42 individual plans whose star-rating does not reflect wide variations in quality of care¹³; and
43

44 Whereas, Medicare Part C Quality Bonus Program increases the cost of Medicare Part C
45 without improving clinical outcomes, with an estimated cost of \$94 billion over 10 years¹²; and
46

47 Whereas, in contrast to the Quality Bonus Program, quality incentive programs under Traditional
48 Medicare are generally budget neutral¹²; and
49

1 Whereas, MedPAC has established a framework for reform of the Quality Bonus Program that
 2 eliminates the focus on administrative measures and takes into account differences in social risk
 3 factors¹²; and
 4

5 Whereas, AMA Policy H-175.981 details a commitment to “eradicate true fraud and abuse from
 6 within the Medicare system”; and
 7

8 Whereas, our AMA has recognized problems with the current Medicare Part C payment
 9 structure leading to its support of “a competitive bidding process to determine federal payments
 10 to Medicare Advantage plans” (H-330.886) and similarly should support other reforms that could
 11 correct the problematic incentives of Medicare Part C; therefore be it
 12

13 RESOLVED, that our AMA-MSS support efforts to strengthen and protect Traditional Medicare;
 14 and be it further
 15

16 RESOLVED, that our AMA-MSS support policies that reduce or eliminate overpayment of
 17 insurance companies under Medicare Part C including, but not limited to:

- 18 (1) Reforming risk adjustment models to use multiple years of diagnostic data as it pertains
 19 to assigning patients risk scores and/or determining payments granted to Medicare Part
 20 C plans;
- 21 (2) Altering the methodology for determining what diagnoses qualify for risk-adjustment to
 22 make it comparable between Medicare Part C and Traditional Medicare;
- 23 (3) Publicly reporting coding pattern differences between Medicare Part C plans and
 24 Traditional Medicare including subsequent contract-level risk adjustments;
- 25 (4) Reforming the benchmark payment rate system to reduce overall payment rates to
 26 insurers;
- 27 (5) Reforming the Quality Bonus Payment program to operate in a budget-neutral manner
 28 and concentrate on clinically important outcomes.

Fiscal Note: TBD

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RELEVANT AMA POLICY

Improving Risk Adjustment in Alternative Payment Models H-385.907

Our AMA supports: (1) risk stratification systems that use fair and accurate payments based on patient characteristics, including socioeconomic factors, and the treatment that would be expected to result in the need for more services or increase the risk of complications; (2) risk adjustment systems that use fair and accurate outlier payments if spending on an individual patient exceeds a pre-defined threshold or individual stop loss insurance at the insurer's cost; (3) risk adjustment systems that use risk corridors that use fair and accurate payment if spending on all patients exceeds a pre-defined percentage above the payments or support aggregate stop loss insurance at the insurer's cost; (4) risk adjustment systems that use fair and accurate payments for external price changes beyond the physician's control; [CMS Rep. 03, I-19; Reaffirmed: CMS Rep. 2, A-22; Reaffirmed: CMS Rep. 04, A-23; Reaffirmation: A-23]

Hierarchical Condition Category Coding D-160.928

Our AMA will continue to work with the Centers for Medicare and Medicaid Services to refine risk adjustment in all alternative payment models and Medicare Advantage plans, particularly to revise risk-adjustment processes, to allow hierarchical condition category (HCC) codes to automatically follow the beneficiary from year-to-year to reflect chronic conditions that will never change. [Res. 112, A-16]

Health Insurance Coverage of High-Risk Patients H-165.842

Our AMA: (1) supports the principle that health insurance coverage of high-risk patients be subsidized through direct risk-based subsidies such as high-risk pools, risk adjustment, and reinsurance, rather than through indirect methods that rely heavily on market regulation; (2) supports state-based demonstration projects to subsidize coverage of high-risk patients through mechanisms such as high-risk pools, risk adjustment, reinsurance, and other risk-based subsidies; (3) prefers reinsurance as a cost-effective and equitable mechanism to subsidize the costs of high-cost and high-risk patients; and (4) supports the establishment of a permanent federal reinsurance program. [CMS Rep. 2, I-07; Reaffirmed: CMS Rep. 9, A-11; Reaffirmed: CMS Rep. 9, A-14; Appended: CMS Rep. 04, I-17; Appended: CMS Rep. 02, A-18; Reaffirmed: CMS Rep. 02, A-19]

Risk Adjustment Refinement in ACO Settings and Medicare Shared Savings Programs D-160.927

Our AMA will continue seeking the even application of risk-adjustment in ACO settings to allow Hierarchical Condition Category risk scores to increase year-over-year within an agreement period for the continuously assigned Medicare Shared Savings Program beneficiaries. [Res. 114, A-16; Modified: Speakers Rep., A-18]

Physician Payment Reform H-390.849

3. Our AMA supports payment methodologies that redistribute Medicare payments among providers based on outcomes (including functional improvements, if appropriate), quality and risk-adjustment measures only if measures are scientifically valid, reliable, and consistent with national medical specialty society- developed clinical guidelines/standards. [CMS Rep. 6, A-09; Reaffirmation A-10; Appended: Res. 829, I-10; Appended: CMS Rep. 1, A-11; Appended: CMS Rep. 4, A-11; Reaffirmed in lieu of Res. 119, A-12; Reaffirmed in lieu of Res. 122, A-12; Modified: CMS Rep. 6, A-13; Reaffirmation I-15; Reaffirmation: A-16; Reaffirmed in lieu of: Res. 712, A-17; Reaffirmed: BOT Action in response to referred for decision:

Res. 237, I-17; Reaffirmation: A-19; Reaffirmed: BOT Action in response to referred for decision Res. 111, A-19]

Elimination of Subsidies to Medicare Advantage Plans D-390.967

1. Our AMA will seek to have all subsidies to private plans offering alternative coverage to Medicare beneficiaries eliminated, that these private Medicare plans compete with traditional Medicare fee-for-service plans on a financially neutral basis and have accountability to the Centers for Medicare and Medicaid Services. [Res. 229, A-07; Modified: CMS Rep. 01, A-17]

Strengthening Medicare Through Competitive Bidding H-330.886

2. Our AMA supports using a competitive bidding process to determine federal payments to Medicare Advantage plans. [CMS Rep. 7, I-13; Reaffirmed: CMS Rep. 01, A-23; Reaffirmed: Res. 216, I-23]

Saving Traditional Medicare H-390.832

1. Our American Medical Association will continue its efforts to fix the flawed Medicare payment system for physicians recognizing that Traditional Medicare is a critical healthcare program while educating the public on the benefits and threats of Medicare Part C expansion.

2. Our AMA will continue to address the funding challenges facing Traditional Medicare through legislative reform and policy changes, while at the same time advocating for sustainable, inflation-adjusted reimbursement to clinicians.

3. Our AMA acknowledges that the term "Medicare Advantage" can be misleading, as it implies a superiority or enhanced value over traditional Medicare, which may not accurately reflect the nature and challenges of these plans. [Res. 216, I-23]

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 203
(A-24)

Introduced by: Areesheh Khan University of Virginia, Maya Muldowney University of Wisconsin, Shalvi Patel University of Virginia, Ishaan Rischie University of Virginia, Muhammad Zulfiqar University of Virginia, Marcus Bennett University of Louisville

Subject: Access to Healthcare for Transgender and Gender Diverse Incarcerated People

Sponsored by: Region 2

Referred to: MSS Reference Committee
(Caitlin Blaukovitch and Shaminy Manoranjithan, Co-Chairs)

1 Whereas, Transgender and Gender Diverse (TGD) people experience higher rates of suicide
2 attempts and substance use than cisgender people;¹ and
3
4 Whereas, among TGD adults, 44% reported recent suicidal ideation, 7% reported a recent
5 suicide attempt, and 21% reported recent non-suicidal self-injury;² and
6
7 Whereas, an increase in access to gender-affirming care has been shown to increase quality of
8 life and decreased rates of self-harm, including 44% lower odds of suicidality in TGD adults;³
9 and
10
11 Whereas, gender-affirming hormones are most often the first or only gender-affirming care TGD
12 patients will seek out and have shown to significantly improve psychological functioning,
13 decrease gender dysphoria, and reduce suicide ideation;⁴ and
14
15 Whereas, a study of almost 30,000 participants showed TGD people with a history of gender-
16 affirming surgery had significantly lower odds of past-month psychological distress, past-year
17 tobacco smoking, and past-year suicidal ideation compared with TGD people with no history of
18 gender-affirming surgery;³ and
19
20 Whereas, studies have shown nearly 20% of TGD individuals report being denied medical care
21 in their community due to their gender identity and that a quarter of TGD incarcerated
22 individuals report being denied access to healthcare during imprisonment;⁵ and
23
24 Whereas, over 6,000 adults incarcerated in prisons in the United States identify as transgender
25 and gender diverse (TGD) and over 7,300 detained juveniles identify as part of the LGBTQ+
26 community;⁶ and
27
28 Whereas, a 2022 survey of LGBTQ+ people in the United States showed that 31 percent had
29 been in some form of incarceration within the last five years;⁷ and
30

1 Whereas, access to healthcare for people who are incarcerated continues to be inadequate,
2 with more than 20% of incarcerated people with a persistent medical condition going without
3 care in state facilities;⁸ and
4

5 Whereas, a systematic review found TGD incarcerated people often felt the inability to express
6 sexuality for fear of mistreatment and found they often face targeted physical and sexual
7 violence, creating an environment which can hinder them from seeking necessary medical
8 care;⁹ and
9

10 Whereas, in a survey of the experiences of TGD incarcerated people conducted over three
11 years and in 31 states, the majority of respondents reported being denied medication to support
12 transition while in prison, worsening their physical and mental health during incarceration
13 compared to before, and experiencing health care providers who did not have knowledge
14 regarding general or medically-specific issues related to transgender people;¹⁰ and
15

16 Whereas, in the 2011 Adams v. Federal Bureau of Prisons case, a transgender incarcerated
17 woman diagnosed with Gender Identity Disorder (GID), was denied access to gender-affirming
18 hormonal therapy, leading her to mutilate her genitals;¹¹ and
19

20 Whereas, in the 2018 Keohane v. Florida Department of Corrections case, Reiyne Keohane, a
21 transgender incarcerated woman, was continuously denied to continue her hormone therapy for
22 her gender dysphoria due to Florida's existing policies that halted the administration of
23 medication;^{12,13} and
24

25 Whereas, in the 2019 Edmo v. Idaho Department of Corrections case, Adree Edmo, a
26 transgender incarcerated woman, received medically necessary gender confirmation surgery
27 after being denied for nearly five years;¹⁴ and
28

29 Whereas, in the 2020 Diamond v. Georgia Department of Corrections case, after 17 years of
30 hormone therapy, transgender woman Ashley Diamond's infrequent and insufficient gender-
31 affirming treatment during incarceration led her to attempt auto castration and suicide;^{15,16} and
32

33 Whereas, in October 2023, the Washington Department of Corrections (DOC) agreed to amend
34 a complaint filed from Disability Rights Washington for the failure of providing timely medical
35 and mental health care to TGD patients, and as part of the agreement DOC will provide gender-
36 affirming healthcare and services such as "any person with active prescriptions for hormone
37 replacement therapy in the community will continue receiving their prescription in prison";¹⁷ and
38

39 Whereas, the Prison Rape Elimination Act (PREA) set national standards to provide a minimum
40 of rights to the incarcerated, including access to medical care for TGD incarcerated people;
41 however, a study evaluating 21 states revealed that only one state meets the PREA
42 standards;¹⁸ and
43

44 Whereas, a separate study showed nineteen states have no policies directly addressing TGD
45 incarcerated individuals, and a handful of states have some policies but lack specific guidance
46 on TGD incarcerated individuals' healthcare, showing the importance for uniform federal
47 guidelines and AMA advocacy to address these groups;¹³ and
48

49 Whereas, in AMA policy [H-185.927](#) clause 1 states the AMA "...recognizes that medical and
50 surgical treatments for gender dysphoria and gender incongruence... are medically necessary

1 as outlined by generally-accepted standards of medical and surgical practice, “ showing existing
2 policy that views access to healthcare for TGD populations as important and necessary; and
3

4 Whereas, AMA policy H-430.986 clause 8 shows that the AMA “...advocates for necessary
5 programs and staff training to address the distinctive health care needs of women and
6 adolescent females who are incarcerated ...including gynecological care and obstetrics care for
7 individuals who are pregnant or postpartum” setting the precedent to also address the distinctive
8 health care needs of TGD incarcerated individuals; and
9

10 Whereas, AMA policy H-430.982 addresses gender assignment preferences for TGD individuals
11 in correctional facilities, showing that AMA has previously supported and understands the need
12 for specific policy for TGD incarcerated populations who have historically and continued to be
13 targeted and discriminated against within prison systems; and
14

15 Whereas, despite existing AMA policy H-430.997 which supports standards of care for
16 incarcerated individuals of correctional facilities, the AMA continuously fails to support policies
17 such as The Equality Act and H.Res.269 that are currently being discussed in Congress,
18 highlighting the need to have specific policy for the targeted TGD population;^{19,20} therefore be it
19

20 RESOLVED, that our American Medical Association advocate for readily accessible gender
21 affirming care to meet the distinct healthcare needs of transgender and gender diverse
22 individuals who are incarcerated, including but not limited to evaluations for gender-affirming
23 surgical procedures and the continuation or initiation of hormone therapy without disruption or
24 delay.

Fiscal Note: TBD

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RELEVANT AMA POLICY

Health Care While Incarcerated H-430.986

Our AMA... (8) advocates for necessary programs and staff training to address the distinctive health care needs of women and adolescent females who are incarcerated, including gynecological care and obstetrics care for individuals who are pregnant or postpartum... (10) Our AMA supports: (a) linkage of those incarcerated to community clinics upon release in order to accelerate access to comprehensive health care, including mental health and substance use disorder services, and improve health outcomes among this vulnerable patient population, as well as adequate funding... (14) Our AMA will collaborate with interested parties to promote the highest quality of healthcare and oversight for those who are involved in the criminal justice system by advocating for health administrators and executive staff to possess credentials and experience comparable to individuals in the community in similar professional roles. [CMS Rep. 02, I-16; Appended: Res. 417, A-19; Appended: Res. 420, A-19; Modified: Res. 216, I-19; Modified: Res. 503, A-21; Reaffirmed: Res. 229, A-21; Modified: Res. 127, A-22; Appended: Res. 244, A-23; Appended: Res. 429, A-23]

Standards of Care for incarcerated individuals of Correctional Facilities H-430.997

Our AMA believes that correctional and detention facilities should provide medical, psychiatric, and substance use disorder care that meets prevailing community standards, including appropriate referrals for ongoing care upon release from the correctional facility in order to prevent recidivism. [Res. 60, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Amended: Res. 416, I-99; Reaffirmed: CEJA Rep. 8, A-09; Reaffirmation I-09; Modified in lieu of Res. 502, A-12; Reaffirmation: I-12 Modified: CSAPH Rep. 1, A-22]

Appropriate Placement of Transgender Prisoners H-430.982

Our AMA: (1) supports the ability of transgender prisoners to be placed in facilities, if they so choose, that are reflective of their affirmed gender status, regardless of the prisoner's genitalia, chromosomal make-up, hormonal treatment, or non-, pre-, or post-operative status; and (2) supports that the facilities housing transgender prisoners shall not be a form of administrative segregation or solitary confinement." [BOT Rep. 24, A-18]

Clarification of Evidence-Based Gender-Affirming Care H-185.927

Our AMA: (1) recognizes that medical and surgical treatments for gender dysphoria and gender incongruence, as determined by shared decision making between the patient and physician, are medically necessary as outlined by generally-accepted standards of medical and surgical practice; [Res. 05, A-16M; Modified: Res. 015, A-21; Modified: Res. 223, A-23; Appended: Res. 304, A-23]

Relevant MSS Positions

Federal Health Insurance Funding for People Experiencing Incarceration 290.008MSS

Our MSS believes that our AMA should (1) advocate for adequate payment to health care provider 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...(2) support information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health services to individuals in the correctional system...(8) advocate for necessary 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...(10) support linkage of those incarcerated to community clinics to accelerate access to comprehensive healthcare. [MSS Res. 076, Nov. 2020]

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 205
(A-24)

Introduced by: Shalvi Patel, University of Virginia School of Medicine; Sarah Finkelstein, University of Virginia School of Medicine; Stephanie Malta, University of Virginia School of Medicine; Rachel Rezabek, University of Virginia School of Medicine; Caroline Sublett, University of Virginia School of Medicine; Areesheh Khan, University of Virginia School of Medicine

Subject: Support for Doula Care Programs

Sponsored by: Region 2, Region 6, American Medical Women's Association Medical Student Division (AMWA MSD)

Referred to: MSS Reference Committee
(Caitlin Blaukovitch and Shaminy Manoranjithan, Co-Chairs)

-
- 1 Whereas, doulas are non-medical trained persons who “provide continuous physical, emotional,
2 and informational support to their client before, during, and shortly after childbirth¹,” and
3
- 4 Whereas, doulas are able to serve as intermediaries between physician and patient, and
5 educate pregnant people on what to expect during labor, and establish birthing plans²; and
6
- 7 Whereas, the American College of Obstetricians and Gynecologists (ACOG) recognizes that
8 “continuous one-to-one emotional support provided by support personnel, such as a doula, is
9 associated with improved outcomes for women in labor³,” and
10
- 11 Whereas, involvement of doulas greatly reduces postpartum depression and anxiety as much
12 as 57.5%^{2,4}; and
13
- 14 Whereas, cesarean delivery has been associated with increased maternal morbidity and
15 mortality, and doula support has been shown to lower the odds of cesarean delivery by
16 52.9%^{2,5}; and
17
- 18 Whereas, ACOG has defended their position that we need to pursue opportunities for safe
19 reduction in the number of primary cesarean sections and highlights that “one of the most
20 effective tools to improve labor and delivery outcomes is the continuous presence of support
21 personnel, such as a doula⁶,” and
22
- 23 Whereas, doula support is also associated with other positive delivery outcomes including
24 reduced low birthweight infants and preterm births, which are closely associated with neonatal
25 mortality/morbidity and inhibited growth and cognitive development⁷⁻⁹; and
26
- 27 Whereas, doula support has shown to improve breastfeeding success, with quicker lactogenesis
28 and continued breastfeeding weeks after childbirth, especially in low income women who had
29 near universal breastfeeding initiation at 97.9% compared to 80.8% of those in the general
30 Medicaid population¹⁰; and

1 Whereas, the American Academy of Pediatrics recommends exclusive breastfeeding until six
2 months of age, followed by continued breastfeeding with appropriate introduction of solid foods
3 in subsequent years, yet CDC data states that only 24.9% of infants received breast milk
4 exclusively at six months^{11,12}; and

5
6 Whereas, maternal breastfeeding confers significant nutritional and immunological benefits to
7 the infant and has shown to reduce incidence and severity of maternal postpartum
8 depression^{13,14}; and

9
10 Whereas, doula support during childbirth and pregnancy can play a role in mitigating effects of
11 social determinants of health by addressing health literacy and social support needs in
12 vulnerable populations¹⁵; and

13
14 Whereas, experiences of mistreatment or racism are detrimental and disproportionately affect
15 people from marginalized social and financial backgrounds, but doula support has been
16 associated with high respectful care metrics that promotes communication, patient autonomy,
17 and respect, thus suggesting the importance of doulas in mitigating disparities in healthcare
18 delivery¹⁶; and

19
20 Whereas, women have become the fastest growing segment of the incarcerated population
21 since 1978 with over 168,000 females (7% of the prison population) in prisons/jails in the U.S. in
22 2021 as compared to only 4% in 1978, and studies have shown that compared to non-
23 incarcerated individuals, incarcerated pregnant individuals were more likely to receive
24 inadequate prenatal care and deliver newborns of low birth weights, which is closely associated
25 with neonatal mortality/morbidity and inhibited growth and cognitive development^{8,17-22}; and

26
27 Whereas, ACOG recommends that “obstetricians-gynecologists and other women’s healthcare
28 practitioners... should foster safe and dignified birthing environments for incarcerated people
29 who give birth in custody and allow these individuals to have the same opportunities to bond
30 with their newborns as nonincarcerated postpartum hospitalized people” and doulas can work to
31 overcome challenges to create these opportunities for incarcerated pregnant individuals²³; and

32
33 Whereas, doulas can reduce the unmet needs of incarcerated pregnant individuals by ensuring
34 that individuals are not shackled during labor, providing privacy during intimate exams if a
35 correctional officer is required to be in the room, verifying that laboring individuals receive
36 appropriate accommodations such as psychosocial support, education, and access to physical
37 resources²⁴⁻²⁶; and

38
39 Whereas, currently, doula programs are offered in a small number of prisons and jails where
40 they provide educational and emotional resources including one-on-one and group sessions on
41 preparing for childbirth, coping with pregnancy and infant separation during incarceration, and
42 lactation counseling^{25,26}; and

43
44 Whereas, pregnant, incarcerated individuals were eager to participate in prison doula
45 programs—everyone who was offered a doula elected to be matched with one—and were highly
46 satisfied with their doula-supported birth experience²⁶; and

47
48 Whereas, current AMA policy H-420.972 states that our AMA promotes programs which provide
49 education and funding directed at women at risk for delivering low birthweight infants; and

50

1 Whereas, current AMA-MSS policy 420.019MSS supports the need for Medicaid coverage for
2 doula services, highlighting that the potential benefits of doula services in marginalized
3 populations are recognized by our MSS; and therefore be it
4

5 Whereas, current AMA policy H-430.986 recognizes the distinctive health care needs of females
6 who are incarcerated and D-420.993 supports addressing disparities in rates of maternal
7 mortality in the United States, but there is no existing policy to support doula programs to
8 address these needs; and
9

10 RESOLVED, that our American Medical Association support access to continuous one-to-one
11 emotional support provided by doulas as nonmedical support personnel including for patients
12 who are incarcerated or detained.

Fiscal Note: TBD

Date Received: 03/31/2024

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RELEVANT [AMA POLICY](#)

Disparities in Maternal Mortality D-420.993

Our AMA: (1) will ask the Commission to End Health Care Disparities to evaluate the issue of health disparities in maternal mortality and offer recommendations to address existing disparities in the rates of maternal mortality in the United States; (2) will work with the CDC, HHS, state and county health departments to decrease maternal mortality rates in the US; (3) encourages and promotes to all state and county health departments to develop, implement, and sustain a maternal mortality surveillance system that centers around health equity; and (4) will work with stakeholders to encourage research on identifying barriers and developing strategies toward the implementation of evidence-based practices to prevent disease conditions that contribute to poor obstetric outcomes, maternal morbidity and maternal mortality in racial and ethnic minorities. [CSAPH Rep. 3, A-09; Appended: Res. 403, A-11; Appended: Res. 417, A-18; Reaffirmed: Res. 229, A-21; Modified: Joint CMS/CSAPH Rep. 1, I-21]

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; Reaffirmed: CSAPH Rep. 1, A-21]

Classification and Surveillance of Maternal Mortality H-420.948

Our AMA will: (1) encourage research efforts to characterize the health needs for pregnant inmates, including efforts that utilize data acquisition directly from pregnant inmates while ensuring appropriate nondiscrimination and privacy safeguards; (2) support legislation requiring all correctional facilities, including those that are privately-owned, to collect and publicly report pregnancy-related healthcare statistics with transparency in the data collection process while ensuring appropriate nondiscrimination and privacy safeguards; (3) encourages data collection on pregnancy and other reproductive health outcomes of incarcerated people and research efforts to characterize the health needs for pregnant inmates, including efforts that utilize data acquisition directly from pregnant inmates; (4) supports 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; (5) opposes the separation of infants from incarcerated pregnant individuals post-partum; and (6) supports solutions, such as community-based programs, which allow infants and incarcerated postpartum individuals to remain together. [Res. 229, A-21; Appended: Res. 431, A-22]

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-10; Reaffirmed: BOT Rep. 04, A-20; Reaffirmed: CSAPH Rep. 06, A-23]

Health Care While Incarcerated H-430.986

Our AMA ... 8. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of women and adolescent females who are incarcerated, including gynecological care and obstetrics care for individuals who are pregnant or postpartum. [CMS Rep. 02, I-16; Appended: Res. 417, A-19; Appended: Res. 420, A-19; Modified: Res. 216, I-19; Modified: Res. 503, A-21; Reaffirmed: Res. 229, A-21; Modified: Res. 127, A-22; Appended: Res. 244, A-23; Appended: Res. 429, A-23]

RELEVANT MSS POLICY

Midwives and Doulas 420.019MSS

Our AMA-MSS support (1) legislative and regulatory mechanisms for the licensing of all credentialled midwives as endorsed by appropriate specialty societies such as the American College of Obstetricians and Gynecologists and (2) Medicaid coverage for doula services.

(MSS Res. 011, A-21) (MSS Res. OF041, Appended, "Increasing Support for Doula Services to Reduce Maternal Mortality," I-23) (MSS Res 12, A-17) (Amended: MSS GC Report A, A-23)

Advocating for the Delivery of Standardized Perinatal Care and Monitoring of Healthcare Outcomes for Incarcerated Pregnant Individuals 65.049MSS

AMA-MSS will ask the AMA to (1) encourage research efforts to characterize the health needs for pregnant inmates, including efforts that utilize data acquisition directly from pregnant inmates; and (2) support legislation requiring all correctional facilities, including those that are privately-owned, to collect and publicly report pregnancy-related healthcare statistics with transparency in the data collection process. (MSS Res. 045, A-21)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 207
(A-24)

Introduced by: Anna Klunk, Philadelphia College of Osteopathic Medicine, Olivia Spaulding, Howard University College of Medicine, Brianna Baldwin, University of Virginia School of Medicine; Alec Calac, UC San Diego School of Medicine, Brianna Irons, UC San Diego School of Medicine; Ethan Brown, Zucker School of Medicine at Hofstra/Northwell; Hailey Baker, University of Minnesota Medical School

Subject: Repatriation of American Indian, Alaska Native, and Native Hawaiian Remains

Sponsored by: Region 1, Region 7, Asian Pacific American Medical Student Association (APAMSA), Association of Native American Medical Students (ANAMS)

Referred to: MSS Reference Committee
(Caitlin Blaukovitch and Shaminy Manoranjithan, Co-Chairs)

1 Whereas, the theft and grave-robbing of human remains from Indigenous, enslaved, and
2 imprisoned populations for medical schools was commonplace throughout the 18th and 19th
3 centuries, and medical institutions lobbied lawmakers to allow for their continued receipt of such
4 remains^{1,2}; and
5
6 Whereas, the Native American Graves Protection and Repatriation Act of 1990 (NAGPRA)
7 mandated the return of Native American remains, funerary objects, sacred objects, and objects
8 of cultural patrimony to lineal descendants, culturally-affiliated Indian Tribes, and Native
9 Hawaiian organizations²; and
10
11 Whereas, the Congressional Budget Office initially estimated it would take 10 years for
12 institutions, including medical schools, to repatriate all covered objects and remains to Native
13 American tribes³; and
14
15 Whereas, over 30 years after the passage of NAGPRA, many universities are still not in
16 compliance and have not taken meaningful steps to enter compliance by returning these human
17 remains and sacred objects⁴; and
18
19 Whereas, updates to NAGPRA effective January 12, 2024 require museums and federal
20 agencies to update inventories that include human remains along with associated funerary
21 objects within five years, to identify geographic origin affiliation for entities with unknown ties
22 due to the prolonged proceedings since the initial passing of NAGPRA^{5,6}; and
23
24 Whereas, a 2023 investigation by ProPublica determined that Harvard's anatomical collection
25 and the University of California system each likely held the remains of thousands of deceased
26 Native Americans⁷; and
27

1 Whereas, the Harvard Peabody Museum still holds the “Woodbury Collection,” which includes
2 the hair clippings and names of as many as 700 Indigenous children who previously attended
3 the U.S. Indian Boarding Schools⁸; and
4

5 Whereas, less than half of the Native American ancestral remains in collections have been
6 repatriated to their traditional caretakers, with over 117,576 Native American individuals still in
7 museum and Federal agency collections⁹⁻¹¹; and
8

9 Whereas, a 2023 audit of California State Universities to assess NAGPRA compliance found
10 more than half had not completed a full inventory or repatriated any remains or articles to tribes,
11 and of those that did repatriate items, they did not do so within NAGPRA compliance¹²⁻¹⁴; and
12

13 Whereas, museums and educational institutions often require Tribal Nations to independently
14 request repatriation rather than reviewing their collections for NAGPRA non-compliant items and
15 working with Tribal Nations to facilitate returns, and often deny these requests, further
16 prolonging the repatriation process¹⁵⁻¹⁷; and
17

18 Whereas, an investigation by ProPublica noted that institutions that do not want to repatriate
19 cultural items claim that there is inadequate evidence to link ancestral human remains to any
20 living people^{6,18}; and
21

22 Whereas, the ownership of sacred items and ancestral remains continues to place strain on
23 relations with Tribal Nations and instills distrust in large universities¹⁹; and
24

25 Whereas, private institutions have been increasingly subject to federal laws governing the
26 repatriation of NAGPRA-compliant remains and inventories, but for-profit institutions, especially
27 those that operate medical schools and hospitals, may not be subject to these statutes²⁰; and
28

29 Whereas, many NAGPRA non-compliant universities have affiliated healthcare centers,
30 contributing to the historical and continued trauma that American Indian and Alaska Native
31 individuals face when seeking healthcare²; and therefore be it
32

33 **RESOLVED**, that our American Medical Association support: (a) the expeditious return of
34 American Indian and Alaska Native anatomical remains, biospecimens, and cultural items from
35 US medical schools to Tribal governments and Native Hawaiian cultural organizations; (b) funds
36 and federal technical assistance for inventory documentation and processing of repatriation
37 claims; and (c) dissemination of best practices for affiliating remains with ancestral claimants.

Fiscal Note: TBD

Date Received: 03/31/2024

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RELEVANT [AMA POLICY](#)

AMA Support of American Indian Health Career Opportunities D-350.976

Our AMA will: (1) work with the Association of American Medical Colleges, American Association of Colleges of Osteopathic Medicine, Association of American Indian Physicians, and Association of Native American Medical Students to increase representation of American Indian physicians in medicine by promoting effective practices in recruitment, matriculation, retention and graduation of American Indian medical students; and (2) study the historical and economic significance of the Morrill Act as it relates to its impact on diversity of the physician workforce. [BOT Action in response to referred for decision: Res. 308, A-22]

Indigenous Data Sovereignty H-460.884

Our AMA: (1) recognizes that American Indian and Alaska Native (AI/AN) Tribes and Villages are sovereign governments that should be consulted before the conduct of research specific to their members, lands, and properties; (2) supports that AI/AN Tribes and Villages' Institutional Review Boards (IRBs) and research departments retain the right to oversee and regulate the collection, ownership, and management of research data with the consent of their members, and that individual members of AI/AN Tribes and Villages retain their autonomy and privacy regarding research data shared with researchers,

AI/AN Tribes and Villages, and governments, consistent with existing protections under 45 CFR 46; and (3) encourages: (a) the use and regular review of data-sharing agreements for all studies between academic medical centers and AI/AN Tribes and Villages be mutually agreed upon and aligned with AI/AN Tribes' and Villages' preferences, and (b) the National Institutes of Health and other stakeholders to provide flexible funding to AI/AN Tribes and Villages for research efforts, including the creation and maintenance of IRBs. [Res. 003, I-22]

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 210
(A-24)

Introduced by: Raheyima Siddiqui, Loyola Stritch School of Medicine; Duane Nguyen,
Loyola Stritch School of Medicine; Ashima Kund, Loyola Stritch School of
Medicine

Subject: Opposition of the Deceptive Relocation of Migrants and Asylum Seekers

Sponsored by: Region 1, Region 6, American Medical Women's Association Medical
Student Division (AMWA MSD)

Referred to: MSS Reference Committee
(Caitlin Blaukovitch and Shaminy Manoranjithan, Co-Chairs)

- 1 Whereas, human trafficking is defined by the United Nations as the “recruitment, transportation,
2 transfer, harboring or receipt of people through force, fraud or deception, with the aim of
3 exploiting them for profit”¹; and
4
- 5 Whereas, migrants have reportedly been falsely promised expedited work papers, manipulated
6 due to their fear of deportation, or completely unaware of where they are going²; and
7
- 8 Whereas, Texas Governor Greg Abbott launched Operation Lone Star in 2021 in response to
9 migrants crossing the United States southern border, spending \$10 billion and relocating over
10 100,000 people to date³; and
11
- 12 Whereas, Florida Governor Ron DeSantis flew two planes of migrants to Martha’s Vineyard
13 after they were told they were going to Boston, leaving them without food, housing, and other
14 basic necessities⁴; and
15
- 16 Whereas, the mayor of Edison, New Jersey warned that he would send bussed migrants back
17 to the border and authorities in Rockford, Illinois, stated that migrants that landed on a charter
18 flight would not be staying⁵; and
19
- 20 Whereas, buses of migrants were driven to Vice President Kamala Harris’ home during a record
21 cold Christmas Eve in 2022 without proper clothing and resources for the weather⁶; and
22
- 23 Whereas, a child transported from Texas to Chicago died en route due to illness present prior to
24 boarding, contrary to claims made by officials that “no passenger presented with a fever or
25 medical concerns”⁷; and
26
- 27 Whereas, an employee of the security system hired to monitor the buses transporting migrants
28 called their conditions “disgusting” and “inhumane”, describing lack of proper facilities for
29 disposal of period products, diapers, and human waste⁸; and
30

1 Whereas, migrants were falsely promised a free trip to Massachusetts in exchange for rent,
2 work, schooling for their children, immigration assistance, and monetary compensation for
3 recruiting other people⁹; and
4

5 Whereas, Diana, a migrant unknowingly bussed to Philadelphia from Del Rio, Texas, reported
6 that her 10-year-old daughter grew very ill during the journey and had to be hospitalized for
7 acute dehydration and a high fever¹⁰; and
8

9 Whereas, volunteer physicians and medical students serving thousands of bussed migrants in
10 Chicago have expressed that they are too overwhelmed and underfunded to meet the medical
11 needs of migrants and asylum seekers new to the city¹¹; and
12

13 Whereas, volunteers in Chicago treating migrants and asylum seekers treated a young boy with
14 an infected laceration with “skin [in] three different flaps”, a 30-year-old man living in a tent that
15 was stabbed on his way back from work, a 25-year-old woman that had a miscarriage in a
16 Texas detention center, and many other medical emergencies¹¹; and
17

18 Whereas, AMA policy supports the humane treatment of all undocumented children and
19 advocates for the auditing of medical conditions and services within detention facilities [H-
20 60.906]; and
21

22 Whereas, AMA policy encourages the exploration of issues affecting refugee health and
23 advocates for the deployment of resources to eliminate health disparities affecting immigrants,
24 refugees or asylees [H-350-957]; therefore be it
25

26 RESOLVED, that our American Medical Association oppose the relocation of migrants and
27 asylum-seekers by state or federal authorities without timely and appropriate resources to meet
28 travelers' needs, especially when deceptive or coercive practices are used; and be it further
29

30 RESOLVED, that our AMA support state and federal efforts to protect the health and safety of
31 traveling migrants and asylum-seekers and investigate possible abuse and human rights
32 violations.

Fiscal Note: TBD

Date Received: 03/31/2024

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RELEVANT [AMA POLICY](#)

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]

Opposing Office of Refugee Resettlement’s Use of Medical and Psychiatric Records for Evidence in Immigration Court H-20.901

Our AMA will: (1) advocate that healthcare services provided to minors in immigrant detention and border patrol stations focus solely on the health and well-being of children; and (2) condemn the use of confidential medical and psychological records and social work case files as evidence in immigration courts without patient consent. [Res. 013, A-19]

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 supports 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. [Res. 804, I-09 Appended: Res. 409, A-15; Reaffirmed: A-19; Appended: Res. 423, A-19; Reaffirmed: I-19]

Care of Women and Children in Family Immigration Detention 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.
 5. Our AMA will advocate for the preferential use of alternatives to detention programs that respect the human dignity of immigrants, migrants, and asylum seekers who are in the custody of federal agencies.
- [Res. 002, A-17 Appended: Res. 218, A-21 Reaffirmed: Res. 234, A-22]

Consideration of the Health and Welfare of U.S. Minor Children in Deportation Proceedings Against Their Undocumented Parents D-60.966

Our AMA: (1) supports that the mental health, physical well-being, and welfare of U.S. citizen minors should be taken into consideration in determining whether undocumented parents of U.S. citizen minors may be detained or deported; and (2) will work with local and state medical societies and other relevant stakeholders to address the importance of considering the health and welfare of U.S. citizen minors in cases where the parents of those minors are in danger of detention or deportation. [Res. 016, A-17]

Opposing the Detention of Migrant Children H-60.906

Our AMA... (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... [Res. 004, I-18]

RELEVANT [MSS POLICY](#)

Oppose Mandatory DNA Collection of Migrants 65.037MSS

AMA-MSS will ask the AMA to oppose the collection and storage of DNA of refugees, asylum seekers, and undocumented immigrants for non-violent immigration-related crimes without non-coercive informed consent. (MSS Emergency Resolution 01, I-19 – Immediate Forward) (AMA Res. 220, Adopted [H-65.955], I-19)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 211
(A-24)

Introduced by: Afareen Jaleel, University of Massachusetts T.H. Chan School of Medicine; Nicholas Wilson, Morehouse School of Medicine; Angel Sheu, Anne Burnett Marion School of Medicine at Texas Christian University; Amber Shirley, Lincoln Memorial University DeBusk College of Osteopathic Medicine; Alyssa Lee, New York Medical College

Subject: Supplemental Security Income (SSI) Savings Penalty Elimination

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

Referred to: MSS Reference Committee
(Caitlin Blaukovitch and Shaminy Manoranjithan, Co-Chairs)

1 Whereas, Supplemental Security Income (SSI) provides essential benefits to meet basic needs
2 for food, clothing, and shelter for 7.5 million individuals who are blind, disabled, or 65 years of
3 age or older, and have little to no income or assets, of which 85% are eligible due to severe
4 disability^{1,2}; and
5

6 Whereas, individuals fall under the SSI income limit if they do not earn more than \$1971 per
7 month from employment before taxes, and couples who both receive SSI fall under the limit if
8 they do not earn more than \$2915 per month from employment before taxes³; and
9

10 Whereas, the total assets, defined as owned property that contains economic value, for SSI
11 eligibility are limited to \$3000 for married couples and \$2000 for individual adults, and thus
12 restricts married couples to having \$1000 less than the asset limit of \$4000 for two unmarried
13 individuals⁴; and
14

15 Whereas, the SSI asset limit includes applicants' cash, bank accounts, stocks, mutual funds,
16 savings bonds, life insurance, property, household goods, burial funds, retirement savings
17 accounts, and more⁵; and
18

19 Whereas, the SSI asset limit, which has reached one-fifth of its original 1972 value after
20 inflation, has not been updated since 1989 nor adjusted for inflation^{4,5}; and
21

22 Whereas, in 2022, the SSI federal benefit rate for a single individual was \$841 per month and
23 \$1,261 per month for married couples thus the total benefits married couples receive is 25%
24 less than what they would have received without marital status^{6,7}; and
25

26 Whereas, the poverty rate for a married couple receiving SSI is 45% compared with 9.8% for
27 two SSI recipients who are not married⁷; and
28

29 Whereas, the SSI Savings Penalty Elimination Act introduced in September 2023
30 (S.2767/H.R.5408) would raise the asset limits to \$10,000 for individuals and \$20,000 for
31 married couples, while adjusting for inflation^{8,9}; and
32

1 Whereas, S.2767/H.R.5408's proposed asset limit would increase the number of SSI
2 beneficiaries by up to 3%⁵ and the costs by 1% of the total program cost over ten years¹⁰; and
3

4 Whereas, SSI is an important pathway to health coverage as beneficiaries in most states are
5 automatically eligible for Medicaid, including states that have not adopted Medicaid Expansion
6 under the Affordable Care Act, thus raising the SSI asset limit at the federal level would facilitate
7 Medicaid access for these disadvantaged populations^{11,12}; and
8

9 Whereas, exceeding the asset limit is the leading cause of erroneous SSI benefit payment and
10 an average of 70,000 SSI beneficiaries have their benefits suspended, and 40,000 have their
11 benefits terminated each year for exceeding the asset limit^{5,13,14}; and
12

13 Whereas, raising the asset limit would result in fewer beneficiaries exceeding them, reducing
14 cost and administrative burdens on SSI beneficiaries and staff since significantly fewer
15 beneficiaries would be subject to overpayments, and churn with suspensions and terminations⁵;
16 and
17

18 Whereas, living with a disability imposes additional costs of living, such as customized
19 wheelchairs, emergency costs, home and automobile modifications, and medical equipment that
20 requires savings to purchase as they are not covered by Medicaid, and households with a
21 disabled member need \$18,000 more per year on average to have the same standard of living
22 as a similar household without a member with a disability^{5,15}; and
23

24 Whereas, more than two-thirds of SSI beneficiaries have no savings, 92% have less than \$500
25 in savings, and 51.6% of all SSI beneficiaries had incomes below the federal poverty line even
26 with SSI benefits, thus SSI benefit by itself is not enough to lift someone above the poverty line,
27 but it can reduce hardship, and in conjunction with S.2767/H.R.5408 the potential to accrue
28 savings would enable financial independence^{5,16}; and
29

30 Whereas, the AMA has advocated for outreach to expand access to SSI (H-90.986), expand
31 Medicare access (D-290.979), cash assistance to alleviate poverty and address social
32 determinants of health (D-60.965); therefore be it
33

34 RESOLVED, that our American Medical Association support increased asset limits for
35 Supplemental Security Income (SSI) eligibility that are indexed to inflation moving forward; and
36 be it further
37

38 RESOLVED, that our AMA support the establishment of individualized equivalent asset limit
39 eligibility requirements for SSI benefits, regardless of marital status.

Fiscal Note: TBD

Date Received: 03/31/2024

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RELEVANT [AMA POLICY](#)

SSI Benefits for Children with Disabilities H-90.986

The AMA will use all appropriate means to inform members about national outreach efforts to find and refer children who may qualify for Supplemental Security Income benefits to the Social Security Administration and promote and publicize the new rules for determining disability. [Res. 420, A-92; Reaffirmed: CMS Rep. 10, A-03; Reaffirmed: CMS Rep. 4, A-13; Reaffirmed: CMS Rep. 01, A-23]

Increase Employment Services Funding for People with Disabilities H-90.964

Our AMA supports increased resources for employment services to reduce health disparities for people with disabilities. [Res. 406, A-23]

Medicaid Expansion D-290.979

(1) Our AMA, at the invitation of state medical societies, will work with state and specialty medical societies in advocating at the state level to expand Medicaid eligibility to 133% (138% FPL including the income disregard) of the Federal Poverty Level as authorized by the ACA and will advocate for an increase in Medicaid payments to physicians and improvements and innovations in Medicaid that will reduce administrative burdens and deliver healthcare services more effectively, even as coverage is expanded.

(2) Our AMA will: (a) continue to advocate strongly for expansion of the Medicaid program to all states and reaffirm existing policies D-290.979, H 290.965 and H-165.823; and (b) work with interested state medical associations and national medical specialty societies to provide AMA resources on Medicaid expansion and covering the uninsured to health care professionals to inform the public of the importance of expanded health insurance coverage to all. [Res. 809, I-12; Reaffirmed: CMS Rep. 02, A-19; Reaffirmed: CMS Rep. 5, I-20; Reaffirmed: CMS Rep. 3, A-21; Reaffirmed: CMS Rep. 9, A-21; Reaffirmed: CMS Rep. 3, I-21; Reaffirmed: Joint CMS/CSAPH Rep. 1, I-21; Appended: Res. 122, A-22]

Recognizing Child Poverty and the Racial Wealth Gap as Public Health Issues and Extending the Child Tax Credit for Families in Need D-60.965

(1) Our AMA recognizes: (1) child poverty as a public health issue and a crucial social determinant of health across the life course; and (2) that the disproportionate concentration of child poverty and generational wealth gaps experienced by Black, American Indian or Alaska Native, and Hispanic families are a consequence of structural racism and a barrier to achieving racial health equity.

(2) Our AMA will advocate for fully refundable, expanded child tax credit and other evidence-based cash assistance programs to alleviate child poverty, ameliorate the racial wealth gap, and advance health equity for families in need. [Res. 247, A-22]

RELEVANT MSS POLICY

Supporting Academic Medical-Legal Partnerships to Address Social Determinants of Health 65.063MSS

(1) AMA-MSS will ask the AMA to support the establishment and funding of medical-legal partnerships and civil legal aid services to meet patients' legal needs. (MSS Res. 024, A-23)

Societal Discrepancies in the Disabled Population and Post-Secondary Disability Resource Center Utilization 90.007MSS

(1) AMA-MSS supports educating medical students and health care professionals on the societal discrepancies endured by the disabled population as well as services provided by 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. (MSS Res 35, I-10)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 213
(A-24)

Introduced by: Nicholas Wilson, Morehouse School of Medicine, Bethany Brumbaugh, Harvard Medical School, Adrienne Nguyen, Des Moines University, Riya Master, University of San Francisco College of Medicine, Riddhi Modi, New York Institute of Technology College of Osteopathic Medicine, Jared Boyce, University of Wisconsin College of Medicine and Public Health, Emmanuel Dean, Morehouse School of Medicine, Jessica Goodwin, Morehouse School of Medicine, Timi Akunwunmi-Williams, Morehouse School of Medicine

Subject: Undocumented Worker Protections

Sponsored by: Region 1

Referred to: MSS Reference Committee
(Caitlin Blaukovitch and Shaminy Manoranjithan, Co-Chairs)

1 Whereas, undocumented workers are defined as individuals who are employed in a country
2 without legal authorization or documentation and account for around 7 million of the U.S.
3 workforce, primarily contributing to the agriculture, farming, and leisure/hospitality industries^{1,2};
4 and

5
6 Whereas, recent years have seen a rise in the abuse faced by undocumented workers, such as
7 rigid work demands without breaks for food or water, wage theft, sexual assault, physical abuse,
8 verbal abuse, underaged minors working in dangerous facilities, and lack of safety equipment
9 and training^{3,4}; and

10
11 Whereas, the abuse of undocumented workers during employment has been shown to increase
12 rates of alcoholism, depression and anxiety, injuries in the upper body region, and social
13 isolation⁵⁻⁸; and

14
15 Whereas, despite legal protections for undocumented workers during employment from the
16 National Labor Relations Board (NLRB), the Department of Labor (DOL), the Equal Employment
17 Opportunity Commission (EEOC), and the Occupational Safety and Health Administration
18 (OSHA), which enforce workplace safety and protection regardless of immigration status, abuse
19 is still prevalent due to fears of legal retaliation and potential deportation⁹⁻¹³; and

20
21 Whereas, given the recent installment of U- and T- visas, undocumented workers are granted
22 temporary visa status if they are found to be victims of employment abuse or human
23 trafficking¹⁴; and

24
25 Whereas, a primary barrier which precludes undocumented immigrants from receiving the
26 benefits of legal protections in the workplace and leaves them vulnerable to abuse is a lack of
27 awareness surrounding protections in the workplace¹⁵; and

28

1 Whereas, education workshops and safety trainings have proven effective in advising
2 undocumented immigrants of their legal and health rights and dangers associated with their
3 job¹⁶⁻¹⁸; and
4

5 Whereas, the provision of occupational safety equipment and promotion of safety trainings has
6 shown to be effective in improving health outcomes and safety during employment for immigrant
7 workers¹⁹⁻²³; and
8

9 Whereas, Section 8.10 of the Code of Ethics encourages physicians to “collaborate with public
10 health and community organizations to reduce violence and abuse” and AMA policy H-430.976
11 encourages safety training and personal protective equipment for incarcerated people; and
12

13 Whereas, our AMA, with a tradition of advocating for marginalized communities, recognizes
14 immigration status as a vital public health concern and has a history of promoting educational
15 resources for immigrant health issues as seen in AMA policy D-350.975; and
16

17 Whereas, in addition to wage theft being a financial consequence of undocumented worker
18 abuse, lack of health insurance coverage for undocumented workers also serves as a financial
19 detriment to seeking treatment for workplace-incurred physical and psychological injury and
20 other health needs; and
21

22 Whereas, undocumented workers are significantly more likely to have low-wage jobs that do not
23 provide employer-sponsored health insurance and limit the ability to afford coverage even when
24 offered, and they are ineligible to enroll in federally-funded coverage, including Medicaid, CHIP,
25 or Medicare, or to purchase coverage through the ACA Marketplace^{24,25}; and
26

27 Whereas, in 2021, around 24% of undocumented immigrants experienced poverty, thus putting
28 the remaining 76% at risk for not meeting the financial eligibility for Medicaid²⁶; and
29

30 Whereas, within the coming decade, a projected 2.8 million undocumented immigrants will be
31 aged 55 years and older, yielding a higher incidence of chronic conditions, such as hypertension
32 and diabetes, which are exacerbated by years of prolonged untreated abuse²⁷; and
33

34 Whereas, around 34% of payroll tax, a federal tax, revenues are used to fund Medicare, and it is
35 estimated that undocumented immigrants contributed around \$2.2 billion to \$3.8 billion to the
36 Medicare Trust Fund through Individual Tax Identification Numbers (ITINs) which has shown
37 that undocumented workers pay billions in federal, state, and local taxes²⁸⁻³¹; and
38

39 Whereas, expansion of Medicare has been demonstrated to improve health outcomes, increase
40 reimbursement for physicians providing uncompensated care, and reduce the uninsured
41 population within the United States³²⁻³⁶; therefore be it
42

43 RESOLVED, that our AMA-MSS support awareness of abuse in undocumented workers and the
44 development of health-related interventions, such as occupational safety trainings and
45 provisions of workplace safety equipment; and be it further
46

47 RESOLVED, that our AMA-MSS support Medicare expansion to undocumented workers
48 through removal of immigration status as eligibility criteria.

Fiscal Note: TBD

Date Received: 03/31/2024

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RELEVANT AMA POLICY

Immigration Status is a Public Health Issue D-350.975

1. Our AMA declares that immigration status is a public health issue that requires a comprehensive public health response and solution.
2. Our AMA recognizes interpersonal, institutional, structural, and systemic factors that negatively affect immigrants' health.
3. Our AMA will promote the development and implementation of educational resources for healthcare professionals to better understand health and healthcare challenges specific for the immigrant population.
4. Our AMA will support the development and implementation of public health policies and programs that aim to improve access to healthcare and minimize systemic health barriers for immigrant communities. [Res. 904, I-22; Reaffirmed: Res. 210, A-23]

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]

Opposition to Regulations That Penalize Immigrants for Accessing Health Care Services D-440.927

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; Reaffirmed: Res. 259, A-23]

Protecting Workers During Catastrophes D-365.995

1. Our American Medical Association will advocate for legislation that creates federal standards of safety and protection of workers during natural or man-made catastrophes.
2. Our AMA will advocate that the United States Department of Labor, the Occupational Safety and Health Administration (OSHA), and other appropriate parties develop and enforce evidence-based policies, guidelines, and protections for workers at their place of employment during catastrophes. [Res. 411, A-23]

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 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; Reaffirmed: Res. 234, A-22]

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]

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 healthcare 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]

Advocating for Heat Exposure Protections for All Workers D-135.967

Our AMA: (1) will advocate for all workers to have access to preventive cool-down rest periods in shaded, ventilated, and/or cooled areas for prevention of injury from sun exposure and heat injury as well as appropriate access to emergency services when signs and symptoms of heat exposure injury; (2) will advocate for legislation that creates federal standards for protections against heat stress and sun exposure specific to the hazards of the workplace; (3) supports policy change at the federal level via legislation or administrative rule changes by the Occupational Safety and Health Administration (OSHA) that would require that workers receive health educational materials about prevention and recognition of heat exhaustion and heat exposure injury that is in the worker's primary language; (4) will work with the United States Department of Labor, OSHA, and other appropriate federal stakeholders to develop and enforce evidence-based policies, guidelines, and protections against heat injury for workers independent of legal status; and (5) recognizes there are particular medical conditions and medications, including but not limited to psychotropics, which increase an individual's vulnerability to the negative impacts of heat

and sun exposure and advocate for recognition of this, as well as additional protections as part of any guidelines, legislation or other policies. [Res. 502, I-21]

Action Regarding Illegal Aliens H-130.967

Our AMA supports the legislative and regulatory changes that would require the federal government to provide reasonable payment for federally mandated medical screening examinations and further examination and treatment needed to stabilize a condition in patients presenting to hospital emergency departments, when payment from other public or private sources is not available. [BOT Rep. MM, A-89; Reaffirmed by BOT Rep. 17 - I-94; Reaffirmed by Ref. Cmt. B, A-96; Reaffirmation A-02; Reaffirmation A-07; Reaffirmed: BOT Rep. 22, A-17]

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]

Options to Maximize Coverage under the AMA Proposal for Reform H-165.823

1. That our AMA advocate for a pluralistic health care system, which may include a public option, that focuses on increasing equity and access, is cost-conscious, and reduces burden on physicians.
2. Our AMA will advocate that any public option to expand health insurance coverage must meet the following standards:
 - a. The primary goals of establishing a public option are to maximize patient choice of health plan and maximize health plan marketplace competition.
 - b. Eligibility for premium tax credit and cost-sharing assistance to purchase the public option is restricted to individuals without access to affordable employer-sponsored coverage that meets standards for minimum value of benefits.
 - c. Physician payments under the public option are established through meaningful negotiations and contracts. Physician payments under the public option must be higher than prevailing Medicare rates and at rates sufficient to sustain the costs of medical practice.
 - d. Physicians have the freedom to choose whether to participate in the public option. Public option proposals should not require provider participation and/or tie physician participation in Medicare, Medicaid and/or any commercial product to participation in the public option.
 - e. The public option is financially self-sustaining and has uniform solvency requirements.
 - f. The public option does not receive advantageous government subsidies in comparison to those provided to other health plans.
 - g. The public option shall be made available to uninsured individuals who fall into the "coverage gap" in states that do not expand Medicaid – having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credits – at no or nominal cost.
3. Our AMA supports states and/or the federal government pursuing auto-enrollment in health insurance coverage that meets the following standards:
 - a. Individuals must provide consent to the applicable state and/or federal entities to share their health insurance status and tax data with the entity with the authority to make coverage determinations.
 - b. Individuals should only be auto-enrolled in health insurance coverage if they are eligible for coverage options that would be of no cost to them after the application of any subsidies. Candidates for auto-enrollment would, therefore, include individuals eligible for Medicaid/Children's Health Insurance Program (CHIP) or zero-premium marketplace coverage.
 - c. Individuals should have the opportunity to opt out from health insurance coverage into which they are auto-enrolled.
 - d. Individuals should not be penalized if they are auto-enrolled into coverage for which they are not eligible or remain uninsured despite believing they were enrolled in health insurance coverage via auto-enrollment.
 - e. Individuals eligible for zero-premium marketplace coverage should be randomly assigned among the zero-premium plans with the highest actuarial values.
 - f. Health plans should be incentivized to offer pre-deductible coverage including physician services in their bronze and silver plans, to maximize the value of zero-premium plans to plan enrollees.

g. Individuals enrolled in a zero-premium bronze plan who are eligible for cost-sharing reductions should be notified of the cost-sharing advantages of enrolling in silver plans.

h. There should be targeted outreach and streamlined enrollment mechanisms promoting health insurance enrollment, which could include raising awareness of the availability of premium tax credits and cost-sharing reductions, and establishing a special enrollment period.

4. Our AMA: (a) will advocate that any federal approach to cover uninsured individuals who fall into the “coverage gap” in states that do not expand Medicaid--having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credit eligibility--make health insurance coverage available to uninsured individuals who fall into the coverage gap at no or nominal cost, with significant cost-sharing protections; (b) will advocate that any federal approach to cover uninsured individuals who fall into the coverage gap provide states that have already implemented Medicaid expansions with additional incentives to maintain their expansions; (c) supports extending eligibility to purchase Affordable Care Act (ACA) marketplace coverage to undocumented immigrants and Deferred Action for Childhood Arrivals (DACA) recipients, with the guarantee that health plans and ACA marketplaces will not collect and/or report data regarding enrollee immigration status; and (d) recognizes the potential for state and local initiatives to provide coverage to immigrants without regard to immigration status. [CMS Rep. 1, I-20; Appended: CMS Rep. 3, I-21; Reaffirmation: A-22; Reaffirmed: CMS Rep. 3, A-22; Reaffirmed: Res. 122, A-22; Modified: Res. 813, I-22; Reaffirmed: CMS Rep. 5, I-23]

Opposing the Use of Vulnerable Incarcerated People in Response to Public Health Emergencies H-430.976

1. Our AMA acknowledges that systemic racism is a root of incarcerated labor policies and practices.

2. Our AMA supports:

(a) Efforts to ensure that all work done by individuals who are incarcerated in correctional facilities is fully voluntary.

(b) Eliminating policies that require forced labor or impose adverse consequences on incarcerated workers who are unable to carry out their assigned jobs due to illness, injury, disability, or other physical or mental limitations.

(c) Eliminating policies that negatively impact good time, other reductions of sentence, parole eligibility, or otherwise extend a person’s incarceration for refusal to work when they are unable to carry out their assigned jobs due to illness, injury, disability, or other physical or mental limitations.

(d) The authority of correctional health care professionals to determine when an individual who is incarcerated is unable to carry out assigned work duties.

3. Our AMA encourages:

(a) Congress and state legislatures to clarify the meaning of “employee” to explicitly include incarcerated workers within that definition to ensure they are afforded the same workplace health and safety protections as other workers.

(b) Congress to enact protections for incarcerated workers considering their vulnerabilities as a captive labor force, including anti-retaliation protections for workers who are incarcerated who report unsafe working conditions to relevant authorities.

(c) Congress to amend the Occupational Safety and Health Act to include correctional institutions operated by state and local governments as employers under the law.

(d) The U.S. Department of Labor to issue a regulation granting the Occupational Safety and Health Administration jurisdiction over the labor conditions of all workers incarcerated in federal, state, and local correctional facilities.

4. Our AMA encourages:

(a) Comprehensive safety training that includes mandatory safety standards, injury and illness prevention, job-specific training on identified hazards, and proper use of personal protective equipment and safety equipment for incarcerated workers.

(b) That safety training is delivered by competent professionals who treat incarcerated workers with respect for their dignity and rights.

(c) That all incarcerated workers receive adequate personal protective equipment and safety equipment to minimize risks and exposure to hazards that cause workplace injuries and illnesses.

(d) Correctional facilities to ensure that complaints regarding unsafe conditions and abusive staff treatment are processed and addressed by correctional administrators in a timely fashion.

5. Our AMA acknowledges that investing in valuable work and education programs designed to enhance incarcerated individuals' prospects of securing employment and becoming self-sufficient upon release is essential for successful integration into society.

6. Our AMA strongly supports programs for individuals who are incarcerated that provides opportunities for advancement, certifications of completed training, certifications of work performance achievements, and employment-based recommendation letters from supervisors. [BOT Rep. 02, I-23]

Relevant AMA-MSS Policy

165.023MSS Medicare Eligibility at Age 60

AMA-MSS will ask the AMA to advocate that the eligibility threshold to receive Medicare as a federal entitlement be lowered from age 65 to 60.(MSS Res. 006, A-21) (Immediately Forwarded to HOD, HOD Res. 123, A-21, Refer for Study)

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 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, I-00) (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) (Reaffirmed: MSS GC Rep B, A-21)

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 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. (AMA Sub Res 417, I-91 Adopted [H-170.980]) (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 GC Rep B, A-21)

365.007MSS Advocating for Heat Exposure Protections for Outdoor Workers

AMA-MSS will: (1) support advocating for outdoor workers to have access to preventive cool-down rest periods in shaded areas for prevention of heat exhaustion and health educational materials in their primary language; (2) support legislation creating a federal standard for protections against heat stress specific to the hazards of the workplace; and (3) support working with the United States Department of Labor, the Occupational Health and Safety Administration, and other appropriate federal stakeholders to develop and enforce evidence-based policies, guidelines, and protections against heat injury for outdoor workers independent of legal status. (MSS Res. 05, I-21)

365.008MSS Protecting Workers During Catastrophes

AMA-MSS will ask (1) that our AMA advocate for legislation that creates federal standards of safety and protection of workers during natural or man-made catastrophes and (2) that our AMA advocate that the United States Department of Labor, the Occupational Safety and Health Administration (OSHA), and other appropriate stakeholders to develop and enforce evidence-based policies, guidelines, and

protections for workers at their place of employment and traveling to and from their place of employment during catastrophes. (MSS Res. 040, A-22) (AMA Res. 411, Adopt as Amended, A-23)

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. (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) (Reaffirmed: MSS GC Rep B, A-21)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 223
(A-24)

Introduced by: Sharon Zeldin, Matthew Linz, Rutgers New Jersey School of Medicine,
Christian Anthony Tallo, University of Connecticut School of Medicine,
Pritika Parmar University of Colorado School of Medicine, Samantha Barr,
University of Wisconsin School of Medicine and Public Health

Subject: Increased Transparency Among Psychotropic Drug Administration in Prisons

Sponsored by: Region 2, Psychiatry Student Interest Group Network (PsychSIGN)

Referred to: MSS Reference Committee
(Caitlin Blaukovitch and Shaminy Manoranjithan, Co-Chairs)

1 Whereas, there is a substantial mental health burden among the incarcerated population, with
2 64% of jail inmates, 54% of state prisoners, and 45% of federal prisoners report mental health
3 concerns;^{1,2} and
4

5 Whereas, the prevalence of mental health disorders among incarcerated individuals is
6 disproportionately higher than the general population (22.8% in 2021), with 37% of federal
7 prisoners and 44% of jail inmates having a prior diagnosis with a mental health disorder, and 14%
8 of federal prisoners and 26% of jail inmate having serious psychological distress;^{3,10} and
9

10 Whereas psychotropic drugs, such as antipsychotics, antidepressants, mood stabilizers, and
11 tranquilizers are often used on incarcerated patients;⁴ and
12

13 Whereas, psychotropic drugs have adverse side effects, including extrapyramidal disorders,
14 neuroleptic malignant syndrome, suicide attempts, and death, some of which may be immediate
15 or delayed, indicating the need for close monitoring if these drugs are used;⁵ and
16

17 Whereas, prisons are known to have staffing deficiencies in their medical units, often resulting in
18 fatal delays to accessing care;^{6,7} and
19

20 Whereas, inmates can be involuntarily medicated if the state has clear, cogent, and convincing
21 evidence that it is in the state's interest at that time, such as for the safety of the inmate or others,
22 bypassing the assessment for capacity;⁸ and
23

24 Whereas, while there is precedent for the use of involuntary use of psychotropic agents in
25 accordance with *Washington v Harper* (1990) to treat incarcerated individuals who may be a
26 danger to self or others, there are also abundant opportunities for abuse and control of
27 incarcerated populations ;⁴ and
28

29 Whereas, many state and federal prisons currently lack transparency regarding their policies of
30 psychotropic drug administration, including but not limited to administration, duration, side effects,
31 and drug(s) of choice;^{4,9} and
32

1 Whereas, there is limited publicly available information describing most states' protocols for
 2 psychotropic drug administration, including but not limited to administration, duration, and drug(s)
 3 of choice;⁹ and
 4

5 Whereas, there is limited data surrounding the incarcerated patient's experience with mental
 6 illness and treatment while incarcerated;⁶ and
 7

8 Whereas, data collection surrounding side effects and complications of use of psychotropic drugs
 9 in incarcerated populations is limited due to the regular exclusion of this population from large
 10 scale population health surveys;⁶ and
 11

12 Whereas, the limited access to these data impedes research and advocacy efforts for this patient
 13 population; therefore be it
 14

15 RESOLVED, that our American Medical Association study issues surrounding the use of
 16 psychotropic medications in the carceral system, including inconsistencies in dosage, frequency,
 17 duration, allowed formularies, side effects, and physician and psychiatrist oversight; and be it
 18 further
 19

20 RESOLVED, that our AMA support increased transparency from state and federal jails and
 21 prisons surrounding protocols pertaining to the administration of psychotropic medications.

Fiscal Note: TBD

Date Received: 03/31/2024

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RELEVANT [AMA POLICY](#)

Medications for Opioid Use Disorder in Correctional Facilities H-430.987

Our AMA advocates for legislation, standards, policies and funding that require correctional facilities to increase access to evidence-based treatment of OUD, including initiation and continuation of medications

for OUD, in conjunction with psychosocial treatment when desired by the person with OUD, in correctional facilities within the United States and that this apply to all individuals who are incarcerated, including individuals who are pregnant, postpartum, or parenting. [Res. 443, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Appended: Res. 223, I-17; Modified: Res. 503, A-21]

Health Care While Incarcerated H-430.986

Our AMA supports: (a) linkage of those incarcerated to community clinics upon release in order to accelerate access to comprehensive health care, including mental health and substance use disorder services, and improve health outcomes among this vulnerable patient population, as well as adequate funding; (b) the collaboration of correctional health workers and community health care providers for those transitioning from a correctional institution to the community; (c) the provision of longitudinal care from state supported social workers, to perform foundational check-ins that not only assess mental health but also develop lifestyle plans with newly released people; and (d) collaboration with community-based organizations and integrated models of care that support formerly incarcerated people with regard to their health care, safety, and social determinant of health needs, including employment, education, and housing. [CMS Rep. 02, I-16; Appended: Res. 417, A-19; Appended: Res. 420, A-19; Modified: Res. 216, I-19; Modified: Res. 503, A-21; Reaffirmed: Res. 229, A-21; Modified: Res. 127, A-22; Appended: Res. 244, A-23; Appended: Res. 429, A-23]

Support for Health Care Services to Incarcerated Persons D-430.997

Our AMA will 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; [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; Reaffirmed: CSAPH Rep. 06, A-23]

Pharmacological Intervention for Agitated Individuals in the Out-of-Hospital Setting H-130.932

Our AMA:

1. Believes that current evidence does not support “excited delirium” or “excited delirium syndrome” as a medical diagnosis and opposes the use of the terms until a clear set of diagnostic criteria are validated.
2. Recognizes that the treatment of medical emergency conditions outside of a hospital is usually done by a subset of healthcare practitioners who are trained and have expertise as emergency medical service (EMS) practitioners. It is vital that EMS practitioners and systems are overseen by physicians who have specific experience and expertise in providing EMS medical direction.
3. Is concerned about law enforcement officer use of force accompanying “excited delirium” that leads to disproportionately high mortality among communities of color, particularly among Black men, and denounces “excited delirium” solely as a justification for the use of force by law enforcement officers.
4. Opposes the use of sedative/hypnotic and dissociative agents, including ketamine, as a pharmacological intervention for agitated individuals in the out-of-hospital setting, when done solely for a law enforcement purpose and not for a legitimate medical reason.
5. Recognizes that sedative/hypnotic and dissociative pharmacological interventions for agitated individuals used outside of a hospital setting by non-physicians have significant risks intrinsically, in the context of age, underlying medical conditions, and also related to potential drug-drug interactions with agents the individual may have taken.
6. Encourages the continued use of the necessary and effective dual-response method of communication between law enforcement and EMS to appropriately care for all patients encountered by first responders, including those patients demonstrating agitated or combative behavior.
7. Calls for comprehensive, independent analysis of law enforcement agencies to:
 - a. Review cases labeled as “excited delirium” to determine frequency of use of the term, including prevalence of its use by race, ethnicity, gender, age, and other demographic factors;
 - b. Assess the available training and guidelines used to prepare law enforcement first responders to respond to individuals with agitated or combative behavior, including de-escalation training;
 - c. Assess efforts to ensure adherence to approved training on an ongoing basis.
8. Calls for comprehensive, independent analysis, performed by appropriate medical and behavioral health professionals, of EMS agencies to:
 - a. Review the usage of ketamine and other sedative-hypnotic medications used to sedate patients with

agitated or combative behavior and correlation of the term “excited delirium” with race, ethnicity, gender, age or other demographic factors;

b. Assess whether existing training and guidelines, including continuous quality improvement processes, have been properly established by supervising EMS medical directors and behavioral health specialists, to:

i. Require appropriate monitoring of any patient who receives sedative/hypnotic and dissociative pharmacological interventions for treatment in the out-of-hospital setting;

ii. Ensure proper use of ketamine and other sedative/hypnotic and dissociative pharmacological interventions under defined protocols/guidelines after appropriate education on indications, usage and complications;

iii. Include an appropriate stepwise approach to the treatment of patients in the out-of-hospital setting, including de-escalation training, that provides safety to the patient and providers; and

c. Assess, on an ongoing basis, that personnel are conducting themselves according to guidelines and training.

9. Urges law enforcement and frontline emergency medical service personnel, who are a part of the “dual response” in emergency situations, to participate in appropriate training, overseen by EMS medical directors. The training should minimally include de-escalation techniques and the appropriate use of pharmacological intervention for agitated individuals in the out-of-hospital setting.

10. Urges medical and behavioral health specialists, not law enforcement, to serve as first responders and decision makers in medical and mental health emergencies in local communities and that administration of any pharmacological treatments in the out-of-hospital setting be done equitably, in an evidence-based, anti-racist, and stigma-free way. [CSAPH Rep. 2, A-21; Appended: BOT Action in response to referred for decision: CSAPH Rep. 2, A-21]

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 308
(A-24)

Introduced by: Jessica MacIntyre, Aaron Kiel, Christian Tallo, Priya Gupta, Krishna Channa, Stephanie Humen, Jacob Brady, University of Connecticut School of Medicine; Adrienne Nguyen, Des Moines University College of Osteopathic Medicine; Alec Camacho, University of Oklahoma School of Community Medicine

Subject: Expanding Medical Education Access and Support for First-Generation Students

Sponsored by: Region 3, Region 7

Referred to: MSS Reference Committee
(Caitlin Blaukovitch and Shaminy Manoranjithan, Co-Chairs)

-
- 1 Whereas, a first-generation student (FGS) is defined as someone whose parent(s) did not
2 complete a 4-year college degree, regardless of other family members' levels of education¹; and
3
4 Whereas, FGSs experience various unique challenges throughout the process of becoming a
5 physician, including feelings of isolation and exclusion from the community, difficulty accessing
6 basic and educational resources, and a lack of faculty or institutional support²; and
7
8 Whereas, FGSs are not explicitly included in the AAMC definition of underrepresented in
9 medicine, defined as racial and ethnic populations that are underrepresented in the medical
10 profession relative to their numbers in the general population³; and
11
12 Whereas, FGSs exhibit diverse intersectional identities in terms of gender, sexual orientation,
13 race, ethnicity, immigration status, and socioeconomic status, and their unique status
14 compounds the challenges they face in medical school, which is often overlooked by the
15 medical community^{4,5}; and
16
17 Whereas, 42% of students graduating with a bachelor's degree are first-generation; however,
18 only 12.4% of medical students, and 8% of MD/PhD matriculants are FGSs, indicating a large
19 disparity in representation of FGS in medical school compared to relative numbers in
20 undergraduate populations.^{6,7,8,9}; and
21
22 Whereas, an AAMC report found medical students increasingly came from families with at least
23 one parent with a bachelor's degree between 1992 to 2008, and while there is no official data
24 since the AAMC committed to increasing medical education diversity in 2018, the enrollment
25 number for FGSs remains disproportionately low^{10,11,12}; and
26

1 Whereas, while competitive and well-equipped FGSs were less likely than continuing-generation
2 graduates to apply and be accepted to accredited medical schools, while once accepted first-
3 generation college graduates were as likely as their continuing-generation peers to
4 matriculate¹³; and

5
6 Whereas, many medical schools often neglect to address the challenges related to being first-
7 generation, including career advice, financial advisement, education and psychological support,
8 and lack of positive encouragement²; and

9
10 Whereas, a diverse medical school class including more FGSs can enhance medical education
11 for all future physicians, improve quality of healthcare, and mitigate health disparities as first-
12 generation students offer a unique perspective that may enable them relate to, and build trust
13 with diverse patient populations^{5,12,14}; and

14
15 Whereas, professional medical societies, such as the AAMC, AMCAS, and select medical
16 colleges, highlight the need to increase support and enrollment for FGSs into medicine¹⁵; and

17
18 Whereas, institutions such as Geisinger Commonwealth School of Medicine have successfully
19 developed an impactful First-Generation and Ally Student Support Committee to offer population
20 specific resources that includes designated faculty and staff allies contacts, specific mentorship
21 and networking opportunities, student meet & greets, a guidebook with discounts to local shops,
22 and a food pantry for FGSs, which can be used as a model for other institutions¹⁶; and

23
24 Whereas, although the AMA supports enhancing diversity in medicine through pipeline
25 programs, educational support programs, and financial support in H-200.951, these policies do
26 not explicitly include first-generation status, and the AMA has not otherwise effectively
27 addressed the disparity in FGS enrollment in medical schools; therefore be it

28
29 RESOLVED, that our American Medical Association collaborate with appropriate stakeholders,
30 such as the AAMC, to increase population-specific supportive measures for first-generation
31 students throughout medical school; and be it further

32
33 RESOLVED, that our AMA amend Policy H-200.951, "Strategies for Enhancing Diversity in the
34 Physician Workforce," as follows:

35
36 **Strategies for Enhancing Diversity in the Physician Workforce, H-**
37 **200.951**

38 Our AMA: (1) supports increased diversity across all specialties in the
39 physician workforce in the categories of race, ethnicity, disability status,
40 sexual orientation, gender identity, socioeconomic origin, ~~and~~ rurality, and
41 first-generation status; (2) commends the Institute of Medicine (now known
42 as the National Academies of Sciences, Engineering, and Medicine) for its
43 report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health
44 Care Workforce," and supports the concept that a racially and ethnically
45 diverse educational experience results in better educational outcomes; (3)

1 encourages the development of evidence-informed programs to build role
2 models among academic leadership and faculty for the mentorship of
3 students, residents, and fellows underrepresented in medicine and in
4 specific specialties; (4) encourages physicians to engage in their
5 communities to guide, support, and mentor high school and undergraduate
6 students with a calling to medicine; (5) encourages medical schools, health
7 care institutions, managed care and other appropriate groups to adopt and
8 utilize activities that bolster efforts to include and support individuals who
9 are underrepresented in medicine by developing policies that articulate the
10 value and importance of diversity as a goal that benefits all participants,
11 cultivating and funding programs that nurture a culture of diversity on
12 campus, and recruiting faculty and staff who share this goal; and (6)
13 continue to study and provide recommendations to improve the future of
14 health equity and racial justice in medical education, the diversity of the
15 health workforce, and the outcomes of marginalized patient populations.

Fiscal Note: TBD

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RELEVANT AMA POLICY

Strategies for Enhancing Diversity in the Physician Workforce H-200.951

Our AMA: (1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin, and rurality; (2) commends the Institute of Medicine (now known as the National Academies of Sciences, Engineering, and Medicine) for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes; (3) encourages the development of evidence-informed programs to build role models among academic leadership and faculty for the mentorship of students, residents, and fellows underrepresented in medicine and in specific specialties; (4) encourages physicians to engage in their communities to guide, support, and mentor high school and undergraduate students with a calling to medicine; (5) encourages medical schools, health care institutions, managed care and other appropriate groups to adopt and utilize activities that bolster efforts to include and support individuals who are underrepresented in medicine by developing policies that articulate the value and importance of diversity as a goal that benefits all participants, cultivating and funding programs that nurture a culture of diversity on campus, and recruiting faculty and staff who share this goal; and (6) continue to study and provide recommendations to improve the future of health equity and racial justice in medical education, the diversity of the health workforce, and the outcomes of marginalized patient populations. [CME Rep. 1, I-06; Reaffirmed: CME Rep. 7, A-08; Reaffirmed: CCB/CLRPD Rep. 4, A-13; Modified: CME Rep. 01, A-16; Reaffirmation A-16; Modified: Res. 009, A-21; Modified: CME Rep. 5, A-21]

Encouraging LGBTQ+ Representation in Medicine D-200.972

Our AMA: (1) will 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) encourages 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) will 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. [Res. 004, A-22]

RELEVANT MSS POLICY

Youth Health Pipeline Programs Initiative 350.014MSS

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 local medical societies to develop pipeline programs that increase underrepresented in medicine (UIM) medical student enrollment, as defined by the AAMC and (2) will collaborate with medical school 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, the Association of Native American Medical Students, and other concerned organizations to support the development of medical career exposure and hands-on educational internship programs for underrepresented in medicine (UIM) and disadvantaged students. (MSS Res 27, I-15) (Amended and Reaffirmed: MSS GC Rep B, A-21)

Marginalized and Minoritized Medical Student Recruitment and Retention Programs 350.001MSS

AMA-MSS will ask the AMA to encourage medical schools to continue and/or develop programs to expose students from first generation and lower socioeconomic backgrounds to the career of medicine; special summer programs to bring students facing financial barriers to medical schools for an intensive exposure to medicine; and conduct retention programs for marginalized and minoritized medical students who may need assistance. (AMA Res 35, I-79 Referred) (CME Rep T, I-79, Adopted) (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 Res 4, I-14) (Reaffirmed: MSS Res 27, I-15) (Reaffirmed: MSS Res 19, I-17) (Amended: MSS GC Report A, A-23)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 311
(A-24)

Introduced by: Daniel Leung, University of Pikeville-Kentucky College of Osteopathic
Medicine

Subject: Expanding Medical Education Access and Support for First-Generation
Students

Sponsored by: American Medical Women's Association Medical Student Division (AMWA
MSD), Asian Pacific American Medical Student Association (APAMSA),
Psychiatry Student Interest Group Network (PsychSIGN)

Referred to: MSS Reference Committee
(Caitlin Blaukovitch and Shaminy Manoranjithan, Co-Chairs)

1 Whereas, even though most residency directors consider a COMLEX-USA score alongside a
2 USMLE score, the most common point residency directors make is that there is no
3 standardization of the two separate board exams and therefore the two separate board exams
4 are not considered equal because of implicit bias, regardless of both tests being considered as
5 legitimate routes to medical licensure;² and
6

7 Whereas, 2022 National Resident Matching Program (NRMP) Director Survey data shows that
8 29% of Program Directors never interview DOs, 49% seldom interview DOs, 28% never rank
9 DOs, and 46% seldom rank DOs;² and
10

11 Whereas, based on 2022 data, when comparing match rates between DO graduates and MD
12 graduates, DO match rates by preferred specialty are lower than MD counterparts except for
13 neurology, radiation oncology, diagnostic radiology, and transitional year programs;³ and
14

15 Whereas, match rates for competitive specialties range from 7.5% for DO students vs 10% for
16 MD students in dermatology, to 6.3% for DO students vs 72% for MD students in vascular
17 surgery showing great disparities between DO and MD graduates;³ and
18

19 Whereas, despite more DO schools opening in the last 15 years to meet the need for more
20 primary care physicians, even primary care specialties show that MD graduates are matched at
21 higher rates than DO graduates;^{3,4} and
22

23 Whereas, NRMP data suggest that osteopathic graduates are not receiving equal opportunities
24 in The Match;⁶ and
25

26 Whereas, the 2022 NRMP data showed that acceptance of COMLEX-USA is irrelevant to the
27 match rate disparities for DO students, regardless of preferred specialty;⁶ and
28

29 Whereas, after the Accreditation Council for Graduate Medical Education/American Osteopathic
30 Association (AOA) accreditation merger completion in 2020, AOA-accredited residencies no

1 longer exist, thus allowing MD graduates to apply to previously DO only residency that
 2 increases their match probability while MD programs do not accommodate DO applicants in the
 3 same way;⁶ therefore be it

4
 5 RESOLVED, that our American Medical Association partner with Accreditation Council for
 6 Graduate Medical Education, Association of American Medical Colleges, American Osteopathic
 7 Association, American Association of Colleges of Osteopathic Medicine, and other appropriate
 8 stakeholders to require all residency programs to report the number of DO and MD applicants
 9 they interview and rank as part of the NRMP Annual Report.

Fiscal Note: TBD

Date Received: 03/31/2024

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RELEVANT [AMA POLICY](#)

H-295.854 Increase Awareness Among Residency, Fellowship, and Academic Programs on the United States-Puerto Rico Relationship Status

1. Our AMA will work with the Liaison Committee on Medical Education (LCME), Middle States Commission on Higher Education (MSCHE), and Association of American Medical Colleges (AAMC) to inform residency and fellowship program directors and training programs in the United States that graduates of medical schools in Puerto Rico that are accredited by the LCME and MSCHE are U.S. medical school graduates.
2. Our AMA supports policies that ensure equity and parity in the undergraduate and graduate educational and professional opportunities available to medical students and graduates from all LCME- and Commission on Osteopathic College Accreditation (COCA)-accredited medical schools. [Res. 305, I-21]

D-310.977 National Resident Matching Program Reform

1. Our AMA will work with the National Resident Matching Program (NRMP) to develop and distribute educational programs to better inform applicants about the NRMP matching process, including the existing NRMP waiver and violations review policies;
2. Our AMA will actively participate in the evaluation of, and provide timely comments about, all proposals to modify the NRMP Match;
3. Our AMA will request that the NRMP explore the possibility of including the Osteopathic Match in the NRMP Match;
4. Our AMA will continue to review the NRMP's policies and procedures and make recommendations for improvements as the need arises, to include making the conditions of the Match agreement more transparent while assuring the confidentiality of the match;

5. Our AMA will work with the Accreditation Council for Graduate Medical Education (ACGME) and other appropriate agencies to assure that the terms of employment for resident physicians are fair and equitable and reflect the unique and extensive amount of education and experience acquired by physicians;
6. Our AMA 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. Our AMA 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. Our AMA will work with the NRMP and other external bodies to develop mechanisms that limit disparities within the residency application process and allow both flexibility and standard rules for applicants;
9. Our AMA 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. Our AMA will work with the NRMP and ACGME to evaluate the challenges in moving from a time-based education framework toward a competency-based system, including: a) analysis of time-based implications of the ACGME milestones for residency programs; b) the impact on the NRMP and entry into residency programs if medical education programs offer variable time lengths based on acquisition of competencies; c) the impact on financial aid for medical students with variable time lengths of medical education programs; d) the implications for interprofessional education and rewarding teamwork; and e) the implications for residents and students who achieve milestones earlier or later than their peers;
11. Our AMA 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. Our AMA 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. Our AMA 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. Our AMA 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. Our AMA encourages the Association of American Medical Colleges to work with U.S. medical schools to identify best practices, including career counseling, used by medical schools to facilitate successful matches for medical school seniors, and reduce the number who do not match;
16. Our AMA supports the movement toward a unified and standardized residency application and match system for all non-military residencies;
17. Our AMA encourages the Educational Commission for Foreign Medical Graduates (ECFMG) and other interested stakeholders to study the personal and financial consequences of ECFMG-certified U.S. IMGs who do not match in the National Resident Matching Program and are therefore unable to get a residency or practice medicine;
18. Our AMA encourages the AAMC, AACOM, NRMP, and other key stakeholders to jointly create a no-fee, easily accessible clearinghouse of reliable and valid advice and tools for residency program applicants seeking cost-effective methods for applying to and successfully matching into residency; and
19. Our AMA will work with appropriate stakeholders to study options for improving transparency in the resident application process. [CME Rep. 4, A-05; Appended: Res. 330, A-11; Appended: Res. 920, I-11; Appended: Res. 311, A-14; Appended: Res. 312, A-14; Appended: Res. 304, A-15; Appended: CME Rep. 03, A-16; Reaffirmation: A-16; Appended: CME Rep. 06, A-17; Appended: Res. 306, A-17; Modified:

Speakers Rep. 01, A-17; Appended: CME Rep. 3, A-21; Modified: CME Rep. 1, A-22; Appended: Res. 328, A-22]

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 313
(A-24)

Introduced by: Ethan Brown ZSOM, Greer Williams ZSOM, Barnabas Obeng-Gyasi IUSM,
David Zuckerman NYMC, Nikhil Dave IUSM

Subject: Opposition to Medical School Admissions Preference for Children of Donors
and Faculty

Sponsored by: American Medical Women’s Association Medical Student Division (AMWA
MSD), Asian Pacific American Medical Student Association (APAMSA)

Referred to: MSS Reference Committee
(Caitlin Blaukovitch and Shaminy Manoranjithan, Co-Chairs)

1 Whereas, our AMA in 2023 opposed the use of legacy admissions, defined as “a preference
2 given by an institution to children of alumni and sometimes to applicants of varying relation to
3 alumni,”¹; and
4

5 Whereas, donor and faculty relations are established by family members who either 1) donate to
6 or 2) attain faculty positions at an institution²; and
7

8 Whereas, children of donors or faculty (CDaF) status has been considered independently of and
9 has not helped applicants gain legacy status at major private universities^{2,3,4}; and
10

11 Whereas, several public universities whose institutional policies prohibit legacy preference have
12 still preferenced CDaF, as seen within the University of California system and at University of
13 Texas Austin^{5,6}; and
14

15 Whereas, CDaF preferences outside of medical schools has been found to significantly disfavor
16 underrepresented minority applicants, with one study of undergraduate admissions observing
17 <7% of admitted students with a faculty parent and <8% of admitted students with a donor
18 parent identifying as Black or Hispanic vs 30% of non-preferenced admitted students^{2,3}; and
19

20 Whereas, among medical school faculty, only 6% of full professors and 10% of total faculty are
21 Black or Hispanic compared to 38% of all 18–24 year-olds, suggesting that a preference for
22 relatives of medical school faculty may act as a preference against Underrepresented in
23 Medicine (URiM) applicants^{7,8}; and
24

25 Whereas, American academic physicians earned an average of \$347,000/annum in 2023,
26 placing them at the 96th percentile of incomes⁹; and
27

28 Whereas, outside of medical schools the likely size of future donations has been explicitly
29 weighed in the preferencing of donor children, such as in the admissions committees of major
30 undergraduate programs^{10,11}; and
31

1 Whereas, only 11% of American families earned over \$200,000/year in 2022 vs over 40% of
2 families with medical school matriculant children in the 2022-2023 application cycle^{12,13}; and
3

4 Whereas, in a 2023 survey of 39 allopathic medical school deans of admissions, several deans
5 acknowledged that preference for CDaF remained a barrier to diversity and favored applicants
6 with racial and socioeconomic advantages¹⁴; and
7

8 Whereas, medical admissions deans have described several factors which may favor CDaF
9 including 1) “offering additional reviews, keeping an eye out for a given application,
10 automatically granting interviews, and maintaining a database of preferred applicants” 2)
11 “[Awarding] bonus points if you knew somebody... or somebody was a donor, and that moved
12 [you] up on the... wait list” and 3) “[That] the development office gets lots of inquiry for particular
13 faculty... Imagine how difficult it would be to say, no [their relative] is not coming.”¹⁴; and
14

15 Whereas, the AAMC framework for advancing health equity states its intent to “identify the
16 subtle manifestations of structural racism that lead to exclusionary admissions processes in
17 medical schools and residency programs”¹⁵; therefore be it
18

19 RESOLVED, that our American Medical Association recognize that relation to donors may be
20 one reason, among many, for an applicant to express interest in a particular school, but
21 otherwise oppose consideration of donor relations in the evaluation of medical school applicants
22 due to its discriminatory impact on the diversity of the physician workforce; and be it further
23

24 RESOLVED, that our AMA work with the Association of American Medical Colleges (AAMC)
25 and American Association of Colleges of Osteopathic Medicine (AACOM) to deemphasize the
26 consideration of donor relation status in medical school admissions; and be it further
27

28 RESOLVED, that our AMA work with AAMC, AACOM, or other relevant stakeholders to
29 investigate the prevalence and impacts of faculty relation status in medical school admissions.

Fiscal Note: TBD

Date Received: 03/31/2024

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RELEVANT [AMA POLICY](#)

Against Legacy Preferences as a Factor in Medical School Admissions H-295.845

Our AMA recognizes that legacy status may be one of many stated reasons an applicant may offer for interest in a particular medical school, but oppose the use of questions about legacy status in the medical school application process due to their discriminatory impact. [Res. 028, A-22]

Racism as a Public Health Threat H-65.952

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

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

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. [CME Rep. 8, I-99; Reaffirmed: CME Rep. 2, A-09; Appended: CME Rep. 3, A-11; Reaffirmed: CME Rep. 1, A-21]

Diversity in Medical Education H-350.970

Our AMA will: (1) request that the AMA Foundation seek ways of supporting innovative programs that strengthen pre-medical and pre-college preparation for minority students; (2) support and work in partnership with local state and specialty medical societies and other relevant groups to provide education on and promote programs aimed at increasing the number of minority medical school admissions; applicants who are admitted; and (3) encourage medical schools to consider the likelihood of service to underserved populations as a medical school admissions criterion. [BOT Rep. 15, A-99; Reaffirmed: CME Rep. 2, A-09; Reaffirmed in lieu of Res. 311, A-15]

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 315
(A-24)

Introduced by: Sofia Lochner, Brianna Ma, California University of Science and Medicine,
Alec Calac, UC San Diego School of Medicine, Onajia Stubblefield,
University of Louisville, Isha Jhingan, University of Oklahoma College of
Medicine

Subject: Removing Headshot Requirements from Medical School, Residency, and
Fellowship Applications

Sponsored by:

Referred to: MSS Reference Committee
(Caitlin Blaukovitch and Shaminy Manoranjithan, Co-Chairs)

-
- 1 Whereas, creating a physician workforce representative of the United States population will
2 require an extensive overhaul of admissions processes and mitigation of potential sources of
3 reviewer bias¹⁻³; and
4
- 5 Whereas, potential sources of reviewer bias in health professional admissions include, but are
6 not limited to, awareness of the applicant's self-reported race and ethnicity, education (e.g.,
7 community college attendance), academic achievement, and standardized assessment
8 measures (e.g., GPA and MCAT), disability status, and physical appearance (e.g., applicant
9 headshot) (CME Report 5, A-21)^{4,5}; and
10
- 11 Whereas, the mandatory inclusion of applicant headshots in medical school⁶, residency⁷⁻¹⁴, and
12 fellowship^{15,16} applications introduces biases, including, but not limited to, stereotyping^{17,18},
13 implicit bias⁸, and halo effect^{19,20} into what should otherwise be a process that seeks to assess
14 an applicant's preparedness for professional advancement¹⁰; and
15
- 16 Whereas, it has been shown that applicants for dermatology residencies who smiled and wore
17 glasses and jackets in their application headshot had significantly higher match outcomes, and
18 while the chances of males matching were not affected by physical gender norms, females who
19 had hair to their shoulders or longer were associated with more favorable match outcomes²¹;
20 and
21
- 22 Whereas, when headshots are included in radiology residency interview considerations,
23 attractiveness is more influential in receiving interviews than race, class ranking, clinical
24 clerkship grades, and Alpha Omega Alpha membership, with obesity having a significant
25 negative effect on interview offers¹²; and
26
- 27 Whereas, seventy-five percent of medical students are from the top two income quintiles and
28 only 5% of medical students are from the bottom quintile²², with the cost of a professional
29 photoshoot ranging from \$150 to \$1,500 dollars²³, headshots may act as a form of financial
30 discrimination against low-income students, many of whom must work to support themselves
31 through the medical school application process²⁴; and
32

1 Whereas, recognizing race is a necessary safeguard in the admissions process (AMA Policy H-
2 350.979), however, this recognition can be effectively discerned through verbal or written
3 disclosure rather than through a photograph, as the latter fails to capture the essence of
4 race^{21,25}; and

5
6 Whereas, it is unnecessary to use photographs to construct a diverse student body, as proven
7 by the University of California system using only written social identity factors²⁶ for the last 27
8 years to successfully create a racially diverse student body²⁷; and

9
10 Whereas, it may be unethical for undergraduate and graduate medical education programs to
11 require applicant headshots, considering guidance from the Equal Employment Opportunity
12 Commission that doing so reveals federally-protected information about an individual¹¹; and

13
14 Whereas, physicians shall respect the rights of patients, colleagues, and other health
15 professionals, and shall safeguard patient confidences and privacy within the constraints of the
16 law (AMA Principles of Medical Ethics IV); therefore be it

17
18 RESOLVED, that our American Medical Association support discontinuing the headshot
19 requirement from all medical school, residency program, and fellowship applications, and be it
20 further

21
22 RESOLVED, that our AMA support blinding selection committees to all applicant's photographs
23 prior to granting interviews in instances where discontinuation of headshot requirements proves
24 unattainable.

Fiscal Note: TBD

Date Received: 03/31/2024

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RELEVANT [AMA POLICY](#)

Mitigating Demographic and Socioeconomic Inequities in the Residency and Fellowship Selection Process D-310.945

Our AMA will: 1. encourage medical schools, medical honor societies, and residency/fellowship programs to work toward ethical, equitable, and transparent recruiting processes, which are made available to all applicants. [CME Rep. 02, I-22]

Strategies for Enhancing Diversity in the Physician Workforce D-200.985

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. [CME Rep. 1, I-06; Reaffirmation I-10; Reaffirmation A-13; Modified: CCB/CLRPD Rep. 2, A-14; Reaffirmation: A-16; Appended: Res. 313, A-17; Appended: Res. 314, A-17; Modified: CME Rep. 01, A-18; Appended: Res. 207, I-18; Reaffirmation: A-19; Appended: Res. 304, A-19; Appended: Res. 319, A-19; Modified: CME Rep. 5, A-21; Modified: CME Rep. 02, I-22; Modified: Res. 320, A-23]

Continued Support for Diversity in Medical Education D-295.963

(3) Work with appropriate stakeholders to commission and enact the recommendations of a forward-looking, cross-continuum, external study of 21st century medical education focused on reimagining the future of health equity and racial justice in medical education, improving the diversity of the health workforce, and ameliorating inequitable outcomes among minoritized and marginalized patient populations. [Res. 325, A-03; Appended: CME Rep. 6, A-11; Modified: CME Rep. 3, A-13; Appended: CME Rep. 5, A-21; Modified: CME Rep. 02, I-22; Appended: Res. 319, A-22; Modified: Res. 319, A-23]

Increase the Representation of Minority and Economically Disadvantaged Populations in the Medical Profession H-350.979

Our AMA supports increasing the representation of minorities in the physician population by: (2) Encouraging all medical schools to reaffirm the goal of increasing representation of underrepresented minorities in their student bodies and faculties. (3) Urging medical school and undergraduate admissions committees to proactively implement policies and procedures that operationalize race-conscious admission practices in admissions decisions, among other factors. (5) Continuing its efforts to increase the proportion of minorities in medical schools and medical school faculty. (9) Recognizing the consideration of race in admissions is a necessary safeguard in creating a pipeline to an environment

within medical education that will propagate the advancement of health equity through diversification of the physician workforce. [CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CME Rep. 01, A-18; Modified: Res. 320, A-23; Appended: Res. 320, A-23]

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 321
(A-24)

Introduced by: Brianna Baldwin, University of Virginia School of Medicine Anna Klunk, Philadelphia College of Osteopathic Medicine; Katie Wilson, Hailey Baker, University of Minnesota Medical School; Michael Shukis, University of Cincinnati College of Medicine

Subject: Humanism in Anatomical Medical Education

Sponsored by: Association of Native American Medical Students (ANAMS)

Referred to: MSS Reference Committee
(Caitlin Blaukovitch and Shaminy Manoranjithan, Co-Chairs)

1 Whereas, medical students commonly experience negative emotional or physical reactions
2 upon beginning cadaveric donor dissection, such as anxiety, apprehension, and shock, and are
3 expected to quickly overcome these emotions to begin their dissections and accomplish their
4 lab work¹⁻²; and
5

6 Whereas, the term *donor(s)* is often used to describe human remains that have been donated
7 for dissection to limit or eliminate the commonly used term “cadaver” which objectifies the
8 human body^{3,4}; and
9

10 Whereas, despite adequately progressing, some medical students begin to experience feelings
11 of emotional discomfort including prolonged guilt towards their donors throughout their anatomy
12 course¹⁻²; and
13

14 Whereas, a diverse medical student community also nurtures religious, cultural, and spiritual
15 views towards deceased bodies that may conflict with anatomic dissection in medical
16 education⁵⁻⁶; and
17

18 Whereas, medical schools across the country have begun implementing cadaver donor
19 ceremonies at the beginning of, during, and/or upon completion of anatomy coursework to
20 convey respect and gratitude towards donors and/or their families⁷⁻⁸; and
21

22 Whereas, while the majority of medical schools incorporate some form of memorial ceremony in
23 their anatomy course, donor names are mentioned in less than half of institutional ceremonies in
24 the United States⁹; and
25

26 Whereas, responses from 370 medical students who participated in a donor memorial ceremony
27 shared positive responses towards their studies, reflection on death, and positive development
28 of empathy compared to those who did not attend the ceremony¹⁰; and
29

30 Whereas, memorial ceremonies and/or daily rituals were shown to have positive educational
31 effects and helped prevent the decline of students' responsibility and respect during their
32 dissection course¹; and
33

1 Whereas, multiple studies have shown that medical students would like to know donors, with
2 knowing increasing their positive response when working with anatomical donors^{1,9}; and
3

4 Whereas, donors supported anonymous disclosure of information after learning that medical
5 students wanted to know more about their background to establish the idea of them as their first
6 patient¹¹; and
7

8 Whereas, in an interview-based study exploring how students viewed donors, “person-minded”
9 medical students developed complex rules regarding respectful behavior towards donors,
10 including habits that reinforced the body donor’s humanity, in contrast to “specimen-minded”
11 students¹²; and
12

13 Whereas, Indigenous medical students who engaged in a cultural ceremony at the University of
14 New Mexico College of Medicine-Tucson were able to show their respect and appreciation to
15 donors, while also supporting their own spiritual, mental, and emotional health¹³; and
16

17 Whereas, humanism in medicine involves establishing patients, patients’ families, and providers
18 at the center of focus, promoting a better understanding of the human experience, and creating
19 humanizing communities and rituals that connect health professionals with their roots and their
20 values to be compassionate, caring, and collaborative clinicians¹⁴; and
21

22 Whereas, humanism has been recognized as essential to medical education with the awarding
23 of the Gold Humanism Award to undergraduate and graduate medical students who incorporate
24 humanism into the practice of medicine¹⁴; and
25

26 Whereas, our AMA recognizes the importance of trainee cultural identity in fostering success in
27 medical education (H-350.957); therefore be it
28

29 RESOLVED, that our American Medical Association support the incorporation of humanism in
30 human anatomy education programs, including, but not limited to, curricular time for reflection,
31 discussion, feedback, and accommodations for learners’ cultural observances surrounding the
32 deceased; donor recognition ceremonies; and HIPAA-compliant recognition of donor
33 backgrounds with students and trainees.

Fiscal Note: TBD

Date Received: 03/31/2024

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RELEVANT [AMA POLICY](#)

Cultural Leave for American Indian Trainees H-350.957

Our AMA recognizes the importance of cultural identity in fostering trainee success and encourages residency programs, fellowship programs, and medical schools to accommodate cultural observances for trainees from American Indian, Alaska Native, and Native Hawaiian communities. [Res. 323, A-22]

Conscience Clause: Final Report H-295.896

Principles to guide exemption of medical students from activities based on conscience include the following:

- (1) Medical schools should address the various types of conflicts that could arise between a physician's individual conscience and patient wishes or health care institution policies as part of regular curricular discussions of ethical and professional issues.
- (2) Medical schools should have mechanisms in place that permit students to be excused from activities that violate the students' religious or ethical beliefs. Schools should define and regularly review what general types of activities a student may exempt as a matter of conscience, and what curricular alternatives are required for students who exempt each type of activity.
- (3) Prospective students should be informed prior to matriculation of the school's policies related to exemption from activities based on conscience.
- (4) There should be formal written policies that govern the granting of an exemption, including the procedures to obtain an exemption and the mechanism to deal with matters of conscience that are not covered in formal policies.
- (5) Policies related to exemption based on conscience should be applied consistently.
- (6) Students should be required to learn the basic content or principles underlying procedures or activities that they exempt. Any exceptions to this principle should be explicitly described by the school.
- (7) Patient care should not be compromised in permitting students to be excused from participating in a given activity. [CME Rep .9, I-98; Reaffirmed: CEJA Rep. 11, A-08; Reaffirmed: CME Rep. 01, A-18]

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 402
(A-24)

Introduced by: Carlene Kranjac, Medical College of Wisconsin; Priyal Shah, Rowan-Virtua School of Osteopathic Medicine; Andrew Norton, University of Wisconsin School of Medicine and Public Health

Subject: Studying the Effects of Plant-Based Meat

Sponsored by: Region 2, Region 4

Referred to: MSS Reference Committee
(Caitlin Blaukovitch and Shaminy Manoranjithan, Co-Chairs)

1 Whereas, alternatives to animal meats is a growing industry, prompting the global food sector
2 undertake efforts to ensure the safety of foods in this category¹⁻⁷; and
3

4 Whereas, meat alternatives can be categorized as plant based, structured plant-derived
5 products designed to replace animal meat, and cultured/lab grown meat, meat grown in vitro
6 from animal cells⁸⁻⁹; and
7

8 Whereas, plant-based meats present considerable nutritional and economic potential without
9 many of the ethical and antibiotic resistance challenges of traditional factory meat production<sup>6-
10 7,10</sup>; and
11

12 Whereas, emerging studies claim health benefits from consuming plant-based meat instead of
13 animal meat, including improved cardiovascular and gut microbiome health, but numerous
14 experts recommend further research into the health effects of plant-based meat
15 consumption^{3,7,11,13-19}; and
16

17 Whereas, lab-grown and plant-based meats have a decreased environmental impact compared
18 to traditional livestock farming due to decreased greenhouse gas emissions, land use, and
19 water consumption^{20,21}; and
20

21 Whereas, research suggests that lab-grown meats have potential health benefits, including
22 reduced risk of bacterial contamination, lower levels of saturated fat and cholesterol, and the
23 absence of antibiotics and growth hormones, leading to improved health outcomes and reduced
24 incidence of diet-related diseases such as obesity, heart disease, and certain types of
25 cancer^{22,23}; and
26

27 Whereas, more research is needed to fully understand health benefits and potential health risks
28 of consuming lab grown meat²³; and
29

30 Whereas, the FDA primarily regulates the production and labeling of plant-based meat;
31 however, individual states have passed legislation on the labeling processes for both plant-
32 based and lab-grown proteins²⁴; and
33

1 Whereas, both the FDA and USDA regulate lab-grown meat, with the FDA overseeing cell
 2 collection and differentiation processes, and the USDA overseeing the cell harvesting process²⁵;
 3 therefore be it

4
 5 RESOLVED, that our AMA-MSS edit the pending transmittal titled “Support for Research on the
 6 Nutritional and Other Impacts of Plant-Based Meat” as follows:

7
 8 “RESOLVED, that our American Medical Association study the
 9 health-related effects of consuming ~~work with appropriate parties to~~
 10 ~~support plant-based and lab-grown meat research funding.~~”

Fiscal Note: TBD

Date Received: 03/31/2024

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RELEVANT [AMA POLICY](#)

H-150.922 Reduction in Consumption of Processed Meats

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

RELEVANT MSS POLICY

Advocating for Plant-Based Meat Research and Regulation 150.046MSS

AMA-MSS will ask that our AMA works with appropriate stakeholders to support plant-based meat research funding. (MSS COLA CGPH Report A, A-22)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 403
(A-24)

Introduced by: Jared Boyce, University of Wisconsin School of Medicine and Public Health; Daniel Resnick, College of Osteopathic Medicine - Pacific Northwest; Austin Le, University of Illinois College of Medicine Peoria; Zoe Wyse, Creighton University; Nicholas Wilson, Morehouse School of Medicine; Adrienne Nguyen, Des Moines University College of Osteopathic Medicine; Alison Blodgett, Indiana University School of Medicine; Riddhi Modi, New York Institute of Technology College of Osteopathic Medicine; Jourdon Robinson, Michigan State University College of Osteopathic Medicine; Priya Patel, Texas Tech University Paul L. Foster School of Medicine; Miriam Borvick, Kirk Kerkorian School of Medicine at University of Nevada, Las Vegas; Sarah Jiang, University of Missouri-Kansas City School of Medicine; Meghan Mallya, University of Texas Medical Branch John Sealy School of Medicine

Subject: Improving Child Disciplinary Education for Caregivers

Sponsored by: Asian Pacific American Medical Student Association (APAMSA)

Referred to: MSS Reference Committee
(Caitlin Blaukovitch and Shaminy Manoranjithan, Co-Chairs)

1 Whereas, corporal punishment (CP) is defined by the United Nations Convention on the Rights
2 of the Child, as “any punishment in which physical force is used and intended to cause some
3 degree of pain or discomfort, however light.”¹; and
4
5 Whereas, as of 2023, over 60 countries have banned CP, including Sweden, due to adverse
6 health outcomes and ineffectiveness discussed above which has noticed a decrease in reported
7 cases of CP^{2,3}; and
8
9 Whereas, the American Academy of Pediatrics (AAP), American Academy of Child and
10 Adolescent Psychiatry (AACAP), and American Professional Society on the Abuse of Children
11 (APSAC) do not support the use of CP or verbal abuse to discipline children and note that it is
12 less effective than time outs, removing privileges, and rewarding desirable behaviors^{4, 5, 6, 7}; and
13
14 Whereas, CP is not legally recognized as child abuse or an Adverse Childhood Experience
15 because physical injuries seldom remain, but it still increases impulsivity, inattention, aggression,
16 depression, anxiety, and decreased empathy in children^{4, 7, 8, 9, 10}; and
17
18 Whereas, CP adversely affects children’s brain development, performance in school, socialization
19 among peers, worsens quality of mother-child attachment, and adolescent suicide rates
20 decreased in countries that implemented full or partial bans on CP^{11, 12, 13, 14, 15, 16}; and
21
22 Whereas, caregiver attitudes and behaviors regarding CP develop within the first 6-12 months of
23 that child’s life, indicating that intervening early in the parenting process (e.g. prenatal period,
24 parent of child < 2 years) holds the greatest chance of reducing CP^{17, 18, 35}; and
25

1 Whereas, parental stressors, such as socioeconomic status and/or difficulty adjusting to the
2 parenting role, cultural norms, and previous childhood experience of CP increase emotional
3 reactivity in caregivers, which contributes to the decision to use CP to discipline children^{19, 20}; and
4

5 Whereas, difficulty regulating negative emotions like anger or frustration among caregivers
6 contributes directly to using CP as an impulsive “quick fix” in response to misbehaving children,
7 and caregivers believe that CP is effective and don’t believe they are “hitting”^{21, 22, 23, 24, 25, 26}; and
8

9 Whereas, a perceived lack of available alternatives to CP contributes to its continued use among
10 parents and, with the exception of removing items of interest (negative punishment), parents did
11 not view other forms of discipline as effective as CP²⁰; and
12

13 Whereas, caregivers with positive attitudes toward CP believe that the professional they seek
14 advice from supports the use of CP to discipline children, and caregivers are more likely to seek
15 advice about using CP from pediatricians than religious leaders, mental health professionals, or
16 other professionals - suggesting that physicians offering “how-to-discipline children”
17 resources/advice does not infringe on parental rights because caregivers are more likely to seek
18 advice from pediatricians and base their attitude toward CP on professional they seek advice
19 from^{21, 22, 23, 24}; and
20

21 Whereas, in 2012, approximately 51% of pediatricians discussed child discipline during clinic
22 visits, and most pediatricians feel somewhat prepared to advise parents/caregivers about child
23 discipline or CP, and children were more likely to associate anger more closely with spanking
24 than with the adult explaining to the child why the child’s misbehavior was harmful (inductive
25 discipline)^{4, 18, 27}; and
26

27 Whereas, Mother Empowerment Programs, initiatives focused on raising awareness of positive
28 parenting techniques and the adverse effects of CP, educational baby books informing caregivers
29 of alternatives to CP, motivational interviewing, and brief one-time interactive multimedia
30 programs teaching skills to redirect poor child behavior are scientifically effective methods of
31 reducing the use of CP and positive attitudes toward CP, but none of these are used clinically^{17,}
32 ^{19, 29}; and
33

34 Whereas, Positive Discipline parenting workshops decreased the use of CP and verbal abuse
35 among caregivers, overall caregiver stress, and hyperactive behaviors among children, while
36 increasing child academic competence³⁰; and
37

38 Whereas, Developing and distributing age-appropriate, religiously- and culturally-concordant
39 disciplining strategies to parents in the clinic or hospital can reduce additional burden on
40 pediatricians^{18, 31}; and
41

42 Whereas, pediatric primary care visits and providing educational materials to expecting caregivers
43 are effective in educating caregivers and changing the culture surrounding the use of CP in the
44 USA, which can aid advocacy efforts seeking to abolish the use of CP in schools and
45 communities, as written in H-515.995³²; and
46

47 Whereas, tools such as the Centers for Disease Control’s *Essentials for Parenting Toddlers and*
48 *Preschoolers* and AAP’s *Effective Discipline to Raise Healthy Children* are available online but
49 are only available in a few languages and the AMA Ed Hub does not have any Continuing Medical
50 Education modules that train physicians how to discuss CP or child discipline with caregivers^{4, 33,}
51 ³⁴; and

1 Whereas, since using CP may be related to challenges regulating anger/frustration, clinic visits
 2 discussing effective forms of discipline can also integrate techniques that help caregivers calm
 3 down when they are stressed, such as stepping away or relaxation techniques^{36, 37}; and
 4

5 RESOLVED, that our American Medical Association collaborate with the American Academy of
 6 Pediatrics, American Academy of Child and Adolescent Psychiatry, American Academy of Family
 7 Physicians, Centers for Disease Control, and other relevant organizations to develop novel
 8 culturally-concordant “how-to-discipline children” educational resources and programs that are
 9 centralized online in multiple languages to be offered to caregivers by the 6 month well child visit
 10 without cost; and be it further

11
 12 RESOLVED, that our AMA work with the relevant specialty societies to develop a standardized
 13 CME training on AMA Ed Hub for residents and physicians.

Fiscal Note: TBD

Date Received: 03/31/2024

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RELEVANT AMA POLICY

Corporal Punishment in Schools H-515.995

The AMA (1) supports the abolition of corporal punishment in schools; (2) encourages universities that train teachers to emphasize alternative forms of discipline during their training; (3) encourages physicians to work toward the abolition of corporal punishment in their communities; and (4) encourages state medical societies to support legislation prohibiting corporal punishment in their state. [BOT Rep. AA, A-85; Reaffirmed CLRPD Rep. 2, I-95; Reaffirmed: CSA Rep. 8, A-05; Modified: CSAPH Rep. 1, A-15]

Adverse Childhood Experiences and Trauma-Informed Care H-515.952

1. Our AMA recognizes trauma-informed care as a practice that recognizes the widespread impact of trauma on patients, identifies the signs and symptoms of trauma, and treats patients by fully integrating knowledge about trauma into policies, procedures, and practices and seeking to avoid re-traumatization.
2. Our AMA supports:
 - a. evidence-based primary prevention strategies for Adverse Childhood Experiences (ACEs);
 - b. evidence-based trauma-informed care in all medical settings that focuses on the prevention of poor health and life outcomes after ACEs or other trauma at any time in life occurs;
 - c. efforts for data collection, research, and evaluation of cost-effective ACEs screening tools without additional burden for physicians.

- d. efforts to educate physicians about the facilitators, barriers and best practices for providers implementing ACEs screening and trauma-informed care approaches into a clinical setting; and
 - e. funding for schools, behavioral and mental health services, professional groups, community, and government agencies to support patients with ACEs or trauma at any time in life; and
 - f. increased screening for ACEs in medical settings, in recognition of the intersectionality of ACEs with significant increased risk for suicide, negative substance use-related outcomes including overdose, and a multitude of downstream negative health outcomes.
3. Our AMA supports the inclusion of ACEs and trauma-informed care into undergraduate and graduate medical education curricula.
 4. Our AMA will collaborate with the CDC and other relevant interested parties to advocate for the inclusion of additional evidence-based categories to the currently existing Adverse Childhood Experiences (ACEs) categories for the purposes of continuing to improve research into the health impacts of ACEs and how to mitigate them.
 5. Our AMA will work with the CDC and other relevant interested parties to advocate for resources to expand research into ACEs and efforts to operationalize those findings into effective and evidence-based clinical and public health interventions.
 6. Our AMA will support the establishment of a national ACEs response team grant to dedicate federal resources towards supporting prevention and early intervention efforts aimed at diminishing the impacts ACEs have on the developing child. [Res. 504, A-19; Appended: CSAPH Rep. 3, A-21; Appended: Res. 914, I-23]

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]

Opposition to Parental Rights Amendments H-60.949

The AMA opposes state or federal legislative proposals (sometimes but not always known as "Parental Rights Amendments") that might give parents the right under law to harm a child or adolescent, and educate its members and the public regarding the potentially dangerous effects such initiatives represent to the public health and particularly to the health of our children. [BOT Rep. 24, A-97; Reaffirmed: BOT Rep. 33, A-07; Reaffirmed: BOT Rep. 22, A-17]

AMA Support for the United Nations Convention on The Rights of the Child H-60.952

Our AMA supports the United Nations Convention on the Rights of the Child and urges the Administration and Congress to support the Convention by ratifying it after considering any appropriate Reservations, Understandings, and Declarations. [BOT Rep. 44, A-96; Reaffirmed: Res. 2, I-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20]

Relevant MSS Policy

60.032MSS Opposition of Corporal Punishment as a Form of Discipline

AMA-MSS (1) opposes the use of corporal punishment in any setting and (2) supports education on the negative effects of corporal punishment and education on more effective discipline strategies. (MSS Res. 70, I-19)

515.015MSS Amending H-515.952, Adverse Childhood Experiences and Trauma Informed Care, to Encourage ACE and TIC Training in Undergraduate Medical Education

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)

60.045MSS Expanding Adverse Childhood Experiences Categories

That our AMA-MSS support (1) collaboration with the CDC and other relevant parties to advocate for the addition of witnessing violence, experiencing discrimination, living in an unsafe neighborhood, experiencing bullying, placement in foster care, migration-related trauma, living in poverty, and any additional categories as needed and justified by scientific evidence to the currently existing Adverse Childhood Experiences (ACEs) categories for the purposes of continuing to improve research into the health impacts of ACEs and how to mitigate them; (2) working with the CDC and other relevant parties to advocate for resources to expand research into ACEs and efforts to operationalize those findings into effective and evidence-based clinical and public health interventions; and (3) the establishment of a national ACEs response team grant to dedicate federal resources to supporting prevention and early intervention efforts aimed at diminishing the impacts ACEs have on the developing chil

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 404
(A-24)

Introduced by: Christian Tallo, Priya Gupta, Jessica MacIntyre, Aaron Kiel, Stephanie Humen; University of Connecticut School of Medicine

Subject: Support for Standardized Periodic Hearing Screenings in Primary Schools

Sponsored by: Region 1

Referred to: MSS Reference Committee
(Caitlin Blaukovitch and Shaminy Manoranjithan, Co-Chairs)

- 1 Whereas, hearing loss has been established as a health barrier to learning, and influences a
2 child's ability to learn, communicate with others, and form relationships^{1,2}; and
3
4 Whereas, students with hearing loss in early academic years are more likely to face an
5 increased likelihood of experiencing decreased long-term academic achievement, higher
6 dropout rates, and fewer employment opportunities^{3,4}; and
7
8 Whereas, mild hearing loss contributes to decreased attentiveness to classroom instruction⁵;
9 and
10
11 Whereas, early hearing aid fitting and regular use improves academic achievement and long
12 term health outcomes in students with hearing loss⁶; and
13
14 Whereas, school hearing screenings improve health outcomes, decrease social health burdens,
15 reduce socioeconomic inequity, and improve early access to preventative healthcare²; and
16
17 Whereas, newborn hearing screenings are currently recommended by the American Academy
18 of Pediatrics, with 1.7% of newborn children being identified with hearing loss⁷; and
19
20 Whereas, illness, trauma, or underlying medical conditions can contribute to the development of
21 new onset or worsening hearing loss in older children, with the prevalence rising to
22 approximately 20% by age 12, indicating a need for continued screenings after newborn
23 testing⁸; and
24
25 Whereas, as many as 25% of states do not implement any form of school hearing screenings
26 due to a lack of national recommendation for screening tests, and the states that do have
27 drastically different screenings in terms of timing and quality⁹; and
28
29 Whereas, regionally implemented school hearing screenings have improved outcomes for
30 school-aged children¹⁰; and
31
32 Whereas, a national standardized recommendation is necessary to promote uniform screenings
33 and implementation, improving early recognition of hearing loss in children²; therefore be it
34

- 1 RESOLVED, that our American Medical Association support periodic hearing screenings in
 2 children based on evidence-based guidelines, including a national recommendation for the
 3 development of standardized periodic hearing screenings in primary schools with appropriate
 4 referral to a physician for a comprehensive audiologic evaluation.

Fiscal Note: TBD

Date Received: 03/31/2024

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RELEVANT AMA POLICY

Encouraging Vision Screenings for Schoolchildren H-425.977

Our AMA: 1) encourages and supports outreach efforts to provide vision screenings for school-age children prior to primary school enrollment; (2) encourages the development of programs to improve school readiness by detecting undiagnosed vision problems; and (3) supports periodic pediatric eye screenings based on evidence-based guidelines with referral to an ophthalmologist for a comprehensive professional evaluation as appropriate. [Res. 430, A-05; Modified: CSAPH Rep. 1, A-15]

Early Hearing Detection and Intervention H-245.970

Our AMA: 1) supports early hearing detection and intervention to ensure that every infant receives proper hearing screening, diagnostic evaluation, intervention, and follow-up in a timely manner; and 2) supports federal legislation that provides for the development and monitoring of statewide programs and systems for hearing screening of newborns and infants, prompt evaluation and diagnosis of children referred from screening programs, and appropriate medical, educational, and audiological interventions and follow-up for children identified with hearing loss. [Res. 514, A-11; Reaffirmed: CMS Rep. 6, I-15]

RELEVANT MSS POLICY

Detection, Diagnosis and Intervention of Hearing Loss in Newborns and Infants 245.066MSS

AMA-MSS will ask the AMA to support the establishment of statewide programs for the early detection and diagnosis of hearing loss as well as interventional programs for all affected newborns and infants. (MSS Late Res 11, I-98) (AMA Res 435, I-98 Referred) (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)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 419
(A-24)

Introduced by: Brooke Birks, Jessy Silver, Michael Russell, Esther Mallet

Subject: Equity in Celiac Disease and/ Food Allergies Research and Resources

Sponsored by: Region 5

Referred to: MSS Reference Committee
(Caitlin Blaukovitch and Shaminy Manoranjithan, Co-Chairs)

1 Whereas, the National Institute of Health defines Celiac disease as a chronic digestive immune
2 disorder that damages the small intestine triggered by eating gluten-containing foods¹; and
3
4 Whereas, food allergies are defined as an immune reaction, which can be life-threatening, to
5 proteins in the food and can be Ig-E mediated or non-IgE-mediated²; and
6
7 Whereas, approximately 1% of Americans are diagnosed with Celiac disease^{3,4}; and
8
9 Whereas, food allergies affect 7.6% of kids and 10.6% of adults, and the prevalence of food
10 allergies is increasing, with some studies determining the rate of increase to be 1.2% per
11 decade across all children and nearly double (2.1%) among black children^{5,6,7}; and
12
13 Whereas, the uptrend in pediatric food allergies has disproportionately affected minoritized
14 populations both in the prevalence of food allergies and in the likelihood for multiple food
15 allergies per child⁸; and
16
17 Whereas, low socioeconomic status families with food allergies face significantly higher health
18 care costs due to increased annual food allergy related emergency department visits and
19 hospitalizations than higher income families⁹; and
20
21 Whereas, the standard of care for food allergies and Celiac disease is allergen and gluten
22 avoidance¹⁰⁻¹²; and
23
24 Whereas, only 5% of gluten-free bread is fortified with mandatory fortified nutrients (calcium,
25 iron, nicotinic acid and thiamine) required in non-gluten free bread¹³; and
26
27 Whereas, the cost of gluten free foods were more than 242% more expensive than regular
28 products, but supply costs for these items have not yet been evaluated ¹⁴; and
29
30 Whereas, the cost of staple foods of a traditional American diet, such as bread and pasta also
31 had significant price differences compared to their wheat-based counterparts-229% and 227%
32 more expensive, respectively¹⁵; and
33

1 Whereas, 9 foods (milk, eggs, fish, shellfish, tree nuts, peanuts, wheat, soybeans, and sesame),
2 account for 90% of food allergies^{16,17}; and
3

4 Whereas, 30% of individuals with a food allergy, also have at least one other food allergy¹⁸; and
5

6 Whereas, children with food allergies and on the recommended elimination diet are more likely
7 to be deficient in body height and weight, which increases as the number of eliminated products
8 increases^{19, 20}; and
9

10 Whereas, families with food allergies face significant social and economic burdens, such as
11 increased anxiety, depression, and higher household and healthcare costs^{7, 21-23}; and
12

13 Whereas, food insecurity is defined as a household unable to acquire adequate food for one or
14 more household members because they had insufficient money and other resources for food²⁴;
15 and
16

17 Whereas, food insecurity is more common in families with food allergies, and this issue was
18 exacerbated by the COVID-19 pandemic^{25,26}; and
19

20 Whereas, families with Supplemental Nutrition Assistance Program (SNAP) benefits, especially
21 those with disabilities, still face significant food insecurity, but there is a lack of information
22 regarding food insecurity in families with health conditions, such as Celiac disease and food
23 allergies²⁷; and
24

25 Whereas, the American Medical Association advocates for the improvement of SNAP to
26 promote adequate nutrient intake and reduce food insecurity, but doesn't specifically mention
27 individuals with dietary restrictions due to medical conditions, such as Celiac disease and food
28 allergies²⁸; and
29

30 Whereas, the American Medical Association advocates for the decrease the price gap between
31 calorie dense and nutrition poor foods and naturally nutrition dense foods to decrease food
32 insecurity, but does not specifically mention individuals requiring allergen- and/or gluten-free
33 foods due to medical conditions²⁹; therefore be it
34

35 RESOLVED, that our American Medical Association support efforts to lower the price of
36 allergen- and gluten- free foods; and be it further
37

38 RESOLVED, that our AMA support federal and state policies to expand mandatory fortified
39 nutrients to gluten-free food options; and be it further
40

41 RESOLVED, that our AMA support efforts to investigate food insecurity in families receiving
42 SNAP benefits that have medical conditions, such as food allergies and/or celiac disease, that
43 potentially increases vulnerability to food insecurity; and be it further
44

45 RESOLVED, that our AMA support efforts to lower the income requirements for families with
46 food allergies and/or Celiac disease and provide additional Supplemental Nutrition Assistance
47 Program (SNAP) benefits to already-qualified families.

Fiscal Note: TBD

Date Received: 03/31/2024

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RELEVANT [AMA POLICY](#)

Improvements to Supplemental Nutrition Programs H-150.937

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.

Our AMA will request that the federal government support SNAP initiatives to (a) incentivize healthful foods and disincentivize or eliminate unhealthy foods and (b) harmonize SNAP food offerings with those of WIC.

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, Reaffirmed: Res. 259, A-23]

Strengthening Supplemental Nutrition Assistance Program (SNAP) H-150.920

Our AMA will: (1) support allowing the use of SNAP benefits to purchase hot, heated, and prepared foods at SNAP-eligible vendors; (2) support expanding SNAP to U.S. territories that currently receive capped block grants for nutrition assistance; (3) actively support elimination of the five-year SNAP waiting period for otherwise qualifying immigrants and expansion of SNAP to otherwise qualifying Deferred Action Childhood Arrivals (DACA) recipients; and (4) advocate for increased federal funding for the Supplemental Nutrition Assistance Program (SNAP) that improves and expands benefits and broadens eligibility.

[Res. 259, A-23]

RELEVANT [MSS POLICY](#)

Decreasing Incidence of Obesity and Negative Sequelae by Reducing the Cost Disparity Between Calorie-Dense, Nutrition Poor Foods and Nutrition-Dense Foods

AMA-MSS will ask the AMA to (1) support efforts to decrease the price gap between calorie dense, nutrition poor (CDNP) foods and naturally nutrition dense (ND) foods to improve health in economically disadvantaged populations by encouraging the expansion, through increased funds and increased enrolment, of existing programs that seek to improve nutrition and reduce obesity such as the Farmer's Market Nutrition Program (FMNP) as a part of the Women, Infants, and Children (WIC) program; and (2) support the novel application of FMNP to existing programs such as the Supplemental Nutrition Assistance Program (SNAP), and apply program models that incentivize the consumption of ND foods in wider food distribution venues than solely farmer's markets as part of WIC.

(MSS Res 23, I-09) (AMA Res 414, A-10 Adopted [H-150.937]) (Reaffirmed: MSS GC Rep A, I-14) (Reaffirmed: MSS GC Rep A, I-19)

Support of the Supplemental Nutrition Assistance Program (SNAP) Education Programs and Research

AMA-MSS (1) supports nutrition education programs for Supplemental Nutrition Assistance Program (SNAP) recipients and (2) opposes changes to SNAP that would increase food insecurity such as rigid work requirements or categorical exclusion of individuals who receive SNAP benefits based on their income level.

(MSS Res 17, A-18)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 422
(A-24)

Introduced by: Shashank Madhu, University of Miami Miller School of Medicine; Elizabeth Darga, Central Michigan University College of Medicine; Lauren St. Peter, University of Kansas School of Medicine- Kansas City; Michaela Kelly, University of Texas Health Science Center San Antonio Long School of Medicine; Mingee Kim, Medical College of Wisconsin; Catriona Hong, University of Connecticut School of Medicine; Olumide Fajolu, University of Colorado School of Medicine; Matthew Linz, Rutgers New Jersey Medical School

Subject: Protecting the Healthcare Supply Chain from the Impacts of Climate Change

Sponsored by: Region 3

Referred to: MSS Reference Committee
(Caitlin Blaukovitch and Shaminy Manoranjithan, Co-Chairs)

1 Whereas, 2023 was the hottest year on record, with average land and ocean surface
2 temperatures 2.12 degrees F above the 20th century average and nearly 0.3 degrees higher
3 than the next hottest year, 2016¹; and
4

5 Whereas, there were 28 weather/climate disasters costing more than \$1 billion per event
6 occurring in 2023 alone, posing risks not only to human and material well-being but also directly
7 impacting healthcare supply chains, whose facilities are located in vulnerable areas²⁻¹⁰; and
8

9 Whereas, institutional capacities of healthcare organizations are susceptible to risks due to
10 climate change, jeopardizing land use for infrastructure and restricting the handling of medical
11 equipment to areas that are not prone to climate-related problems as determined by a climate
12 vulnerability index^{11,12}; and
13

14 Whereas, climate-related disasters are expected to cause shipping delays, and in the last
15 decade have significantly damaged plants manufacturing medical supplies, leading to longer
16 resupply times and temporary global shortages of these crucial products^{13-17,33}; and
17

18 Whereas, While the Biden-Harris Administration has endorsed the Medical Supply Chain
19 Resiliency ACT and empowered the Department of Health and Human Services (HHS) with
20 expanded authority, allocating \$35 million for investments in domestic production of key sterile
21 injectable materials, it has not explicitly addressed the imperative of responding to supply chain
22 disruptions due to climate-related factors¹⁸; and
23

24 Whereas, production and supply storage facilities are relocating manufacturing and distribution
25 back to the U.S. to avoid supply chain shortages and disruptions¹⁹⁻²¹; and
26

27 Whereas, while hospitals are crucial in the medical supply chain, only a small percentage of
28 U.S. healthcare systems conduct climate risk assessments, and existing hazard vulnerability
29 analysis mandated by the U.S. Centers for Medicare and Medicaid Services (CMS) may not

1 adequately address the potential impact of climate change on hospitals, as evidenced by
2 frequent climate-related hospital evacuations and power outages²²⁻²⁴; and

3
4 Whereas, over the past thirty years, the healthcare industry has transitioned to a “just-in-time”
5 system of medical product procurement relying on short-term, single-use disposables, which
6 has made the industry susceptible to unexpected supply chain shocks^{25,26}; and

7
8 Whereas, adoption of medical product reusability strategies saved hospitals \$372 million in
9 2020 alone, with potential for even greater savings and improved supply chain resilience
10 through broader implementation²⁷; and

11
12 Whereas, The House Ways & Means Committee reported current hurdles preventing healthcare
13 systems from transitioning to a reusable model, citing lack of incentives for manufacturers and
14 disagreements about the safety of reusable products²⁸, and

15
16 Whereas, AMA policy H-440.847 addresses the need for funding and stockpiling of necessary
17 medical supplies for catastrophic events, however, it fails to address the critical need to plan for
18 disruptions in manufacturing infrastructure and supply chain operations as a result of
19 catastrophic climate-related events²⁹; and

20
21 Whereas, to ensure access to healthcare during climate disasters, all facilities in the supply
22 chain need to be climate-resilient, which may require relocating them to climate-resilient areas¹¹;
23 and

24
25 Whereas, Massachusetts General Hospital conducted a novel form of risk assessment using
26 climate expert projections to find solutions such as implementing cooling systems in extreme
27 heat waves, mapping areas for flood barriers, and developing strategies to prevent supply chain
28 disruptions²³; and

29
30 Whereas, proactive state and local community investments to address supply chain
31 vulnerabilities resulted in the restoration of operational necessities up to six months earlier than
32 areas without similar investments in the aftermath of Hurricanes Harvey, Irma, and Maria³⁰; and

33
34 Whereas, a dynamic systems model based on natural disaster preparedness predicted an 18-
35 day reduction in the time to deliver supplies through training supply chain staff, aligning
36 production with government regulation, and forming agreements between suppliers and
37 governments³¹; and

38
39 Whereas, as natural disasters become more common, supply chain disruptions will impede the
40 ability of healthcare systems to deliver care, underscoring the need to make healthcare supply
41 chains adaptable to a changing climate and capable of sustainably providing life-saving
42 products to patients^{5,6,32,33}; therefore be it

43
44 RESOLVED, that our American Medical Association support assessments of the vulnerability of
45 existing healthcare supply chains in the context of climate change-related events; and be it
46 further

47
48 RESOLVED, that our AMA support the development of strategies and technologies to
49 strengthen supply chain networks, including relocating facilities to climate-resilient areas and
50 incentivizing the innovation and adoption of reusable medical products to resist the impact of
51 supply chain disturbances.

Fiscal Note: TBD

Date Received: 03/31/2024

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RELEVANT [AMA POLICY](#)

Global Climate Change and Human Health H-135.938

Our AMA: ... (5) Encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently, and that adaptation interventions are equitable and prioritize the needs of the populations most at risk. [CSAPH Rep. 3, I-08; Reaffirmation A-14; Reaffirmed: CSAPH Rep. 04, A-19; Reaffirmation: I-19; Modified: Res. 424, A-22; Modified: CSAPH Rep. 2, I-22]

Declaring Climate Change a Public Health Crisis D-135.966

1. Our AMA declares climate change a public health crisis that threatens the health and well-being of all individuals. 2. Our AMA will protect patients by advocating for policies that: (a) limit global warming to no more than 1.5 degrees Celsius, (b) reduce US greenhouse gas emissions aimed at a 50 percent reduction in emissions by 2030 and carbon neutrality by 2050, and (c) support rapid implementation and incentivization of clean energy solutions and significant investments in climate resilience through a climate justice lens. 3. Our AMA will consider signing on to the Department of Health and Human Services Health Care Pledge or making a similar commitment to lower its own greenhouse gas emissions. 4. Our AMA encourages the health sector to lead by example in committing to carbon neutrality by 2050. 5. Our AMA will develop a strategic plan for how we will enact our climate change policies including advocacy priorities and strategies to decarbonize physician practices and the health sector with report back to the House of Delegates at the 2023 Annual Meeting. [Res. 420, A-22; Appended: CSAPH Rep. 02, I-22]

Pandemic Preparedness H-440.847

Our AMA: ... (3) encourages states to maintain medical and personal protective equipment stockpiles sufficient for effective **preparedness** and to respond to a pandemic or other major public health emergency; and (8) will encourage state and federal efforts to locate the manufacturing of goods used in healthcare and healthcare facilities in the United States. [CSAPH Rep. 5, I-12; Reaffirmation A-15; Modified: Res. 415, A-21; Reaffirmed: CSAPH Rep. 1, I-22; Appended: Res. 924, I-22]

National Drug Shortages H-100.956

Our AMA: ... (4) will advocate that the US Food and Drug Administration (FDA) and/or Congress require drug manufacturers to establish a plan for continuity of supply of vital and life-sustaining medications and vaccines to avoid production shortages whenever possible. This plan should include establishing the necessary resiliency and redundancy in manufacturing capability to minimize disruptions of supplies in foreseeable circumstances including the possibility of a disaster affecting a plant; and (18) Our AMA urges DHHS and the U.S. Department of Homeland Security (DHS) to examine and consider drug shortages as a national security initiative and include vital drug production sites in the critical

infrastructure plan; and (20) Our AMA supports innovative approaches for diversifying the generic drug manufacturing base to move away from single-site manufacturing, increasing redundancy, and maintaining a minimum number of manufacturers for essential medicines; and (21) Our AMA supports the public availability of FDA facility inspection reports to allow purchasers to better assess supply chain risk. [CSAPH Rep. 2, I-11; Modified: CSAPH Rep. 7, A-12; Modified: CSAPH Rep. 2, I-12; Modified: CSAPH Rep. 8, A-13; Modified in lieu of Res. 912, I-13; Modified: CSAPH Rep. 3, A-14; Modified: CSAPH Rep. 2, I-15; Appended: CSAPH Rep. 04, I-17; Modified: CSAPH Rep. 02, A-18; Reaffirmed: CMS Rep. 08, A-19; Reaffirmed: Res. 105, A-19; Modified: CSAPH Rep. 1, I-20; Modified: Res. 503, A-22; Appended: CSAPH 1, I-22; Modified: CSAPH Rep. 1, I-23]

Source and Quality of Medications Critical to National Health and Security H-100.946

Our AMA: (1) supports studies that identify the extent to which the United States is dependent on foreign supplied pharmaceuticals and chemical substrates; (2) supports 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 (3) encourages 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. [Res. 932, I-19; Reaffirmed: CSAPH Rep. 4, I-21]

RELEVANT MSS POLICY

Toward Environmental Responsibility 135.012MSS

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) (Reaffirmed: MSS GC Report A, I-21)

Drug Shortages 100.011MSS

AMA-MSS supports the Council on Science and Public Health Report 7, A-12, "Drug Shortages Update," that contains the following recommendations:

1. Our AMA supports the recommendations of multiple stakeholders' working in a collaborative fashion to implement these recommendations in an urgent fashion.
2. Our AMA will advocate that the U.S. Food and Drug Administration and/or Congress require drug manufacturers to establish a plan for continuity of supply of vital and life-sustaining medications and vaccines to avoid production shortages whenever possible.
3. The Council on Science and Public Health continue to evaluate the drug shortage issue and keep the HOD informed about AMA efforts to address this problem.

Our AMA urges the development of a comprehensive federal report on the root causes of drug shortages. Such an analysis should include economic factors, including federal reimbursement practices, as well as contracting practices by market participants on competition, access to drugs, and pricing (Sub MSS Res 41, A-12) (Modified and Reaffirmed: MSS GC Rep A, I-17) (Reaffirmed: MSS GC Rep A, I- 19)

Longitudinal Capacity Building to Address Climate Action and Justice 40.112MSS

AMA-MSS will ask the AMA to: (1) Declare climate change an urgent public health emergency that threatens the health and well-being of all individuals; (3) Study opportunities for local, state, and federal policy interventions and advocacy to proactively respond to the emerging climate health crisis and advance climate justice with report back to the House of Delegates; (MSS Res. 27, I-21) (AMA Res. 430, Adopt)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 423
(A-24)

Introduced by: Akhil Mahant, University of Rochester School of Medicine and Dentistry, Taylor LaValle, University of Missouri-Columbia School of Medicine, Sneha Kapil, University of Miami Miller School of Medicine, Sarah Bdeir, Wayne State University School of Medicine, Brooke Taylor, University of South Carolina School of Medicine Greenville

Subject: Preventing Heat Related Illness with Appropriate Heat Response Standards

Sponsored by: Region 2, Region 5

Referred to: MSS Reference Committee
(Caitlin Blaukovitch and Shaminy Manoranjithan, Co-Chairs)

-
- 1 Whereas, heat-related illness is one of the largest causes of death due to weather in high-
2 income countries like the U.S.¹; and
3
4 Whereas, there are negative health consequences from acute and chronic heat exposure for
5 individuals, including cardiopulmonary disease, chronic kidney disease, mental health issues,
6 and adverse pregnancy and birth outcomes²; and
7
8 Whereas, the average incidence of heat-related cardiovascular deaths from 2008-2019 was
9 1,651 per year, and in 2036-2065, there is a predicted 126% increase in deaths which indicates
10 a 4,320 per year rise in deaths due to increasing global average temperatures³; and
11
12 Whereas, populations with increased exposure to heat due to urban heat islands, poverty,
13 housing conditions, lack of air conditioning access, living in rural areas, and other conditions
14 have a heightened degree of vulnerability to extreme heat and heat-related illness⁴⁻⁷; and
15
16 Whereas, different formulas (including daily max temperature, ambient temperature, wet-bulb
17 temperature, and heat index) can be used to address and warn the population about heat, but
18 heat index best accounts for the risk of heat-related morbidity and mortality due to inclusion of
19 criteria such as humidity that affect perceived heat^{2,8,9}; and
20
21 Whereas, when New York City's heat emergency plan was implemented using heat index rather
22 than ambient temperature, there was an associated decrease in heat-related illness¹⁰; and
23
24 Whereas, a heat response plan, which can cover a local or broad geographic area, describes
25 and organizes activities between many organizations to prevent heat-related morbidity and
26 mortality¹¹; and
27
28 Whereas, early heat warning alert systems allow for successful implementation of heat
29 response plan interventions, including heat surveillance, heat-health messaging and
30 communication, front-line health, cooling centers, water bottle and fan distribution, energy
31 assistance, and changes to the built environment¹¹⁻¹⁴; and
32

1 Whereas, the World Meteorological Organization recommends setting heat alert thresholds
2 based on the level of heat exposure associated with adverse health outcomes¹³; and
3

4 Whereas, in many regions of the U.S., a local National Weather Service (NWS) Forecast Office
5 issues heat response alerts based on heat index guidelines from the NWS, triggering a heat
6 watch, heat warning, or a heat advisory¹⁵⁻¹⁷; and
7

8 Whereas, currently, NWS heat index thresholds for activation of heat response plans and heat
9 alerts are above the heat index range at which heat-attributable health burden begins^{4,11,15,18};
10 and
11

12 Whereas, the heat index model currently used by the NWS severely underestimates heat index
13 in extreme high heat conditions due to the limitations of polynomial extrapolation by the model
14 ^{12,19,20}; and
15

16 Whereas, the U.S. Department of Energy recently funded research that developed an updated
17 heat index model, hereinafter referred to as the extended heat index model, that defines the
18 heat index for all combinations of temperature and humidity^{12,19,20}; and
19

20 Whereas, the extended heat index model has demonstrated that the heat index model currently
21 used by the NWS underestimates the heat index by up to 20°F, helping explain the discrepancy
22 between current heat alert thresholds and the heat indices at which heat-attributable burden
23 begins^{12, 14}; and
24

25 Whereas, national implementation of the extended heat index model would correct current heat
26 index underestimations and consequently better align existing heat alert thresholds with heat-
27 attributable health burden^{14, 20}; therefore be it
28

29 RESOLVED, that our American Medical Association support the timely implementation of
30 updated heat index formulas to be used by the National Weather Service to better guide
31 Weather Forecast Offices nationwide in deploying heat alert thresholds that correspond with the
32 onset of significant heat-attributable health burden; and be it further

33 RESOLVED, that our AMA support policy efforts to consider vulnerable populations in heat
34 response plans, including where to implement heat-reducing interventions such as cooling
35 centers, energy assistance, and changes to the built environment, such as urban greenspace.

Fiscal Note: TBD

Date Received: 03/31/2024

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RELEVANT [AMA POLICY](#)

Advocating for Heat Exposure Protections for All Workers D-135.967 [Res. 502, I-2]

Heat-Related Illness H-130.951

The AMA recognizes the significant public health threat imposed by heat-related emergencies, and provides the following policy: (1) Physicians should identify patients at risk for extreme heat-related illness such as the elderly, children, individuals with physical or mental disabilities, alcoholics, the chronically ill, and the socially isolated. Patients, family members, friends, and caretakers should be counseled about prevention strategies to avoid such illness. Physicians should provide patients at risk with information about cooling centers and encourage their use during heat emergencies. (2) The AMA encourages patients at risk for heat-related illness to consider wearing appropriate medical identification. [CSA Rep. 10, A-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: CSAPH Rep. 01, A-17]

Global Climate Change and Human Health H-135.938

Our AMA: 1. Supports scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes have adversely affected the physical and mental health of people. We recognize that minoritized and marginalized populations, children, pregnant people, the elderly, rural communities, and those who are economically disadvantaged will suffer disproportionate harm from climate change.

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

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

4. Encourages physicians to assist in educating patients and the public on the physical and mental health effects of climate change and on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability.
5. Encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently, and that adaptation interventions are equitable and prioritize the needs of the populations most at risk.
6. Supports epidemiological, translational, clinical and basic science research necessary for evidence-based global climate change policy decisions related to health care and treatment.
7. Encourages physicians to assess for environmental determinants of health in patient history-taking and encourages the incorporation of assessment for environmental determinants of health in patient history-taking into physician training.

[CSAPH Rep. 3, I-08; Reaffirmation A-14; Reaffirmed: CSAPH Rep. 04, A-19; Reaffirmation: I-19; Modified: Res. 424, A-22; Modified: CSAPH Rep. 2, I-22]

Declaring Climate Change a Public Health Crisis D-135.966

1. Our AMA declares climate change a public health crisis that threatens the health and well-being of all individuals. 2. Our AMA will protect patients by advocating for policies that: (a) limit global warming to no more than 1.5 degrees Celsius, (b) reduce US greenhouse gas emissions aimed at a 50 percent reduction in emissions by 2030 and carbon neutrality by 2050, and (c) support rapid implementation and incentivization of clean energy solutions and significant investments in climate resilience through a climate justice lens. 3. Our AMA will consider signing on to the Department of Health and Human Services Health Care Pledge or making a similar commitment to lower its own greenhouse gas emissions. 4. Our AMA encourages the health sector to lead by example in committing to carbon neutrality by 2050. 5. Our AMA will develop a strategic plan for how we will enact our climate change policies including advocacy priorities and strategies to decarbonize physician practices and the health sector with report back to the House of Delegates at the 2023 Annual Meeting. [Res. 420, A-22; Appended: CSAPH Rep. 02, I-22]

RELEVANT [MSS POLICY](#)

Toward Environmental Responsibility 135.012MSS

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; Reaffirmed: MSS GC Report A, I-21]

Addressing the Health Risks of Extreme Heat 135.027MSS

AMA-MSS will ask the AMA to support (1) funding for subsidizing energy costs and air conditioning units for low-income households to maintain safe temperatures during periods of extreme temperature; and (2) the implementation and enforcement of state and federal temperature standards in prisons, jails, and detention centers, including the implementation of air conditioning in areas that experience dangerously high temperatures. ([MSS Res. OF014, I-23]

Advocating for Heat Exposure Protections for Outdoor Workers 365.007MSS

AMA-MSS will: (1) support advocating for outdoor workers to have access to preventive cool-down rest periods in shaded areas for prevention of heat exhaustion and health educational materials in their primary language; (2) support legislation creating a federal standard for protections against heat stress specific to the hazards of the workplace; and (3) support working with the United States Department of Labor, the Occupational Health and Safety Administration, and other appropriate federal stakeholders to develop and enforce evidence-based policies, guidelines, and protections against heat injury for outdoor workers independent of legal status. (MSS Res. 05, I-21)

Longitudinal Capacity Building to Address Climate Action and Justice 440.112MSS

AMA-MSS will ask the AMA to: (1) Declare climate change an urgent public health emergency that threatens the health and well-being of all individuals; (2) Aggressively advocate for

prompt passage of legislation and policies that limit global warming to no more than 1.5 degrees Celsius over pre-industrial levels and address the health and social impacts of climate change through rapid reduction in greenhouse gas emissions aimed at carbon neutrality by 2050, rapid implementation and incentivization of clean energy solutions, and significant investments in climate resilience through a climate justice lens; (3) Study opportunities for local, state, and federal policy interventions and advocacy to proactively respond to the emerging climate health crisis and advance climate justice with report back to the House of Delegates; and (4) Consider the establishment of a longitudinal task force or organizational unit within the AMA to coordinate and strengthen efforts toward advocacy for an equitable and inclusive transition to a netzero carbon society by 2050, with report back to the House of Delegates. (MSS Res. 27, I-21) (AMA Res. 430, Adopted Alternate Resolution in Lieu of [], A-22)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 425
(A-24)

Introduced by: Sara Kazyak, Wayne State University School of Medicine; Jared Boyce, University of Wisconsin School of Medicine and Public Health; Jara Alvarez-Del-Pino, Indiana University School of Medicine; Nicholas Wilson, Morehouse School of Medicine; Courtney Noetzel, Sam Houston State University School of Medicine; Soneet Kapadia, Long School of Medicine; Alison Blodgett, Indiana University School of Medicine

Subject: Support of Universal School Meals for School Age Children

Sponsored by: Region 2, Region 3, Region 4, American Medical Women's Association Medical Student Division (AMWA MSD), Asian Pacific American Medical Student Association (APAMSA), Association of Native American Medical Students (ANAMS)

Referred to: MSS Reference Committee
(Caitlin Blaukovitch and Shaminy Manoranjithan, Co-Chairs)

- 1 Whereas, the USDA defines food insecurity as the limited or uncertain availability of nutritionally
2 adequate and safe foods, or limited or uncertain ability to acquire acceptable foods in socially
3 acceptable ways¹; and
4
- 5 Whereas, the term "school aged children" refers to children attending school in grades
6 kindergarten through high school²; and
7
- 8 Whereas, in 2022, 12.8% of all households in the United States were classified as food
9 insecure, though this number increases to 17.8% when specifically examining households with
10 children under 18 years of age³; and
11
- 12 Whereas, children of color face food insecurity at disproportionately higher rates than white
13 children, with 22.8% of non-Hispanic Black households and 19.5% of Hispanic households
14 reporting that their children sometimes or often did not have enough to eat during the past
15 week, compared to 8.1 percent of white, non-Hispanic households^{4,5}; and
16
- 17 Whereas, childhood food insecurity negatively impacts a variety of factors, including an
18 individual's future mental and physical health and is associated with a greater risk of lower
19 school performance when compared to food-secure children⁶⁻⁸; and
20
- 21 Whereas, food insecurity can lead to various significant health problems which increase
22 healthcare costs and burden including obesity, heart disease, diabetes and other long term
23 chronic health conditions⁹; and
24
- 25 Whereas, the Community Eligibility Provisions (CEP) of The Healthy, Hunger-Free Kids Act of
26 2010 provides free school breakfast and lunch to schools that have at least 40% of students
27 who are categorically eligible based on household income¹⁰; and
28

1 Whereas, CEP has previously been shown to decrease food insecurity in low income
2 households¹¹; and
3

4 Whereas, when free school meals are provided only to students who qualified financially,
5 students that qualify for free or reduced price meals based on financial need do not utilize these
6 meals due to the negative stigma, judgment, and bullying associated with the utilization of free
7 or reduced price meal services^{12,13}; and
8

9 Whereas, universal school meal programs, known as “Healthy School Meals for All” (HSMFA)
10 programs, provide breakfast and lunch to all students, free of charge to the students and their
11 families¹⁴; and
12

13 Whereas, as of September 2023, only 8 states have passed Healthy School Meals for All
14 policies¹⁶; and
15

16 Whereas, states that have already passed Healthy School Meals for All policies have done so
17 through various methods, including bills, ballot measures, or state budget inclusions, allowing
18 the state to cover the additional expenditures not already covered by national school meal
19 programs¹⁶; and
20

21 Whereas, a majority of parents report that their children are not embarrassed to eat school
22 meals through Healthy School Meals for All programs, though many parents in a state with a
23 HSMFA program state their child would be less likely to eat school meals if they were not
24 provided for all children, negatively impacting a family’s ability to provide enough food for their
25 everyone in their household; and
26

27 Whereas, schools that instituted universal school meals demonstrated improved weight
28 outcomes and increased nutrient intake amongst students^{10, 17,18}; and
29

30 Whereas, organizations including American Academy of Pediatrics, Academy of Nutrition &
31 Dietetics, American Heart Association, American Federation of Teachers, and National
32 Education Association all support initiatives to offer free breakfast and lunch to all school-age
33 children¹⁹; and
34

35 Whereas, current AMA policy opposes decreases in school meals and supports adoption of
36 additional programs during a pandemic, yet it fails to include expansions to existing programs to
37 all students, regardless of income, and does not address negative stigmas that prevent success
38 of school meal programs, particularly when not during a pandemic; therefore be it
39

40 RESOLVED, that our American Medical Association advocate for federal and state efforts to
41 adopt, fund, and implement universal school meal programs that include the provision of
42 breakfast and lunch to all school-aged children, free of charge to families, regardless of income.

Fiscal Note: TBD

Date Received: 03/31/2024

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RELEVANT [AMA POLICY](#)

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.
3. Our AMA supports adoption and funding of alternative nutrition and meal assistance programs during a national crisis, such as a pandemic. [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; Appended: Res. 217, A-21]

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 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 unhealthy 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; Reaffirmed: Res. 259, A-23]

H-150.944 Combating Obesity and Health Disparities

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]

H-150.960 Improving Nutritional Value of Snack Foods Available in Primary and Secondary Schools

The AMA supports the position that primary and secondary schools should follow federal nutrition standards that replace foods in vending machines and snack bars, that are of low nutritional value and are high in fat, salt and/or sugar, including sugar-sweetened beverages, with healthier food and beverage choices that contribute to the nutritional needs of the students. [Res. 405, A-94; Reaffirmation A-04; Reaffirmed in lieu of Res. 407, A-04; Reaffirmed: CSA Rep. 6, A-04; Reaffirmation A-07; Reaffirmation A-13; Modified: CSAPH Rep. 03, A-17]

H-150.925 Food Environments and Challenges Accessing Healthy Food

Our AMA (1) encourages the U.S. Department of Agriculture and appropriate stakeholders to study the national prevalence, impact, and solutions to challenges accessing healthy affordable food, including, but not limited to, food environments like food mirages, food swamps, and food deserts; (2) recognizes that food access inequalities are a major contributor to health inequities, disproportionately affecting marginalized communities and people of color; (3) supports policy promoting community-based initiatives that empower resident businesses, create economic opportunities, and support sustainable local food supply chains to increase access to affordable healthy food; and (4) will advocate for CMS and other relevant agencies to develop, test, and then implement evidence-based innovative models to address food insecurity, such as food delivery and transportation services to supermarkets, food banks and pantries, and local farmers markets for healthy food options. [Res. 921, I-18; Modified: Res. 417, A-21; Appended: Res. 117, A-22]

RELEVANT MSS POLICY

150.003MSS Hunger in America

AMA-MSS will ask the AMA to: (1) reaffirm its opposition to any further decreases in funding levels for maternal and child health programs and (2) reaffirm its interest in continuing to support efforts to identify national food, diet, or nutrient-related public concerns. (AMA Res 132, A-86 Referred) (Reaffirmed: MSS Rep E, I-96) (Reaffirmed: MSS Rep B, I-01) (Reaffirmed: MSS Rep F, I-06) (Reaffirmed: MSS GC Rep D-I-11) (Reaffirmed: MSS GC Rep A, I-19)

150.032MSS Defending Federal Child Nutrition Programs

AMA-MSS will ask that our AMA (1) oppose legislation that reduces or eliminates access to federal child nutrition programs; and (2) reaffirm H-150.962 Quality of School Lunch Program. (MSS Res 09, A-17) (Reaffirmed: MSS GC Report A, A-23)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 427
(A-24)

Introduced by: Thomas Issa, University of California – Los Angeles, Charles Drew University; Jordan Peyer, University of California – Los Angeles; Laila Koduri, Tulane University

Subject: AMA Study on Plastic Pollution Reduction

Sponsored by: Region 2, Region 3, Region 4

Referred to: MSS Reference Committee
(Caitlin Blaukovitch and Shaminy Manoranjithan, Co-Chairs)

- 1 Whereas, plastic products comprise up to 13% of the planet's total carbon budget, prompting
2 global concerns about climate change, marine life, and human health¹; and
3
4 Whereas, exposure to toxic chemicals that are found in plastic products during manufacturing,
5 usage, and disposal have been associated with adverse human health outcomes such as
6 cancers, birth defects, and endocrine and reproductive disruptions²; and
7
8 Whereas, studies have shown a significant relationship between urine levels of bisphenol A, a
9 plastic metabolite, and cardiovascular disease, type II diabetes, and liver enzyme
10 abnormalities^{2, 3}; and
11
12 Whereas, implementing of plastic product consumption accountability measures such as taxes
13 and fees is shown to be one of the most successful initiatives to reduce plastic products
14 consumption^{4, 5, 6}; and
15
16 Whereas, two studies, in Portugal and Turkey, to evaluate the efficacy of implementing a plastic
17 bag tax have showed a 74% and 32.4% reduction in plastic bag consumption respectively^{7, 8};
18 and
19
20 Whereas, a systematic review of 17 peer-reviewed journal articles revealed that imposing taxes
21 and levies on plastic bags significantly reduced plastic bags consumption and shifted the
22 public's attitude and behavior toward using biodegradable and climate friendly products⁹; and
23
24 Whereas, plastic bag tax in Chicago has been shown to be a very effective method in reducing
25 plastic consumption and driving meaningful behavioral change through 3 behavioral
26 mechanisms: reference dependence, salience, and habit formation¹⁰; and
27
28 Whereas, the \$1.3 billion revenue generated by leveraging taxes against single-use plastics in
29 Spain, Italy, and the United Kingdoms provided funds for renewables advocacy campaigns,
30 plastic alternatives research, and offsetting the costs associated with transitioning to clean
31 energy¹¹; and
32

1 Whereas, the United States loses \$255 million in revenue annually due to marine plastic
2 pollution and paid an estimate of \$24.5 billion of taxpayer money in 2019 for waste
3 management and cleaning^{12, 13}; and
4

5 Whereas, the argument of tax burden and small businesses in the US may rise, avoiding a
6 plastic tax on single-use consumer goods such as cups, straws, bottles, and caps by switching
7 to reusable products can save the US single consumer \$5,279 and businesses up to \$10 billion
8 annually^{13,14}; and
9

10 Whereas, a broad AMA study of plastic pollution reduction has the potential to result in multiple
11 actionable recommendations for further AMA action and significantly expand beyond simply
12 encouraging supporting research into microplastics as currently covered by pending transmittal
13 460.028MSS, "Research of Plastic Use in Medicine"; and
14

15 Whereas, instead of submitting a relatively low-impact resolution to HOD, our MSS can replace
16 it with a broader resolution with higher potential for impact; therefore be it
17

18 RESOLVED, that our AMA-MSS amend 460.028MSS, "Research of Plastic Use in Medicine,"
19 which is pending submission to HOD, by addition and deletion as follows:
20

21 **460.028 Research of Plastic Use in Medicine**

22 Our AMA-MSS will ask the AMA to study ways to reduce plastic
23 pollution and its impact on climate change and health, including but
24 not limited to federal, state, and local taxes and limitations on the
25 use of single-use plastic consumer products and other types of
26 plastic, as well as interventions to reduce microplastics.
27

28 AMA-MSS will ask the AMA to amend by addition as follows:

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

30 ~~The AMA: (1) encourages physicians to be spokespersons for~~
31 ~~environmental stewardship, including the discussion of these~~
32 ~~issues when appropriate with patients; (2) encourages the medical~~
33 ~~community to cooperate in reducing or recycling waste; (3)~~
34 ~~encourages physicians and the rest of the medical community to~~
35 ~~dispose of its medical waste in a safe and properly prescribed~~
36 ~~manner; (4) supports enhancing the role of physicians and other~~
37 ~~scientists in environmental education; (5) endorses legislation such~~
38 ~~as the National Environmental Education Act to increase public~~
39 ~~understanding of environmental degradation and its prevention; (6)~~
40 ~~encourages research efforts at ascertaining the physiological and~~
41 ~~psychological effects of abrupt as well as chronic environmental~~
42 ~~changes; (7) encourages international exchange of information~~
43 ~~relating to environmental degradation and the adverse human~~
44 ~~health effects resulting from environmental degradation; (8)~~
45 ~~encourages and helps support physicians who participate actively~~
46 ~~in international planning and development conventions associated~~
47 ~~with improving the environment; (9) encourages educational~~
48 ~~programs for worldwide family planning and control of population~~
49 ~~growth; (10) encourages research and development programs for~~
50 ~~safer, more effective, and less expensive means of preventing~~
51 ~~unwanted pregnancy; (11) encourages programs to prevent or~~

1 ~~reduce the human and environmental health impact from global~~
2 ~~climate change and environmental degradation.(12) encourages~~
3 ~~economic development programs for all nations that will be~~
4 ~~sustainable and yet nondestructive to the environment; (13)~~
5 ~~encourages physicians and environmental scientists in the United~~
6 ~~States to continue to incorporate concerns for human health into~~
7 ~~current environmental research and public policy initiatives; (14)~~
8 ~~encourages research into the effects of microplastics on human~~
9 ~~health; (154) encourages physician educators in medical schools,~~
10 ~~residency programs, and continuing medical education sessions to~~
11 ~~devote more attention to environmental health issues; (165) will~~
12 ~~strengthen its liaison with appropriate environmental health~~
13 ~~agencies, including the National Institute of Environmental Health~~
14 ~~Sciences (NIEHS); (176) encourages expanded funding for~~
15 ~~environmental research by the federal government; and (187)~~
16 ~~encourages family planning through national and international~~
17 ~~support.~~

Fiscal Note: TBD

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RELEVANT [AMA POLICY](#)

Toxic Disposable Consumer Products H-135.940

Our AMA supports federal legislation to create standardized and easily recognizable sites for safe disposal and/or recycling of toxic substances and electronic waste materials in easily accessible locations. [Res. 416, A-08; Reaffirmed: CSAPH Rep. 01, A-18]

Policy to Reduce Waste from Pharmaceutical Sample Packaging H-115.979

Our AMA: (1) supports reducing waste from pharmaceutical sample packaging by making sample containers as small as possible and by using biodegradable and recycled materials whenever possible; and (2) supports the modification of any federal rules or regulations that may be in conflict with this policy. [Res. 508, I-91; Modified: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11; Reaffirmed: CSAPH Rep. 1, A-21]

Conservation, Recycling and Other “Green” Initiatives G-630.100

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

Declaring Climate Change a Public Health Crisis D-135.966

1. Our AMA declares climate change a public health crisis that threatens the health and well-being of all individuals.
2. Our AMA will protect patients by advocating for policies that: (a) limit global warming to no more than 1.5 degrees Celsius, (b) reduce US greenhouse gas emissions aimed at carbon neutrality by 2050, and (c) support rapid implementation and incentivization of clean energy solutions and significant investments in climate resilience through a climate justice lens.
3. Our AMA will develop a strategic plan for how we will enact our climate change policies including advocacy priorities and strategies to decarbonize physician practices and the health sector with report back to the House of Delegates at the 2023 Annual Meeting. [Res. 420, A-22; Appended: CSAPH Rep. 02, I-22]

RELEVANT MSS POLICY

Carbon Pricing to Address Climate Change 135.025MSS

AMA-MSS will ask the AMA to amend D-135.966 by addition and deletion to read as follows:

Declaring Climate Change a Public Health Crisis D-135.966

Our AMA: 1. Our AMA declares climate change a public health crisis that threatens the health and well-being of all individuals. 2. Our AMA will protect patients by advocating for policies that: (a) limit global warming to no more than 1.5 degrees Celsius, (b) reduce US greenhouse gas emissions aimed at carbon neutrality by 2050, and (c) support rapid implementation and incentivization of clean energy solutions and significant investments in climate resilience through a climate justice lens. 3. Our AMA will advocate for federal and state carbon pricing systems and for US support of international carbon pricing. 4. Our AMA will work with the World Medical Association and interested countries' medical associations on international carbon pricing and other ways to address climate change. 5. Our AMA will develop a strategic plan for how we will enact our climate change policies including advocacy priorities and strategies to decarbonize physician practices and the health sector with report back to the House of Delegates at the 2023 Annual Meeting. (MSS Res. 055, A-23)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 601
(A-24)

Introduced by: Alec Calac, UC San Diego School of Medicine, Brianna Irons, UC San Diego School of Medicine; Melody Brown-Clark, Northwestern University Feinberg School of Medicine, Katie Wilson, University of Minnesota Medical School; Michael Shukis, University of Cincinnati College of Medicine; Anna Klunk, Philadelphia College of Osteopathic Medicine; Donald Bourne, University of Pittsburgh School of Medicine

Subject: Advisory Committee on Tribal Affairs

Sponsored by: Region 1, Region 5, Asian Pacific American Medical Student Association (APAMSA), Association of Native American Medical Students (ANAMS)

Referred to: MSS Reference Committee
(Caitlin Blaukovitch and Shaminy Manoranjithan, Co-Chairs)

1 Whereas, there has been an exponential increase in the number of policies adopted or
2 amended by the AMA House of Delegates (28 since 2021), focused on improving the health of
3 the American Indian and Alaska Native (AI/AN) population¹; and
4

5 Whereas, the establishment of the Standing Committee on American Indian Affairs in the
6 Medical Student Section, comprised of nearly two dozen medical students, and majority
7 identifying as AI/AN, has taken leadership and responsibility for these resolutions; and
8

9 Whereas, AMA staff have reported to the Board of Trustees and other key stakeholders within
10 the AMA that they do not have the internal expertise to directly act on all HOD-passed policies
11 specific to AI/AN Tribes and Villages and the Indian Health Service, given a lack of
12 understanding about the federal trust responsibility²; and
13

14 Whereas, there are currently 574 federally-recognized tribes across the United States, each
15 having their own language, traditions, and health needs³; and
16

17 Whereas, a unique political relationship exists between AI/AN Tribes as sovereign Nations and
18 the federal government (i.e., government-to-government) grounded in the U.S. Constitution and
19 numerous treaties, statutes, federal case law, regulations, and executive orders that establish
20 and define a trust responsibility with AI/AN Tribes and Villages⁴; and
21

22 Whereas, this relationship is derived from the political and legal relationship that AI/AN Tribes
23 have with the federal government and is not based on race⁵; and

24 Whereas, the political and socioeconomic factors influencing health outcomes of the AI/AN
25 population, including the different systems by which AI/AN people may receive care, require
26 expert consideration beyond those applied to marginalized communities as a general practice⁶;
27 and
28

1 Whereas, it is of paramount importance that the AMA establish an Advisory Committee on Tribal
2 Affairs, comprised of physicians, residents, and medical students with significant experience
3 and understanding of the unique social and structural determinants of AI/AN health; and
4

5 Whereas, such an approach complements but does not replace the need for more direct
6 involvement and seating of the Association of American Indian Physicians and Indian Health
7 Service in the AMA House of Delegates; and
8

9 Whereas, an Advisory Committee on Tribal Affairs can best advise the Board of Trustees on
10 how to implement policy specific to AI/AN physicians, medical students, patients, and
11 communities; and
12

13 Whereas, tribal governments directly manage and operate more than half of all Indian Health
14 Service healthcare facilities (IHS, Tribal, and Urban), underscoring the need for a diverse range
15 of viewpoints to advise the AMA Board of Trustees that go beyond the potential representation
16 of the Indian Health Service in the House of Delegates⁷; and
17

18 Whereas, special attention to this population, independent of AMA Advisory Committees and/or
19 Sections on LGBTQ Issues, Disability Affairs (newly created), Women's Health, Minority Affairs,
20 and International Medical Graduates, is warranted; and
21

22 Whereas, United Nations (UN) expert bodies recently urged policymakers, advocates, and
23 governmental entities to refrain from conflating, associating, combining, or equating Indigenous
24 Peoples (e.g., AI/AN Tribes and Villages) with non-Indigenous entities, such as minorities,
25 vulnerable groups, or 'local communities', because this minimizes legal obligations to
26 Indigenous Peoples⁸; therefore be it
27

28 RESOLVED, that our American Medical Association: (1) establish an Advisory Committee on
29 Tribal Affairs composed of AMA members who themselves identify as American Indian and
30 Alaska Native (AI/AN) or have direct experience or close professional relationships with AI/AN
31 communities (e.g., members of ANAMS and AAIP) or the Indian Health Service to advise the
32 Board of Trustees on how to implement policy specific to AI/AN communities; and (2) promote
33 and foster educational opportunities for AMA members and the medical community to better
34 understand the contributions of AI/AN communities to medicine and public health, including
35 cultivating a rich understanding and appreciation of AI/AN perspectives on health and wellness.

Fiscal Note: TBD

Date Received: 03/31/2024

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RELEVANT [AMA POLICY](#)

Advocacy for Physicians and Medical Students with Disabilities D-615.977

Our AMA will: (1) establish an advisory group composed of AMA members who themselves have a disability to ensure additional opportunities for including physicians and medical students with disabilities in all AMA activities; (2) promote and foster educational and training opportunities for AMA members and the medical community at large to better understand the role disabilities can play in the healthcare work environment, including cultivating a rich understanding of so-called invisible disabilities for which accommodations may not be immediately apparent; (3) develop and promote tools for physicians with disabilities to advocate for themselves in their own workplaces, including a deeper understanding of the legal options available to physicians and medical students to manage their own disability-related needs in the workplace; and (4) communicate to employers and medical staff leaders the importance of including within personnel policies and medical staff bylaws protections and reasonable accommodations for physicians and medical students with visible and invisible disabilities. [BOT Rep. 19, I-21]

AMA Support of American Indian Health Career Opportunities D-350.976

Our AMA will: (1) work with the Association of American Medical Colleges, American Association of Colleges of Osteopathic Medicine, Association of American Indian Physicians, and Association of Native American Medical Students to increase representation of American Indian physicians in medicine by promoting effective practices in recruitment, matriculation, retention and graduation of American Indian medical students; and (2) study the historical and economic significance of the Morrill Act as it relates to its impact on diversity of the physician workforce. [BOT Action in response to referred for decision: Res. 308, A-22]

Indian Health Service H-350.977

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

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

(3) Manpower: (a) Compensation for Indian Health Service physicians be increased to a level competitive with other Federal agencies and nongovernmental service; (b) Consideration should be given to increased compensation for service in remote areas; (c) In conjunction with improvement of Service facilities, efforts should be made to establish closer ties with teaching centers, thus increasing both the available manpower and the level of professional expertise available for consultation; (d) Allied health professional staffing of Service facilities should be maintained at a level appropriate to the special needs

of the population served; (e) Continuing education opportunities should be provided for those health professionals serving these communities, and especially those in remote areas, and, increased peer contact, both to maintain the quality of care and to avert professional isolation; and (f) Consideration should be given to a federal statement of policy supporting continuation of the Public Health Service to reduce the great uncertainty now felt by many career officers of the corps.

(4) Medical Societies: In those states where Indian Health Service facilities are located, and in counties containing or adjacent to Service facilities, that the appropriate medical societies should explore the possibility of increased formal liaison with local Indian Health Service physicians. Increased support from organized medicine for improvement of health care provided under their direction, including professional consultation and involvement in society activities should be pursued.

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

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

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

REPORT OF THE MEDICAL STUDENT SECTION
GOVERNING COUNCIL

GC Report A
(A-24)

Introduced by: Natasha Topolski, Chair

Subject: Total Eclipse of the Sun(set): 2024 Sunset Review of All 2018 and 2019 MSS Positions & Sunset and Consolidation Mechanism Update (“The Eclipse Report”)

Referred to: MSS Reference Committee
(Caitlin Blaukovitch and Shaminy Manoranjithan, Co-Chairs)

1 **INTRODUCTION**

2
3 To maintain the order, clarity, and relevance of the MSS Positions Compendium, MSS Position
4 630.044MSS, “Sunset Mechanism for AMA-MSS Policy,” originally adopted at I-95, establishes a
5 sunset mechanism with a clear implementation plan whereby every year, the MSS reviews
6 positions adopted, amended, or reaffirmed 5 or 5.5 years prior to determine whether these
7 positions should be retained, referred, or rescinded (i.e. “sunset”). This position also includes
8 language allowing the MSS Governing Council (GC) to recommend positions for consolidation
9 through this process. Of note, MSS Staff has indicated that the AMA has requested that resolved
10 clauses adopted by Sections no longer be called “policy” but instead, positions, to more easily
11 differentiate them from official AMA policy. In light of this change, the MSS GC will use the term
12 “position” for the remainder of the report and recommend updates to 630.044MSS, “Sunset
13 Mechanism for AMA-MSS Policy” accordingly. However, here is the currently in-effect text of
14 630.044MSS:

15
16 **630.044MSS, “Sunset Mechanism for AMA-MSS Policy**

17 AMA-MSS will establish and use a sunset mechanism for AMA-MSS policy with a five-
18 year time horizon whereby a policy will remain viable for five years unless action is taken
19 by the Assembly to reestablish or refer it. The implementation of a sunset mechanism for
20 AMA-MSS policy shall follow the following procedures:

21
22 (1) review of policies will be the ultimate responsibility of the Governing Council, whereby
23 the report is authored by the Chair of the Governing Council with initial policy
24 recommendations being solicited from relevant Standing Committees as appropriate;

25
26 (2) The Governing Council will provide Standing Committees clear guidance regarding
27 criteria for recommendations of retention, retention with amendments, or sunset;

28
29 (3) policy recommendations will be reported to the AMA-MSS Assembly at each Annual
30 Meeting on the five or five and one half year anniversary of a policy's adoption, with a brief
31 rationale accompanying each recommendation;

32
33 (4) a consent calendar format will be used by the Assembly in considering the policies
34 encompassed within the report;

1
2 (5) a vote will not be necessary on policies recommended for rescission as they will
3 automatically expire under the auspices of the sunset mechanism unless referred back to
4 the Governing Council; and

5
6 (6) the MSS Governing Council may recommend policies for consolidation as part of the
7 sunset review process.

8 **DISCUSSION**

9 ***Review Timing & Load***

10 Prior to the MSS A-23 Assembly, the status quo was that the GC prepared the Sunset Report for
11 each Interim Meeting. However, the 2022-2023 MSS GC delayed their annual Sunset Report
12 expected at MSS I-22 until MSS A-23. At the same time, they recommended amendments to
13 630.044MSS to officially change the timeline to the MSS Annual Meeting moving forward.
14 However, that GC only reviewed MSS positions from MSS A-17 and MSS I-17 that had been due
15 for their I-22 Sunset Report. This meant that the previous GC actually only reviewed MSS
16 positions at the 6- and 5.5-year time points and did not include positions from the 5-year time
17 point (from MSS A-18), conflicting with the expectations laid out in 630.044MSS. Upon
18 discovering this error, the 2023-2024 GC compensated by rightfully including MSS positions from
19 MSS A-18 in this Sunset Report that were technically set to expire at A-23.
20

21
22 However, the shift in the cycle created another unrecognized issue. When the shift to Annual was
23 codified, the 5 and 5.5-year reviews were not adjusted. This meant that each Annual Meeting
24 moving forward, a GC should review both MSS positions from the MSS Interim Meeting of one
25 year and the MSS Annual Meeting of the next. For example, MSS positions from MSS I-18 and
26 MSS A-19 were scheduled for inclusion in this report. The current GC felt that given the errors
27 made by both the immediate past GC and previous GCs, the need to review positions from 2
28 separate years could potentially lead to unnecessary confusion and the likelihood of future
29 skipped reviews if inadequate transitions of leadership took place. To simplify the sunset
30 mechanism by simply requiring the review of all MSS positions from both meetings in the same
31 year, the GC included the review of a fourth meeting of MSS positions from MSS I-19. We also
32 recommended amendments to shift the timeline from the 5- and 5.5-year time marks. Thus, the
33 next time a GC conducts a Sunset Review, they would review MSS positions from the Annual and
34 Interim Meetings of the same calendar year. However, we discuss this in more detail later.
35

36 **Therefore, in this Sunset Report, your GC therefore accepted double the review load that**
37 **was expected of them (4 meetings over 2 years, rather than 2 meetings over 1 year) and**
38 **has included reviews of all positions last reaffirmed at A-18, I-18, A-19, and I-19.** The GC
39 members primarily working on this report humorously and colloquially referred to this as the
40 “Eclipse Report,” referencing that this is a “double sunset” and alluding to the solar eclipse
41 observed on Monday, April 8, 2024, the day that finalization of this report began. **Your GC of**
42 **course wants to acknowledge with deep gratitude the immense amount of time and effort**
43 **your MSS Standing Committees contributed to producing a preliminary review of all MSS**
44 **positions, crafting recommendations, and drafting rationales.**
45

46 Finally, your GC also notes that while the [I-18 Sunset Review](#) did occur, the 20 positions
47 recommended for sunseting were never removed from the MSS Positions Compendium. Your
48 GC recognized this after completion of our review and compared the outcomes. Of note, two of
49 the positions that had been recommended to be sunsetted had been subsequently reaffirmed in
50 future cycles and therefore were not set for consideration in this report. Furthermore, given
51 updates to the sunseting process outlined below, there were several other discrepancies

1 between the reviews. Your current GC believed that 17 of the 20 (including the two reaffirmed
2 between I-18 and A-23) recommended to be sunset should remain in our MSS Positions
3 Compendium either as independent MSS Positions or as part of consolidations. Therefore, your
4 GC has recommended that recommendations outlined in this report be adopted in lieu of the
5 original I-18 recommendations.
6

7 **Updates to A-24 Review Process**

8 “Sunset” Criteria: In addition to the doubled review load, your GC built upon updated guidelines
9 utilized in the A-23 Sunset Report. For several years, confusion among MSS members was
10 building regarding guidelines on what to Sunset, what to retain, and what to amend. According to
11 available records, prior to 2021, policies calling for a specific finite action, such as preparing a
12 letter, amending a policy, creating a product, or conducting a study that was completed were
13 generally recommended to be sunset. However, interpretations of this varied. Some interpreted
14 the position being adopted by the AMA HOD to be completing the action, whereas others did not.
15 This resulted in inconsistencies in what was sunset and retained from year to year (and even
16 position to position given the multiple parties involved in reviews). In a [report](#) reviewing the sunset
17 mechanism and process at A-22, the GC at the time recommended that policies solely reaffirming
18 existing AMA policy shall be sunset by default unless otherwise recommended for retention which
19 was in line with their [review process at N-21](#). This was not supported by the MSS Assembly and
20 ultimately not integrated into 630.044MSS. However, because various messages had been
21 released and not all MSS members attended assembly, confusion remained among reviewers.
22 At-23, the [2022 - 2023 GC's Sunset Report](#) outlined that there should be a high threshold to
23 sunset with sole two criteria that would justify sunseting: (1) more recent MSS positions contradict
24 or are in opposition to the position and (2) action requested was completely accomplished by the
25 AMA. While this was more clear, it was often still unclear on how to determine if an action was
26 completely accomplished and concerns about the possibility of regression necessitating that the
27 position remain.
28

29 As an example from this report, it was noticed that the MSS asked the AMA to petition the NBME
30 to add AMA student representation to the National Board at HOD I-98 which was adopted into
31 AMA Policy H-295.893. This request was accomplished and the AMA MSS had student
32 representation on the NBME Board for several years and at the 10 year review at HOD at A-18,
33 the AMA [decided to rescind H-295.893](#). Shortly thereafter, the NBME restructured their student
34 representation and no longer maintained representation on their Board of Directors. Notably, the
35 MSS Sunset Report at I-18 also recommended sunseting for the same reason. Fortunately, due
36 to administrative errors the MSS has retained this MSS position throughout the years and is
37 considering and is considering the implications of the recent change, how best to proceed, and if
38 the AMA no longer maintaining their policy will have implications for advocacy in this area. If this
39 position was not maintained, the institutional memory may have been lost. Similarly, while
40 565.004MSS Policy and Advocacy Opportunities for Medical Students and associated AMA Policy
41 [H-295.953](#) Medical Student, Resident and Fellow Legislative Awareness H-295.953 both are still
42 active, the opportunities created for students when this AMA policy was adopted no longer exist
43 and most current MSS members were unaware that they ever existed. Even your current GC was
44 not aware of this MSS position and AMA policy until beginning to work on the MSS Archives last
45 year emphasizing the importance of maintaining our important positions in the digest. Upon
46 finding the AMA policy, your GC began working on proposals for new opportunities for students
47 and hopes that they can be established soon.
48

49 In light of this, this year your GC further narrowed the sunset criteria to contain three very explicit
50 criteria for sunseting:

- 51 (1) If the requested MSS or HOD study was completed

- 1 (2) If a newer MSS position supersedes it
2 (3) If the position was very outdated (*i.e. an entity does not exist anymore and is no longer*
3 *even potentially actionable*)
4

5 The GC believed that even if the action is completed, the position should remain for institutional
6 memory purposes and to ensure the MSS has the position in the case of potential changing
7 situations. A [detailed protocol for sunset review](#) that included a multiple choice for all the various
8 options for recommendations with prefixed reasoning, along with a free response space for
9 additional rationale and reasons for which option would be chosen in what circumstance. This
10 addressed problems identified in previous sunset reports where inconsistent decisions and
11 rationales led to confusion and disagreement over recommendations across Committees.
12 Standing Committee leaders were also provided with [guidelines on review assignments and](#)
13 [finalization of recommendations](#). This pilot was greatly successful in improving consistency and
14 standardization of reviews across the MSS and also received excellent feedback that we hope
15 will help future GCs continue to iterate this process.
16

17 Outcomes Tracking: This protocol also included for the first time in many years an additional set
18 of actions for Committees to undertake as part of performing a proper sunset review and
19 determining whether a position should be retained or not. The protocol requested Committees to
20 identify and document the House of Delegates (HOD) result and reported AMA implementation
21 actions of all MSS positions submitted to HOD as resolutions, including any reports completed by
22 the AMA as a result of MSS positions (and associated HOD results and implementation actions).
23 The intent of this was to improve our MSS' archive and understand the value and progress that
24 MSS resolutions have contributed to AMA advocacy. This was also used as a trial to determine
25 how Standing Committee members felt about the process and if it was deemed to be a useful
26 experience and skill to develop. This documentation is conveniently located on our [2024 Sunset](#)
27 [Review](#) spreadsheet.

28 Edits to External MSS Positions: This protocol included more explicit instructions regarding
29 appropriately updating language that was designed to be sent to HOD.
30

31 AMA Policy Amendment Request Summarization: First, we used a system sometimes
32 used by previous GCs whereby MSS positions recommending amendments to AMA
33 policies would be amended to summarize the asks, simplify the language, and not have
34 to include the entirety of the AMA policy in our MSS Digest, which can lengthen the Digest
35 unnecessarily, especially when we are only requesting a small amendment or an
36 appended clause where the remainder of the policy is not directly relevant or part of the
37 MSS position. Part of the reason for this is also due to reported confusion, especially from
38 newer members, over whether an MSS position recommending amendments to AMA
39 policies also implies support for the entirety of the AMA policy. While this is not and has
40 never been true, summarizing the ask improves readability and accessibility of the MSS
41 Positions Compendium.
42

43 Converting Transmitted MSS Positions to Past Tense: Second, we recommended
44 converting all MSS positions requesting external action by the AMA (written as "MSS will
45 ask the AMA") to past tense ("asked the AMA") after a position had been submitted to and
46 considered by HOD. (Consideration means that the resolution received the opportunity for
47 full debate in the HOD; Resolutions screened out by a Resolution Committee are deemed
48 "not considered," so this language ensures that we only apply this to resolutions that have
49 successfully been submitted and given a fair chance at passage in HOD.) While this has
50 been discussed as a possibility for several years, previous GCs' Sunset Reports faced
51 other issues, and this switch was never prioritized. The future tense formatting of all MSS

1 positions requesting external AMA action has also been confusing for newer members,
2 who sometimes wonder if that means the MSS has not yet submitted a resolution to HOD
3 (even when that has been the case). Furthermore, there have also been several instances
4 of positions where HOD outcomes are not recorded that have caused confusion of even
5 the most seasoned members of the MSS where it was unclear if the documentation is
6 missing, the position was rescinded from the transmittal queue, or if the position was
7 accidentally never sent. This has caused confusion in even the most seasoned members
8 of the MSS. Therefore, we believe this change also improves readability and clarity of the
9 Digest to differentiate between positions previously considered by HOD and those still
10 pending consideration. The GC is also recommending that moving forward this be done
11 immediately following transmittals through the Section Delegate Policy Proceedings
12 Report.

13
14 As directed by the MSS GC, the MSS stances up for sunset were identified and distributed
15 amongst MSS Standing Committees for their review. Sunset review entails research on each
16 position including its final outcome in the AMA HOD, the resulting AMA policy, and subsequent
17 actions taken by the AMA where applicable. The possible sunset recommendations are:

- 18 ● Sunset: Outdated Position;
- 19 ● Sunset: Study Completed;
- 20 ● Amend: Summarize Amendment;
- 21 ● Amend: Clarify Language;
- 22 ● Amend: Update Outdated Language;
- 23 ● Amend: Convert to Past Tense;
- 24 ● Retain: Important MSS Position.

25
26
27 When substantive amendments to MSS positions were recommended, the [AMA Center for Health
28 Equity and AAMC Center for Health Justice's Guide to Language, Narrative and Concepts](#) was
29 referenced to ensure the most updated, inclusive, equitable, respectful, destigmatized, and
30 person-first language was used.

31 **A-24 Sunset Review Overview**

32 Appendix A outlines recommendations for MSS positions adopted or reaffirmed at Annual 2018,
33 Interim 2018, Annual 2019, and Interim 2019 and thus presented for consideration in this report.

34
35
36 While we gave several amendment options for Standing Committees to choose from, only two
37 categories are presented in this report: Amend: Convert to Past Tense and Amend: Summarize
38 and/or Update language. The Amend: Summarize and/or Update Language merged all
39 recommendations more substantial than converting “will ask” to “asked” and was deemed useful
40 to see in this report. Therefore, we have organized this report by recommendation in the order as
41 follows:

- 42 ● Sunset: Outdated Position
- 43 ● Sunset: Study Completed
- 44 ● Amend: Summarize and/or Update Language
- 45 ● Amend: Convert to Past Tense
- 46 ● Retain: Important MSS Position

47
48
49 This report contains three appendices which contain the recommendations for this report.
50

- 1 • **Appendix A:** Outlines all of the recommendations for MSS positions due for consideration
2 that are addressed in this report.
- 3 • **Appendix B:** Contains tables that contain all of the MSS positions that are being
4 rescinded, amended (with the exception of converting to past tense) with a brief supporting
5 rationale for that recommendation.
- 6 • **Appendix C:** Contains tables outlining MSS positions that were not originally due for
7 consideration but are superseded by MSS positions that were due for consideration and
8 minor consolidations containing at least one MSS position due for consideration in this
9 report.
- 10 • **Appendix D:** Contains all of the MSS positions due for consideration that are addressed
11 through other A-24 reports.

12
13 Your GC recognizes that all MSS Sunset Reports have been lengthy, and the sheer volume of
14 content rendered in these reports is unwieldy to the general MSS membership. Therefore,
15 particularly given that this report covers double the volume of a traditional sunset report, your GC
16 chose not to include language for MSS positions that were retained or solely amended to convert
17 to past tense in the appendix tables below for the sake of brevity and clarity. The language for
18 these MSS positions can be found in the [MSS Digest](#) (*hopefully soon to be MSS Positions*
19 *Compendium*) and our [2024 Sunset Review](#) spreadsheet.

20 21 ***MSS Positions Recommended to be Rescinded***

22 Of the 320 total MSS positions due to be considered in this report, **your GC ultimately did not**
23 **recommend rescinding any positions for substantive (content-based) reasons.** Your GC did
24 recommend rescinding 11 positions that requested a study by either the MSS or the AMA that
25 was subsequently completed.

26
27 Your GC also identified two topics during the review process where more outdated, overlapping,
28 or highly similar positions existed in the compendium. From this review, four MSS positions that
29 were not originally due for consideration were recommended to be rescinded or consolidated
30 within this report. An overview of these topics is below:

31 32 **Improving Research Standards, Approval Processes, and Post-Market Surveillance** 33 **Standards for Medical Devices**

34 The history behind this position is particularly complicated, but after extensive
35 investigation by your current MSS Chair and Section Delegates, this is our best
36 understanding of the events, though we recognize that we are not entirely certain on every
37 single detail. At MSS I-19, Resolves 2 and 3 of MSS Resolution 22 were adopted as
38 270.040MSS Improving Research Standards, Approval Processes, and Post-Market
39 Surveillance Standards for Medical Devices. Resolve 1 of the resolution was referred for
40 study and resulted in CSI CHIT Report A at MSS I-20, which resulted in the adoption of 2
41 recommendations. However, instead of being added to 270.040MSS, the
42 recommendations from CSI CHIT Report A were instead written into a new MSS position
43 with an identical title to 270.043MSS.

44
45 Despite the separation, both positions (270.040MSS and 270.043MSS) were planned by
46 the 2021-2022 Section Delegates and the MSS Caucus to be recombined as the initial
47 resolution originally intended and submitted as a single resolution to HOD A-22. However,
48 at MSS A-22, MSS Resolution 52 was adopted and amended 270.040MSS to add “pre-
49 market assurance,” which added another layer of complexity. At some point, the formatting
50 of MSS Resolution 52’s amendments to 270.040MSS somehow also added new language
51 that overlaps (partially identical, partially non-identical) with some, but not all, of the

1 language in 270.043MSS. We are unsure how the structures of these positions became
2 so confused in prior years.
3

4 In order to account for the possible effects of the related MSS Resolution 52, the 2021-
5 2022 Section Delegates preemptively held the transmittal combining 270.040MSS and
6 270.043MSS, so they could incorporate MSS Resolution 52 upon adoption by the MSS A-
7 22 Assembly. They then immediately forwarded the resolution combining 270.040MSS,
8 270.043MSS, and MSS A-22 Resolution 52 to HOD A-22 the next day. Unfortunately, due
9 to all this complexity, it appears that a clause on confirmatory trials timing from the CSI
10 CHIT Report and the “pre-market assurance” amendment from Resolution 52 were never
11 incorporated into the resolution submitted to HOD, so those portions were never officially
12 sent. However, the HOD A-22 resolution was ultimately referred, resulting in [CSAPH](#)
13 [Report 2 at HOD A-23](#), which in turn resulted in the adoption of [H-480.934](#). This report
14 and AMA policy includes mention of pre-market approval, pre-market assurance, post-
15 market surveillance (referring to confirmatory trials and evidence), and accelerated
16 pathways. Despite the exclusion of the confirmatory trials timing clause and “pre-market
17 assurance” in the HOD resolution, for clarity and ease we will consider these to have been
18 adequately considered by the AMA and therefore “asked by the MSS” via the vehicle of
19 the MSS’ introduction of the HOD resolution. Furthermore, our MSS Caucus at HOD A-23
20 determined that CSAPH’s recommendations aligned with the MSS’ asks and supported
21 adoption.
22

23 In conclusion, the current 270.040MSS and 270.043MSS together appear to be fully
24 updated with all language passed by the MSS, albeit with the incorrect and duplicative
25 language in some areas. Since 270.043MSS should ideally have never existed, we
26 recommend rescission of this position and have closely compared both positions to ensure
27 all unique language has been incorporated into 270.040MSS.
28

29 **Two-Interval Grading**

30 When reviewing the compendium to determine an appropriate recommendation for the
31 MSS position 295.198MSS Engaging Stakeholders for Establishment of Two-Interval, or
32 Pass/Fail, Grading System of Non-Clinical Curriculum in U.S. Medical Schools, your GC
33 identified three additional MSS positions on this topic where the position was either
34 superseded by 295.198MSS [*Supporting Two-Interval Grading Systems for Medical*
35 *Education 295.170MSS*] or the request for study was completed [*Research the Ability of*
36 *Two-Interval Grading of Clinical Clerkships to Minimize Racial Bias in Medical Education*
37 *295.217MSS & Research the Ability of Two-Interval Grading of Clinical Clerkships to*
38 *Minimize Racial Bias in Medical Education 295.231MSS*]. Given this, these policies were
39 included with the recommendation to rescind as part of this report.
40

41 **Consolidations**

42 While reviewing the MSS positions, several topics were identified as potential areas of
43 consolidation. This report covers four minor consolidations involving at least one MSS position
44 due for consideration in this report. An outline of these consolidations is below:
45

46 **De-scheduling Cannabis and its Derivatives**

47 When reviewing the I-18 Sunset report, your GC noticed that the report justified sunseting
48 MSS Position 95.003MSS Marijuana: Medical Use and Research as it was superseded by
49 100.021MSS Opposing the Classification of Cannabidiol as a Schedule 1 Drug. However,
50 100.021MSS only refers to cannabidiol whereas 95.003MSS refers to cannabis where
51 cannabidiol is only one component. Therefore your GC recommends these positions be

1 consolidated into one MSS position covering scheduling of cannabis and its compounds.
2 Notably, the term “marijuana” was converted to “cannabis,” which is considered by many
3 to be the broader, more neutral or unbiased, and scientific or technical term. While often
4 used interchangeably, in some contexts cannabis (which is a genus of plant) is interpreted
5 to include all products of all cannabis plants (including sativa and indica), while marijuana
6 can be interpreted to only refer to cannabis products with high tetrahydrocannabinol (THC)
7 content. Furthermore, the Spanish term “marijuana” may be considered racially insensitive
8 by some as it can implicitly associate cannabis use with Latine individuals, which is
9 problematic due to societal stigmatization, policing, and criminalization of Latine people
10 as well as people who use cannabis. Therefore, “cannabis” is the more appropriate, less
11 questionable, and less controversial term.

12 13 **Access to Evidence-Based Care at Addiction Rehabilitation Facilities and Recovery** 14 **Homes**

15 When reviewing the compendium to determine appropriate recommendations the MSS
16 Committee on Bioethics and Humanities identified that MSS Position 95.012MSS
17 Advocating for the Standardization and Regulation of Outpatient Addiction Rehabilitation
18 Facilities and 95.016MSS A Resolution to Encourage Recovery Homes to Implement
19 Evidence-Based Policies Regarding Access to Medication Assisted Treatment (MAT) for
20 Opioid Use Disorder were strongly related and in fact eventually transmitted together at
21 HOD. Given this, consolidation of these policies is recommended.

22 23 **Clinical Training and Skills Evaluation**

24 When conducting the initial review of the MSS positions due for consideration, your GC
25 noticed four MSS positions addressing clinical skills: 295.114MSS Clinical Skills
26 Assessment Exam and College of Osteopathic Medicine Licensing Exam-Physical Exam
27 Implementation, 295.116MSS Opposition to Clinical Skills Examinations for Physician
28 Medical Re-Licensure, 295.126MSS Medical Student Clinical Training and Education
29 Conditions, and 295.174MSS Evaluation of Standardized Clinical Skills Exams. Upon
30 further review of the MSS Positions compendium, your GC identified the MSS position
31 295.111MSS State Society and State Medical Board Support to Delay Implementation of
32 the USMLE Clinical Skills Assessment Exam, 295.223MSS Respecting Religious
33 Diversity in Medical Education, and 295.150MSS USMLE and COMLEX Exam Fee
34 Burdenthat also addressed clinical skills.

35
36 Given this, your GC considered consolidation for these positions. Ultimately, it was
37 determined that 295.111MSS and 295.114MSS could be consolidated into a new position
38 on Medical Student Clinical Training and Skills Evaluation. In the process of consolidation,
39 your GC also broadened any language referring to specific standardized clinical skills
40 examinations (CSAE and COMLEX-PE) that no longer exist to read “standardized clinical
41 skills examinations.” 295.223MSS addressed student rights in peer physician examination
42 courses and did not seem to fit as well. Moreover, notably unlike the recommended
43 consolidated positions not sent to HOD and therefore was determined that it would be best
44 to remain an independent MSS position. 295.126MSS focused on the clinical training
45 environment and 295.116MSS focused on evaluation of physician clinical skills which
46 were determined would be more appropriate to remain independent MSS positions. While
47 your GC did feel that it would be appropriate to rescind 295.150MSS which asked for an
48 internal study of costs of producing and administering the USMLE and COMLEX
49 computer-based and clinical skills exams, we did not have access to the study at this time
50 and given that it was not due for consideration this year, decided not not make any
51 recommendations regarding this MSS position at this time. Finally, your GC recommended

1 sunsetting of 295.174MSS which only asked for an AMA study. Further justification for the
2 sunset can be found in Appendix B.

3 4 5 **Pre-Participation Sports Examinations**

6 When reviewing the compendium to determine an appropriate recommendation for the
7 MSS position 470.003MSS Pre-Participation Screening in Student Athletes, your GC
8 identified the MSS position 470.001MSS Pre-participation Sports Examinations covering
9 very similar material. Given this, your GC recommends consolidation of these two
10 positions.

11 12 **Trauma Informed Care Resources & Training**

13 When reviewing the compendium to determine an appropriate recommendation for the
14 MSS positions 515.013MSS Trauma-Informed Care Resources and 515.015MSS
15 Amending H-515.952, Adverse Childhood Experiences and Trauma Informed Care, to
16 Encourage ACE and TIC Training in Undergraduate Medical Education, your GC identified
17 the similarity in topic and a third MSS position 295.196MSS Increasing Access to Trauma-
18 Informed Services within Schools.

19
20 The transmittals for 295.196MSS and 515.013MSS were sent at A-19 and created AMA
21 Policy [H-515.952](#) Adverse Childhood Experiences and Trauma-Informed Care.
22 515.015MSS was adopted at I-19 and requested that the new AMA Policy H-515.952 be
23 amended to include support for the inclusion of ACEs and trauma-informed care into
24 undergraduate and graduate medical education curricula. The language from this
25 resolution was suggested and adopted as an amendment to [CSAPH Report 3](#), Addressing
26 Increases in Youth Suicide at A-21. Given the strong connection between all of these
27 positions, your GC recommends consolidation.

28
29 Five additional topics were considered for larger MSS position reviews and consolidations this
30 cycle. These reviews are included in separate GC Position Review & Consolidation reports linked
31 below:

- 32
- 33 • [GC Report D](#): Reproductive Health Positions Consolidation
- 34 • [GC Report E](#): Leave Positions Review and Consolidation
- 35 • [GC Report F](#): Firearm Positions Consolidation
- 36 • [GC Report G](#): MSS Governance Positions Update & Consolidation
- 37 • [GC Report H](#): Alcohol-Related Position Consolidation
- 38

39 Appendix D includes **43 positions that were due for consideration in this report that were**
40 **addressed in other A-24 reports**. With the exception of 665.016MSS Amending G-630.140
41 Lodging, Meeting Venues and Social Functions which is reviewed in [Delegate Report A: MSS](#)
42 [Policy Process and HOD Resolution Queue](#) (as it is still in our MSS Caucus' queue of resolutions
43 to be submitted to HOD), all of the positions were considered via the GC Position Review &
44 Consolidation reports outlined above.

45 46 **MSS Positions Recommended to be Retained**

47 In this report, your GC recommended that 259 MSS positions be retained in the MSS
48 Compendium of Actions. These MSS positions are 1) still relevant and 2) may be used by the
49 MSS Caucus to take positions on items of business in the AMA HOD. Of these 26 are
50 recommended to be retained with amendments to the position language that (1) either summarize
51 the spirit of a MSS position that requested amendments to HOD policy or (2) provide minor

1 updates to terminology to align with current standards or provide minor clarifications. 170 MSS
2 positions are recommended to be retained with minor amendments to convert language to past
3 tense and 63 MSS positions are recommended to be retained as written.

4 ***Sunset Review & Consolidation Mechanism Update***

5 In Recommendation 2 below, your GC recommends major updates to 630.044MSS, “Sunset
6 Mechanism for AMA-MSS Policy.” We did not make these changes lightly and thought critically
7 about the process we conducted this cycle and how it could be improved in the future. These
8 changes were ultimately voted on unanimously with knowledge of their deep impact:
9

- 10
11 1) MSS Policy → MSS Position Update: We editorially amend “policy” to “position” at all
12 relevant points. Additionally, we use the term “MSS Positions Compendium” to align with
13 the recommendations of our MSS A-24 Archives Task Force (ATF) in their [A-24 report](#)
14 also being presented at this Assembly.
- 15 2) Expanding Use of Consolidations: We believe that the evidence of overlapping and
16 redundant positions that resulted in some of our recommendations to consolidate are
17 further evidence of the detrimental effects of our unwieldy Digest, which can be difficult to
18 navigate and identify related policies. A major solution to address this is more regular
19 consolidation. This will not only help to make our compendium more concise but it should
20 also allow for more robust thorough reviews of our MSS positions by having reviewers
21 consider the full context rather than a standalone position. To better emphasize the
22 existing consolidation mechanism, we recommend (1) renaming the 630.044MSS title to
23 include *Sunset and Consolidation Mechanism*, (2) amending clause 6 to strengthen the
24 consolidation language to ensure multiple regular consolidations are conducted by future
25 GCs to appropriately update and streamline our hefty, unwieldy, and often inaccessible
26 Digest, and (3) mirror the language with the Standing Committee process discussed in
27 clause 1 to ensure their involvement moving forward.
- 28 3) Outcomes Tracking: We add clause 7 to ensure that sunset and consolidation processes
29 should include documentation of HOD result and AMA implementation, to reflect the
30 protocol used this cycle, align with MSS ATF A-24 recommendations, and better track the
31 advocacy efforts of the MSS.
- 32 4) Streamlining Minor Editorial Updates: Because the sunset review requires an immense
33 amount of tedious effort that does not necessarily have to wait years to be done, in the
34 added clauses 9 and 10, we automate two portions of the sunset protocol used this cycle,
35 as they are easily verifiable and do not require much additional effort: (1) conversion to
36 past tense after consideration by HOD and (2) rescission after study is completed.
37 Sometimes, MSS positions are considered by HOD in the form of amendments made by
38 our MSS Caucus to other relevant items even if we do not submit a full resolution. This
39 may then result in withdrawal of that resolution from the HOD submission queue, so we
40 allow for this flexibility. We also add in clause 10, “after consideration of the study request
41 by HOD,” as technically an MSS resolution requesting a study may not necessarily be
42 adopted by HOD upon consideration, but the MSS position should still be rescinded as
43 the study has been declined. However, all of these policies would still be subject to the
44 documentation requirement in the additional clause 7 as well as in MSS ATF A-24
45 recommendations, if those are passed.
- 46 5) AMA Policy Amendment Request Summarization: Another part of our sunset protocol,
47 summarization of amendments to existing AMA policy, is not easily automatable, as it
48 requires some more thought regarding grammar, syntax, and content. However, we note
49 that your Section Delegates are already mandated by our MSS Internal Operating

1 Procedures (IOPs), 9.3 Reporting of Caucus Actions, to report to the MSS Assembly on
2 the proceedings of the previous HOD. Therefore, since the Section Delegates (along with
3 the help of Caucus Reference Committee Leads) must already prepare this
4 documentation, simply converting the relatively few MSS positions considered by HOD
5 that amend existing AMA policy would not require very much additional effort. Currently
6 conducting these two processes separated by 4 to 5 years seems illogical. Therefore, this
7 process is incorporated in clause 8.

8 6) Sunset Review Timeline: Lastly, we acknowledge the benefits of the 5-year review
9 timeframe implemented at A-00, however are altering the 5-year timeline back to a 10-
10 year timeline, which would match our HOD's sunset process. Technically, this means that
11 positions would be reviewed at the 10- and 9.5-year time points, to ensure review of all
12 positions from the Annual and Interim Meetings of the same calendar year. Again, the
13 sunset review process is a massive undertaking, and though its goals are laudable, the
14 current process is inefficient and functionally results in relatively little benefit. The vast
15 majority of MSS positions are retained due to ongoing relevance and the possibility for
16 reversal via changes to AMA policy in the future, as well as increasing threat to and
17 regression in medicine and public health in recent years. Very few positions are truly so
18 outdated that they need to be rescinded without some value to our Digest (aside from
19 editorial amendments to ensure inclusive language). As seen in this report, even though
20 we reviewed double the usual load of positions (4 meetings over 2 years), we
21 recommended no rescissions for outdated policy (although there were several included in
22 other consolidation reports). The handful of positions that were rescinded only requested
23 studies that were completed. Moreover, we strongly believe that conducting regular
24 consolidation reviews will provide a more beneficial review of our MSS positions. The
25 Sunset review process often neglects similar positions adopted in different years, creating
26 bloat in our Digest, inadvertently continuing superseded positions despite overlap, and
27 missing opportunities for consolidation. This update is addressed in clause 3 and further
28 rationale is below:

29 a) We believe extending the 5-year timeline to 10 years also allows for more time to
30 see possible implementation actions by the AMA (since policy can take such a long
31 time to pass) and allow for more significant changes in inclusive language to better
32 update positions (though it should also be noted that inclusive language changes
33 to MSS positions can be requested at any time outside of the timeline).
34 Furthermore, the [A-24 ATF Report](#) is recommending that implementation actions
35 are recorded for the MSS a year after the adoption of the resolution, aligning with
36 the release of the final AMA Implementation Report. Following that report, the AMA
37 generally does not promote actions unless it is a major unfulfilled priority.
38 Therefore, documenting implementation at the 1-year mark per ATF
39 recommendations and checking again every 10 years in case any further advocacy
40 occurs appears sufficient to capture major waves in advocacy on an issue, rather
41 than checking at the 5-year mark in the middle of those two time points.

42 b) Again, despite reviewing double the usual load of positions (4 meetings over 2
43 years), we only updated very few positions (only 1 position in this report) for
44 inclusive language, which ideally should have been updated 5 or 10 years ago in
45 a previous sunset report, as the term was already outdated at that time. Its
46 continuation appears to be an oversight from previous years, rather than any
47 indication of the necessity of a 5-year review simply for inclusive language.
48 Furthermore, the switch to conducting more consolidations would still allow for
49 review for inclusive language and in fact, allow for broader updates to language

1 across an entire topic area. The sunset process is not only unnecessary to achieve
2 the specific benefit of inclusive language, but is actually a less preferable way to
3 achieve this goal, as it involves simply updating one position at a time that happens
4 to be at its 5-year time point out of relation to any other similar positions that may
5 also need to be updated for inclusive language.

6 c) It is important to note that changing this timeline means that MSS GCs would not
7 produce sunset reports for the next 5 years, as we realign to the new timeline. For
8 example, the 2024-2025 GC would, under our changes, review all positions from
9 2015. However, these would have just been reviewed in 2020, and so would not
10 be due for review until 2030. Therefore, regular sunset reports would restart with
11 the 2029-2030 GC, which would review positions last reviewed in 2020.

12 d) By no means does your GC believe that future GCs for the next 5 years should be
13 complacent. Despite years of disuse, your GC is finally using our existing
14 consolidation mechanism. We are excited to present three minor consolidations
15 within this report and five major independent consolidation reports to the MSS A-
16 24 Assembly to streamline, simplify, condense, and improve the readability, clarity,
17 usability, accessibility, and congruence with current practices of our Digest. Your
18 GC believes that for the next 5 years, future GCs can spend the immense amount
19 of time and effort that would have otherwise gone to perfunctory, ineffectual sunset
20 reviews instead toward producing as many consolidations as feasible, to
21 meaningfully update and improve the MSS Positions Compendium. We note that
22 simply reviewing all positions from a given year makes it very difficult to review
23 across themes and generate ideas for possible consolidation of related policies
24 that may be from different years. Consolidations are functionally similar to sunset
25 reviews, but involve review based on topic rather than based on a certain time
26 point and consider ways to streamline a group of related positions, rather than
27 reviewing one position from a given topic area at its 5-year time point out of relation
28 to any other similar positions. We believe that thematic review for consolidations
29 would be a far better use of the next 5 GCs' time to make the most substantive
30 improvements and modernization of our MSS Positions Compendium in the history
31 of the MSS, rather than spending that energy to almost entirely retain all positions
32 without any consolidation.

33 e) Previous GCs have struggled with the workload of the sunset report and never had
34 bandwidth to also conduct consolidations, so we believe removing the need to
35 conduct the sunset review for the next 5 years will allow for reinvestment of labor
36 from both GC and Standing Committees into consolidations. Furthermore, clauses
37 8, 9, and 10 ensure that our MSS will not suffer much from the pausing of sunset
38 reports for 5 years, by automating or incorporating into existing efforts the bulk of
39 what would be done during sunset review. Hopefully, this also means that future
40 sunset reviews beginning in 2030 should be far less strenuous, as much of the
41 work will have been completed in a far more timely manner.

42 f) Your GC recognizes the need to ensure robust transition between GCs until 2030
43 to ensure that the sunset process is not forgotten, and we have already
44 communicated with current MSS leaders who will still be in the MSS at that time.
45 As mentioned, we believe that consolidations still allow for structured review of
46 MSS positions, just based on topic instead of time point. We also believe that by
47 incorporating all these amendments into the same MSS position, which will
48 continue to be followed annually through consolidation reviews, we have ensured
49 that the risk of forgetting the sunset process will be quite low. In fact, the position

1 would be used even more regularly than it is now, since twice a year the GC would
2 review positions to ensure compliance with clauses 7-10, so it is highly unlikely
3 that they would be unaware of the sunset mechanism written into the same
4 position.

5
6 The final recommendations of this report are as follows:

7
8 **RECOMMENDATIONS**

9
10 Your AMA-MSS Governing Council recommends that the following be adopted and the remainder
11 of the report be filed:

- 12
13 1. That the recommendations for retention, retention including amendments, and
14 consolidation actions specified in Appendix B, Appendix B, and Appendix C of this report
15 be retained as official, active positions of the AMA-MSS or rescinded as indicated.
16
17 2. That the recommendations regarding MSS positions in Appendix A and Appendix B of this
18 report be adopted.
19
20 3. That our AMA-MSS amend 630.044MSS by addition and deletion as follows:

21
22 630.044MSS Review and Revision of the MSS Positions Compendium via the
23 Sunset ~~and Consolidation~~ Mechanisms ~~for AMA-MSS Policy~~

24
25 AMA-MSS will establish and use a sunset mechanism for AMA-MSS ~~policies~~
26 ~~positions~~ with a ~~ten~~five-year time horizon whereby a ~~policy-position~~ will remain
27 viable for five years unless action is taken by the Assembly to reestablish or refer
28 it. The implementation of a sunset mechanism for AMA-MSS ~~policy-position~~ shall
29 follow the following procedures:

30
31 (1) review of ~~policies-positions~~ will be the ultimate responsibility of the Governing
32 Council, whereby the report is authored by the Chair of the Governing Council with
33 initial ~~policy-position~~ recommendations being solicited from relevant Standing
34 Committees as appropriate;

35
36 (2) The Governing Council will provide Standing Committees clear guidance
37 regarding criteria for recommendations of retention, retention with amendments,
38 or sunset;

39
40 (3) ~~policy-position~~ recommendations will be reported to the AMA-MSS Assembly
41 at each Annual Meeting on the ~~ten~~ five or ~~five~~ nine and one half year anniversary
42 of a ~~policy's-position's~~ adoption, with a brief rationale accompanying each
43 recommendation;

44
45 (4) a consent calendar format will be used by the Assembly in considering the
46 ~~policies-positions~~ encompassed within the report;

47
48 (5) a vote will not be necessary on ~~policies-positions~~ recommended for rescission
49 as they will automatically expire under the auspices of the sunset mechanism
50 unless referred back to the Governing Council; ~~and~~

1
2 (6) the MSS Governing Council ~~may~~ will annually recommend at least three
3 polices for consolidations of groups of related positions, whereby the report(s) are
4 authored by the MSS Chair with recommendations solicited from relevant Standing
5 Committees as appropriate;
6

7 (7) when MSS positions are reviewed via either the sunset or consolidation
8 mechanisms, the result of any positions submitted to HOD and associated
9 implementation actions will be reviewed and documented for archival purposes if
10 not already characterized as part of the sunset review process;
11

12 (8) in their report on the previous HOD's proceedings, the Section Delegates will
13 recommend changes to any MSS positions that amend AMA Policy and were
14 considered by HOD, in order to summarize the amendment's ask and simplify the
15 language; and
16

17 (9) any MSS positions written as "MSS will ask the AMA" will be automatically
18 converted to past tense ("asked the AMA") after consideration by HOD as either a
19 resolution or an amendment; and
20

21 (10) any MSS position (or portion of a position) requesting an AMA or MSS study
22 will automatically sunset after the study is completed by either the AMA or MSS or
23 after consideration of the study request by HOD.
24

25 **ACKNOWLEDGEMENTS**

26 This report would not have been possible without the hard work of countless individuals. Your
27 entire MSS GC meticulously deliberated how to take on the Sunset Review process this year and
28 improve it for future years. However, in particular this report owes its existence to the extraordinary
29 efforts of your MSS Chair, Natasha Topolski, and Section Delegates, Raj Reddy and Laurie Lapp.
30 The GC also extends massive gratitude to all Standing Committee leaders and members who
31 partook in the review process this year. This was an exploratory trial, and we are so grateful for
32 having so many members take this process seriously and put in excellent work. Finally, our MSS
33 Policy Analyst Sarah Langill deserves special recognition for her invaluable contributions
34 throughout the entire process.

APPENDIX A – Sunset Report Recommendations for AMA-MSS Positions

Note: Language for MSS Positions recommended for retention can be found in the [2024 Sunset Review Spreadsheet](#) or the current [MSS Digest](#) and will eventually be retained in the new MSS Positions Compendium [Prototype can be found [here](#) but notably **not** current].

RECOMMENDED FOR SUNSET: OUTDATED - NONE

RECOMMENDED FOR SUNSET: STUDY COMPLETED (TABLE 1)

1. 65.013MSS Marriage-Based Health Disparities Among Gay, Lesbian, Bisexual, and Transgender Families
2. 150.037MSS Utilizing Food Insecurity Screenings in the Emergency medical setting to identify at Risk Individual
3. 160.040MSS Supporting Research into the Use of Mobile Integrated Health Care and Community Paramedicine in Addressing the Primary Care Shortage
4. 215.002MSS Studying Hospital-Enforced Admissions, Testing, and Procedure Quotas
5. 270.039MSS Study of Medical Student, Resident/Fellow, and Physician Voting in Federal, State, and Local Elections
6. 295.174MSS Evaluation of Standardized Clinical Skills Exams
7. 295.202MSS Studying an Application Cap for the National Residency Match Program
8. 305.082MSS Understanding Philanthropic Efforts to Address Medical School Tuition
9. 305.091MSS Understanding Philanthropic Efforts to Address Rise of Medical School Tuition
10. 310.050MSS Addressing the Increasing Number of Unmatched Medical Students
11. 370.013MSS Presumed Consent Organ Donation

RECOMMENDED FOR RETENTION WITH AMENDMENTS: SUMMARIZE AND/OR UPDATE LANGUAGE (TABLE 2)

1. 20.019MSS Modernization of HIV Specific Criminal Laws
2. 20.023MSS Reducing Disparities in HIV Incidence through Pre-Exposure Prophylaxis (PrEP) for HIV
3. 65.026MSS Improving Inclusiveness of Transgender Patients within Electronic Medical Record Systems
4. 90.001MSS Handicapped Parking Spaces
5. 95.013MSS Support Expansion of Good Samaritan Laws
6. 100.023MSS Ensuring Fair Pricing of Drugs Developed with the United States Government
7. 150.038MSS Eliminating Recommendations to Restrict Dietary Cholesterol and Fat
8. 150.042MSS Increased Recognition and Treatment of Eating Disorders in Minority Populations
9. 160.029MSS Protecting Medical Students' Rights as Patients
10. 215.006MSS Amendment to H-150.949 Healthy Food Options in Hospitals
11. 250.029MSS Opposition to Regulations that Penalize Immigrants for Accessing Health Care Services
12. 275.015MSS Medical Licenses for Individuals with DACA Status
13. 295.177MSS Shared Decision-Making in Medical Education

14. 295.199MSS Strengthening Standards for LGBTQ Medical Education
15. 295.211MSS Improving Support and Access for Medical Students with Disabilities
16. 315.003MSS Enabling a Contiguous, National Electronic Health Record Network
17. 350.020MSS Accurate Collection of Preferred Language and Disaggregated Race & Ethnicity to Characterize Health Disparities
18. 440.070MSS Increasing Availability of Bleeding Control Supplies
19. 440.081MSS Adverse Impacts of Delaying the Implementation of Public Health Regulations
20. 460.024MSS Patient Education and Security Risks Involving Direct-to-Consumer Genetic Testing
21. 480.022MSS Encouraging the Development of Multi-Language, Culturally Informed Mobile Health Applications
22. 505.013MSS Amending H-490.913, Smoke-free Environments and Workplaces, and H- 490.907, Tobacco Smoke Exposure of Children in Multi-Unit Housing to Include E-Cigarettes
23. 515.014MSS Reducing the Prevalence of Sexual Assault by testing Sexual Assault Evidence Kits

RECOMMENDED FOR RETENTION WITH AMENDMENTS: PAST TENSE

1. 10.009MSS Use of Protective Eyewear by Young Athletes
2. 20.005MSS HIV Drug Availability
3. 20.006MSS HIV Prevention Through Educational Programs
4. 20.021MSS Support Offering HIV Post Exposure Prophylaxis to All Survivors of Sexual Assault
5. 20.022MSS Decriminalization of Human Immunodeficiency Virus (HIV) Status Non-Disclosure in Virally Suppressed Individuals
6. 60.017MSS Disclosure of Health Status to Children and Adolescents
7. 60.022MSS Altering School Days to Alleviate Adolescent Sleep Deprivation
8. 60.023MSS Legal Protection and Social Services for Commercially Sexually Exploited Youth
9. 60.026MSS Support for Children of Incarcerated Parents
10. 60.027MSS National Guidelines for Guardianship
11. 60.028MSS Ensuring the Best In-School Care for Children with Sickle Cell Disease:
12. 60.030MSS Support for Requiring Investigations into Deaths of Children in Foster Care
13. 60.031MSS Increasing Access to Menstrual Hygiene Products in School Settings
14. 60.033MSS Support for Siblings of Chronically Ill Patients
15. 60.035MSS Student-Centered Approaches for Reforming School Disciplinary Procedures
16. 65.009MSS Same-Sex and/or Opposite Sex Non-Married Partner
17. 65.025MSS Endorsing the Creation of a LGBTQ+ Research IRB Training
18. 65.027MSS Removing Sex Designation from the Public Portion of the Birth Certificate
19. 65.028MSS Encourage Federal Efforts to Expand access to Scheduled Dialysis for Undocumented Persons
20. 65.029MSS Opposing Mandated Reporting of People who Question their Gender Identity
21. 65.033MSS Co-payments in Prisons

22. 65.034MSS Opposition to Federal Ban on SNAP Benefits for Persons Convicted of Drug Related Felonies
23. 65.037MSS Oppose Mandatory DNA Collection of Migrants
24. 65.038MSS Recognizing LGBTQ+ Individuals as Underrepresented in Medicine
25. 90.008MSS Support for Housing Modification Policies
26. 95.009MSS Addressing Emerging Trends in Recreational Drug Abuse
27. 100.005MSS Informational Campaign on Diethylstilbestrol - (DES)
28. 100.008MSS Novel Antibiotics and Antimicrobial Resistance
29. 100.024MSS Supporting Research into the Therapeutic Potential of Psychedelics
30. 105.004MSS Pharmaceutical Advertising in Electronic Health Record Systems
31. 115.003MSS Addressing Drug Overdose and Patient Compliance with Targeted Pharmaceutical Packaging Efforts
32. 120.002MSS Written Medications Instructions for Chronic Multi-Drug Therapy
33. 120.005MSS Tracking and Punishing Distributors of Counterfeit Pharmaceuticals
34. 120.011MSS Personalized Medication Cards
35. 120.016MSS Request for Benzodiazepine-Specific Prescribing Guidelines for Physicians
36. 120.017MSS Expansion of Epinephrine Entity Stocking Legislation
37. 130.002MSS Use of Automatic External Defibrillators
38. 130.004MSS Decreasing Emergency Department Overcrowding
39. 130.006MSS Physician Use of Emergency Lights in Responding to Medical Emergencies
40. 135.002MSS Environmental Protection
41. 135.017MSS Health Impact of Per- and Polyfluoroalkyl Substances (PFAS) Contamination in Drinking Water
42. 135.018MSS Be the Change: Implementing AMA Climate Change Principles Through JAMA Paper Consumption Reduction and Green Healthcare Leadership
43. 135.019MSS Promoting the Use of Multi-Use Devices and Sustainable Practices in the Operating Room
44. 140.012MSS Increasing Prevalence and Utilization of Ethics Committees
45. 140.019MSS Supporting the Establishment of Guidelines Regarding Online Professionalism
46. 140.027MSS Standardization of Medical Ethics Core Competencies for Undergraduate Medical Education
47. 140.028MSS Solitary Confinement
48. 150.003MSS Hunger in America
49. 150.012MSS Allergic Reactions in Schools and Airplanes
50. 150.013MSS Mercury in Food as a Human Health Hazard
51. 150.014MSS Healthy Food Options in Hospitals
52. 150.020MSS Decreasing Incidence of Obesity and Negative Sequelae by Reducing the Cost Disparity Between Calorie-Dense, Nutrition Poor Foods and Nutrition-Dense Foods
53. 150.021MSS Accurate Reporting of Fats in Nutritional Labels
54. 150.028MSS Increasing Healthy Food Choices Among Families Supported by the Supplemental Nutrition Assistance Program
55. 150.029MSS Increasing the Consumption of Healthy Fresh Foods in Food Desert Communities Using Mobile Produce Vendor Programs
56. 150.030MSS Promoting Food Recovery Efforts in Hospitals
57. 150.035MSS Regulating Front-Of-Package Labels on Food Products
58. 150.041MSS Ending Tax Subsidies for Advertisements Promoting Food and Drink of Poor Nutritional Quality Among Children

59. 155.004MSS Advocating for Research on Physician-Initiated Conversations About Treatment Cost
60. 155.006MSS Standardizing Coverage of Applied Behavioral Analysis Therapy for Persons with Autism Spectrum Disorder
61. 155.007MSS Increasing Accessibility to Adult Incontinence Products
62. 160.001MSS Support of Community Health Clinics with Student Involvement
63. 160.012MSS Readability of Medical Notices of Privacy Practices
64. 160.016MSS Promoting Internet-Based Electronic Health Records and Personal Health Records
65. 160.028MSS Improving Home Health Care
66. 165.021MSS Encourage the Final Evaluation Reports of Section 115 Demonstrations at the End of the Demonstration Cycle
67. 160.013MSS Adoption of a Universal Exercise Database and Prescription Protocols for Obesity Prevention
68. 170.014MSS Recognizing the Importance of the Theory of Evolution in Science Education
69. 180.004MSS Sexual Orientation as Health Insurance Criteria
70. 180.015MSS Privacy Issues for Minors Regarding Insurance Company Explanations of Benefits
71. 180.016MSS Emergency Department Insurance Linking
72. 200.002MSS Support of the NHSC Loan Repayment Program
73. 200.018MSS Incorporating Community Health Workers into the U.S. Health Care System
74. 200.020MSS Call for Transparency Regarding the Announcement of 17,000 Cuts to Military Health Providers
75. 215.001MSS Hospital Dress Codes for the Reduction of Nosocomial Transmission of Disease
76. 215.003MSS Preventive Screening and Treatment of Malnutrition in Hospital Patients
77. 245.006MSS Detection, Diagnosis and Intervention of Hearing Loss in Newborns and Infants
78. 245.013MSS Promoting Breastfeeding in Hospitals
79. 245.022MSS Support for Rooming-In of Neonatal Abstinence Syndrome Patients with their Parents
80. 25.003MSS Increased Affordability and Access to Hearing Aids and Related Care
81. 250.010MSS Medical Supply Donations to Foreign Countries
82. 250.020MSS Refugee Health Care
83. 250.024MSS Regulations in Times of Armed Conflict
84. 250.030MSS Opposing the Office of Refugee Resettlement's Use of Medical Psychiatric Records for Evidence in Immigration Court
85. 250.031MSS Supporting Collection of Data on Medical Repatriation
86. 270.016MSS Hate Crimes
87. 270.021MSS National Cosmetics Registry and Regulation
88. 270.037MSS Support for Continued 911 Modernization and the National Implementation of Test- To-911 Service
89. 270.038MSS Exemptions to Work Requirements and Eligibility Expansions in Public Assistance Programs
90. 275.009MSS Voting Rights For AMA-MSS NBME Representatives
91. 275.013MSS Equality for COMLEX and USMLE
92. 295.007MSS Curriculum in Child Abuse and Neglect
93. 295.012MSS Promotion of Infection Control Procedures in the Medical School Setting
94. 295.098MSS Distribution of the AMA Code of Medical Ethics

95. 295.101MSS Support for the Accreditation of US Medical Schools
96. 295.115MSS Support of Business of Medicine Education for Medical Students
97. 295.116MSS Opposition to Clinical Skills Examinations for Physician Medical Re-Licensure
98. 295.117MSS Additions to United States Medical Licensure Examination and College of Osteopathic Medical Licensure Exam
99. 295.122MSS Modernization of Medical Education Assessment and Medical School Accreditation
100. 295.126MSS Medical Student Clinical Training and Education Conditions
101. 295.147MSS Expanding the Visiting Students Application Service for Visiting Student Electives in the Fourth Year
102. 295.149MSS Competency-Based Portfolio Assessment of Medical Students
103. 295.181MSS Providing Greater Emphasis on the Social Determinants of Health in Medical School Curriculum
104. 295.182MSS USMLE Step 1 Timing
105. 295.183MSS Combating Sex-Linked Discrimination of Denying Special Request for Lactation during Medical Board Examination
106. 295.185MSS Evaluation of DACA-Eligible Medical Students, Residents, and Physicians in Addressing Physician Shortages
107. 295.200MSS Investigation of Existing Application Barriers for Osteopathic Medical Students Applying for Away Rotations
108. 295.201MSS Standard Procedure for Accommodations in USMLE and NBME Exams
109. 295.205MSS Report and Recommendations on the Residency Application Process
110. 295.210MSS Requiring Blinded Review of Medical Student Performance
111. 305.054MSS Refinancing Federal Consolidation Loans
112. 305.092MSS Modifying Eligibility Criteria for the Association of American Medical Colleges' Financial Assistance Program
113. 310.031MSS Resident/Fellow Work and Learning Environment
114. 310.039MSS Opposition to Protected Sleep Time
115. 345.018MSS Support for the Use of Psychiatric Advance Directives
116. 345.019MSS Support for Veterans Courts
117. 350.021MSS Addressing the Racial Pay Gap in Medicine
118. 350.024MSS Using X-Ray and Dental Records for Assessing Immigrant Age
119. 350.026MSS Combating Natural Hair and Cultural Headwear Discrimination in Medicine and Medical Professionalism
120. 360.002MSS Increasing Patient Access to Sexual Assault Nurse Examiners
121. 365.005MSS Reimbursement for Post-Exposure Protocol for Needlestick Injuries
122. 370.020MSS Improving Body Donation Regulation
123. 370.022MSS Encouraging Brain and Other Tissue Donation for Research and Educational Purposes
124. 385.002MSS The Patient-Centered Medical Home Concept
125. 420.006MSS High Rates of Cesarean Deliveries
126. 420.007MSS Providing Complete Maternity Care Under the Affordable Care Act
127. 420.014MSS Classification and Surveillance of Maternal Mortality
128. 435.004MSS A No-Fault Professional Liability System
129. 435.009MSS Liability Coverage for Medical Students Completing Extramural Electives
130. 435.010MSS Quantifying Medical Tort Reform
131. 440.008MSS Tuberculosis Resurgence and Physician Awareness
132. 440.012MSS Public Education Announcements for Detection of Skin Cancer
133. 440.013MSS Obesity as a Chronic Disease
134. 440.019MSS Requirement for Daily Free Play in Schools

135. 440.032MSS Restriction of Non-Veterinary Antimicrobials in Commercial Livestock to Reduce Antibiotic Resistance
136. 440.033MSS Placement of Alcohol-Based Hand Sanitizer Dispensers Outside of Public Restrooms
137. 440.035MSS Increasing Advocacy for and Public Awareness of the Lack of a Vaccine-Autism Link
138. 440.040MSS Increased Advocacy for Hepatitis C Virus Education, Prevention, Screening, and Treatment
139. 440.044MSS Sunscreen and Sun Protection Counseling by Physicians
140. 440.045MSS Development of a Standardized Post-Conducted Electrical Device Exposure Medical Protocol and Educational Campaign
141. 440.046MSS Prevention of Mosquito-Transmitted Diseases
142. 440.048MSS Eradicating Homelessness
143. 440.049MSS Labeling and Recommended Protection for Sunglasses
144. 440.069MSS Increased Access to Identification Cards for the Homeless Population
145. 440.071MSS Improving the Health and Safety of Consensual Sex Workers
146. 440.072MSS Sunscreen Dispensers in Public Spaces as a Public Health Measure
147. 440.073MSS Increasing Access to Gang-Related Tattoo Removal in Prison and Community Settings
148. 440.076MSS Developing Diagnostic Criteria and Evidence-Based Treatment Options for Problematic Pornography Viewing
149. 440.077MSS Compassionate Release for Incarcerated Patients
150. 440.078MSS Support for Universal Basic Income Pilot Studies
151. 440.082MSS Recognizing Loneliness as a Public Health Issue
152. 440.083MSS Advancing the Role of Outdoor Recreation in Public Health
153. 440.084MSS Advocating for the Amendment of Chronic Nuisance Ordinances
154. 440.087MSS Restricting Use of Force by Law Enforcement Officers for Improved Public Health Outcomes
155. 450.001MSS AMA Endorsement of the WHO Surgical Safety Checklist
156. 460.005MSS Scientific Implications of Somatic Cell Nuclear Transfer Technology
157. 460.016MSS The Next Transformative Project
158. 460.023MSS Reducing the Cost of Centers for Medicare and Medicaid Services Limited Data Sets for Academic Use
159. 460.105MSS Use of Animals in Research and Education
160. 470.007MSS Athlete Concussion Management and Chronic Traumatic Encephalopathy Prevention
161. 480.019MSS Best Practices for Mobile Medical Applications
162. 480.023MSS Net Neutrality and Public Health
163. 480.024MSS Blockchain in Healthcare: Industry Challenges and Opportunities for Emerging Decentralized
164. 490.019MSS Use of State Tobacco Tax Revenue and Tobacco Settlement Fund Tracking and Publishing
165. 490.024MSS Banning Smoking While Driving in Vehicles in which Minors are Present
166. 505.011MSS Opposing the Sale of Tobacco in Retail and Grocery Stores
167. 515.007MSS Promoting Physician Awareness of the Correlation Between Domestic Violence and Child Abuse
168. 535.003MSS Disclosure of Funding Sources and Industry Ties of Professional Medical Associations and Patient Advocacy Organizations
169. 55.004MSS Use of the Anal Pap Smear as a Screening Tool for Anal Dysplasia

RECOMMENDED FOR RETENTION

1. 10.008MSS Promoting the Universal Use of Bicycle Helmets
2. 10.013MSS Implementing Bike Lanes to Improve Overall Bicyclist Safety
3. 10.014MSS Improving the Safety of Playgrounds through Height Restrictions
4. 15.011MSS Decrease Adolescent Mortality Through More Comprehensive Graduated Driver Licensing Programs
5. 60.025MSS Addressing the Need for Standard Evidence-Based Screening Tools to Improve Care of Adolescent and Pediatric Patients with Depression
6. 60.029MSS Affirming the Right of Minors to Consent to Vaccinations
7. 60.032MSS Opposition of Corporal Punishment as a Form of Discipline
8. 60.034MSS Opposing Efforts that would Prevent Transgender or Questioning Youth from Being Prescribed Puberty-Suppressing Medications by Physicians
9. 65.035MSS Conforming Sex and Gender Designation on Government IDs and Other Documents
10. 65.036MSS Enfranchisement of Incarcerated Persons
11. 95.014MSS Opposition to Lack of Evidence-Based Medicine in Drug Courts
12. 150.027MSS Harms and Benefits of Vitamin and Mineral Supplements
13. 150.036MSS Support of the Supplemental Nutrition Assistance Program (SNAP) Education Programs and Research
14. 150.040MSS Efficacy of Food Prescriptions and Hospital-Based Food Assistance Programs in Addressing Food Insecurity in the U.S.
15. 155.003MSS Price Transparency in Health Care
16. 160.006MSS Development of Low-Literacy Patient Education Materials
17. 160.009MSS Complete Federal Responsibility for Medical Translation Services
18. 160.026MSS Public Reporting of Physician Outcomes
19. 160.027MSS Readability of Patient Materials
20. 160.037MSS Mitigating the Transportation Barrier for Accessibility of Healthcare for the Medicaid Population
21. 160.038MSS Supporting Life Narrative Services in Geriatric Patients
22. 160.039MSS Addressing Health Disparities Through Improved Transition of Care from Pediatric to Adult Care
23. 160.041MSS Expanding On-Site Physician Home Health Care to Low-Income Families and the Chronically Ill
24. 165.003MSS Advocacy or Rapid and Timely Implementation of The State Children's Health Insurance Program
25. 165.017MSS MSS Support for State-by-State Universal Health Care
26. 245.012MSS Continuing the Fight to Lower Infant Mortality in the United States
27. 270.020MSS Professional Promotion Disclosure Registry
28. 270.026MSS Strongly Advocate for Federal Funding for Indian Health Services
29. 295.093MSS FREIDA Online
30. 295.145MSS One Health
31. 295.176MSS Unified Medical Education
32. 295.178MSS Motivational Interviewing in Medical Education
33. 295.184MSS Medical Student Involvement in Handoffs
34. 295.195MSS Introducing Teach-back Education into Medical School Curriculum
35. 295.203MSS Supporting the INCUS Report Recommendations to Explore Further Research into Possible Changes to the USMLE Step 1 Scoring System
36. 295.204MSS Evaluating the Use of Third-Party Resources in Medical Education
37. 305.062MSS Industry Support of Professional Education in Medicine

38. 305.081MSS Addressing Student Debt in Medical School Attrition Due to Mental Illness
39. 310.024MSS Resident Physician Organizations
40. 345.007MSS Improving Physician Mental Health and Reducing Stigma through Revision of Medical Licensure Applications
41. 345.017MSS Support Mental Health Screenings for Detained Minority Youth
42. 345.020MSS Limiting the Use of Restrictive Housing in Adult Correctional Facilities
43. 370.014MSS Removal of Cannabis as a Relative Contraindication for Potential Organ Transplant
44. 370.021MSS Revising the Social Support Criterion of Organ Transplant Waitlist Eligibility
45. 420.011MSS Improving Minors' Access to Prenatal and Pregnancy-Related Care
46. 420.012MSS Support for the Standardization of Care for Postpartum Hemorrhage
47. 440.020MSS Support for Needlestick Prevention
48. 440.043MSS Promoting Celiac Disease Screening Usage and Standards
49. 440.074MSS The Effects of Employment Discrimination on the Health of Formerly Incarcerated Individuals
50. 440.085MSS Urban Forestry as Public Health Infrastructure
51. 460.009MSS Support for Increase in Federal Funding for the National Institutes of Health
52. 460.011MSS Comparative Effectiveness Research
53. 465.002MSS Medical Drone Use in Rural America
54. 465.003MSS Utilization of Telesurgery in Rural America
55. 470.009MSS Supporting a Minimum Age Limit for Tackle Football
56. 480.014MSS Support of Interstate Medical Licensure Compacts
57. 480.021MSS Machine Intelligence and Data Science Literacy
58. 480.025MSS Ethics and Security of Brain-Computer Interfaces
59. 485.003MSS Machine Intelligence in Healthcare
60. 490.020MSS Fighting Securitization of Tobacco Settlement Funds
61. 500.006MSS Restricting the Sale of E-Cigarettes to Minors
62. 525.011MSS Bridging the Gender Pay Gap
63. 525.013MSS Practice-Based Approach to Resolving Maternal Mortality and Morbidity in Racial Minorities

RECOMMENDED FOR CONSOLIDATION

An Asterisk () by a MSS position in this section indicates that this position was not originally due to be considered in this report but was pulled for consideration given the context of other MSS positions being considered.*

IMPROVING RESEARCH STANDARDS, APPROVAL PROCESSES, AND POST-MARKET SURVEILLANCE STANDARDS FOR MEDICAL DEVICES (TABLE 3)

1. 270.040MSS Improving Research Standards, Approval Processes, and Post-Market Surveillance Standards for Medical Devices
2. *270.043MSS Improving Research Standards, Approval Processes, and Post-Market Surveillance Standards for Medical Devices

TWO-INTERVAL GRADING (TABLE 4)

1. 295.198MSS Engaging Stakeholders for Establishment of Two-Interval, or Pass/Fail, Grading System of Non-Clinical Curriculum in U.S. Medical Schools
2. *295.170MSS Supporting Two-Interval Grading Systems for Medical Education
3. *295.217MSS Research the Ability of Two-Interval Grading of Clinical Clerkships to Minimize Racial Bias in Medical Education
4. *295.231MSS Research the Ability of Two-Interval Grading of Clinical Clerkships to Minimize Racial Bias in Medical Education

DE-SCHEDULING CANNABIS AND ITS DERIVATIVES (TABLE 5)

1. 95.003MSS Marijuana: Medical Use and Research
2. *100.021MSS Opposing the Classification of Cannabidiol as a Schedule 1 Drug

ACCESS TO EVIDENCE-BASED CARE AT ADDICTION REHABILITATION FACILITIES AND RECOVERY HOMES (TABLE 6)

1. 95.012MSS Advocating for the Standardization and Regulation of Outpatient Addiction Rehabilitation Facilities
2. 95.016MSS A Resolution to Encourage Recovery Homes to Implement Evidence-Based Policies Regarding Access to Medication Assisted Treatment for Opioid Use Disorder

CLINICAL SKILLS TRAINING AND EVALUATION (TABLE 7)

1. *295.111MSS State Society and State Medical Board Support to Delay Implementation of the USMLE Clinical Skills Assessment Exam
2. 295.114MSS Clinical Skills Assessment Exam and College of Osteopathic Medicine Licensing Exam-Physical Exam Implementation

PRE-PARTICIPATION SPORTS EXAMINATIONS (TABLE 8)

1. *470.001MSS Pre-participation Sports Examinations
2. 470.003MSS Pre-Participation Screening in Student Athletes

TRAUMA-INFORMED CARE RESOURCES & TRAINING (TABLE 9)

1. 295.196MSS Increasing Access to Trauma-Informed Services within Schools
2. 515.013MSS Trauma-Informed Care Resources
3. 515.015MSS Amending H-515.952, Adverse Childhood Experiences and Trauma Informed Care, to Encourage ACE and TIC Training in Undergraduate Medical Education

APPENDIX B

TABLE 1: RECOMMENDED FOR SUNSET: STUDY COMPLETED			
Position #	Title	Position	Rationale
65.013MSS	Marriage-Based Health Disparities Among Gay, Lesbian, Bisexual, and Transgender Families	<p>AMA-MSS supports AMA efforts to evaluate existing data concerning same-sex couples and their dependent children and report back to the House of Delegates to determine whether there is evidence of health care disparities for these couples and children because of their exclusion from civil marriage or (joint) adoption.</p> <p>MSS Timeline (MSS Res 5, A-08) (Reaffirmed: GC Rep B, I-13) (Amended and Reaffirmed: MSS GC Rep A, I-19)</p>	<p>This position’s request is fully completed. This position mirrored language transmitted to HOD via resolution 522 from another delegation at A-08 and was likely adopted for the MSS to have the ability to vocally support the resolution which asked for an AMA study. Resolution 522 was adopted and resulted in CSAPH Report 1 at I-09 that led to the adoption of H-65.973. Given this, the request is complete and the position can be sunsetted.</p> <p>Moreover, at A-10 the MSS adopted 65.014MSS Marriage Equality and Repeal of the Defense of Marriage Act which took a stance acknowledging health disparities for LGBTQ+ individuals and couples, their families, and their children and supporting ending the exclusion of same-sex couples from civil marriage. This position was sent to HOD as AMA Res 209 at I-10 and referred. At A-11 BOT Report 15 Marriage Equality was Adopted resulting in D-265.989. While this policy no longer exists, the sentiment remains in other AMA policies.</p>

TABLE 1: RECOMMENDED FOR SUNSET: STUDY COMPLETED

Position #	Title	Position	Rationale
150.037MS S	Utilizing Food Insecurity Screenings in the Emergency medical setting to identify at Risk Individual	AMA-MSS will study the effectiveness of food prescriptions and hospital-based food assistance programs for those patients identified as food insecure. MSS Timeline: (MSS Res 51 I-18) (MSS CGPH Report A, Adopted [150.040MSS], A-19)	Study was completed at A-19 through CGPH Report A resulting in 150.040MSS Efficacy of Food Prescriptions and Hospital-Based Food Assistance Programs in Addressing Food Insecurity in the U.S.
160.040MS S	Supporting Research into the Use of Mobile Integrated Health Care and Community Paramedicine in Addressing the Primary Care Shortage	AMA-MSS will study mobile medical units as a means of delivering healthcare to underserved communities. MSS Timeline: (MSS Res 28, I-18, CEQM Rep A , A-19)	This position's request was fully completed. CEQM Report A was presented at A-19 recommending no external action. Per the report: "the AMA is not a research institution, and has also shown its support for improving emergency medical services transport through the recent adoption of HOD Resolution H-240.978 ."
215.002MS S	Studying Hospital-Enforced Admissions, Testing, and Procedure Quotas	AMA-MSS will ask the AMA to study the extent to which U.S. hospitals inappropriately interfere in physicians' independent exercise of medical judgment, including but not limited to the use of admissions, testing, and procedure quotas. MSS Timeline: (MSS Res 19, I-13) (Reaffirmed: MSS GC Rep A, I-19) HOD Timeline: (AMA Res 704 , A-14, Adopted as amended with a change in title [D-215.989]) (CMS Rep 5 , A-15, Filed)	This position's request was fully completed. At A-14, MSS Resolution 704 was adopted, which became policy D-215.989 . Subsequently an informational CMS Report 05 was adopted at A-15, completing the study asked by this position. Below is a summary of the report discussion: <i>The AMA is continuing to study the extent to which hospitals interfere in physicians' independent exercise of medical judgment. The Council believes that ensuring patient</i>

TABLE 1: RECOMMENDED FOR SUNSET: STUDY COMPLETED

Position #	Title	Position	Rationale
			<p><i>safety and professional satisfaction require hospital employed physicians to preserve their clinical judgment.</i></p> <p><i>The Council encourages physicians to use AMA resources when considering hospital employment. It is important that a physician consider all aspects of a contract before accepting an offer of employment. State medical associations and the AMA are useful resources if hospital-employed physicians want to seek advice on clinical practices requested of them by their hospital employer. The Council believes the AMA has sufficient resources and policy to help physicians prepare for hospital employment and to advocate on their behalf.</i></p>
270.039MS S	Study of Medical Student, Resident/Fellow, and Physician Voting in Federal, State, and Local Elections	<p>AMA-MSS asked 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.</p> <p>MSS Timeline: (MSS Res. 14, I-19)</p> <p>HOD Timeline: (AMA Res. 616, Adopted as Amended with Title Change, A-22) (BOT</p>	This position's request was fully completed. The original resolution was adopted and addressed in BOT Report 19 at A-23 which did not recommend any new AMA policy.

TABLE 1: RECOMMENDED FOR SUNSET: STUDY COMPLETED

Position #	Title	Position	Rationale
		Report 19, A-23 , Filed)	
295.174MS S	Evaluation of Standardized Clinical Skills Exams	<p>AMA-MSS will ask the AMA to (1) evaluate the benefits and consequences of the implementation of the standardized clinical skills exams as a step for licensure and provide recommendations based on these findings; and</p> <p>(2) evaluate the consequences of the January 2013 changes to the USMLE Step II Clinical Skills Exam and their implications for US medical students.</p> <p>MSS Timeline: (MSS Res 7, A-13) (Reaffirmed: MSS GC Rep A, I-19)</p> <p>HOD Timeline: (AMA Res 904, I-13 Adopted as Amended [D-295.960])</p>	<p>This position's request was fully completed. The resolution was sent to HOD at I-13 as AMA Res 904 and adopted into AMA Policy D-295.960.</p> <p>The Implementation report indicated the following actions were taken and that no further action was required at that time.</p> <p><i>"Our AMA Council on Medical Education met with representatives of the National Board of Medical Examiners (NBME) and Federation of State Medical Boards (FSMB) on March 23, 2014 to discuss the 2013 changes to the United States Medical Licensure Examine (USMLE) Step II Clinical Skills (CS) examination. The NBME, FSMB and Educational Commission for Foreign Medical Graduates (ECFMG) indicated that they will continue to enhance the value of the Step 2 CS examination. Changes to the exam and to the standards for passing reflect changes in medical education, the practice of medicine, assessment science and public expectations. The NBME and FSMB also indicated commitments to making information available to every medical school about</i></p>

TABLE 1: RECOMMENDED FOR SUNSET: STUDY COMPLETED

Position #	Title	Position	Rationale
			<p><i>student performance spring 2014 and making feedback available to individual students by year end. The Council will monitor to verify that these actions are carried out. The House action was transmitted to each medical school, residency program director, directors of medical education at U.S. teaching hospitals and other interested groups via the MedEd Update.”</i></p> <p>Furthermore, the USMLE Step II Clinical Skills Exam no longer exists. While there is a possibility a clinical skills exam may return in the future, the actions requested from this MSS Position are complete and outdated.</p>
295.202MS S	Studying an Application Cap for the National Residency Match Program	<p>AMA-MSS will study the implementation of application limits for the National Residency Match Program (NRMP) through the Electronic Residency Application Services (ERAS) as a means of addressing the increase in residency application volume on individual residency programs.</p> <p>MSS Timeline: (MSS Res. 15, I-19)</p> <p>HOD Timeline: (MSS CME Report A, N-20)</p>	This position’s request was fully completed. MSS CME Report A was presented to the MSS Assembly at N-20 as an information report.
305.082MS S	Understanding Philanthropic	AMA-MSS will (1) study the financial sustainability and factors enabling the	This position's request was completed with the production of the MSS COLRP CME Rep

TABLE 1: RECOMMENDED FOR SUNSET: STUDY COMPLETED

Position #	Title	Position	Rationale
	Efforts to Address Rise of Medical School Tuition	implementation of tuition-free and tuition-reduced undergraduate medical education programs; and (2) study the efficacy of using tuition-free and tuition-reduced undergraduate medical education programs to incentivize primary care specialty choice among medical students. MSS Timeline: (MSS Res 29, I-18)	A (handbook page 360) at A-19. This study produced the MSS position 305.091MSS Understanding Philanthropic Efforts to Address Rise of Medical School Tuition (below) which requested that the AMA-MSS continue to study this topic. Information regarding the outcome of the follow up study can be found below.
305.091MSS	Understanding Philanthropic Efforts to Address Rise of Medical School Tuition	AMA-MSS will 1) continue to study this topic to gain a better understanding of the sustainability of free and reduced medical tuition programs and of the efficacy of these programs in effecting medical specialty choice; and 2) regularly track the tuition reimbursement programs across medical schools to monitor outcomes. MSS Timeline: (MSS COLRP/CME Rep A , A-19)	This position's request was completed with the production of the MSS COLRP CME Rep A at J-21. This study produced the MSS position 295.232MSS Understanding Philanthropic Efforts to Address Rise of Medical School Tuition which requested that this topic be restudied every four years. The next report will be produced for A-25.
310.050MSS	Addressing the Increasing Number of Unmatched Medical Students	AMA-MSS will ask that the AMA (1) study, in collaboration with the Association of American Medical Colleges (AAMC) and the American Osteopathic Association (AOA), the common reasons for failures to match; and (2) study potential pathways for reengagement in the medical field for applicants to the National Resident Matching Program (NRMP) who fail to match.	This position's request was completed. MSS Resolution 304 at I-14 was adopted as amended at I-15 resulting in updates to AMA Policy D-310.977 . Subsequently, CME Report 3 was adopted at A-16 which recommended AMA Policy D-310.977 be further updated to encourage the Association of American Medical Colleges to work with US medical schools to identify best practices,

TABLE 1: RECOMMENDED FOR SUNSET: STUDY COMPLETED

Position #	Title	Position	Rationale
		<p>MSS Timeline: (MSS Res 3, I-14) (Reaffirmed: MSS GC Rep A, I-19)</p> <p>HOD Timeline: (MSS Resolution 304, I-14, Adopted as Amended) (CME Report 3, A-16, Adopted)</p>	<p>including career counseling, used by medical schools to facilitate successful matches for medical school seniors, and reduce the number who do not match. Additionally, the report recommended that existing points from D-305.967, H-200.954 and D-310.977 be reaffirmed. In direct response to the passage of this report, the AAMC, and all medical schools, residency program directors, directors of medical education at U.S. teaching hospitals and other interested groups were notified of the House action.</p> <p>Additionally, the AMA ChangeMedEd Initiative has been actively working to address this issue. ChangeMedEd maintains active close collaborations with medical education entities including the AAMC, AOA, and NRMP. Notably, this includes several convenings of the medical education entities including focus groups, ChangeMedEd Conferences, grant programs such as the Reimagining Residency Initiative, and several educational resources including workshops, webinars, and publications. Of note, the AMA has a strong focus on transitions across the medical education continuum including academic coaching which was in part adopted into AMA policy through this resolution. Furthermore, the</p>

TABLE 1: RECOMMENDED FOR SUNSET: STUDY COMPLETED

Position #	Title	Position	Rationale
			AMA is currently working on developing the next major initiative to transform the UME to GME transition and convened an advisory board with representatives from all relevant stakeholders, a national design panel, and a group of visionaries to support the creation of the initiative. Your MSS Chair, Natasha Topolski, was honored to be invited to participate in this process as part of the National Design Panel in the spring of 2023.
370.013MS S	Presumed Consent Organ Donation	<p>AMA-MSS will ask the AMA to reexamine the ethical considerations of presumed consent and other potential models for increasing the United States organ donor pool.</p> <p>MSS Timeline: (MSS Res 1, I-13) (Reaffirmed: MSS GC Rep A, I-19)</p> <p>HOD Timeline: (Res 001-A-14, Adopted [D-370.985]) (BOT Report 13-A-15, Adopted [H-370.959])</p>	This position's request was fully completed. The original resolution was adopted and addressed in BOT Report 13 Methods to Increase the US Organ Donor Pool was presented at A-15 and resulted in H-370.959 .

TABLE 2: RECOMMENDED FOR RETENTION WITH AMENDMENTS: SUMMARIZE AND/OR UPDATE LANGUAGE

Position #	Title	Original Position	Final Summarized Language & Rationale
20.019MSS	Modernization of HIV Specific Criminal Laws	<p>AMA-MSS will ask the AMA to amend policy H-20.914 via insertion and deletion as follows:</p> <p><u>H-20.914 Discrimination and Criminalization Based on HIV Seropositivity</u></p> <p>Our AMA: 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; and (4) Encourages medical staff to work closely with hospital administration and governing bodies to establish appropriate policies regarding HIV-positive patients; and (5) <u>Supports consistency of federal and state criminal laws with current medical and scientific knowledge and accepted human rights-based approaches to disease</u></p>	<p>AMA-MSS asked the AMA to support consistency of federal and state criminal laws with current medical and scientific knowledge and accepted human rights-based approaches to disease control and prevention, including avoidance of any imposition of unwarranted punishment based on health and disability status, and encourage public education and understanding of the stigma created by HIV criminalization statutes and subsequent negative clinical and public health consequences.</p>

TABLE 2: RECOMMENDED FOR RETENTION WITH AMENDMENTS: SUMMARIZE AND/OR UPDATE LANGUAGE

Position #	Title	Original Position	Final Summarized Language & Rationale
		<p><u>control and prevention, including avoidance of any imposition of unwarranted punishment based on health and disability status; and (6) Encourages public education and understanding of the stigma created by HIV criminalization statutes and subsequent negative clinical and public health consequences.</u></p> <p>(MSS Res 37, I-13) (AMA Res 2, Substitute Res 2 Adopted in lieu, [H-90.914] A-14)</p>	
20.023MSS	Reducing Disparities in HIV Incidence through Pre-Exposure Prophylaxis (PrEP) for HIV	<p>AMA-MSS will ask the AMA to amend AMA Policy H-20.895, Pre-Exposure Prophylaxis (PrEP) for HIV, by insertion to read as follows:</p> <p>H-20.895: Pre-Exposure Prophylaxis (PrEP) for HIV</p> <ol style="list-style-type: none"> 1. Our AMA will educate physicians, <u>physicians in training</u>, and the public about the effective use of pre-exposure prophylaxis for HIV and the US PrEP Clinical Practice Guidelines. 2. Our AMA supports the coverage of PrEP in all clinically appropriate circumstances. 3. Our AMA supports the removal of insurance barriers for PrEP such as prior authorization, mandatory consultation with an infectious disease specialist and other barriers that are not clinically relevant. 4. Our AMA advocates that individuals not be 	AMA-MSS asked the AMA to include medical students, residents, and fellows in PrEP education and encourage discussion of PrEP during routine sexual health counseling, regardless of a patient's current reported sexual behaviors.

TABLE 2: RECOMMENDED FOR RETENTION WITH AMENDMENTS: SUMMARIZE AND/OR UPDATE LANGUAGE

Position #	Title	Original Position	Final Summarized Language & Rationale
		<p>denied any insurance on the basis of PrEP use.</p> <p><u>5. Our AMA encourages the discussion of an education about PrEP during routine sexual health counseling, regardless of a patient's current reported sexual behaviors.</u></p> <p>MSS Timeline: (MSS Res. 03, I-19)</p> <p>HOD Timeline: (AMA Res 933, Adopted as amended [H-20.895],I-22)</p>	
65.026MSS	Improving Inclusiveness of Transgender Patients within Electronic Medical Record Systems	<p>AMA-MSS will ask the AMA to amend policy H-315.967, Promoting Gender, Sex, Sexual Orientation Options on Medicaid Documentation by insertion as follows:</p> <p>Promoting Gender, Sex, Sexual Orientation Options on Medicaid Documentation H-315.967</p> <p>Our AMA: (1) supports the voluntary inclusion of a patient's biological sex, current gender identity, sexual orientation, and preferred gender pronoun(s), <u>preferred name, and an inventory of current anatomy</u> in medical documentation and related forms, including in electronic health records, in a culturally-sensitive and voluntary manner;</p> <p>(2) will advocate for collection of patient data in medical documentation and in medical research studies, according to current best</p>	<p>AMA-MSS asked the AMA to support the inclusion of preferred name and an inventory of current anatomy in medical documentation and related forms, including in electronic health records, in a culturally-sensitive and voluntary manner.</p> <p>Rationale: We recognize that this policy is addressed in the LGBTQ+ CHIT report presented for consideration by the MSS A-24 Assembly. However, until that report passes, we believe this is the best course of action until the Assembly officially votes, at which point this position can be administratively reconciled by the next SDs and staff with the outcome of that report. (SDs and staff can already append/amend existing MSS positions with newly adopted MSS resolutions that are not direct amendments,</p>

TABLE 2: RECOMMENDED FOR RETENTION WITH AMENDMENTS: SUMMARIZE AND/OR UPDATE LANGUAGE

Position #	Title	Original Position	Final Summarized Language & Rationale
		<p>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;</p> <p>(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;</p> <p>(4) will investigate the use of personal health records to reduce physician burden in maintaining accurate patient information instead of having to query each patient regarding sexual orientation and gender identity at each encounter; and</p> <p>(5) will advocate for the incorporation of recommended best practices into electronic health records and other HIT products at no additional cost to physicians.</p> <p>MSS Timeline: (MSS Res 36, A-19)</p> <p>HOD Timeline: (AMA Res. 004, Adopt as Amended [H-315.967], I-19)</p>	<p>similar to HOD staff appending existing HOD policies even when MSS resolutions are written as new resolves, for the purposes of consolidating the compendium and grouping related policies together to more easily see our full position on an issue.)</p>
90.001MSS	Handicapped Parking Spaces	<p>AMA-MSS will ask the AMA to support efforts to educate the public on the appropriate use of parking spaces for the handicapped.</p> <p>MSS Timeline: MSS Rep F, I-98) (Reaffirmed:</p>	<p>AMA-MSS asked the AMA to support efforts to educate the public on the appropriate use of parking spaces for people with mobility disabilities.</p>

TABLE 2: RECOMMENDED FOR RETENTION WITH AMENDMENTS: SUMMARIZE AND/OR UPDATE LANGUAGE

Position #	Title	Original Position	Final Summarized Language & Rationale
		<p>MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13) (Reaffirmed: MSS Rep F, 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)</p> <p>HOD Timeline: (AMA Res 118, I-88 Adopted [H-90.991]) (H-90.991 Rescinded: CCB/CLRPD Rep. 3, A-14)</p>	<p>Rationale: Handicapped is an outdated term as per the AMA AAMC Advancing Health Equity: A Guide to Language, Narrative and Concepts.</p>
95.013MSS	Support Expansion of Good Samaritan Laws	<p>AMA-MSS will ask our AMA to amend policy D-95.977 by insertion to read as follows:</p> <p>911 Good Samaritan Laws D-95.977 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; <u>and (3) will work with the relevant organizations and state societies to raise awareness about the existence and scope of Good Samaritan laws.</u></p> <p>MSS Timeline: (MSS Res 37, A-19)</p> <p>HOD Timeline: (AMA Res. 203, Adopt [D-95.977], I-19)</p>	<p>AMA-MSS asked the AMA to work with the relevant organizations and state societies to raise awareness about the existence and scope of Good Samaritan laws.</p>

TABLE 2: RECOMMENDED FOR RETENTION WITH AMENDMENTS: SUMMARIZE AND/OR UPDATE LANGUAGE

Position #	Title	Original Position	Final Summarized Language & Rationale
100.023MS S	Ensuring Fair Pricing of Drugs Developed with the United States Government	<p>AMA-MSS will ask our AMA to amend policy H-110.987 by insertion to read as follows:</p> <p>RESOLVED, That our American Medical Association amend Policy H-110.987 by addition to read as follows: H-110.987, "Pharmaceutical Costs" 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</p>	<p>New Title: International Reference Pricing</p> <p>AMA-MSS asked the AMA to 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.</p>

TABLE 2: RECOMMENDED FOR RETENTION WITH AMENDMENTS: SUMMARIZE AND/OR UPDATE LANGUAGE

Position #	Title	Original Position	Final Summarized Language & Rationale
		<p>companies. 6. Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation. 7. Our AMA supports legislation to shorten the exclusivity period for biologics. 8. Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens. 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</p>	

TABLE 2: RECOMMENDED FOR RETENTION WITH AMENDMENTS: SUMMARIZE AND/OR UPDATE LANGUAGE

Position #	Title	Original Position	Final Summarized Language & Rationale
		<p>pharmaceutical manufacturers and increase access to affordable drugs for patients; and (c) the expedited review of generic drug applications and prioritizing review of such applications when there is a drug shortage, no available comparable generic drug, or a price increase of 10% or more each year or per course of treatment. 11. Our AMA advocates for policies that prohibit price gouging on prescription medications when there are no justifiable factors or data to support the price increase. 12. Our AMA will provide assistance upon request to state medical associations in support of state legislative and regulatory efforts addressing drug price and cost transparency. 13. Our AMA supports legislation to shorten the exclusivity period for FDA pharmaceutical products where manufacturers engage in anti-competitive behaviors or unwarranted price escalations. <u>14. 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 in individual solution or in conjunction with other approaches.</u></p> <p>MSS Timeline: (MSS Res 49, A-19)</p>	

TABLE 2: RECOMMENDED FOR RETENTION WITH AMENDMENTS: SUMMARIZE AND/OR UPDATE LANGUAGE

Position #	Title	Original Position	Final Summarized Language & Rationale
		HOD Timeline: (AMA Res. 802 , CMS Rep. 4 Amended in Lieu of Res. 802, I-19 [H-110.980][H-110.983][H-110.986][H-460.909][D-330.954])	
150.038MS S	Eliminating Recommendations to Restrict Dietary Cholesterol and Fat	<p>AMA-MSS will ask the AMA to amend AMA Policy H-150.944, “Combating Obesity and Health Disparities,” by deletion to read as follows:</p> <p>Combating Obesity and Health Disparities H-150.944</p> <p>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 non-dairy 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, <u>healthful foods and beverages.</u></p> <p>(MSS Res 40, I-18) (AMA Res 431, A-19, Not Adopted)</p>	AMA-MSS asked the AMA to ensure federal subsidies to encourage the consumption of healthful foods and beverages without basing decisions entirely on their content of fat, added sugars, and cholesterol.
150.042MS S	Increased Recognition and Treatment of Eating Disorders in	AMA-MSS will ask the AMA to amend policy H-150.965, by insertion as follows in order to support increased recognition of disordered eating behaviors in minority populations and	New Title: Counseling for Binge-Eating AMA-MSS asked the AMA to participate efforts to encourage training of all school-based physicians, counselors, coaches,

TABLE 2: RECOMMENDED FOR RETENTION WITH AMENDMENTS: SUMMARIZE AND/OR UPDATE LANGUAGE

Position #	Title	Original Position	Final Summarized Language & Rationale
	Minority Populations	<p>culturally appropriate interventions:</p> <p>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, <u>binge-eating</u>, dieting and weight restrictive behaviors in adolescents and to offer education and appropriate referral of adolescents and their families for <u>culturally informed</u> interventional counseling; and (4) participates in this effort by consulting with appropriate specialty societies and by assisting in the dissemination of appropriate and <u>culturally informed</u> educational and counseling materials pertaining to unhealthy eating, <u>binge-eating</u>, dieting, and weight restrictive behaviors.</p> <p>MSS Timeline: (MSS Res. 84, I-19)</p> <p>HOD Timeline: (MSS Res. 435, A-22, Referred)(CSAPH Rep 07, Adopted as</p>	<p>trainers, teachers and nurses to recognize binge-eating and offer culturally informed interventional counseling by consulting with appropriate specialty societies and by assisting in the dissemination of appropriate and culturally informed educational and counseling materials pertaining to binge-eating.</p>

TABLE 2: RECOMMENDED FOR RETENTION WITH AMENDMENTS: SUMMARIZE AND/OR UPDATE LANGUAGE

Position #	Title	Original Position	Final Summarized Language & Rationale
		amended with title change, [H-150.965], A-23)	
160.029MS S	Protecting Medical Students' Rights as Patients	<p>That our AMA amend policy H- 315.983 by insertion and deletion as follows:</p> <p>H-315.983 Patient Privacy and Confidentiality</p> <p>Our AMA affirms the following key principles that should be consistently implemented to evaluate any proposal regarding patient privacy and the confidentiality of medical information:</p> <p>(a) That there exists a basic right of patients to privacy of their medical information and records, and that this right should be explicitly acknowledged; (b) That patients' privacy should be honored unless waived by the patient in a meaningful way or in rare instances when strong countervailing interests in public health or safety justify invasions of patient privacy or breaches of confidentiality, and then only when such invasions or breaches are subject to stringent safeguards enforced by appropriate standards of accountability; (c) That patients' privacy should be honored in the context of gathering and disclosing information for clinical research and quality improvement activities, and that any necessary departures from the preferred practices of obtaining patients' informed consent and of de-identifying</p>	AMA-MSS asked the AMA to ensure that medical students receive the same rights and responsibilities of patient privacy and confidentiality as physicians.

TABLE 2: RECOMMENDED FOR RETENTION WITH AMENDMENTS: SUMMARIZE AND/OR UPDATE LANGUAGE

Position #	Title	Original Position	Final Summarized Language & Rationale
		<p>all data be strictly controlled; and (d) That any information disclosed should be limited to that information, portion of the medical record, or abstract necessary to fulfill the immediate and specific purpose of disclosure. (2) Our AMA affirms: (a) that physicians <u>and medical students</u> who are patients are entitled to the same right to privacy and confidentiality of personal medical information and medical records as other patients, (b) that when patients exercise their right to keep their personal medical histories confidential, such action should not be regarded as fraudulent or inappropriate concealment, and (c) that physicians <u>and medical students</u> should not be required to report any aspects of their patients' medical history to governmental agencies or other entities, beyond that which would be required by law.</p> <p>(3) Employers and insurers should be barred from unconsented access to identifiable medical information lest knowledge of sensitive facts form the basis of adverse decisions against individuals. (a) Release forms that authorize access should be explicit about to whom access is being granted and for what purpose and should be as narrowly tailored as possible. (b) Patients, and physicians, <u>and medical students</u> should be educated about the</p>	

TABLE 2: RECOMMENDED FOR RETENTION WITH AMENDMENTS: SUMMARIZE AND/OR UPDATE LANGUAGE

Position #	Title	Original Position	Final Summarized Language & Rationale
		<p>consequences of signing overly-broad consent forms. (c) Employers and insurers should adopt explicit and public policies to assure the security and confidentiality of patients' medical information. (d) A patient's ability to join or a physician's participation in an insurance plan should not be contingent on signing a broad and indefinite consent for release and disclosure. (4) Whenever possible, medical records should be de-identified for purposes of use in connection with utilization review, panel credentialing, quality assurance, and peer review. (5) The fundamental values and duties that guide the safekeeping of medical information should remain constant in this era of computerization. Whether they are in computerized or paper form, it is critical that medical information be accurate, secure, and free from unauthorized access and improper use. (6) Our AMA recommends that the confidentiality of data collected by race and ethnicity as part of the medical record, be maintained. (7) Genetic information should be kept confidential and should not be disclosed to third parties without the explicit informed consent of the tested individual. (8) When breaches of confidentiality are compelled by concerns for public health and safety, those breaches must be as narrow in scope and content as possible, must contain the least</p>	

TABLE 2: RECOMMENDED FOR RETENTION WITH AMENDMENTS: SUMMARIZE AND/OR UPDATE LANGUAGE

Position #	Title	Original Position	Final Summarized Language & Rationale
		<p>identifiable and sensitive information possible, and must be disclosed to the fewest possible to achieve the necessary end. (9) Law enforcement agencies requesting private medical information should be given access to such information only through a court order. This court order for disclosure should be granted only if the law enforcement entity has shown, by clear and convincing evidence, that the information sought is necessary to a legitimate law enforcement inquiry; that the needs of the law enforcement authority cannot be satisfied by non- identifiable health information or by any other information; and that the law enforcement need for the information outweighs the privacy interest of the individual to whom the information pertains. These records should be subject to stringent security measures. (10) Our AMA must guard against the imposition of unduly restrictive barriers to patient records that would impede or prevent access to data needed for medical or public health research or quality improvement and accreditation activities. Whenever possible, de-identified data should be used for these purposes. In those contexts where personal identification is essential for the collation of data, review of identifiable data should not take place without an institutional review board (IRB) approved justification for</p>	

TABLE 2: RECOMMENDED FOR RETENTION WITH AMENDMENTS: SUMMARIZE AND/OR UPDATE LANGUAGE

Position #	Title	Original Position	Final Summarized Language & Rationale
		<p>the retention of identifiers and the consent of the patient. In those cases where obtaining patient consent for disclosure is impracticable, our AMA endorses the oversight and accountability provided by an IRB. (11) Marketing and commercial uses of identifiable patients' medical information may violate principles of informed consent and patient confidentiality. Patients divulge information to their physicians only for purposes of diagnosis and treatment. If other uses are to be made of the information, patients must first give their uncoerced permission after being fully informed about the purpose of such disclosures (12) Our AMA, in collaboration with other professional organizations, patient advocacy groups and the public health community, should continue its advocacy for privacy and confidentiality regulations, including: (a) The establishment of rules allocating liability for disclosure of identifiable patient medical information between physicians and the health plans of which they are a part, and securing appropriate physicians' control over the disposition of information from their patients' medical records. (b) The establishment of rules to prevent disclosure of identifiable patient medical information for commercial and marketing purposes; and (c) The establishment of penalties for negligent or deliberate breach of</p>	

TABLE 2: RECOMMENDED FOR RETENTION WITH AMENDMENTS: SUMMARIZE AND/OR UPDATE LANGUAGE

Position #	Title	Original Position	Final Summarized Language & Rationale
		<p>confidentiality or violation of patient privacy rights. (13) Our AMA will pursue an aggressive agenda to educate patients, the public, physicians and policymakers at all levels of government about concerns and complexities of patient privacy and confidentiality in the variety of contexts mentioned. (14) Disclosure of personally identifiable patient information to public health physicians and departments is appropriate for the purpose of addressing public health emergencies or to comply with laws regarding public health reporting for the purpose of disease surveillance. (15) In the event of the sale or discontinuation of a medical practice, patients should be notified whenever possible and asked for authorization to transfer the medical record to a new physician or care provider. Only de-identified and/or aggregate data should be used for "business decisions," including sales, mergers, and similar business transactions when ownership or control of medical records changes hands. (16) The most appropriate jurisdiction for considering physician breaches of patient confidentiality is the relevant state medical practice act. Knowing and intentional breaches of patient confidentiality, particularly under false pretenses, for malicious harm, or for monetary gain, represents a violation of the professional practice of medicine. (17) Our</p>	

TABLE 2: RECOMMENDED FOR RETENTION WITH AMENDMENTS: SUMMARIZE AND/OR UPDATE LANGUAGE

Position #	Title	Original Position	Final Summarized Language & Rationale
		<p>AMA Board of Trustees will actively monitor and support legislation at the federal level that will afford patients protection against discrimination on the basis of genetic testing. (18) Our AMA supports privacy standards that would require pharmacies to obtain a prior written and signed consent from patients to use their personal data for marketing purposes. (19) Our AMA supports privacy standards that require pharmacies and drug store chains to disclose the source of financial support for drug mailings or phone calls. (20) Our AMA supports privacy standards that would prohibit pharmacies from using prescription refill reminders or disease management programs as an opportunity for marketing purposes.</p> <p>MSS Timeline: (MSS Res 8, A-14) HOD Timeline: (AMA Res 2, I-14 Adopted [H-315.983])</p>	
215.006MS S	Amendment to H-150.949 Healthy Food Options in Hospitals	<p>AMA-MSS will ask the AMA to encourage the availability of healthy, plant-based options at Medical Care Facilities by amending H-150.949, Health Food Options in Hospitals to read: Health Food Options in Hospitals Medical Care Facilities H-150.949 (1) Our AMA encourages healthy food options be available, at reasonable prices and easily</p>	<p>AMA-MSS asked the AMA to expand H-150.949 Health Food Options in Hospitals from hospitals to all -medical care facilities.</p>

TABLE 2: RECOMMENDED FOR RETENTION WITH AMENDMENTS: SUMMARIZE AND/OR UPDATE LANGUAGE

Position #	Title	Original Position	Final Summarized Language & Rationale
		<p>accessible, on the premises of hospitals <u>Medical Care Facilities</u>.</p> <p>(2) Our AMA hereby calls on all hospitals <u>Medical Care Facilities</u> and Correctional 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 fat, sodium, and added sugars; (b) eliminating processed meats from menus; and (c) providing and promoting healthy beverages.</p> <p>(3) Our AMA hereby calls for hospital <u>Medical Care Facility</u> cafeterias and inpatient meal menus to publish nutritional information.</p> <p>MSS Timeline: (MSS Res 26, A-19)</p> <p>HOD Timeline: (AMA Res. 904, Adopt as Amended with Title Change “Healthful Food Options in Health Care Facilities” [H-150.949], I-19)</p>	
250.029MS S	Opposition to Regulations that Penalize Immigrants for Accessing Health Care Services	AMA-MSS 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-	<p>New Title: Opposition to Inappropriate Use of Public Charge Against Immigrants</p> <p>AMA-MSS asked the AMA to oppose efforts to deter immigrants and their dependents from seeking healthcare or using public benefits for which they are eligible, including Medicaid, CHIP, WIC, and SNAP.</p>

TABLE 2: RECOMMENDED FOR RETENTION WITH AMENDMENTS: SUMMARIZE AND/OR UPDATE LANGUAGE

Position #	Title	Original Position	Final Summarized Language & Rationale
		<p>20.901 to by addition and deletion to read as follows:</p> <p>HIV, Immigration, and Travel Restrictions H-20.901 to include: Our AMA: (1) supports enforcement of the public charge provision of the Immigration Reform Act of 1990 (PL 101-649) <u>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;</u> (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.</p> <p>MSS Timeline: (MSS Res 01, A-18)</p> <p>HOD Timeline: (AMA Res. 254, A-18, Adopted [D-440.927])</p>	<p>Rationale: Simplified language to “oppose” (inclusive of resolve 1) and removed reference to specific law, also removed specific reference to documented immigrants as some states have expanded benefits to undocumented immigrants by law and the MSS has successfully asked the AMA to support Medicaid and CHIP eligibility for undocumented immigrants and SNAP for DACA recipients. Furthermore, this limitation is not in the current AMA policy. Therefore, this has been updated to “for which they are eligible,” to be inclusive of whoever falls under eligibility criteria as this may continue to change and public charge should not be used against such individuals who are legally eligible for benefits.</p>

TABLE 2: RECOMMENDED FOR RETENTION WITH AMENDMENTS: SUMMARIZE AND/OR UPDATE LANGUAGE

Position #	Title	Original Position	Final Summarized Language & Rationale
275.015MS S	Medical Licenses for Individuals with DACA Status	<p>AMA-MSS will ask the AMA to 1) support the ability of Deferred Action for Childhood Arrivals (DACA) recipients to obtain medical licenses and 2) encourage state medical societies to consider a position of support for these individuals to obtain medical licenses in their respective states.</p> <p>MSS Timeline: (MSS Res. 02, I-19)</p>	<p>AMA-MSS supports (1) the ability of Deferred Action for Childhood Arrivals (DACA) recipients to obtain medical licenses and (2) collaboration with state medical societies to support these individuals.</p> <p>Rationale: This position was discharged from the transmittal queue per Delegate Report C at A-21 and therefore not transmitted to HOD. Given this, it is recommended to be converted to an internal position. The position was discharged because the SDs noted significant advocacy on this topic since the passing of the resolution and the requests were sufficiently being carried out. This includes:</p> <p>(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 ... 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</p>

TABLE 2: RECOMMENDED FOR RETENTION WITH AMENDMENTS: SUMMARIZE AND/OR UPDATE LANGUAGE

Position #	Title	Original Position	Final Summarized Language & Rationale
			<p>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 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.”</p> <p>(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</p> <p>(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</p>

TABLE 2: RECOMMENDED FOR RETENTION WITH AMENDMENTS: SUMMARIZE AND/OR UPDATE LANGUAGE

Position #	Title	Original Position	Final Summarized Language & Rationale
			Deferred Action for Childhood Arrivals – or DACA -- status.
295.177MS S	Shared Decision-Making in Medical Education	<p>AMA-MSS will ask the AMA to (1) amend policy D-373.999 by insertion as follows:</p> <p>D-373.999 Informed Patient Choice and Shared Decision Making</p> <p>(1) Our AMA will work with state and specialty societies, <u>medical schools</u>, and others as appropriate to educate and communicate <u>to medical students</u> and to physicians about the importance of shared decision-making guidance through publications and other educational methods and assist the medical community in moving towards patient-centered care; and</p> <p><u>(2) Collaborate with the appropriate medical education organizations to develop undergraduate medical education recommendations that ensure proficiency in shared decision making and effective use of shared decision- making tools, such as patient decision aids.</u></p> <p>MSS Timeline: (MSS Res 21, I-13)</p> <p>HOD Timeline: Res. 301, A-14 Adopted [D.373.999]</p>	AMA-MSS asked the AMA to work with medical schools to educate and communicate to medical students about the importance of shared decision-making for patient-centered care and collaborate with the appropriate medical education organizations to develop undergraduate medical education recommendations that ensure proficiency in shared decision making and effective use of shared decision-making tools, such as patient decision aids.

TABLE 2: RECOMMENDED FOR RETENTION WITH AMENDMENTS: SUMMARIZE AND/OR UPDATE LANGUAGE

Position #	Title	Original Position	Final Summarized Language & Rationale
295.199MS S	Strengthening Standards for LGBTQ Medical Education	<p>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:</p> <p>Eliminating Health Disparities - Promoting Awareness and Education of Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) Health Issues in Medical Education H-295.878</p> <p>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 <u>basic science</u>,</p>	AMA-MSS asked the AMA to encourage relevant parties to include LGBTQ+ health issues in the basic science, clinical care, and cultural competency curricula for both undergraduate and graduate medical education.

TABLE 2: RECOMMENDED FOR RETENTION WITH AMENDMENTS: SUMMARIZE AND/OR UPDATE LANGUAGE

Position #	Title	Original Position	Final Summarized Language & Rationale
		<p><u>clinical care, and</u> cultural competency curriculum <u>curricula</u> 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.</p> <p>MSS Timeline: (MSS Res 16, A-19)</p> <p>HOD Timeline: (AMA Res. 302, Adopt as Amended [H-295.878], I-19)</p>	
295.211MS S	Improving Support and Access for Medical Students with Disabilities	<p>AMA-MSS will ask the AMA to:</p> <p>(1) Amend policy D-295.929 by addition as follows: D-295.929 – A Study to Evaluate Barriers to Medical Education for Trainees with Disabilities Our AMA will work with relevant stakeholders to study available data on: (1) medical trainees <u>and students</u> with disabilities and consider revision of technical standards for medical education programs; and (2) medical graduates</p>	<p>AMA-MSS supports the AMA's efforts to (1) work with relevant parties to encourage medical education institutions to make their policies for inquiring about and obtaining accommodations related to disability transparent and easily accessible through multiple avenues including, but not limited to, online platforms and (2) ensure students with disabilities are included in AMA advocacy efforts.</p>

TABLE 2: RECOMMENDED FOR RETENTION WITH AMENDMENTS: SUMMARIZE AND/OR UPDATE LANGUAGE

Position #	Title	Original Position	Final Summarized Language & Rationale
		<p><u>and students with disabilities and challenges to employment after training and medical education; and (3) work with relative stakeholders to encourage medical education institutions to make their policies for inquiring about and obtaining accommodations related to disability transparent and easily accessible through multiple avenues including, but not limited to, online platforms.</u></p> <p>(2) Amend policy D-90.991 by addition and deletion as follows: D-90.991 – Advocacy for Physicians with Disabilities 1. Our AMA will study and report back on eliminating stigmatization and enhancing inclusion of physicians <u>and medical students</u> with disabilities including but not limited to: (a) enhancing representation of physicians <u>and medical students</u> with disabilities within the AMA, and (b) examining support groups, education, legal resources and any other means to increase the inclusion of physicians <u>and medical students</u> with disabilities in the AMA. 2. Our AMA will identify medical, professional and social rehabilitation, education, vocational training and rehabilitation, aid, counseling, placement services and other services which will enable physicians <u>and medical students</u></p>	<p>Rationale: This position was discharged from the transmittal queue as part of Delegate Report A at A-22. CME Report 2 at I-21, Study to Evaluate Barriers to Medical Education for Trainees with Disabilities, was adopted as policy Evaluate Barriers to Medical Education for Trainees with Disabilities D-90.990 which covered the spirit of the position. Of note, an AMA Disabilities Advisory Group on physicians and medical students with disabilities is in development as a result of this policy and should be formed by the completion of A-23. Given that this position was not sent to HOD, the spirit of the position was summarized but not converted to past tense.</p>

TABLE 2: RECOMMENDED FOR RETENTION WITH AMENDMENTS: SUMMARIZE AND/OR UPDATE LANGUAGE

Position #	Title	Original Position	Final Summarized Language & Rationale
		<p>with disabilities to develop their capabilities and skills to the maximum and will hasten the processes of their social and professional integration or reintegration.</p> <p>3. Our AMA supports physicians, and physicians-in-training, <u>and medical student</u> education programs about legal rights related to accommodation and freedom from discrimination for physicians, patients, and employees with disabilities.</p> <p>MSS Timeline: (MSS CME Report B, I-19)(Discharged by Delegate Report A, A-22)</p>	
315.003MS S	Enabling a Contiguous, National Electronic Health Record Network	<p>AMA-MSS (1) supports collaboration with appropriate federal government agencies and industry partners to develop and promote legislative and policy initiatives that require the interoperability of independent healthcare systems such that electronic health records data be entirely transferable; and</p> <p>(2) will ask the AMA to study private and public sector initiatives regarding efforts to establish a nationwide health information network and other relevant interoperability initiatives.</p> <p>MSS Timeline: (MSS Res 12, A-13) (Reaffirmed: MSS GC Rep A, I-19)</p>	<p>AMA-MSS (1) supports <u>efforts to</u> collaboration with appropriate federal government agencies and industry partners to develop and promote legislative and policy initiatives that require the interoperability of independent healthcare systems such that electronic health records data be entirely transferable,; and</p> <p>(2) will ask the AMA to study private and public sector initiatives regarding efforts to establish a nationwide health information network and other relevant interoperability initiatives.</p> <p>Rationale: While it is unclear whether</p>

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Position #	Title	Original Position	Final Summarized Language & Rationale
			Resolved 2 was ever send to HOD, several other resolutions were forwarded to HOD within a similar time frame on this topic prompting broad AMA policy [D-478.972] and several reports on the topic and a BOT report. Given this, it is appropriate to amend this policy to delete Resolved 2. However, given that broad EHR interoperability is not yet in existence, we recommend retaining Resolved 1 in a simplified form.
350.020MS S	Accurate Collection of Preferred Language and Disaggregated Race & Ethnicity to Characterize Health Disparities	<p>AMA-MSS will ask the AMA to</p> <p>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 The AMA advocates precision in racial, ethnic, <u>preferred language</u>, and religious designations in medical records, with information obtained from the patient, always respecting the personal privacy of the patient.; and</p> <p>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.</p>	AMA-MSS asked the AMA to advocate for precision in the documentation of preferred language in medical records, with information obtained from the patient and always respecting the personal privacy of the patient.

TABLE 2: RECOMMENDED FOR RETENTION WITH AMENDMENTS: SUMMARIZE AND/OR UPDATE LANGUAGE

Position #	Title	Original Position	Final Summarized Language & Rationale
		<p>MSS Timeline: (MSS Res 29, A-19)</p> <p>HOD Timeline: (AMA Res. 3, Amended [H-315.996], I-19)</p>	
440.070MS S	Increasing Availability of Bleeding Control Supplies	<p>AMA-MSS will ask the AMA to amend Policy H-130.935 by addition as follows:</p> <p>H-130.935: Support for Hemorrhage Control Training</p> <ol style="list-style-type: none"> 1. Our AMA encourages state medical and specialty societies to promote the training of both lay public and professional responders in essential techniques of bleeding control. 2. Our AMA encourages, through state medical and specialty societies, the inclusion of hemorrhage control kits (including pressure bandages, hemostatic dressings, tourniquets and gloves) for all first responders. 3. <u>Our AMA supports the increased availability of bleeding control supplies with adequate and relevant training in schools, places of employment, and public buildings.</u> <p>MSS Timeline: (MSS Res 27, I-18)</p> <p>HOD Timeline: (AMA Res 527, A-19, Adopted as amended [H-130.935])</p>	AMA-MSS asked the AMA to support increased availability of bleeding control supplies with adequate and relevant training in schools, places of employment, and public buildings.
440.081MS S	Adverse Impacts of Delaying the	AMA-MSS will ask AMA to 1) examine the feasibility of filing an amicus brief highlighting	AMA-MSS asked the AMA to support updates to the EPA's Risk Management

TABLE 2: RECOMMENDED FOR RETENTION WITH AMENDMENTS: SUMMARIZE AND/OR UPDATE LANGUAGE

Position #	Title	Original Position	Final Summarized Language & Rationale
	Implementation of Public Health Regulations	<p>the detrimental health effects of municipal solid waste landfill pollution in Court Case #18-cv-03237 (State of California et. Al v EPA et. Al);</p> <p>2) amend H-135.950 Support the Health-Based Provisions of the Clean Air Act to Read as follows: Support the Health-Based Provisions of the Clean Air Act, H-135.950 Our AMA (1) opposes changes to the New Source Review Program of the Clean Air Act; (2) urges the Administration, through the Environmental Protection Agency, to withdraw the proposed New Source Review regulations promulgated on December 31, 2002; (3) opposes further legislation, rules, and regulations that weakens the existing provisions of the Clean Air Act; <u>and (4) support updates to the Risk Management Program such as the Chemical Disaster Rule, that prioritize chemical disaster prevention, emergency preparedness, and accessibility of safety information to the public;</u> 3) recognize the significant health risks associated with pesticide exposure; 4) urge the EPA and other federal regulatory agencies to enforce pesticide regulations, particularly of restricted use pesticides, that safeguard human and environmental health, especially in vulnerable populations including but not limited to</p>	<p>Program Rule, such as the Chemical Disaster Rule, that prioritize chemical disaster prevention, emergency preparedness, and accessibility of safety information to the public.</p> <p>Rationale: Since the first resolve of this position does not actually ask the AMA to file a brief but simply “examine the feasibility,” we treated this portion as functionally equivalent to a refer for decision, as ultimately the AMA Office of General Counsel, and Litigation Center would make that decision, with Board input as needed. While the first resolve asks that highlighting the detrimental health effects of municipal solid waste landfill pollution be included in a brief, since it does not directly ask for a brief, we believed this had more in common with requesting a study from the AMA that includes various components for consideration, except that in this case instead of a study, a possible action (amicus brief) was requested to be considered. We make minor edits to the language in the second resolve to clarify the RMP Rule.</p>

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Position #	Title	Original Position	Final Summarized Language & Rationale
		<p>agricultural workers, immigrant migrant workers, and children; and 5) analyze ongoing regulation delays that impact public health, as deemed appropriate.</p> <p>MSS Timeline: (MSS Res 21, I-17 Referred) (MSS CGPH Rep A, I-18)</p> <p>HOD Timeline: (AMA Res 529, A-19 Adopted as Amended [D-440.925])</p>	
460.024MS S	Patient Education and Security Risks Involving Direct-to-Consumer Genetic Testing	<p>AMA-MSS will ask the AMA to:</p> <p>(1) Address Direct-to-Consumer genetic testing by amending H-460.908, Genomic- Based Personalized Medicine, as follows:</p> <p>H-460.908 – Genomic-Based Personalized Medicine</p> <p>Our AMA: (1) acknowledges the increasingly important role of genomic-based personalized medicine applications in the delivery of care, and will continue to assist in informing physicians about relevant personalized medicine issues; (2) will continue to develop educational resources and point-of-care tools to assist in the clinical implementation of genomic-based personalized medicine applications, and will continue to explore external collaboration and additional funding sources for such projects; (3) will continue to</p>	<p>AMA-MSS supports efforts to</p> <p>(1) 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.</p> <p>(2) educate and inform physicians and patients regarding information about <u>privacy violations, and company ownership of patient data associated with</u> genetic tests that are available directly to consumers.</p> <p>(3) pass laws regarding comprehensive security protection for direct-to-consumer genetic testing results to ensure patient privacy.</p>

TABLE 2: RECOMMENDED FOR RETENTION WITH AMENDMENTS: SUMMARIZE AND/OR UPDATE LANGUAGE

Position #	Title	Original Position	Final Summarized Language & Rationale
		<p>represent physicians' voices and interests in national policy discussions of issues pertaining to the clinical implementation of genomic-based personalized medicine, such as genetic test regulation, clinical validity and utility evidence development, insurance coverage of genetic services, direct-to-consumer genetic testing, and privacy of genetic information; <u>and (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></p> <p>(2) Amend D-480.987, Direct-to-Consumer Marketing and Availability of Genetic Testing by insertion and deletion as follows:</p> <p>D-480.987 – Direct-to-Consumer Marketing and Availability of Genetic Testing [...] (5) will work to educate and inform physicians and patients regarding the types, benefits and risks of genetic tests that are available directly to consumers, including, but not limited to information about the lack of scientific validity associated with some direct-to-consumer tests, <u>privacy violations, and company ownership of patient data.</u>; so that patients can be appropriately counseled on the potential harms</p>	<p>Rationale: <i>This item was passed in the MSS Assembly at Interim 2019. Due to the Covid pandemic, a large transmittal backlog occurred. Ultimately, this item was discharged from the transmittal queue as D-315.970 was passed instead as part of BoT Report 12 at I-21 before this could be brought forward. See A-22 Handbook Page 494 for reference. Given this, the spirit of the position resolved clauses (1), (2), and (4) was summarized into the above position. Resolved clause (3) was rescinded as the amendment was integrated into 200.019MSS.</i></p>

TABLE 2: RECOMMENDED FOR RETENTION WITH AMENDMENTS: SUMMARIZE AND/OR UPDATE LANGUAGE

Position #	Title	Original Position	Final Summarized Language & Rationale
		<p>(3) AMA-MSS will amend 200.019MSS, Improving Genetic Testing and Counseling Services in Hospitals and Healthcare Systems by insertion as follows: 200.019MSS – Improving Genetic Testing and Counseling Services in Hospitals and Healthcare Systems [...] (2) That our AMA encourage efforts to create and disseminate guidelines for best practice standards concerning counseling and <u>data security</u> for genetic test results in <u>medical settings and in direct-to-consumer contexts</u>; (3) That our AMA support further research into and open discourse concerning issues in medical genetics, including the genetic specialist workforce shortage, physician preparedness in the provision of genetic testing and counseling services, and impact of genetic test results and counseling on patient satisfaction.</p> <p>(4) AMA-MSS will ask our AMA to support legislation regarding comprehensive security protection regarding direct-to-consumer genetic testing results to ensure patient privacy.</p> <p>MSS Timeline: (MSS Res. 57, I-19)</p>	
480.022MS S	Encouraging the Development of Multi-Language,	AMA-MSS will ask our AMA to amend policy D-480.972 to read as follows:	AMA-MSS asked the AMA to encourage the development of mobile health applications that employ linguistically appropriate and

TABLE 2: RECOMMENDED FOR RETENTION WITH AMENDMENTS: SUMMARIZE AND/OR UPDATE LANGUAGE

Position #	Title	Original Position	Final Summarized Language & Rationale
	Culturally Informed Mobile Health Applications	<p>Guidelines for Mobile Medical Applications and Devices D-480.972</p> <p>(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.</p> <p>(2) Our AMA will continue to engage with stakeholders to identify relevant guiding principles to promote a vibrant, useful and trustworthy mHealth market.</p> <p>(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.</p> <p>(4) Our AMA will develop and publicly disseminate a list of best practices guiding the development and use of mobile medical applications.</p> <p>(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.</p> <p>(6) Our AMA will collaborate with the Liaison Committee on Medical Education and Accreditation Council for Graduate Medical</p>	culturally informed content catered to underserved and low-income populations.

TABLE 2: RECOMMENDED FOR RETENTION WITH AMENDMENTS: SUMMARIZE AND/OR UPDATE LANGUAGE

Position #	Title	Original Position	Final Summarized Language & Rationale
		<p>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.</p> <p>(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.</p> <p><u>(8) Our AMA encourages the development of mobile health applications that employ linguistically appropriate and culturally informed content catered to underserved and low-income populations.</u></p> <p>MSS Timeline: (MSS Res 10, A-19)</p> <p>HOD Timeline: (AMA Res. 903, Adopt as Amended [D-480.972], I-19)</p>	
505.013MS S	Amending H-490.913, Smoke-free Environments and Workplaces, and H- 490.907, Tobacco Smoke Exposure of Children in Multi-	<p>AMA-MSS will ask the AMA to amend policies H- 490.913, Smoke-free Environments and Workplaces, and H-490.907, Tobacco Smoke Exposure of Children in Multi-Unit Housing, to include e-cigarettes, to read as follows:</p> <p><u>Smoke-free and Vape-free Environments and Workplaces H-490.913</u></p>	<p>AMA-MSS asked the AMA to expand policies H- 490.913, Smoke-free Environments and Workplaces, and H-490.907, Tobacco Smoke Exposure of Children in Multi-Unit Housing, to include e-cigarettes and vape-free environments and workplaces.</p>

TABLE 2: RECOMMENDED FOR RETENTION WITH AMENDMENTS: SUMMARIZE AND/OR UPDATE LANGUAGE

Position #	Title	Original Position	Final Summarized Language & Rationale
	Unit Housing to Include E-Cigarettes	<p>On the issue of the health effects of environmental tobacco smoke (ETS) and passive smoke and vape 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 <u>and vape-free</u> campuses for business, labor, education, and government; (2) (a) honors companies and governmental workplaces that go smoke-free <u>and vape-free</u>; (b) will petition the Occupational Safety and Health Administration (OSHA) to adopt regulations prohibiting smoking and 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; (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</p>	

TABLE 2: RECOMMENDED FOR RETENTION WITH AMENDMENTS: SUMMARIZE AND/OR UPDATE LANGUAGE

Position #	Title	Original Position	Final Summarized Language & Rationale
		<p>entrances to buildings and in all indoor public places, restaurants, bars, and workplaces; and (d) will update draft model state legislation to prohibit smoking <u>and vaping</u> 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 <u>and vape-free</u> schools and eliminating smoking <u>and vaping</u> in public places and businesses and on any public transportation; (ii) enlist the aid of county medical societies in local anti-smoking <u>and anti-vaping</u> 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 <u>and anti-vaping</u> coalitions and to reach out to local chapters of national voluntary health agencies to participate in the promotion of anti-smoking <u>and anti-vaping</u> 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 <u>vape-free</u> for the greater enjoyment of all guests and to further promote their commitment to a happy, healthy lifestyle</p>	

TABLE 2: RECOMMENDED FOR RETENTION WITH AMENDMENTS: SUMMARIZE AND/OR UPDATE LANGUAGE

Position #	Title	Original Position	Final Summarized Language & Rationale
		<p>for children; (d) encourages state or local legislation or regulations that prohibit smoking <u>and vaping</u> in stadia and encourages other ball clubs to following 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, cigar, <u>and e-cigarette</u> smoking 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 non-smoking <u>or a non-vaping</u> 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 <u>and anti-vaping</u> 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 <u>and no vaping</u> policy for such restaurants, and endorses the passage of laws, ordinances and regulations that prohibit smoking and vaping in fast-food restaurants</p>	

TABLE 2: RECOMMENDED FOR RETENTION WITH AMENDMENTS: SUMMARIZE AND/OR UPDATE LANGUAGE

Position #	Title	Original Position	Final Summarized Language & Rationale
		<p>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, <u>vaping</u>, 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 <u>vape-free</u> environment in the military through the use of mechanisms such as health education, smoking <u>and vaping</u> 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 <u>and vaping</u> in their casinos; and (b) legislators and the gaming industry to support the prohibition of smoking and vaping in all casinos and gaming venues.</p> <p>Tobacco Smoke and Vaping Exposure of Children in Multi-Unit Housing to Include E-Cigarettes H-490.907 Our AMA: (1) encourages federal, state and local housing authorities and governments to</p>	

TABLE 2: RECOMMENDED FOR RETENTION WITH AMENDMENTS: SUMMARIZE AND/OR UPDATE LANGUAGE

Position #	Title	Original Position	Final Summarized Language & Rationale
		<p>adopt policies that protect children and non-smoking <u>or non-vaping</u> adults from tobacco smoke <u>and vaping</u> 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 <u>or non-vaping</u> adults from tobacco smoke and vaping exposure by prohibiting smoking <u>and vaping</u> in multi-unit housing.</p> <p>(MSS Res 03, A-19) (AMA Res. 902, Adopt as Amended [H-490.913, H-490.907], I-19)</p>	
515.014MS S	Reducing the Prevalence of Sexual Assault by testing Sexual Assault Evidence Kits	<p>AMA-MSS will ask the AMA to amend policy H-80.999, Sexual Assault Survivors by insertion:</p> <p>H-80.999 – Sexual Assault Survivors</p> <ol style="list-style-type: none"> 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 	AMA-MSS asked the AMA to 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.

TABLE 2: RECOMMENDED FOR RETENTION WITH AMENDMENTS: SUMMARIZE AND/OR UPDATE LANGUAGE

Position #	Title	Original Position	Final Summarized Language & Rationale
		<p>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.</p> <p>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.</p> <p>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.</p> <p><u>5. Our AMA will advocate at the state and federal level for (a) the immediate processing</u></p>	

TABLE 2: RECOMMENDED FOR RETENTION WITH AMENDMENTS: SUMMARIZE AND/OR UPDATE LANGUAGE			
Position #	Title	Original Position	Final Summarized Language & Rationale
		<p><u>of all “backlogged” and new sexual assault examination kits; and (b) additional funding to facilitate the immediate testing of sexual assault evidence kits.</u></p> <p>MSS Timeline: (MSS Res. 28, I-19)</p> <p>HOD Timeline: (AMA Res. 210, Adopted as Amended [H-80.999], A-22)</p>	

APPENDIX C: CONSOLIDATIONS

TABLE 3: IMPROVING RESEARCH STANDARDS, APPROVAL PROCESSES, AND POST-MARKET SURVEILLANCE STANDARDS FOR MEDICAL DEVICES			
Position #	Title	Position	Recommendation and Rationale
270.040MS S	Improving Research Standards, Approval Processes, and Post-Market Surveillance Standards for Medical Devices	<p>AMA-MSS will ask the AMA to: (1) 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;</p> <p>(2) support stronger <u>pre-market assurance and post-market surveillance</u> 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 summary of medical devices approved under expedited programs along with associated clinical trial data and list of reported adverse events; and</p> <p>(3) amend policy H-100.992 to include medical devices by addition as follows:</p> <p>FDA, H-100.992</p>	<p>New Title: FDA Medical Device Regulation Our AMA-MSS asked the AMA to support:</p> <p>A. the application of sound scientific and medical evidence of safety and efficacy derived from controlled trials, real-world data (RWD) fit for regulatory purpose, and/or post-market incident reports as the basis for any FDA decision to approve, withdraw approval of, or change indications for a medical device, analogous to evidence standards used for FDA decisions on medications;</p> <p>B. FDA evaluation of evidence regarding device approval, in consultation with FDA Advisory Committees and expert extramural advisory bodies;</p> <p>C. improvements to the Food and Drug Administration 510(k) exception to ensure the safety and efficacy of medical devices, including stricter guidelines for which devices qualify for 510(k);</p> <p>D. mandates that all 510(k) devices demonstrate equivalent or improved safety and effectiveness compared to</p>

TABLE 3: IMPROVING RESEARCH STANDARDS, APPROVAL PROCESSES, AND POST-MARKET SURVEILLANCE STANDARDS FOR MEDICAL DEVICES

Position #	Title	Position	Recommendation and Rationale
		<p>1. Our AMA reaffirms its support for the principles that:</p> <p>(a) an FDA decision to approve a new drug <u>or medical device</u>, to withdraw a drug <u>or medical device's</u> approval, or to change the indications for use of a drug <u>or medical device</u> 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;</p> <p>(b) this evidence should be evaluated by the FDA, in consultation with its Advisory Committees and expert extramural advisory bodies; and</p> <p>(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 <u>or medical device</u> unless the weight of the evidence from clinical trials, RWD fit for regulatory purpose, and post market reports shows that the drug <u>or medical device</u> is unsafe and/or ineffective for its labeled indications.</p> <p>MSS Timeline: (MSS Res. 22, I-19) (MSS Res. 052, A-22, Substitute Resolution 052 be Adopted in Lieu of the Original)</p>	<p>market devices for the same clinical purpose to;</p> <p>E. stronger pre-market assurance and post-market surveillance requirements, including conditional approval until sufficient post-market data on safety can be collected;</p> <p>F. timely completion of any confirmatory trials, especially for devices approved via expedited programs or based on surrogate endpoints or limited evidence; and</p> <p>G. a public database of expedited device approvals, with related clinical trial and confirmatory trial data and all reported adverse events.</p> <p>When reviewing the compendium to determine an appropriate recommendation for the MSS position 270.040MSS Improving Research Standards, Approval Processes, and Post-Market Surveillance Standards for Medical Devices, MSS position 270.043MSS Improving Research Standards, Approval Processes, and Post-Market Surveillance Standards for Medical Devices was found. Part of the original resolution that yielded 270.040MSS was referred for study and resulted in the CSI CHIT Report A at the</p>

TABLE 3: IMPROVING RESEARCH STANDARDS, APPROVAL PROCESSES, AND POST-MARKET SURVEILLANCE STANDARDS FOR MEDICAL DEVICES

Position #	Title	Position	Recommendation and Rationale
		(Immediately forwarded to HOD, AMA Res. 523 , Referred, A-22)	November 2020 Assembly meeting. While some if not all of the recommendations from this report were integrated into 270.040MSS, a duplicate similar position was created. In addition, another layer of complexity was added when at A-22, Resolution 52 Promoting Algorithmic Stewardship in Healthcare Systems was adopted to amend the pending transmittal on this topic. Of note, while this language was fully integrated into 270.040MSS, it seems as though part of the recommendation to add pre-market surveillance was not integrated into the transmittal. Given this, your GC recommended 270.043MSS, which is less up to date be rescinded and 270.040MSS be retained with amendments to reflect the spirit of the position and to convert to past tense.
270.043MSS	Improving Research Standards, Approval Processes, and Post-Market Surveillance Standards for Medical Devices	<p>1) Our AMA-MSS will ask the AMA to support the principles that: (a) confirmatory trials should be conducted in a timely fashion following accelerated approval of medical devices that are approved based on surrogate endpoints or limited evidence; and</p> <p>(b) the FDA should make the annual summary of medical devices approved under expedited programs more readily available to</p>	Rescind: See rationale above

TABLE 3: IMPROVING RESEARCH STANDARDS, APPROVAL PROCESSES, AND POST-MARKET SURVEILLANCE STANDARDS FOR MEDICAL DEVICES

Position #	Title	Position	Recommendation and Rationale
		<p>the public and consider adding information on confirmatory clinical trials and <u>all reported adverse events</u> for such medical devices</p> <p>2) Our AMA-MSS will ask the AMA to amend policy H-100.992 by addition and deletion as follows:</p> <p>FDA, H-100.91. Our AMA reaffirms its support for the principles that: (a) an FDA decision to approve a new drug <u>or medical device</u>, to withdraw a drug <u>or medical device's</u> approval, or to change the indications for use of a drug <u>or medical device</u> must be based on sound scientific and medical evidence derived from controlled trials, real-world data (RWD) fit for regulatory purpose, and/or post market incident reports as provided by statute;</p> <p>(b) this evidence should be evaluated by the FDA, in consultation with its Advisory Committees and expert extramural advisory bodies; and</p> <p>(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 <u>or medical device</u> unless the weight of</p>	

TABLE 3: IMPROVING RESEARCH STANDARDS, APPROVAL PROCESSES, AND POST-MARKET SURVEILLANCE STANDARDS FOR MEDICAL DEVICES

Position #	Title	Position	Recommendation and Rationale
		<p>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.</p> <p>2. The AMA believes that social and economic concerns and disputes per se should not be permitted to play a significant part in the FDA's decision making process in the course of FDA devising either general or product specific drug regulation.</p> <p>3. It is the position of our AMA that the Food and Drug Administration should not permit political considerations or conflicts of interest to overrule scientific evidence in making policy decisions; and our AMA urges the current administration and all future administrations to consider our best and brightest scientists for positions on advisory committees and councils regardless of their political affiliation and voting history.</p> <p>(MSS CSI CHIT Rep. A, Nov. 2020)</p>	

TABLE 4: TWO-INTERVAL GRADING			
Position #	Title	Position	Recommendation and Rationale
295.198MSS	Engaging Stakeholders for Establishment of Two-Interval, or Pass/Fail, Grading System of Non-Clinical Curriculum in U.S. Medical Schools	<p>AMA-MSS will ask the AMA to amend policy H-295.866 as follows:</p> <p>Supporting Two-Interval Grading Systems for Medical Education H-295.866 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.</p> <p>MSS Timeline: (MSS Res 13, A-19)</p> <p>HOD Timeline: (AMA Res. 301, Adopt [H-295.866], I-19)</p>	AMA-MSS asked the AMA to encourage the establishment of a two-interval grading system for non-clinical curriculum in US medical schools.
295.170MSS	Supporting Two-Interval Grading Systems for Medical Education	<p>AMA-MSS acknowledges the benefits of a two-interval grading system in medical colleges and universities for the non-clinical curriculum.</p> <p>MSS Timeline: (MSS Late Res 2, A-12) (Reaffirmed: MSS GC Report A, I-17) (Reaffirmed: MSS GC Report A, A-23)</p>	Rescind: Superseded by stronger language in 295.198MSS
295.217MSS	Research the Ability of Two-Interval Grading of Clinical Clerkships to Minimize Racial Bias	Our AMA-MSS will research various approaches to grading of clinical clerkships, which may minimize racial bias in medical education.	Rescind: The request of this position was completed at A-21 with the production and adoption of MSS CME MIC Report A .

TABLE 4: TWO-INTERVAL GRADING			
Position #	Title	Position	Recommendation and Rationale
	in Medical Education	MSS Timeline: (MSS Res. 067, Nov. 2020)	
295.231MS S	Research the Ability of Two-Interval Grading of Clinical Clerkships to Minimize Racial Bias in Medical Education	<p>AMA-MSS will ask the AMA to study the impact of two-interval clinical clerkship grading systems on residency application outcomes and clinical performance during residency.</p> <p>MSS Timeline: (I-20: MSS Res 067) (MSS CME MIC Report A, A-21)</p> <p>HOD Timeline: (Res 309: Referred to Study, A-22) (CME Report 4, A-23)</p>	Rescind: The request of this position was completed at A-23 with the production and adoption of CME Report 4 resulting in H-295.851 .

TABLE 5: DE-SCHEDULING CANNABIS AND ITS DERIVATIVES			
Position #	Title	Position	
Consolidated	De-Scheduling Cannabis and its Derivatives	AMA-MSS asked the AMA to advocate for policies that (1) support reclassification of cannabis' status as a Schedule I controlled substance into a more appropriate schedule; and (2) the reclassification of Cannabidiol (CBD) as a non-scheduled drug.	
95.003MSS	Marijuana: Medical Use and Research	<p>AMA-MSS will ask the AMA to support reclassification of marijuana's status as a Schedule I controlled substance into a more appropriate schedule.</p> <p>MSS Timeline: (MSS Res 2, A-08) (Reaffirmed: GC Rep B, I-13) (Attempted Sunset, GC Rep A, I-18)</p> <p>HOD Timeline: (AMA Res 910, I-08 Referred) (CSAPH Rep. 3, I-09 H-95.952)</p>	

100.021MSS	Opposing the Classification of Cannabidiol as a Schedule 1 Drug	<p>AMA-MSS will ask the AMA to support the reclassification of Cannabidiol (CBD) as a non-scheduled drug.</p> <p>MSS Timeline: (MSS Res 64-I-17) (Reaffirmed: MSS GC Report A, A-23) HOD Timeline: (AMA Res 55, A-18, Referred) (CSAPH Rep. 3, I-20 H-120.926)</p>
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TABLE 6: ACCESS TO EVIDENCE-BASED CARE AT ADDICTION REHABILITATION FACILITIES AND RECOVERY HOMES

Position #	Title	Position
Consolidated	Access to Evidence-Based Care at Addiction Rehabilitation Facilities and Recovery Homes	<p>AMA-MSS asked the AMA to advocate for policies that (1) ensure outpatient addiction rehabilitation centers provide patient and community protection in line with evidence-based care; and (2) protect patients who use provider-prescribed, medication assisted treatment for opioid use disorder, including buprenorphine/naloxone combinations, from discrimination that hinders admittance to recovery homes and related resident addiction recovery services.</p>
95.012MSS	Advocating for the Standardization and Regulation of Outpatient Addiction Rehabilitation Facilities	<p>AMA-MSS will ask the AMA to 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.</p> <p>MSS Timeline: (MSS Res 06, A-19) HOD Timeline: (AMA Res. 201, Refer for Study, I-19) (AMA BOT Report 14-NOV-20, Adopted, I-20)</p>
95.016MSS	A Resolution to Encourage Recovery Homes to Implement Evidence-Based Policies Regarding Access to Medication Assisted Treatment for Opioid Use	<p>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 recovery homes and related resident services.</p> <p>MSS Timeline: (MSS CGPH CBH Report A, I-19) HOD Timeline: (AMA Res. 201, Referred, I-19) (AMA BOT Report 14-NOV-20, Adopted, I-20)</p>

	Disorder	
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TABLE 7: CLINICAL SKILLS TRAINING AND EVALUATION

Position #	Title	Position
Consolidated Position	Medical Student Clinical Training and Skills Evaluation	<p>AMA-MSS asked the AMA to</p> <p>(b) encourage medical schools to ensure appropriate emphasis of clinical skills training in medical schools;</p> <p>(a) commend the LCME for making clinical skill competencies a priority;</p> <p>(c) work with the AAMC and LCME to assure that clinical skill competencies are taught and assessed using standardized patient examinations as part of every medical school curriculum, and</p> <p>(d) encourage all LCME accredited medical schools to adopt as policy that all medical students at their institutions pass an OSCE or CSAE as part of the matriculation requirements for the conferring of an MD degree.</p> <p>(e) encourage medical schools to develop mechanisms to assist medical students to meet financial obligations associated with any potential standardized clinical skills examination requirements</p> <p>(f) encourage medical schools to avoid linking passage of any potential standardized clinical skills examination to graduation requirements for at least the first 5 years of the implementation of the exam;</p> <p>(f) strongly encourage the appropriate stakeholders to develop policies to ensure adequate capacity for registration and administration of any standardized clinical skills examinations in order to accommodate all students testing for the initial time as well ensuring students failing the exam can retest within 4 months; and</p> <p>(g) monitor in an ongoing fashion, the implementation of any clinical skills evaluation and its impact on the medical education continuum.</p>
295.111MSS	State Society and State Medical Board Support to Delay Implementation of	<p>AMA-MSS will ask the AMA to (a) commend the LCME for making clinical skill competencies a priority,</p> <p>(b) work with the AAMC and LCME to assure that clinical skill competencies are taught and assessed using standardized patient examinations as part of every medical school curriculum, and</p>

	the USMLE Clinical Skills Assessment Exam	<p>(c) encourage all LCME accredited medical schools to adopt as policy that all medical students at their institutions pass an OSCE or CSAE as part of the matriculation requirements for the conferring of an MD degree.</p> <p>MSS Timeline: (MSS Late Res 1, A-02) (Amended: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I-12) (Reaffirmed: MSS GC Report A, I-17) (Reaffirmed: MSS GC Report A, A-23)</p> <p>HOD Timeline: (AMA Sub Res 308, A-02, Adopted [D-295.968]) (D-295.968 Rescinded:CCB/CLRPD Rep. 4, A-12)</p>
295.114MSS	Clinical Skills Assessment Exam and College of Osteopathic Medicine Licensing Exam-Physical Exam Implementation	<p>AMA-MSS will ask the AMA to: (a) study mechanisms for providing feedback to medical students on their performance on the proposed United States Medical Licensing Exam (USMLE) Clinical Skills Assessment Examination (CSAE) and College of Osteopathic Medicine Licensing Exam-Physical Exam (COMLEX-PE) including but not limited to written narrative feedback, and access to video recording of the exam for possible review with their medical school and communicate these findings to the National Board of Medical Examiners (NBME) and National Board of Osteopathic Medical Examiners (NBOME);</p> <p>(b) encourage medical schools to develop mechanisms to assist medical students to meet financial obligations associated with the requirements for participation in the CSAE and COMLEX-PE;</p> <p>(c) encourage medical schools to avoid linking passage of the CSAE and COMLEX-PE to graduation requirements for at least the first 5 years of the implementation of the exam;</p> <p>(d) encourage medical schools to reevaluate their educational programs to ensure appropriate emphasis of clinical skills training in medical schools;</p> <p>(e) study, in conjunction with the NRMP, AOA, AGCME, and other interested organizations, the potential impact of the CSAE and COMLEX-PE on undergraduate and graduate medical education;</p> <p>(f) strongly encourage the NBME and NBOME to develop policies to ensure adequate capacity for registration and administration of the CSAE and COMLEX-PE in order to accommodate all students testing for the initial time as well ensuring students failing the exam can retest within 4 months; and</p> <p>(g) monitor in an ongoing fashion, the implementation of the CSAE and COMLEX-PE and its impact on the medical education continuum. (2) AMA-MSS will study safeguard measures for students in the first five years of implementation of the Clinical Skills Assessment Exam and COMLEX-PE;</p> <p><i>*Note, portions of this MSS position that only asked for study were sunsetted as per</i></p>

		<p>our guidelines</p> <p>MSS Timeline: (MSS Res 7, A-03) (Amended: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13) (Reaffirmed: MSS GC Rep A, I-19)</p> <p>HOD Timeline: (AMA Amended Res 324, A-03 Adopted in Lieu of Resolution 315 [D-275.985]) (D-275.985 Rescinded: CME Rep. 2, A-13)</p>
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TABLE 8: PRE-PARTICIPATION SPORTS EXAMINATIONS

Position #	Title	Position
Consolidated	Pre-participation Sports Examinations	AMA-MSS asked the AMA to (1) support the inclusion of the American Heart Association screening guidelines in the standardized pre-participation athletic examination for student athletes; (2) recommend the use of further diagnostic modalities for those student athletes identified to be at risk by the American Heart Association screening guidelines, history, or physical examination; (3) support and encourage state medical societies to support implementation of the guidelines established by the American Academy of Pediatrics for pre-participation sports physical examinations.
470.001MSS	Pre-participation Sports Examinations	AMA-MSS will ask the AMA to support and encourage state medical societies to support implementation of the guidelines established by the American Academy of Pediatrics for pre-participation sports physical examinations. MSS Timeline: (AMA Res 166, I-89, Referred) HOD Timeline: (BOT Rep R, A-90 Adopted in Lieu of Res 3 and 166, I-89 [H-470.971])
470.003MSS	Pre-Participation Screening in Student Athletes	AMA-MSS will ask the AMA to: (1) support the inclusion of the American Heart Association screening guidelines in the standardized pre-participation athletic examination for student athletes; and (2) recommend the use of further diagnostic modalities for those student athletes identified to be at risk by the American Heart Association screening guidelines, history, or physical examination. MSS Timeline: (MSS Amended Res 8, A-98) (Modified: GC Rep B, I-13) HOD Timeline: (AMA Res 409, I-98 Referred, CSA Rep. 5, I-99, [H-470.971])

TABLE 9: TRAUMA-INFORMED CARE RESOURCES & TRAINING

Position #	Title	Position
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Consolidated Position	Trauma-Informed Care Resources & Training	<p>AMA-MSS asked the AMA to:</p> <ul style="list-style-type: none"> (1) recognize trauma-informed care, as defined by relevant parties as a practice that realizes the widespread impact of trauma on all patients, recognizes the signs and symptoms of trauma, responds by fully integrating knowledge about trauma into policies, procedures, and practices, seeks to avoid re- traumatization, and understands potential paths for recovery; (2) support trauma-informed care by directing physicians to evidence based resources; (3) supports the inclusion of ACEs and trauma-informed care into undergraduate and graduate medical education curricula. (4) encourage stakeholders to implement trauma-informed school-based services. (5) encourage physicians, residents and medical students to utilize current integrated care approaches that engage school-based trauma informed services
295.196MSS	Increasing Access to Trauma-Informed Services within Schools	<p>AMA-MSS will ask the AMA to (1) encourage physicians, residents and medical students to utilize current integrated care approaches that engage school-based trauma informed services; and (2) encourage stakeholders to implement trauma-informed school-based services.</p> <p>MSS Timeline: (MSS Res 35 I-18)</p> <p>HOD Timeline: (AMA Res 504, A-19, Combined with Res 526 and Adopted [H-515.952])</p>
515.013MSS	Trauma-Informed Care Resources	<p>AMA-MSS will ask the AMA to (1) recognize trauma-informed care, as defined by stakeholders as a practice that realizes the widespread impact of trauma on all patients, recognizes the signs and symptoms of trauma, responds by fully integrating knowledge about trauma into policies, procedures, and practices, seeks to avoid re- traumatization, and understands potential paths for recovery; and (2) support trauma-informed care by directing physicians to evidence based resources.</p> <p>MSS Timeline: (MSS Res 21, I-18)</p> <p>HOD Timeline: (AMA Res 526, A-19, Combined with Res 526 and Adopted [H-515.952])</p>
515.015MSS	Amending H-515.952, Adverse Childhood Experiences and Trauma Informed	<p>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:</p> <p>H-515.952 – Adverse Childhood Experiences and Trauma-Informed Care</p>

	<p>Care, to Encourage ACE and TIC Training in Undergraduate Medical Education</p>	<p>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.</p> <p>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.</p> <p><u>3. Our AMA supports the inclusion of ACEs and trauma-informed care into undergraduate and graduate medical education curricula.</u></p> <p>MSS Timeline: (MSS Res. 64, I-19)</p> <p>HOD Timeline: (Language adopted as an amendment to CSAPH Report 3, A-21 [H-515.952])</p>
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APPENDIX D: POSITIONS DUE FOR CONSIDERATION ADDRESSED IN OTHER A-24 REPORTS

POSITIONS ADDRESSED IN GC REPORT D: REPRODUCTIVE HEALTH POSITION CONSOLIDATION

1. 5.008MSS Expanding AMA Support for Advanced Practice Providers who Provide First- Trimester Abortion Care
2. 75.005MSS Promotion of Emergency Contraception Pills
3. 75.008MSS Opposition to Sole Funding of Abstinence-Only Education
4. 75.009MSS Ending Discrimination Against Contraception
5. 75.012MSS Recognizing Long-Acting Reversible Contraceptives (LARCs) as Efficacious and Economical Forms of Contraception
6. 170.008MSS Increasing HPV Education
7. 170.019MSS Comprehensive Human Papillomavirus (HPV) and Vaccination Education in School Health Curricula
8. 170.015MSS Reducing the Risk of Sexually Transmitted Infections in Patients Age 50 and Older
9. 250.019MSS Global HIV/AIDS Prevention
10. 255.004MSS United Nations Population Fund
11. 295.206MSS Protecting Medical Student Access to Abortion Education and Training
12. 310.048MSS Training in Reproductive Health Topics as a Requirement for Accreditation of Family Medicine Residencies
13. 420.008MSS Advance Directives During Pregnancy
14. 420.013MSS Amendment to Truth and Transparency in Pregnancy Counseling Centers
15. 525.012MSS Transparency Improving Informed Consent for Reproductive Health Services

POSITIONS ADDRESSED IN GC REPORT E: LEAVE POSITIONS REVIEW & CONSOLIDATION

16. 295.197MSS Support for the Study of the Timing and Causes for Leave of Absence and Withdrawal from United States Medical Schools
17. 310.049MSS Equal Paternal and Maternal Leave for Medical Residents

POSITIONS ADDRESSED IN GC REPORT F: FIREARM POSITIONS CONSOLIDATION

18. 145.011MSS Gun Safety Counseling in Undergraduate Medical Education
19. 145.012MSS Use of Individualized Violence Risk Assessments in Reporting of Mental Health Professionals for Firearm Background Checks
20. 145.013MSS Strengthening our Gun Policies on Background Checks and the Mentally Ill
21. 145.014MSS Preventing Fire-Arm Related Injury and Morbidity in Youth
22. 145.015MSS Expansion of Federal Gun Restriction Laws to Include Dating Partners and Convicted Stalkers
23. 145.016MSS Opposition to Armed Campuses
24. 145.017MSS Increasing the Legal Age of Purchasing Ammunition and Firearms from 18 to 21
25. 145.018MSS Development and Implementation of guidelines for Responsible Media Coverage of Mass Shootings
26. 145.019MSS Increasing Firearm Safety to Prevent Accidental Child Deaths

27. 145.020MSS Opposing Unregulated, Non-Commercial Firearm Manufacturing
28. 145.021MSS Support for Warning Labels on Firearm Ammunition Packaging
29. 145.022MSS Firearms: Safety and Regulation AMA Funding of Political Candidates who Oppose Research-Backed Firearm Regulations
30. 295.209MSS Addressing the Need for Firearm Safety in Medical School Curricula

POSITIONS ADDRESSED IN GC REPORT G: MSS GOVERNANCE POSITION UPDATES & CONSOLIDATION

31. 350.019MSS Strengthening AMA-MSS Collaborations with Allied Underrepresented Minority Student Organizations at the Local Chapter Level
32. 565.004MSS Policy and Advocacy Opportunities for Medical Students
33. 630.050MSS Creating a Community Service Project
34. 630.011MSS Improved Access and Programming of Non-Scientific Issues in Medicine
35. 630.049MSS AMA Medical Student Section Vision Statement
36. 660.001MSS Questions of Parliamentary Procedures
37. 645.013MSS Information for the AMA Medical Student Section Assembly Concerning Issues Discussed at the AMA-HOD
38. 645.026MSS Advocating for the Continuation of a Fall Meeting of the Medical Student Section
39. 665.017MSS Re-evaluation of AMA-MSS Region Bylaws
40. 655.022MSS MD/PhD AMA Membership

POSITIONS ADDRESSED IN GC REPORT H: ALCOHOL-RELATED POSITIONS CONSOLIDATION

41. 370.019MSS Support for the Use of Evidence-Based Guidelines for Determining Liver Transplant Waiting Periods in Alcohol-Related Liver Disease
42. 30.006MSS Support of Programs that Discourage Adolescent Alcohol Consumption
43. 30.009MSS Sobriety Checkpoints

DELEGATE REPORT A: MSS POLICY PROCESS AND HOD RESOLUTION QUEUE

44. 665.016MSS Amending G-630.140 Lodging, Meeting Venues and Social Functions

REPORT OF THE MEDICAL STUDENT SECTION
GOVERNING COUNCIL

GC Report C
(A-24)

Subject: Biennial Review of Organizations Seated in the AMA-MSS Assembly
Presented by: MSS Governing Council
Referred to: MSS Reference Committee
(Caitlin Blaukovitch and Shaminy Manoranjithan, Co-Chairs)

1 **INTRODUCTION**
2

3 The MSS Internal Operating Procedures (IOPs) and AMA Bylaws outline a mechanism for
4 establishing and maintaining National Medical Specialty Society (NMSS), Professional Interest
5 Medical Association (PIMA), and National Medical Student Organization (NMSO) representation
6 in the MSS Assembly. Among other requirements, organizations that have been granted voting
7 representation in the Assembly are required to undergo biennial review to ensure that they remain
8 eligible for representation in the MSS Assembly.
9

10 Accordingly, this report assesses whether NMSSs, PIMAs, and NMSOs currently represented in
11 the Assembly continue to meet the eligibility criteria and recommends continuation or not of each
12 organization's representation status.
13

14 **BACKGROUND**
15

16 *A. NMSS and PIMA Eligibility Criteria*
17

18 The student components of National Medical Specialty Societies (NMSSs), Federal Services, and
19 Professional Interest Medical Associations (PIMAs) are granted representation in the MSS
20 Assembly according to guidelines set forth in AMA Bylaw 7.3.3.3 and MSS IOP 10.3.2. The
21 student components of NMSSs and PIMAs that meet the following criteria may be considered for
22 representation in the MSS Assembly:
23

- 24 a. The parent organization must have voting representation in the AMA House of Delegates.
- 25 b. The parent organization must allow for medical student membership.
- 26 c. The parent organization must have established a mechanism that allows for the regular
27 input of medical student views into the issues before the organization.
28

29 *B. NMSO Eligibility Criteria*
30

31 National Medical Student Organizations (NMSOs) are granted representation in the MSS
32 Assembly according to guidelines set forth in AMA Bylaw 7.3.3.4 and MSS IOP 10.3.3. NMSOs
33 that meet the following criteria may be considered for representation in the MSS Assembly:
34

- 35 a. The organization must be national in scope.

- 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, Federal Service, PIMA, or NMSO is requested via an application submitted by the organization to the MSS GC, along with any other documents demonstrating compliance with corresponding criteria, 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 Delegate and Alternate Delegate 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 (2) years, during which time attendance at a minimum of two (2) of the four (4) 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. The Governing Council will notify the organization of its status at the end of the probation period. (MSS IOP 10.3.2.3)

DISCUSSION

A. *Review of NMSS and PIMA Eligibility*

There are currently 16 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 Academy of Ophthalmology (AAO)
5. American College of Preventive Medicine (ACPM)
6. American College of Surgeon (ACS)
7. American Academy of Orthopaedic Surgeons (AAOS)
8. American Society of Plastic Surgeons (ASPS)
9. American Academy of Child & Adolescent Psychiatry (AACAP)
10. American Association of Physicians of Indian Origin (AAPI)
11. American College of Emergency Physicians (ACEP)
12. American College of Medical Quality (ACMQ)
13. American College of Physicians (ACP)
14. American Society of Anesthesiologists (ASA)

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>.

- 1 15. American Society of Military Surgeons of the US (AMSUS)
- 2 16. American Medical Women’s Association (AMWA)
- 3 17. Student Osteopathic Medical Association (SOMA)
- 4 18. Psychiatry Student Interest Group Network (PsychSIGN)
- 5 19. Health Professionals Advancing LGBTQ Equality (GLMA)
- 6

7 Our review found that each of these organizations is in compliance with the established eligibility
 8 criteria as required by biennial review. Each of these organizations meets all three eligibility
 9 criteria. Due to the variety of mechanisms allowing for student input across organizations, the
 10 specific mechanisms for student input in each organization is outlined in Table 1 below.

Table 1: Review of NMSS and PIMA Eligibility

Organization	Criterion 3: The parent organization has a mechanism that allows for the regular input of medical student views into the issues before the organization
American Academy of Family Physicians (AAFP)	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.
American Academy of Pediatrics (AAP)	The AAP has a medical student section with its own subcommittees for leadership opportunities. AAP has medical student liaisons to each of the subcommittees.
American College of Emergency Physicians (ACEP)	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.
American College of Medical Quality (ACMQ)	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.
American College of Physicians (ACP)	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.
American Society of Anesthesiologists (ASA)	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.
American Medical Women’s Association (AMWA)	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).
Health Professionals Advancing LGBTQ Equality (GLMA)	GLMA has a separate medical student committee, Health Professionals in Training Committee, with representation on the GLMA board and coordinates with other GLMA committees

Psychiatry Student Interest Group Network (PsychSIGN)	The Psychiatry Student Interest Group Network (PsychSIGN) has a voting representative on the American Pathological Association Board of Trustees.
Student Osteopathic Medical Association (SOMA)	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.

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)
6. Medical Student Pride Alliance (MSPA)

Our review found that each of these organizations is in compliance with the five criteria for eligibility. Each of the organizations listed below is national in scope. For each organization, 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. For each organization, membership to the organization is available to all medical students. Each organization's purpose and objectives of the organization are consistent with the AMA's purpose and objectives. None of the organizations have their own code of ethics, but each organization's objectives align with the AMA Principles of Ethics.

C. New Representation

Since the most recent biennial review (GC Report A, A-21), 10 new organizations have obtained representation in the MSS Assembly. The new organizations classified as NMSS are listed below:

Table 1: Review of NMSS and PIMA Eligibility

Organization	Application Date	Criterion 3: The parent organization has a mechanism that allows for the regular input of medical student views into the issues before the organization
American Academy of Child & Adolescent Psychiatry (AACAP)	March 2, 2023	
American Academy of Ophthalmology (AAO)	September 21, 2022	
American Academy of Orthopaedic Surgeons (AAOS)	August 11, 2023	

American College of Surgeons (ACS)	August 5, 2023	
American College of Preventive Medicine (ACPM)	May 16, 2023	
American Society of Addiction Medicine (ASAM)		
American Society of Plastic Surgeons (ASPS)		
United States Air Force	August 11, 2023	
United States Army	August 9, 2023	
United States Navy	August 5, 2023	
VA		

Table 1: Review of Observers Seated in MSS Assembly

Organization	Criterion 3: The parent organization has a mechanism that allows for the regular input of medical student views into the issues before the organization
Student Academy of the American Academy of Physician Assistants (AAPA)	
European Medical Student Association (EMSA)	

1 **CONCLUSIONS**

2

3 Your GC notes that the presence and active involvement of NMSO/NMSS/PIMAs in the MSS
4 Assembly provides a valuable opportunity for more medical student views to be represented in
5 the AMA-MSS, as well as an opportunity for the AMA-MSS to hear underrepresented opinions,
6 foster contacts and build partnerships with similar organizations, and improve the diversity of
7 our membership.

8

9 **RECOMMENDATIONS**

10

11 Thus, your MSS Governing Council recommends that the following recommendations be adopted
12 and the remainder of this report be filed:

13

- 1 1. That our AMA-MSS retains the following NMSSs and PIMAs as eligible for AMA-MSS
2 Assembly representation: American Academy of Family Physicians (AAFP), American
3 Academy of Pediatrics (AAP), American College of Emergency Physicians (ACEP),
4 American College of Medical Quality (ACMQ), American College of Physicians (ACP),
5 American Society of Anesthesiologists (ASA), American Medical Women's Association
6 (AMWA), Student Osteopathic Medical Association (SOMA), Psychiatry Student Interest
7 Group Network (PsychSIGN), and Health Professionals Advancing LGBT Equality
8 (GLMA).
9
- 10 2. That our AMA-MSS retains the following NMSOs as eligible for AMA-MSS Assembly
11 representation: American Physician Scientists Association (APSA), Asian Pacific
12 American Medical Student Association (APAMSA), Latino Medical Student Association
13 (LMSA), and Student National Medical Association (SNMA), and Association of Native
14 American Medical Students (ANAMS), Medical Student Pride Alliance (MSPA).
15
- 16 3. That our AMA-MSS recognize the following NMSS, NMSO and PIMA organizations as
17 newly seated organizations in the AMA-MSS Assembly:
 - 18 a. American Academy of Child & Adolescent Psychiatry (AACAP)
 - 19 b. American Academy of Ophthalmology (AAO)
 - 20 c. American Academy of Orthopedic Surgeons (AAOS)
 - 21 d. ACPM (American College of Preventive Medicine)
 - 22 e. ACS (American College of Surgeons)
 - 23 f. ASPS (American Society of Plastic Surgeons)
 - 24 g. United States Air Force
 - 25 h. United States Army
 - 26 i. United States Navy

REPORT OF THE MEDICAL STUDENT SECTION GOVERNING COUNCIL

MSS GC Report D
(A-24)

Subject: MSS Abortion, Contraception, & Sex Education Position Consolidation

Presented by: MSS Governing Council

Referred to: MSS Reference Committee
(Caitlin Blaukovitch and Shaminy Manoranjithan, Co-Chairs)

1 INTRODUCTION

2
3 MSS Position 630.044MSS, "Sunset Mechanism for AMA-MSS Policy," states "the MSS Governing Council
4 may recommend policies for consolidation as part of the sunset review process." This clause was amended
5 into this policy at MSS A-23, but was derived from a similar policy that was sunset at A-23, 645.023MSS,
6 "Medical Student Section Policy Making Procedures." This policy was actually even stronger and stated,
7 "[a]s part of its annual review of MSS policies set to sunset... the MSS Governing Council will undertake
8 policy consolidation for at least one issue," implying that prior to last year, this was intended to be an explicit
9 directive to Governing Councils and not just an enumerated power.

10
11 However, for several years, no Governing Council has undertaken any consolidations as described, despite
12 this policy being reaffirmed during that period, demonstrating that this policy had not been followed as
13 directed. Therefore, as this year's Governing Council would be the first to undertake any consolidations in
14 a long period of time, we decided to compensate for our predecessors and undertake consolidations of
15 multiple issues.

16
17 The intent of these consolidations is to streamline our new MSS Positions Compendium and make the
18 identification and comprehension of MSS positions clearer and more accessible for all members, especially
19 new students learning about AMA and MSS processes. In this report, the MSS Governing Council presents
20 a consolidation of MSS positions related to abortion, contraception, & sex education. After thorough review
21 of the current MSS Digest of Actions, your MSS Governing Council recommends consolidation of the
22 following positions while capturing the original intent and function of the current positions.

24 DISCUSSION

25
26 MSS Positions that overlapped significantly in content and/or function were consolidated together. The
27 appendices at the end of this report provide a color-coded mapping of the consolidated MSS position onto
28 the current MSS positions. In total, 45 positions were consolidated into 3 new positions.

30 RECOMMENDATIONS

31
32 Thus, your MSS Governing Council recommends that the following recommendations be adopted, the
33 following new consolidated positions be retained as active positions of the AMA-MSS, the original
34 comprising positions be rescinded and the remainder of this report be filed:

35
36 RESOLVED, the following MSS Positions:

- 37 • 5.001MSS Public Funding of Abortion Services
- 38 • 5.002MSS Condemnation of Violence Against Abortion Clinics

- 1 • 5.003MSS Patient Confidentiality and Reproductive Health
- 2 • 5.005MSS MSS Stance on Challenges to Women’s Right to Reproductive Health Care Access
- 3 • 5.006MSS Transparency on Restrictions of Care
- 4 • 5.007MSS Ending the Risk Evaluation and Mitigation Strategy (REMS) on Mifepristone
- 5 • 5.008MSS Expanding AMA Support for Advanced Practice Providers who Provide First-
- 6 Trimester Abortion Care
- 7 • 5.009MSS Protecting Access to Abortion and Reproductive Healthcare
- 8 • 5.010MSS AMA Opposition of Heartbeat Laws which Indicate First Evidence of Embryonic
- 9 Cardiac Activity as Presence of Fetal Heartbeat
- 10 • 5.011MSS Coverage and Reimbursement for Abortion Services
- 11 • 5.012MSS Opposition to Restrictions on United States Foreign Aid Allocation for Reproductive
- 12 Healthcare
- 13 • 75.003MSS Contraceptive Programming in the Media
- 14 • 75.005MSS Promotion of Emergency Contraception Pills
- 15 • 75.009MSS Ending Discrimination Against Contraception
- 16 • 75.012MSS Recognizing Long-Acting Reversible Contraceptives (LARCs) as Efficacious and
- 17 Economical Forms of Contraception
- 18 • 75.013MSS Increasing Availability and Coverage for Immediate Postpartum Long-Acting
- 19 Reversible Contraception Placement
- 20 • 75.014MSS Pain Management for Long-Acting Reversible Contraception and other
- 21 Gynecological Procedures
- 22 • 250.019MSS Global HIV/AIDS Prevention
- 23 • 255.004MSS United Nations Population Fund
- 24 • 270.056MSS Condemnation of Non-Therapeutic Sterilization for Contraception of Women with
- 25 Disabilities without Informed Patient Consent
- 26 • 420.008MSS Advance Directives During Pregnancy
- 27 • 420.013MSS Amendment to Truth and Transparency in Pregnancy Counseling Centers
- 28 • 420.020MSS Access to Standard Care for Non-Viable Pregnancy
- 29 • 525.012MSS Transparency Improving Informed Consent for Reproductive Health Services

30

31 be consolidated into the new MSS position:

32

Abortion and Contraception Access

33

The AMA MSS asked the AMA to:

34

(1) Recognize that policies and legislation that limit access to abortion care are serious threats to public health;

35

36

(2) Support explicit codification of protections for abortion care into federal law;

37

38

(3) Oppose legislation, regulation, and other efforts to deny full reproductive autonomy or interfere with medical decision making and the physician-patient relationship;

39

40

(4) Opposes the criminalization of self-managed abortion and the criminalization of patients who access abortions, efforts to enforce criminal and civil penalties or other retaliatory

41

42

efforts against patients and requirements that physicians function as agents of law enforcement, and attempts by the U.S. Department of Justice to subpoena medical records in cases involving abortion;

43

44

(5) Condemn violence directed against abortion clinics and family planning centers as a violation of the right to access health care;

45

46

(6) Oppose all restrictions on public funding for reproductive healthcare, including contraception and abortion, both domestically and abroad;

47

48

(7) Support global humanitarian assistance for comprehensive reproductive health services,

- 1 including contraception and abortion;
- 2 (8) Support continued funding efforts to address the global HIV epidemic and disease
3 prevention worldwide, without mandates determining what proportion of funding must be
4 designated to treatment of HIV/AIDS, abstinence or be-faithful funding directives, or
5 grantee pledges of opposition to the exchange of sex for money or goods; and (2) extend
6 its support of comprehensive family-life education to foreign aid programs, promoting
7 abstinence while also discussing the role of safe sexual practices in disease prevention.
- 8 (9) Support guaranteed coverage of evidence-based abortion services without barriers by all
9 public and private payers, designation of abortion services as an essential health benefit,
10 and collaboration with state medical societies and other interested parties to achieve
11 these goals;
- 12 (10) Oppose restrictions on physicians and other health professionals who provide abortion
13 care from participating in or being reimbursed by federal and state funded or subsidized
14 health coverage;
- 15 (11) Support mifepristone availability for reproductive health indications, including via
16 telemedicine, telehealth, and at retail pharmacies and the FDA's removal of
17 mifepristone's Risk Evaluation and Mitigation Strategy;
- 18 (12) Support equitable education on and access to all forms of evidence-based contraception,
19 including emergency contraception and coverage for long-acting reversible contraception
20 device and placement by all public and private payers (including immediate postpartum
21 and post-abortion settings with separate billing from global obstetric fees);
- 22 (13) To urge print and broadcast media to permit advertising and public service
23 announcements regarding contraception and safe sexual practices;
- 24 (14) Encourage discussion of pain control options, risks, and benefits with patients as part of
25 the shared decision-making process (due to disparities in pain management for
26 gynecological procedures compared to procedures of similarly reported pain) and support
27 research on evidence-based anesthetic and anxiolytic options for long-acting reversible
28 contraception procedures and other gynecological procedures, including but not limited to
29 colposcopy, endometrial biopsy, and LEEP procedures;
- 30 (15) Support that pregnant women with decision-making capacity have the same right to
31 refusal of treatment through advanced directives as non-pregnant women;
- 32 (16) Establish a list of Essential Reproductive Health Services, and advocate for requirements
33 for healthcare organizations to clearly publish online and at points of service which
34 Essential Reproductive Health Services are available or restricted at the organization,
35 including referral information for patients regarding other providers that offer these
36 services within the same coverage area;
- 37 (17) Advocate that any entity offering crisis pregnancy services (sometimes deceptively
38 known as "pregnancy counseling centers") fully and publicly disclose all information
39 regarding medical services, contraception, termination of pregnancy or referral for such
40 services, adoption options, or referral for such services that it does or does not provide,
41 as well as any financial, political, or religious associations and their level of compliance
42 with all federal and state laws, including licensing standards and privacy requirements;
- 43 (18) Discourage marketing, counseling, or coercion (by physical, emotional, or financial
44 means) by any entity offering crisis pregnancy services that aim to divert or interfere with
45 a patient's pursuit of medical care;
- 46 (19) Oppose all public funds for entities offering crisis pregnancy services that do not provide
47 evidence-based medical information and care to patients.
- 48

1 And furthermore, our AMA-MSS:

- 2 (1) supports federal and state efforts to allow appropriately trained and credentialed non-
3 physician clinicians to perform first-trimester medical and aspiration abortions;
4 (2) supports requirements that all medical institutions provide medically accurate
5 information on the full breadth of reproductive health options available for patients,
6 including all evidence-based contraception and abortion, emergency care patients
7 (including during and after miscarriages, abortions, and diagnosis of nonviable
8 pregnancy) and fertility services, regardless of the institution's willingness to perform any
9 of these services, and disclosure of this information to all clinicians employed or seeking
10 employment at the institution;
11 (3) supports prompt and timely referral of patients to accessible healthcare providers
12 (within the same coverage area) offering reproductive services sought by the patient,
13 when a healthcare provider refuses to provide such care and while avoiding any undue
14 burden to the patients;
15 (4) opposes all restrictions (including by health facility) that may hinder patients' timely
16 access to accepted standard of care in both emergent and non-emergent cases of non-
17 viable pregnancy; and
18 (5) opposes the ability of guardians or petitioners to obtain non-therapeutic sterilizations
19 (eg, not for menstrual problems or pregnancy prevention) for patients with disabilities or
20 other patients placed at a power differential.

21
22 RESOLVED, the following MSS Positions:

- 23 ● 65.046MSS Television Broadcast and Online Streaming of LGBTQ+ Inclusive Sexual Encounters
24 and Public Health Awareness on Social Media Platforms
- 25 ● 75.001MSS Mandatory Parental Notification for Minors Seeking Contraceptives Devices
- 26 ● 75.005MSS Promotion of Emergency Contraception Pills
- 27 ● 75.007MSS Preservation of HIV and STD Prevention Programs Involving Safer Sex Strategies
28 and Condom Use
- 29 ● 75.008MSS Opposition to Sole Funding of Abstinence-Only Education
- 30 ● 75.011MSS Informed Consent with Regards to Advertising and Prescribing Contraceptives
- 31 ● 170.003MSS Incorporation of Adoption into Public School Health Education Curriculum
- 32 ● 170.005MSS Teaching Sexual Restraint to Adolescents
- 33 ● 170.007MSS Teaching Preventive Self Examinations to High School Students
- 34 ● 170.008MSS Increasing HPV Education
- 35 ● 170.010MSS Abstinence-Only Education and Federally-Funded Community-Based Initiatives
- 36 ● 170.011MSS Human Papillomavirus (HPV) Inclusion in High School Health Education Curricula
- 37 ● 170.015MSS Reducing the Risk of Sexually Transmitted Infections in Patients Age 50 and Older
- 38 ● 170.016MSS Sexual Violence Education and Prevention in High Schools with Sexual Health
39 Curricula
- 40 ● 170.019MSS Comprehensive Human Papillomavirus (HPV) and Vaccination Education in School
41 Health Curricula
- 42 ● 170.020MSS Sex Education Materials for Students with Limited English Proficiency
- 43 ● 170.021MSS Expansion on Comprehensive Sexual Health Education

44
45 be consolidated into the new MSS position:

46 Comprehensive Sexual Education

47 The AMA-MSS:

- 48 (1) Supports age-appropriate comprehensive sexual education;

- 1 (2) Supports the development of programs to teach self-breast examinations and testicular
2 self-examinations to high school students and encourages county medical societies to
3 assist local high schools in implementing such programs;
- 4 (3) Opposes requiring parental notification of contraceptive care provided to minors;
- 5 (4) Providing accurate and balanced information on the effectiveness, safety and
6 risks/benefits of contraception in all public media;

7
8 Furthermore, our AMA-MSS asked the AMA:

- 9 (1) To reaffirm its policy to reiterate that HIV and STD prevention education must be
10 comprehensive to incorporate safer sex strategies including condom use, not just
11 abstinence, and that these programs be culturally sensitive to the LGBTQ+ community;
- 12 (2) To actively oppose increasing federal and state funding for abstinence-only education,
13 unless future research shows its superiority over comprehensive sex education in terms
14 of preventing negative health outcomes;
- 15 (3) To support the incorporation of information on adoption, sexual violence prevention,
16 dental dams, and other barrier protection methods, and culturally competent materials
17 that are language concordant for Limited English Proficiency (LEP) pupils into public
18 school sex education or family planning curricula;
- 19 (4) Support efforts in the mass media, schools, and communities to make abstinent sexual
20 behavior more socially acceptable and to help students develop the skills and self-
21 confidence they need to restrict their sexual behavior; and this support will include efforts
22 to increase funding and policies at the local, state and federal levels, though not
23 necessarily at the expense of existing policies and encourage school districts to adopt
24 sex education curricula that have a proven record of reducing teenage sexual activity;
- 25 (5) Support public health education relating to emergency contraception pills (ECPs) by
26 working in conjunction with the appropriate specialty societies and organizations to
27 encourage the widespread dissemination of information on ECPs to the medical
28 community, women's groups, health groups, clinics, the public and the media;
- 29 (6) To support the development of programs to teach self-breast examinations to female high
30 school students and testicular self-examinations to male high school students and
31 encourage county medical societies to assist local high schools in implementing such
32 programs;
- 33 (7) To strongly urge existing school health education programs to emphasize the high
34 incidence of human papillomavirus and to discuss the importance of routine pap smears
35 in the prevention of cervical cancer;
- 36 (8) To encourage physicians to educate their patients, particularly those of age 50 and older,
37 on safe-sex practices and on the risk of sexually transmitted infections.

38
39 and be it further

40
41 RESOLVED, the following MSS Positions:

- 42 ● 65.055MSS Including Gender Inclusive Language in Menstrual Healthcare
- 43 ● 75.012MSS Recognizing Long-Acting Reversible Contraceptives (LARCs) as Efficacious and
44 Economical Forms of Contraception
- 45 ● 75.013MSS Increasing Availability and Coverage for Immediate Postpartum Long-Acting
46 Reversible Contraception Placement
- 47 ● 295.073MSS Inclusion of Lactation Management Education in Medical School Curricula
- 48 ● 295.077MSS Medical Student Education on Termination of Pregnancy Issues

- 1 • 295.129MSS Improving Sexual Education in the Medical School Curriculum
- 2 • 295.191MSS Educating Physicians About the Importance of Cervical Cancer Screening for
- 3 Transgender Men Patients
- 4 • 295.206MSS Protecting Medical Student Access to Abortion Education and Training
- 5 • 295.234MSS Supporting Minimum Content Standards of LGBTQ+ Health Curriculum in
- 6 Undergraduate Medical Education
- 7 • 310.048MSS Training in Reproductive Health Topics as a Requirement for Accreditation of
- 8 Family Medicine Residencies

9
10 be consolidated into the new MSS position:

11 Reproductive Care in Medical Education

12 Our AMA-MSS:

- 13 (1) Supports gender-neutral language with regards to reproductive rights including but not
- 14 limited to menstrual products in medical education, clinical training, and clinical practice;
- 15 (2) Supports training for healthcare providers that includes de-gendered language and
- 16 inclusivity for various period products to better understand the needs of all persons who
- 17 menstruate;
- 18 (3) Encourages medical schools to incorporate lactation management education into the
- 19 medical school curriculum where appropriate;
- 20 (4) Supports education on termination of pregnancy issues be included in the medical school
- 21 curriculum;
- 22 (5) Supports that LCME- and COCA-accredited institutions develop minimum content
- 23 requirements in LGBTQ+ health curricula, including relevant terminology, health
- 24 disparities, taking a comprehensive sexual history, developing inclusive clinical
- 25 environments, gender-affirming care for transgender and nonbinary patients, gender-
- 26 affirming physical exam skills, sexual health safety and satisfaction, and intersectional
- 27 experiences of LGBTQ+ people;
- 28 (6) supports our AMA working with the Accreditation Council for Graduate Medical Education
- 29 to protect patient access by advocating for preservation of accreditation requirements for
- 30 family medicine residencies in reproductive health topics, including contraceptive
- 31 counseling, family planning, and counseling for unintended pregnancy.

32
33 Furthermore, our AMA-MSS asked the AMA to:

- 34 (1) Support the training of all primary care providers in the area of preconception counseling;
- 35 (2) Encourage relevant specialty organizations to provide training for physicians regarding (i)
- 36 patients who are eligible for immediate postpartum long-acting reversible contraception,
- 37 and (ii) immediate postpartum long-active reversible contraception placement protocols
- 38 and procedures;
- 39 (3) Encourage all medical schools to train medical students to be able to take a thorough and
- 40 non-judgmental sexual history in a manner that is sensitive to the personal attitudes and
- 41 behaviors of patients in order to decrease anxiety and personal difficulty with sexual
- 42 aspects of health care;
- 43 (4) Issue a public service announcement that encourages patients to discuss concerns
- 44 related to sexual health with their physician and reinforces the AMA's commitment to
- 45 helping patients maintain sexual health and well-being;
- 46 (5) Support regular cancer and sexually transmitted infection screenings in transgender men
- 47 when medically indicated;
- 48 (6) Support opt-out curriculum on abortion education.

1 Appendix A. MSS Positions Consolidated by New Position: Abortion and Contraception Access

#	Title	Position
Consolidated Position	Abortion and Contraception Access	<p>The AMA MSS asked the AMA to:</p> <ul style="list-style-type: none"> (20) Recognize that policies and legislation that limit access to abortion care are serious threats to public health; (21) Support explicit codification of protections for abortion care into federal law; (22) Oppose legislation, regulation, and other efforts to deny full reproductive autonomy or interfere with medical decision making and the physician-patient relationship; (23) Opposes the criminalization of self-managed abortion and the criminalization of patients who access abortions, efforts to enforce criminal and civil penalties or other retaliatory efforts against patients and requirements that physicians function as agents of law enforcement, and attempts by the U.S. Department of Justice to subpoena medical records in cases involving abortion; (24) Condemn violence directed against abortion clinics and family planning centers as a violation of the right to access health care; (25) Oppose all restrictions on public funding for reproductive healthcare, including contraception and abortion, both domestically and abroad; (26) Support global humanitarian assistance for comprehensive reproductive health services, including contraception and abortion; (27) Support continued funding efforts to address the global HIV epidemic and disease prevention worldwide, without mandates determining what proportion of funding must be designated to treatment of HIV/AIDS, abstinence or be-faithful funding directives, or grantee pledges of opposition to the exchange of sex for money or goods; and (2) extend its support of comprehensive family-life education to foreign aid programs, promoting abstinence while also discussing the role of safe sexual practices in disease prevention. (28) Support guaranteed coverage of evidence-based abortion services without barriers by all public and private payers, designation of abortion services as an essential health benefit, and collaboration with state medical societies and other interested parties to achieve these goals; (29) Oppose restrictions on physicians and other health professionals who provide abortion care from participating in or being reimbursed by federal and state funded or subsidized health coverage; (30) Support mifepristone availability for reproductive health indications, including via telemedicine, telehealth, and at retail pharmacies and the FDA's removal of mifepristone's Risk Evaluation and Mitigation Strategy; (31) Support equitable education on and access to all forms of evidence-based contraception, including emergency contraception and coverage for long-acting reversible contraception device and placement by all public and private payers (including immediate postpartum and post-abortion settings with separate billing from global obstetric fees); (32) To urge print and broadcast media to permit advertising and public service announcements regarding contraception and safe sexual practices;

		<p>(33) Encourage discussion of pain control options, risks, and benefits with patients as part of the shared decision-making process (due to disparities in pain management for gynecological procedures compared to procedures of similarly reported pain) and support research on evidence-based anesthetic and anxiolytic options for long-acting reversible contraception procedures and other gynecological procedures, including but not limited to colposcopy, endometrial biopsy, and LEEP procedures;</p> <p>(34) Support that pregnant women with decision-making capacity have the same right to refusal of treatment through advanced directives as non-pregnant women;</p> <p>(35) Establish a list of Essential Reproductive Health Services, and advocate for requirements for healthcare organizations to clearly publish online and at points of service which Essential Reproductive Health Services are available or restricted at the organization, including referral information for patients regarding other providers that offer these services within the same coverage area;</p> <p>(36) Advocate that any entity offering crisis pregnancy services (sometimes deceptively known as "pregnancy counseling centers") fully and publicly disclose all information regarding medical services, contraception, termination of pregnancy or referral for such services, adoption options, or referral for such services that it does or does not provide, as well as any financial, political, or religious associations and their level of compliance with all federal and state laws, including licensing standards and privacy requirements;</p> <p>(37) Discourage marketing, counseling, or coercion (by physical, emotional, or financial means) by any entity offering crisis pregnancy services that aim to divert or interfere with a patient's pursuit of medical care;</p> <p>(38) Oppose all public funds for entities offering crisis pregnancy services that do not provide evidence-based medical information and care to patients.</p> <p>And furthermore, our AMA-MSS:</p> <p>(1) supports federal and state efforts to allow appropriately trained and credentialed non-physician clinicians to perform first-trimester medical and aspiration abortions;</p> <p>(2) supports requirements that all medical institutions provide medically accurate information on the full breadth of reproductive health options available for patients, including all evidence-based contraception and abortion, emergency care patients (including during and after miscarriages, abortions, and diagnosis of nonviable pregnancy) and fertility services, regardless of the institution's willingness to perform any of these services, and disclosure of this information to all clinicians employed or seeking employment at the institution;</p> <p>(3) supports prompt and timely referral of patients to accessible healthcare providers (within the same coverage area) offering reproductive services sought by the patient, when a healthcare provider refuses to provide such care and while avoiding any undue burden to the patients;</p> <p>(4) opposes all restrictions (including by health facility) that may hinder patients' timely access to accepted standard of care in both emergent and non-emergent cases of non-viable pregnancy; and</p> <p>(5) opposes the ability of guardians or petitioners to obtain non-therapeutic sterilizations (eg, not for menstrual problems or pregnancy prevention) for patients with disabilities or other patients placed at a power differential.</p>
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5.001MSS	Public Funding of Abortion Services	Public Funding of Abortion Services: 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.
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.
5.003MSS	Patient Confidentiality and Reproductive Health	AMA-MSS condemns the attempts of the Department of Justice to subpoena medical records in cases involving abortion. (Rationale: Implicit under opposing requirements that physicians function as agents of law enforcement, since subpoenas are requirements and medical records would be used as evidence for possible prosecution.)
5.005MSS	MSS Stance on Challenges to Women's Right to Reproductive Health Care Access	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.
5.006MSS	Transparency on Restrictions of Care	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.
5.007MSS	Ending the Risk Evaluation and Mitigation Strategy (REMS) on Mifepristone	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.
5.008MSS	Expanding AMA Support for Advanced Practice Providers who Provide First- Trimester Abortion Care	AMA-MSS supports state and federal legislation that allows appropriately trained and credentialed advanced practice clinicians to perform first trimester medical and aspiration abortions in accordance with individual state licensing requirements.
5.009MSS	Protecting Access to Abortion and Reproductive Healthcare	AMA-MSS will ask (1) that our AMA amends policy H-100.948, "Ending the Risk Evaluation and Mitigation Strategy (REMS) Policy on Mifepristone (Mifeprex)," by addition and deletion as follows: Supporting Access to Mifepristone (Mifeprex), H-100.948 Our AMA will support mifepristone availability for reproductive health indications, including via telemedicine, telehealth, and at retail pharmacies.

		<p>And (2) that our AMA amends policy H-5.980, "Oppose the Criminalization of Self- Induced Abortion," by addition and deletion as follows:</p> <p>Oppose the Criminalization of Abortion, H-5.980</p> <p>Our AMA: (1) opposes the criminalization of self-managed abortion and the criminalization of patients who access abortions 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-managed abortion and the criminalization of patients who access abortions; and (3) will oppose efforts to enforce criminal and civil penalties or other retaliatory efforts against these patients and requirements that physicians function as agents of law enforcement - gathering evidence for prosecution rather than provider of treatment.</p>
5.010MSS	AMA Opposition of Heartbeat Laws which Indicate First Evidence of Embryonic Cardiac Activity as Presence of Fetal Heartbeat	<p>AMA-MSS will ask the AMA to (1) recognize that policies and legislation that limit access to abortion care are serious threats to public health; (2) advocate for the explicit codification of protections for abortion care consistent with AMA policy into federal law; (3) oppose efforts to exclude provisions from spending bills which limit federal funds from being used for abortion care; and (4) collaborate with relevant stakeholders including state medical societies to encourage amendments to existing state laws so that a "fetal heartbeat" is not inaccurately stated as synonymous with the first evidence of embryonic cardiac activity.</p>
5.011MSS	Coverage and Reimbursement for Abortion Services	<p>AMA-MSS will ask the AMA (1) advocate for legislation and regulation to (a) lift all restrictions on public funding for abortion services and (b) guarantee coverage of evidence-based abortion services by all plans and programs that are publicly funded or subsidized; (2) advocate for policies that guarantee evidence-based abortion services are covered without barriers by private health plans, including designating abortion services as an essential health benefit; (3) work with state medical societies to advocate for policies requiring abortion coverage in state private, public, and subsidized plans; and (4) oppose restrictions on physicians and other health professionals who provide abortion care from participating in or being reimbursed by federal and state funded or subsidized health coverage.</p>
5.012MSS	Opposition to Restrictions on United States Foreign Aid Allocation for Reproductive Healthcare	<p>AMA-MSS will ask the AMA to (1) oppose restrictions on U.S. funding to non-governmental organizations which provide reproductive health care internationally, including but not limited to contraception and abortion care; and (2) support global humanitarian assistance for maternal healthcare and comprehensive reproductive health services, including but not limited to contraception and abortion care. (MSS Res. 041, A23)</p>
75.003MSS	Contraceptive Programming in the Media	<p>AMA-MSS will ask the AMA to urge print and broadcast media to permit advertising and public service announcements regarding contraception and safe sexual practices as a matter of public health awareness.</p>
75.005MSS	Promotion of Emergency Contraception Pills	<p>AMA-MSS will ask the AMA to: (1) support public health education relating to emergency contraception pills (ECPs) by working in conjunction with the appropriate specialty societies and organizations to encourage the widespread dissemination of information on ECPs to the medical community, women's groups, health groups, clinics, the public and the media; and (2) advocate programs that provide improved access to emergency contraception pills for women during after-hours need.</p>

75.009MSS	Ending Discrimination Against Contraception	AMA-MSS will ask the AMA to support the concept of equity among all forms of prescription contraception in order to offer women the option of affordable contraceptives which would include support from state and federal agencies.
75.012MSS	Recognizing Long-Acting Reversible Contraceptives (LARCs) as Efficacious and Economical Forms of Contraception	That our AMA (1) study unintended pregnancies and their consequences with a focus on current efficacious and economic methods to overcome the problem; and (2) support the training of all primary care providers in the area of preconception counseling.
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.
75.014MSS	Pain Management for Long-Acting Reversible Contraception and other Gynecological Procedures	AMA-MSS will ask (1) that our AMA recognizes the disparity in pain management in gynecological procedures compared to procedures of similarly reported pain and encourages discussion of pain control options, risks, and benefits with patients as a part of the shared decision making process and (2) that our AMA supports further research into evidence-based anesthetic and anxiolytic medication options for long-acting reversible contraception procedures and other gynecological procedures, including but not limited to colposcopy, endometrial biopsy, and LEEP procedures.
250.019MSS	Global HIV/AIDS Prevention	AMA-MSS will ask the AMA to (1) support continued funding efforts to address the global HIV epidemic and disease prevention worldwide, without mandates determining what proportion of funding must be designated to treatment of HIV/AIDS, abstinence or be-faithful funding directives, or grantee pledges of opposition to prostitution; and (2) extend its support of comprehensive family-life education to foreign aid programs, promoting abstinence while also discussing the role of safe sexual practices in disease prevention.
255.004MSS	United Nations Population Fund	AMA-MSS will ask the AMA to: (1) support reinstatement of U.S. funding to the United Nations Fund for Population Activities or other United Nations population and reproductive health programs consistent with AMA policy; and (2) educate its members about the possible consequences of the withdrawal of U.S. funding from the United Nations Fund for Population Activities and its support for the reinstatement of such funding.
270.056MSS	Condemnation of Non-Therapeutic Sterilization for Contraception of Women with Disabilities without Informed Patient Consent	AMA-MSS support national legislation that bans guardians or petitioners from attaining a sterilization deemed non-therapeutic (i.e for menstrual control or pregnancy prevention) for patients with disabilities or vulnerable circumstances.

420.008MSS	Advance Directives During Pregnancy	That our AMA-MSS ask our AMA to (1) support that pregnant women with decision-making capacity have the same right to refusal of treatment through advanced directives as non-pregnant women; and (2) study the legality and ethics related to the circumstances under which restrictions and/or exclusions are applied to pregnant women's advance directives.
420.013MSS	Amendment to Truth and Transparency in Pregnancy Counseling Centers	<p>AMA-MSS will ask the AMA to amend policy H-420.954, Truth and Transparency in Pregnancy Counseling Centers to read:</p> <p>H-420.954 – Truth and Transparency in Pregnancy Counseling Centers</p> <ol style="list-style-type: none"> 1. Our AMA supports advocates that any entity offering crisis pregnancy services disclose information on site, in its advertising, and before any services are provided concerning medical services, contraception, termination of pregnancy or referral for such services, adoption options or referral for such services that it does and does not provide, as well as fully disclose any financial, political, or religious association which such entities may have; 2. Our AMA discourages the use of marketing, counseling, or coercion (by physical, emotional, or financial means) by any agency offering crisis pregnancy services that aim to discourage or interfere with a pregnant woman's pursuit of any medical services for the care of her unplanned pregnancy; 3. Our AMA advocates that any entity providing medical or health services to pregnant women tat 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, and additionally disclose their level of compliance to such requirements and laws to patients receiving services; 4. Our AMA opposes the utilization of state and federal funding to finance such entities offering crisis pregnancy services, which do not provide statistically validated evidence-based medical information and care to pregnant women.
420.020MSS	Access to Standard Care for Non-Viable Pregnancy	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 non-viable pregnancy
525.012MSS	Transparency Improving Informed Consent for Reproductive Health Services	AMA-MSS will ask the AMA to (1) work with relevant stakeholders to establish a list of Essential Reproductive Health Services, and (2) advocate for legislation requiring healthcare organizations to clearly publish online and in points of service which Essential Reproductive Health Services are available at the organization along with any restrictions on Essential Reproductive Health Services at the institution, and include referral information to patients of other providers that cover the services within the same coverage area.

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Appendix B. MSS Positions Consolidated by New Position: Comprehensive Sexual Education

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Consolidated Position	Comprehensive Sexual Education	<p>The AMA-MSS:</p> <ol style="list-style-type: none"> (1) Supports age-appropriate comprehensive sexual education; (2) Supports the development of programs to teach self-breast examinations and testicular self-examinations to high school students and encourages county medical societies to assist local high schools in implementing such programs; (3) Opposes requiring parental notification of contraceptive care provided to minors; (4) Providing accurate and balanced information on the effectiveness, safety and risks/benefits of contraception in all public media; <p>Furthermore, our AMA-MSS asked the AMA:</p> <ol style="list-style-type: none"> (1) 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; (2) To actively oppose increasing federal and state funding for abstinence-only education, unless future research shows its superiority over comprehensive sex education in terms of preventing negative health outcomes; (3) To support the incorporation of information on adoption, sexual violence prevention, dental dams, and other barrier protection methods, and culturally competent materials that are language concordant for Limited English Proficiency (LEP) pupils into public school sex education or family planning curricula; (4) 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 encourage school districts to adopt sex education curricula that have a proven record of reducing teenage sexual activity; (5) Support public health education relating to emergency contraception pills (ECPs) by working in conjunction with the appropriate specialty societies and organizations to encourage the widespread dissemination of information on ECPs to the medical community, women's groups, health groups, clinics, the public and the media; (6) To support the development of programs to teach self-breast examinations to female high school students and testicular self-examinations to male high school students and encourage county medical societies to assist local high schools in implementing such programs; (7) 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; (8) To encourage physicians to educate their patients, particularly those of age 50 and older, on safe-sex practices and on the risk of sexually transmitted infections.
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65.046MSS	Television Broadcast and Online Streaming of LGBTQ+ Inclusive Sexual Encounters and Public Health Awareness on Social Media Platforms	<p>Our AMA-MSS will ask our AMA to amend policy H-485.994, "Television Broadcast of Sexual Encounters and Public Health Awareness" by addition and deletion, to read as follows:</p> <p>TELEVISION BROADCAST AND ONLINE STREAMING OF SEXUAL ENCOUNTERS AND PUBLIC HEALTH AWARENESS ON SOCIAL MEDIA PLATFORMS, H-485.994</p> <p>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.</p>
75.001MSS	Mandatory Parental Notification for Minors Seeking Contraceptive Devices	<p>AMA-MSS supports the concept that primary prevention of unplanned pregnancy, particularly among the young, is 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.</p>
75.005MSS	Promotion of Emergency Contraception Pills	<p>AMA-MSS will ask the AMA to: (1) support public health education relating to emergency contraception pills (ECPs) by working in conjunction with the appropriate specialty societies and organizations to encourage the widespread dissemination of information on ECPs to the medical community, women's groups, health groups, clinics, the public and the media; and (2) advocate programs that provide improved access to emergency contraception pills for women during after-hours need.</p>
75.007MSS	Preservation of HIV and STD Prevention Programs Involving Safer Sex Strategies and Condom Use	<p>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.</p>
75.008MSS	Opposition to Sole Funding of Abstinence-Only Education	<p>AMA-MSS will ask the AMA to actively oppose increasing federal and state funding for abstinence-only education, unless future research shows its superiority over comprehensive sex education in terms of preventing negative health outcomes.</p>
75.011MSS	Informed Consent with Regards to Advertising and Prescribing Contraceptives	<p>AMA-MSS: (1) supports continued research that explores alternative mechanisms of contraceptives; and (2) supports the concept of providing accurate and balanced information on the effectiveness, safety and risks/benefits of contraception in all public media and urges that such advertisements include appropriate information on the effectiveness, safety and risk/benefits of various methods with the addition of information regarding possible secondary mechanisms of contraceptive methods when conclusive and quantitative data is available.</p>
170.003MSS	Incorporation of Adoption into Public School Health Education Curriculum	<p>AMA- MSS will ask the AMA to support the incorporation of information on adoption into public school sex education or family planning curricula.</p>

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.
170.007MSS	Teaching Preventive Self Examinations to High School Students	AMA-MSS will ask the AMA to support the development of programs to teach self-breast examinations to female high school students and testicular self-examinations to male high school students and encourage county medical societies to assist local high schools in implementing such programs.
170.008MSS	Increasing HPV Education	AMA-MSS will ask the AMA to: (1) support specific teaching concerning transmission and sequelae in STD education; and (2) reaffirm a commitment to specific HIV and general STD education.
170.010MSS	Abstinence-Only Education and Federally-Funded Community-Based Initiatives	AMA-MSS supports initiatives to: (1) extend AMA 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 H-170.968; (2) oppose federal funding of community-based abstinence-only sex education programs and instead support federal funding of comprehensive sex education programs that teach about contraceptive choices and safe sex while also stressing the importance of abstinence in preventing unwanted teenage pregnancy and sexually transmitted infections; and (3) support school education programs that include recognizing and preventing sexual abuse and dating violence.
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.
170.015MSS	Reducing the Risk of Sexually Transmitted Infections in Patients Age 50 and Older	AMA-MSS will ask the AMA to encourage physicians to educate their patients, particularly those of age 50 and older, on safe-sex practices and on the risk of sexually transmitted infections.
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

		<p>supports the concept of a complementary family life and sexuality education program in the schools at all levels, at local option and direction;</p> <p>(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) utilize classroom teachers and other professionals who have shown an aptitude for working with young people and who have received special training that includes addressing the needs of LGBTQ+ youth; (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;</p> <p>(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;</p> <p>(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;</p> <p>(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;</p> <p>(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;</p> <p>(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</p> <p>(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</p>
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		<p>discussing the roles of condoms and birth control, as endorsed for school systems in this policy; and</p> <p>(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.</p>
170.019MSS	Comprehensive Human Papillomavirus (HPV) and Vaccination Education in School Health Curricula	<p>(1) AMA-MSS encourages school health education programs to emphasize not only HPV association with cervical cancer and genital warts, but also penile, vaginal, vulvar, oropharyngeal, and anal cancers; and (2) AMA-MSS encourages HPV and HPV vaccination school education be more targeted to students at the recommended age of vaccination.</p>
170.020MSS	Sex Education Materials for Students with Limited English Proficiency	<p>MSS will ask our AMA to amend policy H-170.968 by insertion as follows:</p> <p>Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools H-170.968</p> <p>(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;</p> <p>(2) Urges schools at all education levels to implement comprehensive, developmentally appropriate sexuality education programs that: (a) are based on rigorous, peer reviewed science; (b) incorporate sexual violence prevention; (c) show promise for delaying the onset of sexual activity and a reduction in sexual behavior that puts adolescents at risk for contracting human immunodeficiency virus (HIV) and other sexually transmitted diseases and for becoming pregnant; (d) include an integrated strategy for making condoms available to students and for providing both factual information and skill-building related to reproductive biology, sexual abstinence, sexual responsibility, contraceptives including condoms, alternative in birth control, and other issues aimed prevention of pregnancy and sexual transmission of diseases; (e) utilize classroom teachers and other professionals who have shown an aptitude for working with young people and who have received special training that includes addressing the needs of gay, lesbian, and bisexual youth; (f) include ample involvement of parents, health professionals, and other concerned members of the community in the development of the program; and (g) are part of an overall health education program; (h) include culturally competent materials that are language concordant for Limited English Proficiency (LEP) pupils;</p> <p>Continues to monitor future research findings related to emerging initiatives that include abstinence-only, school-based sexuality education, and consent communication to prevent dating violence while promoting healthy relationships, and school-based condom availability programs that address sexually transmitted diseases and pregnancy prevention for young people and report back to the House of Delegates as appropriate;</p> <p>(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;</p> <p>(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;</p>

		<p>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;</p> <p>(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</p> <p>(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;</p> <p>(9) Supports the development of sexual education curriculum that integrates dating violence prevention through lessons on healthy relationships, sexual health and conversations about</p> <p>(10) consent; Encourages physicians and all interested parties to develop best-practice, evidence-based guidelines for sexual education curricula that are developmentally appropriate as well as medically, factually, and technically accurate.</p>
170.021MSS	Expansion on Comprehensive Sexual Health Education	<p>Our AMA-MSS will ask the AMA to amend policy H-170.968 by addition and deletion as follows:</p> <p>SEXUALITY EDUCATION, SEXUAL VIOLENCE PREVENTION, ABSTINENCE, AND DISTRIBUTION OF CONDOMS IN SCHOOLS, H-170.968</p> <p>(1) Recognizes that the primary responsibility for family life education is in the home, and additionally s Supports the concept of a complementary family life and sexuality education program in the schools at all levels, at local option and direction;</p> <p>(2) Urges schools at all education levels to implement comprehensive, developmentally appropriate sexuality education programs that: (a) are based on rigorous, peer-reviewed science; (b) incorporate sexual violence prevention; (c) show promise for delaying the onset of sexual activity and a reduction in sexual behavior that puts adolescents at risk for contracting human immunodeficiency virus (HIV) and other sexually transmitted diseases and for becoming pregnant; (d) include an integrated strategy for making condoms, dental dams, and other barrier protection methods available to students and for providing both factual information and skill-building related to reproductive biology, sexual abstinence, sexual responsibility, contraceptives including condoms, alternatives in birth control, and other issues aimed at prevention of pregnancy and sexual transmission of diseases; (e) utilize classroom teachers and other professionals who have shown an aptitude for working with young people and who have received special training that includes addressing the needs of LGBTQ gay, lesbian, and bisexual youth; (f) appropriately and comprehensively address the sexual behavior of all people, inclusive of sexual and gender minorities; (g) include ample involvement of parents, health professionals, and other concerned members of the community in the development of the program; (h) are part of an overall health education program; (i) include culturally competent materials that are language-appropriate for Limited English Proficiency (LEP) pupils;</p> <p>(3) Continues to monitor future research findings related to emerging initiatives that include abstinence-only, school-based sexuality education, and consent communication to prevent dating violence while promoting healthy relationships, and school-based condom availability programs that address sexually transmitted</p>

		<p>diseases and pregnancy prevention for young people and report back to the House of Delegates as appropriate;</p> <p>(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;</p> <p>(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;</p> <p>(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;</p> <p>(7) Supports federal funding of comprehensive sex education programs that stress the importance of abstinence in preventing unwanted teenage pregnancy and sexually transmitted infections via comprehensive education, and also teach about <u>including</u> contraceptive choices, <u>abstinence</u>, and safer sex, and opposes federal funding of community-based programs that do not show evidence-based benefits; and</p> <p>(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;</p> <p>(9) Supports the development of sexual education curriculum that integrates dating violence prevention through lessons on healthy relationships, sexual health, and conversations about consent; and</p> <p>(10) Encourages physicians and all interested parties to conduct research and develop best-practice, evidence-based, guidelines for sexual education curricula that are developmentally appropriate as well as medically, factually, and technically accurate.</p>
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Appendix C. MSS Positions Consolidated by New Position: Reproductive Care in Medical Education

#	Title	Position
Consolidated Position	Reproductive Care in Medical Education	<p>Our AMA-MSS:</p> <p>(1) Supports gender-neutral language with regards to reproductive rights including but not limited to menstrual products in medical education, clinical training, and clinical practice;</p> <p>(2) Supports training for healthcare providers that includes de-gendered language and inclusivity for various period products to better understand the needs of all persons who menstruate;</p> <p>(3) Encourages medical schools to incorporate lactation management education into the medical school curriculum where appropriate;</p> <p>(4) Supports education on termination of pregnancy issues be included in the medical school curriculum;</p> <p>(5) Supports that LCME- and COCA-accredited institutions develop minimum content requirements in LGBTQ+ health curricula, including relevant terminology, health disparities, taking a comprehensive sexual history, developing inclusive clinical environments, gender-affirming care for transgender and nonbinary patients, gender-affirming physical exam skills, sexual health safety and satisfaction, and intersectional experiences of LGBTQ+ people;</p>

		<p>(6) Supports our AMA working with the Accreditation Council for Graduate Medical Education to protect patient access by advocating for preservation of accreditation requirements for family medicine residencies in reproductive health topics, including contraceptive counseling, family planning, and counseling for unintended pregnancy.</p> <p>Furthermore, our AMA-MSS asked the AMA to:</p> <ol style="list-style-type: none"> (1) Support the training of all primary care providers in the area of preconception counseling; (2) 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-acting reversible contraception placement protocols and procedures; (3) Encourage all medical schools to train medical students to be able to take a thorough and non-judgmental sexual history in a manner that is sensitive to the personal attitudes and behaviors of patients in order to decrease anxiety and personal difficulty with sexual aspects of health care; (4) Issue a public service announcement that encourages patients to discuss concerns related to sexual health with their physician and reinforces the AMA's commitment to helping patients maintain sexual health and well-being; (5) Support regular cancer and sexually transmitted infection screenings in transgender men when medically indicated; (6) Support opt-out curriculum on abortion education.
65.055MSS	Including Gender Inclusive Language in Menstrual Healthcare	AMA-MSS (1) supports gender-neutral language with regards to reproductive rights including but not limited to menstrual products in medical education, clinical training, and clinical practice; (2) supports training for healthcare providers that includes de-gendered language and inclusivity for various period products to better understand the needs of all persons who menstruate; and (3) administratively amends existing MSS policy which includes mention of "feminine hygiene products," namely 160.032MSS, 525.008MSS, 525.009MSS, and 525.015MSS, to replace the phrase "feminine hygiene" with "menstrual."
75.012MSS	Recognizing Long-Acting Reversible Contraceptives (LARCs) as Efficacious and Economical Forms of Contraception	That our AMA (1) study unintended pregnancies and their consequences with a focus on current efficacious and economic methods to overcome the problem; and (2) support the training of all primary care providers in the area of preconception counseling.
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.
295.073MSS	Inclusion of Lactation Management Education in Medical School Curricula	AMA-MSS encourages medical schools to incorporate lactation management education into the medical school curriculum where appropriate.
295.077MSS	Medical Student Education on Termination of Pregnancy Issues	AMA-MSS believes that education on termination of pregnancy issues be included in the medical school curriculum so that medical students receive a satisfactory knowledge of the medical, ethical, legal, and psychological principles associated with termination of pregnancy, although performance of the actual procedure should not be required.
295.129MSS	Improving Sexual Education in the Medical School Curriculum	AMA-MSS will ask the AMA to: (1) encourage all medical schools to train medical students to be able to take a thorough and non-judgmental sexual history in a manner that is sensitive to the personal attitudes and behaviors of patients in order to decrease anxiety and personal difficulty with sexual aspects of health care; and (2) issue a public service announcement that encourages patients to discuss concerns related to sexual health with their physician and reinforces the AMA's commitment to helping patients maintain sexual health and well-being.
295.191MSS	Educating Physicians About the Importance of Cervical Cancer Screening for Transgender Men Patients	AMA-MSS will ask that our AMA amend policy H-160.991 by insertion and deletion to read as follows: Healthcare Needs of <u>LGBTQ+ Lesbian Gay Bisexual and Transgender Populations</u> 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 <u>transgender men when medically indicated</u> 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.
295.206MSS	Protecting Medical Student Access to Abortion Education and Training	AMA-MSS will ask the AMA to amend policy H-295.923, Medical Training and Termination of Pregnancy by insertion and deletion as follows: H-295.923 – Medical Training and Termination of Pregnancy 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. 2. Although observation of, attendance at, or any direct or indirect participation in abortion <u>procedures</u> should not be required, <u>AMA does support opt-out curriculum on abortion education</u> . Further, the AMA supports the opportunity for <u>medical students</u> 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 of Obstetrics and Gynecology and the American College of Obstetricians and Gynecologists' recommendations.
295.234MSS	Supporting Minimum Content Standards of LGBTQ+ Health Curriculum in Undergraduate Medical Education	AMA-MSS supports that LCME- and COCA-accredited institutions develop minimum content requirements in LGBTQ+ health curricula, including relevant terminology, health disparities, taking a comprehensive sexual history, developing inclusive clinical environments, gender-affirming care for transgender and nonbinary patients, gender-affirming physical exam skills, sexual health safety and satisfaction, and intersectional experiences of LGBTQ+ people.
310.048MSS	Training in Reproductive Health Topics as a Requirement for Accreditation of Family Medicine Residencies	AMA-MSS supports our AMA working with the Accreditation Council for Graduate Medical Education to protect patient access by advocating for preservation of accreditation requirements for family medicine residencies in reproductive health topics, including contraceptive counseling, family planning, and counseling for unintended pregnancy.

REPORT OF THE MEDICAL STUDENT SECTION
GOVERNING COUNCIL

MSS GC Report E
(A-24)

Subject: MSS Employment & Educational Leave Positions Review & Consolidation

Presented by: MSS Governing Council

Referred to: MSS Reference Committee
(Caitlin Blaukovitch and Shaminy Manoranjithan, Co-Chairs)

1 **INTRODUCTION**

2

3 MSS Position 630.044MSS, "Sunset Mechanism for AMA-MSS Policy," states "the MSS Governing Council
4 may recommend policies for consolidation as part of the sunset review process." This clause was amended
5 into this policy at MSS A-23, but was derived from a similar policy that was sunset at A-23, 645.023MSS,
6 "Medical Student Section Policy Making Procedures." This policy was actually even stronger and stated,
7 "[a]s part of its annual review of MSS policies set to sunset... the MSS Governing Council will undertake
8 policy consolidation for at least one issue," implying that prior to last year, this was intended to be an explicit
9 directive to Governing Councils and not just an enumerated power.

10

11 However, for several years, no Governing Council has undertaken any consolidations as described, despite
12 this policy being reaffirmed during that period, demonstrating that this policy had not been followed as
13 directed. Therefore, as this year's Governing Council would be the first to undertake any consolidations in
14 a long period of time, we decided to compensate for our predecessors and undertake consolidations of
15 multiple issues.

16

17 The intent of these consolidations is to streamline our new MSS Positions Compendium and make the
18 identification and comprehension of MSS positions clearer and more accessible for all members, especially
19 new students learning about AMA and MSS processes. In this report, the MSS Governing Council presents
20 a review and consolidation of MSS positions related to leave.

21

22 For some relevant context, the Family and Medical Leave Act of 1993 (FMLA) is a federal law providing
23 certain employees with up to 12 weeks of unpaid leave per year. It also requires that their group health
24 benefits be maintained during the leave. FMLA applies to all public agencies, all public and private
25 elementary and secondary schools, and companies with 50 or more employees. Employers must provide
26 an eligible employee with up to 12 weeks of unpaid leave each year for any of the following reasons:

- 27
- 28 ● For the birth and care of the newborn child of an employee;
 - 29 ● For placement with the employee of a child for adoption or foster care;
 - 30 ● For pregnancy complications;
 - 31 ● To care for an immediate family member (i.e., spouse, child, or parent) with a serious health
32 condition; or
 - 33 ● To take medical leave when the employee is unable to work because of a serious health condition.
- 34

35 Over the years, MSS positions as well as AMA policies have sought to support the provisions covered by
36 FMLA as well as support provisions beyond what is currently covered by FMLA. The earliest MSS position
37 related to leave predates the adoption of FMLA (from 1987), and the most recent MSS position seeking to
38 modify AMA policy was adopted at A-22. The MSS currently maintains 17 positions related to family and
39 medical leave.

40

1 Of note, the MSS has sent 13 resolutions related to leave policies to the House of Delegates (HOD) that
 2 were all adopted or adopted as amended and integrated into AMA policy. In addition, several other
 3 delegations have been transmitting leave resolutions to the HOD, notably coming to a peak at I-22 where
 4 5 resolutions addressed leave policies. While all of the resolutions were adopted in some form, several of
 5 the resolutions called for study of leave policies prompting the AMA Council on Medical Education to
 6 produce a report on leave for medical students, residents, and fellows for I-23 [[CME Report 01 Leave](#)
 7 [Policies for Medical Students, Residents, Fellows, and Physicians](#)] that provided the most recent updates
 8 to our AMA leave policies.
 9

10 Below, a review of the MSS positions that have been transmitted to the HOD can be found with the outcome
 11 and associated AMA policy:
 12

MSS Position Number	MSS Position Title	Transmittal Details	HOD Final Outcome	AMA Policy
310.002MSS	Parental Leave Benefits for House Staff	Res 89 Maternity Leave for Housestaff [I-79]	Adopted in Lieu	Policy has been updated significantly since I-79 and has been rescinded in lieu of updated stances. The I-17 adopted language however can be found below: RESOLVED, That the American Medical Association encourage flexibility in residency training programs incorporating maternity leave and alternative schedules for pregnant housestaff
270.003MSS	Broadening Access to Paid Family Leave to Improve Health Outcomes and Health Disparities	AMA Res 163, A-87 Referred → BOT Rep A, A-88	Adopted as Amended	AMA Statement on Family, Medical, and Safe Leave [H-420.979] (Original)
310.049MSS	Equal Paternal and Maternal Leave for Medical Residents	AMA Res 904, I-14	Adopted as Amended	Increasing Practice Viability For Physicians Through Increased Employer And Employee Awareness Of Protected Leave Policies [H-405.960] (Update)
440.050MSS	Measuring the Effect of Paid Sick Leave (PSL) on Health-Care Outcomes	Res 202, A-15, Referred → CMS Rep 3, A-16	Adopted as Amended	AMA Statement on Family, Medical, and Safe Leave [H-420.979] (Update) Paid Sick Leave [H-440.823] (Original)
65.024MSS	FMLA-Equivalent for LGBTQ+ Workers	Res. 002, A-18	Adopted	FMLA Equivalence [H-270.951] (Original)
295.197MSS	Support for the Study of the Timing and Causes for Leave of Absence and Withdrawal from United States Medical Schools	AMA Res 322, A-19	Adopted as amended	Support for the Study of the Timing and Causes for Leave of Absence and Withdrawal from United States Allopathic and Osteopathic Medical Undergraduate and Graduate Education Programs [H-295.856] (Original)
65.051MSS	Cultural Leave for American Indian Trainees	Res 323, A-22	Adopted	Cultural Leave for American Indian Trainees H-350.957 [H-350.957] (Original)

				Eliminating Religious and Cultural Discrimination from Residency and Fellowship Programs and Medical Schools [H-310.923] (Update)
270.048MSS	Expanding Employee Leave to Include Miscarriage and Stillbirth	Res 302, I-22	Alternate Resolution Adopted in Lieu	Increasing Practice Viability For Physicians Through Increased Employer And Employee Awareness Of Protected Leave Policies [H-405.960] (Update) AMA Statement on Family, Medical, and Safe Leave [H-420.979] (Update)
270.049MSS	Amendment to Policy H-405.960, Policies for Parental, Family, and Medical Necessity Leave	Res 303, I-22	Alternate Resolution Adopted in Lieu	Increasing Practice Viability For Physicians Through Increased Employer And Employee Awareness Of Protected Leave Policies [H-405.960] (Update)
310.058MSS	Reporting of Residency Demographic Data	AMA Res 312, I-22	Adopted as Amended	Increasing Practice Viability For Physicians Through Increased Employer And Employee Awareness Of Protected Leave Policies [H-405.960] (Update)
305.094MSS	Increased Education and Access to Fertility Resources for U.S. Medical Students	Res. 306, A-23	Adopted as Amended	Increased Education and Access to Fertility Resources for U.S. Medical Students [H-295.846] (Original)
270.047MSS	Supporting Intimate Partner and Sexual Violence Safe Leave	Res 413, A-23	Adopted as Amended	AMA Statement on Family, Medical, and Safe Leave [H-420.979] (Update)

Notably, the AMA highlights actions taken from two of these resolution on their implementation reports:

- The [AMA Implementation Report for A-18](#) indicates the following action taken as a result of [Res. 002](#) which resulted from **65.024MSS FMLA-Equivalent for LGBTQ+ Workers**:
 - *Our AMA sent a [letter to the Department of Labor](#) advocating for changes to regulations on the Family and Medical Leave Act that would modify the definitions of “family member” and “immediate relative” to “include any individual related by blood or affinity whose close association with the employee is the equivalent of a family relationship” per AMA policy.*
- The [AMA Implementation Report for I-22](#) indicates the following action taken as a result of [AMA Res 312](#) at I-22 which resulted from **310.058MSS Reporting of Residency Demographic Data**:
 - *Letters were sent to the leadership of the Association of Graduate Medical Education and the Organization of Program Director Associations to notify them of new AMA policy encouraging that residency programs annually publish and share with FREIDA and other appropriate stakeholders, self-identified and other demographic data, including but not limited to the composition of their program over the last 5 years by age, historically marginalized, minoritized, or excluded status, sexual orientation and gender identity; and encouraging the Accreditation Council for Graduate Medical Education and other relevant stakeholders to annually collect data on childbirth and parenthood from all accredited US residency programs and publish this data with disaggregation by gender identity and specialty.*
 - *A new question has been added to the National Program Survey asking for a link to an institution’s leave policies; if provided, the link will be added to the program’s listing on FREIDA. Also, FREIDA already asks for and displays the number of paid and unpaid family/medical leave days. This topic is addressed by AGCME Core Institutional Requirement IV.B.3.a).(2).*

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1 **DISCUSSION**
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3 After thorough review of the MSS Digest of Actions, your MSS Governing Council recommends
4 consolidation of 13 of the current leave positions into 3 consolidated positions that capture the original intent
5 and function of the current positions. Of the remaining leave positions, three were previously transmitted to
6 HOD and recommended to be converted to past tense.
7

8 MSS Positions that overlapped significantly in content and/or function were consolidated together. The
9 appendices at the end of this report provide a color-coded mapping of the consolidated MSS position onto
10 the current MSS positions.
11

12 **RECOMMENDATIONS**
13

14 Thus, your MSS Governing Council recommends that the following recommendations be adopted, the
15 following new consolidated positions be retained as active positions of the AMA-MSS, the original
16 comprising positions be rescinded, and the remainder of this report be filed:
17

18 RESOLVED, the following MSS Positions:

- 19 ● 65.024MSS FMLA-Equivalent for LGBTQ+ Workers
- 20 ● 270.003MSS Broadening Access to Paid Family Leave to Improve Health Outcomes and Health
21 Disparities
- 22 ● 270.032MSS Paid Parental Leave
- 23 ● 270.047MSS Supporting Intimate Partner and Sexual Violence Safe Leave
- 24 ● 270.048MSS Expanding Employee Leave to Include Miscarriage and Stillbirth
- 25 ● 295.233MSS Support for Family Planning for Medical Students
- 26 ● 440.050MSS Measuring the Effect of Paid Sick Leave (PSL) on Health-Care Outcomes
27

28 be consolidated into the new MSS Position:

29 Support for Universal, Paid, Family and Medical Leave
30 The AMA-MSS:

- 31 (1) Supports universal paid family and medical leave, especially to a period of 14 weeks or
32 longer, including for at minimum the following conditions:
 - 33 (a) The conditions outlined by the Family and Medical Leave Act of 1993;
 - 34 (b) Parental leave policies that equally encourage parents of all genders to take
35 parental leave;
 - 36 (c) Pregnancy complications, including miscarriage and stillbirth;
 - 37 (d) Concerns for safety, including but not limited to intimate partner violence, sexual
38 violence or coercion, and stalking;
 - 39 (e) Provisions to include of any individuals related by blood or affinity whose close
40 association with the employee is the equivalent of a family relationship;
41

42 Furthermore, the AMA-MSS asked the AMA to: (1) support the expansion of policies regarding
43 family and medical leave to include any individual related by blood or affinity whose close
44 association with the employee is the equivalent of a family relationship; (2) recognize the positive
45 impact of paid safe leave on public health outcomes and support legislation that offers paid and
46 unpaid safe leave and (3) support safe leave provisions for those experiencing any instances of
47 violence, including but not limited to intimate partner violence, sexual violence or coercion, and
48 stalking; (4) support leave policy for miscarriage or stillbirth; (5) recognize the positive impact of
49 paid sick leave on health and support legislation that offers paid sick leave; (6) work with
50 appropriate entities to build on the current body of evidence by studying the health and economic
51 impacts of newly enacted legislation; and (7) advocate for federal and state policies that guarantee
52 employee access to protected paid sick leave.
53

54 RESOLVED, the following MSS Positions:

- 55 ● 270.048MSS Expanding Employee Leave to Include Miscarriage and Stillbirth

- 1 • 270.049MSS Amendment to Policy H-405.960, Policies for Parental, Family, and Medical
- 2 Necessity Leave
- 3 • 310.002MSS Parental Leave Benefits for House Staff
- 4 • 310.049MSS Equal Paternal and Maternal Leave for Medical Residents
- 5 • 295.207MSS Family Planning for Medical Students
- 6

7 be consolidated into the new MSS Position:

8 Leave During Medical Training

9 The AMA-MSS supports efforts by medical schools, residency and fellowship programs to develop
10 easily accessible written policies on family and medical leave for medical trainees, including at
11 minimum the following provisions:

- 12 (1) The conditions outlined by the Family and Medical Leave Act of 1993;
- 13 (2) Leave policy for birth, adoption, and pregnancy complications including stillbirth and
14 miscarriage;
- 15 (3) Duration of leave allowed before and after delivery;
- 16 (4) Parental leave policies that equally encourage parents of all genders to take parental leave;
- 17 (5) Concerns for safety, including but not limited to intimate partner violence, sexual violence
18 or coercion, and stalking;
- 19 (6) Extended leave for trainees with extraordinary and long-term personal or family medical
20 tragedies, without loss of status;
- 21 (7) Clarification of how time can be made up in order to be eligible for graduation without delay
22 and length of leave that would result in delayed graduation or additional training;
- 23 (8) Whether schedule accommodations are allowed, such as modified rotation schedules, no
24 night duties, and flexibility with academic testing schedules.

25
26 RESOLVED, the following MSS Positions:

- 27 • 305.094MSS Increased Education and Access to Fertility Resources for U.S. Medical Students
- 28 • 295.207MSS Family Planning for Medical Students
- 29 • 295.239MSS Increased Education and Access to Fertility-Related Resources for U.S. Physicians
- 30 • 295.233MSS Support for Family Planning for Medical Students
- 31

32 be consolidated into the new MSS Position:

33
34 Increased Education and Access to Fertility Resources for U.S. Trainees

35 The AMA-MSS:

- 36 (1) supports the development of initiatives inclusive of sexual orientation and gender identity
37 by the Association of American Medical Colleges, American Association of Colleges of
38 Osteopathic Medicine, medical schools, residency and fellowship programs, and other
39 appropriate organizations in medical education that promote a culture that is supportive of
40 their medical students and trainees who are parents and to provide openly and easily
41 accessible guidelines and information to prospective and current students regarding family
42 planning including raising awareness about:
 - 43 (a) how peak child-bearing years correspond to the peak career-building years for
44 many medical students and trainees;
 - 45 (b) the significant decline in oocyte quality and quantity and increase in miscarriage
46 and infertility rates, with increasing age in medical students and trainees;
 - 47 (c) the high rate of infertility among medical students, trainees, and physicians;
 - 48 (d) various fertility preservation options and including cryopreservation of oocytes and
49 sperm and associated costs; and work with relevant organizations to increase
50 access to strategies by which medical students and trainees can preserve fertility
51 (such as cryopreservation of oocytes, sperm, and embryos), with associated
52 mechanisms for insurance coverage;
 - 53 (e) breastfeeding policies, accommodations during pregnancy, and resources for
54 childcare that span the institution and surrounding area;

55

1 (2) urges academic and private hospitals and employers to offer counseling for family planning
2 options such as gamete cryopreservation and in vitro fertilization, for medical residents,
3 fellows, and physicians.
4

5 RESOLVED, the following MSS Positions be amended to summarize the spirit and convert the request to
6 past tense as applicable:

- 7 ● 65.051MSS Cultural Leave for American Indian Trainees
- 8 ● 295.197MSS Support for the Study of the Timing and Causes for Leave of Absence and Withdrawal
9 from United States Medical Schools
- 10 ● 310.058MSS Reporting of Residency Demographic Data

Appendix A. MSS Positions Consolidated by New Position: Support for Universal, Paid, Family and Medical Leave

MSS Position Number	Title	Position
Consolidated Position	Support for Universal, Paid, Family and Medical Leave	<p>The AMA-MSS:</p> <ul style="list-style-type: none"> (2) Supports universal paid family and medical leave, especially to a period of 14 weeks or longer, including for at minimum the following conditions: <ul style="list-style-type: none"> (a) The conditions outlined by the Family and Medical Leave Act of 1993; (b) Parental leave policies that equally encourage parents of all genders to take parental leave; (c) Pregnancy complications, including miscarriage and stillbirth; (d) Concerns for safety, including but not limited to intimate partner violence, sexual violence or coercion, and stalking; (e) Provisions to include of any individuals related by blood or affinity whose close association with the employee is the equivalent of a family relationship; <p>Furthermore, the AMA-MSS asked the AMA to: (1) 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; (2) recognize the positive impact of paid safe leave on public health outcomes and support legislation that offers paid and unpaid safe leave and (3) support safe leave provisions for those experiencing any instances of violence, including but not limited to intimate partner violence, sexual violence or coercion, and stalking; (4) support leave policy for miscarriage or stillbirth; (5) recognize the positive impact of paid sick leave on health and support legislation that offers paid sick leave; (6) work with appropriate entities to build on the current body of evidence by studying the health and economic impacts of newly enacted legislation; and (7) advocate for federal and state policies that guarantee employee access to protected paid sick leave</p>
65.024MSS	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.
270.003MSS	Broadening Access to Paid Family Leave to Improve Health Outcomes and Health Disparities	AMA-MSS supports the preference of paid leave and job security, over unpaid, for persons who must forsake work responsibilities for family or medical reasons, including parental leave.
270.032MSS	Paid Parental Leave	Our AMA-MSS (1) supports policy that extends the length of universal paid parental leave, recommending especially a period of 14 weeks or longer; and (2) supports policies that equally encourage parents of all genders to take parental leave.

270.047MSS	Supporting Intimate Partner and Sexual Violence Safe Leave	<p>AMA will ask the AMA to (1) recognize the positive impact of paid safe leave on public health outcomes and support legislation that offers paid and unpaid safe leave and (2) amend the existing policy H-420.979 AMA Statement on Family and Medical Leave to promote inclusivity by addition as follows:</p> <p>AMA Statement on Family and Medical Leave, H-420.979 Our AMA supports policies that provide employees with reasonable job security and continued availability of health plan benefits in the event leave by an employee becomes necessary due to documented medical conditions <u>and/or concerns for safety</u>. Such policies should provide for reasonable periods of paid or unpaid: (1) medical leave for the employee, including pregnancy; (2) maternity leave for the employee-mother; (3) leave if medically appropriate to care for a member of the employee's immediate family, i.e., a spouse or children; (4) leave for adoption or for foster care leading to adoption; <u>and (5) safe leave provisions for those experiencing any instances of violence, including but not limited to intimate partner violence, sexual violence or coercion, and stalking</u>. Such periods of leave may differ with respect to each of the foregoing classifications, and may vary with reasonable categories of employers. Such policies should encourage voluntary programs by employers and may provide for appropriate legislation (with or without financial assistance from government). Any legislative proposals will be reviewed through the Association's normal legislative process for appropriateness, taking into consideration all elements therein, including classifications of employees and employers, reasons for the leave, periods of leave recognized (whether paid or unpaid), obligations on return from leave, and other factors involved in order to achieve reasonable objectives recognizing the legitimate needs of employees and employers.</p>
270.048MSS	Expanding Employee Leave to Include Miscarriage and Stillbirth	<p>AMA-MSS will ask (1) that our AMA amends Policy H-405.960, "Policies for Parental, Family, and Medical Necessity Leave":</p> <p>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:</p> <ol style="list-style-type: none"> 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; <u>and (i) leave policy for adoption; and (j) leave policy for miscarriage or stillbirth.</u> 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

	<p>required to take a minimum leave.</p> <p>5. Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave.</p> <p>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.</p> <p>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) duration of leave allowed after miscarriage or stillbirth; (e)(d) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); (d)(e) whether leave is paid or unpaid; (e)(f) whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (f)(g) whether sick leave and vacation time may be accrued from year to year or used in advance; (g)(h) extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (h)(i) how time can be made up in order for a resident physician to be considered board eligible; (i)(j) what period of leave would result in a resident physician being required to complete an extra or delayed year of training; (j)(k) whether time spent in making up a leave will be paid; and (k)(l) whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling.</p> <p>8. Our AMA endorses the concept of equal parental leave for birth, <u>stillbirth, miscarriage</u>, and adoption as a benefit for resident physicians, medical students, and physicians in practice regardless of gender or gender identity.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>14. These policies as above should be freely available online and in writing to all applicants to medical school, residency or fellowship.</p> <p>And (2) that our AMA amends H-420.979 “AMA Statement on Family and Medical Leave” due to the prevalence of miscarriage and stillbirth and the need for physical and psychological healing afterwards, as follows:</p> <p>AMA Statement on Family and Medical Leave H-420.979</p> <p>Our AMA supports policies that provide employees with reasonable job security and continued availability of health plan benefits in the event leave by an employee becomes necessary due to documented medical conditions. Such policies should provide for reasonable periods of paid or unpaid: (1) medical leave for the employee, including</p>
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		<p>pregnancy, <u>miscarriage, and stillbirth</u>;</p> <p>(2) maternity leave for the employee-mother;</p> <p>(3) leave if medically appropriate to care for a member of the employee's immediate family, i.e., a spouse or children; and</p> <p>(4) leave for adoption or for foster care leading to adoption. Such periods of leave may differ with respect to each of the foregoing classifications, and may vary with reasonable categories of employers. Such policies should encourage voluntary programs by employers and may provide for appropriate legislation (with or without financial assistance from government). Any legislative proposals will be reviewed through the Association's normal legislative process for appropriateness, taking into consideration all elements therein, including classifications of employees and employers, reasons for the leave, periods of leave recognized (whether paid or unpaid), obligations on return from leave, and other factors involved in order to achieve reasonable objectives recognizing the legitimate needs of employees and employers.</p>
295.233MSS	Support for Family Planning for Medical Students	<p>AMA-MSS continues to support family leave related policies brought forth by other delegations so as not to diminish incremental advancement in advocacy related to the topic.</p>
440.050MSS	Measuring the Effect of Paid Sick Leave (PSL) on Health-Care Outcomes	<p>AMA-MSS will ask the AMA to: (1) recognize the positive impact of paid sick leave on health and support legislation that offers paid sick leave; and (2) work with appropriate entities to build on the current body of evidence by studying the health and economic impacts of newly enacted legislation and (3) amend Policy H-440.823 by addition and deletion as follows:</p> <p>Paid Sick Leave H-440.823</p> <p>Our AMA: (1) recognizes the public health benefits of paid sick leave and other discretionary paid time off; (2) supports employer policies that allow employees to accrue paid time off and to use such time to care for themselves or a family member; and (3) supports employer policies that provide employees with unpaid sick days to use to care for themselves or a family member where providing paid leave is overly burdensome.; and (4) <u>advocates for federal and state policies that guarantee employee access to protected paid sick leave.</u></p>

Appendix B. MSS Positions Consolidated by New Position: Leave During Medical Training

MSS Position Number	Title	Position
Consolidated Position	Leave During Medical Training	<p>The AMA-MSS supports efforts by medical schools, residency and fellowship programs to develop easily accessible <u>written policies on family and medical leave for medical trainees, including at minimum the following provisions:</u></p> <ul style="list-style-type: none"> (1) The conditions outlined by the Family and Medical Leave Act of 1993; (2) <u>Leave policy for birth, adoption, and pregnancy complications including stillbirth and miscarriage, and duration of leave allowed before and after these events;</u> (3) <u>Parental leave policies that equally encourage parents of all genders to take parental leave;</u> (4) <u>Concerns for safety, including but not limited to intimate partner violence, sexual violence or coercion, and stalking;</u> (5) <u>Extended leave for trainees with extraordinary and long-term personal or family medical tragedies, without loss of status;</u>

		<p>(6) Flexibility with and clarification of how time can be made up in order to be eligible for graduation without delay and length of leave that would result in delayed graduation or additional training;</p> <p>(7) policies that allow for students to take at least full six week leave without delaying graduation;</p> <p>(8) Whether schedule accommodations are allowed, such as modified rotation schedules, no night duties, and flexibility with academic testing schedules.</p> <p>Furthermore, the AMA-MSS asked the AMA to: (1) Support medical schools developing written policies on parental leave, family leave, and medical leave for medical students that include the following elements: (a) leave policy for birth, adoption, stillbirth, or miscarriage; (b) duration of leave allowed before and after delivery; (c) extended leave for medical students with extraordinary and long-term personal or family medical tragedies, without loss of previously accepted medical school seats, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (d) how time can be made up in order for a medical students to be eligible for graduation without delays; (e) what period of leave would result in a medical student being required to complete an extra or delayed year of training; and (f) whether schedule accommodations are allowed, such as modified rotation schedules, no night duties, and flexibility with academic testing schedules; (2) support greater flexibility in residency training programs for parental leave and alternative residency training schedules for pregnant house staff.</p>
270.047MSS	Supporting Intimate Partner and Sexual Violence Safe Leave	<p>AMA will ask the AMA to (1) recognize the positive impact of paid safe leave on public health outcomes and support legislation that offers paid and unpaid safe leave and (2) amend the existing policy H-420.979 AMA Statement on Family and Medical Leave to promote inclusivity by addition as follows:</p> <p>AMA Statement on Family and Medical Leave, H-420.979</p> <p>Our AMA supports policies that provide employees with reasonable job security and continued availability of health plan benefits in the event leave by an employee becomes necessary due to documented medical conditions <u>and/or concerns for safety</u>. Such policies should provide for reasonable periods of paid or unpaid: (1) medical leave for the employee, including pregnancy; (2) maternity leave for the employee-mother; (3) leave if medically appropriate to care for a member of the employee's immediate family, i.e., a spouse or children; (4) leave for adoption or for foster care leading to adoption; <u>and (5) safe leave provisions for those experiencing any instances of violence, including but not limited to intimate partner violence, sexual violence or coercion, and stalking</u>. Such periods of leave may differ with respect to each of the foregoing classifications, and may vary with reasonable categories of employers. Such policies should encourage voluntary programs by employers and may provide for appropriate legislation (with or without financial assistance from government). Any legislative proposals will be reviewed through the Association's normal legislative process for appropriateness, taking into consideration all elements therein, including classifications of employees and employers, reasons for the leave, periods of leave recognized (whether paid or unpaid), obligations on return from leave, and other factors involved in order to achieve reasonable objectives recognizing the legitimate needs of employees and employers.</p>
270.048MSS	Expanding Employee Leave to Include Miscarriage and Stillbirth	<p>AMA-MSS will ask (1) that our AMA amends Policy H-405.960, "Policies for Parental, Family, and Medical Necessity Leave":</p> <p>Policies for Parental, Family and Medical Necessity Leave H-405.960</p> <p>AMA adopts as policy the following guidelines for, and encourages the implementation of, Parental, Family and Medical Necessity Leave for Medical Students and Physicians:</p> <p>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</p>

		<p>policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement.</p> <p>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; <u>and (j) leave policy for miscarriage or stillbirth.</u></p> <p>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.</p> <p>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.</p> <p>5. Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave.</p> <p>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.</p> <p>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; <u>(c) duration of leave allowed after miscarriage or stillbirth;</u> (e)(d) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); (d)(e) whether leave is paid or unpaid; (e)(f) whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (f)(g) whether sick leave and vacation time may be accrued from year to year or used in advance; (g)(h) extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (h)(i) how time can be made up in order for a resident physician to be considered board eligible; (i)(j) what period of leave would result in a resident physician being required to complete an extra or delayed year of training; (j)(k) whether time spent in making up a leave will be paid; and (k)(l) whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling.</p> <p>8. Our AMA endorses the concept of equal parental leave for birth, <u>stillbirth, miscarriage,</u> and adoption as a benefit for resident physicians, medical students, and physicians in practice regardless of gender or gender identity.</p> <p>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.</p> <p>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.</p> <p>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</p>
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		<p>these residents a complete list of requirements to be completed in order to retain board eligibility.</p> <p>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.</p> <p>14. These policies as above should be freely available online and in writing to all applicants to medical school, residency or fellowship.</p> <p>And (2) that our AMA amends H-420.979 “AMA Statement on Family and Medical Leave” due to the prevalence of miscarriage and stillbirth and the need for physical and psychological healing afterwards, as follows:</p> <p>AMA Statement on Family and Medical Leave H-420.979</p> <p>Our AMA supports policies that provide employees with reasonable job security and continued availability of health plan benefits in the event leave by an employee becomes necessary due to documented medical conditions. Such policies should provide for reasonable periods of paid or unpaid: (1) medical leave for the employee, including pregnancy, miscarriage, and stillbirth;</p> <p>(2) maternity leave for the employee-mother;</p> <p>(3) leave if medically appropriate to care for a member of the employee's immediate family, i.e., a spouse or children; and</p> <p>(4) leave for adoption or for foster care leading to adoption. Such periods of leave may differ with respect to each of the foregoing classifications, and may vary with reasonable categories of employers. Such policies should encourage voluntary programs by employers and may provide for appropriate legislation (with or without financial assistance from government). Any legislative proposals will be reviewed through the Association's normal legislative process for appropriateness, taking into consideration all elements therein, including classifications of employees and employers, reasons for the leave, periods of leave recognized (whether paid or unpaid), obligations on return from leave, and other factors involved in order to achieve reasonable objectives recognizing the legitimate needs of employees and employers.</p>
270.049MSS	Amendment to Policy H-405.960, Policies for Parental, Family, and Medical Necessity Leave	<p>AMA-MSS will ask that our AMA amend Policies for Parental, Family and Medical Necessity Leave H-405.960 as follows:</p> <p>Policies for Parental, Family and Medical Necessity Leave, H-405.960</p> <p>AMA adopts as policy the following guidelines for, and encourages the implementation of, Parental, Family and Medical Necessity Leave for Medical Students and Physicians:</p> <p>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.</p> <p>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.</p>

	<p>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.</p> <p>4. Our AMA encourages <u>medical schools</u>, 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.</p> <p>5. Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave.</p> <p>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.</p> <p>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.</p> <p><u>8. Medical schools should develop written policies on parental leave, family leave, and medical leave for medical students. Such written policies should include the following elements: (a) leave policy for birth, adoption, stillbirth, or miscarriage; (b) duration of leave allowed before and after delivery; (c) extended leave for medical students with extraordinary and long-term personal or family medical tragedies, without loss of previously accepted medical school seats, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (d) how time can be made up in order for a medical students to be eligible for graduation without delays; (e) what period of leave would result in a medical student being required to complete an extra or delayed year of training; and (f) whether schedule accommodations are allowed, such as modified rotation schedules, no night duties, and flexibility with academic testing schedules.</u></p> <p>8-9. 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.</p> <p>9-10. 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. 11. Physicians should be able to return to their</p> <p>10-11. 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.</p>
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		<p>44. 12. 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.</p> <p>42. 13. Our AMA encourages flexibility in residency training programs and medical schools incorporating parental leave and alternative schedules for pregnant trainees/house staff.</p> <p>43. 14. 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.</p> <p>44. 15. These policies as above should be freely available online and in writing to all current trainees and applicants to medical school, residency or fellowship.</p>
310.002MSS	Parental Leave Benefits for House Staff	<p>AMA-MSS will ask the AMA to support greater flexibility in residency training programs for parental leave and alternative residency training schedules for pregnant house staff.</p>
310.049MSS	Equal Paternal and Maternal Leave for Medical Residents	<p>That our AMA amend policy H-405.960 by insertion and deletion as follows:</p> <p>H-405.960 Policies for Maternity, Family and Medical Necessity Leave</p> <p>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 <u>and paternity</u> 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; <u>and</u> (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 <u>and paternity</u> leave without the loss of status. (4) Our AMA encourages residency programs, specialty boards, and medical group practices to incorporate into their maternity <u>and paternity</u> 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,</p>

		<p>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 (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.</p>
295.207MSS	Family Planning for Medical Students	<p>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 parental 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; and (3) supports medical schools providing six weeks of parental leave for medical students of all genders, 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.</p>

Appendix C. MSS Positions Consolidated by Resolve 3

MSS Position Number	Title	Position
Consolidated Position	Increased Education and Access to Fertility Resources for U.S. Trainees	<p>The AMA-MSS:</p> <p>(1) supports the development of initiatives inclusive of sexual orientation and gender identity by the Association of American Medical Colleges, American Association of Colleges of Osteopathic Medicine, medical schools, residency and fellowship programs, and other appropriate organizations in medical education that promote a</p>

		<p>culture that is supportive of their medical students and trainees who are parents and to provide openly and easily accessible guidelines and information to prospective and current students regarding family planning including raising awareness about:</p> <p>(a) how peak child-bearing years correspond to the peak career-building years for many medical students and trainees;</p> <p>(b) the significant decline in oocyte quality and quantity and increase in miscarriage and infertility rates, with increasing age in medical students and trainees;</p> <p>(c) the high rate of infertility among medical students, trainees, and physicians;</p> <p>(d) various fertility preservation options and including cryopreservation of oocytes and sperm and associated costs; and work with relevant organizations to increase access to strategies by which medical students and trainees can preserve fertility (such as cryopreservation of oocytes, sperm, and embryos), with associated mechanisms for insurance coverage;</p> <p>(e) breastfeeding policies, accommodations during pregnancy, and resources for childcare that span the institution and surrounding area;</p> <p>(2) urge academic and private hospitals and employers to offer counseling for family planning options such as gamete cryopreservation and in vitro fertilization, for medical residents, fellows, and physicians.</p>
305.094MSS	Increased Education and Access to Fertility Resources for U.S. Medical Students	<p>AMA-MSS will ask our AMA to work with the Association of American Medical Colleges and other appropriate organizations to develop gender- and sexual minority-inclusive initiatives in medical education that raise awareness about</p> <p>(1) how peak child-bearing years correspond to the peak career-building years for many medical students and trainees;</p> <p>(2) the significant decline in oocyte quality and quantity and increase in miscarriage and infertility rates, with increasing age in medical students and trainees;</p> <p>(3) the high rate of infertility among medical students, trainees, and physicians; and</p> <p>(4) various fertility preservation options and including cryopreservation of oocytes and sperm and associated costs; and work with relevant organizations to increase access to strategies by which medical students can preserve fertility (such as cryopreservation of oocytes, sperm, and embryos), with associated mechanisms for insurance coverage.</p>
295.207MSS	Family Planning for Medical Students	<p>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 parental 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; and (3) supports medical schools providing six weeks of parental leave for medical students of all genders, 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.</p>

295.239MSS	Increased Education and Access to Fertility-Related Resources for U.S. Physicians	AMA-MSS will (1) work with appropriate stakeholders to develop gender and sexuality inclusive educational initiatives for medical trainees of all levels to raise awareness about the high rate of physician infertility, family planning options including cryopreservation, and the financial implications of fertility management and (2) urge academic and private hospitals and employers to offer family planning resources and counseling for options such as gamete cryopreservation and in vitro fertilization, for medical residents, fellows, and physicians.
295.233MSS	Support for Family Planning for Medical Students	AMA-MSS continues to support family leave related policies brought forth by other delegations so as not to diminish incremental advancement in advocacy related to the topic.

Appendix D. MSS Positions Related to Leave that were NOT Consolidated

MSS Position Number	Title	Position
65.051MSS	Cultural Leave for American Indian Trainees	<p>Amendments to Summarize and Convert Language to Past Tense: AMA-MSS will asked the AMA to (1) amend Policy H-310.923, Eliminating Religious Discrimination from Residency Programs, by addition and deletion as follows:</p> <p>H-310.923 – ELIMINATING RELIGIOUS AND CULTURAL DISCRIMINATION FROM RESIDENCY AND FELLOWSHIP PROGRAMS AND MEDICAL SCHOOLS Our AMA encourages residency programs, fellowship programs, and medical schools to: (1) Make an effort to accommodate Allow residents trainees to take leave and attend religious and cultural holidays and observances, including those practiced by American Indians and Alaskan Natives, provided that patient care and the rights of other residents trainees are not compromised; and (2) explicitly inform applicants and entrants about their policies and procedures related to accommodation for religious <u>and cultural</u> holidays and observances.</p> <p>(2) AMA-MSS will asked the AMA to work with the Association of American Indian Physicians, Association of Native American Medical Students, and other appropriate stakeholders to design model cultural leave policies for undergraduate and graduate medical education programs and healthcare employers.</p> <p>Updated Language: AMA-MSS asked the AMA to (1) encourage residency programs, fellowship programs, and medical schools to: allow trainees to take leave and attend religious and cultural holidays and observances, including those practiced by American Indians and Alaskan Natives, provided that patient care and the rights of other residents trainees are not compromised; and explicitly inform applicants and entrants about their policies and procedures related to accommodation for religious and cultural holidays and observances.</p> <p>(2) AMA-MSS asked the AMA to work with the Association of American Indian Physicians, Association of Native American Medical Students, and other appropriate stakeholders to design model cultural leave policies for undergraduate and graduate medical education programs and healthcare employers.</p>

295.140MSS	Written Maternity Policies: A New LCME Accreditation Standard	AMA-MSS will urge the Liaison Committee on Medical Education to add maternity, paternity, and adoption leave policies as an accreditation standard or annotation.
295.197MSS	Support for the Study of the Timing and Causes for Leave of Absence and Withdrawal from United States Medical Schools	Amendments to Convert Language to Past Tense: AMA-MSS will-asked the AMA to support the study of factors surrounding leaves of absence and withdrawal from allopathic and osteopathic medical undergraduate and graduate education programs, including the timing of and reasons for these actions, as well as the sociodemographic information of the students involved.
310.058MSS	Reporting of Residency Demographic Data	Amendments to Convert Language to Past Tense: AMA-MSS will-asked the AMA to: (1) work with appropriate stakeholders to encourage that residency programs annually publish and share with FREIDA and other appropriate stakeholders, (a) demographic data, including but not limited to the composition of their program over the last 5 years by age, gender identity, URM status, and LGBTQIA+ status; (b) parental and family leave policies; and (c) the number and/or proportion of residents who have utilized parental or family leave in the past 5 years; and (2) encourage the Accreditation Council for Graduate Medical Education and other relevant stakeholders to annually collect data on pregnancy, childbirth, and parenthood from all accredited US residency programs and publish this data with disaggregation by gender identity and specialty.

REPORT OF THE MEDICAL STUDENT SECTION
GOVERNING COUNCIL

MSS GC Report F
(A-24)

Subject: MSS Firearm Positions Consolidation

Presented by: MSS Governing Council

Referred to: MSS Reference Committee
(Caitlin Blaukovitch and Shaminy Manoranjithan, Co-Chairs)

1 **INTRODUCTION**

2
3 MSS Position 630.044MSS, "Sunset Mechanism for AMA-MSS Policy," states "the MSS Governing Council
4 may recommend policies for consolidation as part of the sunset review process." This clause was amended
5 into this policy at MSS A-23, but was derived from a similar policy that was sunset at A-23, 645.023MSS,
6 "Medical Student Section Policy Making Procedures." This policy was actually even stronger and stated,
7 "[a]s part of its annual review of MSS policies set to sunset... the MSS Governing Council will undertake
8 policy consolidation for at least one issue," implying that prior to last year, this was intended to be an explicit
9 directive to Governing Councils and not just an enumerated power.

10
11 However, for several years, no Governing Council has undertaken any consolidations as described, despite
12 this policy being reaffirmed during that period, demonstrating that this policy had not been followed as
13 directed. Therefore, as this year's Governing Council would be the first to undertake any consolidations in
14 a long period of time, we decided to compensate and undertake consolidations of multiple issues.

15
16 The intent of these consolidations is to streamline our new MSS Positions Compendium and make the
17 identification and comprehension of MSS positions clearer and more accessible for all members, especially
18 new students learning about AMA and MSS processes. In this report, the MSS Governing Council presents
19 a consolidation of MSS positions related to firearms. After thorough review of the current MSS Digest of
20 Actions, your MSS Governing Council recommends consolidation of the following positions while capturing
21 the original intent and function of the current positions.

22
23 **DISCUSSION**

24
25 MSS Positions that overlapped significantly in content and/or function were consolidated together. The
26 appendices at the end of this report provide a color-coded mapping of the consolidated MSS position onto
27 the current MSS positions.

28
29 **RECOMMENDATIONS**

30
31 Thus, your MSS Governing Council recommends that the following recommendations be adopted and the
32 remainder of this report be filed:

33
34 RESOLVED, the following MSS Positions:

- 35 ● 145.001MSS Handgun Violence
- 36 ● 145.009MSS Regulation of Handgun Safety and Quality
- 37 ● 145.012MSS Use of Individualized Violence Risk Assessments in Reporting of Mental Health
38 Professionals for Firearm Background Checks
- 39 ● 145.013MSS Strengthening our Gun Policies on Background Checks and the Mentally Ill
- 40 ● 145.015MSS Expansion of Federal Gun Restriction Laws to Include Dating Partners and
41 Convicted Stalkers

- 1 ● 145.016MSS Opposition to Armed Campuses
- 2 ● 145.017MSS Increasing the Legal Age of Purchasing Ammunition and Firearms from 18 to 21
- 3 ● 145.018MSS Development and Implementation of guidelines for Responsible Media Coverage of
- 4 Mass Shootings
- 5 ● 145.019MSS Increasing Firearm Safety to Prevent Accidental Child Deaths
- 6 ● 145.020MSS Opposing Unregulated, Non-Commercial Firearm Manufacturing
- 7 ● 145.021MSS Support for Warning Labels on Firearm Ammunition Packaging
- 8 ● 145.022MSS AMA Funding of Political Candidates who Oppose Research-Backed Firearm
- 9 Regulations
- 10 ● 145.024MSS Amendment to AMA Policy Firearms and High-Risk Individuals H-145.972 to
- 11 Include Medical Professionals as a Party Who Can Petition the Court
- 12 ● 145.025MSS New Policies to Respond to the Gun Violence Public Health Crisis
- 13 ● 145.026MSS Addressing Default Proceed Sales of Firearms
- 14 ● 145.027MSS Addressing 'Stand your Ground' Laws
- 15 ● 145.073MSS Support for Comprehensive Safe Firearm Storage Legislation
- 16 ● 365.004MSS Hospital Workplace and Patient Safety and Weapons
- 17 ● 440.119MSS Further Action to Respond to the Gun Violence Public Health Crisis

18
19 Be consolidated into the new MSS Position:

20 Gun Violence Is a Public Health Crisis

21 Our AMA-MSS recognizes that gun violence is a public health epidemic, and supports evidence-

22 based federal, state, and local approaches to reduce gun violence, including but not limited to the

23 following:

- 24 (1) universal background checks and a mandatory minimum 7-day waiting period for people
- 25 buying guns and/or ammunition through any medium, as well as the prohibition of firearm
- 26 sales to individuals for whom a background check has not been completed;
- 27 (2) strengthening of the National Instant Criminal Background Check System (NICS), including
- 28 opposing the destruction of any incomplete background checks for firearm sales and
- 29 advocating for public annual reporting by relevant agencies on inappropriate firearm sales,
- 30 including number of default proceed sales; number of firearms retrieved from individuals
- 31 after these sales through criminal investigations, across state lines, via or other means;
- 32 and average time passed between background check completion and retrieval;
- 33 (3) mandated reporting of patients with mental illnesses who pose a risk to themselves or
- 34 others and procedures by which physicians and other medical professionals, in partnership
- 35 with appropriate stakeholders, can contribute to the inception and development of petitions
- 36 to a court for firearm removal when a high or imminent risk of violence is present;
- 37 (4) individualized violence risk assessments by mental health professionals , rather than
- 38 categorical exclusion criteria, in reports to state or federal authorities for firearm
- 39 background checks;
- 40 (5) expanding prohibitions on firearm purchases to include individuals subject to domestic
- 41 violence restraining orders, convicted stalkers, and persons charged with domestic
- 42 violence and intimate partner violence even if no legal relationship exists;
- 43 (6) prohibition of the inheritance, gifting, or transfer of ownership of firearms without adhering
- 44 to all federal and state requirements for background checks, waiting periods, and licensure;
- 45 (7) prohibition of "multiple sales" of firearms, defined as the sale of multiple firearms to the
- 46 same purchaser within five business days;
- 47 (8) bans on the possession, unsupervised use, and purchase of firearms and ammunition by
- 48 youths under the age of 21;
- 49 (9) bans on the presence of firearms on school campuses;
- 50 (10) federal and state comprehensive safe storage laws and child access prevention laws;
- 51 (11) evidence-based community firearm violence interruption programs and hospital-based
- 52 violence interruption programs;
- 53 (12) strict federal regulation of the manufacture, sale, importation, distribution, and licensing of
- 54 firearms and their component parts;

- 1 (13) bans on: a) the unregulated, non-commercial firearm manufacturing, such as via 3-D
2 printing, regardless of the material composition or detectability of such weapons; and b)
3 the production and distribution of 3-D firearm blueprints;
- 4 (14) application of the same quality and safety standards to both domestically manufactured
5 and imported firearms;
- 6 (15) smart gun technology on all firearms that only allows the lawful owner to use the weapon;
- 7 (16) use of taxes on firearm and ammunition sales to cover medical bills for victims of handgun
8 violence and to fund public education on violence prevention;
- 9 (17) requirements that packaging for any firearm ammunition produced in, sold in, or exported
10 from the United States carry a legible, boxed warning that includes, at a minimum (a) text-
11 based statistics and/or graphic picture- based warning labels related to the risks, harms,
12 and mortality associated with firearm ownership and use, and (b) explicit recommendations
13 that ammunition be stored securely and separately from firearms;
- 14 (18) restrictions on the use of deadly force by firearm under "Stand Your Ground" laws when it
15 can be reasonably avoided;
- 16 (19) development of guidelines by the Centers for Disease Control and Prevention, the National
17 Institute of Mental Health, the Associated Press Managing Editors, the National Press
18 Photographers Association, and other relevant organizations for media coverage of mass
19 shootings in a manner unlikely to provoke additional incidents;
- 20 (20) restrictions on guns and tasers in civilian healthcare delivery settings and comprehensive
21 training of security personnel focusing on patient safety and empathy; and
- 22 (21) refusal by all candidates for public office of contributions from any organization that
23 opposes public health measures to reduce firearm violence.
24

25 Our AMA-MSS asked the AMA to support many of these approaches as well and furthermore asked
26 the AMA to convene a task force for the purposes of working with advocacy groups and other
27 relevant stakeholders to advocate for federal, state, and local efforts to end the gun violence public
28 health crisis; identifying and supporting evidence-based community interventions to prevent gun
29 injury, trauma, and death; monitoring federal, state, and local legislation, regulation, and litigation
30 relating to gun violence; and reporting annually to the House of Delegates on the AMA's efforts to
31 reduce gun violence.
32 and be it further
33

34 RESOLVED, the following MSS Positions:

- 35 ● 145.004MSS Prevention of Unintentional Firearm Accidents in Children
- 36 ● 145.011MSS Gun Safety Counseling in Undergraduate Medical Education
- 37 ● 145.014MSS Preventing Fire-Arm Related Injury and Morbidity in Youth
- 38 ● 145.023MSS Amend H-145.976, to Reimburse Physicians for Firearm Counseling
- 39 ● 295.209MSS Addressing the Need for Firearm Safety in Medical School Curricula
40

41 Be consolidated into new MSS Position:

42 Firearm Safety Education and Counseling

43 Our AMA-MSS asked the AMA to support evidence-based efforts to increase education and patient
44 counseling to reduce gun violence, including but not limited to the following:

- 45 (1) collaboration with relevant parties to increase firearm safety education, including with
46 firearm owners and training organizations to develop and distribute materials appropriate
47 for the clinical setting;
- 48 (2) the inclusion of gun violence epidemiology, firearm safety education, and patient
49 counseling strategies in undergraduate medical education and the development of
50 modules by the Association of American Medical Colleges, Agency for Healthcare
51 Research and Quality, and other relevant organizations, on topics including but not limited
52 to:
 - 53 (a) inquiring as to the presence of household firearms as a part of childproofing the
54 home;
 - 55 (b) educating patients to the dangers of firearms to children;

- 1 (c) encouraging patients to educate their children and neighbors as to the dangers of
- 2 firearms;
- 3 (d) routinely reminding patients to obtain firearm safety locks and store firearms under
- 4 lock and key;
- 5 (3) reimbursement structures that incentivize physicians to counsel patients on firearm safety;
- 6 and
- 7 (4) laws against the restriction of evidence-based firearm safety counseling by physicians,
- 8 other health professionals, and medical students.

Appendix A. MSS Positions Consolidated by Resolve 1.

Position #	Title	Position
Consolidated Position	<u>Gun Violence Is a Public Health Crisis</u>	<p><u>Gun Violence Is a Public Health Crisis</u> Our AMA-MSS recognizes that gun violence is a public health epidemic, and supports evidence-based federal, state, and local approaches to reduce gun violence, including but not limited to the following:</p> <ol style="list-style-type: none"> (1) universal background checks and a mandatory minimum 7-day waiting period for people buying guns and/or ammunition through any medium, as well as the prohibition of firearm sales to individuals for whom a background check has not been completed; (2) strengthening of the National Instant Criminal Background Check System (NICS), including opposing the destruction of any incomplete background checks for firearm sales and advocating for public annual reporting by relevant agencies on inappropriate firearm sales, including number of default proceed sales; number of firearms retrieved from individuals after these sales through criminal investigations, across state lines, via or other means; and average time passed between background check completion and retrieval; (3) mandated reporting of patients with mental illnesses who pose a risk to themselves or others and procedures by which physicians and other medical professionals, in partnership with appropriate stakeholders, can contribute to the inception and development of petitions to a court for firearm removal when a high or imminent risk of violence is present; (4) individualized violence risk assessments by mental health professionals, rather than categorical exclusion criteria, in reports to state or federal authorities for firearm background checks; (5) expanding prohibitions on firearm purchases to include individuals subject to domestic violence restraining orders, convicted stalkers, and persons charged with domestic violence and intimate partner violence even if no legal relationship exists; (6) prohibition of the inheritance, gifting, or transfer of ownership of firearms without adhering to all federal and state requirements for background checks, waiting periods, and licensure; (7) prohibition of “multiple sales” of firearms, defined as the sale of multiple firearms to the same purchaser within five business days; (8) bans on the possession, unsupervised use, and purchase of firearms and ammunition by youths under the age of 21; (9) bans on the presence of firearms on school campuses; (10) federal and state comprehensive safe storage laws and child access prevention laws; (11) evidence-based community firearm violence interruption programs and hospital-based violence interruption programs; (12) strict federal regulation of the manufacture, sale, importation, distribution, and licensing of firearms and their component parts; (13) bans on: a) the unregulated, non-commercial firearm manufacturing, such as via 3-D printing, regardless of the material composition or detectability of such weapons; and b) the production and distribution of 3-D firearm blueprints; (14) application of the same quality and safety standards to both domestically manufactured and imported firearms; (15) smart gun technology on all firearms that only allows the lawful owner to use the weapon;

		<p>(16) use of taxes on firearm and ammunition sales to cover medical bills for victims of handgun violence and to fund public education on violence prevention;</p> <p>(17) requirements 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 firearms;</p> <p>(18) restrictions on the use of deadly force by firearm under "Stand Your Ground" laws when it can be reasonably avoided;</p> <p>(19) development of guidelines by the Centers for Disease Control and Prevention, the National Institute of Mental Health, the Associated Press Managing Editors, the National Press Photographers Association, and other relevant organizations for media coverage of mass shootings in a manner unlikely to provoke additional incidents;</p> <p>(20) restrictions on guns and tasers in civilian healthcare delivery settings and comprehensive training of security personnel focusing on patient safety and empathy; and</p> <p>(21) refusal by all candidates for public office of contributions from any organization that opposes public health measures to reduce firearm violence.</p> <p>Our AMA-MSS asked the AMA to support many of these approaches as well and furthermore asked the AMA to convene a task force for the purposes of working with advocacy groups and other relevant stakeholders to advocate for federal, state, and local efforts to end the gun violence public health crisis; identifying and supporting evidence-based community interventions to prevent gun injury, trauma, and death; monitoring federal, state, and local legislation, regulation, and litigation relating to gun violence; and reporting annually to the House of Delegates on the AMA's efforts to reduce gun violence.</p>
145.001MSS	Handgun Violence	<p>The AMA-MSS recognizes that handgun violence and accidents represent a significant public health hazard, and supports the following methods of addressing this hazard:</p> <p>(1) strict federal regulation of the manufacture, sale, importation, distribution, and licensing of handguns and their component parts, including a mandatory 7-day waiting period and police background check for all handgun purchases;</p> <p>(2) supports the taxation of handgun and handgun ammunition sales to be used to help cover medical bills for the victims of handgun violence and to fund public education on the prevention of violence; and</p> <p>(3) educational programs that can demonstrate a reduction in the deaths and injuries caused by handguns.</p>
145.009MSS	Regulation of Handgun Safety and Quality	<p>AMA-MSS will ask the AMA to support legislation that seeks to apply the same quality and safety standards to domestically manufactured handguns that are currently applied to imported handguns.</p>
145.012MSS	Use of Individualized Violence Risk Assessments in Reporting of Mental Health Professionals for Firearm Background Checks	<p>AMA-MSS encourages mental health professionals to use individualized violence risk assessments, rather than categorical exclusion criteria, in reports to state or federal authorities for firearm background checks.</p>

145.013MSS	Strengthening our Gun Policies on Background Checks and the Mentally Ill	AMA- MSS (1) supports strengthening of the National Instant Criminal Background Check System (NICS) and encourages states to mandate reporting patients with mental illnesses who pose a risk to themselves or others so that their gun licenses can be suspended and their firearms removed until they are deemed fit; (2) encourages the use of smart gun technology on all firearms so that only the lawful owner can discharge a weapon; and (3) supports universal background checks for people buying guns through any medium.
145.015MSS	Expansion of Federal Gun Restriction Laws to Include Dating Partners and Convicted Stalkers	AMA-MSS supports legislation that would expand the current federal prohibitions on firearm purchases to include individuals subject to domestic violence restraining orders, convicted stalkers, and persons charged with domestic violence and intimate partner violence even if no legal relationship exists.
145.016MSS	Opposition to Armed Campuses	AMA-MSS opposes an increase of firearms on school campuses.
145.017MSS	Increasing the Legal Age of Purchasing Ammunition and Firearms from 18 to 21	AMA-MSS support bans on the possession, unsupervised use, and purchase of firearms and ammunition by youths under the age of 21.
145.018MSS	Development and Implementation of guidelines for Responsible Media Coverage of Mass Shootings	AMA-MSS will ask the AMA to encourage the Center for Disease Control, the National Institute of Mental Health, the Associated Press Managing Editors, the National Press Photographers Association, and other relevant organizations to develop guidelines for media coverage of mass shootings in a manner that is unlikely to provoke additional incidents.
145.019MSS	Increasing Firearm Safety to Prevent Accidental Child Deaths	AMA-MSS will ask the AMA to advocate for enactment of Child Access Prevention (CAP) Laws in all 50 states.
145.020MSS	Opposing Unregulated, Non-Commercial Firearm Manufacturing	AMA-MSS will ask the AMA to (1) support legislation that opposes: a) unregulated, non-commercial firearm manufacturing, such as via 3-D printing, regardless of the material composition or detectability of such weapons; b) production and distribution of 3-D firearm blueprints; and (2) issue a statement of concern to Congress and the Bureau of Alcohol, Tobacco, Firearms and Explosives regarding the manufacturing of firearms using 3-D printers and the online dissemination of 3-D firearm blueprints as a public health issue.
145.021MSS	Support for Warning Labels on Firearm Ammunition Packaging	AMA-MSS will ask the AMA to support 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 firearms.
145.022MSS	AMA Funding of Political Candidates who Oppose Research-Backed Firearm Regulations	AMA-MSS will ask the AMA to amend policy G-640.020 as follows: G-640.020 – Political Action Committees and Contributions Our AMA: (1) Believes that better-informed and more active citizens will result in better legislators, better government, and better health care; (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

		<p>AMPAC 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 and 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; and (9) <u>Calls upon all candidates for public office to refuse contributions from any organization that opposes public health measures to reduce firearm violence.</u></p>
145.024MSS	<p>Amendment to AMA Policy Firearms and High-Risk Individuals H-145.972 to Include Medical Professionals as a Party Who Can Petition the Court</p>	<p>AMA-MSS will ask the AMA to (1) work with relevant stakeholders to develop state-specific training programs for medical professionals on how to use Extreme Risk Protection Order/Red Flag Laws;</p> <p>(2) work with relevant stakeholders to update medical curricula with training surrounding how to approach conversations about Extreme Risk Protection Order/Red Flag laws with patients and families; and</p> <p>(3) supports amending policy "Firearms and High-Risk Individuals H-145.972" by addition to read:</p> <p>Firearms and High-Risk Individuals H-145.972 Our AMA supports: (1) the establishment of laws allowing family members, intimate partners, household members, and state, federal and tribal law enforcement personnel to petition a court for the removal of a firearm when there is a high or imminent risk for violence;</p> <p><u>(2) the establishment of laws and procedures through which physicians and other medical professionals can, in partnership with appropriate stakeholders, contribute to the inception and development of such petitions;</u></p> <p>(2)(3) prohibiting persons who are under domestic violence restraining orders, convicted of misdemeanor domestic violence crimes or stalking, from possessing or purchasing firearms; (3)(4) expanding domestic violence restraining orders to include dating partners;</p> <p>(4)(5) requiring states to have protocols or processes in place for requiring the removal of firearms by prohibited persons;</p> <p>(5)(6) requiring domestic violence restraining orders and gun violence restraining orders to be entered into the National Instant Criminal Background Check System; and</p> <p>(6)(7) efforts to ensure the public is aware of the existence of laws that allow for the removal of firearms from high-risk individuals.</p>
145.025MSS	<p>New Policies to Respond to the Gun Violence Public Health Crisis</p>	<p><u>The AMA-MSS will ask the AMA to (1) support evidence-based community firearm violence interruption programs and hospital-based violence interruption programs;</u></p> <p><u>(2) advocate for federal and state policies that prevent inheritance, gifting, or transfer of ownership of firearms without adhering to all federal and state requirements for background checks, waiting periods, and licensure;</u></p> <p><u>(3) advocate for federal and state policies to prevent "multiple sales" of firearms, defined as the sale of multiple firearms to the same purchaser within five business days; and (4) advocate for federal and state policies implementing background checks for ammunition purchases.</u></p>

145.026MSS	Addressing Default Proceed Sales of Firearms	<p>That our AMA amend "Firearm Availability H-145.996" by addition as follows: Firearm Availability H-145.996 1. Our AMA: (a) advocates a waiting period and background check for all firearm purchasers; (b) encourages legislation that enforces a waiting period and background check for all firearm purchasers; (c) opposes firearm sales to individuals for whom a background check has not been completed; (d) opposes destruction of any incomplete background checks for firearm sales; (e) advocates for public annual reporting by relevant agencies on inappropriate firearm sales, including number of default proceed sales; number of firearms retrieved from individuals after these sales through criminal investigations, across state lines, via or other means; and average time passed between background check completion and retrieval; and (f) urges legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic, ceramics, or other nonmetallic materials that cannot be detected by airport and weapon detection devices. 2. Our AMA supports requiring the licensing/permitting of firearms-owners and purchasers, including the completion of a required safety course, and registration of all firearms. 3. Our AMA supports "gun violence restraining orders" for individuals arrested or convicted of domestic violence or stalking, and supports extreme risk protection orders, commonly known as "red-flag" laws, for individuals who have demonstrated significant signs of potential violence. In supporting restraining orders and "red-flag" laws, we also support the importance of due process so that individuals can petition for their rights to be restored. 4. Our AMA advocates for (a) federal and state policies that prevent inheritance, gifting, or transfer of ownership of firearms without adhering to all federal and state requirements for background checks, waiting periods, and licensure; (b) federal and state policies to prevent "multiple sales" of firearms, defined as the sale of multiple firearms to the same purchaser within five business days; and (c) federal and state policies implementing background checks for ammunition purchases.</p>
145.027MSS	Addressing 'Stand your Ground' Laws	<p>That our AMA-MSS support efforts to restrict the use of deadly force by firearm under "Stand Your Ground" laws when it can be reasonably avoided. (MSS Res. OF001, I-23)</p>
145.073MSS	Support for Comprehensive Safe Firearm Storage Legislation	<p>AMA-MSS will ask the AMA to amend "Prevention of Firearm Accidents in Children" H-145.990 by addition to read as follows. Prevention of Firearm Accidents in Children H-145.990 1) Our AMA (a) supports increasing efforts to reduce pediatric firearm morbidity and mortality by encouraging its members to (i) inquire as to the presence of household firearms as a part of childproofing the home; (ii) educate patients to the dangers of firearms to children; (iii) encourage patients to educate their children and neighbors as to the dangers of firearms; and (iv) routinely remind patients to obtain firearm safety locks, to store firearms under lock and key, and to store ammunition separately from firearms;(b) encourages state medical societies to work with other organizations to increase public education about firearm safety; (c) encourages organized medical staffs and other physician organizations, including state and local medical societies, to recommend programs for teaching firearm safety to children; and (d) supports enactment of Child Access Prevention laws and other types of comprehensive safe storage laws that are consistent with AMA policy. 2) Our AMA and all interested medical societies will (a) educate the public about: (b) best practices for firearm storage safety; (c) misconceptions families have regarding child response to encountering a firearm in the home; and (c) the need to ask other families with whom the child interacts regarding the presence and storage of firearms in other homes the child may enter.</p>

365.004MSS	Hospital Workplace and Patient Safety and Weapons	(1) AMA-MSS supports policies which restrict guns and Tasers in civilian health care delivery settings and (2) AMA-MSS supports comprehensive training of security personnel that focus on patient safety and empathy.
440.119MSS	Further Action to Respond to the Gun Violence Public Health Crisis	<p>AMA-MSS will ask that our AMA convene a task force for the purposes of working with advocacy groups and other relevant stakeholders to advocate for federal, state, and local efforts to end the gun violence public health crisis; identifying and supporting evidence-based community interventions to prevent gun injury, trauma, and death; monitoring federal, state, and local legislation, regulation, and litigation relating to gun violence; and reporting annually to the House of Delegates on the AMA's efforts to reduce gun violence.</p> <p>Rationale: This position should be incorporated as it pertains to all the other asks. Even though the AMA has created this Task Force recently, we would NOT recommend sunseting this policy, as the Task Force has only barely begun and is only authorized for 2 years at this time (through the end of 2024), with future reauthorization dependent on action at that time. We believe this position is necessary to ensure that the Task Force is held accountable to all the goals expected of it and to supporting possible reauthorization. We believe placing this with the other firearm positions will also help us understand the various forms of advocacy the Task Force can advance.</p>

Appendix B. MSS Positions Consolidated by Resolve 2.

Position #	Title	Position
Consolidated Position	Firearm Safety Education and Counseling	<p>Our AMA-MSS asked the AMA to support evidence-based efforts to increase education and patient counseling to reduce gun violence, including but not limited to the following:</p> <ul style="list-style-type: none"> (1) collaboration with relevant parties to increase firearm safety education, including with firearm owners and training organizations to develop and distribute materials appropriate for the clinical setting; (2) the inclusion of gun violence epidemiology, firearm safety education, and patient counseling strategies in undergraduate medical education and the development of modules by the Association of American Medical Colleges, Agency for Healthcare Research and Quality, and other relevant organizations, on topics including but not limited to: <ul style="list-style-type: none"> o inquiring as to the presence of household firearms as a part of childproofing the home; o educating patients to the dangers of firearms to children; o encouraging patients to educate their children and neighbors as to the dangers of firearms; o routinely reminding patients to obtain firearm safety locks and store firearms under lock and key; (3) reimbursement structures that incentivize physicians to counsel patients on firearm safety; and (4) laws against the restriction of evidence-based firearm safety counseling by physicians, other health professionals, and medical students.
145.004MSS	Prevention of Unintentional Firearm Accidents in Children	<p>AMA-MSS will ask the AMA to increase efforts to reduce pediatric firearm morbidity and mortality by encouraging its members: (1) to inquire as to the presence of household firearms as a part of childproofing the home; (2) to educate patients to the dangers of firearms to children; (3) to encourage patients to educate their children and neighbors as to the dangers of</p>

		firearms; and (4) to routinely remind patients to obtain firearm safety locks and store firearms under lock and key; and that the AMA encourage state medical societies to work with other organizations to increase public education about firearm safety.
145.011MSS	Gun Safety Counseling in Undergraduate Medical Education	AMA-MSS will ask the AMA to (1) advocate for the inclusion of strategies for counseling patients on safe gun storage and use in undergraduate medical education; (2) add additional language to AMA Policy H-145.976 prohibiting limitations on the ability of medical students to discuss firearms with patients; and (3) advocate that the Association of American Medical Colleges, Agency for Health, Research and Quality, and other relevant professional medical societies develop gun safety counseling modules to be used in undergraduate medical education.
145.014MSS	Preventing Fire-Arm Related Injury and Morbidity in Youth	AMA-MSS will ask the AMA to collaborate with firearms owners and training organizations to develop and distribute firearm safety materials that are appropriate for the clinical setting.
145.023MSS	Amend H-145.976, to Reimburse Physicians for Firearm Counseling	<p>AMA-MSS will ask the AMA to amend Policy H-145.976, "Firearm Safety Counseling in Physician- Led Health Care Teams," by addition as follows:</p> <p>H-145.976 – FIREARM SAFETY COUNSELING IN PHYSICIAN-LED HEALTH CARE TEAMS</p> <p>1. Our AMA: (a) will oppose any restrictions on physicians' and other members of the physician-led health care team's ability to inquire and talk about firearm safety issues and risks with their patients; (b) will oppose any law restricting physicians' and other members of the physician-led health care team's discussions with patients and their families about firearms as an intrusion into medical privacy; and (c) encourages dissemination of educational materials related to firearm safety to be used in undergraduate medical education.</p> <p>2. Our AMA will work with appropriate stakeholders to develop state-specific guidance for physicians on how to counsel patients to reduce their risk for firearm- related injury or death, including guidance on when and how to ask sensitive questions about firearm ownership, access, and use, and clarification on the circumstances under which physicians are permitted or may be required to disclose the content of such conversations to family members, law enforcement, or other third parties.</p> <p>3. Our AMA will support the development of reimbursement structures that incentivize physicians to counsel patients on firearm-related injury risk and prevention.</p>
295.209MSS	Addressing the Need for Firearm Safety in Medical School Curricula	AMA-MSS will ask the AMA to support the inclusion of gun violence epidemiology and evidence-based firearm-related injury prevention education in medical school curricula.

Subject: Review & Consolidation of Positions Relating to MSS Governance

Presented by: MSS Governing Council

Referred to: MSS Reference Committee
(Caitlin Blaukovitch and Shaminy Manoranjithan, Co-Chairs)

1 **INTRODUCTION**

2

3 MSS Position 630.044MSS, "Sunset Mechanism for AMA-MSS Policy," states "the MSS
4 Governing Council (GC) may recommend policies for consolidation as part of the sunset review
5 process." However, for several years, no major consolidations have been conducted. Therefore,
6 as this year's GC would be the first to undertake any major consolidations in a long period of time,
7 we decided to compensate and undertake consolidations of multiple issues.

8

9 The intent of these consolidations is to streamline our new MSS Positions Compendium and make
10 the identification and comprehension of MSS positions clearer and more accessible for all
11 members, especially new students learning about AMA and MSS processes.

12

13 In this report, the MSS GC presents a consolidation of MSS positions related to MSS governance
14 and also recommends appropriate updates.

15

16 **DISCUSSION**

17

18 After thorough review of the current MSS Digest of Actions, your MSS GC recommends
19 consolidation of 27 of the current governance positions into 6 consolidated positions that capture
20 the original intent and function of the current positions. Notably, several of the former MSS
21 positions were only kept in part or updated to reflect current MSS practices and viewpoints.
22 Additionally, the GC recommended minor additions to the new MSS positions that reflect the goals
23 and spirit of the position. These new MSS positions include:

- 24
- 25 1. Optimizing MSS Communications (*Appendix A*)
 - 26 2. Expanding Programming at MSS Meetings (*Appendix B*)
 - 27 3. Medical Student Participation in State and Local Professional Organizations (*Appendix C*)
 - 28 4. Medical Student Dues, Incentives, and Funding (*Appendix D*)
 - 29 5. Supporting MSS Membership Recruitment and Retention (*Appendix E*)
 - 30 6. Medical Student Training Opportunities in Health Policy and Advocacy (*Appendix F*)

31

32 Of the remaining governance positions that were not considered in other A-24 GC reports, 14
33 were recommended for rescission, 1 position was amended, and 25 were recommended for
34 retention. Rationales for MSS positions recommended for rescission can be found in Appendix
35 G.

36

1 MSS Position 665.014MSS was amended such that AMA-MSS will assess each Region's
2 membership numbers and degree of engagement with the AMA-MSS, including effects on
3 Assembly attendance and quorum and Regional Delegate and Alternate Delegate apportionment,
4 in preparation for or at the time of review for possible revisions of the [MSS Internal Operating](#)
5 [Procedures](#) (IOPs), at least every 5 years and consider potential changes to the region structure
6 (states allocated to each region) to be included in those revisions. Furthermore, Region structures
7 and the list of states in each region are specifically codified in the IOPs. Per the IOPs, the IOPs
8 are now scheduled to be reviewed every 4 years by the MSS. Therefore, any such changes to
9 the region structure would be proposed at that time. Finally, because Region membership
10 numbers dictate apportionment of Regional Delegate and Regional Alternate Delegate numbers
11 for our MSS Caucus in HOD, that has also been included.

12
13 MSS Positions that overlapped significantly in content and/or function were consolidated together.
14 The appendices at the end of this report provide a color-coded mapping of the consolidated MSS
15 position onto the current MSS positions. In addition, your GC discovered numerous MSS positions
16 that no longer serve the Section given improvements and innovations by various GCs over the
17 years. We have recommended those positions for rescission and provided rationale for each in
18 the appendices.

19 20 **RECOMMENDATIONS**

21
22 Your AMA-MSS Governing Council recommends that the following be adopted and the
23 remainder of the report be filed:

24
25 RESOLVED, MSS Position 665.014MSS Region Restructure Assessment During IOP Revision
26 Process be amended by addition and deletion as follows:

27
28 ~~(1) The existing AMA-MSS Region structure will remain unchanged and~~

29
30 ~~(2) the (1) AMA-MSS will annually assess and report to the MSS Assembly each~~
31 ~~Region's membership numbers and degree of engagement with the AMA-MSS,~~
32 ~~including effects on Assembly attendance and quorum and Regional Delegate and~~
33 ~~Regional Alternate Delegate apportionment,~~

34
35 ~~(2) in preparation for or at the time of review for possible revisions of the MSS IOPs a~~
36 ~~comprehensive report will be prepared for the MSS Assembly, least every 5 years to~~
37 ~~explore current barriers to medical student participation in the AMA including but not~~
38 ~~limited to cost and value of membership and conference attendance and consider~~
39 ~~potential changes to the Region structure and function (i.e. state and school delegate~~
40 ~~allocation allocated in each Region) to be included in those revisions; and be it further;~~

41
42 ~~(3) Region bylaws will be reviewed and assessed by each Region annually during the~~
43 ~~leadership transitions and strategic planning process;~~

44
45 RESOLVED, that the recommendations for consolidation actions specified in Appendix A - F of
46 this report be retained as official, active positions of the AMA-MSS;

47
48 RESOLVED, the following MSS Positions:

- 49 1. 630.011MSS Improved Access and Programming of Non-Scientific Issues in Medicine
- 50 2. 630.019MSS MSS Master List of Dates

- 1 3. 630.042MSS Improving AMA-MSS Communication
- 2 4. 640.003MSS States Regional Chairs
- 3 5. 645.013MSS Information for the AMA Medical Student Section Assembly Concerning
- 4 Issues Discussed at the AMA-HOD
- 5 6. 650.002MSS Improved Communications Between MSS and RFS and Between RFS and
- 6 YPS

7
8 be consolidated into the new MSS Position:

9
10 Optimizing MSS Communications

11 AMA-MSS will continue to support and explore strategies to optimize communications
12 with general members, including at minimum:

- 13 (1) Production of an electronic newsletter;
- 14 (2) Maintenance of virtual platforms for direct communication with members (i.e.
15 GroupMe) at the national and regional levels;
- 16 (3) Maintenance of an easily accessible and regularly updated list of important
17 events and deadlines for MSS and AMA activities;
- 18 (4) Maintenance of an easily accessible list of items important to the MSS that will be
19 coming before the AMA House of Delegates, updated before each HOD meeting;
- 20 (5) Maintenance of an easily accessible list of outcomes of items important to the
21 MSS considered at the AMA House of Delegates updated after each House of
22 Delegates meeting;
- 23 (6) Maintenance of an easily accessible list of implementation outcomes of items
24 important to the MSS considered at the AMA House of Delegates upon
25 publication of the annual House of Delegates Follow Up Implementation Report;
- 26 (7) Regular dissemination of information about shared initiatives with other AMA
27 entities;
- 28 (8) Ensure MSS Regions maintain active and timely communication with MSS
29 delegates and other general Region members regarding responsibilities and
30 opportunities; and
- 31 (9) Developing and maintaining a series of free online materials providing detailed
32 information on MSS functions and engagement opportunities;

33
34 and be it further

35
36 RESOLVED, the following MSS Positions:

- 37 7. 630.050MSS Creating a Community Service Project
- 38 8. 645.015MSS Non-Voter Participation During the Assembly Portion of the AMA-MSS
- 39 Annual and Interim Meetings
- 40 9. 645.012MSS Health Policy Programming

41
42 be consolidated into the new MSS Position:

43
44 Expanding Programming at MSS Meetings

45 The MSS Governing Council will continue to explore and implement additional
46 programming for attendees of the MSS Annual and Interim Meetings, including but not
47 limited to health policy educational opportunities, residency fairs, workshops, lectures,
48 community service projects, and networking and social opportunities.

49
50 and be it further

1
2 RESOLVED, the following MSS Positions:

- 3 ● 530.023MSS Equal Opportunity in Professional Affiliations for Physicians
- 4 ● 530.024MSS Medical Student Participation in Professional Organizations
- 5 ● 655.001MSS Student Membership in State Medical Societies
- 6 ● 655.003MSS Dual State Society Membership for Medical Students
- 7 ● 655.002MSS Membership Recruitment Methods

8
9 be consolidated into the new MSS Position:

10 MSS Positions Consolidated by New Position: Medical Student Participation in State and

11 Local

12 Professional Organizations

13 AMA-MSS asked the AMA to support and encourage student membership and
14 participation in state and
15 local medical societies by:

- 16 (1) urging its state medical associations and constituent societies to:
 - 17 (1) review and study membership provisions of their bylaws to maintain fair
 - 18 membership standards for equal access for all physicians and medical
 - 19 students
 - 20 (2) seek the removal of any impediments to student membership;
 - 21 (3) encourage societies to establish student dues that do not exceed 50
 - 22 percent of the national student dues;
 - 23 (4) offer membership options for students who are enrolled in medical school
 - 24 for longer than four years;
 - 25 (5) oppose policy that directly or indirectly restricts or restrains any individual
 - 26 member's freedom of choice with respect to professional societies for
 - 27 which they are eligible;
 - 28 (6) provide all medical students equal access to funding and opportunity
 - 29 within the realm of their society.
 - 30 (7) allow medical students to hold membership in the state society in which
 - 31 they attend medical school and also an associates membership in their
 - 32 state of permanent residence not be counted in determining the number
 - 33 of AMA delegates representing a state.
 - 34 (8) support medical student representation in state delegations to the AMA
 - 35 House of Delegates, with the goal of having a proportional number of
 - 36 delegate seats based on student membership.
- 37 (2) working with the Association of American Medical Colleges to promote medical
- 38 student engagement in professional medical societies, including attendance at
- 39 local, state, and national professional organization meetings, during the pre-
- 40 clinical and clinical years.
- 41
- 42

43 and be it further

44
45
46 RESOLVED, the following MSS Positions:

- 47 ● 530.016MSS Creation of Additional Dues Structure for Resident & Fellow Section
- 48 ● 655.022MSS MD/PhD AMA Membership
- 49 ● 655.017MSS Multi-Year Membership Benefit
- 50 ● 655.004MSS Medical Student Membership Benefits

- 1 ● 655.025MSS Increasing the Efficiency of Student Membership Application Processing

2
3 be consolidated into the new MSS Position:

4
5 Medical Student Dues, Incentives, and Funding

6 Our AMA-MSS asked the AMA to:

- 7 (1) create discounted multi-year dues options for medical students and residents for
8 all program lengths including students and residents who take extra years for
9 additional degrees, research, and other leaves of absence while ensuring that
10 recruitment rebates apply to these options;
- 11 (2) support medical student recruitment efforts by providing a tangible membership
12 benefit linked to the multi-year membership option on a continual annual basis.
- 13 (3) provide benefits, free of charge, to new members processed before January until
14 official membership begins in January according to the AMA calendar.
- 15 (4) provide contact information for AMA staff member responsible for benefit
16 inquiries and grievances;
- 17 (5) continue its internal evaluation of the procedures involved in the processing of
18 student membership applications and take steps to decrease delays and
19 increase service to medical student applicants and members.
- 20 (6) explore mechanisms to mitigate costs associated with medical student
21 participation at national, in-person AMA conferences.

22
23 and be it further

24
25
26 RESOLVED, the following MSS Positions:

- 27 ● 655.002MSS Membership Recruitment Methods
- 28 ● 655.005MSS Recruitment Information in AMA and MSS Pamphlets
- 29 ● 640.003MSS States Regional Chairs
- 30 ● 655.034MSS Study a Need-Based Scholarship to Encourage Medical Student
31 Participation in the AMA
- 32 ● 655.028MSS The Designation of Permanent Membership Positions Within Local AMA-
33 MSS Chapters
- 34 ● 350.019MSS Strengthening AMA-MSS Collaborations with Allied Underrepresented
35 Minority Student Organizations at the Local Chapter Level
- 36 ● 655.015MSS Eligibility of Medical Students to Join the AMA while Enrolled in a
37 JointDegree Program
- 38 ● 630.011MSS Improved Access and Programming of Non-Scientific Issues in Medicine
- 39 ● 655.018MSS Membership Retention into Residency
- 40 ● 655.033MSS Establishing a Joint MSS and RFS Approach for Recruitment Initiatives for
41 Incoming MSS Members to the RFS
- 42 ● 655.024MSS Improving Federated Membership Recruitment and Portability

43
44 be consolidated into the new MSS Position:

45 Supporting MSS Membership Recruitment and Retention

46 Our AMA-MSS Governing Council will support and encourage AMA membership through
47 exploring a variety of recruitment and retention methods and implementing, at minimum,
48 the following strategies:

- 49 (1) supporting offering medical students free membership in the AMA and/or
50 constituent societies;

- 1 (2) stressing and distinguishing the benefits of membership on the national, state,
2 and county/local levels in recruitment materials;
- 3 (3) Collaborating with Region Leadership, Medical Student Outreach Program,
4 Marketing and Membership Experience staff and other appropriate AMA staff to:
5 (a) encourage the development of local MSS chapters and state MSS
6 sections in medical schools and states where they do not exist;
7 (b) involve highly organized MSS chapters and state sections in providing
8 organizational information and assistance to developing chapters and
9 sections;
10 (c) encourage MSS chapters to maintain communication and interaction
11 between medical student members and physician members of county and
12 state medical societies; and
13 (d) ensure every medical school designates a permanent position within their
14 local campus section to be responsible for matters pertaining to
15 membership recruitment and retention throughout the school year, and
16 that the local campus section provides the individual's name and contact
17 information to the MSS Governing Council, pertinent Region Leaders, and
18 AMA Medical Student Section Outreach Program when local campus
19 section leadership transitions, or at least annually.
20 (e) support the collaboration between local chapters and allied medical
21 student organizations to increase underrepresented minority medical
22 student participation in the AMA-MSS including the creation of a local DEI
23 Chair and/or liaisons to national medical student organization chapters at
24 their local institution;
25 (f) use peer-to-peer recruitment to identify and recruit students on an
26 individual basis that are enrolled in joint degree programs and who begin
27 their education in disciplines other than medicine.
28 (g) explore methods of disseminating information from the AMA-MSS to local
29 chapters with the goals of increased access, and program development;
30 (h) develop and promote a series of free online modules and presentation
31 templates on a variety of topics which can be used by general members
32 and local campus section leadership to learn about the MSS and other
33 topics of importance to future physicians;
- 34 (4) explore ways to increase awareness of the Medical Student and Resident &
35 Fellow Sections in order to increase membership retention during the transition to
36 residency through strategic collaboration with (a) the AMA-RFS to focus
37 membership strategies to retain student members and recruit new resident
38 members; and (b) medical school deans to find better means to increase
39 awareness such as targeted informational sessions and increased presence at
40 match day and graduation events.
- 41 (5) supporting the development of a system whereby medical student,
42 resident/fellow, and young physician members of the AMA, state, and county
43 medical societies may rapidly transfer their new or existing memberships to the
44 appropriate state and county medical societies of their new program or practice;

45
46 and be it further

47
48 RESOLVED, the following MSS Positions be rescinded:

- 49 1. 630.049MSS AMA Medical Student Section Vision Statement
50 2. 630.069MSS Developing our Regions

- 1 3. 630.073MSS Voting Rights of MSS Speaker and Vice Speaker
- 2 4. 630.076MSS Sunset Report Update
- 3 5. 640.011MSS Region Chair Elections
- 4 6. 660.001MSS Questions of Parliamentary Procedures
- 5 7. 660.017MSS Campaign Reform
- 6 8. 660.026MSS AMA-MSS: Officers – Nomination, Election, and Tenure
- 7 9. 660.036MSS Creating an AMA-MSS Election Task Force
- 8 10. 660.037MSS Expanding the AMA-MSS Governing Council to Include a Diversity,
9 Equity, &
10 Inclusion Officer
- 11 11. 665.001MSS Strengthening of Regional Internal Operating Procedures (IOPs),
12 Creation of
13 Regional Coordinating Committees, and Creation of Membership/
14 Recruitment Chair for Each Region
- 15 12. 665.012MSS Evaluation of AMA-MSS Region Bylaws
- 16 13. 665.015MSS Reevaluation of AMA-MSS Region Bylaws
- 17 14. 665.017MSS Re-evaluation of AMA-MSS Region Bylaws

18
19 and be it further
20

21 RESOLVED that the following MSS Positions be retained as official, active positions of the AMA-
22 MSS:

- 23 1. 530.003MSS JAMA's Editorial Freedom
- 24 2. 530.004MSS Conference Registration Fees
- 25 3. 530.006MSS Donation of Medical Journals
- 26 4. 530.012MSS Product Endorsements
- 27 5. 530.017MSS Creation of a National Labor Organization for Physicians
- 28 6. 530.020MSS Establishing an AMA International Health Consortium
- 29 7. 530.025MSS Sexual Orientation and Gender Identity Demographic Collection by the
30 AMA and
31 Other Medical Organizations
- 32 8. 530.026MSS Anti-Harassment Training
- 33 9. 530.027MSS Environmental Sustainability of AMA National Meetings
- 34 10. 535.001MSS Commendation to the AMA Board of Trustees
- 35 11. 535.003MSS Disclosure of Funding Sources and Industry Ties of Professional Medical
36 Associations and Patient Advocacy Organizations
- 37 12. 540.002MSS Council Elections and Visibility
- 38 13. 550.008MSS Medical Student Regional Delegate Apportionment
- 39 14. 630.007MSS MSS Resolutions
- 40 15. 630.022MSS Recycling at AMA-MSS Meetings
- 41 16. 630.025MSS Changes in MSS Resolutions Forwarded to the AMA House of Delegates
- 42 17. 630.041MSS Inclusion of AOA-Accredited Schools in Policy Language:
- 43 18. 565.001MSS MSS Political Action
- 44 19. 565.002MSS Preserving the AMA's Grassroots Legislative and Political Mission
- 45 20. 565.003MSS Building AMA-MSS Membership through Promotion of AMPAC and State
46 Medical
47 PACs
- 48 21. 645.001MSS Use of the Term "Assembly"
- 49 22. 645.016MSS Student Academy of the American Academy of Physician Assistants
50 Official

- 1 Observer
- 2 23. 645.019MSS European Medical Student Association (EMSA) – Official Observer
- 3 24. 645.026MSS Advocating for the Continuation of a Fall Meeting of the Medical Student
- 4 Section
- 5 25. 645.031MSS MSS Action Items

Appendix A. MSS Positions Consolidated by New Position: Optimizing MSS Communications		
Position #	Title	Position
Consolidated Position	Optimizing MSS Communications	<p>AMA-MSS will continue to support and explore strategies to optimize communications with general members, including at minimum:</p> <ul style="list-style-type: none"> (1) Production of an electronic newsletter; (2) Maintenance of virtual platforms for direct communication with members (i.e. GroupMe) at the national and regional levels; (3) Maintenance of an easily accessible and regularly updated list of important events and deadlines for MSS and AMA activities; (4) Maintenance of an easily accessible list of items important to the MSS that will be coming before the AMA House of Delegates, updated before each HOD meeting; (5) Regular dissemination of information about shared initiatives with other AMA entities; (6) Ensure MSS Regions maintain active and timely communication with MSS delegates and other general Region members regarding responsibilities and opportunities; and (7) Developing and maintaining a series of free online materials providing detailed information on MSS functions and engagement opportunities;
630.011MSS	Improved Access and Programming of Non-Scientific Issues in Medicine	<p>AMA-MSS will: (1) explore better methods of disseminating information from the AMA-MSS to local chapters with the goals of increased access, and program development; and</p> <p>(2) develop a series of modular programs, which can be used by local chapters to educate their members on topics of importance to future physicians, according to the following guidelines: (a) the information must be flexible, dynamic, accessible and cost effective; (b) a variety of topics could be covered, including medical ethics, legal issues in medicine, the lifestyles of various specialties, medicine and the media, medical economics, etc.</p>
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.
630.042MSS	Improving AMA-MSS Communication	AMA-MSS supports the production of a newsletter for student members in electronic formats.

Appendix A. MSS Positions Consolidated by New Position: Optimizing MSS Communications		
Position #	Title	Position
640.003MSS	States Regional Chairs	<p>AMA-MSS, through Regional Chairs will:</p> <p>(1) continue to encourage the development of local MSS chapters and state MSS sections in medical schools and states where they do not exist;</p> <p>(2) involve highly organized MSS chapters and state sections in providing organizational information and assistance to developing chapters and sections;</p> <p>(3) encourage MSS chapters to maintain communication and interaction between medical student members and physician members of county and state medical societies; and</p> <p>(4) ask the MSS to endorse the maintenance of active and timely communication between MSS delegates and Regional Chairs.</p> <p>Note: The role of the Region Chairs is now codified in the MSS IOPs in Section 8, "MSS Regions." Clause 1 is incorporated into 8.1.2 and 8.1.3.2. Clause 2 is incorporated into 8.1.3.3. Clause 3 is contained in 8.1.3.4. Further the spirit of this position is captured by the new consolidated position "Supporting MSS Membership."</p>
645.013MSS	Information for the AMA Medical Student Section Assembly Concerning Issues Discussed at the AMA-HOD	<p>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.</p>
650.002MSS	Improved Communications Between MSS and RFS and Between RFS and YPS	<p>AMA-MSS will report regularly on communications and shared initiatives with the other AMA Sections.</p>

Appendix B. MSS Positions Consolidated by New Position: Expanding Programming at MSS Meetings		
Position #	Title	Position
Consolidated Position	Expanding Programming at MSS Meetings	The MSS Governing Council will continue to explore and implement additional programming for attendees of the MSS Annual and Interim Meetings, including but not limited to health policy educational opportunities, residency fairs, workshops, lectures, community service projects, and networking and social opportunities.
630.050MSS	Creating a Community Service Project	AMA-MSS will undertake a limited local service project as part of its agenda at its Annual and Interim Meetings, at a time determined by the Governing Council, as appropriate based on the schedule of activities.
645.015MSS	Non-Voter Participation During the Assembly Portion of the AMA-MSS Annual and Interim Meetings	<p>(1) AMA-MSS will continue to sponsor a Community Service project during Business Meetings of Medical Student Section.</p> <p>(2) The AMA-MSS Governing Council will:</p> <p>(a) continue to investigate and implement alternative activities for non-voting participants including but not limited to residency fairs, workshops, and lectures;</p> <p>(b) establish a separate convention committee to organize and implement NSP activities during the meetings; and</p> <p>(c) investigate ways to further promote and expand the activities of the sectional meetings.</p>

Appendix C. MSS Positions Consolidated by New Position: Medical Student Participation in State and Local Professional Organizations		
Position #	Title	Position
Consolidated Position	Medical Student Participation in State and Local Professional	<p>AMA-MSS asked the AMA to support and encourage student membership and participation in state and local medical societies by:</p> <p>(1) urging its state medical associations and constituent societies to:</p>

Appendix C. MSS Positions Consolidated by New Position: Medical Student Participation in State and Local Professional Organizations		
Position #	Title	Position
	Organizations	<ul style="list-style-type: none"> (1) review and study membership provisions of their bylaws to maintain fair membership standards for equal access for all physicians and medical students (2) seek the removal of any impediments to student membership; (3) encourage societies to establish student dues that do not exceed 50 percent of the national student dues; (4) offer membership options for students who are enrolled in medical school for longer than four years; (5) oppose policy that directly or indirectly restricts or restrains any individual member's freedom of choice with respect to professional societies for which they are eligible; (6) provide all medical students equal access to funding and opportunity within the realm of their society. (7) 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 not be counted in determining the number of AMA delegates representing a state. (8) support 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. (2) working 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.
530.023MS S	Equal Opportunity in Professional Affiliations for Physicians	AMA-MSS will ask the AMA to: (1) urge its state medical associations and constituent societies to oppose policy that directly or indirectly restricts or restrains any individual member's freedom of choice with respect to professional societies for which they are eligible;

Appendix C. MSS Positions Consolidated by New Position: Medical Student Participation in State and Local Professional Organizations		
Position #	Title	Position
		<p>(2) urge state medical associations to review and study membership provisions of their bylaws to maintain fair membership standards for equal access for all physicians and medical students; and</p> <p>(3) urge state medical associations to provide all medical students equal access to funding and opportunity within the realm of their society.</p>
530.024MS S	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.
655.001MS S	Student Membership in State Medical Societies	<p>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 not exceed 50 percent of the national student dues; and</p> <p>(2) seek the removal of any impediments to student membership in the AMA or in state or county medical societies.</p>
655.003MS S	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.
655.002MS S	Membership Recruitment Methods	<p>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;</p> <p>(2) opposes full subsidization of AMA student dues by constituent societies for more than an initial one-year introductory period for new members;</p>

Appendix C. MSS Positions Consolidated by New Position: Medical Student Participation in State and Local Professional Organizations		
Position #	Title	Position
		(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.

Appendix D. MSS Positions Consolidated by New Position: Medical Student Dues, Incentives, and Funding		
Position #	Title	Position
Consolidated Position	Medical Student Dues, Incentives, and Funding	Our AMA-MSS asked the AMA to: <ul style="list-style-type: none"> (1) create discounted multi-year dues options for medical students and residents for all program lengths including students and residents who take extra years for additional degrees, research, and other leaves of absence while ensuring that recruitment rebates apply to these options; (2) support medical student recruitment efforts by providing a tangible membership benefit linked to the multi-year membership option on a continual annual basis. (3) provide benefits, free of charge, to new members processed before January until official membership begins in January according to the AMA calendar. (4) provide contact information for AMA staff member responsible for benefit inquiries and grievances; (5) continue its internal evaluation of the procedures involved in the processing of student membership applications and take steps to decrease delays and increase service to medical student applicants and members. (6) explore mechanisms to mitigate costs associated with medical student participation at national, in-person AMA conferences.
530.016MS S	Creation of Additional Dues Structure for	AMA-MSS will ask the AMA to create appropriate discounted multi-year dues options for residents in any length of residency.

Appendix D. MSS Positions Consolidated by New Position: Medical Student Dues, Incentives, and Funding		
Position #	Title	Position
	Resident & Fellow Section	
655.022MS S	MD/PhD AMA Membership	AMA-MSS will develop a mechanism for MD/PhD students and other students requiring greater than a 4-year training period to sign up for a longer AMA-MSS membership and make this available on the world wide web.
655.017MSS	Multi-Year Membership Benefit	AMA-MSS will ask the AMA to support medical student recruitment efforts by providing a tangible membership benefit linked to the multi-year membership option on a continual annual basis.
655.004MS S	Medical Student Membership Benefits	AMA-MSS will ask the AMA to: (1) acknowledge all new student applications within two weeks of receipt of applications and that this acknowledgment contain the name and a phone number, which may be dialed collect, of an AMA staff member responsible for benefit inquiries and grievances; (2) ensure the distribution of journals to new members within 8 weeks of receipt of applications; and (3) provide benefits, free of charge, to new members processed before January until official membership begins in January according to the AMA calendar.
655.025MSS	Increasing the Efficiency of Student Membership Application Processing	AMA-MSS encourages the AMA to continue its internal evaluation of the procedures involved in the processing of student membership applications and take steps to decrease delays and increase service to medical student applicants and members.

Appendix E. MSS Positions Consolidated by New Position: Supporting MSS Membership Recruitment and Retention		
Position #	Title	Position
Consolidated Position	Supporting MSS Membership Recruitment and	Our AMA-MSS Governing Council will support and encourage AMA membership through exploring a variety of recruitment and retention methods and implementing, at minimum, the following strategies:

Appendix E. MSS Positions Consolidated by New Position: Supporting MSS Membership Recruitment and Retention		
Position #	Title	Position
	Retention	<ul style="list-style-type: none"> (1) supporting offering medical students free membership in the AMA and/or constituent societies; (2) stressing and distinguishing the benefits of membership on the national, state, and county/local levels in recruitment materials; (3) Collaborating with Region Leadership, Medical Student Outreach Program, Marketing and Membership Experience staff and other appropriate AMA staff to: <ul style="list-style-type: none"> (a) encourage the development of local MSS chapters and state MSS sections in medical schools and states where they do not exist; (b) involve highly organized MSS chapters and state sections in providing organizational information and assistance to developing chapters and sections; (c) encourage MSS chapters to maintain communication and interaction between medical student members and physician members of county and state medical societies; and (d) ensure every medical school designates a permanent position within their local campus section to be responsible for matters pertaining to membership recruitment and retention throughout the school year, and that the local campus section provides the individual's name and contact information to the MSS Governing Council, pertinent Region Leaders, and AMA Medical Student Section Outreach Program when local campus section leadership transitions, or at least annually. (e) support the collaboration between local chapters and allied medical student organizations to increase underrepresented minority medical student participation in the AMA-MSS including the creation of a local DEI Chair and/or liaisons to national medical student organization chapters at their local institution; (f) use peer-to-peer recruitment to identify and recruit students on an individual basis that are enrolled in joint degree programs and who begin their education in disciplines other than medicine. (g) explore methods of disseminating information from the AMA-MSS to local

Appendix E. MSS Positions Consolidated by New Position: Supporting MSS Membership Recruitment and Retention		
Position #	Title	Position
		<p>chapters with the goals of increased access, and program development;</p> <p>(h) develop and promote a series of free online modules and presentation templates on a variety of topics which can be used by general members and local campus section leadership to learn about the MSS and other topics of importance to future physicians;</p> <p>(4) explore ways to increase awareness of the Medical Student and Resident & Fellow Sections in order to increase membership retention during the transition to residency through strategic collaboration with (a) the AMA-RFS to focus membership strategies to retain student members and recruit new resident members; and (b) medical school deans to find better means to increase awareness such as targeted informational sessions and increased presence at match day and graduation events.</p> <p>(5) supporting 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;</p>
655.002MS S	Membership Recruitment Methods	<p>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;</p> <p>(2) opposes full subsidization of AMA student dues by constituent societies for more than an initial one-year introductory period for new members;</p> <p>(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</p> <p>(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.</p>

Appendix E. MSS Positions Consolidated by New Position: Supporting MSS Membership Recruitment and Retention		
Position #	Title	Position
655.005MS S	Recruitment Information in AMA and MSS Pamphlets	<p>(1) It is the policy of the AMA-MSS that recruitment literature distributed to students by the AMA and/or MSS clarify that AMA membership does not automatically imply membership in state or county/local medical societies.</p> <p>(2) AMA-MSS recruitment literature will stress the benefits of membership on the national, state, and county/local levels.</p>
640.003MSS	States Regional Chairs	<p>AMA-MSS, through Regional Chairs will:</p> <p>(1) continue to encourage the development of local MSS chapters and state MSS sections in medical schools and states where they do not exist;</p> <p>(2) involve highly organized MSS chapters and state sections in providing organizational information and assistance to developing chapters and sections;</p> <p>(3) encourage MSS chapters to maintain communication and interaction between medical student members and physician members of county and state medical societies; and</p> <p>(4) ask the MSS to endorse the maintenance of active and timely communication between MSS delegates and Regional Chairs. ← consolidated in Optimizing MSS Communications</p> <p>Note: The role of the Region Chairs is now codified in the MSS IOPs in Section 8, "MSS Regions." Clause 1 is incorporated into 8.1.2 and 8.1.3.2. Clause 2 is incorporated into 8.1.3.3. Clause 3 is contained in 8.1.3.4. Further the spirit of this position is captured by the new consolidated position "Supporting MSS Membership."</p>
655.034MSS	Study a Need-Based Scholarship to Encourage Medical Student Participation in the AMA	<p>1. The 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 association with AMA conference attendance, funding sources of delegates and other conference attendees and needs not met by state medical societies.</p>

Appendix E. MSS Positions Consolidated by New Position: Supporting MSS Membership Recruitment and Retention		
Position #	Title	Position
		2. AMA-MSS will ask the AMA to explore mechanisms to mitigate costs associated with medical student participation at national, in-person AMA conferences.
655.028MSS	The Designation of Permanent Membership Positions Within Local AMA-MSS Chapters	AMA-MSS strongly encourages every medical school to designate a permanent position within their chapter to be responsible for matters pertaining to membership recruitment and retention throughout the school year, and that the chapter provide the individual's name and current mailing address to the AMA Medical Student Section Outreach Program prior to each Annual Meeting.
350.019MSS	Strengthening AMA-MSS Collaborations with Allied Underrepresented Minority Student Organizations at the Local Chapter Level	Strengthening AMA-MSS Collaborations with Allied Underrepresented Minority Student Organizations at the Local Chapter Level: AMA-MSS will (1) support the collaboration between local chapters and allied medical student organizations, including but not limited to Student National Medical Association, Latino Medical Student Association, and Asian Pacific American Medical Student Association, in order to increase underrepresented minority medical student participation in the AMA-MSS, and (2) support regional leadership in promoting Local Chapter creation of a Minority Liaison executive committee position aimed at increasing collaboration between the AMA-MSS and minority student organizations.
655.015MSS	Eligibility of Medical Students to Join the AMA while Enrolled in a Joint Degree Program	AMA-MSS will use peer-to-peer recruitment to identify and recruit, on an individual basis, joint degree students who begin their education in a discipline other than medicine.
630.011MSS	Improved Access and Programming of Non-Scientific Issues in Medicine	AMA-MSS will: (1) explore better methods of disseminating information from the AMA-MSS to local chapters with the goals of increased access, and program development; and (2) develop a series of modular programs, which can be used by local chapters to educate their members on topics of importance to future physicians, according to the following guidelines: (a) the information must be flexible, dynamic, accessible and cost effective; (b) a variety of topics could be covered, including medical ethics, legal issues in medicine, the

Appendix E. MSS Positions Consolidated by New Position: Supporting MSS Membership Recruitment and Retention		
Position #	Title	Position
		<i>lifestyles of various specialties, medicine and the media, medical economics, etc.</i>
655.018MSS	Membership Retention into Residency	AMA-MSS will continue to explore ways to increase awareness of the Medical Student and Resident Fellow Sections in order to increase membership retention during the transition to residency.
655.033MSS	Establishing a Joint MSS and RFS Approach for Recruitment Initiatives for Incoming MSS Members to the RFS	AMA-MSS will: (1) work with the AMA-RFS to focus membership strategies to retain student members and recruit new resident members; and (2) work with medical school deans to find better means to recruit 4th year medical students to the AMA-RFS including increased presence at match day and graduation events.
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.

Appendix F: MSS Positions Consolidated by New Position: Medical Student Training Opportunities in Health Policy and Advocacy		
Position #	Title	Position
Consolidated Position	Medical Student Training Opportunities in Health Policy and Advocacy	AMA-MSS: (1) encourages education on health policy in medical schools by supporting: (a) implementation of teaching strategies that promote outcome based development of behavioral and social science foundations for medical students; (b) appropriate follow-up research based on the implementation of its behavioral and socioeconomic report competencies by the AAMC and other stakeholders;

		<p>(c) the recognition and incorporation of elective advocacy and health policy rotations and fellowships for medical students within the US medical curriculum;</p> <p>(2) asked the AMA continue to explore potential partnerships with the AMA to foster health policy and advocacy training and opportunities for students by including:</p> <p>(a) supporting the recognition and incorporation of elective advocacy and health policy rotations and fellowships for medical students within the US medical curriculum;</p> <p>(b) supporting the establishment and maintenance of AMA medical student health policy and advocacy elective rotations for medical students based in Washington, DC.;</p> <p>(c) maintaining a legislative internship or clerkship opportunity for a medical student in the AMA’s Washington, D.C. Office; and</p> <p>(d) encouraging the AMA to work with state and specialty societies, the AAMC, AACOM, COCA, LCME, and other interested organizations to implement health advocacy rotations and fellowships, and develop a set of model guidelines and curricular goals to be used by state and specialty societies.</p> <p>(e) Exploring potential partnerships with Advocacy Business Unit and other branches of the AMA to enrich our student advocacy opportunities and</p> <p>(f) incorporating educational programming opportunities in health policy into the virtual and national meeting structure</p>
295.171MSS	Health Policy Education in Medical Schools	<p>(1) AMA-MSS encourages medical schools to implement teaching strategies that promote outcome based development of behavioral and social science foundations for medical students; and</p> <p>(2) AMA-MSS encourages the AAMC to engage in appropriate follow-up research based on the implementation of its behavioral and socioeconomic report competencies.</p>
295.173MSS	Policy and Advocacy Rotations for Medical Students	<p>AMA-MSS will ask the AMA to (1) support the recognition and incorporation of elective advocacy and health policy rotations and fellowships for medical students within the US medical curriculum; and</p> <p>(2) work with state and specialty societies, the AAMC, AACOM, COCA, LCME, and other interested organizations to implement health advocacy rotations and fellowships, and develop a set of model guidelines and curricular goals to be used by state and specialty societies.</p>

565.004MSS	Transforming for Tomorrow: Advocacy Framework:	AMA-MSS will ask the AMA to (1) establish medical student health policy and advocacy elective rotations for medical students based in Washington, DC.; and (2) support and encourage internal, state, and specialty organizations to offer health policy and advocacy opportunities for medical students.
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

Appendix D. Positions Recommended for Rescission

Position #	Title	Position	Rationale for Rescission
630.069MSS	Developing 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.	The Governing Council recognizes the MSS could not function without well-coordinated Regions, and we thank the Region Chairs for their service. This position has been incorporated into the MSS IOPs. Clause 1 is included in 8.1.3. Clause 2 is included in Section 8. Clause 3 is a nice sentiment but does not serve a functional purpose from a policy standpoint. We hope that the MSS and future Governing Councils will continue to recognize Region Leaders in more tangible ways than simply retaining a statement in the MSS policy compendium.
630.073MSS	Voting Rights of MSS Speaker and Vice	Our AMA-MSS (1) will amend its Internal Operating Procedures IV.A by deletion as follows:	This directive has been completed and its content incorporated into MSS

Appendix D. Positions Recommended for Rescission			
Position #	Title	Position	Rationale for Rescission
	Speaker	<p>A. Designations. The officers of the MSS shall be the eight Governing Council members: Chair, Vice Chair, AMA Delegate, Alternate AMA Delegate, At-Large Officer, Chair-elect/Immediate Past Chair, Speaker, and Vice Speaker. The Chair-elect/Immediate Past Chair shall be a non-voting member of the Governing Council. The officers of the Assembly for the purpose of business meetings will be the Speaker and Vice Speaker. The Speaker and Vice Speaker shall be non-voting members of the Governing Council.; and</p> <p>(2) amend its Internal Operating Procedures IV.E by addition and deletion as follows:</p> <ol style="list-style-type: none"> 1. The Chair-elect/Chair/Immediate Past Chair of the Governing Council shall serve a two-year term. His or her term as Chair-elect will begin at the conclusion of the Interim Meeting at which he or she is elected. He or she will take office as Chair at the conclusion of the following Annual Meeting, and one year later will become Immediate Past Chair. He or she will serve as Immediate Past Chair until the conclusion of the following Interim Meeting. 2. The other Governing Council members shall serve one-year terms, beginning at the conclusion of the Annual Meeting at which they are elected and ending at the conclusion of the next Annual Meeting of the AMA House of Delegates. 3. Maximum tenure for members of the MSS 	IOP 4.4.5.

Appendix D. Positions Recommended for Rescission			
Position #	Title	Position	Rationale for Rescission
		Governing Council will be two years in any combination of voting or non-voting positions. The periods of service as Chair-elect and Immediate Past Chair shall not count toward the maximum tenure of two years in any combination of voting or non-voting positions.	
630.076MSS	Sunset Report Update	AMA-MSS (1) retain all MSS policies due to be rescinded at the Interim 2022 MSS Assembly and (2) the AMA-MSS Governing Council review all policies retained by the Interim 2022 MSS Assembly and prepare a sunset report for the Annual 2023 MSS Assembly, in accordance with the sunset mechanism outlined in 630.044MSS.	This directive has been completed.
640.011MSS	Region Chair Elections	AMA-MSS will modify its policy on the Region Chairs to allow for direct election of the Region Chairs by the sections, according to the following guideline: New chairs must be selected before Saturday morning of the annual meeting, and the new chair must be present at the annual meeting.	Guidance on the election of Region Chairs is contained in each Region's bylaws as well as in the MSS IOPs.
630.049MSS	AMA Medical Student Section Vision Statement	The AMA-MSS supports the following vision statement for the AMA-MSS: (1) The AMA-MSS core purpose is: the AMA-MSS is dedicated to representing medical students, improving medical education, developing leadership and promoting activism for the health of America; (2) The AMA-MSS Envisioned Future is: The AMA-MSS strives to be the medical students' leading voice for improving medical education, advancing	This is an outdated policy that is superseded by our updated MSS IOPs Purpose and Objectives .

Appendix D. Positions Recommended for Rescission			
Position #	Title	Position	Rationale for Rescission
		<p>health care and advocating for the future of medicine.;</p> <p>(3) The AMA-MSS Objectives are: (a)The leading medical student organization for advancing issues of public wellness, community service, ethics, and health policy; (b) The principal source for obtaining and disseminating information for medical students regarding medical education, residency training, and medical practice;</p> <p>(4) The most representative voice and influential advocate for medical students and their patients; and (5) A dynamic organization that provides value to its medical student members; and</p> <p>(6) The AMA-MSS Core Values are: (a) Advocacy: Caring advocates for our patients, our profession, and our medical student members. (b) Leadership: The stewards of the future of medicine. (c) Excellence: Commitment to provide the highest quality service, products, and information for our members. (d) Integrity: Ethical behavior forms the basis for trust in all our relationships and actions.</p> <p>MSS Timeline: (MSS COLRP Rep B, 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)</p>	
660.001MSS	Questions of Parliamentary Procedures	(1) The AMA-MSS parliamentarian will be either the Speaker or Vice Speaker, whoever is not presiding over the Assembly.	This is in opposition to current practice and our updated MSS IOPs . While the speakers have parliamentary authority, we now have

Appendix D. Positions Recommended for Rescission			
Position #	Title	Position	Rationale for Rescission
		(2) The AMA-MSS Governing Council will appoint a temporary parliamentarian when either the Speaker or Vice Speaker is not present.	a Parliamentary Procedures Convention Committee overseen by the Speakers. This is now codified in the MSS IOPs in section 4.4.5 Speaker and Vice Speaker and section 10.9.4 Parliamentary Procedures Committee .
660.017MSS	Campaign Reform	AMA-MSS encourages all members to recognize the commitments of the candidates at the Interim and Annual meetings and use prudent judgment when inviting them to address group meetings and furthermore strive for fair and equal access to all candidates and all sections, states, and societies.	IOP/Election Task Force addressed election reform, including on this topic, and revisions adopted by the Assembly have been incorporated into the IOPs.
660.026MSS	AMA-MSS: Officers – Nomination, Election, and Tenure	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.	This position is incorporated into the MSS IOPs (11.3.5).
660.036MSS	Creating an AMA-MSS Election Task Force	Our AMA-MSS will create an Election Task Force, consisting of at least two region-appointed voting members from each region and non-voting MSS Governing Council members, to review election rules and processes pertaining to Governing Council elections and provide recommendations for the equitable application and enforcement, and report back to Assembly at A-21.	The directives of this position were fulfilled by the Internal Operating Procedures/Election Task Force Report at A-22 , which established the 2022 IOP Task Force, which authored the following report , which was adopted by the MSS Assembly at I-22. The AMA Council on Constitution & Bylaws disagreed with some of the new language, and the 2022 Task

Appendix D. Positions Recommended for Rescission			
Position #	Title	Position	Rationale for Rescission
			Force and Speakers reconvened to make corrections, which were proffered in this report , which was adopted by the MSS Assembly at A-23.
660.037MSS	Expanding the AMA-MSS Governing Council to Include a Diversity, Equity, & Inclusion Officer	<p>(1) 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;</p> <p>(2) That our AMA-MSS amends its Internal Operating Procedures as follows:</p> <p>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, and 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.</p> <p><u>4.4.6 Diversity, Equity, & Inclusion Officer: The Diversity, Equity, & Inclusion Officer shall:</u></p> <p><u>4.4.6.1 Coordinate the AMA-specific activities of the identity-based National Medical Student Organizations liaisons (as defined in MSS IOP 10.3.3), identity-based Professional Interest Medical Association liaisons (as defined in MSS IOP</u></p>	These amendments were adopted and are now incorporated in the IOPs.

Appendix D. Positions Recommended for Rescission			
Position #	Title	Position	Rationale for Rescission
		<p><u>10.3.2), and identity-based AMA-MSS Standing Committees within the Section.</u></p> <p><u>4.4.6.2 Serve as a liaison between the AMA's Center for Health Equity, the MSS, and the MSS Governing Council.</u></p> <p><u>4.4.6.3 Serve as a liaison between identity-based National Medical Student Organization leadership and the Section.</u></p> <p><u>4.4.6.4 Support the functions of the MSS liaisons to the Minority Affairs Section (MAS), Women Physicians Section (WPS), the Advisory Committee on LGBTQ Issues, and other identity-based sections or groups within the AMA</u></p> <p><u>4.4.6.5 Track demographics in the Section and direct efforts to recruit and retain a more diverse and representative AMA-MSS membership and leadership.</u></p> <p><u>4.4.4.6 Develop and maintain a culture of inclusivity and allyship within the Section.</u></p> <p>6.7.3 First Ballot. At the Interim Meeting, one ballot shall be used by the credentialed MSS Delegate to 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 cast one for each of the four <u>five</u> positions: the Vice Chair, AMA Delegate, At-Large Officer, and Speaker, and <u>Diversity, Equity, & Inclusion Officer</u>. No ballot should be counted if there is more than one vote for a position. All Governing Council</p>	

Appendix D. Positions Recommended for Rescission			
Position #	Title	Position	Rationale for Rescission
		<p>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.</p> <p><u>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 IOP 10.3.3), liaisons to Professional Interest Medical Associations (as defined in MSS IOP 10.3.2) and liaisons to identity-based AMA Sections and Advisory Committees (as defined in AMA Bylaw 7.0.1).</u></p> <p><u>6.8.1 Candidates are strongly encouraged to seek at least one endorsement, and may seek as many endorsements as they choose.</u></p> <p><u>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.</u></p> <p>6.5.7.3 No mode of MSS- or AMA-sponsored communication, including, but not limited to listservs, phone or email lists, or other mass communication methods shall be used for announcements of candidacy, endorsement, or</p>	

Appendix D. Positions Recommended for Rescission			
Position #	Title	Position	Rationale for Rescission
		<p>campaigning <u>unless otherwise outlined in this IOP.</u></p> <p>6.5.9.1 Only MSS members may be involved in a candidate’s campaign. MSS members should not share their opinion in favor of or in opposition to any candidate while acting under any official leadership role within or outside of the organization <u>unless otherwise outlined in this IOP.</u></p> <p>6.7.2 Voting Periods. There shall be one voting period at the Interim Meeting for the selection of the Chair-Elect and Medical Student Trustee. There shall be one voting period at the Annual Meeting for the selection of the Vice Chair, AMA Delegate, At-Large Officer, and Speaker, <u>and Diversity, Equity, & Inclusion Officer.</u> An additional balloting period will be held for the elections of the Alternate Delegate and Vice Speaker.</p> <p>(3) That our AMA-MSS Governing Council, with input from AMA-MSS identity- based Standing Committees and National Medical Student Organization liaisons, appoint an individual 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 allowed to vote until elected by the Section, until the AMA-MSS 2022 Annual Business Meeting election can occur.</p>	
665.001MSS	Strengthening of Regional Internal Operating Procedures	(1) It is the policy of the AMA-MSS that the following sections within each region’s Internal Operating Procedures be standardized: (a) Name, (b) Purpose	Outdated. Despite the policy’s title, the final language does not mention Regional Coordinating Committees,

Appendix D. Positions Recommended for Rescission			
Position #	Title	Position	Rationale for Rescission
	(IOPs), Creation of Regional Coordinating Committees, and Creation of Membership/ Recruitment Chair for Each Region	and Principles, (c) Membership, (d) Method for Substituting Regional Delegates at the National Meetings, (e) Number of Required Meetings, (f) Quorum, (g) Parliamentary Authority, (h) Amendments, and (i) Supremacy and Severability, while leaving the content of the Elections, Voting, and Committees sections up to each region individually; (2) Region Chairs should work with emerging chapters and create a Membership/ Recruitment Chair for their respective region, and (3) Region Chairs should undertake pilot projects to build region funding.	indicating that such language was not adopted. Furthermore, Regions use Bylaws, not IOPs. These practices are already either included within Region Bylaws as standard practice (all of clause 1) or within the purview of Regions to decide in an autonomous manner.
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.	Outdated. All Region Bylaws were recently overhauled prior to the A-23 Assembly.

Appendix D. Positions Recommended for Rescission			
Position #	Title	Position	Rationale for Rescission
		<p>2. That all Medical Student Region Bylaws are in accordance with the prevailing parliamentary code of our AMA per MSS IOP XII.A.</p> <p>3. That the Speaker or Vice Speaker or their 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.</p>	
665.015MSS	Reevaluation of AMA-MSS Region Bylaws:	<p>(1) That our MSS Speaker and Vice Speaker monitor all MSS Regions to ensure compliance with the minimum requirements in GC Report D, A-15; and</p> <p>(2) That Region 6 modify their bylaws to specify the responsibilities of the Region Chair to be in accordance with MSS IOP 8.1.3; and</p> <p>(3) That Region 7 modify their bylaws to describe the Region Chair responsibilities and the selection of Region Delegation Chair to be in accordance with MSS IOP 8.1.3 and MSS IOP 8.3; and</p> <p>(4) That our MSS-COLRP reevaluate the accordance of each Region's bylaws with the</p>	Outdated. These directives were completed and also all Region Bylaws were recently overhauled again for consistency prior to the A-23 Assembly.

Appendix D. Positions Recommended for Rescission			
Position #	Title	Position	Rationale for Rescission
		categories in Tables 1 – 5b and release its findings in an informational report to the Assembly at A-24.	
665.017MSS	Re-evaluation of AMA-MSS Region Bylaws	<p>It is the policy of the MSS:</p> <ol style="list-style-type: none"> 1. That Region 1 modify their bylaws to specify the selection of the Regional Delegate and the responsibilities of the Region Delegation Chair to be in accordance with MSS IOP 8.3 and MSS IOP 8.4; 2. That Region 2 modify their bylaws to specify the responsibilities of the Region Delegation Chair and Region Chair and specify the selection of the Regional Delegate to be in accordance with MSS IOP 8.4, MSS IOP 8.1.3 and MSS IOP 8.3 respectively; 3. That Region 3 modify their bylaws to specify the selection of the Regional Delegate and the responsibilities of the Region Delegation Chair to be in accordance with MSS IOP 8.3 and MSS IOP 8.4; 4. That Region 4 modify their bylaws to include the process in which the Region Chair and, Region Delegates, and Region Delegation Chair are selected and the responsibilities of the Region Delegation Chair and Region Chair to be in accordance with MSS IOP 8.1.3, MSS IOP 8.5, and MSS IOP 8.4; 5. That Region 5 modify their bylaws to specify the selection of the Regional Delegate and the responsibilities of the Region Delegation Chair to be in accordance with MSS IOP 8.3 and MSS IOP 8.4; 6. That Region 6 modify their bylaws to include 	Outdated. This directive has been completed and also all Region Bylaws were recently overhauled prior to the A-23 Assembly.

Appendix D. Positions Recommended for Rescission			
Position #	Title	Position	Rationale for Rescission
		<p>details on the process in which the Region Delegation Chair and Region Delegate is selected and the responsibilities of the Region Delegation Chair and Region Chair, and eliminate the exclusion where the Region Delegation Chair cannot be an Alternate Delegate to be in accordance with MSS IOP 8.1.3, MSS IOP 8.3, and MSS IOP 8.4;</p> <p>7. That Region 7 modify their bylaws to describe the Region Chair responsibilities and the selection and responsibilities on the Region Delegation Chair to be in accordance with MSS IOP 8.1.3 and MSS IOP 8.4; and</p> <p>8. That our MSS-COLRP re-evaluate the accordance of each Region's bylaws with the categories in tables 1-5b and release its findings in an informational report to the Assembly at A-21.</p>	
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.	This is accomplished by the Section Delegates and is specifically incorporated into MSS IOP 9.1.4.6.

REPORT OF THE MEDICAL STUDENT SECTION GOVERNING COUNCIL

MSS GC Report H
(A-24)

Subject: MSS Alcohol-Related Positions Consolidation

Presented by: MSS Governing Council

Referred to: MSS Reference Committee
(Caitlin Blaukovitch and Shaminy Manoranjithan, Co-Chairs)

1 INTRODUCTION

2
3 MSS Position 630.044MSS, "Sunset Mechanism for AMA-MSS Policy," states "the MSS Governing Council
4 may recommend policies for consolidation as part of the sunset review process." This clause was amended
5 into this policy at MSS A-23, but was derived from a similar policy that was sunset at A-23, 645.023MSS,
6 "Medical Student Section Policy Making Procedures." This policy was actually even stronger and stated,
7 "[a]s part of its annual review of MSS policies set to sunset ... the MSS Governing Council will undertake
8 policy consolidation for at least one issue," implying that prior to last year, this was intended to be an explicit
9 directive to Governing Councils and not just an enumerated power.

10
11 However, for several years, no Governing Council has undertaken any consolidations as described, despite
12 this policy being reaffirmed during that period, demonstrating that this policy had not been followed as
13 directed. Therefore, as this year's Governing Council would be the first to undertake any consolidations in
14 a long period of time, we decided to compensate and undertake consolidations of multiple issues.

15
16 The intent of these consolidations is to streamline our new MSS Positions Compendium and make the
17 identification and comprehension of MSS positions clearer and more accessible for all members, especially
18 new students learning about AMA and MSS processes. In this report, the current MSS Governing Council
19 presents a consolidation of MSS positions related to alcohol. After thorough review of the MSS Digest of
20 Actions, your MSS Governing Council recommends consolidation of the following positions while capturing
21 the original intent and function of the current positions.

22 DISCUSSION

23
24
25 MSS Positions that overlapped significantly in content and/or function were consolidated together. The
26 appendices at the end of this report provide a color-coded mapping of the consolidated MSS position onto
27 the current MSS positions.

28 RECOMMENDATIONS

29
30
31 Thus, your MSS Governing Council recommends that the following recommendations be adopted and the
32 remainder of this report be filed:

33
34 RESOLVED, the following MSS Positions:

- 35 • 30.011MSS Expanding Transplant Evaluation Criteria to Include Patients that May Not Satisfy
36 Center-Specific Alcohol Sobriety Requirements
- 37 • 370.019MSS Support for the Use of Evidence-Based Guidelines for Determining Liver Transplant
38 Waiting Periods in Alcohol-Related Liver Disease

39
40 be consolidated into the new MSS Position:

41 Supporting the Use of Evidence-Based Guidelines in Transplant Evaluation

1 AMA-MSS supports:

- 2 (1) Encouraging transplant centers to expand potential recipient evaluation criteria to
- 3 include patients that may not satisfy center-specific alcohol sobriety requirements
- 4 on a case-by-case basis;
- 5 (2) The use of evidence-based guidelines for determining liver transplant waiting
- 6 periods in alcohol-related liver disease; and be it further
- 7

8 RESOLVED, the following MSS Positions:

- 9 ● 30.003MSS Age Requirement for Purchase of Non-Alcoholic Beer
- 10 ● 30.005MSS Boating Under the Influence
- 11 ● 30.006MSS Support of Programs that Discourage Adolescent Alcohol Consumption
- 12 ● 420.002MSS Substance Abuse During Pregnancy
- 13

14 be consolidated into the new MSS Position:

15 Supporting Education on the Health Risks of Alcohol

16 The AMA-MSS supports education on the health effects of alcohol, including but not limited to:

- 17 (1) education on the dangers of alcohol and drug consumption for the safe operation of
- 18 recreational watercraft;
- 19 (2) working with adolescents to both raise awareness of the dangers of alcohol consumption
- 20 by minors as well as to curtail underage drinking in their local populations;
- 21 (3) efforts to educate the general public, especially adolescents, about the effects of alcohol
- 22 use disorder and substance use disorder on prenatal and postnatal development;
- 23 (4) efforts to educate the public and consumers relating to the alcohol content of so-called
- 24 "non- alcoholic" beverages and other substances, including medications, especially as
- 25 related to consumption by minors; and be it further
- 26

27 RESOLVED, the following MSS Positions:

- 28 ● 30.003MSS Age Requirement for Purchase of Non-Alcoholic Beer
- 29 ● 30.005MSS Boating Under the Influence
- 30 ● 30.007MSS Drunk Driving Prevention through Designated Driver Use Promotion
- 31 ● 30.008MSS Support for Medical Amnesty Policies for Underage Alcohol Intoxication
- 32 ● 30.009MSS Sobriety Checkpoints
- 33 ● 30.010MSS Opposition to Alcoholic Industry Marketing Self-Regulation
- 34

35 be consolidated into the new MSS Position:

36 Supporting a Harm Reduction Approach to Alcohol Use

37 The AMA-MSS supports a harm reduction approach in policies related to alcohol consumption,

38 including but not limited to:

- 39 (1) urging businesses that serve alcohol to offer incentives such as free admission, reduced
- 40 food prices, and free non-alcoholic beverages to patrons who elect to be designated drivers
- 41 (2) efforts among universities, hospitals, and legislators to establish medical amnesty policies
- 42 that protect underage drinkers from punishment when seeking emergency medical
- 43 attention for themselves or others, while discouraging underage use of alcohol.
- 44 (3) accurate and appropriate labeling disclosing the alcohol content of all beverages including
- 45 so-called "non-alcoholic" beer and of other substances as well, including over-the-counter
- 46 and prescription medications with removal of "non- alcoholic" from the label of any
- 47 substance containing any alcohol
- 48 (4) enforcement of regulations regarding boating under the influence of alcohol and other
- 49 drugs;
- 50 (5) the use of sobriety checkpoints to deter driving following alcohol consumption;
- 51 (6) working with state medical societies to pursue legislation to overturn bans on the use of
- 52 sobriety checkpoints;
- 53 (7) federal and/or state oversight for all forms of alcohol advertising

Appendix C. MSS Positions Consolidated by Resolve 1.

Position #	Title	Position
Consolidated Position	Supporting the Use of Evidence-Based Guidelines in Transplant Evaluation	AMA-MSS supports: (3) Encouraging transplant centers to expand potential recipient evaluation criteria to include patients that may not satisfy center-specific alcohol sobriety requirements on a case-by-case basis; (4) The use of evidence-based guidelines for determining liver transplant waiting periods in alcohol-related liver disease
30.011MSS	Expanding Transplant Evaluation Criteria to Include Patients that May Not Satisfy Center-Specific Alcohol Sobriety Requirements	AMA-MSS will ask the AMA to encourage transplant centers to expand potential recipient evaluation criteria to include patients that may not satisfy center-specific alcohol sobriety requirements on a case-by-case basis, using medically appropriate criteria supportable by peer-reviewed and published research.
370.019MSS	Support for the Use of Evidence-Based Guidelines for Determining Liver Transplant Waiting Periods in Alcohol-Related Liver Disease	AMA-MSS supports the use of evidence-based guidelines for determining liver transplant waiting periods in alcohol-related liver disease.

Appendix A. MSS Positions Consolidated by Resolve 2.

Position #	Title	Position
Consolidated Position	Supporting Education on the Health Risks of Alcohol	The AMA-MSS supports education on the health risks of alcohol, including but not limited to: (1) education on the dangers of alcohol and drug consumption for the safe operation of recreational watercraft; (2) working with adolescents to both raise awareness of the dangers of alcohol consumption by minors as well as to curtail underage drinking in their local populations; (3) efforts to educate the general public, especially adolescents, about the effects of alcohol use disorder and substance use disorder on prenatal and postnatal development; (4) 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.
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 operation of recreational water craft; and (2) support stringent enforcement of regulations regarding boating under the influence of alcohol and other drugs.
30.006MSS	Support of Programs that Discourage Adolescent Alcohol Consumption	AMA-MSS strongly encourages AMA-MSS sections to work with adolescents in their local communities in order to both raise awareness of the dangers of alcohol consumption by minors as well as to curtail underage drinking in their local populations.

420.002MSS	Substance Abuse During Pregnancy	<p>AMA-MSS will ask the AMA to: (1) continue its ongoing efforts to educate the general public, especially adolescents, about the effects of alcohol use disorder on prenatal and postnatal development and expand these efforts to target substance use disorders; and</p> <p>(2) encourage intensified research into the physical and psychosocial aspects of maternal substance use as well as the development of efficacious prevention and treatment modalities.</p>
30.003MSS	Age Requirement for Purchase of Non-Alcoholic Beer	<p>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.</p>

Appendix B. MSS Positions Consolidated by Resolve 3.

Position #	Title	Position
Consolidated Position	Supporting a Harm Reduction Approach to Alcohol Use	<p>The AMA-MSS supports a harm reduction approach in policies related to alcohol consumption, including but not limited to:</p> <ul style="list-style-type: none"> (8) urging businesses that serve alcohol to offer incentives such as free admission, reduced food prices, and free non-alcoholic beverages to patrons who elect to be designated drivers (9) efforts among universities, hospitals, and legislators to establish medical amnesty policies that protect underage drinkers from punishment when seeking emergency medical attention for themselves or others, while discouraging underage use of alcohol. (10) 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 (11) enforcement of regulations regarding boating under the influence of alcohol and other drugs; (12) the use of sobriety checkpoints to deter driving following alcohol consumption; (13) working with state medical societies to pursue legislation to overturn bans on the use of sobriety checkpoints; (14) federal and/or state oversight for all forms of alcohol advertising
30.003MSS	Age Requirement for Purchase of Non-Alcoholic Beer	<p>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.</p>

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 operation of recreational water craft; and (2) support stringent enforcement of regulations regarding boating under the influence of alcohol and other drugs.
30.007MSS	Drunk Driving Prevention through Designated Driver Use Promotion	AMA-MSS urges businesses that serve alcohol to offer incentives such as free admission, reduced food prices, and free non-alcoholic beverages to patrons who elect to be designated drivers.
30.008MSS	Support for Medical Amnesty Policies for Underage Alcohol Intoxication	AMA-MSS will ask the AMA to support efforts among universities, hospitals, and legislators to establish medical amnesty policies that protect underage drinkers from punishment when seeking emergency medical attention for themselves or others.
30.009MSS	Sobriety Checkpoints	That our AMA (1) support the use of sobriety checkpoints to deter driving following alcohol consumption; and (2) work with state medical societies to pursue legislation to overturn bans on the use of sobriety checkpoints.
30.010MSS	Opposition to Alcoholic Industry Marketing Self-Regulation	<p>Our AMA-MSS will ask our AMA to amend policy H-30.940, Labeling, Advertising, and Promotion of Alcoholic Beverages, by addition and deletion as follows:</p> <p>LABELING, ADVERTISING, AND PROMOTION OF ALCOHOLIC BEVERAGES, H-30.940</p> <p>(1.) (a) Supports accurate and appropriate labeling disclosing the alcohol content of all beverages, including so-called "nonalcoholic" beer and other substances as well, including over-the-counter and prescription medications, with removal of "nonalcoholic" from the label of any substance containing any alcohol; (b) supports efforts to educate the public and consumers about the alcohol content of so-called "nonalcoholic" beverages and other substances, including medications, especially as related to consumption by minors; (c) urges the Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF) and other appropriate federal regulatory agencies to continue to reject proposals by the alcoholic beverage industry for authorization to place beneficial health claims for its products on container labels; and (d) urges the development of federal legislation to require nutritional labels on alcoholic beverages in accordance with the Nutritional Labeling and Education Act. (2.) (a) Expresses its strong disapproval of any consumption of "nonalcoholic beer" by persons under 21 years of age, which creates an image of drinking alcoholic beverages and thereby may encourage the illegal underaged use of alcohol; (b) recommends that health education labels be used on all alcoholic beverage containers and in all alcoholic beverage advertising (with the messages focusing on the hazards of alcohol consumption by specific population groups especially at risk, such as pregnant women, as well as the dangers of irresponsible use to all sectors of the populace); 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). (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) <u>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</u>; (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) <u>opposes the use of the radio and television any form of advertising which links alcoholic products to agents of socialization in order</u> 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,</p>

		<p>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 <u>all</u> advertising directed toward youth, <u>including</u> 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); (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.</p>
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REPORT OF THE MEDICAL STUDENT SECTION
GOVERNING COUNCIL

GC Report I
(A-24)

Subject: Guidelines for Official Observers in the AMA-MSS Assembly
Presented by: Natasha Topolski, Chair
Referred to: MSS Reference Committee
(Caitlin Blaukovitch and Shaminy Manoranjithan, Co-Chairs)

1 **INTRODUCTION**
2

3 MSS Internal Operating Procedure (IOP) 10.3.5.1 states, “National student organizations may
4 apply to the MSS Governing Council for official observer status in the MSS Assembly. Applicants
5 and official observers must demonstrate compliance with guidelines for official observers adopted
6 by the MSS Assembly, and the Governing Council shall make a recommendation to the MSS
7 Assembly concerning the application. The MSS Assembly will make the final determination on
8 the conferring or continuation of official observer status.” This IOP is closely modeled on AMA
9 Bylaw 2.9, “Official Observer.”

10
11 The MSS Assembly currently recognizes two observers: the [American Academy of Physician
12 Associates’ \(AAPA\) Student Academy](#) (645.016MSS) and the [European Medical Student
13 Association \(EMSA\)](#) (645.019MSS).

14
15 However, after consultation with MSS staff and a review of historical documents, any guidelines
16 for official observers adopted by the MSS Assembly as mentioned in IOP 10.3.5.1 have not been
17 identified. This report therefore seeks to create these guidelines.

18
19 **DISCUSSION**
20

21 The MSS Governing Council used existing requirements in IOP 10.3.3 for representatives from
22 National Medical Student Organizations (NMSOs) as well as [AMA Policy G-600.025, “Official
23 Observers in our AMA House,”](#) as the basis for these guidelines, while removing any identifiers
24 that may not be relevant to an observer in the MSS Assembly (especially if the organization is not
25 comprised of medical students and so standards relating to medicine would not necessarily apply
26 to them) and refraining from including any unnecessary regulations that would otherwise befit an
27 organization seeking official voting representation in the MSS Assembly. We do note that it is of
28 strong importance and relevance to the MSS to know an organization’s sources of financial
29 support and affiliations with other entities.

30
31 We removed the provision of “national in scope” as this is inherent in the IOP verbiage, “national
32 student organizations.” We also added flexibility for the governing documents requirement, as not
33 all student organizations, especially those composed of volunteer members without staff, may
34 have these. We did not include an additional requirement regarding when the Governing Council
35 should report applications to the Assembly, because this is already inherently included in IOP
36 10.3.5.1, as the GC would need to report all applications to the Assembly with a recommendation
37 in order for the Assembly to make a final vote before an observer can be admitted anyway. (This

1 differs from the process for NMSOs, where the GC makes a recommendation to the Board of
2 Trustees, or the process for MSS delegates and alternate delegates from national medical
3 specialty societies, federal services, and professional interest medical associations already
4 represented in HOD, where the GC can unilaterally approve those applications.) Current language
5 from AMA Bylaws, AMA Policy, MSS IOPs, and MSS Positions are displayed below.
6

7 **RECOMMENDATION**

8
9 RESOLVED, that our AMA-MSS will:

- 10
- 11 a) invite and consider observer applications from national student organizations that have a
12 vested interest in addressing issues in healthcare and public health, have a majority
13 student membership, and are expected to add a unique perspective or bring expertise to
14 MSS Assembly;
 - 15
 - 16 b) require applications to include the organization's rationale for observer status in the MSS,
17 any governing documents (or if unavailable, a description of the organization's history,
18 structure, operations, and activities), a list of all of the organization's sources of financial
19 support, and a list of all of the organization's affiliations with other entities;
 - 20
 - 21 c) require representatives of observer organizations to be students chosen in a fair and
22 equitable manner by their organization's leadership or membership and certified by their
23 organization's leadership;
 - 24
 - 25 d) allow observer representatives to present their organization's policies, opinions, and
26 interests at appropriate times in the MSS policy process and in the MSS Assembly and
27 report on MSS actions to their organization's leadership and membership; and
 - 28
 - 29 e) use a biennial review process to renew or terminate an organization's observer status
30 analogous to that used for national medical student organizations, with the Governing
31 Council making a recommendation to the MSS Assembly, who will vote to make the final
32 determination.

33 **RELEVANT AMA POLICY**

34 **Official Observer. B-2.9**

35
36 National organizations may apply to the Board of Trustees for official observer status in the House
37 of Delegates. Applicants must demonstrate compliance with guidelines for official observers
38 adopted by the House of Delegates, and the Board of Trustees shall make a recommendation to
39 the House of Delegates concerning the application. The House of Delegates will make the final
40 determination on the conferring of official observer status.
41

42
43 2.9.1 Rights and Privileges. Organizations with official observer status are invited to send one
44 representative to observe the actions of the House of Delegates at all meetings of the House of
45 Delegates. Official observers have the right to speak and debate on the floor of the House of
46 Delegates upon invitation from the Speaker. Official observers do not have the right to introduce
47 business, introduce an amendment, make a motion, or vote.
48

49 **Official Observers in Our AMA House G-600.025**

50 1. Applications for Official Observer status will be reviewed using the following guidelines:

- 1 (A) The organization and the AMA should already have established an informal relationship
2 and have worked together for the mutual benefit of both.
- 3 (B) The organization should be national in scope and have similar goals and concerns about
4 health care issues.
- 5 (C) The organization is expected to add a unique perspective or bring expertise to the
6 deliberations of the House of Delegates.
- 7 (D) The organization does not represent narrow religious, social, cultural, economic, or
8 regional interests so that formal ties with the AMA would be welcomed universally by AMA
9 members.
- 10
- 11 2. An organization granted official observer status in the House shall automatically lose that
12 status if no representative of the organization appears at six consecutive House of Delegates
13 meetings.
- 14
- 15 3. Organizations granted official observer status include the following:
- 16 Accreditation Association for Ambulatory Health Care (1993)
17 Alliance for Continuing Medical Education (1999)
18 Alliance for Regenerative Medicine (2014)
19 Ambulatory Surgery Center Association (2005)
20 American Academy of Physician Assistants (1994)
21 American Association of Medical Assistants (1994)
22 American Board of Medical Specialties (2014)
23 American Dental Association (1982)
24 American Health Quality Association (1987)
25 American Hospital Association (1992)
26 American Nurses Association (1998)
27 American Podiatric Medical Association (2018)
28 American Public Health Association (1990)
29 Association of PeriOperative Nurses (2000)
30 Association of State and Territorial Health Officials (1990)
31 Commission on Graduates of Foreign Nursing Schools (1999)
32 Council of Medical Specialty Societies (2008)
33 Educational Commission for Foreign Medical Graduates (2011)
34 Federation of State Medical Boards of the United States, Inc. (2000)
35 Federation of State Physician Health Programs (2006)
36 Medical Group Management Association (1988)
37 Medical Professional Liability Association (2013)
38 National Association of County and City Health Officials (1990)
39 National Commission on Correctional Health Care (2000)
40 National Council of State Boards of Nursing (2000)
41 National Indian Health Board (2013)
42 Society for Academic Continuing Medical Education (2003)
43 US Pharmacopeia (2003)
- 44 [BOT Rep. 27, I-98; BOT Rep. 1, A-99; BOT Rep. 11, I-99; BOT Rep. 1 and 5, A-00; BOT
45 Rep. 5 and 12, I-00; Consolidated: CLRPD Rep. 3, I-01; Appended: BOT Rep. 17, A-03;
46 Appended: BOT Rep. 2, A-05; Appended: BOT Rep. 7, A-06; Appended: BOT Rep. 10, A-08;
47 Appended: BOT Rep. 26, A-11; Appended: BOT Rep. 3, A-13; Appended: BOT Rep. 7, I-13;
48 Appended: BOT Rep. 2, A-14; Appended: BOT Rep. 14, A-14; Appended: BOT Rep. 43, A-
49 18]

1 **RELEVANT AMA-MSS POSITIONS**

2
3 **IOP 10.3.5 Official Observers**

4 10.3.5.1 National student organizations may apply to the MSS Governing Council for official
5 observer status in the MSS Assembly. Applicants and official observers must demonstrate
6 compliance with guidelines for official observers adopted by the MSS Assembly, and the
7 Governing Council shall make a recommendation to the MSS Assembly concerning the
8 application. The MSS Assembly will make the final determination on the conferring or
9 continuation of official observer status.

10
11 10.3.5.2 Organizations with official observer status are invited to send one representative to
12 observe the actions of the Assembly at all meetings of the MSS Assembly. Official observers
13 have the right to speak and debate on the floor of the Assembly upon invitation from the
14 Speaker. Official observers do not have the right to introduce business, introduce an
15 amendment, make a motion, or vote.

16
17 **IOP 10.3.3 National Medical Student Organizations**

18 10.3.3.1 The following criteria have been developed for national medical student
19 organizations to qualify for representation in the MSS Assembly (AMA Bylaw 36 7.3.3.4.1):

20 10.3.3.1.1 The organization must be national in scope. 10.3.3.1.2 A majority of the
21 voting members of the organization must be medical students enrolled in educational
22 programs (AMA Bylaw 1.1.1).

23 10.3.3.1.3 Membership in the organization must be available to all medical students,
24 without discrimination.

25 10.3.3.1.4 The purposes and objectives of the organization must be consistent with
26 the AMA's purposes and objectives.

27 10.3.3.1.5 The organization's code of medical ethics must be consistent with the
28 AMA's Principles of Medical Ethics.

29
30 10.3.3.2 Application process. A member of the national leadership of the interested national
31 medical student organizations should submit to MSS staff a written application on behalf of
32 the organization containing sufficient information to establish that the organization meets the
33 above criteria. The application must also include the following:

34 10.3.3.2.1 The organization's governing documents (e.g., charter, constitution,
35 bylaws, code of medical ethics). If the organization does not have a code of medical
36 ethics, they will be expected to be aligned with the AMA's Principles of Medical Ethics.

37 10.3.3.2.2 A list of the sources of the organization's financial support, other than the
38 dues of its medical student members.

39 10.3.3.2.3 A list or description of all of the organization's affiliations.

40 10.3.3.2.4 Any additional information to assist the MSS Governing Council in
41 reviewing applications may be requested.

42 10.3.3.2.5 The Governing Council shall review the application. If it recommends that
43 the organization be granted representation in the MSS Assembly Meeting, the
44 recommendation shall be submitted to the AMA Board of Trustees for review. If
45 approved by the AMA Board of Trustees, the organization may be represented in the
46 MSS Assembly Meeting by one MSS Delegate and one Alternate MSS Delegate.

47 10.3.3.2.6 The Governing Council will annually report any applications from national
48 medical student organizations for representation in the MSS Assembly, along with the
49 resultant recommendation.

1
2 10.3.3.3 Biennial Review. Each national medical student organization represented in the MSS
3 Assembly will be required to reconfirm biennially that it continues to meet the criteria for
4 eligibility by submitting such information and documentation as may be required by the
5 Governing Council. Organizations will be notified by the Governing Council of the time of their
6 review and will be asked to submit appropriate documentation. Failure to participate in the
7 biennial review process or to meet the established criteria will be reported to the Governing
8 Council for action.

9 10.3.3.4 The Governing Council may recommend discontinuance of the
10 representation by a national medical student organization on the basis that the
11 organization fails to maintain its responsibilities (Section 10.3.3.5). The
12 recommendation shall be submitted to the AMA Board of Trustees for review. If
13 approved by the AMA Board of Trustees, the representation of the national medical
14 student organization in the MSS Assembly Meeting shall be discontinued.

15 10.3.3.4.1 Should the Governing Council believe an organization in the MSS
16 Assembly has failed to verify fulfillment or meet the criteria for representation, the
17 organization's leadership, including the current and immediate past Delegate and
18 Alternate Delegate will be emailed with notice of this failure and the timeline for
19 correction to prevent termination. 10.3.3.4.2 An organization will have thirty (30) days
20 from the receipt of the notice to respond and make efforts to address the concerns of
21 the Governing Council. 10.3.3.4.3 If the organization does not respond within thirty
22 (30) days or has not made an effort to address the concerns then their representation
23 in the organization will be terminated

24 10.3.3.4.4 Information regarding any organizations that have had their representation
25 in the MSS Assembly terminated and why will be shared with the General Assembly
26 at the next national meeting.

27
28 10.3.3.5 The MSS Delegate and Alternate MSS Delegate selected by each national medical
29 student organization granted representation at the Assembly Meeting shall:

30 10.3.3.5.1 Be medical student members of the AMA (Section 3).

31 10.3.3.5.2 Not hold any voting office on the MSS Governing Council (Section 4).

32 10.3.3.5.3 Not serve as the Medical Student Trustee, on an AMA Council, or as a
33 national AMA Liaison (Section 11).

34 10.3.3.5.4 Be chosen in a fair and equitable manner allowing open representation and
35 medical student input.

36 10.3.3.5.5 Be certified in writing by the president, or other appropriate representative,
37 of the organization they will be representing.

38 10.3.3.5.6 Have full voting rights including the right to vote in any elections at the
39 conclusion of the organization's two-year initial probationary period with regular
40 attendance (AMA Bylaws 7.3.3.4.3).

41 10.3.3.5.7 Be able to present their organization's policies and opinions as part of
42 representing the interests of their medical student constituency in Assembly Meetings.

43 10.3.3.5.8 Report on the actions of the MSS to the national medical student
44 organization. 10.3.3.5.9 Cooperate in enhancing the MSS membership.

45
46 **645.016MSS Student Academy of the American Academy of Physician Assistants Official**
47 **Observer**

48 The AMA-MSS will invite the Student Academy of the American Academy of Physician Assistants
49 to send a non-voting Official Observer to all meetings of the AMA-MSS Assembly. (MSS Rep B,

1 I-99) (Reaffirmed: MSS Rep A, I-04) (Reaffirmed: MSS GC Report B, I-09) (Reaffirmed: MSS GC
2 Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)

3
4 **645.019MSS European Medical Student Association (EMSA) – Official Observer**
5 The AMA-MSS will invite the European Medical Students Association to send a non-voting Official
6 Observer to all meetings of the AMA-MSS Assembly. (MSS Rep E, A-02) (Reaffirmed: MSS Rep
7 C, I-07) (Reaffirmed: MSS GC Report C, I-12) (Reaffirmed: MSS GC Report A, I-17) (Reaffirmed:
8 MSS GC Report A, A-23)

REPORT OF THE MEDICAL STUDENT SECTION
GOVERNING COUNCIL

GC Report J
(A-24)

Introduced by: Natasha Topolski, Chair
Subject: Use of Inclusive Language in AMA Policy
Referred to: MSS Reference Committee
(TBD)

1 **INTRODUCTION**
2

3 As your Governing Council and Standing Committees conducted our sunset review process, and
4 as our Archives Task Force began piloting their archives process, we noted many AMA policies
5 with outdated language. In 2021, the AMA, via its Center for Health Equity, and the Association
6 of American Medical Colleges (AAMC), via its Center for Health Justice, together published the
7 language guide, [Advancing Health Equity: A Guide to Language, Narrative and Concepts](#).
8

9 At A-23, HOD adopted [H-65.942, "Supporting the Use of Gender-Neutral Language,"](#) amended
10 from an MSS resolution. This served as a model for broad-based updates to the AMA policy
11 compendium. Notably, after extensive debate, HOD stated that the "reaffirmation and sunset
12 processes" should be used to amend current AMA policies for this purpose, as staff alleged that
13 a one-time update to the compendium would be a major effort with high cost.
14

15 At HOD I-23, the American Academy of Pediatrics Delegation submitted [Resolution 607, "Equity-
16 Focused Person-First Language in AMA Reports and Policies."](#) The resolution asked the AMA to
17 amend current policies via the sunset process and write Board and Council reports to reflect
18 language consistent with the AMA/AAMC language guide. The resolution also asked HOD
19 delegations to write resolutions consistent with the guide and educate members on its use when
20 writing resolutions. However, the resolution was not considered due to the recommendation of
21 the Interim Meeting Resolution Committee.
22

23 The MSS has a pending resolution to be submitted to HOD: 630.077MSS, "Inclusive Language
24 for Immigrants in Relevant Past and Future AMA Policies." A new MSS Open Forum post was
25 proposed for the A-24 Assembly, ["Person First Language for People Who Are Incarcerated,"](#)
26 analogous to 630.077MSS. After review, the poster ultimately decided not to proceed with a
27 resolution and to instead submit an MSS Action Item to your Governing Council, which resulted
28 in requests to MSS staff to inquire how inclusive language, whether from the guide or otherwise,
29 was currently being used to update AMA policies.
30

31 This led to the discovery that existing AMA policies are not routinely updated for inclusive
32 language via the reaffirmation or sunset processes. Such changes must be initiated by a Council
33 member or staff member, as inclusive language is not part of the current protocol. AMA staff has
34 informed us that AMA policies cannot be updated in any other manner, unless directed by a policy
35 adopted at HOD requesting such changes. Furthermore, no directive exists to ensure inclusive
36 language is also used for new policies or amendments.

1 Your Section Delegates note that updates to MSS positions for inclusive language via our sunset
2 process have already been standard practice for several years. The use of reaffirmation in the
3 MSS outside of the sunset process is very limited as it only applies to the few MSS resolutions
4 that create or amend internal MSS positions.

5 6 **DISCUSSION**

7
8 Your Section Delegates thank the students who brought forward this Action Item for identifying a
9 gap in AMA staff procedures that limits our AMA's steps toward health equity. This is now the
10 third resolution proposed in the MSS attempting to fix one component of outdated language, and
11 future resolutions can be expected to address other components. Given the potential for these
12 piecemeal fixes to unnecessarily increase our MSS queue of resolutions to HOD, we believe that
13 it would be most beneficial to bring a single broad resolution to request all the policy changes we
14 expect at once, satisfying the needs of 630.077MSS and the Action Item on incarcerated
15 language as well as addressing all other outdated language. Because such an ask would
16 supersede 630.077MSS, we suggest rescinding this position. This means that this report's
17 recommendations would create no net difference in our MSS resolution queue, as we would be
18 adding one position to the queue and rescinding another.

19
20 Of course, ideally an MSS submission can be avoided altogether if AAP resubmits their resolution.
21 However, while we have been unable to confirm this so far via our MSS representative from AAP.
22 Since the HOD A-24 resolution submission deadline is after the MSS report deadline and after
23 our VRC closes, we believe that this report should be adopted to add this ask to our MSS queue
24 as a safeguard, in case AAP does not resubmit. If AAP does confirm they will resubmit their
25 resolution, then our MSS Caucus can withhold submitting this report's recommendations to a
26 future HOD, and our MSS Caucus can instead use this report's recommendation as a basis to
27 support the AAP resolution. If AAP does not resubmit, our MSS Caucus will be ready to submit
28 this language at a future HOD.

29
30 We also want to note two specific differences between our recommendation below and AAP's
31 language. First, AAP specifically mentions the AMA/AAMC language guide. However, we felt that
32 the MSS, unlike other delegations, would be uniquely criticized for mentioning this in our resolve
33 as tying AMA policy to a specific document, as our resolves receive considerably more scrutiny
34 than others' resolutions. This could potentially lead to make the language guide a lightning rod for
35 debate in HOD, and we do not want to inadvertently risk harming efforts to promote inclusive
36 language by our AMA Center for Health Equity. Similar issues have previously been raised
37 regarding the [AMA's Organizational Strategic Plan to Embed Racial Justice and Advance Health
38 Equity](#), written by the Center but endorsed by the Board of Trustees. Unfortunately, the plan was
39 debated at multiple HODs, with attempts by delegations to revoke or significantly amend the plan.
40 We hesitate to open a similar debate on the language guide. Given that we are not specifically
41 referencing the guide, we added other adjectives into our recommendations below.

42
43 Second, while AAP's resolves mention encouraging other delegations to use equity-focused,
44 person-first language in their resolutions, again, we worried that due to the special scrutiny on the
45 MSS, such language would not be perceived well by other delegations of attending physicians
46 who believe that medical students are telling them how to write their resolutions and educate their
47 members, and that this could lead to strained relationships. However, our mention of "all future
48 AMA policies and amendments" is meant to be inclusive of both Board and Council reports and
49 any other delegations' resolutions that are adopted or amended at HOD. This would ensure that
50 even if a resolution is submitted to HOD with outdated language, Reference Committee and other
51 AMA staff would be directed throughout the HOD process (Online Forums, Reference Committee

1 hearings and reports, and even potentially after HOD passage, if corrections are still needed) to
2 ensure that the final policy adopted by HOD reflects inclusive language. Therefore, we believe
3 our language appropriately accounts for the different situations included in the AAP resolution,
4 without risking any additional ill perception of the MSS.

5 6 **RECOMMENDATIONS**

7
8 Your AMA-MSS Governing Council recommends that the following be adopted and the remainder
9 of the report be filed:

10
11 RESOLVED, that our American Medical Association amend existing policies via the
12 reaffirmation and sunset processes to ensure the use of the most updated, inclusive,
13 equitable, respectful, destigmatized, and person-first language and use such language in
14 all future AMA policies and amendments; and be it further

15
16 RESOLVED, that our AMA-MSS rescind 630.077MSS, "Inclusive Language for
17 Immigrants in Relevant Past and Future AMA Policies," as it is superseded by the first
18 resolve, and accordingly withdraw this resolution from our HOD submission queue.

19 20 **RELEVANT AMA POLICY**

21 22 **Eliminating Use of the Term "Mental Retardation" by Physicians in Clinical Settings H-70.912**

23
24 Our American Medical Association recommends that physicians adopt the term "intellectual
25 disability" instead of "mental retardation" in clinical settings. [Res. 024, A-19]

26 27 **Person-First Language for Obesity H-440.821**

28 Our AMA: (1) encourages the use of person-first language (patients with obesity, patients affected
29 by obesity) in all discussions, resolutions and reports regarding obesity; (2) encourages the use
30 of preferred terms in discussions, resolutions and reports regarding patients affected by obesity
31 including weight and unhealthy weight, and discourage the use of stigmatizing terms including
32 obese, morbidly obese, and fat; and (3) will educate health care providers on the importance of
33 person-first language for treating patients with obesity; equipping their health care facilities with
34 proper sized furniture, medical equipment and gowns for patients with obesity; and having
35 patients weighed respectfully. [Res. 402, A-17; Modified: Speakers Rep., I-17]

36 37 **Supporting the Use of Gender-Neutral Language H-65.942**

38 Our American Medical Association will (1) Recognize the importance of using gender-neutral
39 language such as gender neutral pronouns, terms, imagery, and symbols in respecting the
40 spectrum of gender identity, (2) prospectively amend all current AMA policy, where appropriate,
41 to include gender-neutral language by way of the reaffirmation and sunset processes, (3) utilize
42 gender-neutral language in future policies¹ internal communications, and external
43 communications where gendered language does not specifically need to be used, (4) encourage
44 the use of gender-neutral language in public health and medical messaging, (5) encourage other
45 professional societies to utilize gender-neutral language in their work, and (6) support the use of
46 gender-neutral language in clinical spaces that may serve both cisgender and gender-diverse
47 individuals. [Res. 602, A-23]

48 49 **RELEVANT [MSS POLICY](#)**

50 51 **65.040MSS Supporting the Use of Gender-Neutral Language**

1 Our AMA-MSS will ask our AMA to: (1) Recognize the importance of using gender-neutral
2 language such as gender-neutral pronouns, terms, imagery, and symbols in respecting the
3 spectrum of gender identity, (2) revise all relevant policies to utilize gender-neutral language in
4 place of gendered language where such text inappropriately appears, (3) utilize gender-neutral
5 language in future policies, internal communications, and external communications where
6 gendered language does not specifically need to be used, (4) encourage the use of gender-
7 neutral language in public health and medical messaging, (5) encourage other professional
8 societies to utilize gender-neutral language in their work, and (6) support the use of gender-neutral
9 language in clinical spaces that may serve both cisgender and gender-diverse individuals.

10
11 **65.050MSS The Importance of Consistent Terminology for LGBTQ+ Related Policy and**
12 **Assessment of Current AMA-MSS Policy on LGBTQ+ Affairs**

13 AMA-MSS will utilize the combined terminology recommendation and catalog of existing AMA-
14 MSS policy to fully update existing AMA-MSS policy relating to LGBTQ+ Affairs to make it
15 consistent with all other policies and the current best practices for language relating to the
16 LGBTQ+ population.

17
18 **65.055MSS Including Gender Inclusive Language in Menstrual Healthcare**

19 AMA-MSS (1) supports gender-neutral language with regards to reproductive rights including but
20 not limited to menstrual products in medical education, clinical training, and clinical practice; (2)
21 supports training for healthcare providers that includes de-gendered language and inclusivity for
22 various period products to better understand the needs of all persons who menstruate; and (3)
23 administratively amends existing MSS policy which includes mention of “feminine hygiene
24 products,” namely 160.032MSS, 525.008MSS, 525.009MSS, and 525.015MSS, to replace the
25 phrase “feminine hygiene” with “menstrual.”

26
27 **630.041MSS Inclusion of AOA-Accredited Schools in Policy Language**

28 It is the policy of the AMA-MSS that resolutions and internal policies specifically recognize
29 osteopathic students whenever appropriate. (MSS Sub Res 14, A-96)
30 (Reaffirmed: MSS Rep B, I-01) (Reaffirmed: MSS Rep F, I-06) (Reaffirmed:
31 MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16) (Reaffirmed:
32 MSS GC Report A, I-21)

REPORT OF THE MEDICAL STUDENT SECTION DELEGATES

SD Report A
(A-24)

Introduced by: Rajadhar Reddy, Section Delegate and Laurie Lapp, Section Alternate Delegate

Subject: Delegate Report A: MSS Policy Process and HOD Resolution Queue

Referred to: MSS Reference Committee
(Caitlin Blaukovitch and Shaminy Manoranjithan, Co-Chairs)

1 INTRODUCTION

2
3 MSS Internal Operating Procedure (IOP) 10.8.7 states that “Once resolutions with external asks
4 are adopted by the MSS Assembly, they must be submitted in the name of the MSS to the AMA
5 HOD [House of Delegates] meeting within one year of adoption at the Section Delegates’
6 discretion, unless withdrawn from the queue by the MSS Assembly or directed by the MSS
7 Assembly to be submitted at a specific AMA HOD meeting. Transmittals may be delayed up to
8 one additional year, by a two-thirds (2/3) vote of the MSS Caucus, taken prior to each additional
9 meeting.”

10
11 Resolves of all MSS-adopted resolutions are included in the [MSS Digest of Policy Actions](#). If a
12 resolution only establishes an MSS position and does not request any “external” AMA action,
13 then the adopted language is only retained as an “internal” position in the [MSS Digest](#) and is not
14 submitted to HOD.

15
16 MSS IOP 10.8.8 outlines special circumstances “not within the control of the MSS” when “the
17 transmittal process outlined in 10.8.8 may be suspended for one meeting and an alternative
18 process implemented at the discretion of the Section Delegates.” This IOP is only provided for
19 context and is not relevant to this report.

20
21 The MSS Section Delegates are responsible for submitting resolutions to HOD. The MSS
22 Caucus, comprised of the Section Delegates, Regional Delegates and Alternate Delegates, and
23 any medical student serving on another HOD Delegation who accepts the Section Delegate’s
24 invitation to join (IOP 9.1.1), is responsible for advocating for MSS-authored resolutions in HOD.

25 STATUS OF THE MSS RESOLUTION SUBMISSION QUEUE

26
27
28 The MSS’ standard practice at the time of the HOD Interim 2019 Meeting was to submit all MSS
29 resolutions adopted at an Assembly to the next HOD meeting (eg, HOD I-19 for resolutions
30 adopted by the MSS A-19 Assembly). Exceptions were made if the MSS Assembly voted to
31 “immediately forward” resolutions to the HOD Meeting taking place at the same conference,
32 shortly after that MSS Assembly’s conclusion. Between A-14 and I-19, the total number of
33 resolutions submitted to each HOD meeting (including immediately forwarded items) ranged from
34 13 to 31 resolutions.

35

1 Due to the COVID-19 pandemic, delegations were not allowed to submit resolutions to HOD A-
2 20. The 3 virtual Special Meetings that followed (I-20, A-21, and I-21) utilized a Special Meeting
3 Resolution Committee (distinct from the Resolution Committee standardly used at HOD Interim
4 Meetings). The Special Meeting Resolution Committee severely restricted the number of items
5 that could be considered at each HOD and limited the MSS' ability to advocate for our resolutions
6 in HOD.

7
8 This led to the development of a "backlog" of MSS-adopted resolutions that had not yet been
9 considered and debated by HOD. The MSS Caucus used a variety of mechanisms to determine
10 which items to submit to each HOD Special Meeting; descriptions of these processes can be
11 found in prior iterations of Delegate Report A from previous MSS Assemblies. Previous MSS
12 Section Delegates also used these reports to withdraw certain resolutions from the queue if their
13 asks had been considered and debated by HOD via other mechanisms, such as items introduced
14 by other AMA delegations and entities or amendments to those items.

15
16 When HOD resumed standard functions without a Special Meeting Resolution Committee at its
17 A-22 Meeting, the number of items that could be considered was no longer restricted at Annual
18 Meetings. However, the Interim Meeting Resolution Committee is still in place. Efforts to instate
19 a permanent Resolution Committee at all HODs have been repeatedly defeated. One of the MSS
20 resolutions being submitted to AMA A-24 with the support of the Resident & Fellow Section (RFS)
21 seeks to also remove the Interim Meeting Resolution Committee.

22
23 At A-22, I-22, and A-23, our MSS Caucus diligently and successfully worked through the majority
24 of our MSS resolution backlog. For I-23, given the relatively low number of remaining items in
25 queue, your MSS Caucus decided to submit all remaining MSS resolutions to HOD I-23 in an
26 effort to clear the backlog, except for items held for specific strategic reasons. However, your
27 MSS Caucus also understood that because the Interim Meeting Resolution Committee would
28 inevitably screen some items out, those resolutions would return to the backlog, preventing full
29 clearance until HOD A-24. A total of 39 resolutions were submitted to HOD I-23 (including 3
30 combinations of a total of 8 individual resolutions and 1 resolution immediately forwarded by the
31 MSS Assembly). Based on Resolution Committee recommendations, HOD did not consider 12
32 (including the immediate forward and 1 of the combinations).

33
34 In addition to the 12 resolutions that returned to the backlog, 12 resolutions which had previously
35 been held for strategic reasons still remained, 1 of which was amended and 1 of which was
36 rescinded by the MSS I-23 Assembly. An additional 22 policy items were adopted by the MSS I-
37 23 Assembly. This left us with a total of 45 policy items in queue for submission to HOD A-24. As
38 our MSS Caucus meeting to certify submissions is Sunday, April 14 and the resolution
39 submission deadline for HOD is Wednesday, April 24, after the publication of this report but before
40 our MSS Reference Committee's review, the next sections detail our plan regarding management
41 of this queue, but we ask for understanding that some actions may change based on events that
42 occur in the next few weeks.

43
44 Furthermore, reflecting on how our Assembly has evolved over the past year as a result of the
45 MSS A-23 Resolution Task Force report and numerous other systemic changes instituted since,
46 your Section Delegates recommend amendments to 645.032MSS, "Resolution Task Force
47 Update 2022" (the title has an error, as this was passed in 2023) and 630.025MSS, "Changes in
48 MSS Resolutions Forwarded to the AMA House of Delegates." Please see Recommendations 3
49 and 4 for rationale.

1 Your Section Delegates also note that this recurring report is actually a relatively new addition
2 and was only instated at MSS I-20 by our former Section Delegate Pauline Huynh and Section
3 Alternate Delegate Justin Magrath to track our backlog in the wake of COVID and the instatement
4 of the Special Meeting Resolution Committee. We thank our predecessors for their foresight and
5 thoughtfulness in stewarding our MSS members' advocacy. However, as the backlog will officially
6 be cleared at HOD A-24, we no longer see the need for a regular iteration of this report. Since
7 the beginning of our term, your Section Delegates have made the HOD queue as well as the list
8 of forthcoming HOD reports (noting those that relate to MSS resolutions submitted to HOD)
9 publicly available and easily accessible on the MSS Microbrick. Therefore, this will be the final
10 edition of this report. Moving forward, the current Delegate Report B on HOD Policy Proceedings
11 (as required by IOP 9.3, "Reporting of Caucus Actions") will be the only regular Delegate Report,
12 as was the status quo prior to COVID (unless of course, future Delegates decide to add other
13 regular Delegate Reports).

14
15 **FOR INFORMATIONAL PURPOSES: ACTIONS TAKEN BY THE MSS SECTION DELEGATES**
16 **AND MSS CAUCUS REGARDING MSS TRANSMITTALS**

17
18 **ACTION 1:** With a vote of concurrence from your MSS Caucus (by acclamation for all but the
19 last, and with an 82% vote for the last), the current plan is that your Section Delegates will ensure
20 that the 37 resolutions below are submitted to HOD A-24 in some form, whether by the MSS or
21 by another delegation.

22
23 *Note: Your Section Delegates have worked diligently and thoughtfully to select resolutions that*
24 *may be appropriate for other delegations to introduce as the sponsor instead of the MSS and to*
25 *ensure that these delegations can be trusted to submit these resolutions in our stead, so that we*
26 *are not inadvertently delaying submission of a resolution. Some of these attempts have failed,*
27 *due to different delegations' unique logistical processes, but this is not for lack of effort on our*
28 *part. However, some seem very encouraging. As we are still working on some of these*
29 *opportunities, not all may be displayed in the list below. In these cases, the MSS would not be*
30 *listed at the top of the resolution as a sponsor, but would still vocally support the resolution on*
31 *the HOD online member forums, in the live Reference Committee hearings, and on the HOD floor*
32 *if needed. The reason for not listing the MSS as a cosponsor on these items is due to concerns*
33 *from other delegations over the MSS' resolution volume. Even if the MSS is listed as a cosponsor,*
34 *the resolution is displayed under the MSS in the "List of Resolutions by Sponsor" in the HOD*
35 *Handbook. Furthermore, even the MSS' name at the top of a resolution as a cosponsor can give*
36 *the impression to those reviewing that the MSS is sponsoring too many items, even if other*
37 *delegations are also listed.*

- 38
39 1) Guardianship and Conservatorship Reform (from MSS I-22)
40 2) Opposing Pay-to-Stay Incarceration Fees (from MSS A-23)
41 a) *Possible submission by American College of Legal Medicine*
42 3) Indian Water Rights (from MSS A-23)
43 4) Medical-Legal Partnerships & Legal Aid Services (from MSS A-23)
44 5) Humanitarian Efforts to Resettle Refugees (from MSS A-23)
45 a) *Possible submission by the Minority Affairs Section*
46 6) Fairness for International Medical Students (from MSS I-22)
47 7) Racial Misclassification (from MSS A-23)
48 8) Occupational Screenings for Lung Disease (from MSS I-22)
49 9) Fragrance Regulation (from MSS A-22 & I-22)

- 1 10) Improvements to Medicaid Benefits (from MSS A-21, I-21, & I-22)
- 2 11) Biosimilar Use Rates and Prevention of Pharmacy Benefit Manager Abuse (from MSS A-
- 3 23)
- 4 12) Medigap Protections (from MSS I-23)
- 5 13) Infertility Coverage (from MSS A-22 & I-23)
- 6 14) Opposition to the Hospital Readmissions Reduction Program (from MSS I-23)
- 7 15) Opposition to Medicaid Estate Recovery (from MSS I-23)
- 8 16) Removal of the Interim Meeting Resolution Committee (from MSS A-21)
- 9 17) Amendments to AMA Bylaws to Enable Medical Student Leadership Continuity (from MSS
- 10 I-22 & I-23)
- 11 18) Voter Protections During and After Incarceration (from MSS I-23)
- 12 a) *Possible submission by the Minority Affairs Section*
- 13 19) Improving Supplemental Nutrition Programs (from MSS I-23)
- 14 20) Support for Paid Sick Leave (from MSS I-23)
- 15 21) Supporting the Health of Our Democracy (from MSS I-23)
- 16 a) *Possible submission by the Minority Affairs Section*
- 17 22) Native American Voting Rights (from MSS I-23)
- 18 23) Public Service Loan Forgiveness Reform (from MSS I-23)
- 19 a) *Submission by Oklahoma*
- 20 24) Antidiscrimination Protections for LGBTQ+ Youth in Foster Care (from MSS I-23)
- 21 25) Default Proceed Firearm Sales & Safe Storage Laws (from MSS I-23)
- 22 26) Access to Public Restrooms (from MSS I-23)
- 23 27) Missing and Murdered Indigenous Persons (from MSS I-23)
- 24 a) *Submission by Oklahoma*
- 25 28) Screening for Image Manipulation in Research Publications (from MSS I-23)
- 26 29) Toxic Heavy Metals (from MSS I-23)
- 27 30) Mitigating the Harms of Colorism and Skin Bleaching Agents (from MSS I-23)
- 28 31) Tribally Directed Precision Medicine Research (from MSS I-23)
- 29 32) Annual Holocaust Remembrance Event (from MSS I-23)
- 30 33) End Attacks on Health and Human Rights in Palestine and Israel (from MSS I-23)
- 31 34) American Indian and Alaska Native Language Revitalization and Elder Care (from MSS
- 32 I-23)
- 33 35) Protections Against Surgical Smoke Exposure (from MSS I-23)
- 34 36) Indian Health Service Youth Regional Treatment Centers (from MSS I-23)
- 35 37) Addressing the Health Risks of Extreme Heat (from MSS I-23)
- 36

37 Regarding the resolution titled “Removal of the Interim Meeting Resolution Committee,” a similar
38 resolution was passed by the Resident & Fellow Section (RFS) years back. We asked if they
39 would cosponsor the resolution, but their resolution included a second resolve (displayed below)
40 aligned with the intent of the resolution but not included in the MSS-adopted resolution. With a
41 vote of concurrence by acclamation by your MSS Caucus (above the $\frac{2}{3}$ threshold for
42 cosponsorship), we will cosponsor a resolution together with RFS and include this second
43 resolve:

- 1 ● RESOLVED, that our AMA remove constraints on the scope of business at Interim
2 Meetings, which is regulated by the Resolution Committee, by amending AMA Bylaw B-
3 2.12.1.1, "Business of Interim Meeting," by deletion as follows:

4 ~~**2.12.1.1 Business of Interim Meeting**~~

5 ~~The business of an Interim Meeting shall be focused on advocacy and legislation.~~
6 ~~Resolutions pertaining to ethics, and opinions and reports of the Council on Ethical and~~
7 ~~Judicial Affairs, may also be considered at an Interim Meeting. Other business requiring~~
8 ~~action prior to the following Annual Meeting may also be considered at an Interim~~
9 ~~Meeting. In addition, any other business may be considered at an Interim Meeting by~~
10 ~~majority vote of delegates present and voting.~~

11
12 For information, here is the list of HOD A-24 reports derived from MSS resolutions:

- 13
14 1. BOT Support for Mental Health Courts (from HOD A-23)
15 2. BOT Drug Policy Reform (from HOD A-23)
16 3. BOT Supporting Harm Reduction (from HOD A-23)
17 4. BOT The Significance of the Morrill Act and It's Impact on the Diversity of the Physician
18 Workforce (from HOD A-22)
19 5. BOT Environmental Sustainability of AMA National Meetings and Supporting Carbon
20 Offset Programs for Travel for AMA Conferences (from HOD A-23, combined with Illinois
21 resolution)
22 6. BOT Encouraging Collaboration Between Physicians and Industry in AI (Augmented
23 Intelligence) Development (from HOD A-23)
24 7. BOT Study of Mechanisms to Mitigate the Cost of Medical Student Participation in the
25 AMA (from HOD A-22)
26 8. CEJA Guidelines on Chaperones for Sensitive Exams (from HOD I-22)
27 9. CEJA Physicians' Use of Social Media for Product Promotion and Compensation (from
28 HOD A-22)
29 10. CMS Movement Away from Employer-Sponsored Health Insurance (from HOD A-23)
30 11. CMS Billing for Traditional Healing Services (from HOD A-23)
31 12. CSAPH Decreasing Youth Access to E-cigarettes (from HOD I-22)
32 13. CSAPH Clarifying the Roles of BMI as a Measure in Medicine (from HOD A-22; initial
33 report at HOD A-23, [RefCom recs partially adopted](#) and partially referred back)
34 14. CSAPH Amending Policy H-525.988, "Sex and Gender Differences in Medical Research"
35 (from HOD A-23)
36 15. CSAPH Study of Chemical Castration in Incarceration (from HOD A-23)
37 16. CSAPH Comparative Effectiveness Research (from HOD A-23)

38
39 **ACTION 2:** With a vote of concurrence by acclamation from your MSS Caucus, your Section
40 Delegates merged the following resolutions, consolidating the arguments in the whereas clauses
41 while retaining all MSS-adopted resolves, and will ensure their submission in their combined form
42 in their combined form to HOD A-24. Beginning with the HOD I-23 submission process, your MSS
43 Section Delegates also contacted the original MSS primary authors of most of these resolutions
44 to ask for their input into this strategy and were granted their assent.

- 45
46 ❖ Fragrance Regulation, which combined:
47 ➤ Promoting a Fragrance-Free Health Care Environment (160.045MSS), and
48 ➤ Increasing Regulation and Labeling of Fragrances in Personal Care Products,
49 Cosmetics, and Drugs (270.053MSS)

1 ➤ *Note: This combination was submitted to HOD I-23 but was not recommended for*
2 *consideration by the Resolution Committee and was not extracted to attempt*
3 *consideration. The primary author was consulted at all steps.*

4 ❖ Improvements to Medicaid Benefits, which combined:

- 5 ➤ Establishing Comprehensive Dental Benefits Under State Medicaid Programs
6 (290.009MSS)
7 ➤ Support for Vision Screenings and Visual Aids for Adults Covered by Medicaid
8 (290.010MSS)
9 ➤ Medicaid Hearing Coverage (180.025MSS)

10 ❖ Default Proceed Firearm Sales and Safe Storage Laws, which combined:

- 11 ➤ Addressing Default Proceed Sales of Firearms (145.026MSS)
12 ➤ Support for Comprehensive Safe Firearm Storage Legislation (145.073MSS)

13
14 **ACTION 3:** With votes of concurrence (with an 80% vote for the first, above the $\frac{2}{3}$ threshold for
15 delaying a transmittal beyond 1 year, and by acclamation for the rest), your Section Delegates
16 will not submit the following resolutions to HOD A-24, due to forthcoming related resolutions or
17 reports submitted for consideration and debate by the MSS A-24 Assembly. These resolutions
18 will be retained in the queue for future HOD submission at this time, unless further action is taken
19 by the MSS Assembly.

20
21 ❖ Inclusive Language for Immigrants in AMA Policies (630.077MSS)

- 22 ➤ Related MSS A-24 Report: GC Report F - Updates to AMA Policy with Inclusive
23 Language

24 ❖ Research of Plastic Use in Medicine (460.028MSS)

- 25 ➤ Related MSS A-24 Resolution: Study on Plastic Pollution Reduction

26 ❖ Advocating for Plant-Based Meat Research and Regulation (150.046MSS)

- 27 ➤ Related MSS A-24 Resolution: Studying the Effects of Plant-Based Meat

28 ❖ Expanding AMA's Position on Healthcare Reform Options (165.030MSS)

- 29 ➤ *Note: This position has the same title as 165.022MSS but is distinct.*

- 30 ➤ Related MSS A-24 Report: this report (see Recommendation 1 below)

31 ❖ Amending G-630.140 Lodging, Meeting Venues and Social Functions (665.016MSS)

- 32 ➤ Related MSS A-24 Report: this report (see Recommendation 2 below)

33
34 **RECOMMENDATIONS**

35
36 1) That our AMA-MSS

- 37 a) amend MSS Position 165.020MSS, "Single Payer Solution," as follows to
38 incorporate the content of 165.022MSS, "Expanding AMA's Position on
39 Healthcare Reform Options" and 165.030MSS, also identically titled "Expanding
40 AMA's Position on Healthcare Reform Options," to create a unified consolidated
41 position,

- 42 b) accordingly rescind 165.022MSS and 165.030MSS, and

- 43 c) with the concurrence of a vote by acclamation from your MSS Caucus, withdraw
44 the resolution related to 165.030MSS from our HOD queue:

- 45 i) *Note: 165.030MSS was adopted at MSS A-23 and was in our queue to be*
46 *submitted to a future HOD meeting. A similar resolution sponsored by the*
47 *New England Delegation was submitted to and debated at HOD I-23.*
48 *Ultimately, the resolution was partially referred, with expected report back*

1 at HOD I-24. Submission of an MSS resolution is no longer necessary at
2 this time, as we will use our existing internal MSS positions to advocate on
3 the resultant HOD I-24 report. These changes also reflect protocols used
4 by the MSS Governing Council and Standing Committees for the MSS A-
5 24 Sunset Review Process to clarify when the MSS asked for an external
6 action at HOD. The combined policy timeline is provided for context. The
7 word “national” is added to the title differentiate this position from
8 165.017MSS, “MSS Support for State-by-State Universal Health Care,” but
9 is intentionally left out of the underlined addition, as our external actions in
10 HOD are specifically about “single payer” and do not differentiate between
11 national or state, though of course “national” would be the common
12 interpretation.
13

14 **165.020MSS National Single Payer Healthcare Solution**

15 AMA-MSS supports the implementation of a national single payer system, ~~and (2)~~
16 ~~While~~ our AMA-MSS shall prioritize its support of a federal single payer system, our
17 AMA-MSS may continue to advocate for intermediate federal policy solutions including
18 but not limited to a federal Medicare, Medicaid, or other public insurance option that
19 abides by the guidelines for health systems reform in 165.019MSS and 165.024MSS.

20 Our AMA-MSS asked the AMA to remove opposition to single payer from AMA policy,
21 adopt a neutral stance on single payer healthcare reform, and instead evaluate single
22 payer proposals by the extent to which they align with the AMA’s policy on healthcare
23 reform.

24 (MSS Res 12, A-17) (MSS Res 40, I-17) (AMA Res 108, A-18, Referred) (CMS Report 2,
25 A-19, Not Adopt) (Amended: MSS GC Report A, A-23) (MSS Res. 048, A-23) (AMA Res
26 818 from New England Delegation, I-23, Referred)
27

- 28 2) That our AMA-MSS amend MSS Position 665.016MSS, “Amending G-630.140 Lodging,
29 Meeting Venues and Social Functions,” as follows and with the concurrence of a vote by
30 acclamation from your MSS Caucus, accordingly withdraw this resolution from our HOD
31 queue:

32 a) *Note: This resolution was originally passed at MSS A-19, prior to COVID, when*
33 *the MSS Physicians of the Future Summit (POTFS) regional meetings were still*
34 *held in-person. Since COVID, POTFS has moved entirely virtual, and region*
35 *leadership has repeatedly indicated no interest in moving back to an in-person*
36 *format due to logistical difficulties and inequities in access to travel, lodging, etc*
37 *for yet another MSS-related meeting. However, your MSS Governing Council*
38 *recognizes that the opinions of our MSS membership and region leadership may*
39 *change in the future and keeping options available long-term for upcoming*
40 *generations of MSS members is important. For example, after the most recent*
41 *POTFS in January 2024, interest was again renewed in possibly hosting MSS*
42 *regional meetings in-person. At HOD I-22, Resolution 602 introduced by the*
43 *Southeastern Delegation (16 states, DC, and PR), TX, and the American College*
44 *of Radiology sought to amend G-630.140 to remove the restrictions on AMA*
45 *meeting venues altogether. Due to the increasing criminalization of abortion,*
46 *gender-affirming care, and other types of care, as well as increased risk of*
47 *violence and discrimination toward individuals from minoritized communities, the*
48 *removal of restrictions altogether would force AMA members to risk their safety to*
49 *attend and participate in AMA meetings. Our MSS Caucus did not support the*
50 *resolution, but did support the one-word amendment to G-630.140 in line with*

1 665.016MSS to exempt MSS regional meetings from those restrictions, due to the
2 far more limited number of options (or sometimes, no options) in a region as
3 opposed to the entire nation. Students who are already in states that would be
4 restricted should have the future opportunity to propose hosting MSS meetings
5 near them, especially in regions where many or all states have prohibitive laws.
6 MSS regions' members should have autonomy over deciding collectively where to
7 hold their meetings. These considerations do not apply to AMA national meetings.
8 Our MSS Chair Natasha Topolski (then Chair-Elect) testified to this effect on
9 behalf of our MSS Caucus in the Reference Committee F hearing. The resolution
10 was referred to the AMA Board of Trustees. They released their report at HOD I-
11 23, which recommended removing the restriction altogether in line with Resolution
12 602. However, the report was referred back, with the next iteration expected at
13 HOD A-24. Your Chair has communicated extensively and repeatedly with multiple
14 Trustees regarding the MSS' view that restrictions should remain in light of
15 increasing concerns, but that exceptions should be made for MSS meetings that
16 are not national. Trustees have confirmed that these points have been discussed
17 at length by the Board. While the Board's A-24 iteration of the report has not yet
18 been released, Trustees have confirmed that even if HOD votes to keep the broad
19 restrictions in place, MSS national leadership can request exceptions as needed
20 to be approved by the Board on a case-by-case basis. Given the long history and
21 many conversations on this topic and due to the sensitivity over opening this AMA
22 policy to amendments and our MSS Caucus' previous desire to retain restrictions
23 for national meetings, your MSS Governing Council believes that this is a
24 reasonable and appropriate compromise. Because our Chair has directly and
25 repeatedly made this request to the Board and received a response that
26 adequately addresses the initial goal of the resolution, your Section Delegates
27 believe that this equates to "asking the AMA" (functionally the same as submitting
28 the resolution) and has fulfilled the goal of this MSS Position's original language.
29 We offer appropriate amendments to reflect both the previous requests and the
30 plan for requesting exceptions moving forward.

31
32 **665.016MSS Amending G-630.140 Lodging, Meeting Venues and Social Functions**
33 Our AMA-MSS asked the AMA to support exemptions to our AMA policy on locations of
34 meetings organized or primarily sponsored by the AMA, in order to allow the MSS to hold
35 regional, state, or local meetings for MSS members in areas that would otherwise be
36 restricted under AMA policy. Our AMA-MSS, via the MSS Governing Council and Medical
37 Student Trustee, will request that the AMA make such exceptions as needed.

38
39 ~~AMA-MSS will ask our AMA to amend policy G-630.140 Lodging, Meeting Venues, and~~
40 ~~Social Functions to read as follows:~~

41 ~~Lodging, Meeting Venues, and Social Functions G-630.140~~

42 ~~(1) Our AMA supports choosing hotels for its meetings, conferences, and conventions~~
43 ~~based on size, service, location, cost and similar factors. (2) Our AMA shall attempt, when~~
44 ~~allocating meeting space, to locate the Section Assembly Meetings in the House of~~
45 ~~Delegates Meeting hotel, or in a hotel close in proximity. (3) All meetings and conferences~~
46 ~~organized and/or primarily sponsored by our AMA will be held in a town, city, county or~~
47 ~~state that has enacted comprehensive legislation requiring smoke free worksites and~~
48 ~~public places (including restaurants and bars), unless intended or existing contracts or~~
49 ~~special circumstances to justify an exception to this policy, and our AMA encourages state~~
50 ~~and local medical societies, national medical specialty societies and other health~~

1 ~~organizations to adopt a similar policy. (4) It is the policy of our AMA not to hold national~~
2 ~~meetings organized and/or primarily sponsored by our AMA, in cities, counties, or states,~~
3 ~~or pay member, officer or employee dues in any club, restaurant, or other institution, that~~
4 ~~has exclusionary policies, including but not limited to, policies based on race, color,~~
5 ~~religion, national origin, ethnic origin, language, creed, sex, sexual orientation, gender,~~
6 ~~gender identity and gender expression, disability, or age unless intended or existing~~
7 ~~contracts or special circumstances justify an exception to this policy. (5) Our AMA staff~~
8 ~~will work with facilities where AMA meetings are held to designate an area for~~
9 ~~breastfeeding and breast pumping.~~

10
11 3) That our AMA-MSS:

- 12 a) amend 645.032MSS, "Resolution Task Force Update 2022" and divide it into two
13 policies as follows; and
14 b) accordingly rescind 630.007MSS and 630.025MSS, as their content has been
15 incorporated into the proposed amendments to 645.032MSS and clarified to
16 reflect longstanding routine MSS practice.

17
18 *Note: Most of the below changes make editorial corrections to the formatting of*
19 *the MSS A-23 Resolution Task Force report recommendations in our Digest to*
20 *better reflect the Task Force's intent of two positions with their corresponding titles,*
21 *instead of the structure of the recommendations also being copied over ("adopt*
22 *the following," "and be it further"). Additionally, "2022" is an error. The last*
23 *paragraph is struck because (a)'s ask for rescission of policies is simply an*
24 *administrative directive and does not need to be retained in the Digest after its*
25 *completion, and the outdated and confusing "Statements of Support" section has*
26 *been removed; (b) was added to support the creation of our MSS Archives Task*
27 *Force to study strategies for institutional memory, and since the findings of their*
28 *study are now available via their report, the "investigation" is complete and this*
29 *language is no longer needed here in this position, as any further actions on this*
30 *front should be appropriately included as recommendations of that report; and (c)*
31 *has been incorporated as the 8th point of 645.032MSS with a clarification of the*
32 *scope of the re-evaluation and a definitive timeline.*

33
34 *One substantive change is included, to delete the explicit use of reaffirmation as*
35 *a standard type of recommendation on MSS resolutions moving forward. To be*
36 *very clear, this does NOT propose removing reaffirmation as part of the sunset*
37 *process, as that would still remain and is clearly outlined in 630.044MSS. This only*
38 *refers to the use of reaffirmation on a given new MSS resolution introduced for*
39 *debate by the Assembly. Since the MSS A-23 Resolution Task Force report,*
40 *reaffirmation in the MSS has no relationship to resolutions requesting external*
41 *action in HOD whatsoever. Any external MSS resolutions found to be redundant*
42 *with AMA policies are simply recommended to be "not adopted" by the Reference*
43 *Committee with an explanation of the relevant policies. Despite a few concerns*
44 *that this might increase the likelihood of resolution adoption due to the negativity*
45 *associated with "not adopt," the MSS has fortunately seen no deficits from the*
46 *removal of reaffirmation as an option for external resolutions. This is likely due to*
47 *a combination of extensive education on the purpose and impact of quality*
48 *resolutions across the MSS, redirection of resolutions into alternative advocacy*
49 *pathways, and an atmosphere that does not frame defeat of a resolution as a*
50 *negative prospect but simply an outcome of a robust and thoughtful democratic*

1 *process and a common experience for many experienced members that should*
2 *be destigmatized, as many authors go on to pass resolutions in the future.*

3
4 *Aside from the sunset process, which is clearly defined in 630.044MSS,*
5 *reaffirmation in the MSS is now only used for resolutions requesting an MSS*
6 *internal stance and can only be used to reaffirm existing MSS positions. Given the*
7 *very few internal MSS resolutions, the range of items for which reaffirmation can*
8 *even be considered is quite narrow. Additionally, external resolutions are generally*
9 *of higher import and priority to the MSS; if we are able to successfully regulate the*
10 *passage of external resolutions via “not adopt” alone, we have no good reason to*
11 *specifically keep a special mechanism of reaffirmation for internal resolutions*
12 *when we could similarly simply “not adopt” those resolutions if needed. We also*
13 *believe that the continued removal of reaffirmation has the potential to greatly*
14 *reduce possible confusion over the complexities of parliamentary procedure in the*
15 *MSS Assembly. Currently, all our [parliamentary procedure resources](#) must include*
16 *reaffirmation, despite its extremely limited potential for use. Students already*
17 *regularly report difficulty learning parliamentary procedure (including on feedback*
18 *surveys), especially in the compressed timeframe of the Assembly, so attempts to*
19 *further streamline our processes to remove unnecessary and unused components*
20 *is likely to have benefit with no deficit.*

21
22 *Furthermore, your Section Delegates considered whether removing internal*
23 *reaffirmation in the MSS Assembly would potentially have any downstream effects*
24 *on MSS members who eventually attend HOD without knowledge of the function*
25 *of reaffirmation. However, even on that point, your Section Delegates believe this*
26 *is unlikely to have any effect. Aside from the HOD sunset process (which is similar*
27 *to the MSS process), reaffirmation not only plays a relatively limited role in HOD,*
28 *but is also a unique and distinct process itself that functions very differently from*
29 *MSS, with no significant relationship to our use in the Assembly (eg, initial*
30 *recommendations are made by Council staffs, determinations by a Rules*
31 *Committee, extractions via a separate process prior to Reference Committee*
32 *hearings, etc). Each cohort of MSS Caucus members has to be yearly taught anew*
33 *how HOD reaffirmation works anyway because it is so different from the MSS*
34 *Assembly’s historical use, with explicit clarifications that the HOD process is*
35 *separate and has its own dynamics to consider that cannot depend on an*
36 *understanding of MSS Assembly reaffirmation. The use of reaffirmation in the*
37 *HOD is also far more aggressive than its typical use in the MSS, as it is commonly*
38 *applied to many resolutions that the MSS believes would be very impactful and*
39 *high-quality, as well as similar resolutions from other delegations. In fact, at HOD*
40 *I-23, every single resolution was removed from the Reaffirmation Consent*
41 *Calendar. At the 2023-2024 HOD Resolution Modernization Task Force’s Open*
42 *Forum at HOD I-23, discussions also occurred on whether the Reaffirmation*
43 *Consent Calendar should no longer be used in the future. We are likely to see*
44 *recommendations regarding this issue from the Task Force’s final report at HOD*
45 *A-24.*

46
47 *The removal of reaffirmation from the MSS Assembly would actually probably only*
48 *improve learning, since confusion would be reduced over Caucus members’*
49 *previous knowledge of MSS reaffirmation and trying to differentiate between them;*
50 *they would only have to primarily focus on learning the HOD reaffirmation process.*

1 *Furthermore, reaffirmation in HOD is a fairly brief stage and is almost entirely*
2 *managed by our Section Delegates anyway, so its wide relevance to other*
3 *members beyond them is limited. Additionally, since the MSS would still retain*
4 *reaffirmation via our sunset process, students still have the opportunity to learn*
5 *about its meaning from those annual reports and the annual sunset review process*
6 *conducted by our standing committees and their hundreds of members, so*
7 *additional protections to ensure that members are aware of its importance are*
8 *already in place. This would also provide the necessary education to understand*
9 *how reaffirmation is used in the HOD sunset process. For the likely myriad and*
10 *multifaceted benefits of simplification without any evidence to expect negative*
11 *effects, we propose removing reaffirmation as a standard action on MSS*
12 *resolutions.*

13
14 *We propose incorporating the content of 630.007MSS and 630.025MSS into*
15 *645.032MSS, in order to keep all of our MSS positions relating to the policy*
16 *process in one unified place for clarity and ease. These two positions were the*
17 *only ones reaffirmed by the MSS A-23 Resolution Task Force, but were not*
18 *incorporated into the main policy. We believe these positions, regarding the*
19 *inappropriate editing of MSS resolutions, are highly important and want to make*
20 *sure they are easily seen whenever any member references 645.032MSS.*

21
22 *The content of 630.007MSS is incorporated into the newly added clause 9 of*
23 *645.032MSS almost verbatim, with some restructuring of the sentence for*
24 *syntactical purposes, the removal of the word “councils” as our MSS does not have*
25 *any councils besides the Governing Council, and a clarification and expansion of*
26 *the types of entities who cannot edit resolutions (including the Governing Council).*
27 *We also add “reformatting,” as this is currently longstanding practice for many*
28 *years in the MSS that staff will reformat resolutions to fit the resolution template*
29 *accordingly.*

30
31 *The content of 630.025MSS is incorporated into the newly added clause 10 of*
32 *645.032MSS. To reflect current longstanding practice for many years in the MSS,*
33 *we clarify that this position is solely intended to apply to the resolve clauses of*
34 *MSS-adopted resolutions, for which this serves as an important protection to*
35 *preserve and respect the democratic voice of the MSS Assembly. However, for*
36 *many years, Section Delegates have revised the titles and whereas clauses of*
37 *resolutions after their adoption by the MSS and prior to their submission to HOD,*
38 *while still retaining and respecting the spirit of the authors’ arguments. (This is also*
39 *common practice for the Resident & Fellow Section.) The reasons for this are*
40 *myriad and have significant implications for the success of resolutions in HOD:*

- 41
42
- 43 • *whereas clauses can be updated with new information or additional*
 - 44 *references to strengthen an argument (this was especially important due*
 - 45 *to the backlog, as years could pass before HOD submission.*
 - 46 • *whereas clauses and titles can be significantly condensed and shortened*
 - 47 *to be easier to read for HOD delegations (a very common complaint),*
 - 48 • *whereas clauses can be revised for clarity or corrections in arguments that*
 - 49 *may have inadvertently been misrepresented during the drafting process,*
 - 50 *whereas clauses referring to MSS-specific arguments (such as existing*
MSS positions) that may be helpful to support the resolution’s passage in

1 *the Assembly can be removed prior to HOD, where they would no longer*
2 *be relevant,*

- 3 ● *whereas clauses that refer to specific specialties or medical societies can*
4 *be revised or removed to avoid potentially offending another delegation or*
5 *misrepresenting their position (another common complaint),*
- 6 ● *whereas clauses and titles can be adjusted to better reflect the content of*
7 *the final resolves adopted by the MSS Assembly,*
- 8 ● *whereas clauses can be revised for general improvement on a longer,*
9 *more relaxed timeframe before HOD, rather than being beholden to*
10 *authors who may often have limited bandwidth to put full effort into writing*
11 *whereas clauses during the drafting stage in MSS, and*
- 12 ● *titles can be adjusted to be more attractive or less provocative and possibly*
13 *offensive for other HOD delegations or to increase timeliness, to*
14 *encourage reading the full resolution and resolves before jumping to*
15 *conclusions.*

16
17 *While your Section Delegates agree that resolve clauses should be highly*
18 *protected, the ability to respectfully revise whereas clauses and titles is an*
19 *important one, similar to all the other actions taken by our MSS Caucus to testify*
20 *on resolutions, make arguments, and vote on possible amendments and*
21 *compromises to advocates to give our resolutions the best possible chance of*
22 *changing AMA policy. Therefore, we ask to clarify that the content of 630.025MSS*
23 *refers to protecting the resolve clauses of MSS-adopted resolutions from*
24 *inappropriate edits, and does not apply to other components of the resolution*
25 *(whereas clauses, titles, references, and existing policy).*

26
27 **645.032 MSS Policy Process RESOLUTION TASK FORCE UPDATE 2022**

28 **AMA-MSS adopt the following as our MSS Policy Process:**

- 29 1. The MSS Section Delegates will ensure that all items of business submitted for
30 consideration to each MSS Assembly meeting undergo a comprehensive review process
31 evaluating their impact, feasibility, timeliness, and evidence basis.
- 32 2. The draft resolution review process should include opportunities for participation by
33 MSS Caucus members; MSS members on AMA Councils; appropriate MSS region
34 officers; MSS standing committees; MSS members with significant HOD experience; and
35 MSS members who liaise with other AMA Sections and groups, specialty societies,
36 professional interest medical
37 associations, medical student organizations (including identity-based groups), and
38 medical education bodies.
- 39 3. The MSS Section Delegates will decide the timeline for the policy cycle preceding each
40 MSS Assembly and will design the criteria used to review items of business.
- 41 4. Resolutions submitted by the correct deadline in the correct format as determined by
42 the MSS Section Delegates prior to start of the policy cycle may not be rejected for
43 submission for consideration by the MSS Assembly based on their content after
44 organizational review for legal issues.
- 45 5 . Per the MSS IOPs, submitted resolutions will be sent to the MSS Reference
46 Committee, which will make recommendations to the Assembly for disposition of its items
47 of business. The Reference Committee Report will use a consent calendar format. In
48 order for an item to be heard by the MSS Assembly, it must be extracted from the
49 Reference Committee Consent Calendar. The Order of Business for each MSS Assembly
50 meeting will follow the order listed in the MSS Reference Committee report for that

1 meeting. Items of business will be categorized by Reference Committee
2 recommendations for “adoption,” “adoption as amended,” “adoption in lieu of,” “referral,”
3 “not adoption,” ~~“reaffirmation in lieu of,”~~ etc. The order of items in each category will be
4 randomized. The MSS Reference Committee must include a meaningful rationale for their
5 recommendations made on each item of business. Any MSS member may extract any
6 item from the Reference Committee Report for debate at the MSS Assembly. No other
7 requirements, such as testimony or votes, are necessary for an item to be extracted. The
8 Section Delegates shall

9 provide opportunities for extraction both in advance of the MSS Assembly remotely and
10 at the beginning of the Assembly. Extractions made in advance of the MSS Assembly
11 should be published in real-time as they are submitted.

12 6. The AMA-MSS Internal Operating Procedures (IOPs) and Digest of Actions will be
13 made available on the AMA-MSS Web site, with updates made prior to the beginning of
14 the Policy Cycle for each Annual and Interim Meeting of the Assembly.

15 7. A resolution template will be made publicly available to assist resolution authors in
16 formatting their resolutions. ~~and be it further~~

17 8. Upon final submission to the MSS for consideration by the Assembly, MSS resolutions,
18 including the “whereas” and “resolve” clauses and footnotes, may not be altered by staff
19 or any MSS leader, member, committee, or other entity prior to the MSS Assembly
20 Meeting without the consent of the author, with the exception of retyping and reformatting.

21 9. The MSS Section Delegates (when they agree) may make grammatical or syntax
22 changes to the resolve clauses of MSS resolutions after they are adopted by the
23 Assembly and before they are forwarded to the House of Delegates, but in no
24 circumstances can the meaning or intent of the resolve clauses be altered. Further, the
25 MSS Speaker and Vice Speaker must be advised of any change made to resolve clauses
26 before the resolution is forwarded to the House of Delegates and must concur that the
27 change in grammar or syntax does not alter the meaning or intent of the resolve clauses.
28 The MSS Speaker or Vice Speaker, may not, under any circumstance, initiate the change
29 in grammar or syntax on any MSS resolution.

30 10. Our AMA-MSS will reevaluate 645.032MSS, 645.033MSS, and the MSS Policy
31 Process in general in a Governing Council report to be presented to the MSS A-26
32 Assembly.

33 **645.033MSS Additional MSS Caucus Operations**

34 ~~AMA-MSS adopt the following as Additional MSS Caucus Operations:~~

35 1. The MSS Section Delegates have the ability to nominate existing policies in the MSS
36 Digest of Actions to the queue to be transmitted to a future HOD meeting, based on
37 strategic considerations. These nominations must be approved by a majority vote of the
38 MSS Caucus.

39 2. The MSS Caucus can co-sponsor resolutions in the name of the MSS with another
40 HOD delegation.

41 a. Co-sponsoring a resolution authored by another delegation must be approved
42 by a $\frac{2}{3}$ vote of the MSS Caucus.

43 b. The MSS Section Delegates have the authority to add other delegations as co-
44 sponsors of MSS-authored resolutions.

45
46
47 ~~AMA-MSS (1) rescind all statements of formal support for AMA policies listed in the~~
48 ~~section “AMA-MSS Statements of Support for HOD Policies” of the MSS Digest of Policy~~
49 ~~Actions; (2) investigate strategies for (a) preserving institutional memory, which would~~
50 ~~document the results of MSS resolutions and actions taken by the AMA in response to~~

1 ~~policies passed by the AMA HOD and (b) reporting this information to the original~~
2 ~~resolution authors and MSS assembly; and (3) that these changes, and the AMA-MSS~~
3 ~~resolutions process as a whole, be reevaluated in an AMA-MSS Governing Council report~~
4 ~~to be presented 3 years after the adoption of these recommendations.~~

REPORT OF THE MEDICAL STUDENT SECTION
STANDING COMMITTEE TASK FORCE

SCTF Report
(A-24)

Introduced by: MSS Standing Committee Task Force
Subject: MSS Standing Committee Task Force Annual Report
Referred to: MSS Reference Committee
(Caitlin Blaukovitch and Shaminy Manoranjithan, Co-Chairs)

1 **INTRODUCTION**
2

3 The American Medical Association Medical Student Section (AMA-MSS) currently consists of 16
4 Standing Committees, which are overseen by the MSS Vice Chair. These Standing Committees,
5 each focus on specific areas, serve as crucial components of the Medical Student Section, and
6 bring together experts in specific areas to address relevant issues within the section. However,
7 there has been a growing level of confusion regarding the roles of these Standing Committees in
8 terms of programming, advocacy, responsibilities during AMA meetings and throughout the policy
9 cycle.

10
11 There has been an increasing number of requests, from both within and outside of Standing
12 Committees, to expand their abilities and projects, including the authoring of self-generated
13 reports and the development of additional advocacy content. Additionally, there is a desire among
14 members to establish a structure for MSS Standing Committees to collaborate with AMA
15 Councils. Section 7 of the current AMA-MSS Internal Operating Procedures (IOPs) states that
16 the MSS Standing Committees and Task Forces should be appointed by the AMA-MSS
17 Governing Council (GC) to support the mission of the MSS.
18

19 With anticipated changes to the IOPs that would allow the MSS Assembly to vote on the creation
20 of new Standing Committees, it has become necessary to address concerns raised by Standing
21 Committee members and leadership. These concerns include Standing Committee size,
22 membership selection process, leadership selection process, and ensuring a dedicated and
23 engaged membership. Although a report was commissioned in 2005 leading to 640.013MSS
24 to outline the creation, maintenance, and dissolution of standing and ad-hoc committees, it was
25 never completed.
26

27 Over the years, the AMA staff and GCs have made efforts to determine the most effective means
28 of supporting Standing Committee initiatives. To address the aforementioned concerns, our MSS
29 voted at the A-23 meeting that a Standing Committee Task Force (SCTF) be assembled by the
30 AMA-MSS GC following the conclusion of the A-23 meeting. The adopted language currently
31 under 640.017 MSS is below:
32

33 RESOLVED, Following the conclusion of the A-23 meeting, the AMA-MSS GC will
34 assemble a SCTF to evaluate and provide recommendations on structure and operations
35 of our MSS Standing Committees; and be it further

1
2 RESOLVED, the SCTF will be chaired by the MSS Governing Council Vice Chair and
3 Chair, who will both be non-voting members of the Task Force, and include opportunities
4 for input from Standing Committees; and be it further

5
6 RESOLVED, the SCTF will submit an update on their progress to the assembly at I-23,
7 and a completed report with their findings at A-24.

8
9 A [preliminary report](#) was drafted by your SCTF and presented to assembly at I-23. Upon receiving
10 feedback on the preliminary report both live at assembly and through various virtual forums and
11 feedback forms, your SCTF conducted further deliberations and presents the final SCTF report
12 below.

13 14 **BACKGROUND**

15 16 **Task Force Objectives:**

- 17 → Evaluate the current structure of MSS Standing Committees and identify areas for
18 improvement.
- 19 → Clarify the roles and responsibilities of Standing Committees in relation to programming,
20 advocacy, responsibilities at AMA meetings, and tasks throughout the policy cycle.
- 21 → Determine guidelines for expanding the responsibilities of Standing Committees, such as
22 self-generated reports and increased advocacy content.
- 23 → Establish a framework for collaboration between MSS Standing Committees and AMA
24 Councils.
- 25 → Address concerns regarding Standing Committee size, membership selection process,
26 leadership selection process, and membership commitment.
- 27 → Provide recommendations on the structure and operations of MSS Standing Committees
28 to enhance their effectiveness and impact.

29
30 More information regarding your SCTF vision, objectives, and plans can be found in your SCTF
31 [Charter](#).

32 33 **Current Standing Committees:**

34 A Standing Committee (SC) within the AMA-MSS is a permanent committee established to
35 oversee specific, continuous functions or areas of interest in the organization. It plays a crucial
36 role in the review and recommendation of policies, with its scope and existence determined by
37 the GC or the MSS Assembly. Applications for Standing Committee leadership and membership
38 are submitted to the GC shortly following the annual conference in June. All applicants submit the
39 same application and rank which Standing Committees they are interested in applying to as well
40 as if they are interested in leadership. Standing Committee leadership is appointed by the AMA-
41 MSS GC and generally consists of between three and four leaders per Standing Committee with
42 varying numbers of Co-Chairs and Co-Vice Chairs depending on the committee. The GC solicits
43 feedback from previous Standing Committee leadership regarding suggestions for leadership
44 structures and new Standing Committee leadership. Standing Committee general membership is
45 selected by Standing Committee leadership with approval by the GC. Mid-cycle applications for
46 general membership are submitted in December and selection follows the same process as with
47 the first cycle of general membership applications. Standing Committees are instrumental in
48 supporting the mission of the MSS as outlined in the AMA-MSS Internal Operating Procedures.
49 There are currently 16 Standing Committees in the MSS, and basic information about each
50 Standing Committee can be found in Appendix A.

1
2 **Statement on the General Function of a Standing Committee**

3 Standing Committees serve a multifaceted role within the AMA-MSS, primarily focused on policy
4 review, advocacy, and programming. They are responsible for examining policies, analyzing
5 resolutions, and providing critical testimonies at both the Virtual Reference Committee (VRC) and
6 AMA-MSS assembly. Standing Committees particularly assist through such roles as report
7 authoring and policy assessments such as Sunset reviews. In advocacy, Standing Committees
8 tactfully navigate through various mediums like interface with National Organizations (NMSOs
9 etc.), advocacy related publications, and grassroots advocacy. Programming is another pivotal
10 aspect of Standing Committees, engaging in diverse activities from national AMA Annual and
11 Interim conferences and Virtual/Interconference Programming with the potential for offering
12 continuing medical education credit (CME) to advising on Grand Rounds and fostering
13 collaboration within and beyond the organization, including other AMA Sections.

14
15 **DISCUSSION**

16
17 **1. Proposal for Standing Committee Restructure**

18 **1.1. General Overview**

- 19 1.1.1. Your SCTF considered mirroring the HOD Councils and structure, but
20 opted against this for numerous reasons. Primarily, the difference in policy
21 burden across certain Standing Committees and a difference in need and
22 student experience required to convene an analogous Standing Committee
23 to the Council on Constitution and Bylaws and the Council on Ethics and
24 Judicial Affairs.
- 25 1.1.2. An assessment of our current selection of Standing Committees found 16
26 committees to be an unwieldy number of committees that still left large
27 gaps in topic coverage, policy review, and student identities and interests.
28 The current structure also requires over 50 student leaders, which is
29 difficult to maintain and manage.
- 30 1.1.3. To create a new structure from the ground up, topics were collated from
31 current Standing Committee survey data, a thorough review of past and
32 present resolutions, the AMA House of Delegates (HOD) policy
33 compendium, and the current Section Delegate's review topics. This
34 comprehensive list allowed us to assign these topics into Standing
35 Committees in such a way that they adequately cover policy review while
36 providing enough overlap to ensure multiple Standing Committees can
37 reasonably be assigned the same resolution. This overlap will provide
38 better feedback to authors, more carefully formulated information to the
39 assembly, and will avoid authors from reviewing their own resolutions due
40 to being members of the most relevant Standing Committee.
- 41 1.1.4. The new structure also keeps the Standing Committees broad enough to
42 allow for longitudinal adjustments, improve leadership structure, and
43 increase the diversity of committee membership. Topic distribution and
44 dynamic committee size allow for rapid response and prioritization of
45 emerging health policy issues responsive to the structure and function of
46 the AMA.
- 47 1.1.5. Your SCTF is recommending that Standing Committees be categorized
48 into Divisions with Division leaders that serve as central liaisons for the GC
49 and are requisite recipients in all external communications. This new
50 structure is designed to serve as additional support for Standing

1 Committees, enhance collaboration between Standing Committees, and
 2 create additional leadership development opportunities.

3 1.1.6. **Standing Committee Size.** While we agree that if students want to be
 4 involved that they should be, we do recognize that there is a possibility of
 5 reaching a capacity in Standing Committees that will not allow for adequate
 6 experience and opportunities to be available for individuals on those
 7 Standing Committees. Because of this, your SCTF recommends that each
 8 Standing Committee should have at least 20 members, but no more than
 9 50 members.

10 1.1.6.1. This range of members is inclusive of members in subcommittees.

11 1.1.6.2. To acknowledge the dynamic differences between Standing
 12 Committee changes in member caps may be approved by the GC
 13 with direction from Division and Standing Committee leaders.

15 1.2. Divisions, Standing Committees, & Topics (See Appendix A for figure)

17 1.2.1. Division 1: *Healthcare Systems & Quality (HSQ)*

18 1.2.1.1. Committee on Healthcare Economics & Health Administration

19 1.2.1.1.1. This Committee addresses the intersection of healthcare
 20 economics and management. Special focuses of this
 21 Committee include advocating for systemic improvements
 22 in healthcare delivery and coverage, collaborating to
 23 promote understanding, proposing innovative, cost-
 24 effective advocacy solutions and ensuring equitable access
 25 to quality care. Given the current review subject categories,
 26 this Committee would generally review topics from the
 27 *Health Coverage* Forum.

28 1.2.1.1.2. This Committee shall interface with the AMA Council on
 29 Medical Service (CMS) and Students for a National Health
 30 Program (SNaHP).

31 1.2.1.2. Committee on Clinical Practice & Ethics

32 1.2.1.2.1. This Committee identifies gaps in clinical practice guidelines
 33 and emerging best practices for engaging with communities
 34 with unmet health needs. Special focuses of this Committee
 35 include civil rights, mental health services reform, and
 36 medical ethics. Given the current review subject categories,
 37 this Committee would generally review topics from the
 38 *Clinical Practice and Ethics* Forum.

39 1.2.1.2.2. This Committee shall interface with the AMA Council on
 40 Medical Service (CMS) and the AMA Council on Ethics and
 41 Judicial Affairs (CEJA).

42 1.2.1.2.3. This Committee will be encouraged to interface with the
 43 AMA Journal of Ethics and students that serve as editorial
 44 fellows.

45 1.2.1.3. Committee on Legislation and Intergovernmental Affairs

46 1.2.1.3.1. This Committee considers the legal jurisprudence and
 47 feasibility of policy issues taken up by the MSS, including
 48 implications of federal policy and AMA advocacy on local,
 49 state, territorial, and tribal governments. Special focuses of
 50 this Committee include civil rights and trust responsibility
 51 between the United States and Tribal governments as it

relates to health care delivery. Given the current review subject categories, this Committee would generally review topics from the *Civil Rights and Social Policy and Public Health* categories however, would likely have significant overlap with some of the other forums as well.

1.2.1.3.2. This Committee shall interface with the AMA Council on Legislation (COL), the student representative to the American Medical Political Action Committee (AMPAC), and the Governmental Relations and Advocacy Fellow (GRAF).

1.2.2. **Division 2: Science, Technology, and Public Health (STAPH)**

1.2.2.1. Committee on Science & Technology

1.2.2.1.1. This Committee is focused on scientific and technological advancements as well as the impact of these advancements on academic research, medical education, and bioethics. Special focuses of this Committee include mobile and digital health applications, health information management, climate change, pharmaceutical development, and sports. Given the current review subject categories, this Committee would generally review topics from the *Science And Technology* Forum.

1.2.2.1.2. This Committee shall interface with the AMA Council on Ethical and Judicial Affairs (CEJA), the AMA Council on Science and Public Health (CSAPH), and the student representative from the American Physician Scientists Association.

1.2.2.1.3. This Committee will also take on the tasks associated with the MSS Poster Showcases at Annual and Interim meetings as well as the AMA's virtual poster competition.

1.2.2.1.4. This Committee will be encouraged to interface with the Journal of the AMA (JAMA) and explore opportunities for medical students with this entity.

1.2.2.2. Committee on Global & Public Health

1.2.2.2.1. This Committee is focused on current and emerging public health issues in and outside the US. Special focuses of this Committee include infectious diseases, climate change, war, immigration, domestic gun violence, nutrition, trauma and accident avoidance, and substance use. Given the current review subject categories, this Committee would generally review topics from the *Public Health* Forum.

1.2.2.2.2. This Committee shall interface with the AMA Council on Science and Public Health (CSAPH). In addition, this Committee may also interface with the Medical Students for a Sustainable Future (MS4SF), International Federation of Medical Student Organizations (IFMSA), and other relevant National Medical Student Organizations.

1.2.3. **Division 3: Health Equity & Medical Education (HEME)**

1.2.3.1. Committee on Medical Education

1.2.3.1.1. This Committee is focused on medical education, not only at the medical school level, but also amongst residents,

1 fellows, and continuing education for attendings. Special
2 focuses of this Committee include physician equity, trainee
3 equity, licensure and discipline. Given the current review
4 subject categories, this Committee would generally review
5 topics from the Medical Education Forum.

6 1.2.3.1.2. This Committee shall interface with the AMA Council on
7 Medical Education (CME), National Resident Matching
8 Program (NRMP), Liaison Committee on Medical Education
9 (LCME), National Board of Medical Examiners (NBME),
10 Association of American Colleges (AAMC), and First
11 Generation and Low Income in Medicine (FGLIMed),
12 Student Osteopathic Medical Association (SOMA), Council
13 of Osteopathic Student Government Presidents (COGSP) .

14 1.2.3.2. Committee on Gender, Sexuality, & Reproduction

15 1.2.3.2.1. This Committee is focused on LGBTQ+ affairs, women's
16 health, and reproductive rights. There is a significant
17 amount of overlap across these and related topics, so this
18 combination of topic areas will allow for a more
19 comprehensive evaluation of important issues within these
20 areas. Given the current review subject categories, this
21 Committee would likely review topics from across all the
22 categories addressing issues of gender, sexuality and
23 reproduction..

24 1.2.3.2.2. This Committee shall interface with the AMA Women
25 Physician Section Student Representative, AMA LGBTQ+
26 Advisory Committee Student Representative, and student
27 representatives from the American Medical Women's
28 Association, Medical Student Pride Alliance, GLMA, and
29 Medical Students for Choice.

30 1.2.3.3. Committee on Health Justice

31 1.2.3.3.1. This Committee is focused on racial equity and issues that
32 disproportionately affect minority groups and historically
33 marginalized populations. Special focuses of this
34 Committee include ethical, social, legal, and health
35 concerns affecting these populations, as well as the health
36 management and payer systems most utilized by these
37 respective populations, and advocacy for civil and human
38 rights, and mental health. Given the current review subject
39 categories, this Committee would generally review topics
40 from the *Civil Rights and Social Policy* Forum.

41 1.2.3.3.2. This Committee shall interface with NMSOs such as Student
42 National Medical Association (SNMA), Association of Native
43 American Medical Students (ANAMS), Asian Pacific
44 American Medical Student Association (APAMSA), South
45 Asian Medical Student Association (SAMSA), Latino
46 Medical Student Association (LMSA), Medical Students with
47 Disability and Chronic Illness (MSDCI), the AMA Minority
48 Affairs Section (MAS), and the AMA Disability Advisory
49 Committee.
50

1 1.2.4. **Subcommittees and Task Forces.** Given the consolidation of the
2 Standing Committees, there have been concerns that unique groups and
3 populations underneath them may not be as represented as well as before.
4 With this understanding, we are recommending that task forces and
5 subcommittees underneath the larger Committee could function to
6 establish and promote collaborations within a Committee, while also
7 providing an internal, Committee driven structure to recognize those groups
8 or form task forces in response to the shifting medical landscape.

9 1.2.4.1. These Standing Committee subcommittees and task forces will be
10 up to the discretion of Division and Standing Committee leadership
11 as they deem necessary with consultation from the GC.

12 1.2.4.2. Initial topic- and identity-based subcommittees, based on feedback
13 solicited by your SCTF, have been recommended for the first year
14 of implementation (AY 2025-26) and are outlined in the
15 Implementation Plan section of this report. These
16 recommendations promote continuity of Standing Committee
17 actions amidst an extensive restructuring process.
18

19 1.2.5. **Restructuring of the Committee on Long Range Planning (COLRP)**

20 1.2.5.1. Purpose and Responsibilities: COLRP will exist outside of the
21 division structure under the purview of the chair with a separate
22 selection process detailed below. The renewed function of COLRP
23 is to offer counsel to the current GC, Councilors, and BOTs, upon
24 request by the GC. Key areas of involvement include:

25 1.2.5.1.1. Supplying longitudinal and institutional knowledge and
26 insights based on past experiences and institutional
27 knowledge.

28 1.2.5.1.2. Maintaining a permanent suggestion form regarding Region
29 Bylaws, MSS Internal Operating Procedures, and AMA
30 Bylaws. This Committee will assist in drafting and
31 suggesting updates to these governing documents on an
32 appropriate timeline.

33 1.2.5.1.3. Commenting and testifying on all MSS governance
34 resolutions.

35 1.2.5.1.4. This Committee shall interface with the AMA Council on
36 Long Range Planning and Development (COLRPD) and
37 AMA Council on Constitution & Bylaws (CCB).

38 1.2.5.2. Membership Composition: COLRP will consist of experienced MSS
39 leaders who will serve in an advisory capacity to the GC. Previously
40 elected student leaders, including those who have served on the
41 GC and the BOT student representatives, will be invited to join for
42 the remainder of their time in the MSS with the option to decline
43 membership. Notably, former GC and BOT student representatives
44 who concurrently hold a national MSS leadership position will not
45 be invited to join and generally are discouraged from participating
46 but exceptions can be made by MSS Chair discretion. Of note,
47 given that this Committee is designed to interact with the MSS Chair
48 most closely, an exception will also be made for former MSS Chairs
49 that remain in the MSS that may hold other leadership positions.
50 Immediate Past MSS Chairs that no longer are in the MSS are
51 encouraged to liaison with the Committee to the best of their ability.

- 1 1.2.5.3. Other experienced leaders including former experienced national
2 leaders such as MSS Councilors, and GRAFs are strongly
3 encouraged to apply to join. Other members with significant
4 leadership experience such as regional leaders and Standing
5 Committee leaders are also welcome to apply on an annual basis.
6 1.2.5.4. Aside from the invited members with aforementioned former
7 leadership, all other members will be selected by the MSS Chair
8 after soliciting input from the GC and invited members. Preference
9 may be awarded to applicants with experience in realms not
10 adequately covered by existing members.
11 1.2.5.5. Size: The MSS Chair should be able to determine the number of
12 members for their term, however your SCTF recommends that the
13 size be around 10 members.
14 1.2.5.6. Leadership and Reporting Structure: COLRP will report directly to
15 the MSS Chair.
16

17 **1.3. Statement on Membership:** While membership and recruitment is an essential
18 function of the MSS and vital to our continued success as a section, we determined
19 that membership and recruitment initiatives are best executed at a regional level
20 rather than through a dedicated Standing Committee. Regional Membership or
21 Engagement Chairs are able to individually work with executive boards at schools
22 in the region to help facilitate recruitment efforts and share resources, ideas, and
23 even collaborate on events. While there is value in inter-region collaboration and
24 sharing of resources for recruitment efforts, we do not believe a Standing
25 Committee is the most effective way to achieve this. For example, we highly
26 recommend the At-Large Officer (ALO), along with other GC leaders, continue to
27 coordinate monthly meetings with Engagement Chairs from each region to discuss
28 recruitment efforts and coordinate national recruitment initiatives, which have
29 largely not included previous Standing Committee involvement. Additional
30 suggestions included integrating other individuals, such as the outreach leaders,
31 to these meetings. A Standing Committee that functions unassociated with
32 Engagement Chairs and the ALO is not efficacious, thus we recommend re-
33 allocating the role of membership and recruitment to the discretion of the MSS GC
34 to oversee at a regional level.
35

36 **1.4. Statement on Community Service:** When considering community service within
37 our MSS, we have consistently seen community service projects at each Interim
38 and Annual meeting. However, outside of these two meetings, it is difficult for the
39 Community Service Committee to remain engaged in similar activities since
40 members are from across the country. Additionally, the AMA currently supports
41 community service projects at the chapter level through the Medical Student
42 Outreach Program (MSOP) Section Involvement Grant (SIG). These funds can be
43 used for local chapter community service projects without the need of oversight
44 from a MSS Committee. Given this information, we propose that community
45 service initiatives can become integrated into Convention Committees or standing
46 committee-led programming to continue community service projects at the
47 meetings. Community service may also occur at the regional level and Regional
48 Community Service Chairs are welcome to consider collaboration opportunities for
49 national initiatives.
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51
- 1.5. **Statement on Advocacy:** Although advocacy is integral to our MSS, these initiatives are best dispersed among all Standing Committees. With adequate training on grassroots advocacy, each Standing Committee and Division can engage and collaborate amongst each other with their issues without the need for a stand-alone committee. Additionally, the GRAF directly engages with AMA advocacy staff who may provide support to our MSS advocacy efforts brought forward by all Standing Committees. Standing Committees will be encouraged to work with Division Leads to ensure This role will also support committee members in preparing and submitting [MSS Action Items](#) (MSSAIs) for proposed AMA action on specific issues.
- 1.6. **Statement on Ethics:** While ethics remains a cornerstone of our MSS, your SCTF believes it is important to ensure that ethics is integrated into all Standing Committees and their functions. Your SCTF believes each Standing Committee and Division should engage in collaborative discussions and address ethical considerations within their respective areas. Your SCTF believes that Standing Committees should remain vigilant in incorporating discussions of ethics within their programming and other functions as they apply to their respective topic areas. However, in addition to the general focus among Standing Committees, the Committee on Clinical Practice & Ethics will have a special focus on medical ethics and the Committee on Science and Technology will have a special focus on bioethics. In addition, we encourage the future GC and Division leaders to maintain close connections with the AMA Journal of Ethics and continue to foster collaboration and opportunities for students to engage. Finally, we wanted to mention that we value the Bioethics Grand Rounds currently hosted by the current Committee on Bioethics and Humanities and implore future leadership to consider implementing bioethics topics and humanities into the new programming structure.
- 1.7. **Statement on Committee on Impact Policy and Action (IMPACT):** In regards to resolution review, the purpose of Standing Committees is to serve as expert bodies in their topic area. Thus, Standing Committees should be heavily involved in resolution review, but the current precedent is that Standing Committees are often not adequately trained for the resolution review process. The goal of the new Division structure is to allow for adequate training, institutional memory, and oversight to ensure that Standing Committees can execute their function of being expert bodies. As such, we determined the function of resolution review would by nature of this new structure be appropriately distributed among the Standing Committees. Instead of one Standing Committee focused broadly on resolution reviews, each Standing Committee will accomplish that function by having members conduct full resolution reviews including content, novelty, and impact. Committee members conducting reviews will receive the same training as Regional Delegate/Alternate Delegate reviewers. Using this training, their topic based expertise, and historical knowledge, Standing Committees will cover the necessary resolution reviews. Their institutional and tailored knowledge of policy in specific areas ideally will also enhance the quality of these reviews.
- 1.7.1. Given the significant focus of this group on resolution review, your SCTF highly recommends that novice MSS members participate in IMPACT as a training experience for their inaugural policy cycle. During this time period, IMPACT leaders will mentor new members on the MSS structure and support them in determining opportunities to engage further in the MSS. Additionally, first time IMPACT members are encouraged to attend public

1 events hosted by Standing Committees to learn more about their
2 functioning.

3 1.7.1.1. Your SCTF believes this will provide interested new members the
4 background of policy review prior to applying for Standing
5 Committees or the MSS Caucus.

6 1.7.1.2. IMPACT members will be encouraged to apply to the Standing
7 Committee of their choice after completion of their inaugural policy
8 cycle with IMPACT. Completion of a policy cycle with this group will
9 be noted on future Standing Committee applications.

10 1.7.1.3. After their inaugural policy cycle, members would also have the
11 opportunity to apply to IMPACT as well as to Standing Committees
12 after their inaugural policy cycle.

13 1.7.2. Your SCTF anticipates that applications for IMPACT should be included
14 alongside general Standing Committee applications with the option for
15 Section Delegates to disseminate and accept additional delayed
16 applications to allow members to join IMPACT after the general Standing
17 Committee deadline if they are interested in participating in the policy cycle.

18 1.7.3. Your SCTF recognizes that there are benefits of having additional
19 members participating in the resolution review process beyond MSS
20 Caucus and Standing Committee members, both as a stepping stone to
21 Region Delegate roles and to provide a cushion for the variability of
22 engagement of caucus members. Therefore, your SCTF considers the
23 existence of IMPACT as a “bonus caucus” and would provide additional
24 general resolution review. The task force feels that this group does not fit
25 within the Standing Committee structure that would be under the purview
26 of Division leaders and ultimately the Vice Chair. Your SCTF believes that
27 the creation and oversight of this group would most logically fall under the
28 direct purview of the Section Delegates (SDs). This change will allow the
29 SDs to have the flexibility to utilize this group as they see fit given the ever-
30 changing needs of the policy cycle. Your SCTF believes this transition has
31 additional benefits such as allowing members the ability to join IMPACT as
32 well as another topic-based Standing Committee they are interested in,
33 instead of having to choose between the two.

34 1.7.3.1. IMPACT's role will be reassessed during the A-26 GC Report on
35 Standing Committees. At that time, GC will recommend changes to
36 IMPACT based on the implementation plan and objectives that
37 have been outlined as well as feedback from relevant stakeholders
38 (Section Delegates, Standing Committee Chairs and Vice Chairs,
39 Division leadership, other GC Members, Staff, etc) regarding their
40 ability to function as a training ground for novice MSS members and
41 as a Bonus Caucus.

42 43 **2. Proposal for Leadership Structure**

44 **2.1. GC Oversight**

45 2.1.1. Your SCTF, based on GC feedback and experiences, recognized that
46 additional support was needed by the GC to effectively serve and manage
47 the numerous Standing Committees and numerous points of contact within
48 the current structure.

49 2.1.2. Based on feedback by Standing Committee leaders and members, your
50 SCTF recognizes the benefits of having GC support in Standing Committee
51 tasks and operations.

- 1 2.1.3. Given this, your SCTF proposes the following Division structure intended
2 to aid the GC in managing the Standing Committee Structure and
3 operations while also providing tailored points of contacts for Standing
4 Committee leaders to ensure adequate support for GC members, as well
5 as Standing Committee leaders.
6 2.1.3.1. Your SCTF anticipates that leaders across both Standing
7 Committees and Divisions will predominantly be students exhibiting
8 profound executive acumen. These individuals will shoulder
9 significant responsibilities, ranging from educational initiatives and
10 mentorship to ensuring the seamless functionality and superior
11 deliverables of each Standing Committee.
12 2.1.4. The GC will ultimately have oversight of this entire structure to ensure
13 seamless coordination and collaboration with the many external AMA and
14 internal MSS entities.
15 2.1.4.1. The Vice Chair will continue to have the primary responsibility of
16 coordinating the internal operations of the MSS, including but not
17 limited to the MSS standing and ad-hoc committees.
18

19 **2.2. Division Leadership Structure**

- 20 2.2.1. The Division leaders will serve as central liaisons for the GC and are
21 requisite recipients in all external communications. Your SCTF wants to
22 emphasize that this Division structure does not preclude Standing
23 Committee leaders from directly communicating with GC, but rather serves
24 as an additional resource to leaders to address frequently asked questions
25 and tasks.
26 2.2.2. Each Division shall be led by three Division Co-Chairs, as outlined in 2.2.4.
27 2.2.3. It is required that candidates for Division leadership should have held
28 Standing Committee leadership positions as outlined in 2.3 within the
29 Division they are applying for.
30 2.2.3.1. If no candidate meets the requirements outlined in 2.2.3, the
31 requirement may be waived upon the discretion of the Vice Chair.
32 2.2.4. Each Division Co-Chair will address the appropriate core responsibilities of
33 each Division.
34 2.2.4.1. Resolution: This Division leader will be responsible for coordinating
35 with the SDs and managing the Standing Committees under their
36 Division to conduct resolution reviews for the internal MSS
37 resolution cycle. Additional responsibilities for this role include
38 training members within their Division on effective resolution
39 reviews as well as being present at Standing Committee meetings
40 that are specific to resolution review to serve as an advisory figure
41 during discussions.
42 2.2.4.2. Reports: This Division leader will be responsible for managing and
43 coordinating with Standing Committees to complete reports for their
44 Division. Additional tasks for this role include scheduling and
45 participating in meetings regarding reports planning and writing,
46 providing training and advising with reports, and ensuring that all
47 reports being authored under their Division meet necessary
48 deadlines and milestones during the policy cycle.
49 2.2.4.3. Programming and Advocacy: This Division leader will be
50 responsible for coordinating and managing advocacy initiatives and
51 programming events respective to their Division for the section.

1 Responsibilities include working with the Vice Chair and Standing
2 Committee leaders to plan and coordinate programming and open
3 house events, working with the GRAF and Standing Committee
4 leaders to promote advocacy initiatives and foster inter-Committee
5 and inter-Division collaborations. This role will also support
6 Standing Committee members in preparing and submitting MSSAIs
7 for proposed AMA action on specific issues.

8 2.2.4.4. Additional Common Responsibilities: Division leaders will all be
9 expected to uphold some common expectations. These
10 expectations include serving in a mentorship capacity to Standing
11 Committee Leaders and general members, handling any potential
12 conflicts, both personal and professional related to Standing
13 Committee responsibilities, that may arise, ensuring adequate
14 Standing Committee leadership review and potential
15 impeachments. In addition, the Division Co-Chairs will work with
16 Standing Committee leaders to plan and implement Standing
17 Committee specific strategic plans.
18

19 2.3. Standing Committee Leadership Structure

20 2.3.1. Every Standing Committee will be presided over by a Chair.

21 2.3.2. The delineation of Standing Committee Vice Chairs will be dependent upon
22 the functions and responsibilities of the Standing Committee.

23 2.3.3. It is recommended, though *not required*, that Standing Committee
24 leadership should have at least one policy cycle worth of experience within
25 the Standing Committee.

26 2.3.4. Internal Standing Committee structure, and subcommittees, can be
27 developed and altered on an individual Standing Committee level based on
28 the direction of Standing Committee leaders and feedback from Division
29 leaders.

30 2.3.4.1. These internal structures may be presided over selected
31 subcommittee leaders based upon the discretion of Standing
32 Committee Leadership and Division leadership
33

34 2.4. Other Leadership

35 2.4.1. Additional leadership positions shall be considered and acted on
36 accordingly by formal proposal to and upon consultation with the GC and
37 COLRP.
38

39 2.5. Selection of Leadership

40 2.5.1. GC Involvement: The GC will be involved in the selection and oversight of
41 all Division and Standing Committee leadership.

42 2.5.2. Division leadership Selection: The GC and outgoing Division leadership will
43 be involved in the selection of the incoming Division leadership.

44 2.5.3. Standing Committee Chair Selection: The GC, outgoing Division
45 leadership, incoming Division leadership, and outgoing Standing
46 Committee Leadership will select the incoming Chairs for each Standing
47 Committee.
48

49 2.5.4. Standing Committee Vice Chair Positions: Outgoing Standing Committee
50 Leadership will work with the incoming Chair of each Standing Committee
to identify Standing Committee Vice-Chair positions needed for the new

1 year based on the needs and responsibilities of their respective Standing
2 Committees.

3 2.5.4.1. Standing Committee Vice Chair Selection: The new Division
4 leadership and new Standing Committee Chair will then select the
5 incoming Vice-Chairs.
6

7 **2.6. Timeline of Leadership and General Member Selection**

8 2.6.1. Division Leadership and Standing Committee Chairs:

9 2.6.1.1. Applications will be released early spring, roughly 3-4 months
10 before the Annual Meeting.

11 2.6.1.1.1. Members can rank the top three available positions they are
12 interested in applying for which can include both Divisonal
13 and Standing Committee leadership. They will have a
14 chance to explain why they are interested in each position.

15 2.6.1.2. New Division leadership will be selected first, followed by the
16 selection of Standing Committee Chairs. These selections will be
17 finalized roughly 1-3 months before the Annual Meeting.

18 2.6.1.3. The incoming Division leadership and Standing Committee Chairs
19 will be officially announced during the Annual MSS Assembly.

20 2.6.2. Standing Committee Vice Chairs:

21 2.6.2.1. Applications for Standing Committee Vice Chairs will be released
22 alongside the general Standing Committee member applications
23 prior to the Annual meeting and due after the Annual meeting..

24 2.6.2.2. Available Standing Committee Vice Chair positions will be identified
25 internally for application prior to Annual.

26 2.6.3. General Standing Committee Member:

27 2.6.3.1. Applications for one-year terms will be released prior to Annual
28 meeting and due after the Annual meeting. Applications for half-
29 year terms will be released prior to the Interim meeting and due
30 after the Interim meeting.

31 2.6.3.2. We recommend that the following be included in general member
32 applications:

33 2.6.3.2.1. Summary of Standing Committee Structure, overview of
34 each Standing Committee with specific past examples of
35 projects and programming done, and additional pertinent
36 information to the function of the Standing Committee

37 2.6.3.2.2. Tailored personal statement(s) and CV.

38 2.6.3.2.3. Response to an advocacy prompt specific to the Division(s)
39 being applied to.

40 2.6.3.2.4. A short listing of previous AMA-MSS involvement and/or
41 other health policy-related experiences, including state
42 society involvement.

43 2.6.3.2.5. Checkboxes to acknowledge the following things:

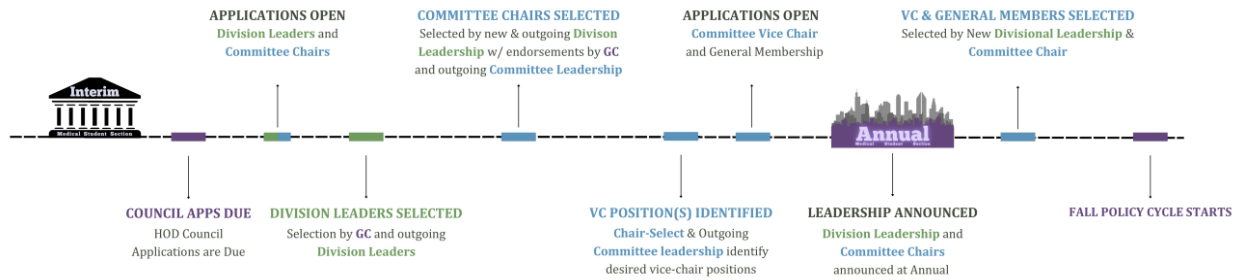
44 2.6.3.2.5.1. Commitment to attending meetings (unless
45 extenuating circumstances arise, such as financial
46 difficulties with attending the meeting or personal- or
47 school-related conflicts).

48 2.6.3.2.5.2. Roles and Responsibilities.

49 2.6.3.2.5.3. Attestation of acknowledgement of responsibilities
50 and commitments

51 2.6.3.2.5.4. Agree to follow the AMA Code of Conduct.

1 2.6.3.2.5.5. Declare if you used language models/AI support



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3. Proposal for Function

3.1. Involvement in Policy Cycle

- 3.1.1. Standing Committees will be required to review resolutions that are relevant to their area of expertise, appropriately comment on the open forum, first draft, and VRC, and provide thorough and engaging testimony at MSS assembly for every resolution that falls under their purview.
- 3.1.2. Standing Committee members can individually write a resolution, but Standing Committees may not officially author a resolution.
- 3.1.3. Standing Committees are required to comment on the VRC on all resolutions that they are assigned to.
- 3.1.4. Standing Committees are required to give testimony on the AMA-MSS Assembly floor as subject matter experts on all resolutions they reviewed in that cycle.
- 3.1.5. Division and Standing Committee leaders are encouraged to attend open MSS Caucus meetings to stay informed and provide feedback on items relating to their area(s) of expertise as Division and Standing Committee leaders.

3.1.6. Resolution Review

- 3.1.6.1. Resolution Onboarding will be held twice a year by Division Resolutions Chairs with oversight by the Vice Chair and SDs to ensure Standing Committee members are all adequately trained to review resolutions.
- 3.1.6.2. Standing Committees will be actively involved in resolution review under the direction of Division Resolution Chairs in coordination with the Vice Chair and SDs, providing thorough reviews as subject matter experts.
- 3.1.6.3. Review Assignments to each Division will be done by the Vice Chair under the direction of the SDs.
- 3.1.6.4. Oversight, deadlines, and integration with the policy cycle will be determined by the SDs in coordination with the Vice Chair and enforced by Division Resolution Chairs.
 - 3.1.6.4.1. It is encouraged that Division Resolution Chairs work with Standing Committee leaders to plan and help facilitate resolution review meetings
- 3.1.6.5. Division Resolutions Chairs and Standing Committee Leaders will work together to coordinate resolution review assignments within

1 their Division/Standing Committee, ensuring that timely and
2 thorough reviews are conducted.
3

4 **3.1.7. Reports**

5 3.1.7.1. Report Assignments: Standing Committee Report assignments will
6 be requested by the MSS Assembly or MSS GC and assigned to a
7 specific Standing Committee by the MSS GC.

8 3.1.7.1.1. GC will take into account original authorship team
9 membership on Standing Committees when assigning
10 reports to Standing Committees to ensure fairness.

11 3.1.7.1.2. GC will assign each report to no more than two Standing
12 Committees with equal involvement with the expectation of
13 equitable contributions

14 3.1.7.1.3. Each Standing Committee on the report should have a
15 Standing Committee lead that is responsible for
16 coordinating their Standing Committee's involvement in the
17 report and will serve as a primary author(s) on the report

18 3.1.7.1.3.1. Standing Committee Leads must be experienced
19 report writers.

20 3.1.7.1.4. Standing Committees may not self-generate reports, but
21 should be encouraged to pursue alternative advocacy or
22 educational initiative.

23 3.1.7.1.5. Standing Committees writing reports should maintain active
24 communication with the appropriate national leaders and
25 original resolution authors as subject-matter experts.

26 3.1.7.2. Report Components: The Standing Committee Report Template
27 was recently revised with the purpose of streamlining the process
28 of sending MSS policy to the HOD as shown in Appendix A.

29 3.1.7.2.1. The updated template requires that Standing Committees
30 include resolved clauses in reports that are recommended
31 to be sent to HOD.

32 3.1.7.2.2. Additionally, the SCTF feels strongly that MSS reports
33 continue to require discussion sections to provide valuable
34 perspective for the MSS Assembly, Standing Committees,
35 and MSS Caucus when considering the report and
36 advocating for it at the HOD.

37 3.1.7.3. Acknowledgments:

38 3.1.7.3.1. Report Leads, report authors, and original resolution
39 authors should be credited.

40 3.1.7.3.2. Standing Committees will submit a formalized author list to
41 AMA staff, SDs, and the MSS Vice Chair upon submission
42 of the final report.

43 3.1.7.3.2.1. An authorship contribution guide should be provided
44 by the Vice Chair to Standing Committee leads

45 3.1.7.3.2.2. Standing Committee leads on reports are
46 encouraged to ensure that report members meet a
47 minimum level of contribution to the report as
48 deemed appropriate by Standing Committee
49 leadership in order to receive Co-authorship credit
50 on the report.

51 3.1.7.4. Report Deadlines

- 1 3.1.7.4.1. Reports deadlines will be set by the SDs in coordination with
2 the Vice Chair.
3 3.1.7.4.2. Reports will be due at the next Assembly meeting after
4 assignment. For example, Reports assigned at I-20 will be
5 due at A-21.
6 3.1.7.4.3. One extension will be granted without question. Further
7 extensions will be granted upon approval of the Vice Chair
8 and SDs.
9 3.1.7.4.4. The Vice Chair will coordinate report transitions between
10 Standing Committee and Division leaders and members, if
11 necessary.
12 3.1.7.5. Report Onboarding and training will be held twice a year by Division
13 Reports Chairs with oversight by the Vice Chair and SDs to give
14 Standing Committee members guidance in writing a report.
15
16 3.1.7.6. Report Timing Report deadlines are recommended to be offset from
17 resolution deadlines.
18
19 3.1.7.7. Report Review Reports must undergo the same review as original
20 resolutions and other items of business.
21
22 3.1.7.8. Position Recission: Reports requested by an Assembly directive
23 should recommend rescission of the MSS position asking for the
24 the report to ensure the MSS Positions Compendium remains
25 current.

26 3.1.8. **Sunset Review & AMA Implementation Tracking**

27 3.1.8.1. Sunset Review:

- 28 3.1.8.1.1. As per 630.044MSS, MSS positions automatically expire
29 after five years unless the MSS Assembly votes to retain
30 them. In order to determine whether or not to retain MSS
31 positions, the MSS Chair will oversee an annual Sunset
32 Report to review all positions set to expire.
33
34 3.1.8.1.2. Under the directive of the MSS Chair with the assistance of
35 Division Chairs, Standing Committees will be responsible
36 for conducting a primary review of all positions last
37 reaffirmed five years ago and four and a half years ago that
38 are set to expire as part of the annual Sunset Review
39 process. More information regarding this process can be
40 found in the A-24 Sunset report. However, of note, the SCTF
41 discussed suggestions of increasing the Sunset timeline
42 back to a ten year review. Ultimately, the SCTF felt strongly
43 that the MSS maintain the five year review. This allows for
44 a more up to date digest and more institutional memory
45 given there is much higher student and staff turn-over over
46 the course of ten years.
47 3.1.8.1.2.1. The primary review will consist of examining any
48 changes to AMA policy or AMA actions associated
49 with this position and making a recommendation to
50 whether the MSS should retain, amend, or rescind
51 (sunset) the MSS position in the context of the

current compendium. Notably, review of AMA actions associated with the position is a new task that was added by the 2023 - 2024 MSS GC to provide the MSS better context of the impact of MSS resolutions.

3.1.8.1.3. The MSS Chair will provide clear instructions and necessary resources for Standing Committee members to conduct the primary review.

3.1.8.1.4. The final report will be compiled by the MSS GC for review and approval by the MSS Assembly.

3.1.8.2. AMA Implementation Tracking:

3.1.8.2.1. As mentioned in 3.1.8.1.2.1, Standing Committee members will support the MSS in archiving actions taking on MSS positions adopted prior to A-23 as part of the Sunset review process.

3.1.8.2.2. For positions adopted after A-23, staff will support the MSS in archiving these positions when the Implementation Reports are available on the [AMA Archives website](#) at the final one-year follow up timepoint. However, Division and Standing Committee leaders will be expected to also review the archives of positions relevant to their area and share this information with members as appropriate.

3.2. **Virtual Programming**

3.2.1. Concerning programming initiatives led by Standing Committees outside the time frame of the AMA-MSS Annual and Interim Assemblies, your SCTF recommends the following actions to ensure consistency and quality:

3.2.1.1. Events

3.2.1.1.1. Mandatory Event Hosting by Division: To ensure active engagement and contribution to the educational mission of AMA-MSS, each Division should host at least one event per MSS year (from one Annual meeting to the next). This requirement will promote diverse and enriching programming, reflecting the varied interests and expertise within AMA-MSS.

3.2.1.1.2. Standing Committees are recommended to host at least one virtual event per year, but are not limited to one.

3.2.1.1.3. Collectively, there should be one virtual programming event hosted by a designated Standing Committee per month.

3.2.1.1.3.1. Standing Committees are highly encouraged to coordinate planning programming sessions so that one Standing Committee is presenting each month.

3.2.1.1.4. Event materials should be stored and publicly accessible to MSS members in perpetuity.

3.2.1.1.5. Open Houses: Divisions and Standing Committees will be required to host open house events for members to learn about the Standing Committees, their functions, and their topics of interest. These events are encouraged to have substantial educational content regarding their topics of

interest and interactive components.

3.2.1.2. Standardization of Application Process for Standing Committee Events: The Vice Chair, in collaboration with AMA staff and the MSS Chair, should develop and implement a standardized application process for Standing Committees as they organize events throughout the year. This process should be established at the start of each MSS year to provide clear direction and support for Standing Committees. Division leaders will work with the Vice Chair and Standing Committee leaders to fill out the application for events throughout the year.

3.2.1.2.1. Advance Release of Application: To allow ample time for thoughtful and comprehensive programming proposals, the application should be made available at least one month before the submission deadline. This advance release will enable potential organizers to plan, collaborate, and refine their proposals effectively.

3.2.1.2.2. Standardization for Applying for CME Credit: Recognizing the value of Continuing Medical Education (CME) for medical professionals, the Vice Chair should work with AMA staff to standardize the application process for CME credit for events organized by Standing Committees. This standardization will facilitate the offering of valuable educational opportunities to individuals beyond the AMA-MSS.

3.2.1.3. Timeline:

3.2.1.3.1. At the start of the MSS year, Divisions and Standing Committees will coordinate with the Vice Chair and sign up for months to host virtual programming sessions.

3.2.1.3.2. At least one month leading up to the event, each Standing Committee will fill out the standardized application for Standing Committee events open to only MSS members

3.2.1.3.3. At least two to three months leading up to the event, each Standing Committee will fill out the standardized application for Standing Committee events open to members outside MSS.

3.2.1.3.3.1. This step applies to ad hoc Standing Committee events, as well.

3.2.1.3.4. Advance Notice of Program Details

3.2.1.3.4.1. Final event details should be sent to the MSS Vice Chair and MSS Staff at least two weeks in advance for events open to only MSS members

3.2.1.3.4.2. Final event details should be sent to the MSS Vice Chair and MSS Staff at least one month in advance for events open to other sections and/or the public

3.2.1.3.4.3. Event information will be provided to MSS membership and other relevant interested parties at least one week in advance

3.3. Training and Onboarding

1 3.3.1. It is crucial for our general members and new leaders of Standing
2 Committees and Divisions to feel supported and well-prepared for their
3 respective roles. We feel that adequate training and standardized
4 onboarding, via live and asynchronous methods, across the different
5 Divisions and Standing Committees, with opportunities to tailor training
6 according to the unique responsibilities and functions of each Division or
7 Standing Committee, will ensure that everyone receives high quality
8 preparation for their roles. Deadlines and guidelines will also be set prior to
9 the start of the resolution and report cycle so that new members will be
10 supported by Standing Committees so they may be active members of
11 each cycle they are Standing Committee members.

12
13 3.3.2. Division and Standing Committee Leader Training:

14 3.3.2.1. The current timeline of leadership selection of Division leadership
15 and Standing Committee Chairs is intended to allow for a transition
16 and training period for these roles prior to the onset of their terms
17 at the Annual meeting.

18 3.3.2.2. Division and Standing Committee leaders will spend the transition
19 time prior to the Annual meeting working with the outgoing Division
20 and Standing Committee leaders to understand the functions and
21 responsibilities of their roles

22 3.3.2.2.1. It is recommended that Division and Standing Committee
23 leaders create and update written documents outlining
24 major events and responsibilities for their respective
25 leadership positions

26
27 3.3.3. Standing Committee Member Training:

28 3.3.3.1.1. It is recommended for Division leaders to be in charge of
29 onboarding new members based on their respective roles
30 (i.e. Resolution Chair will train members on resolution
31 review)

32 3.3.3.1.2. Standing Committee leaders will act as the main point of
33 contact for their Standing Committee members to ensure
34 individuals are onboarded properly and act as day-to-day
35 mentors.

36 3.3.3.1.2.1. When applicable, Standing Committee leaders can
37 collaborate with Division leaders to provide
38 clarification to Standing Committee members about
39 certain responsibilities and issues

40 3.3.3.1.3. Both Division leaders and Standing Committee leaders
41 should generate and update easily accessible
42 transition/onboarding documents to pass on information to
43 members.

44
45 3.3.4. Standing Committee Specific Strategic Plan: Each Standing Committee will
46 be required to create an annual three point strategic plan. Your SCTF
47 recommends that the three points include (1) Policy Process Involvement
48 (2) Programming, Advocacy, and Educational Activities (3) Training and
49 Standing Committee Member Experience.

50 3.3.4.1. The Vice Chair and Division Leads will help facilitate a strategic
51 planning session with the Standing Committee leadership within a

1 month of leadership selection.

2 3.3.4.2. Standing Committees will report on Strategic Plan
3 accomplishments to the incoming Standing Committee leadership,
4 Division, and GC as a part of transitioning leadership.

5
6 **4. Leadership & Member Review and Recall.** Your SCTF recommends implementing a
7 process for reviewing the quality of all leaders' work to ensure that their tasks are done
8 well and that those they are leading feel well supported. This process would enable the
9 leaders under review to learn ways to strengthen and improve their leadership skills, or, if
10 necessary, enable a process for removal of any individual from their position that does not
11 meet the minimum standards and replacement with someone else for the sake of the
12 Standing Committee/Division. A recommended avenue to achieve this is as follows:

13
14 4.1.1. Division Leader Review Process:

15 4.1.1.1. The Vice Chair will serve as an overseer of the Division Chairs and
16 ensure that minimum standards are being upheld.

17 4.1.1.2. Should any Division Chair not fulfill their duties, the Vice Chair and
18 other GC members shall hold a meeting with that individual to
19 discuss potential next steps in resolving the issues or dismissal and
20 replacement of the Division Chair.

21
22 4.1.2. Standing Committee Leader Review Process:

23 4.1.2.1. One of the roles of the Division leaders requires that they serve as
24 mentors to the Standing Committee leaders and members.
25 Because of this, Division leaders will conduct regular check-ins with
26 the Standing Committee leaders to ensure they are meeting all
27 requirements of their position, in addition to meeting their personal
28 goals for growth.

29 4.1.2.2. Should the Division leadership leader feel that a Standing
30 Committee leader is not meeting their minimum requirements for
31 their position, they may involve the Vice Chair of the GC to attempt
32 to remedy the situation.

33 4.1.2.3. Standing Committee leadership and membership may also raise
34 concerns regarding leaders they believe are not fulfilling their duties
35 to the Division leadership who may elevate the situation to the Vice
36 Chair, if necessary.

37
38 4.1.3. Concerns Regarding Leadership:

39 4.1.3.1. If any member or fellow leader wishes to raise a concern regarding
40 the actions of a Division leader or Standing Committee leader, then
41 they may initiate the conversation and/or submit a formal recall
42 request with the Division leaders not involved in the process and/or
43 Vice Chair.

44 4.1.3.2. Division leaders may handle situations as they deem appropriate,
45 but there will be an opportunity for those involved to appeal the
46 decision made by the Division leaders. At that point, the Division
47 leaders will involve the Vice Chair and other applicable parties such
48 as the DEI Chair when requested that can assist with fairly handling
49 the situation.

50 4.1.3.2.1. For concerns regarding Division leadership, the Vice Chair
51 and GC will oversee the handling of concerns brought up as

they deem appropriate.

4.1.4. Disciplinary Action & Recall of Officers:

4.1.4.1. If attempts to remedy the situation are unsuccessful, a process may begin to recall the officer that is not fulfilling their duties.

4.1.4.2. This process shall include the individuals involved in the original selection process for the leader in question. The Vice Chair will call a meeting of these individuals to review the available information and make a determination regarding the recall of officers or other disciplinary action.

4.1.4.2.1. If the responsibilities of the leader remain unmet for four weeks following attempts at resolving the situation with the Vice Chair, then a vote will take place to remove the leader from their position. This will require a 2/3 vote to be final.

4.1.4.2.2. The position must be filled within 30 days.

4.1.4.3. Should a replacement for any Division or Standing Committee leader become necessary, preference will be given to any eligible applicants who applied for the position originally, but applications will be made available to all members who meet the minimum requirements for the position as outlined in this report above. Selection will follow the same protocol as the original application period.

4.1.5. Member Review Process:

4.1.5.1. Due to the limited number of members accepted per Standing Committee, there will be minimum requirements for any member selected that must be upheld in order to continue their membership.

4.1.5.1.1. For those selected after Annual, midterm review will be held at the time of Interim meeting by the Standing Committee leaders and Division leaders if necessary. Any members who did not uphold their minimum requirements will be informed of their dismissal from the Standing Committee. Members who are at risk of not meeting requirements, will be notified in advance and given steps to improve their involvement.

4.1.5.1.2. New applications will be considered after the Interim meeting to replace any newly available positions following any possible dismissals.

4.1.5.1.3. Any member who has previously been dismissed from a Standing Committee may apply again for the next cycle of applications, but the dismissal will appear on any subsequent applications.

5. Mechanism for Standing Committee Review and Future Alterations to Structure

5.1. Due to the ever-changing nature of the MSS, your SCTF believes there should be a mechanism in place that would allow for alterations to the structure recommended in this report. A periodic review at specific intervals will ensure that the Standing Committees continue to serve the current mission and goals of the members of the MSS.

- 1 5.1.1. Reviewing Entity: Your SCTF recommends the recreation of a task force to
2 review any potential alterations following the implementation of the
3 Standing Committee structure outlined in this report.
4
- 5 5.1.2. Review Timing: Your SCTF recommends that the 2024-2025 GC release a
6 report regarding the implementation of the new Standing Committee
7 structure at A-25. In a similar fashion to the recurring task force that has
8 been commissioned to review the Internal Operating Procedures of the
9 MSS, the recurring SCTF will be assembled and write a report in four year
10 cycles. The first task force will be created at the conclusion of A-25 and
11 submit a preliminary report at I-25 and a final report at A-26.
12
- 13 5.1.3. Decision Making Body: Your SCTF recommends that each SCTF Final
14 Report be voted on and adopted by the MSS Assembly at the Annual
15 meeting at which it is published.
16

17 **6. Communication and Knowledge Dissemination**

- 18 6.1. **Communication**. In an effort to ensure adequate dissemination of knowledge is
19 achieved, your SCTF recommends that the GC work with staff to create avenues
20 for centralized communication tools, aiming to foster seamless interaction among
21 members. Your SCTF recommends the following as potential options that could
22 be implemented and utilized moving forward:
23

24 6.1.1. Communication Within the Division and Standing Committee Structure:

25 6.1.1.1. Internal Archives & Data Storage:

- 26 6.1.1.1.1. Your SCTF recommends that the GC create a centralized
27 Google Drive folder for each Division and Standing
28 Committee to store documents and information utilized by
29 their Standing Committee. This will provide safeguards to
30 ensure records and information is not lost during any
31 transitions. Your SCTF recommends that the GC create
32 both Standing Committee member-only folders for the
33 Standing Committees to use and public folders for Standing
34 Committees to share resources and deliverables.
35
36

37 6.1.1.2. GC Communication: Your SCTF recommends that the Vice Chair:

- 38 6.1.1.2.1. Maintain a written communication platform (i.e. GroupMe)
39 with all Division leaders and Standing Committee Chairs to
40 provide regular updates, answer real time questions, and
41 foster discussion among leaders;
42 6.1.1.2.2. Maintain a centralized repository for leaders to view
43 information that could otherwise get buried in a group chat
44 or email;
45 6.1.1.2.3. Host at least two to three Standing Committee leader check
46 in calls a semester to provide updates, foster discussion and
47 collaboration across all Divisions and ensure needs are
48 being adequately met;
49 6.1.1.2.4. Communicate regularly with Division leaders specifically
50 through at minimum maintaining a written communication
51 platform and sharing updates;

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6.1.1.3. Division Leadership Communication: Your SCTF recommends that the Division leadership is included in the Standing Committee written communication platforms, meetings, and emails;

6.1.1.4. Standing Committee Communication: Your SCTF recommends that all Standing Committees maintain at minimum:

6.1.1.4.1. A central communication platform to disseminate information to (i.e. Groupme)

6.1.1.4.2. An Internal Standing Committee calendar for members to keep track of meetings, deadlines, and events.

6.1.2. Communication Beyond Standing Committee Members:

6.1.2.1. Your SCTF recognizes the value of the work Standing Committees do and believes it is important to elevate this work. Your SCTF recommends that the GC continue to utilize internal mechanisms for promotion of Standing Committee events and resources including but not limited to utilization of the internal MSS Channels such as the [MSS Hub](#), [MSS Groupme](#), and [MSS Calendar](#). In addition to the internal channels, your SCTF feels strongly that the GC should advocate for Standing Committees to be more prominently featured in external platforms that include the [AMA Instagram](#), [Twitter](#), and Website which currently features basic information about Standing Committees on the [MSS Standing Committees](#) webpage and [news highlights](#) webpage, however, further details on these pages, new individual pages for Standing Committees, or highlights in news articles could be interesting avenues to explore. While there was significant interest for Standing Committees to have their own webpages or platforms to share data, AMA staff has expressed that this would likely be infeasible, we encourage the GC and Division leaders to explore potential compromises.

6.1.3. **Involvement of Councilors, NMSOs, and other stakeholders.** We believe that institutional memory is essential and requires keeping more experienced members involved, as well as including those who serve in roles outside of the MSS in the everyday functions of our Standing Committees.

6.1.3.1. Your SCTF believes utilization of the MSS members to the AMA Councils is the most efficient way to encourage collaboration and communication between the Standing Committees and AMA Councils.

6.1.3.1.1. The respective councils for which your SCTF believes each Standing Committee should interface with is listed in 1.2.

6.1.3.1.2. Your SCTF recommends that MSS Councilors be strongly encouraged to attend all meetings for their respective Standing Committees to provide insight and guidance regarding issues at the HOD level, as well as to serve as a liaison for mentorship between the Standing Committee and Council.

- 1 7.2.6.1.1. Committee on Healthcare Economics & Health
2 Administration
- 3 7.2.6.1.2. Committee on Clinical Practice & Ethics
- 4 7.2.6.1.3. Committee on Legislation & Intergovernmental Affairs
- 5 7.2.6.1.3.1.1. Subcommittee on Tribal Affairs and the
6 Indian Health Service
- 7 7.2.6.1.4. Committee on Science & Technology
- 8 7.2.6.1.4.1.1. Subcommittee on Research and Poster
9 Showcase
- 10 7.2.6.1.4.1.2. Subcommittee on Artificial Intelligence
- 11 7.2.6.1.5. Committee on Global & Public Health
- 12 7.2.6.1.5.1.1. Subcommittee on Immigrant and Refugee
13 Health
- 14 7.2.6.1.5.1.2. Subcommittee on Firearm Violence
- 15 7.2.6.1.5.1.3. Subcommittee on "One Health"
- 16 7.2.6.1.6. Committee on Medical Education
- 17 7.2.6.1.6.1.1. Subcommittee on IMG, Osteopathic, and
18 Allopathic Licensure Parity
- 19 7.2.6.1.7. Committee on Gender, Sexuality, & Reproduction
- 20 7.2.6.1.7.1.1. Subcommittee on Women in Medicine
- 21 7.2.6.1.7.1.2. Subcommittee on LGBTQ+ Affairs
- 22 7.2.6.1.7.1.3. Subcommittee on Reproductive Health
- 23 7.2.6.1.7.2. Committee on Health Justice
- 24 7.2.6.1.7.2.1. Subcommittee on Disability Affairs
- 25 7.2.6.1.7.2.2. Subcommittee on Minority Affairs
- 26 7.2.6.2. These subcommittees are subject to change, as outlined in the
27 report above, at the discretion of Division and Standing Committee
28 leadership by the end of March, at which time they will begin
29 working with the Vice Chair and Division leaders, respectively, to
30 develop plans for the new Standing Committees.
- 31
- 32 7.3. Phase 3: Around A-25
- 33 7.3.1. Applications for Standing Committees will reflect the new Standing
34 Committees as outlined in this report. The Vice Chair, Division Chairs, and
35 Standing Committee Chairs will work in conjunction to select:
- 36 7.3.1.1. Standing Committee Vice Chairs,
- 37 7.3.1.2. Subcommittees for applicable Standing Committees,
- 38 7.3.1.3. The inaugural members.
- 39 7.3.2. The GC will publish an informational report regarding the steps that have
40 been taken and will be taken to finalize the transition to the new Standing
41 Committee structure at A-25.
- 42
- 43 7.4. Phase 4: 2025 - 2026 Implementation Task Force
- 44 7.4.1. A new SCTF will be formed to review the functioning of the new structure
45 and write an informational report regarding the progress of transitions at
46 the I-25 meeting. They will also write a final report with any
47 recommendations at the A-26 meeting.
- 48
- 49 7.5. Phase 5: Task Force Reconvenes for Review at A-29
- 50 7.5.1. The next reviewing task force will convene following A-29 and continue in
51 a similar fashion at four-year intervals.

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3 **8. MSS Positions Review**

4 8.1. A table detailing each MSS position that currently addresses Standing Committee
5 functions and your SCTF recommendations regarding these policies with the
6 associated rationale can be found in Appendix B.
7

8 **CONCLUSION**

9
10 The Standing Committee Task Force (SCTF) embarked on a comprehensive review of the
11 existing Standing Committee structures, aiming to enhance their efficacy, relevance, and
12 functionality. After consulting with the Standing Committee leaders, additional MSS leadership,
13 and compiling the feedback from the I-23 Preliminary report, the task force identified several
14 priorities and now proposes the aforementioned Standing Committee structure and leadership.
15

16 **RECOMMENDATIONS**

17
18 Your MSS Standing Committee Task Force (SCTF) recommends that the following
19 recommendations be adopted and the remainder of this report is filed:
20

21 RESOLVED, that the AMA-MSS Governing Council (a) implement the recommendations of the
22 Standing Committee Task Force to restructure the Standing Committee framework and
23 leadership model, (b) clarify Standing Committee responsibilities and objectives, and (c) enhance
24 operational efficiency, and (d) report back on the status of report implementation by A-25; and be
25 it further
26

27 RESOLVED, that the AMA-MSS Governing Council (a) implement the Division structure as
28 outlined in section 2.2, and (b) include the timeline and requirements for leadership selection as
29 outlined by Section 2.6; and be it further
30

31 RESOLVED, that the AMA-MSS Governing Council (a) restructure the existing 16 Standing
32 Committees into the proposed 8 Standing Committees as outlined by Section 1.2, and (b) include
33 the timeline and requirements for leadership selection as outlined by Section 2.6; and be it further
34

35 RESOLVED, that the AMA-MSS Governing Council restructure the Committee on Long Range
36 Planning to serve in an advisory capacity led by the MSS GC Chair as outlined by Section 1.2.5;
37 and be it further
38

39 RESOLVED, that the AMA-MSS Governing Council restructure the Committee on Impact, Policy,
40 and Action (IMPACT) to serve as a group led by the MSS Section Delegates with an emphasis
41 on training as outlined by Section 1.7; and be it further
42

43 RESOLVED, that the AMA-MSS Governing Council require that Standing Committees produce
44 resolved clauses for reports that are recommended to be transmitted to the AMA House of
45 Delegates and be it further
46

47 RESOLVED, that every Standing Committee leadership team develop a detailed strategic plan at
48 the beginning of their terms; and be it further
49

50 RESOLVED, that the AMA-MSS Governing Council develop a leadership and membership review
51 and recall system as outlined in Section 4; and be it further

1
2 RESOLVED, that the AMA-MSS follow the implementation plan outlined in Section 7 stating that
3 the current Standing Committees will remain for the 2024-2025 term and the new timeline will
4 begin in January of 2025 by selection of leadership for the 2025 - 2026 Division and Standing
5 Committee Chairs, overlapping with the existing structure; and be it further
6

7 RESOLVED, A new Standing Committee Task Force will be formed to review the functioning of
8 the new structure and write an informational report regarding the progress of transitions at the I-
9 25 meeting. They will also write a final report with any recommendations at the A-26 meeting;
10 and be it further

11
12 RESOLVED, The Standing Committee structure and functioning be reviewed on four-year
13 intervals after the completion of the 2025-2026 task force with the next report due at A-30; and
14 be it further

15
16 RESOLVED, that the AMA-MSS rescind 640.008MSS and 640.017MSS and amend
17 640.001MSS, 640.013MSS, and 640.014MSS as outlined in Appendix B.

18
19 **ACKNOWLEDGEMENTS**

20
21 We extend our thanks to our dedicated task force members: Alec Calac, Anand Singh, Andrew
22 Norton, Brianna Baldwin, Caitlin Blaukovitch, Heidi Ventresca, Priya Desai, Radhika Patel and to
23 our task force Co-Chairs, Natasha Topolski and Dhruv Puri. Our appreciation also goes to our
24 engaged Standing Committee leaders and members for their foundational insights crucial to
25 development of this report. We're also deeply grateful for the invaluable feedback from many
26 stakeholders including the MSS Governing Council and numerous other current and former
27 leaders. Finally, we would like to thank the MSS Staff for all of their valuable insight with a
28 particular note of gratitude to our MSS Policy Analyst, Sarah Langill and MSS Director, Shane
29 McGoey. Finally, we acknowledge the 2022-2023 MSS Governing Council and A-23 Assembly
30 members for entrusting us with this important task.

31
32
33 **APPENDIX A: Other Resources Links**

- 34
35 1. [Pre-SCTF Standing Committees](#)
36 2. [New Standing Committee Graphic](#)
37 3. [New Report Template](#)
38 4. [\[TEMPLATE\] Report Members and Contribution Tracker](#)

39
40 **APPENDIX B: MSS Positions Review**

MSS Position	Recommendation
<p>640.001MSS MSS Task ForceCommittee on Long Range Planning It is the policy of the AMA-MSS that the Committee on Long Range Planning should be a Committee, appointed by the ChairGC, to study issues referred by the GC as well as structure, function, and strategic planning issues relating to the future of the MSS.</p>	<p>Amend: Your SCTF report recommends that new COLRP members will be appointed by the Chair. See 1.2.5.</p>
<p>640.008MSS MSS Committee Reports It is the policy of the AMA-MSS that the AMA-MSS GC may suggest</p>	<p>Rescind: GC review of all items of business is now provided on the MSS</p>

41

<p>changes to Committee reports but may not alter them without consultation with and agreement of the Committee. Further, the GC may include an addendum to the Committee report, should a dissenting opinion exist, to distinguish the opinions of the GC from those of the Committee. (MSS Rep L, I-91, Adopted in lieu of MSS Res 44, A-91)</p>	<p>Virtual Reference Committee.</p>
<p>640.013MSS AMA-MSS Standing Committees The AMA-MSS GC 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 GC’s goals, 30 days in advance of the monetary need; and (3) seek funding for two conference calls per Committee per year.</p>	<p>Rescind 1: This report was not previously completed, but was functionally completed with this report. Retain 2: This position is important to retain to ensure funding opportunities for Standing Committees. Rescind 3: Modern conference calls are now generally video calls that do not require funding. Therefore, this ask is adequately covered by Resolved 2.</p>
<p>640.014MSS Regional Representation on MSS Committees The AMA-MSS GC will (1) continue to empower regions and work toward increasing diversity on all MSS Committees by promoting Standing Committee applications and considering using regional diversity including demographics such as regional membership and training program type on the MSS Standing Committee applications as one of the selection criteria for all MSS Committee.</p>	<p>Amend: Maintaining regional diversity among Standing Committees is important to ensure multiple perspectives are heard. Your SCTF decided to broaden the scope of this policy to include other types of diversity.</p>
<p>640.017MSS Establishment of a GC SCTF The AMA-MSS GC will assemble a SCTF to (1) evaluate and provide recommendations on structure and operations of our MSS Standing Committees; (2) be Chaired by the MSS GC Vice Chair and Chair, who will both be non-voting members of the Task Force, and include opportunities for input from Standing Committees; and (3) submit an update on their progress to the Assembly at I-23, and a completed report with their findings at A-24.</p>	<p>Rescind: This report fulfills the asks of this policy</p>

RELEVANT MSS POSITIONS

Sunset Mechanism for AMA-MSS Policy 630.044MSS

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 or refer 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 GC, whereby the report is authored by the Chair of the GC with initial policy recommendations being solicited from relevant Standing Committees as appropriate;
- (2) The GC will provide Standing Committees clear guidance regarding criteria for recommendations of retention, retention with amendments, or sunset;

(3) policy recommendations will be reported to the AMA-MSS Assembly at each Annual Meeting on the five or five and one half year anniversary of a policy's adoption, with a brief rationale accompanying each recommendation;

(4) a consent calendar format will be used by the Assembly in considering the policies encompassed within the report;

(5) a vote will not be necessary on policies recommended for rescission as they will automatically expire under the auspices of the sunset mechanism unless referred back to the GC; and

(6) the MSS GC may recommend policies for consolidation as part of the sunset review

MSS Task Force on Long Range Planning 640.001MSS

It is the policy of the AMA-MSS that the Committee on Long Range Planning should be a Committee, appointed by the GC, to study issues referred by the GC as well as structure, function, and strategic planning issues relating to the future of the MSS.

MSS Committee Reports 640.008MSS

It is the policy of the AMA-MSS that the AMA-MSS GC may suggest changes to Committee reports but may not alter them without consultation with and agreement of the Committee. Further, the GC may include an addendum to the Committee report, should a dissenting opinion exist, to distinguish the opinions of the GC from those of the Committee.

AMA-MSS Standing Committees 640.013MSS

The AMA-MSS GC 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 GC's goals, 30 days in advance of the monetary need; and

(3) seek funding for two conference calls per Committee per year.

Regional Representation on MSS Committees 640.014MSS

The AMA-MSS GC will (1) continue to empower regions and work toward increasing diversity on all MSS Committees by using regional diversity as one of the selection criteria for all MSS Committees.

Expanding the AMA-MSS GC to Include a Diversity, Equity, & Inclusion Officer 660.037MSS

(1) That our AMA-MSS expands its GC to include an annually elected Diversity, Equity, and Inclusion Officer empowered to and charged with the sustainable prioritization of these values within our section;

(2) That our AMA-MSS amends its Internal Operating Procedures as follows:

4.1 Designations. The officers of the MSS shall be the ~~eight nine~~ eight GC members: Chair, Vice Chair, AMA Delegate, Alternate Delegate, At- Large Officer, Chair-Elect, Immediate Past Chair, Speaker, ~~and~~ Vice Speaker, and Diversity, Equity, and Inclusion Officer. The Chair-Elect/Immediate Past Chair shall be non- voting members of the GC. 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:

4.4.6.1 Coordinate the AMA-specific activities of the identity-based National Medical Student Organizations liaisons (as defined in MSS IOP 10.3.3), identity-based Professional Interest Medical Association liaisons (as defined in MSS IOP 10.3.2), and identity-based AMA-MSS Standing Committees within the Section.

4.4.6.2 Serve as a liaison between the AMA's Center for Health Equity, the MSS, and the MSS GC.

4.4.6.3 Serve as a liaison between identity-based National Medical Student Organization leadership and the Section.

4.4.6.4 Support the functions of the MSS liaisons to the Minority Affairs Section (MAS), Women Physicians Section (WPS), the Advisory Committee on LGBTQ Issues, and other identity-based sections or groups within the AMA

4.4.6.5 Track demographics in the Section and direct efforts to recruit and retain a more diverse and representative AMA-MSS membership and leadership.

4.4.4.6 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 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 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 GC 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 IOP 10.3.3), liaisons to Professional Interest Medical Associations (as defined in MSS IOP 10.3.2) and liaisons to identity-based AMA Sections and Advisory Committees (as defined in AMA Bylaw 7.0.1).

6.8.1 Candidates are strongly encouraged to seek at least one endorsement, and may seek as many endorsements as they choose.

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.

6.5.7.3 No mode of MSS- or AMA-sponsored communication, including, but not limited to listservs, phone or email lists, or other mass communication methods shall be used for announcements of candidacy, endorsement, or campaigning unless otherwise outlined in this IOP.

6.5.9.1 Only MSS members may be involved in a candidate's campaign. MSS members should not share their opinion in favor of or in opposition to any candidate while acting under any official leadership role within or outside of the organization unless otherwise outlined in this IOP.

6.7.2 Voting Periods. There shall be one voting period at the Interim Meeting for the selection of the Chair-Elect and Medical Student Trustee. There shall be one voting period at the Annual Meeting for the selection of the Vice Chair, AMA Delegate, At-Large Officer, ~~and~~ Speaker, and Diversity, Equity, & Inclusion Officer. An additional balloting period will be held for the elections of the Alternate Delegate and Vice Speaker.

(3) That our AMA-MSS GC, with input from AMA-MSS identity-based Standing Committees and National Medical Student Organization liaisons, appoint an individual 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 GC, but not allowed to vote until elected by the Section, until the AMA-MSS 2022 Annual Business Meeting election can occur.

Establishment of a GC SCTF 640.017MSS

The AMA-MSS GC will assemble a SCTF to (1) evaluate and provide recommendations on structure and operations of our MSS Standing Committees;

(2) be chaired by the MSS GC Vice Chair and Chair, who will both be non-voting members of the Task Force, and include opportunities for input from Standing Committees; and

(3) submit an update on their progress to the Assembly at I-23, and a completed report with their findings at A-24.

MSS Action Items 645.031MSS

A list of all MSS 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 MSS Action Item implementation status with interested students.

RESOLUTION TASK FORCE UPDATE 2022: AMA-MSS adopt the following as our MSS Policy Process 645.032MSS

1. The MSS Section Delegates will ensure that all items of business submitted for consideration to each MSS Assembly meeting undergo a comprehensive review process evaluating their impact, feasibility, timeliness, and evidence basis.

2. The draft resolution review process should include opportunities for participation by MSS Caucus members; MSS members on AMA Councils; appropriate MSS region officers; MSS Standing Committees; MSS members with significant HOD experience; and MSS members who liaise with other AMA Sections and groups, specialty societies, professional interest medical associations, medical student organizations (including identity-based groups), and medical education bodies.

3. The MSS Section Delegates will decide the timeline for the policy cycle preceding each MSS Assembly and will design the criteria used to review items of business.

4. Resolutions submitted by the correct deadline in the correct format as determined by the MSS Section Delegates prior to start of the policy cycle may not be rejected for submission for consideration by the MSS Assembly based on their content after organizational review for legal issues.

5. Per the MSS IOPs, submitted resolutions will be sent to the MSS Reference Committee, which will make recommendations to the Assembly for disposition of its items of business. The Reference Committee Report will use a consent calendar format. In order for an item to be heard by the MSS Assembly, it must be extracted from the Reference Committee Consent Calendar. The Order of Business for each MSS Assembly meeting will follow the order listed in the MSS Reference Committee report for that meeting. Items of business will be categorized by Reference Committee recommendations for “adoption,” “adoption as amended,” “adoption in lieu of,” “referral,” “not adoption,” “reaffirmation in lieu of,” etc. The order of items in each category will be randomized. The MSS Reference Committee must include a meaningful rationale for their recommendations made on each item of business. Any MSS member may extract any item from the Reference Committee Report for debate at the MSS Assembly. No other requirements, such as testimony or votes, are necessary for an item to be extracted. The Section Delegates shall provide opportunities for extraction both in advance of the MSS Assembly remotely and at the

beginning of the Assembly. Extractions made in advance of the MSS Assembly should be published in real-time as they are submitted.

6. The AMA-MSS Internal Operating Procedures (IOPs) and Digest of Actions will be made available on the AMA-MSS Web site, with updates made prior to the beginning of the Policy Cycle for each Annual and Interim Meeting of the Assembly.

7. A resolution template will be made publicly available to assist resolution authors in formatting their resolutions.; and be it further AMA-MSS adopt the following as Additional MSS Caucus Operations:

1. The MSS Section Delegates have the ability to nominate existing policies in the MSS Digest of Actions to the queue to be transmitted to a future HOD meeting, based on strategic considerations. These nominations must be approved by a majority vote of the MSS Caucus.

2. The MSS Caucus can co-sponsor resolutions in the name of the MSS with another HOD delegation. a. Co-sponsoring a resolution authored by another delegation must be approved by a $\frac{2}{3}$ vote of the MSS Caucus. b. The MSS Section Delegates have the authority to add other delegations as co-sponsors of MSS-authored resolutions.

AMA-MSS (1) rescind all statements of formal support for AMA policies listed in the section "AMA-MSS Statements of Support for HOD Policies" of the MSS Digest of Policy Actions; (2) investigate strategies for (a) preserving institutional memory, which would document the results of MSS resolutions and actions taken by the AMA in response to policies passed by the AMA HOD and (b) reporting this information to the original resolution authors and MSS assembly; and (3) that these changes, and the AMA-MSS resolutions process as a whole, be reevaluated in an AMA-MSS Governing Council report to be presented 3 years after the adoption of these recommendations.

REPORT OF THE MEDICAL STUDENT SECTION
ARCHIVES TASK FORCE

ATF Report
(A-24)

Introduced by: Archives Task Force
Subject: MSS Archives Task Force Report
Referred to: MSS Reference Committee
(Caitlin Blaukovitch and Shaminy Manoranjithan, Co-Chairs)

1 **INTRODUCTION**
2

3 At the 2023 Annual Meeting of the AMA Medical Student Section (MSS), the Resolution Task
4 Force published a sweeping review of the MSS policy cycle and recommended detailed edits
5 to consolidate policy, reduce redundancies, eliminate overly prescriptive requirements, and
6 create new opportunities for future innovation and improvement. One recommendation was for
7 the AMA MSS to investigate methods to effectively track and report actions taken by the MSS
8 and outcomes that resulted from policies originally written by the MSS. The language adopted
9 at A-23 is below:

10 RESOLVED, That our AMA-MSS will investigate strategies for (a) preserving
11 institutional memory, which would document the results of MSS resolutions and
12 actions taken by the AMA in response to policies passed by the AMA HOD and (b)
13 reporting this information to original resolution authors and the MSS assembly.

14 Currently, actions taken by our MSS assembly are stored in the Summary of MSS Assembly
15 actions 1999-2022, a 1185-page PDF document listing final outcomes of each MSS Assembly
16 and the MSS Digest of Actions, a 315-page PDF document organized by topic. Access to full
17 drafts of resolutions and reports or their affiliated authors is limited, outside of previous meeting
18 handbooks that are each also 1000-page PDF documents. Searching and navigating these
19 PDFs is unwieldy for even experienced members attempting to understand our MSS history,
20 let alone new members. Furthermore, outcomes of resolutions that were forwarded to the AMA
21 House of Delegates (HOD) are inconsistently reported and difficult to interpret. There is
22 currently no official mechanism for tracking and regular reporting actions taken in response to
23 policies passed at the AMA HOD by the MSS. Updates are given at the discretion of the
24 Government Relations and Advocacy Fellow and Student Board of Trustees Member or if a
25 student directly asks through submission of a MSS Action Item (MSSAI).

26 The 2023-2024 Governing Council felt strongly that the most appropriate way to achieve this
27 goal would be to assemble an Archives Task Force (ATF) consisting of MSS members
28 interested in enhancing our process of archiving actions and outcomes of our MSS. The
29 Governing Council also believes that the ATF would be well equipped to make
30 recommendations on best practices of archiving other MSS materials including presentations,
31 webinars, handbooks, transition documents, and other products of the MSS. The official ATF
32 Charter can be found [here](#).

33
34 **BACKGROUND**
35

1 The archival information of the MSS is currently found in multiple diverse documents. These
2 documents, while accessible and containing imperative information, are difficult to navigate. Here
3 your ATF has listed these documents and their descriptions.
4

5 **MSS Resources:**

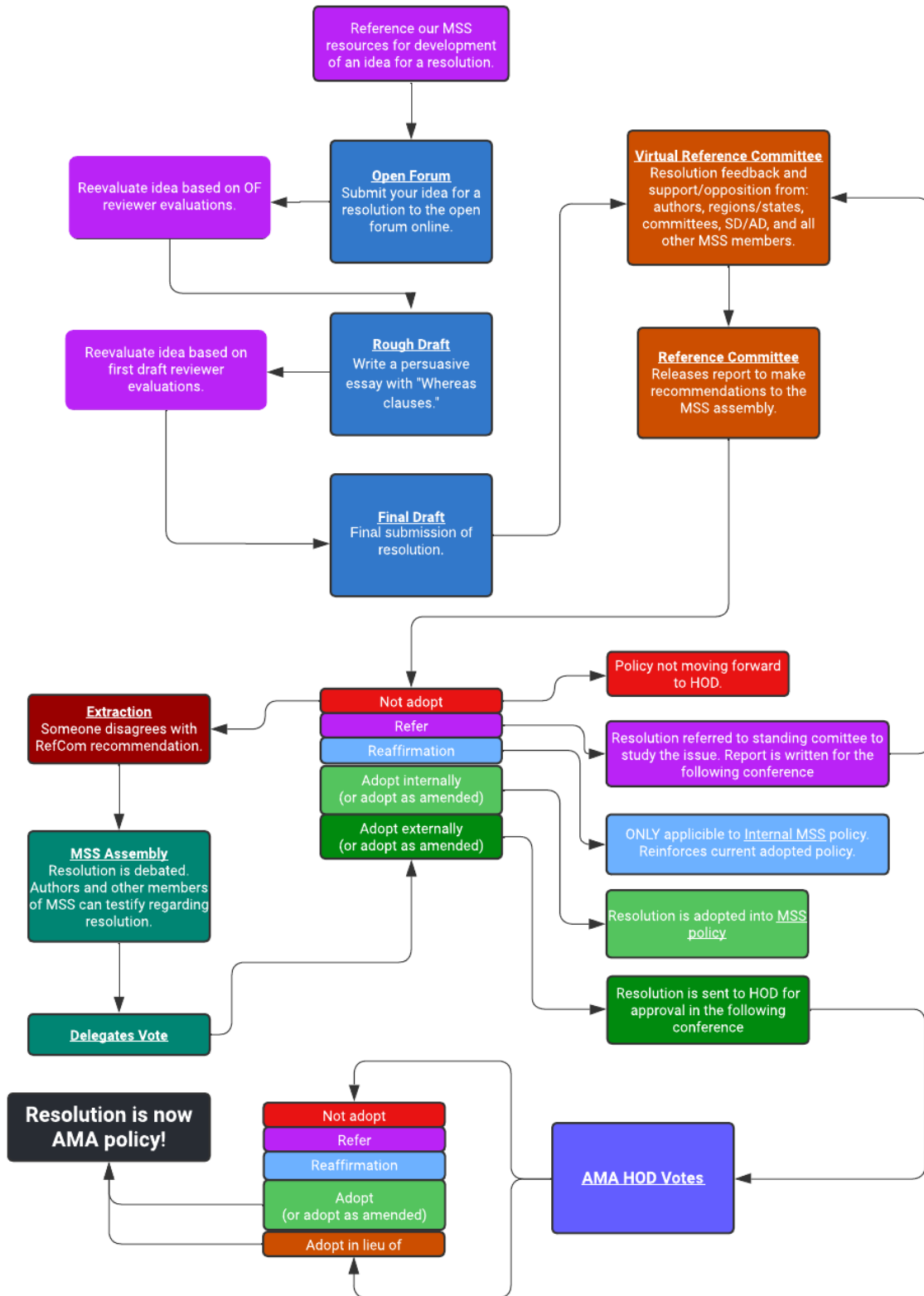
- 6 ● [MSS Policymaking Webpage](#): an official page on the AMA website outlining the MSS
7 policy making process with links to useful resources for MSS members, notably including
8 the:
 - 9 ○ Current AMA archive documents (*outlined below*)
 - 10 ○ [Links to resolution writing resources](#),
 - 11 ○ [Open Forum](#)
 - 12 ○ [Virtual Reference Committee](#)
 - 13 ○ [MSS Action Item Request Form](#)
- 14 ● **Assembly Resources:**
 - 15 ○ [MSS Assembly Microbrick](#)
 - 16 ○ [Motion Tracker](#)
 - 17 ○ [Logistics](#)
 - 18 ○ [Reference Committee \(RefCom\) Report](#)
 - 19 ○ [Assembly Notes](#): Taken by the MSS Policy Analyst and available upon request.
- 20 ● **HOD Resources:**
 - 21 ○ [MSS HOD Microbrick](#)
- 22 ● **Formal Archives:**
 - 23 ○ **MSS Assembly Archives:**
 - 24 ■ [MSS Digest of Actions](#): a 315 page PDF organized by topic of all of the
25 positions adopted by the MSS Assembly.
 - 26 ○ **HOD Archives:**
 - 27 ■ [Delegate Report A](#): a document released by the Section Delegates
28 indicating the status of pending MSS-authored resolutions to the HOD at
29 each MSS Assembly.
 - 30 ■ [Delegate Report B](#): a document released by the Section Delegates
31 indicating the proceedings of the previous MSS Assembly.
 - 32 ○ **MSS Assembly & HOD:**
 - 33 ■ [Summary of MSS Assembly Actions 1999-2022](#): a 1185-page PDF
34 document listing final outcomes at each Assembly, including positions on
35 resolutions that were not adopted and reaffirmed and reports that were filed
36 without recommendations. Outcomes of MSS items sent to the HOD are
37 also reported.
 - 38 ■ [Conference Summary of Actions](#): a PDF document detailing the actions
39 taken on each MSS resolution presented at a specific conference both at
40 the MSS Assembly and HOD level.

41
42 **AMA Resources:**

- 43 ● [AMA Policy Finder](#): a search engine that generates AMA policy based on keyword search.
44 A timeline of when the policy was adopted, reaffirmed, and amended is also included.
45 However, links to resolution texts and actions taken on the policy are not included. There
46 is no MSS equivalent of this.
- 47 ● [Council Report Finder](#): a search engine that generates AMA Council Reports based on
48 keyword search. Links to the original report are included. There is no MSS equivalent.
- 49 ● [Federal and State Correspondence Finder](#): a search engine that generates
50 correspondence of the AMA in legislature including testimony, sign-on letters, and
51 comment letters.
- 52 ● [Litigation Center Case Summary Finder](#): a search engine generating AMA action in
53 litigation.

- 1 ● [Business of the AMA House of Delegates Meeting Webpage](#): Leading up to, during, and
2 for the months after an annual or interim meeting, this page exists and contains all of the
3 resolutions, reports, and reference committee reports. The [annotated reference](#)
4 [committee reports](#) which have the HOD outcome are the first resources available to check
5 out outcomes normally being published no later than a day or so after the conference!
6 ● [Archives House of Delegates Meetings Webpage](#): This webpage on the official AMA
7 website contains links to the proceedings of the HOD for each conference, statuses on
8 the implementation of passed resolutions and reports, and a link to the AMA digital
9 archives.
 - 10 ○ [Proceedings of House of Delegates](#): a webpage for each HOD including final
11 resolution and report outcomes, election results, and other resources.
 - 12 ○ [Status on Implementation of Resolutions and Reports](#): a document released after
13 each conference indicating implementation of AMA resolutions and report
14 recommendations once adopted. The document is updated at 6 months and 1 year
15 after adoption.
 - 16 ○ [AMA Digital Archives](#): Archives of AMA proceedings dating back to 1847 including
17 a digest of official actions, historical monographics, HOD proceedings, and AMA
18 transactions.

19
20 In order to identify the actions and implementations of the MSS, one must traverse the contents
21 of each source for its own novel information regarding the topic at hand. In the development of
22 resolutions, identifying the information each source provides is crucial to creating novel and
23 influential work. The following flow chart illustrates the lifecycle of an MSS resolution:



1
2 **DISCUSSION**

3
4 This report outlines the ATF's recommendations and rationale for archives moving forward.

5
6 Your ATF has provided a list of items below, ordered by priority, to indicate the amount of time
7 and effort the task force allocated to address each item.

1
2 **Top Priority Items**

- 3 ● Policy Archives
- 4 ● Archives

Sustainability

5
6 **Medium Priority Items**

- 7 ● Big Topic Policy History Docs
- 8 ● Standing Committee Archives
- 9 ● Resources for Member Archives
- 10 ● Regional Archives Best Practices

11
12 **Additional Topics Discussed**

- 13 ● Membership Archives
- 14 ● Engagement Archives
- 15 ● Journal of the MSS
- 16 ● State Advocacy / Sharing
- 17 ● Outreach Archives

18
19 **SUGGESTED RECOMMENDATIONS AND RATIONALE**

20
21 **Top Priority: Policy Archives**

22
23 Your ATF concluded that the top priority for this task force to address is the creation of a system
24 to archive MSS items as they are presented at the assemblies, and to track the progression of
25 these items through the HOD as well as all actions taken by the AMA as it relates to the original
26 policy proposed. Your ATF focused this report on addressing this issue.

27
28 Conversion of PDF Archives into Spreadsheets: Over the past decade, the MSS has naturally
29 transitioned to organizing items of business for both the MSS Assembly and for the HOD
30 meetings in spreadsheet formats (i.e. Excel or Google Sheets). The utilization of such a
31 structure has proven to be easily accessible, user friendly, and an asset in policy organization,
32 particularly in comparison to the lengthening PDF/word documents. Your ATF believes
33 consolidating the numerous policy resources into highly organized and straightforward
34 spreadsheet documents is one way to allow members to access all pertinent information
35 regarding MSS positions and AMA actions, including authorship. Your ATF has provided
36 examples of the aforementioned spreadsheets with this report. Your ATF discussed the
37 possibility of a searchable digest similar to the AMA Policy Finder and while it was agreed that
38 it would be highly valuable if feasible, there were concerns about implementation and
39 sustainability at this time.

40
41 **MSS Assembly Archives:**

42
43 MSS Digest Spreadsheet: Currently positions adopted by the MSS Assembly are stored in
44 the [MSS Digest of Actions](#): a 315 page PDF organized by topic of all of the positions adopted
45 by the MSS Assembly. The ATF proposes converting this into a [MSS Positions Compendium](#)
46 spreadsheet format that would be more easily navigable. The current draft of the new format
47 includes four active sheets: (1) "Intro" which contains a list of all of the topics and links to
48 policies that fall under those topics in the next tab, (2) "MSS Positions" which includes all
49 active MSS positions and information regarding the policy timeline and HOD outcome if
50 applicable, (3) "Titles Only" which includes a list of all of the stance titles, and (4) "Rescinded
51 Positions" which includes positions that have been removed from our compendium. **Note the
52 linked spreadsheet is not a complete resource. Resolutions from A-23 and I-23 are not
53 included and there are several other items that require additional information. Of note, as seen*

1 above, the ATF recommends that this new resource be called the MSS Positions
2 Compendium. MSS Staff has indicated that the AMA has requested that resolved clauses
3 adopted by sections no longer be called policy but instead, positions. In light of this change,
4 the ATF recommends this title change.

5
6 Annotated RefCom Report: Your ATF is recommending that MSS Assembly outcomes be
7 recorded in an Annotated RefCom Report format. This is a report that is currently produced
8 at the HOD level [[HOD Example](#)] and includes the HOD recommendation, a summary of
9 debate, and the final outcome. Your ATF is considering replacing the current [MSS Conference](#)
10 [Summary of Actions](#) with this report. Your ATF believes that the Annotated RefCom Report
11 provides more information, would be easier to fill out, and is more in line with HOD, therefore
12 making it a better option than the current MSS Conference Summary of Actions.

13
14 Your ATF also recommends that moving forward the MSS [Historical Summary of Actions](#) be
15 concatenated into an Annotated RefCom Report with actions from all conferences.

16
17 MSS Assembly Archives Sustainability: These resources must be regularly updated. Given the
18 volume of resolutions and other actions passed by the MSS, maintaining these resources will
19 require considerable time and effort. Therefore, the success of these changes depends on
20 reliable documentation of actions taken at both the MSS Assembly meetings. In the past,
21 notes regarding the MSS Assembly proceedings have been sourced from multiple parties,
22 including our AMA-MSS Policy Analyst, the Logistics Convention Committee, and the Motion
23 Tracker. This burden could be distributed in more than one way. Some possible options are
24 outlined below:

- 25 ● **Convention Committees**: Another possible avenue that your ATF is exploring includes
26 utilizing a convention committee to assist in the archiving process. An advantage to this
27 specifically is the opportunity to have this committee involved with note taking during the
28 conference as well.
 - 29 ○ **Archives**: The ATF is considering utilization of a dedicated Archives Convention
30 Committee to assist in notetaking in addition to the archival process, aiming to
31 streamline this process and maintain consistency.
 - 32 ○ **Logistics**: The logistics convention committee is responsible for tracking
33 amendments and final actions taken by the MSS on each item of business during
34 assembly. Given this, Logistics could be a reasonable entity to help with MSS
35 Assembly Archives.
 - 36 ○ **RefCom**: Given RefCom's' high familiarity with the resolutions, they could be a
37 good group to assist in archival tasks during assembly such as note taking and
38 updating outcomes.
- 39 ● **Standing Committees**: The ATF also considered utilizing standing committees for this
40 function. The Standing Committee Task Force (SCTF) discussed the possibility of
41 Standing Committees supporting the MSS in this process and agreed that it could fall
42 under the purview of Standing Committees and be integrated into their roles.
- 43 ● **Staff**: The ATF also contemplated the idea of requesting the help of staff in completing
44 these tasks, but this option will require further discussion. All solutions to this challenge
45 will require organized and consistent work from many individuals.

46
47 **HOD Archives:**

48
49 HOD Archives Spreadsheet: This would be a new resource for MSS members to more easily
50 track policies sent to the HOD from the MSS. The ATF envisions this resource including
51 information on the lifecycle of the resolution from MSS to HOD including the original MSS
52 resolution text, final language adopted by MSS, HOD Annotated RefCom Reports, final HOD
53 outcome and language, Policy Finder Links, Actions Taken by the AMA, Notes & News

1 Coverage, and possibly authorship. In this [link](#), an incomplete example is provided for
2 resolutions submitted to the HOD at A-22 to provide assembly an idea of what the ATF is
3 considering.

- 4 • Final Outcome Archives: A crucial function of these archives will ensure the MSS records
5 the final language of MSS items voted on by the HOD. In the past, there have been several
6 policies passed by the MSS in the HOD that were not accurately represented on the Policy
7 Finder. Given this, having a record of the final language will ensure that we are able to
8 confirm that the language published in the official AMA Policy Finder is correct. While
9 original final outcome notes may take place in the HOD Microbrick or other documents,
10 this information would be officially archived in the HOD Archives Spreadsheet.
- 11 • Actions & Press: The ATF believes that it is important to track the actions taken by our
12 AMA on AMA policies originally written by the MSS. While the AMA has the [Status on
13 Implementation of Resolutions and Reports](#) for each conference, these documents are
14 difficult to navigate and do not provide an appropriate record for the MSS. The ATF
15 recommends that actions taken by the AMA are recorded in an internal MSS Resource to
16 make it easy for members to view outcomes of our work. The ATF recommends that this
17 information is officially stored on the HOD Archives Spreadsheet. Examples of this can be
18 found in columns labeled “Actions Taken by the AMA” and “Notes and News Coverage”
19 in the sample HOD Archives Spreadsheet. Additionally, based on interfacing with Staff
20 and our SCTF, we recommend a one-year policy check-in, which includes reviewing
21 actions and documenting implementation. This will be accomplished by the MSS Staff or
22 dividing work among Standing Committees and other interested parties based on topic.
- 23 • Authorship: The ATF has heard from several members that there is an interest in
24 improving our tracking of original authorship. In the example HOD Archives Spreadsheet
25 template, an example of authorship tracking is included.
- 26 • Communication: To improve communication with our MSS members and authors, the ATF
27 recommends publicizing the Final Outcomes Archive (similar to this [summarized
28 Microbrick](#) developed for I-23) for each conference through MSS Channels and directly
29 with the authors that contributed to resolutions transmitted at the respective conference
30 through an email list collected when the resolution was originally submitted. The ATF also
31 recommends that implementation information also be directly shared with the MSS
32 Channels and original authors directly via the email list when the AMA actions are
33 recorded from the one-year follow up AMA Implementation Report using a document
34 similar to the [A-22 HOD MSS Resolutions Archive Prototype](#). Staff and the GC can
35 determine if any consents are needed to store the contact information for sharing this
36 information.

37
38 This task force continues to weigh options for tracking final MSS items transmitted to HOD.
39 However, your ATF has determined that regardless of the method, all actions should be
40 reported in a single, easily-accessible place. Thus, actions taken by the MSS could flow from
41 the MSS conference microbrick to HOD transmittals to an archival clearinghouse. Students
42 will then be able to follow resolutions and actions taken by the MSS throughout the policy
43 lifecycle.

44
45 HOD Debate Archives: This information will help current and future MSS members track allied
46 delegations in the HOD, provide authors with information about past testimony, and help direct
47 the feasibility and strategy for future policies.

48
49 The 2023-2024 MSS Section Delegates have implemented and refined a number of tools to
50 create the MSS HOD Debate Archives. First, the MSS Caucus and House Coordination
51 Committee (HCC) utilize a “microbrick,” (which is a historical moniker used to describe the
52 spreadsheets with resolution information in the MSS that predates most of our current MSS
53 members). The MSS Caucus Microbrick contains all of the Caucus’ notes on all items of HOD

1 business. It contains the strategic notes and reviews of the Caucus and HCC. Additionally,
2 the SDs have implemented Caucus “Nanobricks,” which are locations for the Caucus and
3 HCC to take detailed notes prior to and during hearings regarding positions and actions taken
4 on items of business. Linked is an example of the A-24 [Nanobrick Template](#) and [Notebrick](#)
5 [Template](#) to support this process.
6

7 MSS HOD Archives Sustainability: In addition to the MSS Assembly, documentation of actions
8 taken at the HOD is equally important. Below the ATF has outlined several options for
9 stakeholders who may be reasonable to contribute to archive development and maintenance:

- 10 ● **Convention Committees**: Your ATF is exploring utilization of a convention committee to
11 assist in the archiving process. An advantage to this specifically is the opportunity to have
12 this committee involved with note taking during the conference as well.
 - 13 ○ **House Coordination Committee (HCC)**: HCC already is responsible for assisting
14 in note taking during HOD RefComs and could be an excellent group to assist in
15 some of the MSS HOD Archives development.
 - 16 ○ **Archives**: The ATF is considering utilization of a dedicated Archives Convention
17 Committee to assist in notetaking in addition to the archival process, aiming to
18 streamline this process and maintain consistency.
- 19 ● **Standing Committees**: Existing Standing Committees could take responsibility for
20 tracking resolutions and actions that fall within their purview. Alternatively, the MSS, as
21 deemed by the MSS Governing Council, could establish a standing committee specifically
22 dedicated to updating and maintaining archives throughout the year. Another option could
23 be to have the Committee on Long Range Planning (COLRP) or a similar committee that
24 functions in a more general capacity to assist in updating actions taken by the AMA on
25 resolutions passed by the MSS at HOD.
- 26 ● **Staff**: The ATF also contemplated the idea of requesting the help of staff in completing
27 these tasks, but this option will require further discussion. All solutions to this challenge
28 will require organized and consistent work from many individuals.
29

30 **ATF Suggested Policy Documents Overview:**

31 MSS Assembly Documents:

- 32 1. [MSS Assembly Microbrick](#): Will exist in a similar form to current microbricks acting as a
33 resource for members to keep track of items being presented to assembly for each
34 conference.
35
- 36 2. [MSS Handbook](#): Will exist in a similar format to the current handbooks acting as a source
37 for full resolution text.
- 38 3. [Conference Annotated RefCom Report](#): This would include both the RefCom
39 recommendation post VRC and a write up of assembly debate and the final
40 recommendation. This document would take the place of the [Conference Summary of](#)
41 [Actions](#). The ATF is considering the creation of a Journal of the MSS (JAMA-MSS) that
42 would include outcomes of the MSS assembly in a similar format to the annotated RefCom
43 report in addition to other content. If the MSS is able to create JAMA-MSS, it may
44 encompass the annotated RefCom Report.
- 45 4. [Historical Annotated RefCom Report](#): The ATF is also considering options for the long
46 summary of actions pdf that concatenates the summary of actions from each conference
47 and has yet to decide how exactly this would look. However, the ATF would like HOD
48 outcomes to be included underneath the MSS outcomes for each item when possible
49 rather than including it as a separate item. This would replace the summary of actions
50 PDF. (Both conference level and historical) and the digest would replace the PDF
51 [Summary of MSS Assembly Actions 1999-2022](#).
- 52 5. [MSS Positions Compendium](#): The [MSS Digest PDF](#) would be replaced with the MSS
53 Positions Compendium. [[Rough Prototype](#)]

1
2 **HOD Documents:**

- 3 1. [MSS HOD Microbrick](#): Contains all HOD resolutions and information regarding MSS
4 positions, testimony, and strategy. For the I-23 cycle, the Section Delegates also produced
5 a new [summarized version](#) with the MSS position and outcomes for all items.
6 2. [MSS Resolutions Archive](#): A new resource for MSS members to more easily track policies
7 sent to the HOD from the MSS including final outcomes and actions taken by the AMA.
8 3. [HOD Debate Archives](#): This information will help current and future MSS members keep
9 track of allied delegations in the HOD for certain resolutions or policy realms [[Nanobrick](#)
10 [Template](#) and [Notebrick Template](#)]

11
12 **Archives Guides & Education:**

13
14 As this archive of policy and actions changes, MSS members will need new ways to efficiently
15 search the archive. These strategies and methods will depend on the structure and
16 organization of the final archive. This task force will develop and publicize strategies to track
17 previous actions taken by the MSS, as well as efficient ways to locate relevant policy. These
18 can be maintained by the relevant standing committee or committees in the future.

19
20 **Medium Priority:**

21
22 The medium priority items ranked from highest priority to lowest priority include several suggested
23 archives for the ATF to consider. These items are items we hoped to address in more detail prior to
24 report finalization, however, were unable to fully address and welcome feedback from assembly
25 regarding interest and feasibility options moving forward.

- 26
27 1. [Historical Policy Summaries](#) (*title subject to change*): ATF considered several options for
28 updating MSS members on actions taken by the AMA on topics of particular interest to the
29 MSS, including a yearly recap newsletter that could be sent to members via email or made
30 available on the website for easy access. The ATF also considered having a shared folder
31 with one pagers written by MSS Standing Committees on “MSS Hot Topics,” which could
32 include history of actions taken by the MSS with more detail about debate, advocacy, and
33 politics surrounding some of the more controversial topic areas or areas where the MSS
34 has changed positions. Topics for this may include health coverage, gun control, AI/AN
35 rights, LGBTQ rights and others of particular interest to the MSS. Your ATF is seeking
36 feedback from all members on these proposed solutions.
37
38 2. [Standing Committee Archives](#): The ATF is also considering a standing committee archive.
39 This would include a central location where resources produced by standing committees
40 such as guides and webinars would be available for MSS members. The ATF is also
41 considering creating frameworks for Standing Committees to ensure their internal
42 documents are stored and passed down from year to year. The ATF and SCTF were not
43 able to meet to discuss this but hope to work with new leadership to develop sustainable
44 archives for standing committees.
45
46 3. [Resources for Individual Member Archives](#): Current and past members have called for
47 formalized tracking of contributions to resolutions. This has been a particular point of
48 interest for students applying to residency. Your ATF is considering the benefits of
49 maintaining an archive of past and present members and exploring solutions for
50 maintaining such an archive centrally or offering resources for members to track their
51 contributions on their own. Your ATF will also seek out feedback from current MS4s and
52 the NRMP student representative to determine what information is needed for students to
53 accurately represent their work and how we can best track and provide this information.

1 Linked [HERE](#) is a sample contribution tracker for individual members to track contributions
2 to policy including authorship, review, and testimony. Furthermore, the ATF believes it is
3 important to maintain a citation guide on how to cite resolutions and represent organized
4 medicine involvement on CVs and residency application materials.

- 5
6 4. Regional Archives Best Practices: While the ATF believes that regions should have
7 autonomy over their archives, the ATF is considering multiple options to offer to regions
8 as best practices for keeping regional archives. This would include providing template
9 documents for tracking policy, activities, and other region documents. The ATF plans to
10 reach out to region leadership to obtain direct feedback on this item.

11
12 **Other Topics Discussed:**

13
14 The ATF concluded that Membership Archives, Engagement Archives, Engagement on the
15 Collegiate Level, Journal of the MSS, and State Advocacy/Sharing would be included as low
16 priority ventures to be pursued should the ATF have the capacity to address them and member
17 interest following the publication of this report.

- 18
19 1. Membership Archives: The ATF is considering creating membership archives for both
20 current and past MSS membership.
21 a. **Current Membership Archives**: Would be overseen by the AMA-MSS At-Large
22 Officer and Regional Membership Chairs. This would be a resource for national
23 and regional leadership to track local campus section leadership and potentially
24 general membership that consent to having their contact information shared.
25 b. **MSS Alumni Archives**: This would be an online membership archive of current
26 and past members that would exist for the purpose of having an easy tool to search
27 AMA/MSS members and potentially the leadership positions they held, years of
28 service, and years of membership. This can be further divided into subcommittees,
29 regions, etc. Students would be able to use this tool to reach out to students who
30 were involved in areas of the MSS that they were interested in getting involved in
31 or are currently practicing in specialties or advocacy areas of interest. This would
32 be an opt in system where information would only be provided with appropriate
33 consent.
34
35 2. Engagement Archives: The engagement archives would include the tracking of AMA MSS
36 and AMA Foundation awards and scholarships in addition to highlights and standout
37 achievements from AMA chapters, regions, and standing committees.
38
39 3. Journal of the MSS (JAMA-MSS): The creation of a Journal of the MSS has been an area
40 of interest for several years now to create a way to compile the work done by student
41 leaders through the AMA, including but not limited to abstracts for posters presented at
42 conferences, internal and external policies, and highlights for actions taken by our AMA-
43 MSS. The journal would facilitate the ability for students and other interested parties to
44 locate their work as publications through venues such as the AMA website and potentially
45 Google Scholar. We also discussed the option of having the abstracts for the Research
46 Challenge and Poster Showcase published in this journal. Aside from archival purposes,
47 the ATF believes it would be excellent to explore other partnerships with JAMA such as
48 creation of student editorial board positions. The current Committee on Scientific Issues
49 and Membership & Engagement also have members interested in this initiative.
50
51 4. State Advocacy Collaborations: The ATF has also considered potentially creating an
52 archive repository for student members from state and specialty societies to share
53 resolutions passed at their state that students from other states might be interested in

1 bringing to their state HOD or the AMA. Your Section Delegates have begun this process
2 in consultation with former Section Alt Delegate Justin Magrath by creating the [MSS State
3 Resolution Collaborative \(https://tinyurl.com/MSSStateResoCollab\)](https://tinyurl.com/MSSStateResoCollab), which provides a
4 Google Form to collect efforts, a collection of template resolutions eagerly offered by
5 authors for free use on various major issues across a number of policy sectors that either
6 the AMA will debate at future meetings or that might be important for a state society to
7 consider (to massively reduce the workload required to write a resolution from scratch), a
8 tab for state society policies on these issues, and a tab for state society meeting dates.
9 While this collaborative needs more work and promotion, this could potentially be
10 expanded with other major issues. Thanks to the suggestion of Region 2 Policy Chair and
11 LGBTQ+ Standing Committee Vice Chair Andrew Norton, your Section Delegates also
12 added an option to all resolution reviews to mark whether a given resolution would be a
13 good fit for a state society resolution (for example, if policy is not needed at the AMA level,
14 but state jurisdiction presents an opportunity for advocacy). This was promoted to
15 reviewers, who regularly now offer that advice. Authors are also encouraged to utilize their
16 teams and find additional collaborators via the MSS Updates GroupMe and network to
17 submit a resolution through multiple societies, to effect change on a broader level through
18 the power of collaboration between members in different states. Your GC also hosted the
19 first-ever State Leader Summit back in January for state society MSS leaders to gather
20 and discuss common priorities and problems across their societies. The GroupMe created
21 from this event offers an opportunity for further collaboration on resolution sharing, with
22 coordinated efforts to submit resolutions to multiple state societies. The current GC is also
23 working on creating archives of student leadership at state societies and this is something
24 the ATF may consider looking into the utility and sustainability of maintaining such
25 archives.

- 26
27 5. Outreach: The ATF also considered working with staff to develop formal outreach archives
28 that could include information on official outreach endeavors to other national student
29 organizations, medical schools and undergraduate institutions. These archives could be
30 mined to determine success of outreach activities and adjust strategy accordingly.

31 32 **CONCLUSION**

33
34 The ATF was created to research best practices for preserving MSS institutional memory and
35 tracking actions taken by the AMA HOD for resolutions passed by the MSS. Based on discussion,
36 the recommendations of your ATF are highlighted in the report, and sorted by priority. The top
37 priority for the ATF is the policy archives, which notably includes the conversion of PDF archives
38 into easily searchable spreadsheets, and creating an archive of HOD outcomes and actions taken
39 by the AMA on items originally authored by the MSS. We also are considering the benefits of
40 converting the Summary of Actions documents into annotated RefCom reports. There is a
41 proposal to help track resolution authorship. Sustainability and maintenance of the archive was
42 another top priority of the ATF, with MSS Staff and several convention committees and standing
43 committees being suggested for archive maintenance.

44
45 The ATF also identified other areas where archives could be useful including historical policy
46 summaries, standing committee archives, resources for individual member archives, regional
47 archival best practices, membership archives, engagement archives, outreach archives, a journal
48 of the MSS, and an archival process for state advocacy collaborations.

49
50 Of these, the ATF partially addressed membership archives by recommending that the MSS
51 maintain current membership archives accessible to MSS Staff, GC, and Regional Executive
52 Councils that track local campus section leadership and general membership who consent to
53 sharing their contact information. In addition, the ATF recommended that the MSS maintain an

1 alumni archive that students could use to find mentors, speakers for events, and utilize for other
2 collaboration purposes. The ATF also attempted to address individual member archives and
3 recommended that the AMA maintain a guide on how to cite resolutions and represent organized
4 medicine involvement on CVs and residency application materials to support students. The ATF
5 also considered and explored opportunities to engage with the Journal of the AMA (JAMA) which
6 could include the creation of a trainee journal under the JAMA Network and/or opportunities for
7 students to participate on editorial boards for the journal. Finally, the ATF explored the possibility
8 of creating and maintaining a state resolution collaborative archive and recommended exploring
9 potential avenues to promote this collaboration.

10
11 There were a select number of priorities and topics that the ATF was unable to address in this
12 report. The ATF discussed best practices for historical policy summaries to update MSS members
13 on topics of interest of the MSS, however a recommendation for how to implement this topic has
14 not been included in this report. Similarly, the development of standing committee archives was
15 discussed to preserve the resources produced by standing committees, but no recommendation
16 for implementation of these archives has been included in this report. The ATF also considered
17 engagement archives to track highlights and achievements of members, as well as outreach
18 archives to keep track of outreach of endeavors of the MSS. The ATF is willing to help develop
19 these archives, but an official recommendation has not been proposed. Finally, the ATF
20 discussed regional archives best practices to help guide region leaders in the archival of their
21 region's documents and resources and is looking to work in conjunction with region leaders to
22 develop these best practices. The ATF agreed that these topics are important to address for the
23 archival integrity of the MSS and should be further addressed.

24
25 Given this, and the major changes outlined regarding the policy archives, the ATF feels strongly
26 that maintaining the task force for one additional year to continue to investigate archiving practices
27 and to provide further recommendations to the topics that have not been addressed in this report
28 would be in the best interest of our section. Working with the GC, the ATF would be able to ensure
29 that its recommendations are applied and adjust recommendations based on their utility in the
30 MSS. Additionally, several new and unique mechanisms have been proposed and the feasibility
31 of some of these recommendations has not been fully explored, yet. Therefore, an additional year
32 would provide time for the feasibility of these mechanisms to be addressed, and would allow for
33 correction or further refinement to occur. The ATF recommends reports back at I-24 and A-25 to
34 update the MSS Assembly on implementation of the recommendations and further
35 recommendations.

36
37 **RECOMMENDATIONS**

38
39 RESOLVED, that our AMA-MSS maintain a MSS Positions Compendium containing (1) all current
40 MSS positions, outcomes of resolutions that were sent to the AMA House of Delegates, and actions
41 taken by the AMA as a result of AMA Policy originally proposed by the MSS and (2) a separate
42 section for rescinded MSS positions with accompanying rationale for their rescission; and be it
43 further

44
45 RESOLVED, That our AMA-MSS maintain a MSS Resolutions Archive that will include at minimum
46 authorship information, links to the original resolution, final language adopted by the MSS, final
47 language adopted by the HOD, links to the HOD Policy Finder, implementation notes regarding AMA
48 actions, and links to media coverage resulting from the resolution; and be it further

49
50 RESOLVED, That our AMA-MSS report information to the original MSS resolution and/or report
51 authors regarding outcomes of resolution forwarded to HOD and implementation of associated
52 adopted AMA policy; and be it further

53
54 RESOLVED, that our AMA-MSS produce an annotated reference committee report indicating the

- 1 final assembly outcome at each meeting; and be it further
2
3 RESOLVED, that our AMA-MSS produce and maintain archives of notes on information gathered
4 regarding other delegations stances on MSS items and actions taken by the MSS Caucus at HOD;
5 and be it further
6
7 RESOLVED, that our AMA-MSS explore opportunities to engage with the Journal of the AMA
8 (JAMA); and be further
9
10 RESOLVED, that our AMA-MSS pursue and promote efforts that encourage state to state
11 collaboration within policy and advocacy; and be it further
12
13 RESOLVED, that our AMA-MSS maintain a guide on how to cite resolutions and represent
14 organized medicine involvement on CVs and residency application materials; and be it further
15
16 RESOLVED, That our AMA-MSS develop and maintain a current membership archive accessible
17 to MSS Staff, GC, and Regional Executive Councils that tracks local campus section leadership and
18 general membership who consent to sharing their contact information; and be it further
19
20 RESOLVED, That our AMA-MSS develop and maintain a database of MSS alumni who consent to
21 share their information to serve as resources for the MSS; and be it further
22
23 RESOLVED, That our AMA MSS maintain an Archives Task Force which will continue to investigate
24 strategies for (a) preserving institutional memory, (b) reporting this information to the MSS, and (c)
25 monitor the implementation of changes adopted as a result of the A-24 Archives Task Force Report
26 and will work with GC to report back to the MSS Assembly at I-24 and A-25.
27

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29
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39 to the Standing Committee leaders and members who conducted an archives review as part of the
40 A-24 Sunset review process allowing us to learn more about the process and workload, and
41 feasibility. Finally, we would like to thank the 2023 Resolution Task Force and A-23 Assembly
42 members for giving us the opportunity to study and provide recommendations regarding this
43 important component of our MSS.

RELEVANT MSS POSITIONS

Sunset Mechanism for AMA-MSS Policy 630.044MSS

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 or refer 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 GC, whereby the report is authored by the Chair of the GC with initial policy recommendations being solicited from relevant Standing Committees as appropriate;

- (2) The GC will provide Standing Committees clear guidance regarding criteria for recommendations of retention, retention with amendments, or sunset;
- (3) policy recommendations will be reported to the AMA-MSS Assembly at each Annual Meeting on the five or five and one half year anniversary of a policy's adoption, with a brief rationale accompanying each recommendation;
- (4) a consent calendar format will be used by the Assembly in considering the policies encompassed within the report;
- (5) a vote will not be necessary on policies recommended for rescission as they will automatically expire under the auspices of the sunset mechanism unless referred back to the GC; and
- (6) the MSS GC may recommend policies for consolidation as part of the sunset review

RESOLUTION TASK FORCE UPDATE 2022: AMA-MSS adopt the following as our MSS Policy Process 645.032MSS

1. The MSS Section Delegates will ensure that all items of business submitted for consideration to each MSS Assembly meeting undergo a comprehensive review process evaluating their impact, feasibility, timeliness, and evidence basis.
2. The draft resolution review process should include opportunities for participation by MSS Caucus members; MSS members on AMA Councils; appropriate MSS region officers; MSS Standing Committees; MSS members with significant HOD experience; and MSS members who liaise with other AMA Sections and groups, specialty societies, professional interest medical associations, medical student organizations (including identity-based groups), and medical education bodies.
3. The MSS Section Delegates will decide the timeline for the policy cycle preceding each MSS Assembly and will design the criteria used to review items of business.
4. Resolutions submitted by the correct deadline in the correct format as determined by the MSS Section Delegates prior to start of the policy cycle may not be rejected for submission for consideration by the MSS Assembly based on their content after organizational review for legal issues.
5. Per the MSS IOPs, submitted resolutions will be sent to the MSS Reference Committee, which will make recommendations to the Assembly for disposition of its items of business. The Reference Committee Report will use a consent calendar format. In order for an item to be heard by the MSS Assembly, it must be extracted from the Reference Committee Consent Calendar. The Order of Business for each MSS Assembly meeting will follow the order listed in the MSS Reference Committee report for that meeting. Items of business will be categorized by Reference Committee recommendations for "adoption," "adoption as amended," "adoption in lieu of," "referral," "not adoption," "reaffirmation in lieu of," etc. The order of items in each category will be randomized. The MSS Reference Committee must include a meaningful rationale for their recommendations made on each item of business. Any MSS member may extract any item from the Reference Committee Report for debate at the MSS Assembly. No other requirements, such as testimony or votes, are necessary for an item to be extracted. The Section Delegates shall provide opportunities for extraction both in advance of the MSS Assembly remotely and at the beginning of the Assembly. Extractions made in advance of the MSS Assembly should be published in real-time as they are submitted.

6. The AMA-MSS Internal Operating Procedures (IOPs) and Digest of Actions will be made available on the AMA-MSS Web site, with updates made prior to the beginning of the Policy Cycle for each Annual and Interim Meeting of the Assembly.

7. A resolution template will be made publicly available to assist resolution authors in formatting their resolutions.; and be it further AMA-MSS adopt the following as Additional MSS Caucus Operations:

1. The MSS Section Delegates have the ability to nominate existing policies in the MSS Digest of Actions to the queue to be transmitted to a future HOD meeting, based on strategic considerations. These nominations must be approved by a majority vote of the MSS Caucus.

2. The MSS Caucus can co-sponsor resolutions in the name of the MSS with another HOD delegation. a. Co-sponsoring a resolution authored by another delegation must be approved by a $\frac{2}{3}$ vote of the MSS Caucus. b. The MSS Section Delegates have the authority to add other delegations as co-sponsors of MSS-authored resolutions.

AMA-MSS (1) rescind all statements of formal support for AMA policies listed in the section "AMA-MSS Statements of Support for HOD Policies" of the MSS Digest of Policy Actions; (2) investigate strategies for (a) preserving institutional memory, which would document the results of MSS resolutions and actions taken by the AMA in response to policies passed by the AMA HOD and (b) reporting this information to the original resolution authors and MSS assembly; and (3) that these changes, and the AMA-MSS resolutions process as a whole, be reevaluated in an AMA-MSS Governing Council report to be presented 3 years after the adoption of these recommendations.

REPORT OF THE MEDICAL STUDENT SECTION
COMMITTEE ON ECONOMICS AND QUALITY IN MEDICINE, WOMEN IN MEDICINE
COMMITTEE, AND COMMITTEE ON LGBTQ+ AFFAIRS

CEQM WIM LGBTQ+ Report A
(A-24)

Introduced by: MSS Committee on Economics and Quality in Medicine, Women in
Medicine Committee, and Committee on LGBTQ+ Affairs

Subject: Coverage for Care Provided After Sexual Assault

Referred to: MSS Reference Committee
(Caitlin Blaukovitch and Shaminy Manoranjithan, Co-Chairs)

1 **INTRODUCTION**

2 At the Annual 2023 (A-23) MSS Assembly, MSS Resolution 078, "Coverage for Care Provided
3 After Sexual Assault" asked the AMA to improve coverage for services following a sexual assault
4 in response to financial constraints of covering these services in many states. The resolution, with
5 the following resolve clause, was referred for study:
6

7 RESOLVED, That AMA policy H-80.999 "Sexual Assault Survivors" be amended by
8 addition to include coverage for additional services following a sexual assault to reduce
9 patient costs, as follows:

- 10 1. Our AMA supports the preparation and dissemination of information and best
11 practices intended to maintain and improve the skills needed by all practicing
12 physicians involved in providing care to sexual assault survivors.
13 2. Our AMA advocates for the legal protection of sexual assault survivors' rights
14 and work with state medical societies to ensure that each state implements these
15 rights, which include but are not limited to, the right to: (a) receive a medical
16 forensic examination free of charge, which includes but is not limited to HIV/STD
17 testing and treatment, pregnancy testing and prevention, drug testing, treatment
18 of injuries, and collection of forensic evidence; (b) preservation of a sexual
19 assault evidence collection kit for at least the maximum applicable statute of
20 limitation; (c) notification of any intended disposal of a sexual assault evidence kit
21 with the opportunity to be granted further preservation; (d) be informed of these
22 rights and the policies governing the sexual assault evidence kit; and (e) access
23 to emergency contraception information and treatment for pregnancy prevention.
24 3. Our AMA will support efforts to cover the cost of all medical care involved in
25 the immediate management of all patients presenting after a sexual assault,
26 regardless of insurance status.
27 4. Our AMA will collaborate with relevant stakeholders to develop
28 recommendations for implementing best practices in the treatment of sexual
29 assault survivors, including through engagement with the joint working group
30 established for this purpose under the Survivor's Bill of Rights Act of 2016.
31 5. Our AMA will advocate for increased post-pubertal patient access to Sexual
32 Assault Nurse Examiners, and other trained and qualified clinicians, in the
33 emergency department for medical forensic examinations.
34 6. Our AMA will advocate at the state and federal level for (a) the timely
35 processing of all sexual examination kits upon patient consent; (b) timely
36 processing of "backlogged" sexual assault examination kits with patient consent;

1 and (c) additional funding to facilitate the timely testing of sexual assault
2 evidence kits.
3

4 The MSS Reference Committee recommended referral of the resolution with the following
5 rationale:

6 VRC testimony was in opposition. Your Reference Committee agrees with testimony that
7 resolution is well-intended, but the asks are not feasible. We appreciate that Illinois has
8 adopted legislation on this issue and believe it could potentially be used as a model to
9 strengthen future language. We agree that the resolution would be strengthened through
10 further study and would urge the committees to address the following questions: 1.) Is this
11 resolution feasible? 2.) How would the costs of this medical care be covered? 3.) What is
12 the evidence for adding “drug testing” in clause 2? Your Reference Committee
13 recommends Resolution 078 be referred.
14

15 During the MSS Assembly, no one extracted the item, so the Reference Committee
16 Recommendation to refer passed via the consent calendar.
17

18 Your Governing Council assigned this report to the Committee on Economics and Quality in
19 Medicine (CEQM) Women in Medicine Committee (WIM), and Committee on LGBTQ+ Affairs
20 (LGBTQ+) with the following possible questions for consideration: 1.) Is this resolution feasible?
21 2.) How would the costs of this medical care be covered? 3.) What is the evidence for adding
22 “drug testing” in clause 2?
23

24 In this following whereas clauses and subsequent discussion, we provide an overview of current
25 practices for victims of sexual assault who present for medical care, and the financial costs of
26 covering this care in states that provide coverage for this care. We describe potential areas in
27 which our AMA could expand its advocacy on this topic before ultimately delivering our
28 recommendation on the referred clauses.
29

30 **WHEREAS CLAUSES**

31

32 Whereas, when a sexual assault victim presents for immediate medical care, a certified individual
33 – either a sexual assault nurse examiner (SANE) or a sexual assault forensic examiner (SAFE)–
34 completes a complete medical forensic exam¹; and
35

36 Whereas, a complete medical forensic exam consists of a comprehensive sexual history, physical
37 exam documenting evidence of all physical injuries including but not limited to the external and
38 internal genital areas, and DNA collection of vagina, rectum, anus, fingernails, hair, and saliva
39 samples¹, and

40 Whereas, in addition to completing a medical forensic exam, post-exposure prophylaxis treatment
41 and testing for sexually transmitted disease (STIs) such as gonorrhea, chlamydia, trichomonas,
42 HIV, HPV, Hepatitis B and pregnancy prevention is recommended with adequate follow-up care²;
43 and
44

45 Whereas, while usage of hospital services and seeking care at the Emergency Department (ED)
46 after sexual assault has increased almost 20 fold from 2006 to 2019 and admission rates
47 decreased by three fold in the same time frame, up to 2/3 of cases still go unreported^{3,4}; and
48

49 Whereas, an increasing proportion of sexual assault survivors are young females with lower
50 incomes and males, who represent a vulnerable group⁴; and
51

1 Whereas, while states are generally required to cover the full cost of medical forensic exams to
2 qualify for certain grants such as the Services, Training, Officers, Prosecutors (STOP) grants,
3 gaps still lead to an average out-of-pocket cost of 347 dollars for people with private insurance
4 seeking care, with an overall average out-of-pocket cost averaging around 4,000 dollars in
5 2019^{5,6}; and

6
7 Whereas, even privately-insured sexual assault victims pay, on average, 14% of emergency
8 department costs out-of-pocket, with charges for self-pay patients exceeding 3,500 dollars on
9 average⁷; and

10
11 Whereas, of the intimate partner violence physical violence victims and rape victims seeking
12 mental health counseling, 32-36 percent of those costs were paid out of pocket⁷; and

13
14 Whereas, under the Illinois law, The Sexual Assault Survivors Emergency Treatment Act
15 (SASETA), sexual assault survivors must not be billed directly for costs of services, transportation,
16 or medications, which includes insurance deductibles, co-pays, co-insurance, denial of insurance
17 claims, or any out-of-pocket expenses^{8,9}; and

18
19 Whereas, under SASETA, if sexual assault survivors are not eligible for medical assistance
20 program benefits, are not covered by public or private insurance, or opt out of billing their private
21 insurance provider, healthcare service reimbursement can be submitted to the Illinois Sexual
22 Assault Emergency Treatment Program for reimbursement⁹; and

23
24 Whereas, per California law, if a patient has consented to evidence collection and medical exam,
25 healthcare facilities must not charge the sexual assault survivor for the cost of exam or STI and
26 pregnancy testing, which includes no indirect charges through third party payers such as private
27 insurance companies or California Medicaid, and the local government agency in jurisdiction of
28 offense will be charged¹⁰; and

29
30 Whereas, per California law, if a patient sustains injuries from sexual assault, treatment of injuries
31 is patient responsibility; however, patients may apply for Crime Victim Compensation/Victim
32 Assistance Programs for reimbursement of out-of-pocket costs up to \$46,000 for most medical
33 bills, therapy, funeral/burial costs, wage loss, loss of financial support, and job retraining costs¹⁰;
34 and

35
36 Whereas, the Sexual Assault Services Formula Grant Program (SASP) is the first federally funded
37 program available to states and territories to provide financial assistance to direct interventions
38 and related assistance for victims of sexual assault (including rape crisis centers and other non-
39 profit organizations) and provided awards totaling \$51.86 million in 2023¹¹; and

40
41 Whereas, all 50 states and Washington DC have Crime Victim Compensation programs in place
42 to provide direct financial reimbursement to eligible sexual assault survivors who report the crime
43 to law enforcement, comply with investigation, and apply within a timely manner and per federal
44 law, CVC programs must cover lost wages or loss of support, medical costs, and mental health
45 counseling, as well as other costs which vary by state^{12,13}; and

46
47 Whereas, in Texas, eligible victims of sexual assault may apply to receive up to \$50,000 to cover
48 costs related to emergency medical care for sexual assault exams under Crime Victims'
49 Compensation or Emergency Medical Care Compensation¹⁴; and

50

1 Whereas, in a sample of private insurance claims from large employers, 66% of privately-insured
2 people who presented for a rape kit after sexual assault were charged out of pocket costs, often
3 exceeding 300 dollars⁵; and

4
5 Whereas, Black survivors are more likely to experience assault by an intimate partner and less
6 likely to access mental health care than White survivors¹⁵; and

7
8 Whereas, most patients who visit the ED for sexual assault are women, but as few as 21% of
9 survivors even seek medical care^{4,16}; and

10
11 Whereas, barriers to seeking out medical care after sexual assault have been identified to include
12 ethnic and cultural minorities, people with disabilities, financial vulnerability, sexual and gender
13 minorities, patients with mental health conditions, patients with substance use disorder, and older
14 age¹⁷; and

15
16 Whereas, Illinois has successfully adopted and implemented legislation to provide appropriate
17 medical care for sexual assault survivors with no out of pocket costs through a mix of payer and
18 provider mandates, reimbursement guarantees, and payor of last resort arrangements^{9,18}; and

19
20 Whereas, the payer mandates for coverage without deductibles, copays, or coinsurance for
21 specified services are similar to many other mandates under the Affordable Care Act and other
22 legislation^{18,19}; and

23
24 Whereas, the State of Illinois already pays for these services for patients covered by Medicaid so
25 the incremental cost to the State is only payor of last resort costs which only applies to the 7% of
26 Illinois residents who are uninsured^{18,20}; and

27
28 Whereas, Illinois demonstrated that the financial burden of absorbing the out of pocket costs of
29 appropriate care for sexual assault survivors at Medicaid rates was sustainable without additional
30 funding sources²¹; and

31
32 Whereas, the Illinois State Medical Society has advocated for the program's expansion and
33 further updates to optimize reimbursement²²; and

34
35 Whereas, the model that Illinois adopted does not rely on any unique feature of the state and
36 could be reasonably adopted in any state through an insurance mandate with Medicaid supported
37 backstop for the uninsured²³; and

38
39 Whereas, current AMA policy (H-20.900, H-80.999, H-180.958, H-515.956 and H-515.967)
40 advocates for access, best practices, medical forensic examinations free of charge, and
41 protection of privacy of sexual assault survivors; and

42
43 Whereas, current AMA policy does address coverage of medical forensic exams, it does not
44 address coverage of care of additional services often required nor does it address reduction in
45 barriers to seeking care; and therefore be it

46 **CONCLUSION**

47
48 In this report, we have examined current legislation, existing out of pocket costs, and precedent
49 for providing reimbursement for sexual assault survivors. We have demonstrated that coverage
50 of existing out of pocket costs and reimbursement is feasible and well within the scope of the
51 AMA to advocate for coverage. Sexual assault survivors who seek healthcare may have limited

1 access to the necessary resources that are not covered under existing legislation, and it is
2 important to ensure that they are able to have that funding.

3
4 **RECOMMENDATION**

5
6 Your Committee on Economics and Quality in Medicine (CEQM) Women in Medicine
7 Committee (WIM), and Committee on LGBTQ+ Affairs (LGBTQ+) recommend that the following
8 recommendations are adopted in lieu of MSS Resolution 078 and the remainder of this report
9 be filed:

10
11 RESOLVED, that the American Medical Association amend policy H-80.999 “Sexual Assault
12 Survivors” by addition as follows:

13
14 1. Our AMA supports the preparation and dissemination of
15 information and best practices intended to maintain and improve
16 the skills needed by all practicing physicians involved in providing
17 care to sexual assault survivors.

18 2. Our AMA advocates for the legal protection of sexual assault
19 survivors’ rights and work with state medical societies to ensure that
20 each state implements these rights, which include but are not
21 limited to, the right to: (a) receive a medical forensic examination
22 free of charge, which includes but is not limited to HIV/STD testing
23 and treatment, pregnancy testing and prevention, drug testing,
24 treatment of injuries, and collection of forensic evidence; (b)
25 preservation of a sexual assault evidence collection kit for at least
26 the maximum applicable statute of limitation; (c) notification of any
27 intended disposal of a sexual assault evidence kit with the
28 opportunity to be granted further preservation; (d) be informed of
29 these rights and the policies governing the sexual assault evidence
30 kit; and (e) access to emergency contraception information and
31 treatment for pregnancy prevention.

32 3. Our AMA advocates for federal and state efforts to reduce
33 financial barriers that limit survivors’ ability to seek physical and
34 mental health care and social services after sexual assault,
35 including survivors’ compensation funds and specialized programs
36 to cover emergency, inpatient, and outpatient services and
37 eliminate out-of-pocket expenses, especially for patients who are
38 uninsured, underinsured, or out-of-network.

39 4. 3- Our AMA will collaborate with relevant stakeholders to develop
40 recommendations for implementing best practices in the treatment
41 of sexual assault survivors, including through engagement with the
42 joint working group established for this purpose under the Survivor’s
43 Bill of Rights Act of 2016.

44 5. 4- Our AMA will advocate for increased post-pubertal patient
45 access to Sexual Assault Nurse Examiners, and other trained and
46 qualified clinicians, in the emergency department for medical
47 forensic examinations.

48 6. 5- Our AMA will advocate at the state and federal level for (a) the
49 timely processing of all sexual examination kits upon patient
50 consent; (b) timely processing of “backlogged” sexual assault
51 examination kits with patient consent; and (c) additional funding to
52 facilitate the timely testing of sexual assault evidence kits.

1 7. 6. Our AMA supports the implementation of a national database
2 of Sexual Assault Nurse Examiner and Sexual Assault Forensic
3 Examiner providers.
4

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6
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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.
5. Our AMA will advocate at the state and federal level for (a) the timely processing of all sexual examination kits upon patient consent; (b) timely processing of "backlogged" sexual assault examination kits with patient consent; and (c) additional funding to facilitate the timely testing of sexual assault evidence kits.
6. Our AMA supports the implementation of a national database of Sexual Assault Nurse Examiner and Sexual Assault Forensic Examiner providers.

Advocacy on the US Department of Education's Spring 2022 Title IX Rules on Sexual Harassment and Assault in Education Programs D-515.976

1. Our AMA will communicate with the US Department of Education in support of their efforts to reconsider their 2020 Title IX rule on sexual harassment and assault in educational settings, including undergraduate and graduate medical education, and encourage development of a rule that preserves the safety and wellbeing of all people affected by sexual assault, in line with current AMA policy.

Protection of the Privacy of Sexual Assault Victims H-515.967

1. The AMA opposes the publication or broadcast of sexual assault victims' names, addresses, images or likenesses without the explicit permission of the victim. The AMA additionally opposes the publication (including posting) or broadcast of videos, images, or recordings of any illicit activity of the assault. The AMA opposes the use of such video, images, or recordings for financial gain and/or any form of benefit by any entity.

Addressing Sexual Assault on College Campuses H-515.956

1. 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.

HIV, Sexual Assault, and Violence H-20.900

1. Our AMA: (1) believes that HIV testing and Post-Exposure Prophylaxis (PEP) should be offered to all survivors of sexual assault who present within 72 hours of a substantial exposure risk, that these survivors should be encouraged to be retested in six months if the initial test is negative, and that strict confidentiality of test results be maintained; and (2) supports: (a) education of physicians about the effective use of HIV Post-Exposure Prophylaxis (PEP) and the U.S. PEP Clinical Practice Guidelines, and (b) increased access to, and coverage for, PEP for HIV, as well as enhanced public education on its effective use.

Access to Emergency Contraception H-75.985

1. 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.

Preventive Medical Care Coverage for All H-165.840

1. Our AMA advocates for (1) health care reform that includes evidence-based prevention insurance coverage for all; (2) evidence-based prevention in all appropriate venues, such as primary care practices, specialty practices, workplaces and the community.

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

1. Our AMA will: (1) encourage the adoption of universal screening of all adults for hepatitis C, in alignment with Centers for Disease Control and Prevention (CDC) recommendations; (2) encourage the CDC, Indian Health Service (IHS), 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) advocate, in collaboration with state and specialty medical societies, as well as patient advocacy groups, for the elimination of sobriety requirements, fibrosis restrictions, and prescriber restrictions for coverage of HCV treatment by public and private payers; (5) support programs aimed at training physicians in the screening, treatment and management of patients infected with HCV; (6) 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; (7) recognize correctional physicians, and physicians in other public health settings, as key stakeholders in the development of HCV treatment guidelines; (8) encourage equitable reimbursement for those providing treatment; and(9) encourage the allocation of targeted funding to increase HCV treatment for IHS patients insured by plans subject to HCV treatment restrictions.

Addressing Sexual Violence and Improving American Indian and Alaska Native Women's Health Outcomes D-350.985

1. Our AMA advocates for mitigation of the critical issues of American Indian/Alaska Native women's health that place Native women at increased risk for sexual violence, and encourages allocation of sufficient resources to the clinics serving this population to facilitate health care delivery commensurate with the current epidemic of violence against Native women.
2. Our AMA will collaborate with the Indian Health Service, Centers for Disease Control and Prevention (CDC), Tribal authorities, community organizations, and other interested stakeholders to develop programs to educate physicians and other health care professionals about the legal and cultural contexts of their American Indian and Alaska Native female patients as well as the current epidemic of violence against Native women and the pursuant medical needs of this population.
3. Our AMA will collaborate with the Indian Health Service, CDC, Tribal authorities, and community organizations to obtain or develop appropriate American Indian and Alaska Native women's health materials for distribution to patients in the spirit of self-determination to improve responses to sexual violence and overall health outcomes.

Financing Care for HIV/AIDS Patients H-20.907

1. Believes that current private insurance and existing public programs, coupled with a significant expansion of state risk pools, provide the best approach to assuring adequate access to health expense coverage for HIV-infected persons and persons with AIDS;
2. Supports the development of a clinical staging system based on severity of HIV disease as a replacement for the AIDS diagnosis as a basis for determining health, disability, and other benefits;
3. Supports increased funding for reimbursement and other incentives by public and private payers to encourage (a) expanded availability for therapies and interventions widely accepted by physicians as medically appropriate for the prevention and control of HIV disease and (b) for alternatives to in-patient care of persons with HIV disease, including intermediate care facilities, skilled nursing facilities, home care, residential hospice, home hospice, and other support systems;
4. Supports government funding of all medical services that are deemed appropriate by both the patient and physician for pregnant seropositive women lacking other sources of funding;
5. Supports broad improvements in and expansion of the Medicaid program as a means of providing increased coverage and financial protection for low-income AIDS patients;
6. Supports, and favors considering introduction of, legislation to modify the Medicaid program to provide for a yearly dollar increase in the federal share of payments made by states for care of all patients in proportion to the amount of increase in costs incurred by each state program for care of HIV-positive individuals and patients with AIDS over the preceding year;
7. Encourages the appropriate state medical societies to seek establishment in their jurisdictions of programs to pay the private insurance premiums from state and federal funds for needy persons with HIV and AIDS; and strongly supports full appropriation of the amounts authorized under the Ryan White CARE Act;

8. Supports consideration of an award recognition program for physicians who donate a portion of their professional time to testing and counseling HIV-infected patients who could not otherwise afford these services.

REPORT OF THE MEDICAL STUDENT SECTION
COMMITTEE ON ECONOMICS & QUALITY IN MEDICINE
COMMITTEE ON LEGISLATION & ADVOCACY

CEQM COLA Report A
(A-24)

Introduced by: MSS Committee on Economics & Quality in Medicine (CEQM) and MSS
Committee on Legislation & Advocacy (COLA)

Subject: Opposing Private Equity Acquisitions of Healthcare Practices

Referred to: MSS Reference Committee
(Caitlin Blaukovitch and Shaminy Manoranjithan, Co-Chairs)

1 **INTRODUCTION**

2
3 At the Annual 2023 (A-23) MSS Assembly, MSS Resolution 15, “Opposing Private Equity
4 Acquisitions of Healthcare Practices” asked the AMA-MSS to oppose the acquisition of healthcare
5 practices by private equity firms due to potential negative impact on patient care. The resolution,
6 with the following resolved clauses, was referred for study:
7

8 RESOLVED, That our AMA-MSS recognizes that acquisition of healthcare practices by
9 PE firms often has detrimental consequences for patients and providers; and be it further

10
11 RESOLVED, That our AMA-MSS opposes the acquisition of healthcare practices by PE
12 firms due to their detrimental effects on healthcare access, patient outcomes, and
13 increased financial burden on the health care system.
14

15 The MSS Reference Committee recommended referral of the resolution with the following
16 rationale:
17

18 VRC testimony was mixed. Your Reference Committee agrees with testimony that there
19 is not enough evidence outrightly oppose private equity acquisition of healthcare practices.
20 The Council on Medical Service is doing a series of reports related to health care
21 consolidation and a study will enable the MSS to establish a position on this specific
22 component of that topic that will be useful going forward. We recommend that these HOD
23 reports be considered along with further study from the MSS. Your Reference Committee
24 recommends Resolution 015 be referred.
25

26 During the MSS Assembly, the item was extracted by the authorship team. Multiple testifiers
27 spoke in opposition to the MSS Reference Committee recommendation to refer due to assertions
28 of private equity’s detrimental effects on medicine. The Assembly voted to agree with the MSS
29 Reference Committee recommendation to refer the resolution.
30

31 Our Governing Council assigned this report to the Committee on Economics & Quality in Medicine
32 and the Committee on Legislation & Advocacy with the following possible questions for
33 consideration: Is there enough and significant evidence on the impact of private equity on
34 healthcare? How feasible is a resolution opposing private equity acquisition?
35

1 In this following whereas clauses and subsequent discussion, we provide an overview of current
2 private equity involvement in healthcare practices. We consider how private equity firms have
3 been involved in healthcare and its effects on patients, clinicians, and the healthcare system at
4 large. We describe how private equity acquisitions intersect with AMA interests before ultimately
5 delivering our recommendation on the referred clauses.
6

7
8 **WHEREAS CLAUSES**
9

10 Whereas, private equity is an asset class comprising equity securities and debt in non-publicly
11 traded companies with limitations in transparency and reporting in comparison to the most
12 common non-profit class for hospitals;¹ and
13

14 Whereas, private equity capital comes from both private equity firms and limited partners which
15 include insurers, pension funds, banks, endowments, and sovereign wealth funds;² and
16

17 Whereas, private equity owned 7.5% of all non-government-operated acute care hospitals in 2017
18 and over 5% of dermatology, gastroenterology, urology, and ophthalmology practices in the U.S.
19 in 2019;³⁻⁵ and
20

21 Whereas, private equity investment in healthcare increased from \$41.5 billion in 2010 to \$119
22 billion in 2019;⁶ and
23

24 Whereas, in 2021, a single private equity firm controlled 30% of the market share in 28% of
25 metropolitan areas, and 50% of the market share in 13% of metropolitan areas;⁶ and
26

27 Whereas, a 2023 study using Medicare Part A claims data showed that compared to 259 matched
28 control hospitals private equity acquisition at 51 hospitals was associated with a 25.4% increase
29 in hospital-acquired conditions including a 27% increase in falls and a 38% increase in central
30 line-associated bloodstream infections despite the placement of 16% fewer central lines;⁷ and
31

32 Whereas, a 2021 cohort study comparing 302 nursing homes acquired by private equity firms
33 from 2013-2017 to 9,562 other for-profit nursing homes documented an 8.7% relative increase in
34 hospitalizations and an 11.1% relative increase in emergency department visits among residents
35 of private equity-owned facilities post-acquisition;⁸ and
36

37 Whereas, a 2021 study comparing 130 private equity-owned hospitals to 688 matched controls
38 found mean Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)
39 patient experience scores to be nearly 3 points lower among private equity-owned facilities;⁹ and
40

41 Whereas, emergency department visits increased by 11.1% and hospitalizations increased by
42 8.7% in PE-owned nursing homes;⁸ and
43

44 Whereas, in a study from 2020, private equity acquired hospitals showed an increased adjusted
45 total charge per inpatient day of \$407 ($P < .001$) compared to non-acquired hospitals over the same
46 period of time;¹⁰ and
47

48 Whereas, in a study of US physician practices that were acquired by private equity firms from
49 2016 to 2020 being matched with non-PE control practices, the PE-acquired physician practices
50 exhibited after two years an average increase of \$71 (+20%) charged per claim ($P < .001$) and
51 \$23 (+11%) in the allowed amount per claim ($P < .001$);¹¹ and
52

1 Whereas, one systematic review from 2023 found consistently higher charge-to-cost ratios across
2 emergency departments, hospital systems, nursing homes, and medical specialty groups,
3 attributed to increased negotiated prices between healthcare systems and private insurers,
4 increases in direct charges to payers, shifts to higher reimbursed procedures, and amassed
5 market power and spillover effects;⁵ and
6

7 Whereas, PE theoretically can provide struggling, smaller healthcare practices with infrastructure,
8 management, and stability while allowing physicians to have more stable work responsibilities;¹²
9 and
10

11 Whereas, PE firms can theoretically provide healthcare practices with capital needed for growth
12 and adaptation to the constantly changing healthcare market;¹³ and
13

14 Whereas, rural Texas health system Little River Healthcare, owned by private equity firm
15 Riverside Capital and Monroe Capital, permanently shuttered in 2018 after filing for bankruptcy,
16 leading to the closure of the only acute-care hospital in the area;¹⁴ and
17

18 Whereas, many states currently restrict the corporate practice of medicine to prevent interference
19 with a physician's independent medical judgment and to mitigate the conflicting obligations of
20 corporations and physicians;¹⁵ and
21

22 Whereas, current oversight consists of patchwork legislation across state lines, and individual
23 review of operations, transactions, and outcomes of PE-owned practices by federal bodies,
24 resulting in inadequate regulation that exposes patients to rising costs and adverse outcomes;
25 and
26

27 Whereas, U.S. Federal Trade Commission has seldom reviewed PE acquisitions of physician
28 practices in the past, but the FTC has recently shifted focus to target PE for anticompetitive
29 schemes in healthcare, including by data sharing with HHS and DOJ to help antitrust enforcers
30 identify strategically small "roll up" acquisitions that might otherwise evade antitrust enforcers;^{16,17}
31 and
32

33 Whereas, there has been a recent push for federal oversight via Congressional investigations and
34 DOJ legal cases directed at the finances and operations of PE-owned practices, and multiple
35 state laws limiting the scope of corporate investment in medicine.^{18,19}
36
37

38 **CURRENT AMA POLICY & EFFORTS**

39

40 The AMA is aware of concerns around private equity involvement in healthcare and has passed
41 policies to protect against some of their effects. For example, Policy H-310.901 "The Impact of
42 Private Equity on Medical Training", passed in I-22, seeks to protect residents and trainees from
43 private equity takeovers of residency programs. An education session at A-22 also hosted
44 speakers who warned about the ethical concerns of private equity acquisitions.
45

46 The Council on Medical Service published a report on A-23 broadly looking at the corporate
47 practice of medicine, but not private equity in particular. Policy D-140.951 "Establishing Ethical
48 Principles for Physicians Involved in Private Equity Owned Practices", asks for a study to be
49 performed on the ethical challenges of private equity ownership of medical practices, with a
50 report expected at A-24.
51
52

1 **CONCLUSION**

2
3 As detailed in our report, there are multiple instances of decreased quality of care and safety
4 metrics in private-equity owned healthcare facilities compared to facilities without private-equity
5 ownership. Despite these disparities, private-equity acquisition of healthcare facilities continues
6 to rise. Although we could not find concrete evidence of private-equity acquisition improving
7 quality of care, we recognize that outside capital may be necessary for healthcare facilities that
8 require financial assistance to continue operations. Our AMA-MSS does not have existing policy
9 addressing the role of private-equity in healthcare. Taking these factors into account, we came
10 to the conclusion that our AMA-MSS should have policy recognizing the consequences of
11 private-equity acquisition and supporting increased regulation of these acquisitions.
12

13
14 **RECOMMENDATION**

15 Your Committee on Economics & Quality in Medicine and Committee on Legislation & Advocacy
16 (COLA) recommend that the following recommendations are adopted in lieu of Resolution 015
17 and the remainder of this report be filed:

18 RESOLVED, that our AMA-MSS oppose the acquisition of healthcare practices by
19 private equity (PE) firms, especially when such acquisitions are not immediately
20 necessary for the continued operations of such practices; and be it further
21

22 RESOLVED, that our AMA-MSS support increased regulation of PE acquisitions in order
23 to better align with the goals of healthcare.
24

25
26 **ACKNOWLEDGEMENTS**

27
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RELEVANT AMA AND AMA-MSS POLICY

Establishing Ethical Principles for Physicians Involved in PE Owned Practices D-140.951

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

The Impact of PE on Medical Training H-310.901

Our AMA will:

1. Affirm that an institution or medical education training program academic mission should not be compromised by a clinical training site's fiduciary responsibilities to an external corporate or for-profit entity.
2. Encourage GME training institutions, programs, and relevant stakeholders to:
 - a. demonstrate transparency on mergers and closures, especially as it relates to PE acquisition of GME programs and institutions, and demonstrate institutional accountability to their trainees by making this information available to current and prospective trainees;
 - b. uphold comprehensive policies which protect trainees, including those who are not funded by Medicare dollars, to ensure the obligatory transfer of funds after institution closure;
 - c. empower designated institutional officials (DIOs) to be involved in institutional decision-making to advance such transparency and accountability in protection of their residents, fellows, and physician faculty;
 - d. develop educational materials that can help trainees better understand the business of medicine, especially at the practice, institution, and corporate levels;
 - e. develop policies highlighting the procedures and responsibilities of sponsoring institutions regarding the unanticipated catastrophic loss of faculty or clinical training sites and make these policies available to current and prospective GME learners.

3. Encourage necessary changes in Public Service Loan Forgiveness Program (PSLF) to allow medical students and physicians to enroll in the program even if they receive some or all of their training at a for-profit or governmental institution.
4. Support publicly funded independent research on the impact that PE has on graduate medical education.
5. Encourage physician associations, boards, and societies to draft policy or release their own issue statements on PE to heighten awareness among the physician community.
6. Encourage physicians who are contemplating corporate investor partnerships to consider the ongoing education and welfare for trainee physicians who train under physicians in that practice, including the financial implications of existing funding that is used to support that training.

Corporate Practice of Medicine H-160.887

Our AMA acknowledges that the corporate practice of medicine: (1) has the potential to erode the patient-physician relationship; and (2) may create a conflict of interest between profit and best practices in residency and fellowship training.

Corporate Investors H-160.891

1. Our AMA encourages physicians who are contemplating corporate investor partnerships to consider the following guidelines:
 - a. Physicians should consider how the practice's current mission, vision, and long-term goals align with those of the corporate investor.
 - b. Due diligence should be conducted that includes, at minimum, review of the corporate investor's business model, strategic plan, leadership and governance, and culture.
 - c. External legal, accounting and/or business counsels should be obtained to advise during the exploration and negotiation of corporate investor transactions.
 - d. Retaining negotiators to advocate for best interests of the practice and its employees should be considered.
 - e. Physicians should consider whether and how corporate investor partnerships may require physicians to cede varying degrees of control over practice decision-making and day-to-day management.
 - f. Physicians should consider the potential impact of corporate investor partnerships on physician and practice employee satisfaction and future physician recruitment.
 - g. Physicians should have a clear understanding of compensation agreements, mechanisms for conflict resolution, processes for exiting corporate investor partnerships, and application of restrictive covenants.
 - h. Physicians should consider corporate investor processes for medical staff representation on the board of directors and medical staff leadership selection.
 - i. Physicians should retain responsibility for clinical governance, patient welfare and outcomes, physician clinical autonomy, and physician due process under corporate investor partnerships.
 - j. Each individual physician should have the ultimate decision for medical judgment in patient care and medical care processes, including supervision of non-physician practitioners.
 - k. Physicians should retain primary and final responsibility for structured medical education inclusive of undergraduate medical education including the structure of the program, program curriculum, selection of faculty and trainees, as well as education and disciplinary issues related to these programs.
2. Our AMA supports improved transparency regarding corporate investment in physician practices and subsequent changes in health care prices.

3. Our AMA encourages national medical specialty societies to research and develop tools and resources on the impact of corporate investor partnerships on patients and the physicians in practicing in that specialty.
4. Our AMA supports consideration of options for gathering information on the impact of private equity and corporate investors on the practice of medicine

REPORT OF THE MEDICAL STUDENT SECTION
COMMITTEE ON MEDICAL EDUCATION AND COMMITTEE ON DISABILITY AFFAIRS

CME CDA Report A
(A-24)

Introduced by: MSS Committee on Medical Education and Committee on Disability Affairs

Subject: Studying Effects of Online Education on Medical Education Outcomes During Covid-19 Pandemic

Referred to: MSS Reference Committee
(Caitlin Blaukovitch and Shaminy Manoranjithan, Co-Chairs)

1 **INTRODUCTION**

2
3 At the 2022 MSS Interim meeting, Resolution 25 asked the AMA to conduct research studying
4 the impact of online education and distance learning towards undergraduate medical education.
5 While relevant due to the significant changes in medical education caused by the COVID-19
6 pandemic, VRC testimony favored the resolution be referred due to the original resolution's lack
7 of an objective that would meaningfully change AMA policy and actions beyond what already
8 exists. The overall consensus was that the issue of online education and distance learning was
9 important to the MSS, but further study was warranted to determine if there were aspects of the
10 issue that the AMA could act upon.

11
12 As such, MSS Resolution 25 was referred to the AMA-MSS Committee on Medical Education
13 and Committee on Disability Affairs for the report to be completed prior to the AMA-MSS A-23
14 meeting. The resolved statement was as follows:

15
16 **RESOLVED**, That our AMA support research on how distance learning impacted
17 undergraduate medical education outcomes including standardized test scores, mental
18 health, and self-efficacy.

19
20 During the initial report process and review of AMA policy, it was determined that several AMA
21 policies already existed that support the recommendations that were being made by the report's
22 scope. Briefly, it was found that AMA policy already emphasizes the need for medical schools
23 and residency programs to prioritize the mental health and self-efficacy of medical students (H-
24 345.970), and already supports using effective measures to determine teaching effectiveness
25 (D-295.329) along with already supporting the study of non-traditional instruction formats and
26 accreditation monitoring of "clinical competence" (H295.995). As a result, the AMA-MSS
27 Committee on Medical Education and Committee on Disability Affairs communicated with the
28 original authors of Interim 2022 MSS Resolution 25 to promote a study of a broader objective.
29 The Interim 2023 Reference Committee asked for the report to be re-referred in order to (1)
30 widen the scope of the report beyond the COVID-19 pandemic, and (2) investigate long
31 distance learning, which is distinct from COVID-19 learning.

32
33 In the following whereas clauses and subsequent sections, we provide an overview of current
34 research on undergraduate medical education curriculum with respect to distance learning, its
35 incorporation into hybrid or blended medical education, and educational outcomes, such as core
36 clinical competencies and mental health, as well as a review of current AMA policy relevant to
37 this topic.

38

1 **BACKGROUND**

2
3 Whereas, Distance learning is a method of study in which teachers and students do not meet in
4 a physical space, such as a lecture hall or classroom, but use the internet, e-mail, online video
5 conference, etc. to attend classes or other educational activities¹; and
6

7 Whereas, The urgency of the COVID-19 pandemic disrupted the well-established, traditional
8 structure of medical education that heavily weighted in-person learning, and required rapid and
9 novel adaptations to existing medical school curricula to incorporate distance learning^{2,3}; and
10

11 Whereas, Distance learning may be used by medical schools as a component of both hybrid
12 coursework, such as a lecture that is available for students to attend in-person or online
13 (synchronously or asynchronously), and/or blended coursework, such as a lecture that is
14 required in-person enhanced with online resources⁴; and
15

16 Whereas, During the COVID-19 pandemic, many students endorsed high levels of mental
17 burden, and 72% of medical students reported anxiety about performance on online exams^{5,6};
18 and
19

20 Whereas, Medical knowledge self-efficacy (perception of good academic performance) among
21 medical students during the COVID-19 pandemic was an important factor that influenced their
22 desire to work⁷; and
23

24 Whereas, 78% of medical schools switched to distance learning due to the COVID-19 pandemic
25 which may have been the catalyst for a new “online era” in medical education⁸; and
26

27 Whereas, A multi-national study, including students at United States medical schools,
28 demonstrated that 66% of participants felt that online learning led to insufficient opportunities to
29 interact with fellow classmates⁸; and
30

31 Whereas, The same study found that medical students desired a medical curriculum that
32 incorporated online learning approximately 42% of the time and on-site learning 58% of the
33 time⁸; and
34

35 Whereas, In a survey of over 2,000 UK medical students, the majority felt that online learning is
36 not as effective and that they would prefer face-to face learning instead⁹; and
37

38 Whereas, A cross-sectional study comparing online-only, hybrid, and on-site only learning of
39 evidence-based medical curricula demonstrates that a hybrid model offers increased learning
40 motivation, autonomy, and satisfaction, while also increasing the efficiency of delivery of the
41 material, which in turn increases students’ understanding of the material¹⁰; and
42

43 Whereas, A 2022 survey conducted at the Virginia Commonwealth University School of
44 Medicine found that increased third-semester attendance negatively correlated with Step 1
45 scores¹¹; and
46

47 Whereas, A 2022 AAMC survey found that 70% of medical students used non-institution
48 created videos and other online content (3rd party resources) daily or weekly for medical
49 information¹²; and
50

1 Whereas, Distance learning may reduce the financial burden of medical school (for example,
2 reduced transportation costs) and potentially reduce the impact of socioeconomic barriers on
3 academic performance; and
4

5 Whereas, Distance learning may increase the flexibility, and therefore accessibility, of medical
6 education, particularly for students with disabilities¹³; and
7

8 Whereas, It remains unknown what impact distance learning has on various knowledge-based
9 and behavioral-based core competencies of medical education, such as teamwork, leadership,
10 communication, and self-efficacy, among others described by the AAMC¹⁴; therefore be it
11

12 **CURRENT AMA POLICY & EFFORTS**

13
14 Current AMA policy has a strong foundation in support for adequacy of medical student
15 education, for mental health resources, and in support of novel, evidence-based, strategies to
16 meet novel education and application concerns. Policy exists that calls for support for explicit
17 plans to maintain critical education resources (H-305.942), monitoring systems for burnout and
18 depression for medical students (D-345.983), and access to mental health resources for
19 undergraduate medical students (H-345.970).
20

21 Regarding medical education, AMA policy supports utilization or effective measures to
22 determine teaching effectiveness (D-295.329), regular evaluation of all components of clinical
23 education, appropriate use of simulation (D-295-330), medical school study of non-traditional
24 instruction formats including online learning (H-305.925), and continued monitoring of
25 accreditation standards of 'clinical competence' as demonstrated in medical school (H-295.995).
26

27 During the height of the COVID-19 pandemic, the AMA specifically recognized effects of the
28 pandemic as barriers for resident and fellow learning (D-310.946) and its negative impact on
29 young adult mental health in the U.S. (H-60.937). Additionally, during the height of the COVID-
30 19 pandemic, our AMA supported temporary elimination of the Clinical Skills portion of licensing
31 exams and repeated sitting for licensing examinations if a prior attempt was failed at the height
32 of the COVID-19 pandemic, which may reflect an understanding for the challenges of an
33 education obtained during the COVID-19 pandemic (D-275.950).
34

35 While extant policy advocates for a federal commission to examine U.S. medical preparations
36 and response to the COVID-19 pandemic to inform future preparedness, we do not have policy
37 to support guidance on distance learning in medical education and training.
38

39 **DISCUSSION**

40
41 This report investigates and summarizes the current body of research exploring the impact of
42 distance learning, particularly in the setting of the COVID-19 pandemic on medical education.
43 Within distance learning, this report addresses hybrid and blended education models on
44 knowledge- and non-knowledge-based medical professional competencies and characteristics
45 such as student learning, well-being, and self-efficacy. We included consideration of the
46 different ways that distance learning has been incorporated into medical curricula, possible
47 outcomes that can be impacted by a switch to online education and how those outcomes are
48 measured, feedback from medical students pertaining to their use of distance learning in the
49 wake of the COVID-19 pandemic, and previous AMA policy that addresses assessment and
50 evaluation of evolving medical curricula.
51

1 Review of relevant literature revealed that the COVID-19 pandemic did indeed cause a large
2 shift toward greater inclusion of distance learning in medical curricula. Multiple studies
3 highlighted the convenience and flexibility that distance learning brought to medical education,
4 and the positive impacts this yielded in terms of increased flexibility for maintaining well-being
5 and self-management of learning schedule. However, these studies also highlighted some of
6 the academic and mental health drawbacks of distance learning, such as anxiety towards
7 academic performance given the paucity of outcomes data in the advent of increased distance
8 learning as well as the social isolation that comes with increased medical education that is not
9 in-person.

10
11 This literature review also demonstrated a lack of research investigating the impact of distance
12 learning (whether as a component of hybrid or blended medical education) on medical
13 professional core competencies outside of medical knowledge, such as teamwork, leadership,
14 communication, and self-efficacy. These qualities are integral components of physician
15 performance among patients as well as physicians and other healthcare workers. These also
16 appear to be qualities that are uniquely impacted by distance learning considering multiple
17 surveys finding that students' mental health was impacted by the increased social isolation that
18 is associated with increased medical education that is not in-person. Moreover, the evidence
19 that does exist surrounding distance learning's impact on student mental health does not
20 consider the potential ramifications of worsened student mental health on medical student
21 academic performance and overall well-being.

22
23 Review of current AMA policy demonstrates that substantial policy already exists that advocates
24 for continuing research into evaluating, developing, and improving medical school curricula.
25 Additionally, the AMA has a strong body of policies that emphasize the importance of
26 researching strategies to improve medical student wellness and all concomitant factors.
27 Currently no AMA policy exists that specifically references studying curriculum elements that
28 improve different components of medical professional core competencies such as those
29 mentioned above. Existing AMA policy broadly supports such a study.

30
31 As stated in the introduction, this resolution was originally debated for its originality, impact, and
32 ability to add meaningful change from what already exists in AMA policy. The original resolution
33 raises questions about the impact of distance learning on medical professional core
34 competencies – a topic that is poorly understood, significantly impacts undergraduate medical
35 education, and increasingly relevant since the COVID-19 pandemic. As such, the topic warrants
36 further study and it would be appropriate to request that our AMA study the impact of distance
37 learning on medical professional core competencies.

38 39 **CONCLUSION**

40
41 In summary, multiple studies demonstrate that distance learning in undergraduate medical
42 education curricula has increased compared to before the COVID-19 pandemic. In addition, this
43 shift in medical education curricula has impacted medical student mental health and medical
44 school performance. However, there is a need to conduct further research into the impact of
45 distance learning on several important medical professional core competencies, such as
46 teamwork, leadership, communication, and self-efficacy. The AMA has extensive policy that
47 supports research and actions related to evaluating and modifying medical education curricula
48 to improve medical student mental health as well as medical education delivery and outcomes.
49 As such, the AMA should study the impact of distance learning and third-party educational
50 resources on knowledge- and behavioral-based medical professional core competencies and
51 medical student mental health.
52

1 **RECOMMENDATIONS**

2
3 Your Committee on Medical Education and Committee on Disability Affairs recommend that the
4 following recommendations are *adopted in lieu of* and the remainder of this report is filed:

5
6 RESOLVED, That our AMA study the impact of curricular structure including distance learning
7 and third-party educational resources in undergraduate medical education on knowledge- and
8 behavioral-based core competencies of medical education and student mental health.

9
10 **ACKNOWLEDGEMENTS:**

11
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RELEVANT AMA & AMA-MSS POLICIES:

AMA Policy

The Effect of the COVID-19 Pandemic on Graduate Medical Education D-310.946

Our AMA will: (1) work with relevant stakeholders to advocate for equitable compensation and benefits for residents and fellows who are redeployed to fulfill service needs that may be outside the scope of their specialty training; and (2) urge the Accreditation Council for Graduate Medical Education (ACGME) and specialty boards to consider reducing case numbers and clinic visits with revised holistic measures to recognize resident/fellow learning, given the drastic educational barriers confronted during the COVID-19 pandemic.

The Ecology of Medical Education: The Infrastructure for Clinical Education H-305.942

The AMA recommends the following to ensure that access to appropriate clinical facilities and faculty to carry out clinical education is maintained: (1) That each medical school and residency program identify the specific resources needed to support the clinical education of trainees, and should develop an explicit plan to obtain and maintain these resources. This planning should include identification of the types of clinical facilities and the number and specialty distribution of full-time and volunteer clinical faculty members needed. (2) That affiliated health care institutions and volunteer faculty members be included in medical school and residency program resource planning for clinical education when appropriate. (3) That medical school planning for clinical network development include consideration of the impact on the education program for medical students and resident physicians. (4) That accrediting bodies for undergraduate and graduate medical education be encouraged to adopt accreditation standards that require notification of changes in clinical affiliations, in order to ensure that changes in the affiliation status of hospitals or other clinical sites do not adversely affect the education of medical students and resident physicians.

Communication and Clinical Teaching Curricula D-295.329

Our AMA will: 1. encourage the Liaison Committee on Medical Education to continue to enforce accreditation standards requiring that faculty members and resident physicians are prepared for and evaluated on their teaching effectiveness; 2. encourage the Accreditation Council for Graduate Medical Education to create institutional-level standards related to assuring the quality of faculty teaching; 3. encourage medical schools and institutions sponsoring graduate medical education programs to offer faculty development for faculty and resident physicians in time-efficient modalities, such as online programs, and/or to support faculty and resident participation in off-site programs; 4. encourage medical educators to develop and utilize valid and reliable measures for teaching effectiveness; and 5. encourage medical schools to recognize participation in faculty development for purposes of faculty retention and promotion.

Update on the Uses of Simulation in Medical Education D-295.330

Our AMA will: 1. continue to advocate for additional funding for research in curriculum development, pedagogy, and outcomes to further assess the effectiveness of simulation and to implement effective approaches to the use of simulation in both teaching and assessment; 2. continue to work with and review, at five-year intervals, the accreditation requirements of the Liaison Committee on Medical Education (LCME), the Accreditation Council for Graduate Medical Education (ACGME), and the Accreditation Council for Continuing Medical Education (ACCME) to assure that program requirements reflect appropriate use and assessment of simulation in education programs; 3. encourage medical education institutions that do not have accessible resources for simulation-based teaching to use the resources available at off-site simulation centers, such as online simulated assessment tools and simulated program development assistance; 4. monitor the use of simulation in high-stakes examinations administered for licensure and certification as the use of new simulation technology expands; 5. further evaluate the appropriate use of simulation in interprofessional education and clinical team building; and 6. work with the LCME, the ACGME, and other stakeholder organizations and institutions to further identify appropriate uses for simulation resources in the medical curriculum.

Improving Mental Health Services for Undergraduate and Graduate Students H-345.970

Our AMA supports: (1) strategies that emphasize de-stigmatization and enable timely and affordable access to mental health services for undergraduate and graduate students, in order to improve the provision of care and increase its use by those in need; (2) colleges and universities in emphasizing to undergraduate and graduate students and parents the importance, availability, and efficacy of mental health resources; and (3) collaborations of university mental health specialists and local public or private practices and/or health centers in order to provide a larger pool of resources, such that any student is able to access care in a timely and affordable manner.

Study of Medical Student, Resident, and Physician Suicide D-345.983

Our AMA will: (1) explore the viability and cost-effectiveness of regularly collecting National Death Index (NDI) data and confidentially maintaining manner of death information for physicians, residents, and medical students listed as deceased in the AMA Physician Masterfile for long-term studies; (2) monitor progress by the Association of American Medical Colleges, the American Association of Colleges of Osteopathic Medicine, and the Accreditation Council for Graduate Medical Education (ACGME) to collect data on medical student and resident/fellow suicides to identify patterns that could predict such events; (3) support the education of faculty members, residents and medical students in the recognition of the signs and symptoms of burnout and depression and supports access to free, confidential, and immediately available stigma-free mental health and substance use disorder services; (4) collaborate with other stakeholders to study the incidence of and risk factors for depression, substance misuse and substance use disorders, and attempted and completed suicide among physicians, residents, and medical students; and (5) work with appropriate stakeholders to explore the viability of developing a standardized reporting mechanism for the collection of current wellness initiatives that institutions have in place to inform and promote meaningful mental health and wellness interventions in these populations.

Youth and Young Adult Suicide in the United States H-60.937

Our AMA:

- 1) Recognizes child, youth and young adult suicide as a serious health concern in the US;
- 2) Encourages the development and dissemination of educational resources and tools for physicians, especially those more likely to encounter child, youth or young adult patients,

addressing effective suicide prevention, including screening tools, methods to identify risk factors and acuity, safety planning, and appropriate follow-up care including treatment and linkages to appropriate counseling resources;

- 3) Supports collaboration with federal agencies, relevant state and specialty societies, schools, public health agencies, community organizations, and other stakeholders to enhance awareness of the increase in child, youth and young adult suicide and to promote protective factors, raise awareness of risk factors, support evidence-based prevention strategies and interventions, encourage awareness of community mental health resources, and improve care for children, youth and young adults at risk of suicide;
- 4) Encourages efforts to provide children, youth and young adults better and more equitable access to treatment and care for depression, substance use disorder, and other disorders that contribute to suicide risk;
- 5) Encourages continued research to better understand suicide risk and effective prevention efforts in children, youth and young adults, especially in higher risk sub-populations such as those with a history of childhood trauma and adversity, Black, LGBTQ+, Hispanic/Latinx, Indigenous/Native Alaskan youth and young adult populations, and children in the welfare system;
- 6) Supports the development of novel technologies and therapeutics, along with improved utilization of existing medications to address acute suicidality and underlying risk factors in children, youth and young adults;
- 7) Supports research to identify evidence-based universal and targeted suicide prevention programs for implementation in middle schools and high schools;
- 8) Will publicly call attention to the escalating crisis in children, youth and young adult mental health in this country in the wake of the Covid-19 pandemic;
- 9) Will advocate at the state and national level for policies to prioritize children's, youth's, and young adult's mental, emotional, and behavioral health;
- 10) Will advocate for comprehensive system of care including prevention, management, and crisis care to address mental and behavioral health needs for children, youth, and young adults; and
- 11) Will advocate for a comprehensive approach to the youth, and young adult mental and behavioral health crisis when such initiatives and opportunities are consistent with AMA policy.

Recommendations for Future Directions for Medical Education H-295.995

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 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.

(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 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.

Retirement of the National Board of Medical Examiners Step 2 Clinical Skills Exam for US Medical Graduates: Call for Expedited Action by the American Medical Association D-275.950

Our AMA: (1) will 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 - Performance Evaluation Exam; (2) in collaboration with the Educational Commission for Foreign Medical Graduates (ECFMG), will advocate for an equivalent, equitable, and timely pathway for international medical graduates to demonstrate clinical skills competency; (3) strongly encourages 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 credentialing bodies to encourage the elimination of these centralized, costly and low-value exams; and (4) will 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.

Principles of and Actions to Address Medical Education Costs and Student Debt H-305.925

The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty. To help address this issue, our American Medical Association (AMA) will:

1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.
2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs--such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector--to promote practice in underserved areas, the military, and academic medicine or clinical research.
3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.
5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.
6. Work to reinstate the economic hardship deferment qualification criterion known as the "20/220 pathway," and support alternate mechanisms that better address the financial needs of trainees with educational debt.
7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.
8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.
9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).
10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided.
11. Work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment.
12. Encourage medical schools to (a) Study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, and combined baccalaureate/MD or DO programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education; (b) Engage in fundraising activities to increase the availability of scholarship support, with the

support of the Federation, medical schools, and state and specialty medical societies, and develop or enhance financial aid opportunities for medical students, such as self-managed, low-interest loan programs; (c) Cooperate with postsecondary institutions to establish collaborative debt counseling for entering first-year medical students; (d) Allow for flexible scheduling for medical students who encounter financial difficulties that can be remedied only by employment, and consider creating opportunities for paid employment for medical students; (e) Counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation; (f) Inform students of all government loan opportunities and disclose the reasons that preferred lenders were chosen; (g) Ensure that all medical student fees are earmarked for specific and well-defined purposes, and avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees; (h) Use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies; (i) Work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.

13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.

14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals: (a) Eliminating the single holder rule; (b) Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training; (c) Retaining the option of loan forbearance for residents ineligible for loan deferment; (d) Including, explicitly, dependent care expenses in the definition of the "cost of attendance"; (e) Including room and board expenses in the definition of tax-exempt scholarship income; (f) Continuing the federal Direct Loan Consolidation program, including the ability to "lock in" a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs; (g) Adding the ability to refinance Federal Consolidation Loans; (h) Eliminating the cap on the student loan interest deduction; (i) Increasing the income limits for taking the interest deduction; (j) Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001; (k) Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating; (l) Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.

15. Continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases.

16. Continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students, and monitor the short-and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.

17. Collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.

18. Continue to monitor the availability of and encourage medical schools and residency/fellowship programs to (a) provide financial aid opportunities and financial

planning/debt management counseling to medical students and resident/fellow physicians; (b) work with key stakeholders to develop and disseminate standardized information on these topics for use by medical students, resident/fellow physicians, and young physicians; and (c) share innovative approaches with the medical education community.

19. Seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt. The AMA believes that it is improper for physicians not to repay their educational loans, but assistance should be available to those physicians who are experiencing hardship in meeting their obligations.

20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician participation in the program, and will: (a) Advocate that all resident/fellow physicians have access to PSLF during their training years; (b) Advocate against a monetary cap on PSLF and other federal loan forgiveness programs; (c) Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed; (d) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note; (e) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the employer's PSLF program qualifying status; (f) Advocate that the profit status of a physician's training institution not be a factor for PSLF eligibility; (g) Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed; (h) Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas; (i) Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes; (j) Monitor the denial rates for physician applicants to the PSLF; (k) Undertake expanded federal advocacy, in the event denial rates for physician applicants are unexpectedly high, to encourage release of information on the basis for the high denial rates, increased transparency and streamlining of program requirements, consistent and accurate communication between loan servicers and borrowers, and clear expectations regarding oversight and accountability of the loan servicers responsible for the program; (l) Work with the United States Department of Education to ensure that applicants to the PSLF and its supplemental extensions, such as Temporary Expanded Public Service Loan Forgiveness (TEPSLF), are provided with the necessary information to successfully complete the program(s) in a timely manner; and (m) Work with the United States Department of Education to ensure that individuals who would otherwise qualify for PSLF and its supplemental extensions, such as TEPSLF, are not disqualified from the program(s).

21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student load burden.

22. Strongly advocate for the passage of legislation to allow medical students, residents and fellows who have education loans to qualify for interest-free deferment on their student loans while serving in a medical internship, residency, or fellowship program, as well as permitting the conversion of currently unsubsidized Stafford and Graduate Plus loans to interest free status for the duration of undergraduate and graduate medical education.

23. Continue to monitor opportunities to reduce additional expense burden upon medical students including reduced-cost or free programs for residency applications, virtual or hybrid interviews, and other cost-reduction initiatives aimed at reducing non-educational debt.

24. Encourage medical students, residents, fellows and physicians in practice to take advantage of available loan forgiveness programs and grants and scholarships that have been historically underutilized, as well as financial information and resources available through the Association of American Medical Colleges and American Association of Colleges of Osteopathic Medicine, as required by the Liaison Committee on Medical Education and Commission on Osteopathic College Accreditation, and resources available at the federal, state and local levels.

25. Support federal efforts to forgive debt incurred during medical school and other higher education by physicians and medical students, including educational and cost of attendance debt.

26. Support that residency and fellowship application services grant fee assistance to applicants who previously received fee assistance from medical school application services or are determined to have financial need through another formal mechanism.

REPORT OF THE MEDICAL STUDENT SECTION
COMMITTEE ON LGBTQ AFFAIRS AND
COMMITTEE ON HEALTH INFORMATION TECHNOLOGY

LGBTQ+ CHIT Report A
(A-24)

Introduced by: MSS Committee on LGBTQ Affairs (LGBTQ+) and Health Information
Technology (CHIT)

Subject: Improving Usability of Electronic Health Records for Transgender and
Gender Diverse Patients

Referred to: MSS Reference Committee
(Caitlin Blaukovitch and Shaminy Manoranjithan, Co-Chairs)

1 INTRODUCTION

2
3 At the Annual 2023 (A-23) MSS Assembly, MSS Resolution 072, “Improving Usability of Electronic
4 Health Records for Transgender and Gender Diverse Patients” asked the AMA to amend and
5 bolster their current policies on Electronic Health Records to encourage accurate documentation
6 for transgender and gender diverse patients to accurately describe patient sex and gender
7 identity, as current documentation systems lead to inconsistent medical histories for transgender
8 patients. The resolution, with the following resolve clauses, was referred for study:

9
10 RESOLVED, That our AMA will amend policy H-315.967 “Inclusive Gender, Sex, and Sexual
11 Orientation Options on Medical Documentation” by addition and deletion to read as follows.

12 **Promoting Inclusive Gender, Sex, and Sexual Orientation Options on** 13 **Medical Documentation, H315.967**

14 Our AMA: (1) supports the voluntary inclusion of a patient's ~~biological~~
15 ~~sex~~current clinical sex, sex assigned at birth, current gender identity, legal sex
16 on identification documents, sexual orientation, ~~preferred~~-gender pronoun(s),
17 ~~preferred~~-chosen name, and clinically relevant, sex specific anatomy in
18 medical documentation, and related forms, including in electronic health
19 records, in a culturally-sensitive and voluntary manner, with efforts to improve
20 visibility and awareness of transgender and gender diverse patients' chosen
21 name and pronouns in all relevant EHR screens and to de-emphasize or
22 conceal legal name except when required for insurance and billing purposes;
23 (2) Will advocate for the inclusion of an organ inventory encompassing medical
24 transition history and a list of current present organs in EHRs, with efforts to
25 link organ-specific examinations and cancer screenings to the current organ
26 inventory rather than sex or gender identity; (23). Will advocate for collection
27 of patient data in medical documentation and in medical research studies,
28 according to current best practices, that is inclusive of sexual orientation,
29 gender identity, and other sexual and gender minority traits for the purposes
30 of research into patient and population health; (34) Will research the problems
31 related to the handling of sex and gender within health information technology
32 (HIT) products and how to best work with vendors so their HIT products treat
33 patients equally and appropriately, regardless of sexual or gender identity;
34 (45) Will investigate the use of personal health records to reduce physician
35

1 burden in maintaining accurate patient information instead of having to query
2 each patient regarding sexual orientation and gender identity at each
3 encounter; and (56) Will advocate for the incorporation of recommended best
4 practices into electronic health records and other HIT products at no additional
5 cost to physicians automatically. ; and be it further
6

7 RESOLVED, That our AMA advocates for increased education and training on usage of gender
8 identity and related transgender-inclusive functions in electronic healthcare records within
9 healthcare institutions; and be it further

10
11 RESOLVED, That our AMA advocates for easy transferability of transgender-inclusive functions
12 between different electronic healthcare record systems and that this transfer capability is included in
13 the healthcare institutions' training and education for staff; and be it further
14

15 RESOLVED, That this resolution be immediately forwarded to the AMA House of Delegates.

16
17 The MSS Reference Committee recommended non-adoption of the resolution with the following
18 rationale:
19

20 VRC testimony was mixed and supportive of the spirit of the resolution. Your Reference
21 Committee agrees with testimony that the asks of the second and third Resolves are
22 covered under existing policy and the first Resolve is not actionable. Your Reference
23 Committee notes that the current policy being amended was presented to the AMA several
24 years ago by the MSS. At the time "clinically relevant, sex specific anatomy in medical
25 documentation, and related forms, including in electronic health records" was interpreted
26 as an organ inventory. We agree that the additions to this existing policy will not
27 meaningfully change AMA advocacy and neither will further amendments. Your Reference
28 Committee recommends Resolution 072 not be adopted.
29

30 The item was extracted by the authors and the following discussions took place.

- 31 ● Multiple testifiers spoke against the proposal due to concerns that the proposed
32 amendments would not meaningfully change or add to current policy.
- 33 ● However, the vote on non-adoption failed and the authors motioned to refer the resolution
34 while multiple testifiers spoke in favor of referral.
- 35 ● The Assembly voted to agree with the author's recommendation to refer the resolution to
36 strengthen the language for the House of Delegates and evaluate the feasibility of the
37 resolution.
 - 38 ○ RESOLVED, that our AMA supports the use of inclusive practices for recording
39 accurate information on sex and gender in EHR.

40
41 Your Governing Council assigned this report to the Committee on Global and Public Health
42 (LGBTQ+) and Committee on Health Information Technology (CHIT) with the following memo:
43

44 When writing your report, please focus on the feasibility of the resolution. Other research may be
45 helpful to provide a background, but it is not necessary to include all of this information in your
46 final report. A well-written report should be concise and should clearly outline the
47 recommendations made by your committee.
48

49 The following Question to be addressed was provided:
50

51 1) How can this resolution be strengthened to elicit more action from the AMA?

1
2 In the following whereas clauses and subsequent discussion, we will provide an overview of
3 current EHR practices on sex and gender identity. We examine how sex and gender in the EHR
4 affects transgender and gender diverse patients and the adverse experiences that transgender
5 individuals can experience due to ambiguity surrounding their sex, gender identities, and medical
6 histories. We describe how current EHR practices could be improved to capture more accurate
7 information about transgender and gender diverse patients to improve outcomes.

8
9 **WHEREAS CLAUSES**

10
11 Whereas, The Electronic Health Record (EHR) system plays a vital role in helping doctors track patient
12 demographics, clinical notes, diagnoses, and test results¹ ; and

13
14 Whereas, EHR systems reflect an assumption that everyone is cisgender, and many EHRs do not
15 provide sufficient flexibility or inclusivity for transgender and gender diverse (TGD) patients who do
16 not fit into the traditional binary of sex and gender²⁻⁴; and

17
18 Whereas, Sex assigned at birth may inadequately describe current clinical sex for transgender
19 patients whose medical transition altered their secondary sex characteristics, hormone levels, or
20 genitals⁴; and

21
22 Whereas, Multiple studies have demonstrated that the changes in chemistry and hematology
23 parameters from masculinizing and feminizing hormone therapies overall show good correlation
24 with cisgender male and female reference values^{5,6}; and

25
26 Whereas, The legal sex found on identity documents should not be used as a proxy for current sex
27 because it can be clinically misleading in many circumstances⁷; and

28
29 Whereas, Both sex assigned at birth and current anatomy are needed to inform clinical
30 decisions, while legal sex may be required for billing and insurance purposes^{8,9}; and

31
32 Whereas, Due to a variety of financial and institutional barriers, many TGD people may not be able
33 to formally change their legal name to reflect their chosen name; thus, their chosen name may not
34 appear on insurance and medical documentation¹⁰ ; and

35
36 Whereas, In TGD patient chart notes, the correct pronouns are used less than 40% of the time,
37 assigned sex at birth is recorded accurately less than 54% of the time and only 46% of TGD
38 patients were recorded with the proper ICD codes⁸; and

39
40 Whereas, Gender identity data includes chosen name, pronouns, current gender identity, and
41 sex listed on original birth certificate¹¹ ; and

42
43 Whereas, The term "sexual preference" suggests that an individual's sexual orientation is a choice¹²⁻
44 ¹⁴; and

45
46 Whereas, The term "preferred name" and "preferred pronouns" imply optional use by providers as
47 opposed to the term "chosen name" which removes the implication of elective use¹²⁻¹⁴;and

48
49 Whereas, The term "preferred name" is a broad term which can be applied to any patient (i.e. Sue vs
50 Susan) and is not specific to the "chosen name" associated with some gender-diverse individuals
51 leading to the patient's chosen name being documented in quotes or parentheses alongside their
52 legal deadname (i.e. Mark "Mary" Moore)¹⁵;and

53

1 Whereas, in most EMR a space for documenting “preferred name” exists alongside documenting
2 “legal name”, no such separate space exists to document a patient’s chosen name in a way that
3 minimizes appearance of legal names inconsistent with chosen name in documents presented to the
4 patient¹⁵; and
5

6 Whereas, the Office of the National Coordinator for Health Information Technology’s (ONC) sets
7 “preferred name” as standard and the AMA advocates for “preferred name” in communications with
8 ONC as opposed to chosen name¹⁶; and
9

10 Whereas, Forty percent of TGD people attempt suicide within their lifetime, with young people
11 being most likely to do so, and TGD youth who addressed by their chosen name experience
12 lower rates of depression, suicidal ideation, and suicidal behavior^{11,17}; and
13

14 Whereas, Misgendering is when a person is addressed or described with pronouns that do not
15 reflect their gender identity¹¹, and is associated with experiences of depression, stress, and
16 stigma^{18,19}; and
17

18 Whereas, Deadnaming is a form of misgendering that often occurs in healthcare settings in which a
19 transgender person is inadvertently addressed by their birth name which they no longer use, often
20 triggering gender dysphoria²⁰; and
21

22 Whereas, Storing gender identity data in inconsistent locations across EHR platforms and
23 institutions adds further confusion to what is already a challenging topic for healthcare workers to
24 understand²¹; and
25

26 Whereas, Twenty-three percent of TGD people have avoided necessary medical care due to fear
27 of being disrespected or mistreated, with misnaming and misgendering cited as common
28 reasons for doing so¹⁰; and
29

30 Whereas, Automated cancer screening reminders for TGD patients may cause discomfort and
31 increased mistrust in medical professionals when the screening reminders are linked to sex
32 assigned at birth instead of the patient’s present organs; this can be prevented by organ
33 inventories, which list the patient’s present organs, and are recommended by the World
34 Professional Association for Transgender Healthcare^{2,8,22-24}; and
35

36 Whereas, Many TGD people undergo medical and surgical gender-affirming interventions
37 including hormone replacement therapy, masculinizing chest surgery, breast augmentation,
38 hysterectomy, and genital surgeries, which may lead to an organ inventory that does not align
39 with the binary view of sex and gender upon which EHRs are structured²⁵; and
40

41 Whereas, Patient sex as recorded in EHRs is used to generate health screenings, medication
42 dosages, and laboratory test ranges by taking into account assumed hormonal history and
43 anatomy typical for the specified sex²⁶; and
44

45 Whereas, TGD people with a uterus have a 37% lower odds of being up to date on their Pap
46 testing compared with cisgender people²⁷⁻³⁰; and
47

48 Whereas, Incorrect application of sex-based risk stratification tools for bone health³¹ and
49 cardiovascular disease³², predicting hypoxemia in anesthetized patients during surgery⁴, and
50 estimated glomerular filtration rate³³ further compound poor TGD health outcomes¹⁰; and
51

52 Whereas, Over half of healthcare professionals reported their EHRs have one field for both sexual
53 orientation and gender identity rather than separate fields for each, only 27% had the ability to
54 record patient pronouns, and 55% had the ability to record chosen name²¹; and when EHRs have

1 inclusive options, these features are often hidden behind a paywall or only available through
2 opting in to turn the features on³⁴; and
3

4 Whereas, Only 10-20% of customers utilize trans-inclusive options in EHRs that have them, and
5 only a quarter of all patients have their gender identity listed in the EHR^{9,35}; and
6

7 Whereas, Our AMA policy D-478.995 urges EHR vendors to adopt social determinants of health
8 templates without adding further cost to medical providers; and
9

10 Whereas, Our AMA policy H-315.967 advocates for the inclusion of gender identity-related
11 demographics in medical documentation and incorporation of recommended best practices into
12 electronic health records; however, the suggestions for what to include leave an incomplete picture
13 of transgender patients' medical history, leading to unhelpful ambiguity of advocacy efforts;
14 therefore be it
15

16 **CURRENT AMA POLICY & EFFORTS**

17

18 Current AMA policy robustly covers LGBTQ+ specific sex and gender data in the EHR, education
19 on best practices for LGBTQ+ healthcare, and EHR interoperability. However, current language
20 does not follow best practices for LGBTQ+ inclusive sex and gender language.
21

22 Policy H315.967 has previously been interpreted as supporting the inclusion of an organ inventory in
23 the EHR in the form of "documentation of clinically relevant sex specific anatomy." Additionally, chosen
24 name and gender pronouns are covered in H315.967 but under the term "preferred name, and
25 preferred gender pronouns." The language "preferred pronouns" and "preferred name" is not within
26 current best practices for describing chosen name and gender pronouns by implying usage is optional.
27 Lastly, the term Biological sex is ambiguous and the term "sex assigned at birth" serves as a better
28 alternative in communicating the intended information.
29

30 In regard to LGBTQ+ healthcare education policy H 160.991 adequately describes the AMA's stance
31 on taking active leadership and exploring opportunities for collaboration on LGBTQ+ competent
32 healthcare. H 160.991 is a broad non-prescriptive policy which allows for action to be taken for
33 education on any practices which would improve LGBTQ+ healthcare including improved EHR
34 documentation.
35

36 EHR interoperability is adequately covered in policy D-478.972 for universal standards of healthcare.
37 As per H 160.991 the AMA recognizes LGBTQ+ competent healthcare as a universal standard of care
38 but review of actions taken by the AMA reveals no significant action being taken on LGBTQ+ standards
39 of care within the EHR.
40

41 **CONCLUSION**

42

43 We appreciate the referral of this resolution and acknowledge the important points this
44 resolution raises about the inclusiveness, accuracy, and interoperability of the medical record.
45 Ultimately, your Committees on LGBTQ+ Affairs and Health Information Technology found
46 some of the amendments in Resolve 1 would provide a substantial change to current AMA
47 advocacy, while the asks of Resolves 2 and 3 could be accomplished under current AMA policy,
48

49 With respect to the first resolve, the Committees concluded that some of the amendments
50 proposed would lead to meaningful advocacy change and thus recommend adopt in lieu with
51 modified amendments.
52

1 To decrease the stigmatizing language, we recommend striking preferred in “preferred
2 pronouns” and using the term “Chosen name” instead of “Preferred Name”. Current AMA
3 advocacy and communication recommends the integration of “preferred name” in EHR systems,
4 but as outlined in the whereas clauses, “preferred name” can suggest an elective nature of its
5 use. “Chosen name” on the other hand is promoted by transgender and gender-diverse
6 advocates as the appropriate term to ensure that the importance of utilizing the chosen name
7 provided is highlighted. In order to ensure that AMA advocacy is consistent, an additional
8 Resolved Clause was added to ask the AMA to utilize “chosen name” instead of “preferred
9 name” in all advocacy efforts.

10
11 To clarify the term “biological sex” we suggest the phrase “sex assigned at birth” but find the
12 term “current clinical sex” confusing and adequately covered in the context of documentation of
13 sex specific anatomy. We retained the amendment “legal sex on identification documents” as
14 this information can be important to have in EHR systems for billing and insurance verification
15 purposes.

16
17 We also chose to retain the amendments asking for the AMA to specifically advocate for the
18 concealment of legal name and to promote the visibility of chosen names on EHR softwares as
19 we believe this specific ask is important to guide AMA advocacy. Allowing for legal names and
20 chosen names to be equally visible on EHR softwares can facilitate confusion for providers and
21 lead to individuals being called by the incorrect name, which in turn can harm and distress to
22 patients. This advocacy ask is valuable in its specificity to ensure that the incorporation of legal
23 names into EHR systems in addition to chosen names does not inadvertently harm the patients
24 this policy is aiming to help.

25
26 With respect to the second resolve, the AMA has existing policy in the form of H-160.991, Health
27 Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations stating that the AMA
28 will take leadership in education on LGBTQ+ competent care as well as collaborating with pertinent
29 organizations to further education. While the second resolve provides a specific action which could
30 be taken under existing policy, its asks would be better suited for a Governing Council action item.

31
32 With respect to the third resolve advocating for the transferability of transgender-inclusive
33 functions between EHRs, the Committees concluded that existing policy D-478.972, EHR
34 Interoperability, already speaks to the transferability of universal healthcare standards, and thus
35 the third resolve would likely be viewed as reaffirmation of current policy. However, the
36 Committees believe that a Governing Council action item may be appropriate in this case to
37 urge the AMA to take action on existing policy and reinforce that such items as organ
38 inventories are considered universal standards under this policy.

39
40 With respect to resolve four, our committees do not feel immediate forwarding is in the best
41 interest of our resolution’s success in the HOD.

42
43 **RECOMMENDATION**

44
45 Your Committees on LGBTQ Affairs (LGBTQ+) and Committee on Health Information
46 Technology (CHIT) recommend(s) that the recommendations be adopted in lieu of Resolution
47 072 and the remainder of this report be filed:

48
49 RESOLVED, that our American Medical Association amend policy H-315.967 “Inclusive Gender,
50 Sex, and Sexual Orientation Options on Medical Documentation” by addition and deletion to
51 read as follows.

1
2 **Promoting Inclusive Gender, Sex, and Sexual Orientation Options**
3 **on Medical Documentation, H-315.967**

4 Our AMA: (1) supports the voluntary inclusion of a patient's ~~biological~~
5 ~~sex~~, sex assigned at birth, current gender identity, legal sex on
6 identification documents, sexual orientation, ~~preferred~~—gender
7 pronoun(s), ~~preferred~~—chosen name, and clinically relevant, sex-
8 specific anatomy in medical documentation, and related forms,
9 including in electronic health records, in a culturally-sensitive and
10 voluntary manner, with efforts to improve visibility and awareness of
11 transgender and gender diverse patients' chosen name and pronouns
12 in all relevant EHR screens and to de-emphasize or conceal legal
13 name except when required for insurance and billing purposes; (2) Will
14 advocate for collection of patient data in medical documentation and in
15 medical research studies, according to current best practices, that is
16 inclusive of sexual orientation, gender identity, and other sexual and
17 gender minority traits for the purposes of research into patient and
18 population health; (3) Will research the problems related to the
19 handling of sex and gender within health information technology (HIT)
20 products and how to best work with vendors so their HIT products treat
21 patients equally and appropriately, regardless of sexual or gender
22 identity; (4) Will investigate the use of personal health records to
23 reduce physician burden in maintaining accurate patient information
24 instead of having to query each patient regarding sexual orientation
25 and gender identity at each encounter; and (5) Will advocate for the
26 incorporation of recommended best practices into electronic health
27 records and other HIT products at no additional cost to physicians; and
28 be it further
29

30 RESOLVED, that our AMA supports the use of the term “chosen name” over “preferred name,”
31 recognizing the value of the term “chosen name” to transgender and gender-diverse patients.
32

33 **ACKNOWLEDGEMENTS**
34

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RELEVANT AMA AND AMA-MSS POLICY

National Health Information Technology D-478.995

1. Our AMA will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care. 2. Our AMA: (A) advocates for standardization of key elements of electronic health record (EHR) and computerized physician order entry (CPOE) user interface design during the ongoing development of this technology; (B) advocates that medical facilities and health systems work toward standardized login procedures and parameters to reduce user login fatigue; and (C) advocates for continued research and physician education on EHR and CPOE user interface design specifically concerning key design principles and features that can improve the quality, safety, and efficiency of health care; and (D) advocates for continued research on EHR, CPOE and clinical decision support systems and vendor accountability for the efficacy, effectiveness, and safety of these systems.

3. Our AMA will request that the Centers for Medicare & Medicaid Services: (A) support an external, independent evaluation of the effect of Electronic Medical Record (EMR) implementation on patient safety and on the productivity and financial solvency of hospitals and physicians' practices; and (B) develop, with physician input, minimum standards to be applied to outcome-based initiatives measured during this rapid implementation phase of EMRs. 4. Our AMA will (A) seek legislation or regulation to require all EHR vendors to utilize standard and interoperable software technology components to enable cost efficient use of electronic health records across all health care delivery systems including institutional and community based settings of care delivery; and (B) work with CMS to incentivize hospitals and health systems to achieve interconnectivity and interoperability of electronic health records systems with independent physician practices to enable the efficient and cost effective use and sharing of electronic health records across all settings of care delivery. 5. Our AMA will seek to incorporate incremental steps to achieve electronic health record (EHR) data portability as part of the Office of the National Coordinator for Health Information Technology's (ONC) certification process. 6. Our AMA will collaborate with EHR vendors and other stakeholders to enhance transparency and establish processes to achieve data portability. 7. Our AMA will directly engage the EHR vendor community to promote improvements in EHR usability. 8. Our AMA will advocate for appropriate, effective, and less burdensome documentation requirements in the use of electronic health records. 9. Our AMA will urge EHR vendors to adopt social determinants of health templates, created with input from our AMA, medical specialty societies, and other stakeholders with expertise in social determinants of health metrics and development, without adding further cost or documentation burden for physicians.

Promotion of LGBTQ-Friendly and Gender-Neutral Intake Forms D-315.974 Our AMA will develop and implement a plan with input from the Advisory Committee on LGBTQ Issues and appropriate medical and community based organizations to distribute and promote the adoption of the recommendations pertaining to medical documentation and related forms in AMA policy H-315.967, "Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation," to our membership.

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.

Removing Financial Barriers to Care for Transgender Patients H-185.950 Our AMA supports public and private health insurance coverage for treatment of gender dysphoria as recommended by the patient's physician

Affirming the Medical Spectrum of Gender H-65.962

Our AMA opposes any efforts to deny an individual's right to determine their stated sex marker or gender identity.

Reducing Suicide Risk Among Lesbian, Gay, Bisexual, Transgender, and Questioning Youth Through Collaboration with Allied Organizations H-60.927

Our AMA will partner with public and private organizations dedicated to public health and public policy to reduce lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth suicide and improve health among LGBTQ youth.

EHR Interoperability D-478.972

Our AMA:

- (1) will enhance efforts to accelerate development and adoption of universal, enforceable electronic health record (EHR) interoperability standards for all vendors before the implementation of penalties associated with the Medicare Incentive Based Payment System; (2) supports and encourages Congress to introduce legislation to eliminate unjustified information blocking and excessive costs which prevent data exchange;
- (3) will develop model state legislation to eliminate pricing barriers to EHR interfaces and

connections to Health Information Exchanges;

(4) will continue efforts to promote interoperability of EHRs and clinical registries; (5) will seek ways to facilitate physician choice in selecting or migrating between EHR systems that are independent from hospital or health system mandates;

(6) will seek exemptions from Meaningful Use penalties due to the lack of interoperability or decertified EHRs and seek suspension of all Meaningful Use penalties by insurers, both public and private;

(7) will continue to take a leadership role in developing proactive and practical approaches to promote interoperability at the point of care;

(8) will seek legislation or regulation to require the Office of the National Coordinator for Health Information Technology to establish regulations that require universal and standard interoperability protocols for electronic health record (EHR) vendors to follow during EHR data transition to reduce common barriers that prevent physicians from changing EHR vendors, including high cost, time, and risk of losing patient data; and

(9) will review and advocate for the implementation of appropriate recommendations from the "Consensus Statement: Feature and Function Recommendations to Optimize Clinician Usability of Direct Interoperability to Enhance Patient Care," a physician-directed set of recommendations, to EHR vendors and relevant federal offices such as, but not limited to, the Office of the National Coordinator, and the Centers for Medicare and Medicaid Services.

REPORT OF THE MEDICAL STUDENT SECTION
MINORITY ISSUES COMMITTEE AND COMMITTEE ON SCIENTIFIC ISSUES

MSS MIC CSI CAIA Report
(A-24)

Introduced by: Minority Issues Committee, Committee on Scientific Issues, and the
Committee on American Indian Affairs

Subject: Increasing Access to Medical Interpreters in Research and Support for
Increased Diversity in Genetic Research

Referred to: MSS Reference Committee
(Caitlin Blaukovitch and Shaminy Manoranjithan, Co-Chairs)

1 **INTRODUCTION**

2 At the Interim 2023 (I-23) MSS Assembly, MSS Resolution 028, “The Use of Language
3 Interpreters in Medical and Clinical Research” asked the AMA to support the use of interpreters
4 for participants with limited English proficiency in medical and clinical research. The resolution,
5 with the following resolve clauses, was referred for study:

6
7 RESOLVED, That our AMA supports the use of language interpreters in research
8 participation to promote equitable data collection and outcomes; and be it further

9
10 RESOLVED, That our AMA encourages research institutions to budget for the use of
11 language interpreters in medical and clinical research proposals; and be it further

12
13 RESOLVED, That our AMA collaborates with the American Society for Physicians in
14 Clinical Research to encourage relevant stakeholders to develop guidelines for the
15 appropriate implementation of language interpreters in medical and clinical research.

16
17 The MSS Reference Committee recommended referral of the resolution with the following
18 rationale:

19
20 VRC testimony was mixed between general support, support with amendments, and
21 reaffirmation. Your Reference Committee supports the spirit of the resolution and agrees with
22 concerns regarding the downstream consequences of expanding interpreter and translation
23 services in clinical/medical research. We recommend amendments to strike the second and
24 third Resolves:

25 RESOLVED, That our AMA encourages all Institutional and Research Review Boards to
26 develop and publish transparent guidance on the enrollment of medical and clinical
27 research participants with Limited English Proficiency.

28
29 Additionally, we recommend amendments to the first Resolve to read as follows:

30 RESOLVED, Our AMA supports the use of language interpreters and translators in
31 clinical and medical research participation to promote equitable data collection and
32 outcomes; and be it further.

33
34 During the MSS Assembly,

- 35 ● The item was not extracted, so the Reference Committee Recommendation to refer
36 passed via the consent calendar.

1 Your Governing Council assigned this report to the Minority Issues Committee, Committee on
2 Scientific Issues, and the Committee on American Indian Affairs with the following possible
3 questions for consideration:1.) What potential training is required to provide specific research
4 study interpretation and translation services? 2.) Do programs need to invest not just in the cost
5 of medical interpreter services, but in training to meaningfully communicate information from
6 clinical studies? 3.) What is the role of IRB and institutional guidelines in accomplishing the asks
7 of this resolution? 4.) How can this item be strengthened with other possible mechanisms to
8 increase equity in medical studies with greater inclusion of Limited English Proficiency
9 individuals?

10
11 Also, at the Interim 2023 (I-23) MSS Assembly, MSS Resolution 043 “Support for Increased
12 Diversity in Genetic Research” asked the AMA to support diversifying and recruiting
13 underrepresented persons for genetic research. The resolution, with the following resolve
14 clauses, was referred for study:

15
16
17 RESOLVED, That our AMA support the diversification of genetic research to include
18 subjects from multiple genetic ancestries; and be it further

19
20 RESOLVED, That our AMA support the recruitment of individuals from underrepresented
21 genetic ancestry groups for participation in genetic research studies, especially those
22 regarding genetic risk; and be it further

23
24 RESOLVED, That our AMA encourage the NIH to increase funding for outreach and
25 recruitment of members of underrepresented genetic ancestry groups and the sharing of
26 such deidentified genetic data with the scientific community; and be it further

27
28 RESOLVED, That our AMA promotes public education regarding PRSs and genetic
29 research participation in order to aid in the recruitment of diverse ancestry cohorts for
30 future genetic studies; and be it further

31
32 RESOLVED, That the AMA amend Policy H-460.909, “Comparative Effectiveness
33 Research,” by addition and deletion to read as follows:

34
35 Comparative Effectiveness Research H-460.909

36
37 The following Principles for Creating a Centralized Comparative Effectiveness Research
38 Entity are the official policy of our AMA:

39 **PRINCIPLES FOR CREATING A CENTRALIZED COMPARATIVE EFFECTIVENESS**
40 **RESEARCH ENTITY:**

41 A. Value. Value can be thought of as the best balance between benefits and costs, and
42 better value as improved clinical outcomes, quality, and/or patient satisfaction per dollar
43 spent. Improving value in the US healthcare system will require both clinical and cost
44 information. Quality comparative clinical effectiveness research (CER) will improve health
45 care value by enhancing physician clinical judgment and fostering the delivery of patient-
46 centered care.

47 B. Independence. A federally sponsored CER entity should be an objective, independent
48 authority that produces valid, scientifically rigorous research.

49 C. Stable Funding. The entity should have secure and sufficient funding in order to
50 maintain the necessary infrastructure and resources to produce quality CER. Funding
51 source(s) must safeguard the independence of a federally sponsored CER entity.

1 D. Rigorous Scientifically Sound Methodology. CER should be conducted using rigorous
2 scientific methods to ensure that conclusions from such research are evidence-based and
3 valid for the population studied. The primary responsibility for the conduct of CER and
4 selection of CER methodologies must rest with physicians and researchers.

5 E. Transparent Process. The processes for setting research priorities, establishing
6 accepted methodologies, selecting researchers or research organizations, and
7 disseminating findings must be transparent and provide physicians and researchers a
8 central and significant role.

9 F. Significant Patient and Physician Oversight Role. The oversight body of the CER entity
10 must provide patients, physicians (MD, DO), including clinical practice physicians, and
11 independent scientific researchers with substantial representation and a central decision-
12 making role(s). Both physicians and patients are uniquely motivated to
13 provide/receive quality care while maximizing value.

14 G. Conflicts of Interest Disclosed and Minimized. All conflicts of interest must be disclosed
15 and safeguards developed to minimize actual, potential and perceived conflicts of interest
16 to ensure that stakeholders with such conflicts of interest do not undermine the integrity
17 and legitimacy of the research findings and conclusions.

18 H. Scope of Research. CER should include long term and short term assessments of
19 diagnostic and treatment modalities for a given disease or condition in a defined
20 population of patients. Diagnostic and treatment modalities should include drugs,
21 biologics, imaging and laboratory tests, medical devices, health services, or
22 combinations. It should not be limited to new treatments. In addition, the findings should
23 be re-evaluated periodically, as needed, based on the development of new alternatives
24 and the emergence of new safety or efficacy data. The priority areas of CER should be on
25 high volume, high cost diagnosis, treatment, and health services for which there is
26 significant variation in practice. Research priorities and methodology should factor in any
27 systematic variations in disease prevalence or response across groups by genetic
28 ancestry, gender, age, geography, and economic status; and be it further

29 I. Dissemination of Research. The CER entity must work with health care professionals
30 and health care professional organizations to effectively disseminate the results in a timely
31 manner by significantly expanding dissemination capacity and intensifying efforts to
32 communicate to physicians utilizing a variety of strategies and methods. All research
33 findings must be readily and easily accessible to physicians as well as the public without
34 limits imposed by the federally supported CER entity. The highest priority should be placed
35 on targeting health care professionals and their organizations to ensure rapid
36 dissemination to those who develop diagnostic and treatment plans.

37 J. Coverage and Payment. The CER entity must not have a role in making or
38 recommending coverage or payment decisions for payers.

39 K. Patient Variation and Physician Discretion. Physician discretion in the treatment of
40 individual patients remains central to the practice of medicine. CER evidence cannot
41 adequately address the wide array of patients with their unique clinical characteristics, co-
42 morbidities and certain genetic characteristics. In addition, patient autonomy and choice
43 may play a significant role in both CER findings and diagnostic/treatment planning in the
44 clinical setting. As a result, sufficient information should be made available on the
45 limitations and exceptions of CER studies so that physicians who are making
46 individualized treatment plans will be able to differentiate patients to whom the study
47 findings apply from those for whom the study is not representative.

48
49 The MSS Reference Committee recommended referral of the resolution with the following
50 rationale:

51

1 VRC testimony was mixed. Your Reference Committee agrees with testimony that the
2 resolution is not reaffirmation of existing policies H-460.909, D-350.981, and H-460.911. The
3 House Coordination Committee slated Resolution 043 as reaffirmation of current policy that
4 supports diversity in clinical research, but we agree that the resolution focuses specifically on
5 genetic ancestry which is distinct from race and includes not only clinical research but also
6 basic science research. However, your Reference Committee has concerns about the impact
7 of this resolution as many initiatives including the NIH All of Us Project are collecting genetic
8 and health data with an emphasis on including individuals that have historically not been
9 included in this type of research. The Reference Committee questions the impact of AMA
10 action in this realm and whether the proposals including “outreach” and “public education” are
11 the most efficacious method to improve genetic ancestry representation in research. Referral
12 of this item would allow our MSS to gather more research and find the best solution to the
13 problem.

14
15 During the MSS Assembly,

- 16 ● The item was not extracted, so the Reference Committee Recommendation to refer
17 passed via the consent calendar.

18
19
20 In this following whereas clauses and subsequent discussion, we will address VRC concerns for
21 both resolutions with additive research. For both resolutions, we will provide background on the
22 topic, the issue we are hoping to address, and the gap in AMA policy the resolutions may or may
23 not fill.

24 **WHEREAS CLAUSES**

25 **Resolution 028**

26
27
28
29 Whereas, Individuals who have limited English proficiency (LEP) are defined as those, “...who
30 do not speak English as their primary language and who have a limited ability to read, speak,
31 write, or understand English...”¹; and

32
33 Whereas, Nearly 9% of the United States population, or 25 million citizens, are considered
34 individuals with LEP, a majority of which identify as Latino or Asian²⁻⁴; and

35
36 Whereas, Language barriers cause and perpetuate health inequities within traditionally
37 marginalized communities including in insurance status, continuity of care, access to
healthcare, and chronic disease outcomes⁵⁻¹¹; and

38
39 Whereas, the use of professional language interpreters has been shown to improve satisfaction
40 and communication outcomes for the patient, while language barriers have been identified as a
41 factor contributing to clinical trial participation for LEP individuals¹¹⁻²⁰; and

42
43 Whereas, Title VI of the Civil Rights Act mandates certified language interpreter services
44 be provided to patients with LEP when receiving care, while Section 1557 requires
federally funded health care providers to provide language services^{21,22}; and

45
46 Whereas, the Language Access Plan developed by the Department of Health and Human
47 Services (HHS) has taken preliminary steps the ensure federal financial assistance recipients
48 can use federal grant monies to provide language assistance services, however, this is still in its
developmental stages and does not include clinical research²³; and

1 Whereas, A certified medical interpreter (CMI) has been certified by a professional organization
2 or government entity through rigorous testing while a qualified healthcare interpreter has been
3 assessed for professional skills, demonstrates a high level of proficiency in at least two
4 languages, and has the appropriate training and experience to interpret with skill and
5 accuracy²⁴; and

6 Whereas, Currently there are no federal laws regulating whether hospital systems hire certified
7 vs. non-certified medical interpreters, and further, certification is only offered in 6 languages:
8 Spanish, Cantonese, Mandarin, Russian, Korean, and Vietnamese from the National Board of
9 Certification (NBCMI) for Medical Interpreters, while the Certification Commission for Healthcare
10 Interpreters (CCHI) only offers Arabic, Mandarin and Spanish Certifications^{25,26}; and

11 Whereas, Continuing education is required for most medical interpreter certifications and is
12 typically offered by professional interpreter and translator associations, such as the American
13 Translators Association (ATA), posing another barrier to hiring and maintaining a CMI
14 license^{27,28}; and

15 Whereas, There also exists a lack of representation of individuals from traditionally
16 marginalized racial and ethnic communities in medical and clinical research studies, commonly
17 due to exclusion of participants who cannot communicate in English, further exacerbating health
18 inequities due to limited generalizability²⁹⁻³⁷; and

19 Whereas, Nearly 20% of all trials listed on Clinicaltrials.gov between Jan 2019 - Dec 2020 listed
20 English proficiency as a requirement to participate³³; and
21

22 Whereas, Informed consent should be delivered to participants and their legally authorized
23 representatives in the language most easily understood to them as required by the HHS³⁸⁻⁴⁰;
24 and

25 Whereas, The lack of translated informed consent forms, increased time needed to consent
26 patients with LEP, and ambiguous guidance from the federal government and related agencies
27 contribute to challenges with recruiting and retaining research participants with LEP^{34,35,41,42}; and
28 Whereas, The Food and Drug Administration and HHS's Office for Human Research
29 Protections oversee approximately 2,300 U.S.-based Institutional Review Boards (IRBs),
30 operated by about 1,800 separate organizations⁴³; and

31 Whereas, Despite a multitude of regulations investigators must abide by, IRBs provide little
32 guidance on providing non-English information, consent documents, and supplemental
33 educational tools and such guidelines often vary by local IRB institution, thereby placing the
34 burden of adequate language services guidance on institution and research group good
35 practices⁴⁵⁻⁴⁷; and

36

37 Whereas, Federal guidelines outline requirements to provide language assistance to those who
38 require it in healthcare programs and research, yet there has been little success implementing
39 these guidelines in medical and clinical research⁴⁸; and

40 Whereas, there is significant variation in guidance between separate research centers'
41 IRBs regarding the inclusion of research participants with LEP, highlighting the need for
42 upstream interventions through more assertive federal direction⁴⁵; and

43 Whereas, In-person language interpretation can cost anywhere between \$45-150 per hour or an
44 extra \$300 per patient^{49,50}; and

1 Whereas, One study found that while use of non-certified language interpreters in the informed
2 consent process was initially less costly, the inaccurate translation incurred further costs
3 downstream that ultimately made the cost of certified language interpreters comparable⁵¹ and

4 Whereas, Inequitable representation in clinical and medical research is costly to both individual
5 health and societal prosperity, as reinforced by a recent report which estimated that total
6 elimination of health inequities in diabetes, heart disease, and hypertension has a value of
7 approximately \$11 trillion, greatly outweighing the cost of interpretation services⁵² ; and

8 Whereas, Increasing collaborative research in LEP and health literacy may be beneficial in
9 communicating relevant findings from clinical studies and increasing research participation in
10 individuals with LEP^{1,2,53-56}; therefore be it

11
12 **Resolution 043 “Support for Increased Diversity in Genetic Research”**

13
14 Whereas, Genetic research studies have historically included poorly diversified cohorts with 78%
15 of genome-wide association study (GWAS) participants identifying as non-Hispanic White,
16 10% identifying as Asian, 2% identifying as African American, 1% identifying as Hispanic or
17 Latino, and <1% identifying as American Indian and Alaska Native, Native Hawaiian and Other
18 Pacific Islander¹⁻³; and

19
20 Whereas, GWAS do not reflect the United States’ population demographics, as the U.S.
21 population is 59.3% non-Hispanic White, 18.9% Hispanic or Latino, 13.6% African American,
22 6.1% Asian, 1.3% American Indian and Alaska Native, and 0.3% Native Hawaiian and Other
23 Pacific Islander⁴; and

24
25 Whereas, Race and ethnicity are “socially ascribed identities,” while genetic ancestry is defined
26 as the genetic origin of a given population and via greater genetic similarity within a given
27 population^{5,6,13,14}; and

28
29 Whereas, Many genetic markers associated with a given trait or disease are used for the
30 determination of genetic risk for said trait or disease through a method called polygenic risk
31 scores (PRS) through the use of GWAS data⁷; and

32
33 Whereas, The ability of PRS to accurately assess genetic risk for disease within the general
34 population depends on the diversity of the subjects used for generating the PRS²; and

35
36 Whereas, PRS generated using genetic data from one specific genetic ancestry population have
37 been shown to be less accurate for a different genetic ancestry population^{8,9}; and

38
39 Whereas, PRS has the potential to be used as a screening tool for a variety of diseases
40 including cancer, diabetes, cardiovascular disease, and mental health disorders as part of
41 preventive care¹⁰; and

42
43 Whereas, PRSs have been shown to identify 10-20 times as many individuals at risk of coronary
44 artery disease compared to monogenic variants which may better capture patients who may
45 benefit from lipid-lowering therapy¹¹; and

46
47 Whereas, Failure to account for genetic differences in pharmaceutical studies can lead to
48 adverse health outcomes; As an example, in 2008 in Sub-Saharan Africa failure to account for
49 G6PD-mutations led to withdrawal of antimalarial chloroquine-dapsone²; and

50
51 Whereas, Lack of a diversified population in genomic studies of hypertrophic cardiomyopathy

1 misclassified a variant in African-Americans as pathogenic due to the allele's rarity in the
2 majority White populations studied^{15,16}; and

3
4 Whereas, Systematic review has demonstrated that certain ethnicities and races did not
5 participate in genetics studies due to decreased understanding of genetics and a lack of
6 knowledge about genomic studies, though were willing to participate when this barrier was
7 addressed¹⁶; and

8
9 Whereas, The exclusion of certain allelic variants in research poses a large public health
10 burden, and may lead to increased adverse outcomes and therefore potential for increased
11 costs^{16,18}; and

12 Whereas, The NIH National Human Research Genome Institute requires funded clinical sites to
13 enroll a minimum of 60% participants of non-European ancestry, medically underserved
14 populations, or populations who experience poorer health outcomes¹⁷; and

15
16 Whereas, The NIH National Human Research Genome Institute uses many pragmatic clinical
17 trial designs to build its structural evidence base, which exclude patients who lack insurance or
18 Medicaid coverage¹⁷; and

19
20 Whereas, The NIH All of Us Research Program aims to accelerate health research through
21 addressing the need for diversity, though still lacks inclusion of certain demographics in their
22 study, including gender identity and education status¹⁹; and

23
24 Whereas, Disadvantaged populations face unique barriers in participating in research studies,
25 including language discordance, lack of trust in the healthcare establishment, financial burden,
26 low literacy, lack of transportation, and lack of information²⁰; and

27
28 Whereas, AMA policy H-65.952 “recognizes racism, in its systemic, cultural, interpersonal, and
29 other forms, as a serious threat to public health, to the advancement of health equity, and a barrier
30 to appropriate medical care and states “our AMA will work to prevent and combat the
31 influences of racism and bias in innovative health technologies”; and

32
33 Whereas AMA policy D-350.981 recognizes the dangers of racial essentialism in medicine,
34 states they “will collaborate with appropriate stakeholders and content experts to develop
35 recommendations on how to interpret or improve clinical algorithms that currently include race-
36 based correction factors” and “support research that promotes anti-racism strategies to mitigate
37 algorithmic bias in medicine”; and

38
39 Whereas, AMA policy H-65.953 “recognizes that race is a social construct and is distinct from
40 ethnicity, genetic ancestry, or biology”, “supports ending the practice of using race as a proxy for
41 biology or genetics in medical education, research, and clinical practice”, “encourages
42 governmental agencies and nongovernmental organizations to increase funding for research
43 into the epidemiology of risks and damages related to racism and how to prevent or repair them.”,
44 and “recommends that clinicians and researchers focus on genetics and biology, the
45 experience of racism, and social determinants of health, and not race, when describing risk
46 factors for disease”, but does not acknowledge the importance of diversity in genetic research;
47 and

48
49 Whereas, AMA policy H-460.911 supports increasing minority, female, and other
50 underrepresented group participation in clinical trials; and

51

1 Whereas, AMA policy H-480.944 supports research and open discourse in medical genetics;
2 therefore be it

3 4 **FURTHER DISCUSSION**

5
6 Resolution 043 is well written on an important topic to further equity in medical and basic
7 science research. The spirit of the resolution is strongly supported, however, there are current
8 efforts to advance this cause. The federally funded research group H3Africa focuses on the vast
9 genetic diversity in the African continent, which is specifically mentioned as a gap in genetic
10 research equity in the resolution²¹. Additionally, the goal of the NIH All of Us project is to create
11 a diverse health database including people from all races, ethnicities, genders, sexes, sexual
12 orientations, and economic backgrounds to determine disease risk factors more accurately²².
13 This project also looks to gather data for precision medicine in which treatments are catered to
14 patients based on genetics, environment, and other personalized information²³. As of July 2019
15 there were 230,000 participants with the goal of reaching 1 million participants by 2024²⁴. Within
16 this group 51% of participants were non-white and 80% of participants fell into an
17 underrepresented group²⁴. Due to this, we regretfully feel the passage of the resolution would
18 not meaningfully advance advocacy.

19 20 **CURRENT AMA POLICY & EFFORTS**

21
22 Current AMA policy has demonstrated dedication in distinguishing race, a social construct
23 category, from inherent biological traits or genetic ancestry (D-350.981, H-65.953). The AMA
24 recommends that clinicians and researchers focus on genetics when describing risk factors for
25 disease (H-65.953). The AMA supports the representation of underrepresented groups,
26 including Black Individuals/African Americans, Hispanics, Asians/Pacific Islanders/Native
27 Hawaiians, and Native Americans in clinical trials through increased recruitment efforts and trial
28 accessibility (H-460.911). Through two reports (*REPORT 3 of the COUNCIL on SCIENCE and*
29 *PUBLIC HEALTH (A-16) The Precision Medicine Initiative (Reference Committee E); JOINT*
30 *REPORT of the COUNCIL on MEDICAL SERVICE and the COUNCIL on SCIENCE and*
31 *PUBLIC HEALTH (I-17) Payment and Coverage for Genetic/Genomic Precision Medicine*
32 *(Reference Committee J)*), the AMA has demonstrated dedication to supporting the collection of
33 genetic data with the goal of improving precision-based medicine, defined as “prevention and
34 treatment that takes into account individual variations in genes, environment, and lifestyle”.
35 Understanding “individual variations in genes” can be accomplished by focusing on recruiting
36 individuals from underrepresented genetic ancestry groups in genetic research studies to
37 strengthen the research data repository. The AMA has placed efforts towards this goal through
38 its support of the Precision Medicine Initiative, which is now called the All of Us initiative, to
39 increase patient recruitment and participation by improving awareness of the initiative.
40 Regarding uncertainties on how to regulate genetic/genomic testing in relation to payment and
41 coverage policies, which can potentially present as a barrier to patient access to life-altering
42 care, “the AMA, in collaboration with several national medical specialty societies, has developed
43 legislative principles to guide its advocacy efforts in this arena.”

44 The asks of the proposed resolution expand on D-460.976, which acknowledges the need to
45 personalize healthcare through genetics and molecular medicine to create a stronger focus on
46 prospective care models. Additionally, as mentioned previously, two reports have discussed
47 AMA’s focus and activity in regards to obtaining genetic, environmental, and lifestyle data with
48 the goal of improving precision-based medicine. Due to AMA’s ongoing advocacy and
49 involvement in the All of Us initiative, further AMA advocacy on this issue would unlikely result in
50 meaningful change.

1 **CONCLUSION**

2
3 Based on our review of the evidence in the resolution provided above, we discovered that
4 competent healthcare interpreters are essential for improving current healthcare environments
5 by facilitating effective communication, ameliorating patient satisfaction, diminishing medical
6 expenses, and advancing positive health outcomes. Both limited English proficiency and low
7 health literacy pose challenges to accomplishing optimal health management during clinical
8 interventions, the existing discrepancy in medical material reliability levels depicts additional
9 impediments for individuals to grasp and access medical information. Individuals can benefit
10 from employing qualified interpreter workforces and achieve equity in their healthcare, through
11 competent training processes and enhanced collaborative research efforts, including IRB and
12 institutional assistance. While the AMA has a strong policy to advocate equitable practices in
13 healthcare, the policies feature restricted inclusion of LEP individuals in medical and clinical
14 research, as well as in terms of practical clinical settings. Therefore, the resolution is presented
15 to ensure all people, particularly those with LEP, have equitable access to comprehend their
16 medical information, promote research, and eventually lead to better health outcomes.

17
18 **RECOMMENDATION**

19
20 Your Minority Issues Committee, Committee on Scientific Issues, and the Committee on
21 American Indian Affairs recommend that the following recommendations be *adopted in lieu of*
22 **Resolution 028**, The Use of Language Interpreters in Medical and Clinical Research, and the
23 remainder of this report be filed:

- 24
25 1. RESOLVED, Our AMA supports the use of language interpreters and translators in
26 clinical and medical research participation to promote equitable data collection and
27 outcomes; and be it further
28 2. RESOLVED, That our AMA encourages all Institutional and Research Review Boards to
29 develop and publish transparent guidance on the enrollment of medical and clinical
30 research participants with Limited English Proficiency and provide recommendations for
31 interpreter services that meet their requirements; and be it further
32 3. RESOLVED, That our AMA advocate for the Department of Health and Human Services
33 and Office for Human Research Protections (OHRP) to update their guidance on
34 “Informed Consent of Subjects Who Do Not Speak English (1995)” encourage the
35 creation of a federal standard upon which individual IRBs may base recommendations;
36 and be it further
37

38 Your Minority Issues Committee, Committee on Scientific Issues, and the Committee on
39 American Indian Affairs recommend that **Resolution 043**, Support for Increased Diversity in
40 Genetic Research, *not be adopted*, and the remainder of this report be filed.

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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.
2. Our AMA recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care.
3. Our AMA encourages the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of: (a) the causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism; and (b) how to prevent and ameliorate the health effects of racism.
4. Our AMA: (a) supports the development of policy to combat racism and its effects; and (b) encourages governmental agencies and nongovernmental organizations to increase funding for research into the epidemiology of risks and damages related to racism and how to prevent or repair them.
5. Our AMA will work to prevent and combat the influences of racism and bias in innovative health technologies.

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

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 results 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-460.911 Increasing Minority, Female, and other Underrepresented Group Participation in Clinical Research

1. Our AMA advocates that:

a. The Food and Drug Administration (FDA) and National Institutes of Health (NIH) conduct annual surveillance of clinical trials by gender, race, and ethnicity, including consideration of pediatric and elderly populations, to determine if proportionate representation of women and minorities are maintained in terms of enrollment and retention. This surveillance effort should be modeled after National Institute of Health guidelines on the inclusion of women and minority populations. b. The FDA have a page on its web site that details the prevalence of minorities and women in its clinical trials and its efforts to increase their enrollment and participation in this research; and c. Resources be provided to community level agencies that work with those minorities, females, and other underrepresented groups who are not proportionately represented in clinical trials to address issues of lack of access, distrust, and lack of patient awareness of the benefits of trials in their health care. These minorities include Black Individuals/African Americans, Hispanics, Asians/Pacific Islanders/Native Hawaiians, and Native Americans.

2. Our AMA recommends the following activities to the FDA in order to ensure proportionate representation of minorities, females, and other underrepresented groups in clinical trials: a. Increased fiscal support for community outreach programs; e.g., culturally relevant community education, community leaders' support, and listening to community's needs; b. Increased outreach to all physicians to encourage recruitment of patients from underrepresented groups in clinical trials; c. Continued education for all physicians and physicians-in-training on clinical trials, subject recruitment, subject safety, and possible expense reimbursements, and that this education encompasses discussion of barriers that currently constrain appropriate recruitment of underrepresented groups and methods for increasing trial accessibility for patients; d. Support for the involvement of minority physicians in the development of partnerships between minority communities and research institutions; and e. Fiscal support for minority, female, and other underrepresented groups recruitment efforts and increasing trial accessibility.

3. Our AMA advocates that specific results of outcomes in all clinical trials, both pre- and post-FDA approval, are to be determined for all subgroups of gender, race and ethnicity, including consideration of pediatric and elderly populations; and that these results are included in publication and/or freely distributed, whether or not subgroup differences exist.

BOT Rep. 4, A-08Reaffirmed: CSAPH Rep. 01, A-18Modified: Res. 016, I-22

H-480.944 Improving Genetic Testing and Counseling Services

Our AMA supports: (1) appropriate utilization of genetic testing, pre- and post-test counseling for patients undergoing genetic testing, and physician preparedness in counseling patients or referring them to qualified genetics specialists; (2) the development and dissemination of guidelines for best practice standards concerning pre- and post-test genetic counseling; and (3) research and open discourse concerning issues in medical genetics, including genetic specialist workforce levels, physician preparedness in the provision of genetic testing and counseling services, and impact of genetic testing and counseling on patient care and outcomes. (Res. 913, I-16)

D-460.976 Genomic and Molecular-based Personalized Health Care

Our AMA will:

(1) continue to recognize the need for possible adaptation of the US healthcare system to prospectively prevent the development of disease by ethically using genomics, proteomics, metabolomics, imaging and other advanced diagnostics, along with standardized informatics tools to develop individual risk assessments and personal health plans;

(2) support studies aimed at determining the viability of prospective care models and measures that will assist in creating a stronger focus on prospective care in the US healthcare system;

(3) support research and discussion regarding the multidimensional ethical issues related to prospective care models, such as genetic testing;

(4) maintain a visible presence in genetics and molecular medicine, including web-based resources and the development of educational materials, to assist in educating physicians about relevant clinical practice issues related to genomics as they develop; and

(5) promote the appropriate use of pharmacogenomics in drug development and clinical trials.

(CSAPH Reaffirmed Rep 01, A-20)

440.116MSS Recognizing the Burden of Rare Disease

AMA-MSS will ask the AMA to: (1) recognize the under-treatment and under-diagnosis of orphan diseases, the burden of costs to health care systems and affected individuals, and the health disparities among patients with orphan diseases; and (2) support efforts to increase awareness of patient registries, to improve diagnostic and genetic tests, and to incentivize drug companies to develop novel therapeutics to better understand and treat orphan diseases. (MSS Amended Res 027, A-22 adopted, MSS RES 190 HOD pending)

Certified Translation and Interpreter Services D-385.957

Our AMA will: (1) work to relieve the burden of the costs associated with translation services implemented under Section 1557 of the Affordable Care Act; and (2) advocate for legislative and/or regulatory changes to require that payers including Medicaid programs and Medicaid managed care plans cover interpreter services and directly pay interpreters for such services, with a progress report at the 2017 Interim Meeting of the AMA House of Delegates.

Use of Language Interpreters in the Context of the Patient-Physician Relationship H-160.924

1. AMA policy is that: (1) further research is necessary on how the use of interpreters--both those who are trained and those who are not--impacts patient care; (b) treating physicians shall respect and assist the patients' choices whether to involve capable family members or friends to provide language assistance that is culturally sensitive and competent, with or without an interpreter who is competent and culturally sensitive; (c) physicians continue to be resourceful in

their use of other appropriate means that can help facilitate communication--including print materials, digital and other electronic or telecommunication services with the understanding, however, of these tools' limitations--to aid Limited English Proficiency (LEP) patients' involvement in meaningful decisions about their care; and (d) physicians cannot be expected to provide and fund these translation services for their patients, as the Department of Health and Human Services' policy guidance currently requires; when trained medical interpreters are needed, the costs of their services shall be paid directly to the interpreters by patients and/or third party payers and physicians shall not be required to participate in payment arrangements.

2. Our AMA recognizes the importance of using medical interpreters as a means of improving quality of care provided to patients with LEP including patients with sensory impairments.

2.1.1 Informed Consent

Informed consent to medical treatment is fundamental in both ethics and law. Patients have the right to receive information and ask questions about recommended treatments so that they can make well-considered decisions about care. Successful communication in the patient-physician relationship fosters trust and supports shared decision making.

The process of informed consent occurs when communication between a patient and physician results in the patient's authorization or agreement to undergo a specific medical intervention. In seeking a patient's informed consent (or the consent of the patient's surrogate if the patient lacks decision-making capacity or declines to participate in making decisions), physicians should:

(a) Assess the patient's ability to understand relevant medical information and the implications of treatment alternatives and to make an independent, voluntary decision.

(b) Present relevant information accurately and sensitively, in keeping with the patient's preferences for receiving medical information. The physician should include information about:

(i) the diagnosis (when known);

(ii) the nature and purpose of recommended interventions;

(iii) the burdens, risks, and expected benefits of all options, including forgoing treatment.

(c) Document the informed consent conversation and the patient's (or surrogate's) decision in the medical record in some manner. When the patient/surrogate has provided specific written consent, the consent form should be included in the record.

In emergencies, when a decision must be made urgently, the patient is not able to participate in decision making, and the patient's surrogate is not available, physicians may initiate treatment without prior informed consent. In such situations, the physician should inform the patient/surrogate at the earliest opportunity and obtain consent for ongoing treatment in keeping with these guidelines.

7.1.2 Informed Consent in Research

Informed consent is an essential safeguard in research. The obligation to obtain informed consent arises out of respect for persons and a desire to respect the autonomy of the individual deciding whether to volunteer to participate in biomedical or health research.

For these reasons, no person may be used as a subject in research against his or her will.

Physicians must ensure that the participant (or legally authorized representative) has given voluntary, informed consent before enrolling a prospective participant in a research protocol.

With certain exceptions, to be valid, informed consent requires that the individual have the capacity to provide consent and have sufficient understanding of the subject matter involved to form a decision. The individual's consent must also be voluntary.

A valid consent process includes:

(a) Ascertaining that the individual has decision-making capacity.

(b) Reviewing the process and any materials to ensure that it is understandable to the study population.

(c) Disclosing:

- (i) the nature of the experimental drug(s), device(s), or procedure(s) to be used in the research;
- (ii) any conflicts of interest relating to the research, in keeping with ethics guidance;
- (iii) any known risks or foreseeable hazards, including pain or discomfort that the participant might experience;
- (iv) the likelihood of therapeutic or other direct benefit for the participant;
- (v) that there are alternative courses of action open to the participant, including choosing standard or no treatment instead of participating in the study;
- (vi) the nature of the research plan and implications for the participant;
- (vii) the differences between the physician's responsibilities as a researcher and as the patient's treating physician.

(d) Answering questions the prospective participant has.

(e) Refraining from persuading the individual to enroll.

(f) Avoiding encouraging unrealistic expectations.

(g) Documenting the individual's voluntary consent to participate.

Participation in research by minors or other individuals who lack decision-making capacity is permissible in limited circumstances when:

(h) Consent is given by the individual's legally authorized representative, under circumstances in which informed and prudent adults would reasonably be expected to volunteer themselves or their children in research.

(i) The participant gives his or her assent to participation, where possible. Physicians should respect the refusal of an individual who lacks decision-making capacity.

(j) There is potential for the individual to benefit from the study.

In certain situations, with special safeguards in keeping with ethics guidance, the obligation to obtain informed consent may be waived in research on emergency interventions.

Informed Consent and Decision-Making in Health Care H-140.989

(1) Health care professionals should inform patients or their surrogates of their clinical impression or diagnosis; alternative treatments and consequences of treatments, including the consequence of no treatment; and recommendations for treatment. Full disclosure is appropriate in all cases, except in rare situations in which such information would, in the opinion of the health care professional, cause serious harm to the patient.

(2) Individuals should, at their own option, provide instructions regarding their wishes in the event of their incapacity. Individuals may also wish to designate a surrogate decision-maker. When a patient is incapable of making health care decisions, such decisions should be made by a surrogate acting pursuant to the previously expressed wishes of the patient, and when such wishes are not known or ascertainable, the surrogate should act in the best interests of the patient.

(3) A patient's health record should include sufficient information for another health care professional to assess previous treatment, to ensure continuity of care, and to avoid unnecessary or inappropriate tests or therapy.

(4) Conflicts between a patient's right to privacy and a third party's need to know should be resolved in favor of patient privacy, except where that would result in serious health hazard or harm to the patient or others.

(5) Holders of health record information should be held responsible for reasonable security measures through their respective licensing laws. Third parties that are granted access to patient health care information should be held responsible for reasonable security measures and should be subject to sanctions when confidentiality is breached.

(6) A patient should have access to the information in his or her health record, except for that information which, in the opinion of the health care professional, would cause harm to the patient or to other people.

(7) Disclosures of health information about a patient to a third party may only be made upon consent by the patient or the patient's lawfully authorized nominee, except in those

cases in which the third party has a legal or predetermined right to gain access to such information.

Support for Standardized Interpreter Training D-300.976

Our AMA: (1) encourages physicians and physicians in training to improve interpreter-use skills and increase education through publicly available resources such as the American Association of Medical College's "Guidelines for Use of Medical Interpreter Services"; and (2) will 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, and other relevant stakeholders to develop a cohesive Continuing Medical Education module offered through the AMA Ed Hub for physicians to effectively and appropriately use interpreter services to ensure optimal patient care.

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REPORT OF THE MEDICAL STUDENT SECTION
WOMEN IN MEDICINE COMMITTEE
COMMITTEE ON LEGISLATION & ADVOCACY
COMMITTEE ON LGBTQ+ AFFAIRS

WIM COLA LGBTQ+ Report A
(A-24)

Introduced by: MSS Committees on Women in Medicine Committee (WIM), Committee on Legislation & Advocacy (COLA), and Committee on LGBTQ+ Affairs (LGBTQ+)

Subject: Addressing Gender-Based Disparities on Health-Related Consumer Goods (The Pink Tax)

Referred to: MSS Reference Committee
(Caitlin Blaukovitch and Shaminy Manoranjithan, Co-Chairs)

1 **INTRODUCTION**

2
3 At the Annual 2023 (A-23) MSS Assembly, MSS Resolution 049, "Addressing Gender-Based
4 Disparities on Health-Related Consumer Goods (The Pink Tax)", asked the AMA to recognize
5 and address price differences in health-related consumer goods based on the gender of the
6 consumers. The resolution, with the following resolved clauses, was referred for study:

7
8 RESOLVED, That our AMA recognizes the existence of a gender-based disparity in
9 health-related consumer goods; and be it further

10
11 RESOLVED, That our AMA will work with state medical societies to raise awareness of
12 substantially similar health-related products that are priced differently based on the
13 gender of the consumers and advocate for further regional study of this disparity.

14
15 The MSS Reference Committee recommended referral of the resolution with the following
16 rationale:

17
18 VRC testimony was mixed. Your Reference Committee agrees with testimony that the
19 evidence presented to support the gender-based disparity in healthcare goods is
20 insufficient and outdated. Your Reference Committee recommends referral to strengthen
21 the evidence for gender-based disparities specifically in healthcare goods, the effect of
22 this disparity on health outcomes, and further clarify the AMA's role in addressing this
23 issue. We recommend that our MSS standing committees study the following questions
24 1.) Is this resolution feasible? 2.) Are the asks of this resolution within the scope of the
25 AMA? Your Reference Committee recommends Resolution 049 be referred.

26
27 During the MSS Assembly, the item was extracted by authors and the following discussion took
28 place. Most testimony supported referral to clarify language and strengthen evidence. The
29 assembly voted to agree with the MSS Reference Committee decision to refer.

30
31 Your Governing Council assigned this report to the Women in Medicine Committee (WIM),
32 Committee on Legislation & Advocacy (COLA), and Committee on LGBTQ+ Affairs (LGBTQ+),
33 with the following possible questions for consideration:

- 1) Is this resolution feasible?
- 2) Is this resolution within the scope of the AMA?

In the following whereas clauses and subsequent discussion, we sought to define gender-based pricing disparities, and detail ways in which they specifically impact healthcare.

WHEREAS CLAUSES

Whereas, gender based pricing discrimination involves the practice of segmentation of similar products, including personal care products, clothing, and health insurance, by gender such that female products are often priced at a higher rate^{1,2}; and

Whereas, current research on gender disparities centers a gender binary despite the reality that gender is a social construct, thereby excluding many individuals who may be targets of pricing disparities³⁻⁶;

Whereas, up to 80% of consumer based products are segmented by gender, with female targeted products costing up to 7% more than male targeted products^{1,7}; and

Whereas, the 2015 New York City Department of Consumer Affairs study found that products marketed as “women’s products” were more than twice as likely to be priced higher than men’s products, with senior home health care products (i.e. supports, braces, canes and adult diapers) marketed towards women being priced 8% higher than those marketed towards men and the largest price disparity being 13% for personal care products (i.e. deodorants, body wash and razors)⁸; and

Whereas, a 2018 U.S. Government Accountability Office investigation on gender-based price differences found that deodorants, shaving creams, and disposable razor blades targeted towards female consumers had higher prices compared to similar products advertised toward male consumers⁹⁻¹¹; and

Whereas, a 2017 JAMA Dermatology study found that Minoxidil prescriptions were priced significantly more per volume for female patients compared to male patients¹²; and

Whereas, facial moisturizers marketed towards female consumers were on average \$3.09 more per ounce than moisturizers marketed towards male consumers, despite no significant differences in the products’ targeted skin-concerns¹³; and

Whereas, the gender pay gap, the median hourly earnings of women compared to men, has remained stable over the past two decades with women earning an average of 82% of what men earned¹⁴⁻¹⁹; and

Whereas, married and partnered couples headed by women have less median income than men, and one of the factors contributing to this gender wealth gap in female-led households is a lifetime accumulation of lower earnings compared to men²⁰⁻²²; and

Whereas, the gender pay gap differs widely by race and ethnicity with black women earning 70-80% of what white men earned and hispanic women earning 65-79% of what white men earned, in 2022¹⁷; and

1 Whereas, household gender structure, income, race, and education level are related to net
2 worth and as such, female-headed households, the majority of which (~54%) are led by non-
3 white females, perform the worst with regards to assets accumulation²³; and
4

5 Whereas, although women default less frequently on mortgages, women may pay higher
6 mortgage rates than men relative to their default risk^{10,11}; and
7

8 Whereas, not only do women spend more than 15 billion dollars annually more than men on
9 healthcare costs, but women also paid 18% more on average for out-of-pocket medical
10 expenses than men despite having similar insurance coverage²⁴; and
11

12 Whereas, studies have shown that older women are disproportionately affected by Medicare
13 due to gaps in coverage for long-term-care services and higher out of pocket expenses, with
14 2010 healthcare spending, including premiums, averaging \$5,036 for older women compared to
15 \$4,363 for older men²⁵; and
16

17 Whereas, feminine hygiene products are a necessity, and past efforts have made these
18 products tax-exempt in 24 states, but many women still pay taxes ranging from 4-7% on
19 menstrual products, and lack of affordable access to menstrual products increases exposure to
20 health risks such as urinary tract infection, thrush, and mental health disorders such as
21 depression and anxiety²⁶⁻³¹; and
22

23 Whereas, the compounding effects of increasing wage gap, gender pricing disparities, and sole
24 household income earners result negative overall effects on health and quality of life as women
25 are up to four times more likely to experience depression and anxiety³²⁻³⁵; and
26

27 Whereas, psychological and financial stress is associated with increased risk for chronic
28 conditions, including cardiovascular disease and Alzheimer's disease³⁶⁻⁴⁰; and
29

30 Whereas, a 2022 study found that financial stress affected metabolic outcomes in male and
31 female patients differently, with male patients demonstrating higher prevalence of
32 triglyceridemia and female patients demonstrating a broader range of metabolic abnormalities
33 including prediabetes, abdominal obesity, metabolic syndrome, and dyslipidemia³⁹; and
34

35 Whereas, minimizing pricing disparities and the wage gap would decrease the rate of major
36 depressive disorder and generalized anxiety disorders in populations affected by these
37 disparities⁴¹⁻⁴⁵; and
38

39 Whereas, local legislations, such as Miami-Dade County and New York City, New York, and
40 state legislations, such as Vermont, and California, have laws prohibiting price discrimination
41 based upon a person's gender, but these vary in their application to goods and services^{11,31}; and
42

43 Whereas, The Pink Tax Repeal Act, seeking to prohibit manufacturers from selling similar
44 products at different prices based on the gender of the intended purchaser, has been introduced
45 several times, most recently to the House in 2021, but has never passed⁴⁶; and
46

47 Whereas, while the AMA has several policies considering feminine hygiene products as tax
48 exempt, medical necessities that need increased access for individuals who use them (H-
49 525.974, H-270.953, H-525.973), existing AMA policy does not address comprehensive gender-
50 based disparities; and therefore be it
51

52 **CONCLUSION**

1
2 We highlight the already existent and worsening gender wealth gaps, continuing differences in
3 pricing in everyday living, and most importantly, the segmentation of pricing within healthcare-
4 related goods and services, thereby further widening the wealth gap. As detailed in our report,
5 there is evidence of increased cost disproportionately affecting female consumers, even in the
6 healthcare setting. While our AMA has strong policy regarding disparate taxes on menstrual
7 products, there is a lack of policy addressing other gender-based pricing disparities. With
8 increased evidence and a focus on the role gender-based pricing disparities play in healthcare
9 settings and products, we came to the conclusion that the AMA should have additional policy
10 supporting efforts to minimize this practice.

11 12 **RECOMMENDATION**

13
14 Your Women in Medicine Committee, Committee on Legislation & Advocacy, and Committee on
15 LGBTQ+ Affairs, recommend(s) that the following recommendation is adopted in lieu of
16 Resolution 049 and the remainder of this report be filed:

17
18 RESOLVED, that our American Medical Association support federal and state efforts to
19 minimize gender-based pricing disparities.

20 21 **ACKNOWLEDGEMENTS**

22
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RELEVANT AMA POLICY

Considering Feminine Hygiene Products as Medical Necessities H-525.974

Our AMA: (1) encourages the Internal Revenue Service to classify feminine hygiene products as medical necessities; (2) will 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; and (3) encourages the American National Standards Institute, the Occupational Safety and Health Administration, and other relevant stakeholders to establish and enforce a standard of practice for providing free, readily available menstrual care products to meet the needs of workers.

Tax Exemptions for Feminine Hygiene Products H-270.953

Our AMA supports legislation to remove all sales tax on feminine hygiene products.

Increasing Access to Hygiene and Menstrual Products H-525.973

Our AMA: (1) recognizes the adverse physical and mental health consequences of limited access to menstrual products for school-aged individuals; (2) supports the inclusion of medically necessary hygiene products, including, but not limited to, menstrual hygiene products and diapers, within the benefits covered by appropriate public assistance programs; (3) will advocate for federal legislation and work with state medical societies to increase access to menstrual hygiene products, especially for recipients of public assistance; and (4) encourages public and private institutions as well as places of work and education to provide free, readily available menstrual care products to workers, patrons, and students.

RELEVANT AMA ACTIONS

Comment Letter to IRS (October 9, 2018)

On behalf of the physician and medical student members of the American Medical Association (AMA), I am writing to encourage the Internal Revenue Service (IRS) to classify menstrual care products as a qualifying medical expense so that these products may be eligible for reimbursement with a flexible spending account (FSA), health savings account (HSA), or other tax-preferred accounts.

Comment Letter to U.S. House of Representatives (April 29, 2022)

On behalf of the physician and medical student members of the American Medical Association (AMA), I am writing to express the AMA's support for H.R. 3614, the "Menstrual Equity for All Act of 2021." This legislation would help assist women and girls, especially among historically underserved and marginalized populations, with obtaining needed menstrual products, including tampons, pads, liners, and other similar products. Menstrual products are a necessity each month for millions of individuals across the United States, yet studies have shown that one in four women and girls reports struggling to afford menstrual products—often referred to as "period poverty"—and one in 10 college students in the U.S. is affected by period poverty. As part of the bill's comprehensive, multifaceted approach, the AMA is particularly supportive of the following critically needed provisions that would help to alleviate period poverty:

- Incentivizing colleges and universities to implement pilot programs that provide free menstrual products to students;
- Giving states the option to use federal grant funds, which already provide funding for health and wellness efforts, to provide students with free menstrual products in schools;
- Requiring Medicaid to cover the cost of menstrual products;
- Allowing homeless assistance providers to use grant funds that cover shelter necessities (such as blankets and toothbrushes) to also use that money to purchase menstrual products;
- Ensuring that incarcerated individuals and detainees in federal (including immigration detention centers), state, and local facilities have access to free menstrual products, including requiring guidance on distribution; and
- Requiring all public federal buildings, including buildings in the U.S. Capitol complex, to provide free menstrual products in restrooms.

Why stigma prevents treating menstrual hygiene as essential (December 16, 2020)

RELEVANT AMA-MSS POSITIONS

65.055 MSS Including Gender Inclusive Language in Menstrual Healthcare

AMA-MSS (1) supports gender-neutral language with regards to reproductive rights including but not limited to menstrual products in medical education, clinical training, and clinical practice; (2) supports training for healthcare providers that includes de-gendered language and inclusivity for various period products to better understand the needs of all persons who menstruate; and (3) administratively amends existing MSS policy which includes mention of “feminine hygiene products,” namely 160.032MSS, 525.008MSS, 525.009MSS, and 525.015MSS, to replace the phrase “feminine hygiene” with “menstrual.” (MSS Res. 0287, I-22)

525.015 MSS Providing Widespread Access to Menstrual Products

(1) Our AMA-MSS will ask the AMA to encourage public and private institutions as well as places of work to provide free, readily available menstrual care products to workers and patrons. (2) Our AMA-MSS will ask the AMA to amend policy H-525.974, “Considering Feminine Hygiene Products as Medical Necessities,” as follows: 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.; and (3) the Occupational Safety and Health Administration, and other relevant stakeholders to establish and enforce a standard of practice for providing free, readily available menstrual care products to meet the needs of workers. (MSS Res. 106, Nov. 2020) (AMA Res. 209, I-21, Adopted [H-525.973])

525.011 MSS 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)

525.009 MSS Improving Transparency in Ingredient Lists for Cosmetic and Menstrual Hygiene Products

AMA-MSS 1) supports improved consumer reporting of ingredients that may be harmful in cosmetic and menstrual hygiene products; and (2) supports health professionals in counseling patients about the known risks of toxic ingredients in beauty and personal care products, including menstrual hygiene products. (MSS Res 27, I-17) (Amended: MSS GC Report A, A-23)

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)

60.031MSS Increasing Access to Menstrual Hygiene Products in School Settings

AMA-MSS will ask the AMA to (1) recognize the adverse physical and mental health consequences of limited access to menstrual products for school-aged individuals and (2) support the distribution of menstrual products and inclusion of menstrual product disposal systems in education institutions. (MSS Res. 41, I-19) (AMA Res. 209, I-21, Adopted [H525.973])

160.032MSS Menstrual Products

Our AMA-MSS supports the distribution of readily available menstrual products in publicly funded institutions, including but not limited to schools, correctional facilities and shelters. (MSS Res 17, I-16) (Reaffirmed: MSS GC Report A, I-21)

525.008MSS Improved Accessibility of Menstrual Products for Incarcerated and Socioeconomically Disadvantaged Woman

AMA-MSS will ask the AMA to (1) classify, and encourage the Internal Revenue Service to classify, menstrual hygiene products as medical necessities; (2) support Flexible Spending Account, Health Savings Account, and Health Reimbursement Arrangement reimbursement of menstrual hygiene products; and (3) support consistent and ready access of menstrual hygiene products across all publicly funded institutions, including but not limited to housing units utilized by previously incarcerated and socioeconomically disadvantaged individuals. (MSS Res 50-I-17) (Amended: MSS GC Report A, A-23)

525.016MSS Inclusion of Hygiene Products in Supplemental Nutrition Programs

AMA-MSS will ask the AMA to: (1) support the inclusion of medically necessary hygiene products including, but not limited to menstrual hygiene products and diapers, within the benefits covered by appropriate public assistance programs; (2) advocate for federal legislation that increases access to menstrual hygiene products, especially for recipients of public assistance; and (3) work with state medical societies to advocate for state legislation that increases access to menstrual hygiene products, especially for recipients of public assistance. (MSS Res. 044, A-21) (AMA Res. 209, I-21, Adopt [H-525.973])

REPORT OF THE MEDICAL STUDENT SECTION
GOVERNING COUNCIL

MSS GC Report B
(A-24)

Introduced by: Natasha Topolski, MSS Chair
Subject: Medical Student Section Action Item (MSSAI) Report
Referred to: MSS Reference Committee
(Caitlin Blaukovitch and Shaminy Manoranjithan, Co-Chairs, Co-Chairs)

1 **DISCUSSION**

2
3 Pursuant to 645.031MSS outlined below, the following informational report details the actions
4 taken by your Medical Student Section (MSS) Governing Council (GC) in response to submitted
5 Medical Student Section Action Items (MSSAIs).

6
7 **MSS Action Items 645.031MSS**

8 A list of all MSS Action Items received during the period between MSS national meetings
9 will be included in the Meeting Handbook as official MSS Actions, along with their
10 implementation status. Additionally, the MSS should create an opportunity for the
11 Governing Council to discuss MSS Action Item implementation status with interested
12 students.

13
14 The MSS GC aims to ensure that member voices are heard throughout the MSS and provides
15 the [Medical Student Section Action Item Request Form](#) to allow any member to submit ideas or
16 concerns they would like to be addressed by the MSS GC. Upon receipt of an MSSAI, the MSS
17 GC will meet to discuss the request and respond to the author individually with the course of
18 action to be taken in response to their submission. The status of all MSSAIs that have been
19 submitted since the Interim 2023 meeting are detailed in the report below. The status of MSSAIs
20 submitted prior to the Interim 2023 meeting can be found in the [MSSAI Digest](#) located on the
21 Medical Student Section Action Item Request Form webpage linked above. In addition, if there
22 are significant updates to any of the unfulfilled MSSAIs or additional MSSAIs are submitted
23 between the finalization of this report and the Annual Meeting, they may be linked on the website
24 as well. As a reminder, all members are welcome to reach out to the MSS Chair or MSS Staff to
25 inquire about the status of any MSSAI.

26
27 There were 14 MSSAIs submitted between October 2023 and March 2024 when this report was
28 finalized.

29
30 **MSSAI Title: AMA Litigation Center Action Regarding PFAS**

31
32 **Action Requested:** The AMA passed the strong explicit policy [H-135.916 Per- and](#)
33 [Polyfluoroalkyl Substances \(PFAS\) and Human Health](#) at I-19. The EPA has given multiple

34 orders to attempt to regulate a plastics company's use of manufacturing procedures that
35 were found to create PFAS as byproducts. On March 22, a three-judge panel of the 5th
36 U.S. Circuit Court of Appeals ruled against the EPA. We ask that the AMA Litigation Center
37 engage in this case as it continues through appellate processes on the basis of our AMA
38 policy, such as authoring or signing onto an amicus brief.
39

40 We would also like to inquire via the appropriate AMA channels (AMA leadership and staff)
41 whether the Medical Society Consortium on Climate and Health (of which the AMA is a
42 member) is engaged with this case to act on other ways the AMA can be involved in this.
43

44 **GC Response:** Staff forwarded this request to the Litigation Center, who said this case
45 had not previously been on their radar. After further review, the Litigation Center
46 determined that they did not feel it was appropriate to file a brief at this time, as they would
47 like to see what action the EPA takes, including whether it decides to seek review by the
48 United States Supreme Court. However, the Litigation Center communicated that they
49 would actively monitor this docket moving forward. The GC is currently in the process of
50 inquiring whether the Medical Society Consortium on Climate and Health is involved and
51 if there are other avenues to engage.
52

53 *Submitted: 03/29/24*
54

55 **MSSAI Title: *AMA Stance on DEI in Medicine***

56
57 **Action Requested:** A bill proposed by urologist/representative Greg Murphy would ban
58 DEI in medical school (by preventing them access to federal funding) via [the EDUCATE](#)
59 [Act](#). AMA should put out a statement in response to this as the NMA has.
60

61 **GC Response:** The GC reached out to AMA Advocacy staff to request a statement. In
62 response to MSS and other parties that reached out, the AMA released the following
63 [statement](#) with 11 other organizations generally stating our commitment to DEI but leaving
64 out any specific mention of the bill or its sponsor, Rep Greg Murphy, MD from North
65 Carolina. GC is in discussion with the Resident & Fellow Section (RFS) and other Sections
66 regarding a response to the statement and requests to the Board for more active and
67 explicit engagement on this bill, including with the sponsors.
68

69 *Submitted: 03/22/24*
70

71 **MSSAI Title: *Supporting Protections in Homeless Shelters***

72
73 **Action Requested:** Encourage the AMA BOT to write a letter to the United States
74 Department of Housing and Urban Development to encourage implementation of shelter-
75 based care, and expansion of funds in the Emergency Solutions Grant (ESG) for
76 availability to homeless shelters.
77

78 **GC Response:** The GC contacted the author to identify current bills that the AMA could
79 potentially comment on regarding these issues. The author identified ([H.R.4941: Providing](#)
80 [Access to Treatment and Housing \(PATH\) Act of 2023](#) and [H.R.5254: Housing for All Act](#)

81 [of 2023](#). This information was elevated to AMA Advocacy staff and we are awaiting a
82 response regarding feasibility and potential next steps.

83
84 *Submitted: 02/24/24*

85
86 **MSSAI Title: *Shifting Towards Active Wheelchair Symbol***

87
88 **Action Requested:** Bring awareness of the active wheelchair symbol by working with the
89 Board of Trustees and/or recently formed Advisory Committee on Disability Affairs to
90 request that the U.S. Access Board and International Organization for Standardization
91 consider endorsing the use of the updated New York Dynamic Wheelchair Symbol Sign.

92
93 **GC Response:** The GC consulted with AMA Staff including the Center for Health Equity
94 to The AMA Disability Advisory Group will not convene until after the Annual meeting.
95 Given this, the GC consulted with AMA Staff including the Center for Health Equity to
96 solicit input on the request. Staff from the Center for Health Equity provided feedback on
97 considerations that should be taken when implementing use of such a symbol, such as
98 use of multiple symbols to ensure compliance with multiple sets of federal, state, or local
99 requirements. Once the Disability Advisory Group has officially convened, the GC will send
100 the request for their consideration along with the feedback from the Center for Health
101 Equity.

102
103 *Submitted: 02/20/24*

104
105 **MSSAI Title: *Tuition and Fee Transparency***

106
107 **Action Requested:** Request that our AMA Board of Trustees and Change MedEd
108 coalition publicize the issue of tuition transparency and ask that medical schools release
109 student-accessible tuition breakdowns.

110
111 **GC Response:** The GC reached out to the AMA Medical Education staff regarding what
112 actions the AMA has previously taken regarding tuition transparency. Staff provided the
113 GC with information on actions taken on AMA. According to the report, while AMA has
114 been active in advocating for decreasing the cost of medical education, particularly
115 regarding loan forgiveness, there have been very few public actions in response to tuition.
116 The last direct action provided to the GC was on [D-305.983](#) where the AMA provided
117 information to medical school, residency program directors, regarding opposition to mid-
118 year and retroactive tuition increases in 2003. Given this, the GC has asked the Medical
119 Education Staff the best way of proceeding with this request and is awaiting next steps.

120
121 *Submitted: 02/04/24*

122
123 **MSSAI Title: *Supporting Article Libraries in Medical School***

124
125 **Action Requested:** Request that The AMA Board of Trustees write a letter to highly
126 accessed journals to request decreased fees for accessing their literature compendium. I
127 would be very open to other avenues to address the issue of increased accessibility to

128 published scholarly research and would appreciate the AMA-MSS GC for their direction
129 on this issue.

130

131 **GC Response:** The GC reached out to the AMA Medical Education staff regarding actions
132 the AMA has taken to promote decreased fees for accessing medical and scientific
133 journals' literature compendium. [H-215.987](#), the AMA policy associated with this ask was
134 originally adopted at A-90 and implementation reports were not readily accessible to staff.
135 Given this, the GC has asked the Medical Education Staff the best way of proceeding with
136 this request and is awaiting next steps.

137

138 *Submitted: 02/04/24*

139

140 **MSSAI Title: *Accessibility of Medical Diagnostic Equipment of State and Local Government***
141 ***Entities***

142

143 **Action Requested:** We ask the AMA to submit a formal public comment supporting this
144 89 FR 2183. Supporting this ruling is crucial for ensuring equal access to healthcare
145 services for individuals with disabilities, preventing delayed or incomplete medical care,
146 and upholding medical ethics.

147

148 **GC Response:** The GC informed the authors about the [public comment](#) sent on behalf of
149 the American Medical Association in support of 89 FR 2183.

150

151 *Submitted: 01/31/24*

152

153 **MSSAI Title: *Person First Language for People Who Are Incarcerated***

154

155 **Action Requested:** RESOLVED: The AMA will revise policies that have not used person
156 first language for people who are incarcerated.

157

158 **GC Response:** This Action Item prompted the production of [GC Report J, "Use of](#)
159 [Inclusive Language in AMA Policy,](#)" which will be presented for debate by the MSS A-24
160 Assembly and addresses this issue in detail with recommendations.

161

162 *Submitted: 01/26/24*

163

164 **MSSAI Title: *Stakeholders in Progressing Residency Application Platforms***

165

166 **Action Requested:** The AMA should draft a letter to APGO and ACOG Division of
167 Education and Academic Affairs:

168 (1) supporting involvement of current and recent residency applicants in development and
169 subsequent changes to Residency Application systems;

170 (2) support the utilization of applicant and recent applicant-directed surveys to be taken
171 into account;

172 (3) to increase the limit (if any) of experiences able to be presented on applications to, at
173 minimum, 15.

174

175 **GC Response:** The GC connected with the American Medical Association Learner
176 Advisory Group (LAG) for the Transforming the [UME to GME transition: Right Resident,
177 Right Program, Ready Day One Reimagining Resident Grant](#) (AMA LAG RRR Grant),
178 which provided funding support and oversaw the development of the new OBGYN
179 residency application (ResidencyCas). The LAG Chair, Bukky Akingbola informed us that
180 the trainee group has been heavily involved in the development and review process and
181 the changes to the process and the application itself bore out of the feedback from the
182 recent applicant survey that is sent out after match each year. Additionally, the GC also
183 was able to connect with Dr. Maya Hammoud, the PI for the AMA LAG RRR Grant who
184 indicated that while the grant is ending, the team absolutely plans to continue to have
185 learner involvement in improving the system year over year.

186
187 Because point 3 is not technically an MSS position, and because comments both for and
188 against the current 10 activity limit in ERAS were heard in our GC discussion, we did not
189 feel comfortable commenting on whether this should or should not apply to ResidencyCas.
190 However, the GC did enquire with Dr. Hammoud about what the current plans were for
191 the experiences section of ResidencyCas and if the team had plans to provide guidance
192 on how to best approach this section. Dr. Hammoud indicated that ResidencyCAS will
193 have a limit of 12 experiences. In addition, there will be another separate section to enter
194 additional 3 non-medical experiences to allow non-traditional applicants or those with non-
195 traditional paths to enter relevant experiences to reflect “distance traveled.” Furthermore,
196 the hobbies and interest section is also separate. Dr. Hammoud also expressed that
197 developers recognize that holistic review must reflect those with non-traditional
198 experiences and will make sure to guide applicants to what is important.

199
200 The GC communicated this information with the author and suggested that they may also
201 want to consider writing a resolution on the topic in a future MSS policy cycle that could
202 be submitted to HOD to ask our AMA to take action, if the MSS Assembly adopts it. The
203 GC will also suggest that they examine other components of the application that could use
204 improvement to better meet applicant needs, such as proposed limitations on the number
205 of research items students can include in their application, and to ensure that the
206 resolution is generalized to all residency and fellowship application systems.

207
208 *Submitted: 01/21/24*

209
210 **MSSAI Title: *Requesting AMA Public Support on the Renewal of the Undetectable Firearms***
211 **Act**

212
213 **Action Requested:** One kind of catch-all message could be to simply urge legislators to
214 support appropriate vehicles for reauthorization of the Undetectable Firearms Act (UFA).
215 Ultimately, when this has been extended on the appropriations bills, the appropriators tend
216 to say that they will follow what leadership says and that, ultimately, the Judiciary
217 Committee Chairs/Ranking Members have jurisdiction over a broader extension.
218 Therefore, it may be beneficial for the AMA to submit a letter to the Judiciary Committee
219 and/or the Appropriations Committee chair/ranking members asking for support on
220 reauthorization of UFA.
221

222 **GC Response:** The GC requested that our MSS Chair, Natasha Topolski, who is also our
223 MSS member on the AMA Firearm Injury Prevention Task Force, ask the Task Force's
224 staff to inquire with Advocacy Staff about submitting a letter to the leadership of the
225 Judiciary Committee and/or the Appropriations Committee in support of reauthorization of
226 the Undetectable Firearms Act. We were informed that they declined due to timing and
227 prioritization. Of note, while the GC was not directly informed of specific reasons the
228 request was deemed lower priority, the bill was expected to be incorporated into the
229 Consolidated Appropriations Act which was due for vote in early March. This Act was also
230 planned to include provisions relating to Medicare payment cuts (the current #1 AMA
231 advocacy priority which was recently called for by the HOD at A-23 through three widely
232 supported resolutions considered together [see [Alternate Resolution 214](#)] resulting in
233 strengthened AMA policy on the topic as seen in [D-385.945](#), [D-390.922](#), [H-390.849](#), and
234 [D-390.946](#)). While we reiterate that the GC is not aware of the exact reasoning, when
235 considering action items, it is important to take into context not just the request at hand
236 but also other political considerations, which can be complicated and multifaceted. Staff
237 said they would continue to monitor this issue and consider future opportunities to weigh
238 in. Ultimately, the Undetectable Firearms Act was [reauthorized through 2031](#) as part of
239 the [Consolidated Appropriations Act](#) without AMA involvement.

240

241

Submitted: 01/19/24

242

243 **MSSAI Title: *Chestfeeding Area on Assembly Floor***

244

245

Action Requested: Dedicated space in which parents could express milk/ or feed their
246 infant/child during conference activities and assembly.

247

248

GC Response: The GC shared the request with AMA staff who are currently investigating
249 feasibility and implementation.

250

251

Submitted: 01/15/24

252

253 **MSSAI Title: *Tribal Public Health Authority***

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255

Action Requested: Ask AMA to work with the South Dakota State Medical Association
256 and the regional Tribal Epidemiology Center and lend its support to developing public
257 data-sharing agreements that respect AMA policies on Tribal Public Health Authority and
258 Indigenous Data Sovereignty.

259

260

GC Response: The GC connected with the [AMA Advocacy Resource Center](#) (ARC) staff
261 which coordinates AMA involvement in state-level advocacy to determine if there was an
262 opportunity to engage with this issue. The ARC staff was able to connect with the [South
263 Dakota State Medical Association](#) (SDMA) who reached out to the South Dakota Secretary
264 of Health who confirmed there is an active data-sharing agreement in place that was
265 signed this spring.

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Submitted: 01/05/24

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269 **MSSAI Title: *Calling for a Ceasefire***

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Action Requested: We urge our American Medical Association (AMA) to align with numerous humanitarian and medical organizations worldwide in urging Congress Members to advocate for the following measures: an immediate ceasefire, the release of all hostages, unrestricted entry of humanitarian assistance into Gaza, the restoration of essential resources such as food, water, electricity, and medical supplies, and a commitment to upholding international law.

We urge the American Medical Association to uphold this culture of generosity and extend support to hospitals and healthcare facilities in Gaza. This can be accomplished through direct donations or by endorsing initiatives such as medical supply drives aimed at replenishing healthcare facilities in the region.

GC Response: The GC elevated the first request to the AMA staff and the AMA Board of Trustees. We were informed by individual Trustees that they did not feel it was appropriate to make additional comments beyond [their November statement made just prior to HOD I-23](#), without new policy created by the AMA HOD. Your GC recognizes that the opportunity to create policy by the HOD was prevented by the resolution not being considered at I-23 and testifiers for the resolution not being able to present their arguments. GC met with the team who submitted the Action Item to discuss future directions and discussed the possibility of asking for a listening session between the Board and physicians advocating to end the violence in Gaza. In response, the GC sent an [official memo](#) to the Board asking for a listening session open to AMA members. Trustees informed us that they felt it would be more appropriate for the issue to be debated in-person at the House of Delegates, where AMA members can openly share their perspectives.

The GC elevated the second request by sending an [official memo](#) through our MSS members on the AMA Foundation Board of Directors. The Foundation said they are not able to provide monetary aid at this time.

Despite these outcomes, your GC remains committed to finding additional opportunities to work with the students who submitted these requests and any other students advocating on this crisis, as well as forwarding other requests as they arise. For example, GC is currently partnering with the MSS Minority Issues Committee to implement their proposal for an educational program at the MSS A-24 Assembly on “War, Violence & Displacement & Their Effects on Population Health”.

Submitted: 12/10/23

MSSAI Title: *Comprehensive Reproductive Health Education in the Preclinical Undergraduate Medical Education Curriculum*

Action Requested: 1) We ask that the Committee on Medical Education (CME) meet and collaborate with relevant stakeholders (e.g. ACOG, APGO, OB-GYN faculty, medical students, medical school deans, etc.) to define comprehensive reproductive health, with

316 explicit mention of contraception and termination of pregnancy, to be used in the context
317 of medical education.

318

319 2) We ask that the CME develop a report using the most updated information available
320 (with results from surveys of medical schools, if deemed necessary) detailing the quantity
321 and content of comprehensive reproductive medical education provided to students in the
322 preclinical curriculum.

323

324 3) We ask that the CME write a letter to the AAMC and formally request that reproductive
325 health topics be added to the AAMC Curriculum Reports, thereby compelling medical
326 schools to disclose the extent of reproductive health education provided during the
327 preclinical undergraduate medical curriculum.

328

329 **GC Response:** The GC determined that this request was generally not within scope for
330 the AMA as our Med Ed staff has expressed that the AMA's purview does not involve
331 direct or specific curricular development or provisions to that effect, aside from general
332 statements of support for other organizations engaging in these efforts. The existing policy
333 does not really give a strong directive for our AMA to take these particular actions, since
334 we are not the best organization for these types of activities.

335

336 Regarding the first action requested, the GC discussed that the AMA generally prefers to
337 leave creation of definitions most pertinent to a specific specialty to the speciality and it is
338 unlikely that the AMA would convene OB-GYN faculty or medical school deans for this
339 purpose. Other organizations whose primary purpose is medical education and specifically
340 curriculum would be better suited to engage in these efforts, especially regarding a
341 particular area of health that requires expertise feedback. However, the AMA Board of
342 Trustees has recently convened a Task Force to Preserve the Patient-Physician
343 Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted (based on
344 AMA Policies [G-605.009](#) and [D-5.998](#)). [You can see their I-23 report on their progress here.](#) The GC will share this request with them to determine if it is something they feel
345 would be within their scope.

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347 Regarding the second action requested, neither our AMA Council nor our MSS Committee
348 necessarily have access to curricular survey data, nor would we be considered the best
349 entities to define "reproductive health."

350

351 Regarding the third action requested, the GC reached out to our AAMC liaison to see what
352 is being done in this space and how/if these requests can be made. The AAMC liaison
353 was not immediately aware and further information is still pending.

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356 *Submitted: 10/21/23*

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358 **RECOMMENDATION**

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360 Your MSS Governing Council recommends GC Report B be filed.

REPORT OF THE MEDICAL STUDENT SECTION DELEGATES

SD Report B
(A-24)

Introduced by: MSS Section Delegates

Subject: Delegate Report B: Policy Proceedings of the Interim 2023 House of Delegates Meeting

Referred to: MSS Reference Committee
(Caitlin Blaukovitch and Shaminy Manoranjithan, Co-Chairs)

1 **INTRODUCTION**

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3 The following informational report details the actions taken by the MSS Caucus at the Interim
4 2023 Meeting of the AMA House of Delegates, pursuant to MSS Internal Operating Procedure
5 (IOP) 9.3, which states,

6 "9.3 Reporting of Caucus Actions. The Section Delegates shall be responsible for
7 authoring a report of actions taken, which shall be presented to the MSS Assembly at
8 the next national meeting. This report will list the resolved clauses of all AMA HOD items
9 of business for which the MSS took a position, and will specifically identify those items
10 of business for which the MSS Caucus took a position that was not grounded in existing
11 internal policy."
12

13 Per the MSS IOPs, positions of the MSS Caucus are decided in the following manner:
14 Amended MSS Internal Operating Procedure 9.2, "Determining MSS Caucus Positions states:

15 "9.2 Determining MSS Caucus Positions.

16 9.2.1 For all MSS Caucus activities requiring a vote, all members of the MSS
17 Caucus shall be given one vote.

18 9.2.2 A quorum of at least one half of voting members must participate for a vote
19 to be valid.

20 9.2.3 In the AMA HOD, the MSS Caucus must take positions on items of
21 business that are consistent with the existing policy of the MSS as defined in the
22 MSS Digest of Actions whenever relevant MSS policy exists.

23 9.2.4 In areas where relevant MSS policy exists, but the interpretation is
24 uncertain, a majority vote of a quorum of MSS Caucus will determine the MSS
25 Caucus's interpretation.

26 9.2.5 When an item of business is before the AMA HOD that is of significant
27 importance to the MSS, but for which no MSS policy exists, any member of the
28 MSS Caucus may move that the MSS take a position on the item. Such a motion
29 requires a second by another Caucus member and a two-thirds ($\frac{2}{3}$) majority vote
30 of a quorum of the MSS Caucus to pass.

31 9.2.5.1 Positions set using these procedures are only valid for the
32 duration of that AMA HOD meeting.

33 9.2.6 The MSS Caucus may not take positions that are contrary to existing MSS
34 policy."
35

36 Your Section Delegates note that iterations of this report prior to our term beginning with the I-
37 23 cycle served as lengthy archival documents. The length and detail of previous versions of
38 this report, while comprehensive, were not readily usable by general MSS membership. In an
39 effort to make this report more usable and enduring for institutional memory purposes, your
40 Section Delegates structured the I-23 iteration of this report such that it contained only links to
41 all resolutions and the final recommendations from the annotated Reference Committee
42 reports. In an ongoing effort to streamline this report's structure and wield this as a tool to
43 improve the institutional memory of the MSS, we have utilized a similar structure for this report.
44 In addition, we have created the [MSS Archive of HOD Proceedings](#) (colloquially referred to as
45 "the Membrick"), which can be made publicly available to all MSS members current and future
46 and contain records of all HODs moving forward in a single easily accessible location. Our
47 intent is that this document shall be a living archive which future Section Delegates can easily
48 use in the creation of this report, and that the general MSS membership may use it as a tool to
49 learn the history of the MSS and further the advocacy of our Section.

50

51 **MSS RESOLUTIONS AT HOD I-23**

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53 The MSS transmitted a total of 38 resolutions to the House of Delegates. As some resolutions
54 resulted in multiple outcomes, the total outcomes sum to over 38:

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- Adopted: 5
- Adopted as Amended: 10
- Adopted in Lieu: 3
- Referred for Decision: 1
- Referred for Study: 8
- Reaffirmed in Lieu: 0
- Not Adopted: 1

63 The following MSS resolutions were transmitted on time to the I-23 meeting but were listed Not
64 for Consideration by the Interim Meeting Resolution Committee, which is used at all Interim
65 Meetings:

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- [003 Guardianship and Conservatorship Reform](#)
- [209 Opposing Pay-to-Stay Incarceration Fees](#)
- [211 Indian Water Rights](#)
- [212 Medical-Legal Partnerships & Legal Aid Services](#)
- [214 Humanitarian Efforts to Resettle Refugees](#)
- [303 Fairness for International Medical Students](#)
- [602 Inclusive Language for Immigrants in Relevant Past and Future AMA Policies](#)
- [810 Racial Misclassification](#)
- [907 Occupational Screenings for Lung Disease](#)
- [911 Support for Research on the Nutritional and Other Impacts of Plant-Based Meat](#)
- [912 Fragrance Regulation](#)

78 The follow MSS resolution was immediately forwarded by the MSS I-23 Assembly. The
79 Resident & Fellow Section served as primary sponsor, with the Minority Affairs Section and
80 MSS as cosponsors. This was considered on time under AMA Bylaw 2.11.3.1.2, "Resolutions -
81 AMA Sections." It was also listed Not for Consideration by the Interim Resolution Committee.

82

83

- [610 End Attacks on Health and Human Rights in Palestine and Israel](#)

84 Of these items, the MSS attempted to extract the following:

85

86

- [211 Indian Water Rights](#)
- [214 Humanitarian Efforts to Resettle Refugees](#)

87 - [610 End Attacks on Health and Human Rights in Palestine and Israel](#)

88
89 Additionally, the American Association of Public Health Physicians (AAPHP) Delegation
90 attempted to extract [810 Racial Misclassification](#).

91
92 Ultimately, the House of Delegates voted to not consider these items.

93
94 Appendix 1 contains the final HOD Actions taken pursuant to each MSS-authored resolution as
95 their final outcome. For all MSS resolutions the MSS Delegates supported the items as their
96 original authors. Resolutions are listed in order of HOD Action. Each resolution is linked to its
97 original transmittal. Each outcome is linked to its final language in PolicyFinder or other
98 outcome as applicable.

99
100 **NON-MSS ITEMS AT HOD I-23**

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102 There were 127 items of business at the HOD I-23 Meeting. Of the 89 items not authored by the
103 MSS, the MSS took an active position on 41 items. Appendix 2 contains the MSS actions and
104 HOD actions for each item of business. Resolutions are listed in order of HOD Action. Each
105 resolution is linked to its original transmittal. Each outcome is linked to its final language in
106 PolicyFinder or other outcome as applicable. For brevity, resolves were not included in the
107 appendices.

108
109 **ACKNOWLEDGEMENTS**

110
111 Laurie Lapp, Section Alternate Delegate; Rajadhar Reddy, Section Delegate; Adrina Kocharina,
112 RefCom AC&B Lead; Sara Kazyak, RefCom AC&B Lead; Juliana Bacigalupi, RefCom B Lead;
113 Sneha Krish, RefCom B Lead; Krishna Channa, RefCom B Lead; Radhika Patel, RefCom C
114 Lead; Shaminy Manoranjithan, RefCom C Lead; Will Maher, RefCom F Lead; Samantha
115 Thomas, RefCom F Lead; Julia Silverman, RefCom J Lead; Jared Buteau, RefCom J Lead;
116 Priya Desai, RefCom K Lead; Preetham Bachina, RefCom K Lead; Alex Soltany, RefCom K
117 Lead

Appendix 1. MSS Actions and HOD Actions on MSS Resolutions

Resolution Title <i>with link to transmittal</i>	MSS Action	HOD Action <i>linked to RefCom report</i>
002 Support for International Aid for Reproductive Healthcare	MSS Delegates supported the resolution as written.	Adoption as Amended.
003 Guardianship and Conservatorship Reform	MSS Delegates supported the resolution as written as its authors. The MSS did not attempt to extract this item from the Not for Consideration list. The MSS will transmit this item to the HOD at a later meeting.	This item was listed Not for Consideration by the Interim Resolution Committee. The item was not extracted from the Not for Consideration list.
004 Reconsideration of Medical Aid in Dying	MSS Delegates supported the resolution as written as its authors.	Amended resolution referred.
006 Inappropriate Use of Health Records in Criminal Proceedings	MSS Delegates supported the resolution as written as its authors.	Adopted.
007 Improving Access to Forensic Medical Evaluations and Legal Representation for Asylum Seekers	MSS Delegates supported the resolution as written as its authors. The RefCom rec was to strike R1 and adopt R2 as amended. The MSS extracted the item and moved for referral in order to preserve R1.	Referred.

202 Protecting the Health of Patients Incarcerated in For-Profit Prisons	<p>MSS Delegates supported the resolution as written as its authors. Following the RefCom recommendation to reaffirm existing policy, the MSS extracted this item and testified in support of referral.</p>	<p>Referred.</p>
203 Anti-Discrimination Protections for Housing Vouchers	<p>MSS Delegates supported the resolution as written as its authors. The MSS was amenable to the alternate language proposed by the Reference Committee.</p>	<p>Alternate Resolution 203 adopted in lieu of Resolution 203.</p>
204 Increasing PrEP & PEP Access	<p>MSS Delegates supported the resolution as written as its authors and was amenable to the amendments from the RefCom.</p>	<p>Adopted as amended.</p>
209 Opposing Pay-to-Stay Incarceration Fees	<p>MSS Delegates supported the resolution as written as its authors. The MSS did not attempt to extract this item from the Not for Consideration list. The MSS will transmit this item to the HOD at a later meeting.</p>	<p>This item was listed Not for Consideration by the Interim Resolution Committee. The item was not extracted from the Not for Consideration list.</p>
210 Immigration Status in Medicaid & CHIP	<p>MSS Delegates supported the resolution as written as its authors.</p>	<p>Adopted</p>
211 Indian Water Rights	<p>MSS Delegates supported the resolution as written as its authors. The MSS attempted to extract this item from the Not for Consideration list, but ultimately the item was not extracted. The MSS will transmit this item to the HOD at a later meeting.</p>	<p>This item was listed Not for Consideration by the Interim Resolution Committee. The item was not extracted from the Not for Consideration list.</p>

<p>212 Medical-Legal Partnerships & Legal Aid Services</p>	<p>MSS Delegates supported the resolution as written as its authors. The MSS did not attempt to extract this item from the Not for Consideration list. The MSS will transmit this item to the HOD at a later meeting.</p>	<p>This item was listed Not for Consideration by the Interim Resolution Committee. The item was not extracted from the Not for Consideration list.</p>
<p>213 Health Technology Accessibility for Aging Patients</p>	<p>MSS Delegates supported the resolution as written as its authors. The RefCom rec appeared to be adopt as amended and was later changed to reaffirm existing policy. The MSS extracted this item to move for referral.</p>	<p>Referred.</p>
<p>214 Humanitarian Efforts to Resettle Refugees</p>	<p>MSS Delegates supported the resolution as written as its authors. The MSS attempted to extract this item from the Not for Consideration list, but ultimately the item was not extracted. The MSS will transmit this item to the HOD at a later meeting.</p>	<p>This item was listed Not for Consideration by the Interim Resolution Committee. The item was not extracted from the Not for Consideration list.</p>
<p>215 A Public Health-Centered Criminal Justice System</p>	<p>MSS Delegates supported the resolution as written as its authors. The RefCom rec was referral, and the MSS was amenable to this recommendation.</p>	<p>Referred.</p>
<p>302 Medical Student Reports of Disability-Related Mistreatment</p>	<p>MSS Delegates supported the resolution as written as its authors.</p>	<p>Adopt as amended</p>
<p>303 Fairness for International Medical Students</p>	<p>MSS Delegates supported the resolution as written as its authors. The MSS did not attempt to extract this item from the Not for Consideration list. The MSS will transmit this item to the HOD at a later meeting.</p>	<p>This item was listed Not for Consideration by the Interim Resolution Committee. The item was not extracted from the Not for Consideration list.</p>

304 Health Insurance Options for Medical Students	<p>MSS Delegates supported the resolution as written as its authors.</p>	<p>Adopt as amended</p>
601 Carbon Pricing to Address Climate Change	<p>MSS Delegates supported the resolution as written as its authors. The RefCom recommended referral, and the MSS was amenable to this.</p>	<p>Referred.</p>
602 Inclusive Language for Immigrants in AMA Policies	<p>MSS Delegates supported the resolution as written as its authors. The MSS did not attempt to extract this item from the Not for Consideration list. The MSS will transmit this item to the HOD at a later meeting.</p>	<p>This item was listed Not for Consideration by the Interim Resolution Committee. The item was not extracted from the Not for Consideration list.</p>
606 Prevention of Healthcare-Related Scams	<p>MSS Delegates supported the resolution as written as its authors.</p>	<p>Adopted.</p>
<p>610 End Attacks on Health and Human Rights in Palestine and Israel</p>	<p>MSS Delegates supported the resolution as written as its authors. The MSS attempted to extract this item from the Not for Consideration list, but ultimately the item was not extracted. The MSS will transmit this item to the HOD at a later meeting.</p>	<p>This item was listed Not for Consideration by the Interim Resolution Committee. The item was not extracted from the Not for Consideration list.</p>
801 Improving Pharmaceutical Access and Affordability	<p>MSS Delegates supported the resolution as written as its authors.</p>	<p>Adopted.</p>
802 Improving Nonprofit Hospital Charity Care Policies	<p>MSS Delegates supported the resolution as written as its authors. The RefCom rec was referral, and the MSS was amenable to this recommendation.</p>	<p>Referred.</p>

803 Improving Medicaid and CHIP Access and Affordability	<p>MSS Delegates supported the resolution as written as its authors. The RefCom recommended alternate Resolution 803 be adopted in lieu. The MSS extracted to move for original language.</p>	<p>Adopted as amended.</p>
810 Racial Misclassification	<p>MSS Delegates supported the resolution as written as its authors. The MSS attempted to extract this item from the Not for Consideration list, but ultimately the item was not extracted. The MSS will transmit this item to the HOD at a later meeting.</p>	<p>This item was listed Not for Consideration by the Interim Resolution Committee. The item was not extracted from the Not for Consideration list.</p>
811 Expanding the Use of Medical Interpreters	<p>MSS Delegates supported the resolution as written as its authors.</p>	<p>Adopt as amended</p>
812 Indian Health Service Improvements	<p>MSS Delegates supported the resolution as written as its authors. The RefCom recommended adoption as amended, including the deletion of R2 and R4. The MSS was amenable to these amendments.</p>	<p>Adopt as amended</p>
813 Strengthening Efforts Against Horizontal & Vertical Consolidation	<p>MSS Delegates supported the resolution as written as its authors.</p>	<p>Adopt as amended</p>
903 Supporting Emergency Anti-Seizure Interventions	<p>MSS Delegates supported the resolution as written as its authors.</p>	<p>Alternate Resolution 903 adopted in lieu of Resolution 903 with title change</p>
904 Universal Return-to-Play Protocols	<p>MSS Delegates supported the resolution as written as its authors.</p>	<p>Alternate Resolution 904 adopted in lieu of Resolution 904</p>

905 Support for Research on the Relationship Between Estrogen and Migraine	<p>MSS Delegates supported the resolution as written as its authors.</p>	<p>Not adopted</p>
906 Online Content Promoting LGBTQ+ Inclusive Safe Sex Practices	<p>MSS Delegates supported the resolution as written as its authors.</p>	<p>Adopted as amended</p>
907 Occupational Screenings for Lung Disease	<p>MSS Delegates supported the resolution as written as its authors. The MSS did not attempt to extract this item from the Not for Consideration list. The MSS will transmit this item to the HOD at a later meeting.</p>	<p>This item was listed Not for Consideration by the Interim Resolution Committee. The item was not extracted from the Not for Consideration list.</p>
909 High Risk HPV Subtypes in Minoritized Populations	<p>MSS Delegates supported the resolution as written as its authors.</p>	<p>Referred for decision</p>
910 Sickle Cell Disease Workforce	<p>MSS Delegates supported the resolution as written as its authors.</p>	<p>Adopted</p>
911 Support for Research on the Nutritional and Other Impacts of Plant-Based Meat	<p>MSS Delegates supported the resolution as written as its authors. The MSS did not attempt to extract this item from the Not for Consideration list. The MSS will transmit this item to the HOD at a later meeting.</p>	<p>This item was listed Not for Consideration by the Interim Resolution Committee. The item was not extracted from the Not for Consideration list.</p>
912 Fragrance Regulation	<p>MSS Delegates supported the resolution as written as its authors. The MSS did not attempt to extract this item from the Not for Consideration list. The MSS will transmit this item to the HOD at a later meeting.</p>	<p>This item was listed Not for Consideration by the Interim Resolution Committee. The item was not extracted from the Not for Consideration list.</p>

913 Public Health Impact of Industrialized Farms	MSS Delegates supported the resolution as written as its authors.	Adopted as amended
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Appendix 2. MSS Actions and HOD Actions on Non-MSS Items

Item Title with link to transmittal	MSS Action	HOD Action
CEJA 01 Physicians' Use of Social Media for Product Promotion and Compensation	MSS Delegates supported the resolution as written with online testimony and in-person RefCom testimony.	Referred back to CEJA.
Speakers 03 Report of the Election Task Force 2	MSS Delegates opposed recommendations 11, 12, and 27.	Rec 11 adopted as amended, rec 12 referred, rec 27 not adopted.
005 Adopting a Neutral Stance on Medical Aid in Dying	MSS Delegates supported the sentiment of this resolution as it aligned with our resolution 004.	Not adopt.
009 Physicians Arrested for Non-Violent Crimes While Engaged in Public Protests	The MSS vocally supported this item.	Referred.
216 Saving Traditional Medicare	The MSS Caucus voted to support this resolution in the absence of an internal MSS position. MSS Delegates supported this resolution with online testimony and in-person RefCom testimony.	Adopt as amended
217 Addressing Work Requirements for J-1 Visa Waiver Physicians	MSS Delegates supported this resolution with online testimony and in-person RefCom testimony.	Referred
219 Improving Access to Post-Acute Medical Care for Patients with Substance Use Disorder	MSS Delegates supported this resolution with online testimony and in-person RefCom testimony.	Adopt as amended

(SUD)		
CME 01 Leave Policies for Medical Students, Residents, Fellows, and Physicians	Partially derived from MSS resolutions: 302 and 303 . MSS Delegates supported this item with online and in-person RefCom testimony.	Adopt as amended
CME 03 Ensuring Equity in Interview Processes for Entry to Undergraduate and Graduate Medical Education	Derived from MSS Resolution 311 at I-22. MSS Delegates supported this item with online and in-person RefCom testimony.	Adopt as amended
CME 05 Organizations to Represent the Interests of Resident and Fellow Physicians	MSS Delegates supported this resolution with online testimony and in-person RefCom testimony.	Adopt
301 Clarification of AMA Policy D-310-948 "Protection of Resident and Fellow Training in the Case of Hospital or Training Program Closure"	MSS Delegates were supportive of this item and proffered an amendment on the VRC, which was accepted and added to the final RefCom Rec.	Adopt as amended
305 Addressing Burnout and Physician Shortages for Public Health	MSS Delegates supported this resolution with online testimony and in-person RefCom testimony.	Refer for deision
308 Cease Reporting of Total Attempts of USMLE STEP1 and COMLEX-USA Level 1 Examinations	MSS Delegates supported this item as written.	This item was listed Not for Consideration by the Interim Resolution Committee. The item was not extracted from the Not for Consideration list.
BOT 12 AMA Meeting Venues and Accessibility	MSS Delegates opposed the report's amendments to clause 4 of G-630.140 on VRC and supported an	Referred.

	amendment proposed in live RefCom. MSS Delegates supported the RefCom rec to refer.	
603 Improving the Efficiency of the House of Delegates Resolution Process	MSS Delegates supported this item as written.	This item was listed Not for Consideration by the Interim Resolution Committee. The item was not extracted from the Not for Consideration list.
604 Updating Language Regarding Families and Pregnant Persons	MSS Delegates supported this item as written.	This item was listed Not for Consideration by the Interim Resolution Committee. The item was not extracted from the Not for Consideration list.
608 Confronting Ageism in Medicine	MSS Delegates supported this item as written.	This item was listed Not for Consideration by the Interim Resolution Committee. The item was not extracted from the Not for Consideration list.
CMS 01 ACO REACH	This was derived from MSS Resolution 822 at I-22. MSS Delegates supported this item on VRC and in-person RefCom.	Adopt
CMS 03 Strengthening Network Adequacy	MSS Delegates supported this item on VRC and with live RefCom testimony.	Adopt as amended
CMS 05 Medicaid Unwinding Update	MSS Delegates supported this item and proposed an amendment on VRC. Also supported AAP amendments in live RefCom.	Adopt as amended
CMS 07 Sustainable Payment for Community Practices	MSS Delegates supported this item on VRC, and then supported the AAP's recommendation to refer the report back in RefCom.	Referred

808 Prosthodontic Coverage after Oncologic Reconstruction	MSS Delegates supported this item on VRC and in RefCom.	Alternate Resolution 808 adopted in lieu
815 Long-Term Care and Support Services for Seniors	MSS Delegates supported this item on VRC and in RefCom.	Alternate Resolution 815 adopted in lieu
816 Reducing Barriers to Gender-Affirming Care through Improved Payment and Reimbursement	MSS Delegates supported this item as written.	This item was listed Not for Consideration by the Interim Resolution Committee. The item was extracted from the Not for Consideration list. This item was ultimately adopted.
817 Expanding AMA Payment Reform Work and Advocacy to Medicaid and other non-Medicare payment modules for Pediatric Healthcare and Specialty Populations	MSS Delegates supported this item on VRC and in RefCom.	Adopted as amended
818 Amendment to AMA policy on health care system reform proposals	MSS Delegates supported this item on VRC and in RefCom.	R1 not adopted, R2 referred
820 Affordability and Accessibility of Overweight and Obesity	MSS Delegates supported this item on VRC and in RefCom.	Alternate Resolution 806 adopted in lieu
BOT 02 Opposing the Use of Vulnerable Incarcerated People in Response to Public Health Emergencies	Report was derived from an MSS resolution that was referred at I-22. The MSS vocally supported this item.	Adopted and filed
BOT 03 Update on Climate Change & Health - AMA Activities	CA, RFS, MSS, etc requested strategic plan on climate expected at A-23; BOT did not write a plan and only provided an advocacy update; AAP re-	Referred

	requested for I-23; now, BOT still did not write a plan and still only provided an advocacy update; MSS Caucus voted to refer back.	
BOT 14 Funding for Physicians to Provide Safe Storage Devices to Patients with Unsecured Firearms in the Home	MSS supported this item on VRC and in RefCom.	Adopted and filed
CSAPH 01 Drug Shortages: 2023 Update	Partially derived from MSS resolution	Adopted as amended
CSAPH 02 Precision Medicine and Health Equity	Tried to append MSS resolution 106 from I-23. Failed.	Referred
CSAPH 03 HPV-Associated Cancer Prevention	MSS proposed amendment for requiring vaccine for school attendance	Referred
CSAPH 04 Supporting and Funding Sobering Centers	Report derived from MSS resolution	Adopted as amended
CSAPH 05 Promoting the Use of Multi-Use Devices and Sustainable Practices in the Operating Room	Report derived from MSS resolution	Adopted
901 Silicosis from Work with Engineered Stone	MSS proposed amendment to incorporate language from MSS resolution 907, I-23 "Occupational Screenings for Lung Disease" (which was slated as not for consideration) -- amendment failed in RefCom	Adopted as amended
902 Post Market Research Trials	MSS supported this item on VRC and in RefCom.	Adopted as amended

<p>914 Adverse Childhood Experiences</p>	<p>AAP worked with MSS authors to craft language. The MSS supported this item with online testimony and in-person RefCom testimony.</p>	<p>Adopted as amended.</p>
<p>916 Elimination of Buprenorphine Dose Limits</p>	<p>MSS supported this item on VRC and in RefCom.</p>	<p>Alternate resolution 916 adopted in lieu of</p>
<p>917 Advocating for Education and Action Regarding the Health Hazards of PFAS Chemicals</p>	<p>MSS supported this item as written.</p>	<p>This item was listed Not for Consideration by the Interim Resolution Committee. The item was not extracted from the Not for Consideration list.</p>
<p>923 Eliminating Eligibility Criteria for Sperm Donors Based on Sexual Orientation</p>	<p>MSS supported this item on VRC and in RefCom.</p>	<p>Adopt</p>

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Late Resolution 001
(A-24)

Introduced by: Ryan Englander, University of Connecticut; Justin Magrath, Tulane University; Heidi Ventresca, Louisiana State University - Shreveport

Subject: MSS Endorsements in the AMA House of Delegates

Sponsored by:

Referred to: MSS Reference Committee
(TBA, Chair)

1 Whereas, AMA House of Delegates (HOD) elections are extremely important, as they determine
2 who will execute on policy adopted by the House of Delegates on the Board of Trustees and
3 who will consider referred items on AMA Councils; and
4
5 Whereas, the MSS has historically not endorsed candidates in AMA HOD elections; and
6
7 Whereas, the Resident and Fellow Section (RFS) similarly does not endorse external
8 candidates; however the Young Physician Section (YPS) has an endorsement process that is
9 highly sought after by candidates; and
10
11 Whereas, over the past several years there have been growing discussions regarding whether
12 the MSS should endorse AMA HOD candidates, and if so under what process; and
13
14 Whereas, endorsing candidates in AMA HOD elections has significant potential benefits
15 including the prospect of influencing the outcome of elections and subsequent action on policy
16 of interest to the MSS; and
17
18 Whereas, a study will enable us to elucidate the interest of HOD candidates in receiving an
19 endorsement from the MSS as well as potential risks that could occur in response to the
20 implementation of such a process; therefore be it
21
22 RESOLVED, that our AMA-MSS study endorsing candidates in AMA House of Delegates
23 elections with report back regarding whether the MSS should consider endorsing candidates
24 and if so, the process by which such endorsements may be made.

Fiscal Note: TBD

Date Received: 05/23/2024

RELEVANT MSS INTERNAL OPERATING PROCEDURES

9 MSS Caucus to the HOD.
9.1 MSS Caucus Structure.

9.1.1 The MSS Caucus voting membership is comprised of the following members:

9.1.1.1 The Section Delegates;

9.1.1.2 MSS Regional Delegates and Regional Alternate Delegates;

9.1.1.3 Medical student members of a constituent (state), specialty, or professional interest medical society delegation who accept an invitation from the Section Delegates to attend the MSS caucus (Section 4.4.3.2.1).

9.1.2 MSS Caucus non-voting members consist of those serving on an AMA Council, in an AMA Liaison position (Section 4.7), or on the MSS HOD Coordination Committee (HCC).

9.1.3 Caucus meetings. Caucus meetings shall include all voting and non-voting members of the Caucus, as well as other MSS members wishing to attend.

9.1.3.1 "Closed meetings" may be called at the discretion of the Section Delegates. Attendance at "closed Caucus meetings" is composed of voting Caucus members, MSS staff, and any individuals with explicit permission to attend from the Section Delegates.

9.1.3.2 MSS members who are not part of the MSS Caucus are not eligible to vote and may only participate in discussion with explicit permission from the Section Delegates.

9.1.4 The MSS Section Delegate and Section Alternate Delegate shall be considered the Chair and Vice Chair of the Caucus respectively and their responsibilities in those positions include, but are not limited to:

9.1.4.1 Attempting to contact all members eligible to the MSS Caucus before each AMA HOD meeting.

9.1.4.2 Overseeing debate, discussion, and voting that occurs within the MSS Caucus.

9.1.4.3 Assigning Regional Delegates, Regional Alternate Delegates, and members of the MSS HOD Coordination Committee (HCC) to serve on ad hoc Caucus Reference Committees.

9.1.4.4 Speaking on behalf of the MSS or delegating the responsibility to speak on specific items of business to MSS members of their choosing in Reference Committee hearings and the HOD.

9.1.4.5 Developing general MSS strategy for supporting or opposing HOD items of business.

9.1.4.6 Coordinating and negotiating with the leadership of other groups and sections within the HOD.

9.2 Determining MSS Caucus Positions.

9.2.1 For all MSS Caucus activities requiring a vote, all members of the MSS Caucus shall be given one vote.

9.2.2 A quorum of at least one half of voting members must participate for a vote to be valid.

9.2.3 In the AMA HOD, the MSS Caucus must take positions on items of business that are consistent with the existing policy of the MSS as defined in the MSS Digest of Actions whenever relevant MSS policy exists.

9.2.4 In areas where relevant MSS policy exists, but the interpretation is uncertain, a majority vote of a quorum of MSS Caucus will determine the MSS Caucus's interpretation.

9.2.5 When an item of business is before the AMA HOD that is of significant importance to the MSS, but for which no MSS policy exists, any member of the MSS Caucus may move that the MSS take a position on the item. Such a motion requires a second by another Caucus member and a two-thirds ($\frac{2}{3}$) majority vote

of a quorum of the MSS Caucus to pass. 9.2.5.1 Positions set using these procedures are only valid for the duration of that AMA HOD meeting.

9.2.6 The MSS Caucus may not take positions that are contrary to existing MSS policy.