AMA House of Delegates Handbook

2024 Interim Meeting
Walt Disney World Swan and Dolphin Resort
Nov. 8–12

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

#AMAmtg
@AmerMedicalAssn

i24

MEMORANDUM FROM THE SPEAKER OF THE HOUSE OF DELEGATES

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

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

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

- **The Interim Meeting is focused on advocacy issues. A resolution committee (see AMA Bylaw 2.13.3) considers each resolution and recommends that the item be considered or not considered at the Interim Meeting. Items that meet the following definition of advocacy or that are considered urgent are recommended for acceptance:**

  Active use of communication and influence with public and private sector entities responsible for making decisions that directly affect physician practice, payment for physician services, funding and regulation of education and research, and access to and delivery of medical care.

  Resolutions pertaining to ethics should also be included in the agenda. Remaining items are recommended against consideration, but any delegate may request consideration when resolutions are presented for consideration (during Saturday's "Second Opening" Session). A simple majority of those present and voting is required for consideration.

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

AMA
AMERICAN MEDICAL ASSOCIATION

UNDERSTANDING THE RECORDING OF AMERICAN MEDICAL ASSOCIATION POLICY

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

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

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

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

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

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

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

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

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

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

LIST OF MATERIALS INCLUDED IN THIS HANDBOOK (I-24)

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

The informational reports contain no recommendations and will be filed on Saturday, November 9, unless a request is received for referral and consideration by a Reference Committee (similar to the use of a consent calendar).

1. **Memorandum from the Speaker**

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

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

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

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

6. **Hotel Maps**

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

8. **Reference Committee Schedule and Room Assignments**

9. **Note on Order of Business**

10. **Summary of Fiscal Notes**

11. **List of Resolutions by Sponsor**

FOLLOWING COLLATED BY REFERRAL

12. **Report(s) of the Board of Trustees - Michael Suk, MD, JD, MPH, MBA, Chair**

01	Augmented Intelligence Development, Deployment, and Use in Health Care	B
02	On-Site Physician Requirements for Emergency Departments	B
03	Stark Law Self-Referral Ban	B
04	Addressing Work Requirements For J-1 Visa Waiver Physicians	B
05	Protecting the Health of Incarcerated Patients	J
06	Health Technology Accessibility for Aging Patients	B
07	Reevaluation of Scoring Criteria for Rural Communities in the National Health Service Corps Loan Repayment Program	K
08	Increasing Access to Medical Care for People Seeking Asylum	C&B
09	Corporate Practice of Medicine Prohibition	B

10	AMA Efforts on Medicare Payment Reform	Info. Report
11	Carbon Pricing to Address Climate Change	K
12	Eliminating Eligibility Criteria for Sperm Donors Based on Sexual Orientation	Info. Report
13	AMA/Specialty Society RVS Update Committee	J
14	Privacy Protection and Prevention of Further Trauma for Victims of Distribution of Intimate Videos and Images Without Consent	C&B
15	Published Metrics for Hospitals and Hospital Systems	J
16	AMA Reimbursement of Necessary HOD Business Meeting Expenses for Delegates and Alternates	F
17	Environmental Sustainability of AMA National Meetings	Info. Report
18	Expanding Protections of End-of-Life Care	C&B
19	Update on Climate Change and Health AMA Activities	Info. Report
20	2024 AMA Advocacy Efforts	Info. Report
21	Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care is Banned or Restricted	Info. Report

13. Report(s) of the Council on Constitution and Bylaws - Jerry P. Abraham, MD, MPH, Chair

01	Resolution Deadline Clarification	C&B
02	Name Change for Reference Committee	C&B
03	Bylaw Amendments to Address Medical Student Leadership	C&B

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

01	Expanding Access to Palliative Care	C&B
02	Protecting Physicians Who Engage in Contracts to Deliver Health Care Services	C&B

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

01	Research Handling of De-Identified Patient Data	Info. Report
02	Amendment to E-2.1.1, “Informed Consent”	Info. Report
03	Amendment to E-3.1.1, “Privacy in Health Care”	Info. Report
04	Amendment to E-3.2.4 “Access to Medical Records by Data Collection	Info. Report
05	Amendment to E-3.3.2, “Confidentiality and Electronic Medical Records”	Info. Report
06	Physicians’ Use of Social Media for Product Promotion and Compensation	Info. Report
07	Short-Term Global Health Clinical Encounters	Info. Report

16. Report(s) of the Council on Long Range Planning and Development - Michelle Berger, MD, Chair

01	Academic Physicians Section Five-Year Review	F

17. Report(s) of the Council on Medical Education - Krystal Tomei, MD, MPH, Chair

01	Medication Reconciliation Education	C
02	Updates to Recommendations for Future Directions for Medical Education	C

18. Report(s) of the Council on Medical Service - Stephen Epstein, MD, MPP, Chair

01	Nonprofit Hospital Charity Care Policies	J
02	Unified Financing Health Care System	J
03	Time-Limited Patient Care	J
04	Biosimilar Coverage Structures	J

19. Report(s) of the Council on Science and Public Health - John T. Carlo, MD, MBA, Chair

01	Cannabis Therapeutic Claims in Marketing and Advertising	K
02	Drug Shortages: 2024 Update	K
03	HPV-Associated Cancer Prevention	K
04	Reducing Sodium Intake to Improve Public Health	K
05	Teens and Social Media	K

20. Report(s) of the HOD Committee on Compensation of the Officers - Claudette Dalton, MD, Chair

01	Report of the House of Delegates Committee on Compensation of the Officers	F

21. Report(s) of the Speakers - Lisa Bohman Egbert, MD, Speaker; John H. Armstrong, MD, Vice Speaker

01	Report of the Election Task Force 2	F
02	Reconciliation Report	Info. Report

22. Resolutions

001	Addressing Gender-Based Pricing Disparities	C&B
002	Anti-Doxxing Data Privacy Protection	C&B
003	On the Ethics of Human Lifespan Prolongation	C&B
004	Improving Usability of Electronic Health Records for Transgender and Gender Diverse Patients	C&B
005	Updating the AMA Definition of Infertility	C&B
006	Opposition to the Deceptive Relocation of Migrants and Asylum Seekers	C&B
007	Supporting Diversity in Research	C&B
008	Missing and Murdered Black Women and Girls	C&B
009	Opposition to Creation or Enforcement of Civil Litigation, Commonly Referred to as Civil Causes of Action	C&B
201	Boarding Patients in the Emergency Room	B
202	Illicit Drugs: Calling for a Multifaceted Approach to the “Fentanyl” Crisis	B
204	Support for Physician-Supervised Community Paramedicine Programs	B
205	Native American Medical Debt	B
206	Protect Infant and Young Child Feeding	B
207	Accountability for G-605.009: Requesting A Task Force to Preserve the Patient-Physician Relationship Task Force Update and Guidance	B
208	Medicare Part B Enrollment and Penalty Awareness	B
210	Laser Surgery	B
211	Water Bead Injuries	B
212	Addressing the Unregulated Body Brokerage Industry	B
213	Sustainable Long-term Funding for Child Psychiatry Access Programs	B
214	Advocating for Evidence-Based Strategies to Improve Rural Obstetric Health Care and Access	B
215	Advocating for Federal and State Incentives for Recruitment and Retention of Physicians to Practice in Rural Areas	B
216	Clearing Federal Obstacles for Supervised Injection Sites	B
217	Expand Access to Skilled Nursing Facility Services for Patients with Opioid Use Disorder	B

218	Time Sensitive Credentialing of New Providers with an Insurance Carrier	B
219	Advocate to Continue Reimbursement for Telehealth / Telemedicine Visits Permanently	B
220	MIPS Reform	B
221	Medicare Coverage for Non-PAR Physicians	B
222	Rollback on Physician Performance Measures	B
223	Mandated Economic Escalators in Insurance Contracts	B
225	Elimination of Medicare 14-Day Rule	B
226	Information Blocking Rule	B
227	Medicare Payment Parity for Telemedicine Services	B
302	Strengthening Parental Leave Policies for Medical Trainees and Recent Graduates	C
304	Payment and Benefit Parity for Fellows	C
305	Removing Board Certification as a Requirement for Billing for Home Sleep Studies	C
306	Streamlining Continuing Medical Education Across States and Medical Specialties	C
601	Expanding AMA Meeting Venue Options	F
602	Delaying the ETF Endorsement Timeline Revision for Section IOP Revisions	F
604	Opposing Discrimination and Protecting Free Speech Among Member Organizations of Organized Medical Associations	F
605	AMA House of Delegates Expenses	F
606	Protecting Free Speech and Encouraging Respectful Discourse Among Member Organizations of Organized Medical Associations	F
607	AMA House of Delegates Venues	F
801	Reimbursement for Managing Portal Messages	J
802	Address Physician Burnout with Inbox Management Resources and Increased Payment	J
803	Healthcare Savings Account Reform	J
804	Improving Public Assistance for People with Disabilities	J
805	Coverage for Care for Sexual Assault Survivors	J
807	Expanded Pluralism in Medicaid	J
808	Requirement to Communicate Covered Alternatives for Denied Medications	J
809	Minimum Requirements for Medication Formularies	J
810	Immediate Digital Access to Updated Medication Formulary for Patients and Their Physicians	J
811	AMA Practice Expense Survey Geographic Analysis	J
812	Advocate for Therapy Cap Exception Process	J
813	Insurance Coverage for Pediatric Positioning Chairs	J
814	Legislation for Physician Payment for Prior Authorization	J
815	Addressing the Crisis of Pediatric Hospital Closures and Impact on Care	J
817	ACA Subsidies for Undocumented Immigrants	J
818	Payment for pre-certified/preauthorized procedures	J

819	Establishing a New Office-Based Facility Setting to Pay Separately from the Medicare Physician Fee Schedule for the Technical Reimbursement of Physician Services Using High-Cost Supplies	J
820	State Medicaid Coverage of Home Sleep Testing	J
821	Patient Access to Asthma Medications	J
822	Resolution on Medicare Coverage for Non-Emergent Dialysis Transport	J
823	Reigning in Medicare Advantage - Institutional Special Needs Plans	J
824	Ophthalmologists Required to Be Available for Level I & II Trauma Centers	J
901	Heat Alerts and Response Plans	K
902	Advancing Menopause Research and Care	K
903	Improving the Identification of Intimate Partner Violence (IPV) in People with Disabilities	K
904	Regulation of Ionized Radiation Exposure for Healthcare Workers	K
905	Regulation and Transparency of Contaminants in Menstrual Hygiene Products	K
907	Call for Study: The Need for Hospital Interior Temperatures to be Thermally Neutral to Humans within Those Hospitals	K
909	Support of Universal School Meals for School Age Children	K
910	Food Insecurity Among Patients with Celiac Disease, Food Allergies, and Food Intolerance	K
911	Adequate Masking and HPV Education for Health Care Workers (including those over age 45)	K
912	Assuring Representation of Older Age Adults in Clinical Trials	K
913	Sexually Transmitted Infections are on the Rise in the Senior Population	K
915	Reducing Barriers in Sports Participation for LGBTQIA+ People	K
916	Access to Healthcare for Transgender and Gender Diverse People in the Carceral System	K
917	Mpox Global Health Emergency Recognition and Response	K
918	Healthcare in Tribal Jails	K
919	Improving Rural Access to Comprehensive Cancer Care Service	K
920	Revise FAA Regulations to Include Naloxone (Narcan) in the On-Board Medical Kit for Commercial Airlines flying within the Continental United States	K
922	Advocating for the Regulation of Pink Peppercorn as a Tree Nut	K
923	Updated Recommendations for Child Safety Seats	K
926	Development of Climate Health Education Tools for Physicians	K
928	Public Safety Agencies Data Collection Enhancement	K
929	Safety Concerns Regarding Inadequate Labeling of Food Products Upon Ingredient Changes with Known Major Food Allergens	K
930	Economic Factors to Promote Reliability of Pharmaceutical Supply	K

23. Resolutions Not for Consideration

203	Alternative Pathways for International Medical Graduates	B
209	Physician Liability for AI and Other Technological Advances in Medicine	B
224	Update the status of Virtual Credit card policy, EFT fees, and lack of Enforcement of Administrative Simplification Requirements by CMS	B

301	Reopening Schools Closed by the Flexner Report	C
303	Transparency and Access to Medical Training Program Unionization Status, Including Creation of a FREIDA Unionization Filter	C
307	Humanism in Anatomical Medical Education	C
603	Study of Grading Systems in AMA Board Reports	F
806	Study of the Federal Employee Health Benefit Plan (FEHBP)	J
816	Study of CO-OP Insurance as a Vehicle for Public Healthcare Insurance Option	J
906	Call for Study: Should Petroleum-Powered Emergency Medical Services (EMS) Vehicles in Urban Service Areas be Replaced by Renewably-Powered Electric Vehicles?	K
908	Support for Doula Care Programs	K
914	Protecting the Healthcare Supply Chain from the Impacts of Climate Change	K
921	In Support of a National Drug Checking Registry	K
924	Public Health Implications of US Food Subsidies	K
925	Improving Public Awareness of Lung Cancer Screening and CAD in Chronic Smokers	K
927	The Creation of Healthcare Sustainability Lecture Series	K

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

Preamble

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

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

Declaration

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

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

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

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

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

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

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

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

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

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

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

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

Delegate/Alternate Delegate Job Description, Roles and Responsibilities

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

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

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

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

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

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

SEATING ALLOCATION – 2024 INTERIM MEETING

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

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

ANESTHESIOLOGY - 10
American Society of Anesthesiologists (ASA) – 8
American Society of Regional Anesthesia and Pain Medicine (ASRAPM) - 2

ARS – 1
American Rhinologic Society (ARS) - 1

CARDIOLOGY - 15
American College of Cardiology (ACC) - 7
American Society of Echocardiography (ASE) - 2
American Society of Nuclear Cardiology (ASNC) – 1
Heart Rhythm Society (HRS) - 1
Society for Cardiovascular Angiography and Interventions (SCAI) – 2
Society for Cardiovascular Magnetic Resonance (SCMR) - 1
Society of Cardiovascular Computed Tomography (SCCT) – 1

CHEST PHYSICIANS - 4
American College of Chest Physicians (CHEST) (ACCP) – 4
Delegates – 3
Resident and Fellow Section Delegate – 1

CRITICAL CARE MEDICINE- 2
Society of Critical Care Medicine (SCCM) - 2

DERMATOLOGY - 14
American Academy of Dermatology Assoc. (AAD) – 6
Former President (Resneck) – 1
Delegates - 5
American College of Mohs Surgery (ACMS) – 1
American Contact Dermatitis Society (ACDS) - 1
American Society for Dermatologic Surgery Assoc (ASDSA) - 3
American Society of Dermatopathology (ASD) - 1
Society for Investigative Dermatology (SID) - 1
Society for Pediatric Dermatology (SPD) – 1

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

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

FAMILY PHYSICIANS - 25
American Academy of Family Physicians (AAFP) - 25

GASTROENTEROLOGY - 6
American College of Gastroenterology (ACG) - 2
American Gastroenterological Association (AGA) - 2
American Society for Gastrointestinal Endoscopy (ASGE) - 2

GERIATRIC MEDICINE - 2
American Geriatrics Society (AGS) – 2

GREAT LAKES - 64
Illinois - 19
Trustee (Siddiqui) – 1
Delegates - 12
Medical Student Regional Delegate- 1
Resident and Fellow Section Delegate - 1
American College of Legal Medicine (ACLM) - 1
American Med Women's Association (AMWA) - 1
American Osteopathic Association (AOA) – 1
Society of Nuclear Medicine and Molecular Imaging (SNMMI) - 1
Indiana - 7
Trustee (Welsh) – 1
Delegates – 5
Medical Student Regional Delegate- 1
Michigan – 16
Delegates - 14
Medical Student Regional Delegate – 1
Resident and Fellow Section Delegate - 1
Ohio - 13
Delegates (minus Speaker) - 11
Medical Student Regional Delegate – 1
Resident and Fellow Section Delegate – 1
Wisconsin - 9
Delegates - 5
Medical Student Regional Delegate – 1
Resident and Fellow Section Delegate - 1
Undersea & Hyperbaric Medical Society (UHMS) – 2
Delegate -1
Resident and Fellow Section Delegate – 1

HEART OF AMERICA - 11
Kansas – 4
Delegates - 3
Medical Student Regional Delegate- 1
Missouri – 7
Delegates - 5
Medical Student Regional Delegate- 1
Resident and Fellow Section Delegate – 1

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

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

INFECTIOUS DISEASE – 2
Infectious Diseases Society of America (IDSA) - 2

INTERNAL MEDICINE - 37
American College of Lifestyle Medicine (ACLM) – 1
American College of Physicians (ACP) – 35
Trustee (Fryhofer) – 1
Delegates – 34
Former President (Wilson)
Renal Physicians Association (RPA) - 1

MOBILITY CAUCUS - 12
American Acad of Orthopaedic Surgeons (AAOS) – 4
Delegates – 4
Former President (Gurman)
American Association for Hand Surgery (AAHS) - 1
American Orthopaedic Association (AOrA) - 1
American Orthopaedic Foot and Ankle Society (AOFAS) - 1
American Society for Surgery of the Hand (ASSH) - 1
American Society of Interventional Pain Physicians (ASIPP) - 1
International Society for the Advancement of Spine Surgery (ISASS) – 1
North American Spine Society (NASS) - 2

NEUROSCIENCES – 31
Academy of Consultation-Liaison Psychiatry (ACLP) – 1
American Academy of Addiction Psychiatry (AAAP) - 1
American Academy of Child and Adolescent Psychiatry (AACAP) - 2
American Academy of Hospice and Palliative Medicine (AAHPM) - 2
American Academy of Neurology (AAN) – 5
Delegates – 3
Resident and Fellow Section Delegates - 2
American Academy of Pain Medicine (AAPM) - 1
American Acad of Psychiatry and the Law (AAPL) - 1
American Assoc for Geriatric Psychiatry (AAGP) - 1
American Association of Neurological Surgeons (AANS) - 2
Former President (Carmel) - 1
Delegate – 1
American Psychiatric Association (APA) - 10
Former President (Harris) – 1
Delegates - 8
Resident and Fellow Section Delegate – 1
Congress of Neurological Surgeons (CNS) - 2
GLMA : Health Professionals Advancing LGBTQ Equality – 1
North American Neuromodulation Society (NANS) - 1
International Pain and Spine Intervention Society (IPSIS) - 1

NEW ENGLAND - 33
Connecticut – 9
Trustee (Breig) – 1
Delegates - 4
Medical Student Regional Delegates- 3
Resident and Fellow Section Delegate - 1
Maine - 2
Massachusetts - 16
Delegates - 13
Medical Student Regional Delegate- 1
Resident and Fellow Section Delegate – 1
Amer Assn of Neuromuscular & Electrodiagnostic Med (AANEM)- 1
New Hampshire - 1
Rhode Island - 4
Delegates - 2
Resident and Fellow Section Delegates - 2
Vermont – 1

NEW YORK - 27
Delegates - 23
Medical Student Regional Delegate - 1
American College of Nuclear Medicine (ACNM) - 1
American Society of Neuroradiology (ASNR) - 2

NORTH CENTRAL - 17
Iowa – 5
Delegates – 4
Outpatient Endovascular and Interventional Society (OEIS) - 1
Minnesota – 6
Delegates - 5
Americas Hernia Society (AHS) - 1
Nebraska – 2
North Dakota - 2
South Dakota - 2

OBSTETRICIANS AND GYNECOLOGISTS - 19
American Association of Gynecologic Laparoscopists (AAGL) - 2
American College of Medical Genetics and Genomics (ACMGG) - 1
American College of Obstetricians and Gynecologists (ACOG) – 15
Trustee (Koirala) - 1
Delegates – 14
Former President (Wah)
American Soc for Reproductive Medicine (ASRM) - 1

ONCOLOGY - 7
Association for Clinical Oncology (ASCO) – 7
Delegates – 5
Former President (McAneny)
Resident and Fellow Section Delegates – 2

PACWEST CONFERENCE – 84
Alaska - 1
Arizona - 8
Delegates – 5
American Coll of Radiation Oncology (ACRO) - 1
American Institute of Ultrasound in Medicine (AIUM) – 2
California - 41
Trustee (Ding) - 1
Delegates - 32
Medical Student Regional Delegates - 2
Resident and Fellow Section Delegates - 2
American Clinical Neurophysiology Soc (ACNS) – 1
American Soc for Radiation Oncology (ASRO) – 2
North American Neuro-Ophthalmology Society (NANOS) – 1
Colorado - 8
Delegates - 6
Medical Student Regional Delegate - 1
Obesity Medicine Association (OMA) – 1

PACWEST CONFERENCE (cont'd)
Hawaii - 2
Idaho - 1
Montana - 1
Nevada – 3
Delegates - 2
Resident and Fellow Section Delegate – 1
New Mexico – 4
Delegates – 2
Resident and Fellow Section Delegate - 1
American Academy of Allergy, Asthma & Immunology (AAAAI) – 1
Oregon – 5
Delegates - 4
Medical Student Regional Delegate- 1
Utah – 3
Washington – 6
Wyoming – 1

PALTmed – 1
Post-Acute and Long-Term Care Medical Association (PALTmed) – 1

PATHOLOGY - 9
American Society for Clinical Pathology (ASCP) – 3
American Society of Cytopathology (ASC) - 1
College of American Pathologists (CAP) – 4
National Association of Medical Examiners (NAME) - 1

PEDIATRICS - 9
American Academy of Pediatrics (AAP) – 9
Trustee (Garretson) - 1
Delegates - 5
Resident and Fellow Section Delegates - 3

PENNSYLVANIA - 17
Trustee (Heine) - 1
Delegates - 14
Resident and Fellow Section Delegate – 1
American Association of Physicians of Indian Origin (AAPIO) – 1

PHYSICAL MEDICINE AND REHABILITATION - 5
American Academy of Physical Med & Rehabilitation (AAPMR) – 4
Delegates - 3
Resident and Fellow Section Delegate - 1
Association of Academic Physiatrists (AAPHY) - 1

PREVENTIVE MEDICINE - 6
Aerospace Medical Association (AsMA) - 1
American Academy of Insurance Medicine (AAIM) - 1
American Association of Public Health Physicians (AAPHP) – 1
American College of Medical Quality (ACMQ) - 1
American College of Occupational & Environmental Med (ACOEM) - 1
American College of Preventive Medicine (ACPM) - 1

RADIOLOGY - 17
American College of Radiology (ACR) – 9
Delegates – 8
Former President (Johnson)
Resident and Fellow Section Delegate - 1
American Roentgen Ray Society (ARRS) – 3
Association of Academic Radiology (AAR) - 1
Radiological Society of North America (RSNA) – 3
Society of Interventional Radiology (SIR) - 1

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

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

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

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

SOUTHEASTERN - 113
Alabama – 4
Arkansas – 4
Trustee (Ferguson) – 1
Delegates – 2
Medical Student Regional Delegate- 1
Delaware - 2
Former Board Chair (Permut) – 1
Delegate - 1
District of Columbia - 2
Florida – 21
Trustee (Butler) - 1
Delegates – 17
Medical Student Regional Delegate- 1
National Medical Association (NMA) - 1
The Triological Society (TS) - 1
Georgia – 6
Kentucky – 5
Louisiana - 7
Maryland - 8
Delegates – 6
Medical Student Regional Delegate - 1
Acad of Physicians in Clinical Research (APCR) - 1
Mississippi – 4
Delegates – 3
Resident and Fellow Section Delegate - 1
New Jersey - 9
Delegates - 8
Medical Student Regional Delegate- 1

SOUTHEASTERN (cont'd)
North Carolina – 7
Delegates - 6
Medical Student Regional Delegate- 1
Oklahoma – 7
Delegates - 4
Medical Student Regional Delegate- 1
Resident and Fellow Section Delegates - 2
Puerto Rico - 2
South Carolina – 5
Delegates – 4
Medical Student Regional Delegate- 1
Tennessee – 8
Delegates – 6
Medical Student Regional Delegate- 1
American Vein and Lymphatic Society (AVLS) - 1
Virginia – 10
Delegates - 8
Medical Student Regional Delegate- 1
Resident and Fellow Section Delegate - 1
West Virginia – 2

SURGEONS - 45
American Academy of Cosmetic Surgery (AACS) - 1
American Acad of Facial Plastic and Reconstructive Surgery (AAFPRS) – 1
American Academy of Ophthalmology (AAO) – 5
Delegates - 4
Resident and Fellow Section Delegate - 1
American Academy of Otolaryngic Allergy (AAOA) - 1
Amer Acad of Otolaryngology - Head & Neck Surgery (AAOHNS) - 3
American Association for Thoracic Surgery (AATS) - 1
American Association of Plastic Surgeons (AAPS) - 1
American College of Surgeons (ACS) - 8
Delegates (minus Vice Speaker) – 7
Resident and Fellow Section Delegate - 1
American Society for Aesthetic Plastic Surgery (ASAPS) – 1
American Society for Metabolic and Bariatric Surgery (ASMBS) - 1
American Society for Reconstructive Microsurgery (ASRMS) - 1
American Society of Breast Surgeons (ASBS) - 1
American Society of Cataract and Refractive Surgery (ASCTRS) - 2
American Society of Colon and Rectal Surgeons (ASCRS) - 1
American Soc of Maxillofacial Surgeons (ASMS) - 1
Amer Soc of Ophthalmic Plastic & Reconstructive Surg (ASOPRS) - 1
American Society of Plastic Surgeons (ASPS) – 4
Trustee (Jeffers) – 1
Delegates - 3
American Society of Retina Specialists (ASRS) - 1
American Society of Transplant Surgeons (ASTS) - 1
American Venous Forum (AVF) – 1
International Coll of Surgeons-US Section (ICS-US) - 1
Society for Vascular Surgery (SVS) - 1
Society of Amer Gastrointestinal Endoscopic Surgeons (SAGES) - 2
Society of Laparoscopic and Robotic Surgeons (SLRS) - 2
Society of Thoracic Surgeons (STS) - 2

TERRITORIES - 2
Guam - 1
Virgin Islands - 1

TEXAS - 25
Former President (Bailey) - 1
Delegates - 20
Medical Student Regional Delegate – 1
Resident and Fellow Section Delegate – 1
American College of Allergy, Asthma & Immunology (ACAAI) – 1
International Society of Hair Restoration Surgery (ISHRS) – 1

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

UROLOGY - 5
American Assoc of Clinical Urologists (AACU) - 2
American Urological Association (AUA) – 3
Trustee (Underwood) – 1
Delegates - 2

OFFICIAL OBSERVERS - 29
Accreditation Association for Ambulatory Health Care
Alliance for Continuing Education in the Health Professions
Alliance for Regenerative Medicine
Ambulatory Surgery Center Association
American Academy of Physician Associates
American Association of Medical Assistants
American Board of Medical Specialties
American Dental Association
American Health Quality Association
American Hospital Association
American Nurses Association
American Podiatric Medical Association
American Public Health Association
Association of periOperative Registered Nurses
Association of State and Territorial Health Officials
Commission on Graduates of Foreign Nursing Schools
Council of Medical Specialty Societies
Educational Commission for Foreign Medical Graduates
Federation of State Medical Boards
Federation of State Physician Health Programs
Medical Group Management Association
Medical Professional Liability Association
National Association of County and City Health Officials
National Commission on Correctional Health Care
National Council of State Boards of Nursing
National Indian Health Board
Society for Academic Continuing Medical Education
US Pharmacopeia
United States Professional Association for Transgender Health

TELLERS - 3

HOUSE OF DELEGATES · WALT DISNEY WORLD SWAN AND DOLPHIN RESORT (I-24)

Audience Left — STAGE — Audience Right

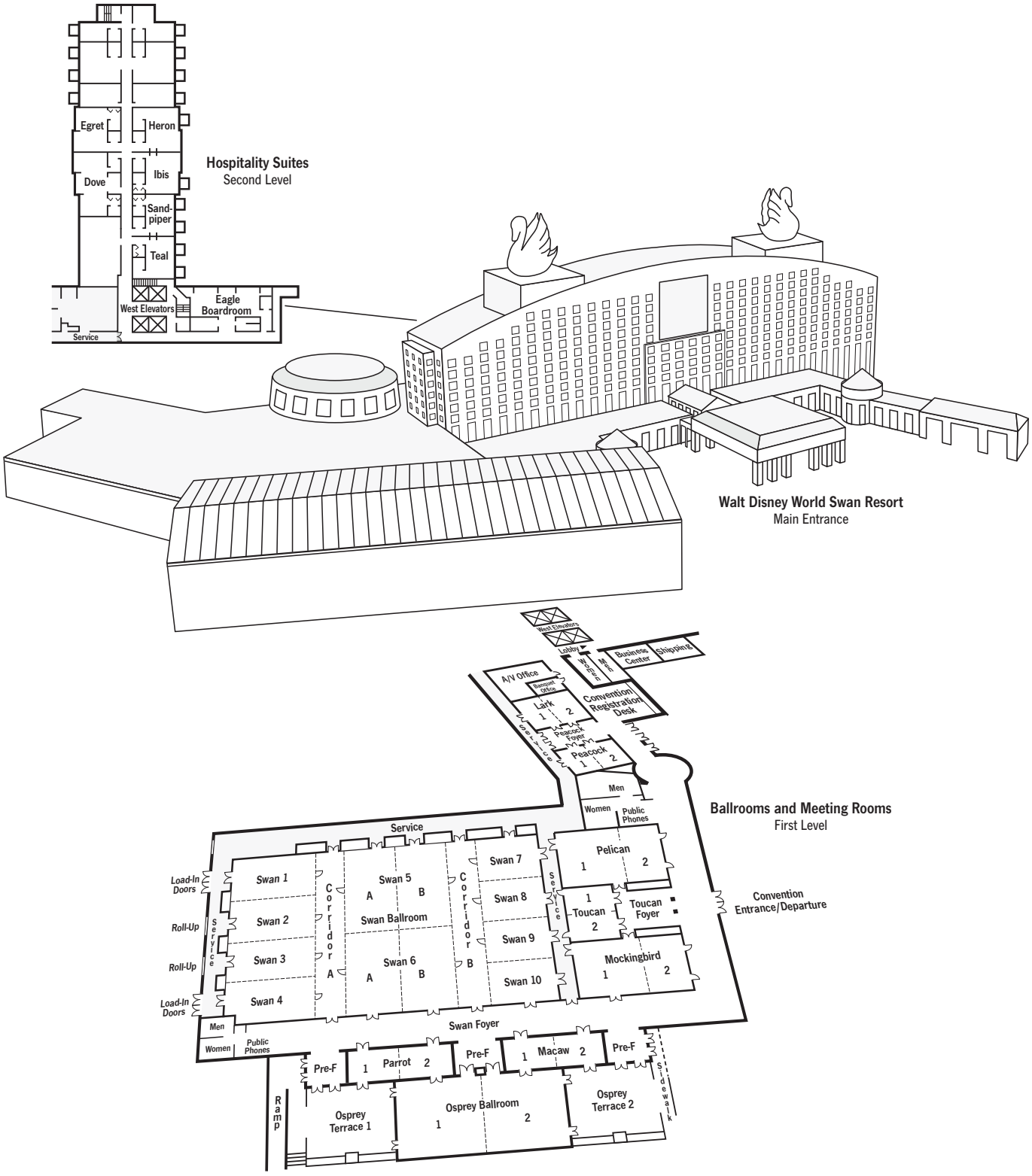
SPEAKER — VICE SPEAKER

SEAT	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	SEAT
ROW	COLORADO - 8								OBSTETRICIANS & GYNECOLOGISTS - 19					SERVICES - 6			ROW
1					MSS			OMA	ACOG	ACOG	WAH	ACOG	ACOG	NAVY	ARMY	VA	1
2	ARIZONA - 8								OBSTETRICIANS & GYNECOLOGISTS					SERVICES			2
						AIUM	AIUM	ACRO	ACOG	ACOG	ACOG	ACOG	ACOG	AMSUS	AF	USPHS	
3	NEVADA - 3		ID - 1	NEW MEXICO - 4					OBSTETRICIANS & GYNECOLOGISTS					NEW YORK - 27			3
		RFS				RFS		AAAAI	KOIRALA	ACOG	ACOG	ACOG	ACOG	ASNR	ASNR	ACNM	
4	CALIFORNIA - 41							WY - 1	OBSTETRICIANS & GYNECOLOGISTS					NEW YORK			4
									AAGL	AAGL	ACMGG	ASRM					
5	CALIFORNIA								NEW YORK								5
				MSS	MSS								MSS				
6	CALIFORNIA								NEW YORK								6
				RFS	RFS			NANOS									
7	CALIFORNIA								NEW YORK					CARDIOLOGY - 15			7
							ASRO	ASRO					SCMR	SCCT	ASE	ASE	
8	CALIFORNIA								CARDIOLOGY								8
								ACNS	SCAI	SCAI	HRS	ASNC	ACC	ACC	ACC	ACC	
9	WASHINGTON - 6						CALIFORNIA		SURGEONS - 45				ARS - 1	CARDIOLOGY			9
								DING	SLRS	SLRS	SAGES	SAGES		ACC	ACC	ACC	
O	UTAH - 3			OREGON - 5					SURGEONS								10
						MSS			ACS	ACS	ACS	ACS/RFS	ACS	ACS	ACS	ACS	
11	NEUROSCIENCES - 31				MT - 1	HAWAII - 2		AK - 1	SURGEONS								11
	CARMEL	AANS	CNS	CNS					ASCTRS	ASCTRS	ICSUS	ASBS	ASCRS	ASMS	AVF	SVS	
12	NEUROSCIENCES						VI - 1	GU - 1	SURGEONS								12
	AAHPM	AAHPM	AAPM	APA	APA	APA			ASOPRS	AAO	AAO	AAO/RFS	AAO	AAO	ASRMS	ASMBS	
13	NEUROSCIENCES								SURGEONS								13
	GLMA	APA	APA	APA	RFS	APA	APA	HARRIS	AAFPRS	JEFFERS	ASPS	ASPS	ASPS	AACS	AAPS	ASAPS	
14	NEUROSCIENCES								SURGEONS								14
	AAGP	AAPL	AACAP	AACAP	AAAP	ACLP	NANS	STS	STS	ASTS	AATS	AAOA	AAOHNS	AAOHNS	AA0HNS	ASRS	
15	GERIATRIC MED - 2	NEUROSCIENCES							RHODE ISLAND - 4				CONNECTICUT - 9				15
			IPSIS	AAN	RFS	RFS	AAN	AAN		RFS	RFS		RFS	MSS			
16	MOBILITY - 12						PHYSICAL MED & REHAB - 5		MAINE - 2			CONNECTICUT					16
	ASSH	AAHS	AOFAS	ISASS	NASS	NASS	PMR	PMR	PMR			BREIG		MSS	MSS		
17	MOBILITY						PM&R		VT - 1	MASSACHUSETTS - 16							17
	AAOS	AAOS	AAOS	GURMAN	AOrA	ASIPP	PMR/RFS	AAPHY		AANEM	MSS						
18	PENNSYLVANIA - 17								MASSACHUSETTS								18
									AAPIO		RFS						
19	PENNSYLVANIA								NH - 1	MASSACHUSETTS		UROLOGY - 5					19
							RFS	HEINE				AUA	UNDERWOOD	AUA	AACU	AACU	
20	RADIOLOGY - 17								MISSOURI - 7								20
	ACR	ACR	ACR	ACR	ACR/RFS	ACR	ACR	ACR	JOHNSON			MSS	RFS				
21	RADIOLOGY								SECTIONS - 12			KANSAS - 4					21
	RSNA	RSNA	RSNA	SIR	AAR	ARRS	ARRS	ARRS	YPS	MSS	RFS	SPS		MSS			
22	DERMATOLOGY - 14								SECTIONS			ANESTHESIOLOGY - 10					22
	ASDSA	ASDSA	ASDSA	SPD	SID	ASD	ACDS	PPPS	IPPS	IMG	WPS						
23	DERMATOLOGY								SECTIONS			ANESTHESIOLOGY					23
	AAD	AAD	AAD	RESNECK	AAD	AAD	ACMS	LGBTQ+	OMSS	APS	MAS				ASRAPM	ASRAPM	

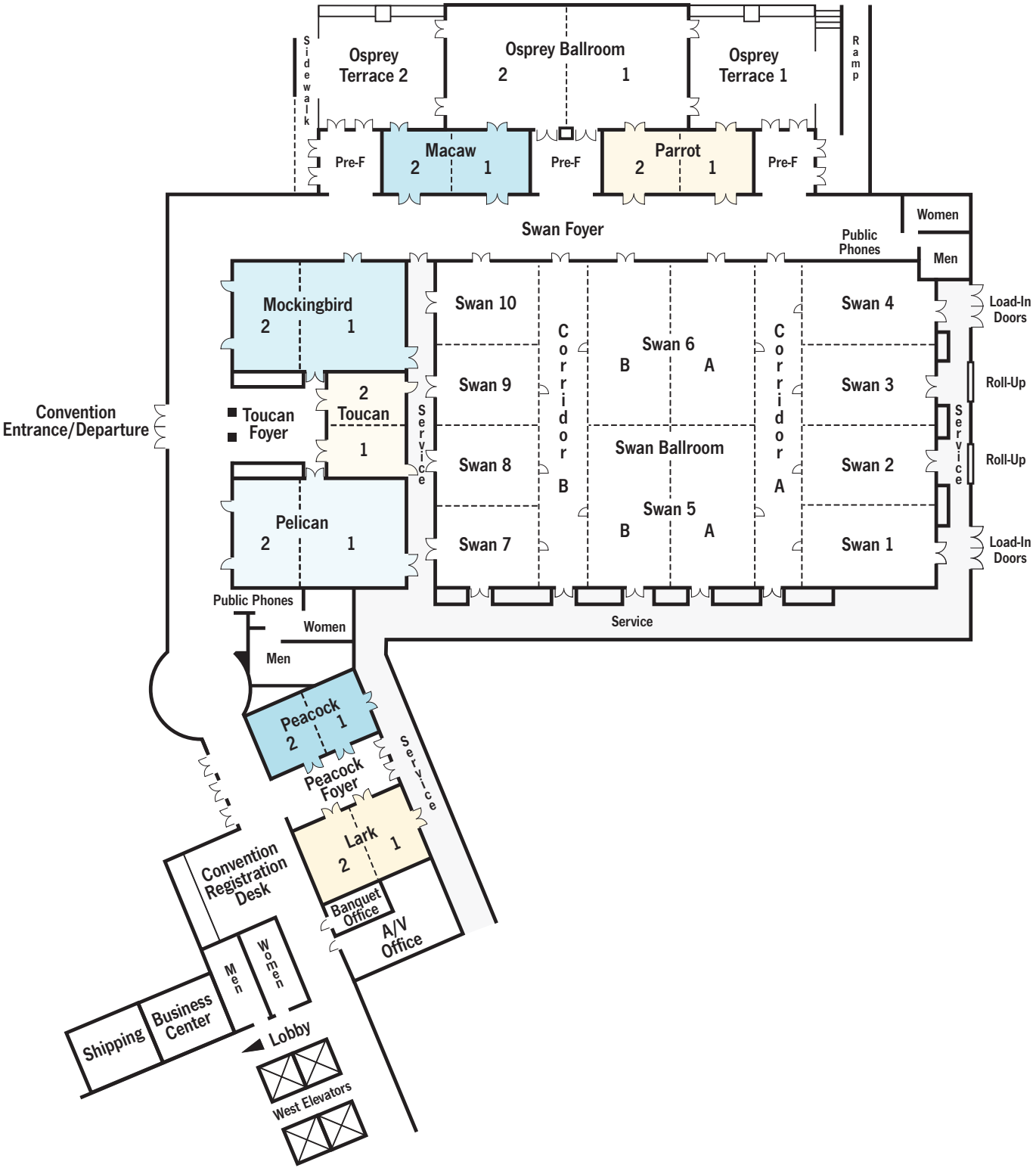
SEAT	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	SEAT
ROW				SOUTH DAKOTA - 2		IOWA - 5				CRITICAL CARE MED - 2		PEDIATRICS - 9					ROW
1	T	T	T					OEIS					RFS				1
2	ONCOLOGY - 7					MINNESOTA - 6						PEDIATRICS					2
			RFS	RFS						AHS	GARRETSON		RFS	RFS			
3	ONCOLOGY		INFECTIOUS DISEASE - 2		North Dakota - 2		NEBRASKA - 2		INTERNAL MEDICINE - 37								3
		MCANENY							WILSON							ACLM	
4	THORACIC MEDICINE - 2		ENDOCRINOLOGY - 3			HEMATOLOGY - 2		PALTMED - 1	INTERNAL MEDICINE								4
			ES	ES	AACE												
5	KENTUCKY - 5					ADDICTION MEDICINE - 3			INTERNAL MEDICINE								5
							LEVIN										
6	DC - 2		WEST VIRGINIA - 2		PREVENTIVE MEDICINE - 6				INTERNAL MEDICINE								6
					AAIM	AAPHP	ACOEM	ACPM	FRYHOFER								
7	MARYLAND - 8					PREVENTIVE MEDICINE			INTERNAL MEDICINE						FAMILY PHYSICIANS - 25		7
				MSS			ACMQ	ASMA	RPA								
8	ALABAMA - 4				MARYLAND	SLEEP MED - 2			FAMILY PHYSICIANS								8
					APCR												
9	OKLAHOMA - 7							X	FAMILY PHYSICIANS								9
			RFS	MSS	RFS												
10	LOUISIANA - 7						AMGA - 1		FAMILY PHYSICIANS						WISCONSIN - 9		10
11	NORTH CAROLINA - 7						RHEUMATOLOGY - 2			WISCONSIN							11
				MSS						USHM	UHMS/RFS	RFS	MSS				
12	TENNESSEE - 8								ILLINOIS - 19								12
				MSS		AVLS			AMWA	SIDDIQUI			RFS				
13	VIRGINIA - 10								ILLINOIS								13
			MSS	RFS					AOA				MSS				
14	FLORIDA - 21				VIRGINIA		ILLINOIS		MICHIGAN - 16								14
			BUTLER	MSS				SNMMI	ACLM				RFS				
15	FLORIDA								MICHIGAN								15
								NMA				MSS					
16	FLORIDA						MICHIGAN		OHIO - 13								16
				TS								MSS					
17	SOUTH CAROLINA - 5					CHEST PHYSICIANS - 4			OHIO								17
				MSS				RFS					RFS				
18	GEORGIA - 6					PUERTO RICO - 2			X	INDIANA - 7							18
										WELSH			MSS				
19	ARKANSAS - 4				DELAWARE - 2		PATHOLOGY - 9					GASTROENTEROLOGY - 6					19
		FERGUSON	MSS		PERMUT	CAP	CAP	CAP	CAP	ACG	ACG	AGA	AGA	ASGE	ASGE		
20	NEW JERSEY - 9						PATHOLOGY						TEXAS - 25				20
				MSS			ASC	ASCP	ASCP	ASCP	NAME	BAILEY					
21	MISSISSIPPI - 4			NEW JERSEY		TEXAS											21
		RFS									RFS						
22	EMERGENCY MEDICINE - 11						TEXAS										22
				RFS	RFS	STACK					MSS						
23	EMERGENCY MEDICINE				HOSPITAL MEDICINE - 3		TEXAS										23
							ISHRS	ACAAI									

WALT DISNEY WORLD SWAN RESORT

Meeting Space Aerial View



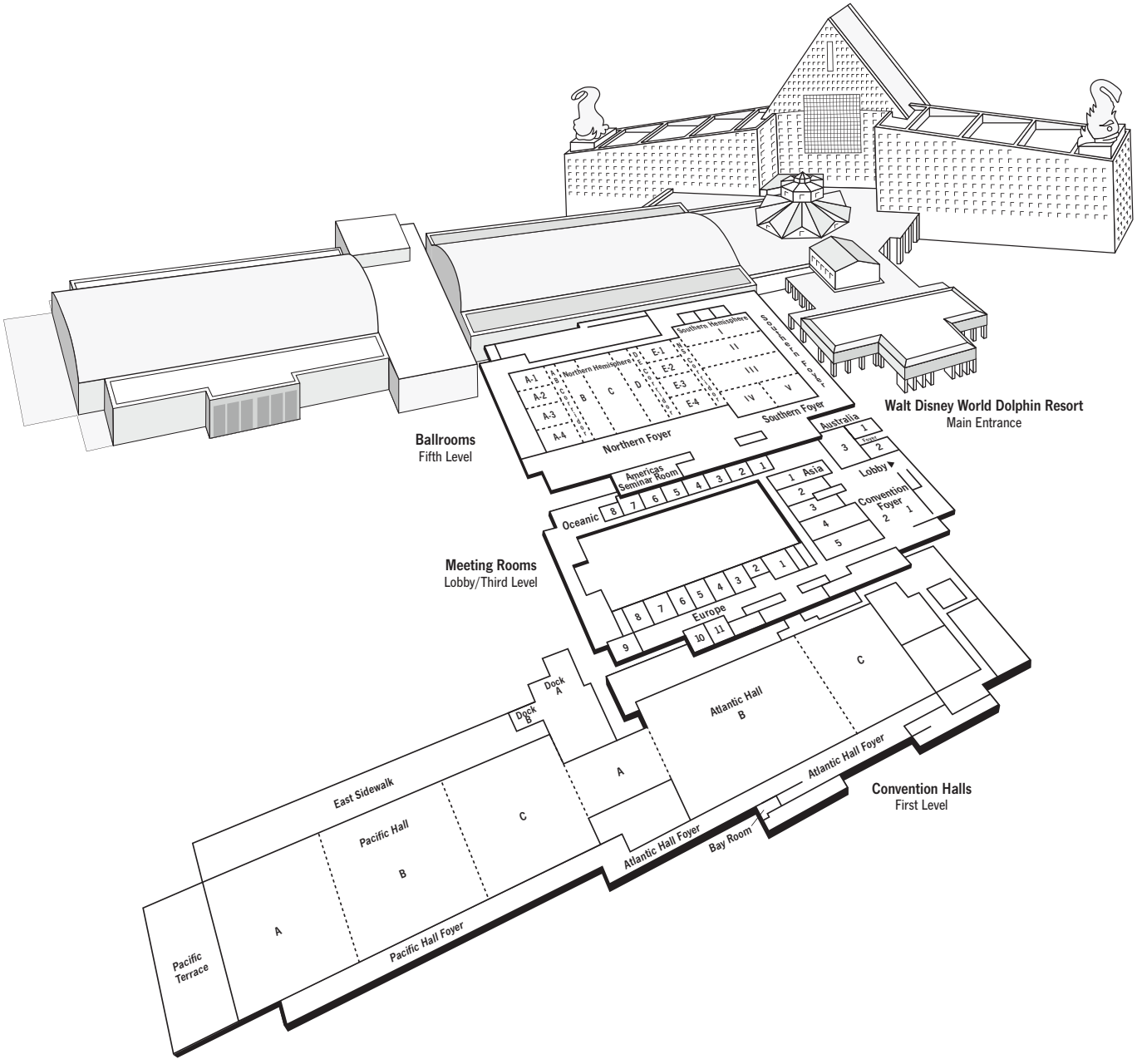
First Level


Sidewalk
Osprey Terrace 2
Osprey Ballroom
2
1
Osprey Terrace 1
Ramp
Pre-F
Macaw
2
1
Pre-F
Parrot
2
1
Pre-F
Swan Foyer
Women
Public Phones
Men
Mockingbird
2
1
Swan 10
Swan 4
Load-In Doors
Swan 9
Swan 6
B
A
Swan 3
Roll-Up
Convention Entrance/Departure
Toucan Foyer
2
Toucan
1
Service
Corridor B
Corridor A
Service
Swan 8
Swan Ballroom
Swan 2
Roll-Up
Pelican
2
1
Swan 5
B
A
Swan 7
Swan 1
Load-In Doors
Public Phones
Service
Women
Men
Peacock
2
1
Peacock Foyer
Service
Lark
2
1
Convention Registration Desk
Banquet Office
A/V Office
Men
Women
Shipping
Business Center
Lobby
West Elevators

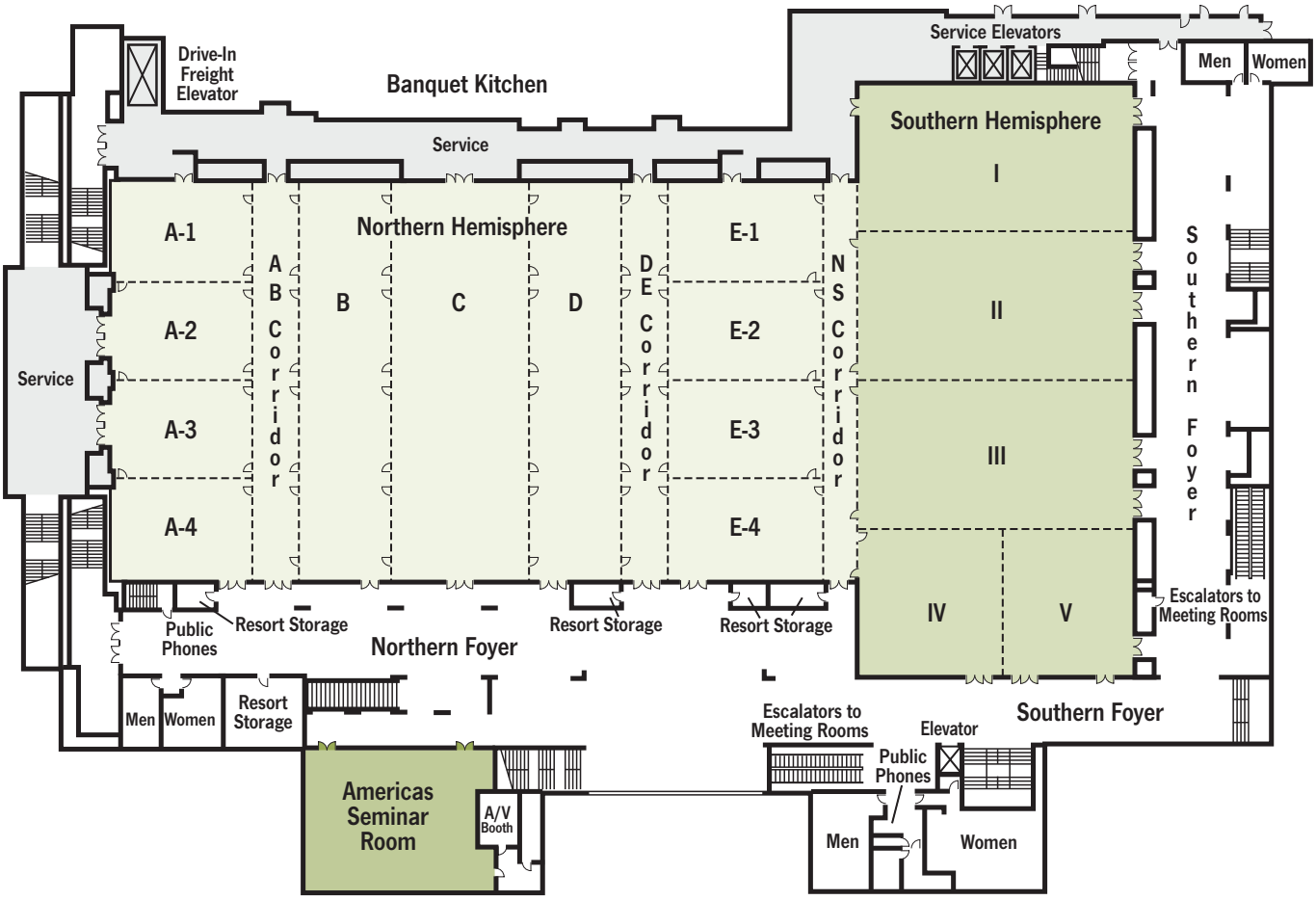
Second Level

WALT DISNEY WORLD DOLPHIN RESORT

Meeting Space Aerial View



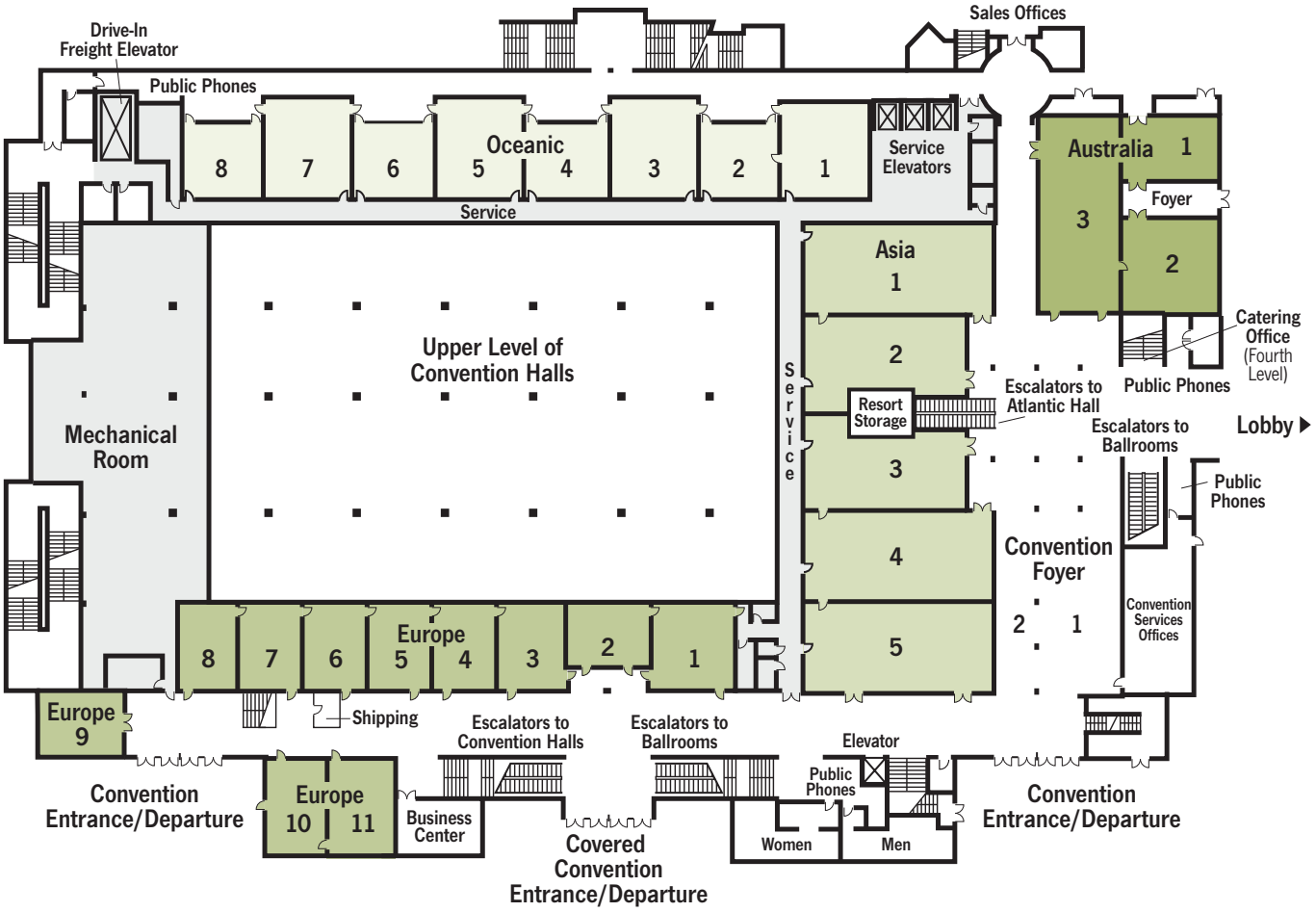
Fifth Level



FEATURES:

- 10,000 square foot sound booth running along the side of both ballrooms
- Programmable lighting and hang points in ceiling
- Extensive ventilation system permitting indoor pyrotechnics
- Drive-in freight elevator: 23'L x 10'W x 12'H; load limit: 12,000 lbs.
- Fully scalable DS-3 class Internet service, delivered via our fiber-optic and Ethernet backbone, available in the ballrooms and foyers
- Wireless access available throughout the ballrooms and foyers
- Salon B and Salon D in the Hemispheres Ballroom cannot stand alone
- Built-in A/V booth in Americas Seminar Room
- Complimentary house phone in Americas Seminar Room
- Convention network infrastructure managed by on-site technicians
- On-site audio/visual services department

Lobby/Third Level



FEATURES:

- Both fluorescent and incandescent adjustable lighting
- Simultaneous recording of presentation through a central audio mixer
- Each room includes four solid walls with bulletin board wall to maximize sound proofing, built-in A/V screen, and patches for microphone and video
- Drive-in freight elevator: 23'L x 10'W x 12'H; load limit: 12,000 lbs.
- Fully scalable DS-3 class Internet service, delivered via our fiber-optic and Ethernet backbone, available in all meeting rooms and foyers
- Wireless access available throughout all meeting rooms and foyers
- Complimentary house phone in meeting rooms
- Australia Boardroom
  - Projection display system and upgraded A/V system with touchpad control
  - Warm, modern décor with luxurious blonde wood paneling
  - Executive board table for 16 with over-sized ergonomic leather chairs
  - Private entry area
  - Connected his/hers lavatories

2024 INTERIM MEETING OF THE AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Official Call to the Officers and Members of the American Medical Association to attend the November 2024 Interim Meeting of the House of Delegates in Orlando, Florida, November 8 – 12, 2024.

The House of Delegates will convene at 6:00 p.m., on November 8 at the Walt Disney World Swan and Dolphin Resort.

STATE ASSOCIATION REPRESENTATION IN THE HOUSE OF DELEGATES

Alabama 4
Alaska 1
Arizona 5
Arkansas 2
California 32
Colorado 6
Connecticut 4
Delaware 1
District of Columbia 2
Florida 17
Georgia 6
Guam 1
Hawaii 2
Idaho 1
Illinois 12
Indiana 5
Iowa 4
Kansas 3
Kentucky 5
Louisiana 7
Maine 2
Maryland 6
Massachusetts 13
Michigan 14
Minnesota 5
Mississippi 3
Missouri 5
Montana 1
Nebraska 2
Nevada 2
New Hampshire 1
New Jersey 8
New Mexico 2
New York 23
North Carolina 6
North Dakota 2
Ohio 12
Oklahoma 4
Oregon 4
Pennsylvania 14
Puerto Rico 2
Rhode Island 2
South Carolina 4
South Dakota 2
Tennessee 6
Texas 20
Utah 3
Vermont 1
Virgin Islands 1
Virginia 8
Washington 6
West Virginia 2
Wisconsin 5
Wyoming 1

SPECIALTY SOCIETY REPRESENTATION IN THE HOUSE OF DELEGATES

American Academy of Child and Adolescent Psychiatry 2
American Academy of Dermatology 5
American Academy of Family Physicians 25
American Academy of Hospice and Palliative Medicine 2
American Academy of Neurology 3
American Academy of Ophthalmology 4
American Academy of Orthopaedic Surgeons 4
American Academy of Otolaryngology-Head and Neck Surgery 3
American Academy of Pediatrics 5
American Academy of Physical Medicine and Rehabilitation 3
American Academy of Sleep Medicine 2
American Association of Clinical Urology, Inc. 2
American Association of Gynecologic Laparoscopists 2
American College of Cardiology 7
American College of Chest Physicians (CHEST) 3
American College of Emergency Physicians 8
American College of Gastroenterology 2
American College of Obstetricians and Gynecologists 14
American College of Physicians 34
American College of Radiology 8
American College of Rheumatology 2
American College of Surgeons 8
American Gastroenterological Association 2
American Geriatrics Society 2
American Institute of Ultrasound in Medicine 2
American Psychiatric Association 8
American Roentgen Ray Society 3
American Society for Clinical Pathology 3
American Society for Dermatologic Surgery 3
American Society for Gastrointestinal Endoscopy 2
American Society for Radiation Oncology 2
American Society of Addiction Medicine 2
American Society of Anesthesiologists 8
American Society of Cataract and Refractive Surgery 2
American Society of Echocardiography 2
American Society of Hematology 2
American Society of Neuroradiology 2
American Society of Plastic Surgeons 3
American Society of Regional Anesthesia and Pain Medicine 2
American Thoracic Society 2
American Urological Association 2
Association for Clinical Oncology 5
College of American Pathologists 4
Congress of Neurological Surgeons 2
Infectious Diseases Society of America 2
North American Spine Society 2
Radiological Society of North America 3
Society for Cardiovascular Angiography and Interventions 2
Society of American Gastrointestinal Endoscopic Surgeons 2
Society of Critical Care Medicine 2
Society of Hospital Medicine 3
Society of Laparoscopic and Robotic Surgeons 2
Society of Thoracic Surgeons 2
The Endocrine Society 2

Remaining eligible national medical specialty societies (76) are entitled to one delegate each.

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

State Medical Associations	312
National Medical Specialty Societies	311
Professional Interest Medical Associations	3
Other National Societies (AMWA, AOA, NMA)	3
Medical Student Regional Delegates	26
Resident and Fellow Delegate Representatives	35
Sections	12
Services	5
Total Delegates	**707**

Registration facilities will be maintained at the Walt Disney World Swan and Dolphin Resort Atlanta B Foyer.

Bruce A. Scott, MD
President

Lisa Bohman Egbert, MD
Speaker, House of Delegates

Toluwalase A. Ajayi, MD
Secretary

2024 - 2025

OFFICIALS OF THE ASSOCIATION

BOARD OF TRUSTEES (OFFICERS)

President – Bruce A. Scott ..... Louisville, Kentucky
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Speaker, House of Delegates - Lisa Bohman Egbert ..... Dayton, Ohio
Vice Speaker, House of Delegates - John H. Armstrong ..... Ocala, Florida

David H. Aizuss (2028), *Chair-Elect* ..... Encino, California
Geralyn R. Breig (2028) ..... West Port, Connecticut
Madelyn E. Butler (2025) ..... Tampa, Florida
Alexander Ding (2026) ..... Louisville, Kentucky
Scott Ferguson (2026) ..... West Memphis, Arkansas
Sandra Adamson Fryhofer (2026) ..... Atlanta, Georgia
Melissa Garretson (2028) ..... Fort Worth, Texas
Marilyn J. Heine (2026) ..... Dresher, Pennsylvania
Lynne Jeffers (2028) ..... Oxnard, California
Pratistha Koirala (2025) ..... Danbury, Connecticut
Ilse R. Levin (2028) ..... Silver Spring, Maryland
Aliya Siddiqui (2025) ..... Milwaukee, Wisconsin
Michael Suk (2027), *Chair* ..... Danville, Pennsylvania
Willie Underwood, III (2027) ..... Buffalo, New York
David Welsh (2028) ..... Batesville Indiana

COUNCILS OF THE AMA

COUNCIL ON CONSTITUTION AND BYLAWS
Jerry P. Abraham, Los Angeles, California, Chair (2025); John H. Armstrong, Ocala, Florida, Vice Speaker: Ex Officio (2025); Mark N. Bair, Highland, Utah (2027); Adrina Kocharian, Minneapolis, Minnesota, (Student) (2025); Mary Ann Contogiannis, Greensboro, North Carolina, Vice Chair, (2025); Lisa Bohman Egbert, Dayton, Ohio, Speaker: Ex Officio (2025); Christopher E. Gribbin, Princeton, New Jersey (2028); Daniel O. Pfeifle, Indianapolis, Indiana (Resident) (2025); Kevin C. Reilly, Sr., Grovetown, Georgia (2026); Steven C. Thornquist, Bethany, Connecticut (2026).
Secretary: Janice Robertson, Chicago, Illinois.

COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS
Rebecca W. Brendel, Boston, Massachusetts, Vice Chair, (2026); Arthur R. Derse, Shorewood, Wisconsin (2030); Sophia A. Doerr, Madison, Wisconsin, (Student) (2025); Charles J. Hickey, Mechanicsburg, Ohio (2031); Michael G. Knight, Washington, District of Columbia (2029); Jeremy A. Lazarus, Greenwood Village, Colorado, Chair (2025); Larry E. Reaves, Fort Worth, Texas (2027); Daniel P. Sulmasy, Washington, District of Columbia (2028); Kelsey C. Mumford, Pflugerville, Texas, (Resident) (2026).
Secretary: Amber Comer, Chicago, Illinois.

COUNCIL ON LEGISLATION
Vijaya L. Appareddy, Chattanooga, Tennessee (2025); Maryanne C. Bombaugh, Falmouth, Massachusetts (2025); Claude D. Brunson, Ridgeland, Mississippi (2025); Michael D. Chafty, Kalamazoo, Michigan (2025); Gary W. Floyd, Corpus Christi, Texas (2025); Benjamin Z. Galper, McLean, Virginia (AMPAC Liaison) (2024); Merrilee Aynes Gober, Atlanta, Georgia (Alliance Rep) (2025); Ross F. Goldberg, Miami, Florida (2025); Tracy L. Henry, Lithonia, Georgia (2025); Tripti C. Kataria, Chicago, Illinois, Vice Chair, (2025); Laurie L. Lapp, Madison, Wisconsin (Student) (2025); Sophia E. Spadafore, New York, New York (Resident) (2025); Ann Rosemarie Stroink, Heyworth, Illinois (2025); Marta J. Van Beek, Iowa City, Iowa, Chair (2025).
Secretary: George Cox, Washington, District of Columbia.

COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT
Edmond B. Cabbabe, St. Louis, Missouri (2025); Erin K. Harnish, Longview, Washington (2028); Moudi K. Hubeishy, Chicago, Illinois (Resident) (2026); Gary R. Katz, Dublin, OH (2027); G. Sealy Massingill, Fort Worth, Texas (2027); Gary D. Thal, Chicago, Illinois (2025); Michelle A. Berger, Austin, Texas, Chair (2026); Jan M. Kief, Merritt Island, Florida, Vice Chair (2027); Shilpen A. Patel, San Francisco, California (2028); Dhruv Puri, Pleasanton, California (Student) (2025).
Secretary: Susan Close, Chicago, Illinois.

COUNCIL ON MEDICAL EDUCATION
Suja M. Mathew, Hinsdale, Illinois (2026); Sherri S. Baker, Edmond, Oklahoma (2025); Kelly J. Caverzagie, Omaha, Nebraska, Vice Chair (2027); Ricardo R. Correa Marquez, Phoenix, Arizona (2027); Louito C. Edje, Cincinnati, Ohio (2025); Robert B. Goldberg, Morristown, New York (2025); Shannon M. Kilgore, Los Altos, California (2027); Daniel C. Lee, Mobile, Alabama (Resident) (2025); Radhika B. Patel, Sugarland, Texas (Student) (2025); Seema Sidhu, Morgan Hill California (2028); Krystal L. Tomei, Lyndhurst, Ohio, Chair (2025); Daniel M. Young, Vestal, New York (2027).
Secretary: Tanya Lopez, Chicago, Illinois.

COUNCIL ON MEDICAL SERVICE
A. Patrice Burgess, Boise, Idaho (2027); Alain A. Chaoui, Peabody, Massachusetts (2025); Steven L. Chen, San Diego, California (2028); Betty S. Chu, Detroit, Michigan, Chair-Elect (2026); Alice Coombs, Richmond, Virginia (2027); Erick A. Eiting, New York, New York (2028); Stephen K. Epstein, Needham, Massachusetts, Chair (2026); Ravi Goel, Cherry Hill, New Jersey (2026); Hari S. Iyer Detroit, Michigan (Resident) (2025); Justin W. Magrath New Orleans, Louisiana (Student) (2025); Sheila Rege, Pasco, Washington (2026); Ezequiel Silva, III, San Antonio, Texas (2028).
Secretary: Linda Walsh, Chicago, Illinois.

COUNCIL ON SCIENCE AND PUBLIC HEALTH
Ankush K. Bansal, Loxahatchee, Florida (2027); Joanna Bisgrove, Evanston, Illinois (2026);John T. Carlo, Dallas, Texas, Chair (2025); Joshua M. Cohen, New York, New York (2026); David R. Cundiff, Ilwaco, Washington (2026); Rachel Ekaireb, Sacramento, California (Resident) (2026); Mary E. LaPlante, Broadview Heights, OH (2025); Marc Mendelsohn, St. Louis, MO (2027); Tamaan K. Osbourne-Roberts, Denver, Colorado (2027); Padmini D. Ranasinghe, Baltimore, Maryland, Chair-Elet (2026); Rajadhar T. Reddy, Round Rock, Texas (Student) (2025); Raymond K. Tu, Washington, DC (2028).
Secretary: Andrea Garcia, Chicago, Illinois.

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

EX OFFICIO MEMBERS OF THE HOUSE OF DELEGATES

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

FORMER PRESIDENTS

Susan R. Bailey	2020-2021	Patrice A. Harris	2019-2020	William G. Plested, III	2006-2007
David O. Barbe	2017-2018	J. Edward Hill	2005-2006	Jack Resneck, Jr	2022-2023
Lonnie R. Bristow	1995-1996	Ardis D. Hoven	2013-2014	J. James Rohack	2009-2010
Peter W. Carmel	2011-2012	Daniel H. Johnson, Jr.	1996-1997	Randolph D. Smoak, Jr.	2000-2001
Yank D. Coble, Jr.	2002-2003	Jeremy A. Lazarus	2012-2013	Steven J. Stack	2015-2016
Richard F. Corlin	2001-2002	Barbara L. McAneny	2018-2019	Robert M. Wah	2014-2015
Nancy W. Dickey	1998-1999	Alan R. Nelson	1989-1990	Cecil B. Wilson	2010-2011
Andrew W. Gurman	2016-2017	John C. Nelson	2004-2005	Percy Wootton	1997-1998
Gerald E. Harmon	2021-2022	Nancy H. Nielsen	2008-2009		

FORMER TRUSTEES

Herman I. Abromowitz	1997-2005	Alan C. Hartford	1989-1990	Rebecca J. Patchin	1988-1989
Susan Hershberg Adelman	1998-2002	Drayton Charles Harvey	2020-2023	Rebecca J. Patchin	2003-2011
Kendall S. Allred	2008-2009	William A. Hazel, Jr	2004-2009	Stephen R. Permut	2010-2018
Raj S. Ambay	2009-2011	Cyril M. Hetsko	2003-2011	Pamela Petersen-Crair	1996-1998
Joseph P. Annis	2006-2014	J. Edward Hill	1996-2004	Dina Marie Pitta	2015-2016
Grayson W. Armstrong	2019-2021	Ardis D. Hoven	2005-2012	William G. Plested, III	1998-2005
John H. Armstrong	2002-2006	William E. Jacott	1989-1998	Stephen Pool	1995-1996
Maya A. Babu	2013-2017	Hillary D. Johnson	2001-2002	Liana Puscas	1999-2001
Susan R. Bailey	2011-2018	Matthew D. Kagan	1999-2000	Kevin C. Reilly	2003-2005
Timothy E. Baldwin	1987-1989	Christopher K. Kay	2008-2012	Ryan J. Ribeira	2013-2014
David O. Barbe	2009-2016	William E. Kobler	2012-2020	J. James Rohack	2001-2008
Regina M. Benjamin	1995-1998	Russell W.H. Kridel	2014-2022	David A. Rosman	2002-2004
Scott L. Bernstein	1991-1992	Edward L. Langston	2003-2011	Samantha L. Rosman	2005-2009
Stefano M. Bertozzi	1986-1988	Matthew C. Lawyer	2004-2005	Raymond Scalettar	1985-1994
David J. Brailer	1985-1986	Jeremy A. Lazarus	2005-2011	Bruce A. Scott	1998-2002
Lonnie R. Bristow	1985-1994	W. J. Lewis	1979-1984	Carl A. Sirio	2010-2018
Peter Carmel	2002-2010	Audrey J. Ludwig	1990-1991	Sarah Mae Smith	2019-2020
Alice A. Chenault	1984-1985	Thomas J. Madejski	2020-2024	Randolph D. Smoak, Jr.	1992-1999
Yank D. Coble	1994-2001	Justin B. Mahida	2009-2010	Steven J. Stack	2006-2014
David S. Cockrum	1993-1994	Omar Z. Maniya	2016-2017	Michael Suk	1994-1995
MaryAnn Contogiannis	1989-1993	Barbara L. McAneny	2010-2017	Andrew M. Thomas	1997-1999
Malini Daniel	2012-2013	William A. McDade	2016-2020	Jeffrey A. Towson	1998-1999
Christopher M. DeRienzo	2006-2008	Mary Anne McCaffree	2008-2016	Georgia A. Tuttle	2011-2019
Nancy W. Dickey	1989-1997	Joe T. McDonald	2005-2006	Jordan M. VanLare	2011-2012
Alexander Ding	2011-2013	Samuel J. Mackenzie	2014-2015	Robert M. Wah	2005-2013
William A. Dolan	2007-2011	Sandeep “Sunny” Mistry	2000-2001	Peter Y. Watson	2001-2003
Willarda Edwards	2016-2024	Mario Motta	2018-2022	Monica C. Wehby	2011-2013
Timothy T. Flaherty	1994-2003	Elizabeth Blake Murphy	2020-2021	Kevin W. Williams	2016-2020
Melissa J. Garretson	1992-1993	Alan R. Nelson	1980-1988	Meredith C. Williams	2010-2011
Michael S. Goldrich	1993-1997	John C. Nelson	1994-2003	Cecil B. Wilson	2002-2009
Julie K. Goonewardene	2012-2016	Nancy H. Nielsen	2005-2007	Percy Wootton	1991-1996
Andrew W. Gurman	2007-2015	Albert J. Osbahr, III	2011-2019		
Patrice A. Harris	2011-2018	Harris Pastides	2020-2024		

SPECIALTY AND SERVICE SOCIETY REPRESENTATIVES
2024 Interim Meeting of the AMA House of Delegates

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

American Academy of Emergency Medicine	Joseph Wood, MD, JD
American Association of Endocrine Surgeons	Dina Elaraj, MD
American Association of Hip and Knee Surgeons	Beau Kildow, MD
American College of Correctional Physicians	Charles Lee, MD
American Dermatological Association	Murad Alam, MD
American Epilepsy Society	David M. Labiner, MD
American Foregut Society	Jonathan A. Levy, MD
American Society for Laser Medicine and Surgery	George Hruza, MD
American Society of Nephrology	Jeffrey S. Berns, MD
American Society of Neuroimaging	Ryan Hakimi, MD
American Urogynecologic Society	Jennifer Wu, MD
Association of Professors of Dermatology	Christopher R. Shea, MD
International Academy of Independent Medical Evaluators	Gary Pushkin, MD
Korean American Medical Association	Jennifer Inhae Lee, MD
United States and Canadian Academy of Pathology	Nicole Riddle, MD

MEMBERS OF THE HOUSE OF DELEGATES SPECIAL MEETING - NOVEMBER 2024
The following is a list of delegates and alternate delegates to the House of Delegates as reported to the Executive Vice President

Medical Association of the State of Alabama

Delegate(s)

B Jerry Harrison, Haleyville AL

John Meigs Jr, Brent AL

William Schneider, Huntsville AL

George C. Smith, Lineville AL

Alternate Delegate(s)

Alexis Mason, Tuscaloosa AL

Jane Weida, Tuscaloosa AL

Tom Weida, Tuscaloosa AL

Amanda Williams, Montgomery AL

Regional Medical Student Alternate Delegate(s)

Marc Erickson , Dothan AL

Rhea Nichani, Dothan AL

Arizona Medical Association

Delegate(s)

Veronica K. Dowling, Lakeside AZ

Gary R. Figge, Tucson AZ

Michael Hamant, Tucson AZ

M Zuhdi Jasser, Phoenix AZ

Marc Leib, Phoenix AZ

Alternate Delegate(s)

Ilana Addis, Tucson AZ

David Baltazer, Scottsdale AZ

Timothy Fagan, Tucson AZ

Jacquelyn Hoffman, Tucson AZ

Nadeem Kazi, Casa Grande AZ

Arkansas Medical Society

Delegate(s)

Stephen Magie, Conway AR

Eugene Shelby, Little Rock AR

Alternate Delegate(s)

Danny Wilkerson, Little Rock AR

Alan Wilson, Monticello AR

Regional Medical Student Delegate(s)

Clara I. Puente, Little Rock AR

California Medical Association

Delegate(s)

Jerry P Abraham, Los Angeles CA

Barbara J. Arnold, Sacramento CA

Patricia L. Austin, Alamo CA

Dirk Stephen Baumann, Burlingame CA

Jeffrey Brackett, Ventura CA

Peter N. Bretan, Novato CA

J Brennan Cassidy, Newport Beach CA

Maisha Draves, Fairfield CA

Suparna Dutta, Oakland CA

Kyle P. Edmonds, San Diego CA

Rachel Ekaireb, Sacramento CA

George Fouras, Los Angeles CA

Anjalee Galion, Santa Ana CA

Dev A. GnanaDev, Upland CA

Robert Hertzka, Rancho Santa Fe CA

Samuel Huang, Los Angeles CA

Jeff Klingman, Orinda CA

John Maa, San Francisco CA

Ramin Manshadi, Stockton CA

California Medical Association

Delegate(s)

Theodore Mazer, Fort Myers FL

Kelly McCue, Davis CA

Mihir Parikh, La Jolla CA

Stephen Parodi, Oakland CA

Albert Ray, San Diego CA

Ryan J. Ribeira, Mountain View CA

Katrina Saba, Oakland CA

Seema Sidhu, Fremont CA

Tatiana W. Spirtos, Redwood City CA

James J. Strebig, Irvine CA

Illan Strygler, Commerce CA

Holly Yang, San Diego CA

Frank Zhou, Los Angeles CA

Alternate Delegate(s)

Ameena Ahmed, Oakland CA

Alpesh Amin, Anaheim CA

Jack Chou, Baldwin Park CA

Jade Cook, Los Angeles CA

James Cotter, Napa CA

Diana Dayal, Los Angeles CA

Michele Evans, Rocklin CA

Sergio Flores, San Diego CA

David Friscia, San Diego CA

Douglas Gibson, Folsom CA

Raminder Gill, Sacramento CA

Brian Grady, San Francisco CA

Catherine Gutfreund, Santa Rosa CA

Jennifer Hone, Santa Barbara CA

Janet Jacobson, Anaheim CA

Scott Richard Karlan, West Hollywood CA

California Medical Association

Alternate Delegate(s)

Mark H. Kogan, San Pablo CA

Sudeep Kukreja, Orange CA

Man Kit Leung, San Francisco CA

Stacey Ludwig, Los Angeles CA

Debbie Lupeika, Redding CA

Chang Na, Bakersfield CA

Bing Pao, Rcho Santa Fe CA

Smita Rouillard, Fresno CA

Sion Roy, Malibu CA

Raymond Tsai, Lost Hills CA

William Tseng, San Diego CA

Shannon Udovic-Constant, San Francisco CA

Valencia Walker, Los Angeles CA

Patricia Wang, Antioch CA

Barbara Weissman, Pacifica CA

Anna Yap, Carmichael CA

Resident and Fellow Sectional Delegate(s)

Pauline Huynh, Oakland CA

Helene Nepomuceno, Las Vegas NV

Resident and Fellow Sectional Alternate Delegate(s)

Abnishek Dharan, El Paso TX

J. Steven Ekman, Washington DC

Ethan Fan, Plano TX

Revati Gummaluri, Flemington NJ

Regional Medical Student Delegate(s)

Jessica Kim, San Jose CA

Elisabeth McCallum, Irvine CA

Regional Medical Student Alternate Delegate(s)

Thomas S. Issa, Lancaster CA

Kelly C Ngo, Orange CA

Current as of: 9/20/2024

California Medical Association

Regional Medical Student Alternate Delegate(s)

Rebecca Shaneck, Montclair CA

Colorado Medical Society

Delegate(s)

David Downs, Denver CO

Jan Kief, Merritt Island FL

Rachelle M. Klammer, Denver CO

A. "Lee" Morgan, Denver CO

Tamaan Osbourne-Roberts, Denver CO

Lynn Parry, Littleton CO

Alternate Delegate(s)

Carolynn Francavilla, Lakewood CO

Mark Johnson, Louisville CO

Brigitta J. Robinson, Centennial CO

Michael Volz, Englewood CO

Resident and Fellow Sectional Delegate(s)

Jacob Altholz, Las Vegas NV

Regional Medical Student Delegate(s)

Dakota R. Hitchcock, Denver CO

Connecticut State Medical Society

Delegate(s)

Katherine L. Harvey, Canton CT

Kathleen A. LaVorgna, Norwalk CT

Bollepalli Subbarao, Middletown CT

Steven C. Thornquist, Bethany CT

Alternate Delegate(s)

M. Natalie Achong, Unionville CT

Raymond Lorenzoni, Woodbridge CT

Stacy Taylor, New Hartford CT

Michael Virata, Woodbridge CT

Connecticut State Medical Society

Resident and Fellow Sectional Delegate(s)

Daniel Kerekes, New Hyde Park NY

Resident and Fellow Sectional Alternate Delegate(s)

Pawan Mathew, Winchester MA

Regional Medical Student Delegate(s)

Amanda Kahn, Farmington CT

Julia Silverman, Farmington CT

Lizzie Suschana, Farmington CT

Regional Medical Student Alternate Delegate(s)

Catriona Hong, Glastonbury CT

Vedika Karandikar, Farmington CT

Jessica Macintyre, Farmington CT

Medical Society of Delaware

Delegate(s)

Janice Tildon-Burton, Newark DE

Alternate Delegate(s)

Matthew Burday, Wilmington DE

Medical Society of the District of Columbia

Delegate(s)

Peter E. Lavine, Washington DC

Raymond K. Tu, Washington DC

Alternate Delegate(s)

Neal D Barnard, Washington DC

Matthew Lecuyer, Washington DC

Resident and Fellow Sectional Alternate Delegate(s)

Rijul Asri, Princeton NJ

Florida Medical Association

Delegate(s)

Ankush Bansal, Westlake FL

Rebekah Bernard, Fort Myers FL

Florida Medical Association

Delegate(s)

Charles J. Chase, Winter Park FL

Andrew Cooke, Mount Dora FL

Lisa Cosgrove, Jacksonville FL

Eva Crooke, Tampa FL

Mark Dobbertien, Orange Park FL

Michelle Falcone, Miami FL

Shelley C. Glover, Clermont FL

Tra'Chella Johnson Foy, Jacksonville FL

John Montgomery, Fleming Island FL

Ralph Jacinto Nobo, Bartow FL

Michael L. Patete, Venice FL

Sanjay Pattani, Windermere FL

Alan B. Pillersdorf, Lake Worth FL

Mark Rubenstein, Jupiter FL

Michael Andrew Zimmer, St Petersburg FL

Alternate Delegate(s)

Shawn Baca, Boca Raton FL

Rose Berkun, Williamsville NY

Michael Cromer, Tampa FL

Aaron Elkin, Hollywood FL

Ronald Frederic Giffler, Davie FL

Raphael C. Haciski, Naples FL

Ryan Hall, Lake Mary FL

Karen Harris, Gainesville FL

Marc J. Hirsh, Delray Beach FL

Rebecca Lynn Johnson, Tampa FL

Vicki Norton, Boca Raton FL

Arthur E. Palamara, Hollywood FL

Thomas G. Peters, Jacksonville FL

Sergio B. Seoane, Lakeland FL

Florida Medical Association

Alternate Delegate(s)

Natalia Solenkova, Aventura FL

Regional Medical Student Delegate(s)

Alex Tolbert, Tallahassee FL

Regional Medical Student Alternate Delegate(s)

Boyd W. Colbrunn, Miami FL

Sneha Kapil, St. Augustine FL

Medical Association of Georgia

Delegate(s)

John S. Antalis, Dalton GA

S William Clark III, Waycross GA

Billie Luke Jackson, Macon GA

Zachary Lopater, Macon GA

Ali R Rahimi, Atlanta GA

Charles Wilmer, Atlanta GA

Alternate Delegate(s)

Keisha Callins, Macon GA

Shamie Das, Atlanta GA

Fonda A. Mitchell, Atlanta GA

Hawaii Medical Association

Delegate(s)

Angela Pratt, Honolulu HI

Jerry Van Meter, Honolulu HI

Alternate Delegate(s)

Elizabeth A. Ignacio, Kahului HI

Idaho Medical Association

Delegate(s)

A. Patrice Burgess, Boise ID

Alternate Delegate(s)

Zachary Warnock, Pocatello ID

Illinois State Medical Society

Delegate(s)

Rodney Alford, Watseka IL

Thomas M. Anderson, Chicago IL

Howard Axe, Grayslake IL

Christine Bishof, Elmhurst IL

Howard Chodash, Springfield IL

Niva Lubin-Johnson, Chicago IL

James L. Milam, Grayslake IL

Robert Panton, Elmwood Park IL

Adam Roussas, Chicago IL

Shastri Swaminathan, Westmont IL

Piyush Vyas, Lake Forest IL

Steven D. Williams, Bourbonnais IL

Alternate Delegate(s)

Aadil Ahmed, Forest Park IL

Smitha Arekapudi, Chicago IL

Nancy Church, Chicago IL

Scott A. Cooper, Chicago IL

Richard A. Geline, Glenview IL

Anne Langguth, Hindsdale IL

Megi Maci, Quincy MA

Martha Menchaca, Brookfield IL

Vikram B. Patel, South Barrington IL

Holly Rosencranz, Champaign IL

Judith G Savage, Tinley Park IL

Resident and Fellow Sectional Delegate(s)

Jacob Cabrejas, Chicago IL

Resident and Fellow Sectional Alternate Delegate(s)

Jean-Luc Germany, Haverhill MA

Allison Young, Chicago IL

Illinois State Medical Society

Regional Medical Student Delegate(s)

Kayla Tran, North Chicago IL

Indiana State Medical Association

Delegate(s)

Heidi Dunniway, Evansville IN

Vidya S. Kora, Michigan City IN

William Mohr, Kokomo IN

Rhonda Sharp, Lagrange IN

Thomas Vidic, Elkhart IN

Alternate Delegate(s)

Deepak Azad, Floyds Knobs IN

Roberto Darroca, Muncie IN

Lisa Hatcher, Columbia City IN

Stacie Wenk, Evansville IN

Regional Medical Student Delegate(s)

Sydney Clark, W Lafayette IN

Iowa Medical Society

Delegate(s)

Robert Lee, Johnston IA

Douglas Martin, Dakota Dunes SD

Douglas Peters, W Burlington IA

Victoria Sharp, Iowa City IA

Alternate Delegate(s)

Alison Lynch, Iowa City IA

Brian Privett, Cedar Rapids IA

Regional Medical Student Alternate Delegate(s)

Adrienne Nguyen, Des Moines IA

Kansas Medical Society

Delegate(s)

Debra Doubek, Manhattan KS

Robert Gibbs, Parsons KS

Kansas Medical Society

Delegate(s)

Arthur D. Snow, Shawnee Mission KS

Alternate Delegate(s)

Gerhard A. Fast, Hesston KS

Kimberly Swan, Overland Park KS

Regional Medical Student Delegate(s)

Maddy Mash, Kansas City KS

Regional Medical Student Alternate Delegate(s)

Lauren St. Peter, Kansas City KS

Kentucky Medical Association

Delegate(s)

David J. Bensema, Lexington KY

J Gregory Cooper, Cynthiana KY

Shawn C. Jones, Paducah KY

John L. Roberts, Louisville KY

Donald J. Swikert, Edgewood KY

Alternate Delegate(s)

Evelyn M. Jones, Paducah KY

Neal J. Moser, Taylor Mill KY

Monalisa Tailor, Louisville KY

R. Brent Wright, Glasgow KY

Louisiana State Medical Society

Delegate(s)

Luis M. Alvarado, Mandeville LA

Kamel Brakta, Shreveport LA

George Ellis, New Orleans LA

Deborah Fletcher, Shreveport LA

William Freeman, Prairieville LA

Clayton Runfalo, Prairieville LA

Alternate Delegate(s)

Donnie Batie, Baton Rouge LA

Louisiana State Medical Society

Alternate Delegate(s)

Kristin Lynch Grimes, Baton Rouge LA

Smita Prasad, Springfield LA

Maine Medical Association

Delegate(s)

Richard A. Evans, Dover Foxcroft ME

Maroulla S. Gleaton, Augusta ME

Alternate Delegate(s)

Dieter Kreckel, Rumford ME

MedChi: The Maryland State Medical Society

Delegate(s)

Harbhajan Ajrawat, Potomac MD

Loralie Dawn Ma, Fulton MD

Shannon Pryor, Chevy Chase MD

Gary Pushkin, Baltimore MD

Padmini Ranasinghe, Baltimore MD

Stephen J. Rockower, Bethesda MD

Alternate Delegate(s)

Renee Bovelle, Silver Spring MD

Anuradha Reddy, Ellicott City MD

Whitney Sambhariya, Baltimore MD

Bruce Wollman, Potomac MD

James J. York, Millersville MD

Resident and Fellow Sectional Alternate Delegate(s)

Mollie Dreicer, Omaha NE

Regional Medical Student Delegate(s)

Preetham Bachina, Baltimore MD

Massachusetts Medical Society

Delegate(s)

Maryanne C. Bombaugh, Mashpee MA

Theodore A Calianos II, Mashpee MA

Massachusetts Medical Society

Delegate(s)

Alain A. Chaoui, Boxford MA

Emily Cleveland Manchanda, Andover MA

Dennis Dimitri, Worcester MA

Henry Dorkin, Newton MA

Ronald Dunlap, Weymouth MA

Christopher Garofalo, N Attleboro MA

David A. Rosman, Stoneham MA

Kenath Shamir, Fall River MA

Spiro Spanakis, Shrewsbury MA

Ellana Stinson, Boston MA

Lynda M. Young, Worcester MA

Alternate Delegate(s)

Elizabeth Conner, Boston MA

Eli Freiman, Watertown MA

Brittny Garcia, Boston MA

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Weijie Lin, Long Island City NY

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Delegate(s)

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Delegate(s)

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Maristella Evangelista, Birmingham MI

Danielle Rochlin, Stanford CA

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Alternate Delegate(s)
Ai-Yui Maria Tan, Maywood IL

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Jason Jameson, Phoenix AZ

Alternate Delegate(s)
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Ruchika Talwar, Philadelphia PA

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Delegate(s)
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Army

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Barbara L. McAneny, Albuquerque NM

Kristina Novick, West Chester PA

Association for Clinical Oncology

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Amber Clark, Trussville AL

Association of Academic Radiology

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Susan Strate, Wichita Falls TX

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Marynghi Le, Riverside CA

Joseph Sanfrancesco, Charleston SC

Emily Volk, Louisville KY

College of American Pathologists

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Nada Mohamed, Temple TX

Congress of Neurological Surgeons

Delegate(s)

Joshua Rosenow, Chicago IL

Ann R. Stroink, Heyworth IL

Alternate Delegate(s)

Maya A. Babu, Englewood FL

Laura Stone McGuire, Chicago IL

Endocrine Society, The

Delegate(s)

Amanda Bell, Kansas City MO

Palak U. Choksi, Ann Arbor MI

Alternate Delegate(s)

Barbara Onumah, Bowie MD

Daniel Spratt, Portland ME

GLMA: Health Professionals Advancing LGBT Equality

Delegate(s)

Jason S. Schneider, Atlanta GA

Heart Rhythm Society

Delegate(s)

Timothy Larsen, Chicago IL

International College of Surgeons-US Section

Delegate(s)

Joshua Mammen, Omaha NE

Alternate Delegate(s)

Rifat Latifi, Valhalla NY

International Pain and Spine Intervention Society

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William D. Mauck, Rochester MN

Alternate Delegate(s)

Kate Sully, Niceville FL

International Society for the Advancement of Spine Surgery

Delegate(s)

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Alternate Delegate(s)

Anthony Digiorgio, San Francisco CA

International Society of Hair Restoration Surgery

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Alternate Delegate(s)

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Delegate(s)

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Candace Schoppe, Grapevine TX

National Medical Association

Delegate(s)

Nelson Adams, Miami Shores FL

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Navy

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Delegate(s)
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North American Spine Society

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Ethan Lazarus, Lone Tree CO

Alternate Delegate(s)
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Alternate Delegate(s)
Leslie Eber, Golden CO

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Kevin C. Reilly, Elizabethtown KY

Laura E. Traube, San Luis Obispo CA

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Alternate Delegate(s)
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Delegate(s)
Kanae Mukai, Salinas CA

Alternate Delegate(s)
Irfan Zeb, Morgantown WV

Society of Critical Care Medicine

Delegate(s)
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Tina R. Shah, Atlanta GA

Alternate Delegate(s)
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Daniel Udrea, Loma Linda CA

Society of Hospital Medicine

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Delegate(s)

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Delegate(s)

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Alternate Delegate(s)
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Delegate(s)
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Rachel Solnick, New York NY

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Delegate(s)
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Alternate Delegate(s)
Christopher Libby, Anaheim CA

Current as of: 9/20/2024

Reference Committee Hearing Room Assignments
Saturday, November 9

1:30pm		**Room**
Amendments to Constitution & Bylaws		Southern Hemisphere Salon II
B	Legislative advocacy	Northern Hemisphere Salon D
C	Advocacy on medical education	Southern Hemisphere Salon I
F	AMA governance and finance	Pacific AB
J	Advocacy on medical service, practice, and insurance	Southern Hemisphere Salon III
K	Advocacy on science and public health	Southern Hemisphere Salon IV/V

AMERICAN MEDICAL ASSOCIATION
HOUSE OF DELEGATES

2024 Interim Meeting
Notes on Orders of Business

Swan and Dolphin Resort, Orlando, FL
Pacific A-B Ballroom

FIRST SESSION, Friday, November 8, 6:00pm

SECOND SESSION, Saturday, November 9, 12:30 – 1:00pm

THIRD SESSION, Monday, November 11, 10:00am – 6:00pm

FOURTH SESSION, Tuesday, November 12, 8:00am – completion of business

Summary of Fiscal Notes (I-24)

Report(s) of the Board of Trustees

01	Augmented Intelligence Development, Deployment, and Use in Health Care	Minimal
02	On-Site Physician Requirements for Emergency Departments	Minimal
03	Stark Law Self-Referral Ban	Minimal
04	Addressing Work Requirements For J-1 Visa Waiver Physicians	Minimal
05	Protecting the Health of Incarcerated Patients	Minimal
06	Health Technology Accessibility for Aging Patients	Minimal
07	Reevaluation of Scoring Criteria for Rural Communities in the National Health Service Corps Loan Repayment Program	Minimal
08	Increasing Access to Medical Care for People Seeking Asylum	Minimal
09	Corporate Practice of Medicine Prohibition	Minimal
10	AMA Efforts on Medicare Payment Reform	Info. Report
11	Carbon Pricing to Address Climate Change	Minimal
12	Eliminating Eligibility Criteria for Sperm Donors Based on Sexual	Info. Report
13	AMA/Specialty Society RVS Update Committee	Minimal
14	Privacy Protection and Prevention of Further Trauma for Victims of Distribution of Intimate Videos and Images Without Consent	Minimal
15	Published Metrics for Hospitals and Hospital Systems	Minimal
16	AMA Reimbursement of Necessary HOD Business Meeting Expenses for Delegates and Alternates	$2 million
17	Environmental Sustainability of AMA National Meetings	Info. Report
18	Expanding Protections of End-of-Life Care	Minimal
19	Update on Climate Change and Health AMA Activities (BOT Report 03-I-23)	Info. Report
20	2024 AMA Advocacy Efforts	Info. Report
21	Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care is Banned or Restricted	Info. Report

Report(s) of the Council on Constitution and Bylaws

01	Resolution Deadline Clarification	Minimal
02	Name Change for Reference Committee	Minimal
03	Bylaw Amendments to Address Medical Student Leadership	Minimal

Report(s) of the Council on Ethical and Judicial Affairs

01	Expanding Access to Palliative Care	Minimal
02	Protecting Physicians Who Engage in Contracts to Deliver Health Care Services	Minimal

Opinion(s) of the Council on Ethical and Judicial Affairs

01	Research Handling of De-Identified Patient Data	Info. Report
02	Amendment to E-2.1.1, “Informed Consent”	Info. Report
03	Amendment to E-3.1.1, “Privacy in Health Care”	Info. Report
04	Amendment to E-3.2.4 “Access to Medical Records by Data Collection	Info. Report
05	Amendment to E-3.3.2, “Confidentiality and Electronic Medical Records”	Info. Report
06	Physicians’ Use of Social Media for Product Promotion and Compensation	Info. Report
07	Short-Term Global Health Clinical Encounters	Info. Report

Report(s) of the Council on Long Range Planning and Development

01	Academic Physicians Section Five-Year Review	Within Current Budget

Report(s) of the Council on Medical Education

01	Medication Reconciliation Education	Minimal
02	Updates to Recommendations for Future Directions for Medical Education	Moderate

Report(s) of the Council on Medical Service

01	Nonprofit Hospital Charity Care Policies	Minimal
02	Unified Financing Health Care System	Minimal
03	Time-Limited Patient Care	Modest
04	Biosimilar Coverage Structures	Modest

Report(s) of the Council on Science and Public Health

01	Cannabis Therapeutic Claims in Marketing and Advertising	Minimal
02	Drug Shortages: 2024 Update	Minimal
03	HPV-Associated Cancer Prevention	Moderate
04	Reducing Sodium Intake to Improve Public Health	Minimal
05	Teens and Social Media	Moderate

Report(s) of the HOD Committee on Compensation of the Officers

01	Report of the House of Delegates Committee on Compensation of the Officers	Estimated annual cost of Recommendations 2, 3 and 4 is $185,175 based on data for July 1, 2023 - June 30, 2024

Report(s) of the Speakers

01	Report of the Election Task Force 2	Minimal
02	Reconciliation Report	Info. Report

Resolutions

001	Addressing Gender-Based Pricing Disparities	Minimal
002	Anti-Doxxing Data Privacy Protection	Modest
003	On the Ethics of Human Lifespan Prolongation	Modest
004	Improving Usability of Electronic Health Records for Transgender and Gender Diverse Patients	Minimal
005	Updating the AMA Definition of Infertility	Moderate
006	Opposition to the Deceptive Relocation of Migrants and Asylum Seekers	Minimal
007	Supporting Diversity in Research	Modest
008	Missing and Murdered Black Women and Girls	Modest
009	Opposition to Creation or Enforcement of Civil Litigation, Commonly Referred to as Civil Causes of Action	Minimal
201	Boarding Patients in the Emergency Room	Modest
202	Illicit Drugs: Calling for a Multifaceted Approach to the “Fentanyl” Crisis	Moderate
204	Support for Physician-Supervised Community Paramedicine Programs	Minimal
205	Native American Medical Debt	Minimal
206	Protect Infant and Young Child Feeding	Modest

207	Accountability for G-605.009: Requesting A Task Force to Preserve the Patient-Physician Relationship Task Force Update and Guidance	To Be Determined
208	Medicare Part B Enrollment and Penalty Awareness	Moderate
210	Laser Surgery	Minimal
211	Water Bead Injuries	Modest
212	Addressing the Unregulated Body Brokerage Industry	Moderate
213	Sustainable Long-term Funding for Child Psychiatry Access Programs	Modest
214	Advocating for Evidence-Based Strategies to Improve Rural Obstetric Health Care and Access	Minimal
215	Advocating for Federal and State Incentives for Recruitment and Retention of Physicians to Practice in Rural Areas	Modest
216	Clearing Federal Obstacles for Supervised Injection Sites	Modest
217	Expand Access to Skilled Nursing Facility Services for Patients with Opioid Use Disorder	Modest
218	Time Sensitive Credentialing of New Providers with an Insurance Carrier	Modest
219	Advocate to Continue Reimbursement for Telehealth / Telemedicine Visits Permanently	Modest
220	MIPS Reform	Modest
221	Medicare Coverage for Non-PAR Physicians	Modest
222	Rollback on Physician Performance Measures	Moderate
223	Mandated Economic Escalators in Insurance Contracts	Modest
225	Elimination of Medicare 14-Day Rule	Modest
226	Information Blocking Rule	Modest
227	Medicare Payment Parity for Telemedicine Services	Modest
302	Strengthening Parental Leave Policies for Medical Trainees and Recent Graduates	Minimal
304	Payment and Benefit Parity for Fellows	Minimal
305	Removing Board Certification as a Requirement for Billing for Home Sleep Studies	Modest
306	Streamlining Continuing Medical Education Across States and Medical Specialties	Modest
601	Expanding AMA Meeting Venue Options	Minimal
602	Delaying the ETF Endorsement Timeline Revision for Section IOP Revisions	Minimal
604	Opposing Discrimination and Protecting Free Speech Among Member Organizations of Organized Medical Associations	Minimal
605	AMA House of Delegates Expenses	$2.82 million annually based on current delegate count. Would increase if delegate count increases.
606	Protecting Free Speech and Encouraging Respectful Discourse Among Member Organizations of Organized Medical Associations	Minimal
607	AMA House of Delegates Venues	Minimal
801	Reimbursement for Managing Portal Messages	Modest
802	Address Physician Burnout with Inbox Management Resources and Increased Payment	Modest

803	Healthcare Savings Account Reform	Modest
804	Improving Public Assistance for People with Disabilities	Minimal
805	Coverage for Care for Sexual Assault Survivors	Modest
807	Expanded Pluralism in Medicaid	Moderate
808	Requirement to Communicate Covered Alternatives for Denied Medications	Modest
809	Minimum Requirements for Medication Formularies	Modest
810	Immediate Digital Access to Updated Medication Formulary for Patients and Their Physicians	Modest
811	AMA Practice Expense Survey Geographic Analysis	Moderate
812	Advocate for Therapy Cap Exception Process	Modest
813	Insurance Coverage for Pediatric Positioning Chairs	Modest
814	Legislation for Physician Payment for Prior Authorization	Modest
815	Addressing the Crisis of Pediatric Hospital Closures and Impact on Care	Moderate
817	ACA Subsidies for Undocumented Immigrants	Minimal
818	Payment for pre-certified/preauthorized procedures	Modest
819	Establishing a New Office-Based Facility Setting to Pay Separately from the Medicare Physician Fee Schedule for the Technical Reimbursement of Physician Services Using High-Cost Supplies	Moderate
820	State Medicaid Coverage of Home Sleep Testing	Minimal
821	Patient Access to Asthma Medications	Minimal
822	Resolution on Medicare Coverage for Non-Emergent Dialysis Transport	Modest
823	Reigning in Medicare Advantage - Institutional Special Needs Plans	Modest
824	Ophthalmologists Required to Be Available for Level I & II Trauma Centers	Modest
901	Heat Alerts and Response Plans	Minimal
902	Advancing Menopause Research and Care	Modest
903	Improving the Identification of Intimate Partner Violence (IPV) in People with Disabilities	Modest
904	Regulation of Ionized Radiation Exposure for Healthcare Workers	Minimal
905	Regulation and Transparency of Contaminants in Menstrual Hygiene Products	Minimal
907	Call for Study: The Need for Hospital Interior Temperatures to be Thermally Neutral to Humans within Those Hospitals	Modest
909	Support of Universal School Meals for School Age Children	Modest
910	Food Insecurity Among Patients with Celiac Disease, Food Allergies, and Food Intolerance	Minimal
911	Adequate Masking and HPV Education for Health Care Workers (including those over age 45)	Modest
912	Assuring Representation of Older Age Adults in Clinical Trials	Moderate
913	Sexually Transmitted Infections are on the Rise in the Senior Population	$80,454 Contract with third parties to develop educational content for physicians
915	Reducing Barriers in Sports Participation for LGBTQIA+ People	$80,067 Contract with third parties to develop educational content for physicians

916	Access to Healthcare for Transgender and Gender Diverse People in the Carceral System	Modest
917	Mpox Global Health Emergency Recognition and Response	Moderate
918	Healthcare in Tribal Jails	Modest
919	Improving Rural Access to Comprehensive Cancer Care Service	Modest
920	Revise FAA Regulations to Include Naloxone (Narcan) in the On-Board Medical Kit for Commercial Airlines flying within the Continental United States	Modest
922	Advocating for the Regulation of Pink Peppercorn as a Tree Nut	Minimal
923	Updated Recommendations for Child Safety Seats	Minimal
926	Development of Climate Health Education Tools for Physicians	$765,754 Contract with third-parties to develop educational content; development of a taskforce
928	Public Safety Agencies Data Collection Enhancement	Moderate
929	Safety Concerns Regarding Inadequate Labeling of Food Products Upon Ingredient Changes with Known Major Food Allergens	Minimal
930	Economic Factors to Promote Reliability of Pharmaceutical Supply	Minimal

Not for Consideration

203	Alternative Pathways for International Medical Graduates	To Be Determined
209	Physician Liability for AI and Other Technological Advances in Medicine	Minimal
224	Update the status of Virtual Credit card policy, EFT fees, and lack of Enforcement of Administrative Simplification Requirements by CMS	Modest
301	Reopening Schools Closed by the Flexner Report	Moderate
303	Transparency and Access to Medical Training Program Unionization Status, Including Creation of a FREIDA Unionization Filter	Minimal
307	Humanism in Anatomical Medical Education	Minimal
603	Study of Grading Systems in AMA Board Reports	Modest
806	Study of the Federal Employee Health Benefit Plan (FEHBP)	Modest
816	Study of CO-OP Insurance as a Vehicle for Public Healthcare Insurance Option	Moderate
906	Call for Study: Should Petroleum-Powered Emergency Medical Services (EMS) Vehicles in Urban Service Areas be Replaced by Renewably-Powered Electric Vehicles?	Modest
908	Support for Doula Care Programs	Minimal
914	Protecting the Healthcare Supply Chain from the Impacts of Climate Change	Minimal
921	In Support of a National Drug Checking Registry	Minimal
924	Public Health Implications of US Food Subsidies	Modest
925	Improving Public Awareness of Lung Cancer Screening and CAD in Chronic Smokers	$43,166 Initiating a public health campaign
927	The Creation of Healthcare Sustainability Lecture Series	$261,553 Contract with third-parties to develop educational content; development of a taskforce

RESOLUTIONS – BY SPONSOR (I-24)

SPONSOR	Reso #	TITLE
Academic Physicians Section	907	Call for Study: The Need for Hospital Interior Temperatures to be Thermally Neutral to Humans within Those Hospitals
American Academy of Child and Adolescent Psychiatry	213	Sustainable Long-term Funding for Child Psychiatry Access Programs
American Academy of Ophthalmology	824	Ophthalmologists Required to Be Available for Level I & II Trauma Centers
	210	Laser Surgery
	211	Water Bead Injuries
American Academy of Physical Medicine & Rehabilitation	813	Insurance Coverage for Pediatric Positioning Chairs
American Association of Clinical Urologists	814	Legislation for Physician Payment for Prior Authorization
American Association of Public Health Physicians	918	Healthcare in Tribal Jails
American College of Obstetricians and Gynecologists	214	Advocating for Evidence-Based Strategies to Improve Rural Obstetric Health Care and Access
	215	Advocating for Federal and State Incentives for Recruitment and Retention of Physicians to Practice in Rural Areas
	919	Improving Rural Access to Comprehensive Cancer Care Service
American College of Rheumatology	227	Medicare Payment Parity for Telemedicine Services
American College of Surgeons	306	Streamlining Continuing Medical Education Across States and Medical Specialties
American Psychiatric Association	008	Missing and Murdered Black Women and Girls
American Society for Reproductive Medicine	005	Updating the AMA Definition of Infertility
American Thoracic Society	820	State Medicaid Coverage of Home Sleep Testing
	821	Patient Access to Asthma Medications
Association for Clinical Oncology	225	Elimination of Medicare 14-Day Rule
	226	Information Blocking Rule
	930	Economic Factors to Promote Reliability of Pharmaceutical Supply
Iowa	811	AMA Practice Expense Survey Geographic Analysis
Kansas	009	Opposition to Creation or Enforcement of Civil Litigation, Commonly Referred to as Civil Causes of Action

SPONSOR	Reso #	TITLE
LGBTQ Section	004	Improving Usability of Electronic Health Records for Transgender and Gender Diverse Patients
	915	Reducing Barriers in Sports Participation for LGBTQIA+ People
	916	Access to Healthcare for Transgender and Gender Diverse People in the Carceral System
	917	Mpox Global Health Emergency Recognition and Response
Louisiana	807	Expanded Pluralism in Medicaid
	823	Reigning in Medicare Advantage - Institutional Special Needs Plans
Medical Student Section	204	Support for Physician-Supervised Community Paramedicine Programs
	205	Native American Medical Debt
	901	Heat Alerts and Response Plans
	909	Support of Universal School Meals for School Age Children
	910	Food Insecurity Among Patients with Celiac Disease, Food Allergies, and Food Intolerance
Michigan	212	Addressing the Unregulated Body Brokerage Industry
	812	Advocate for Therapy Cap Exception Process
Minority Affairs Section	006	Opposition to the Deceptive Relocation of Migrants and Asylum Seekers
	007	Supporting Diversity in Research
	817	ACA Subsidies for Undocumented Immigrants
Mississippi	808	Requirement to Communicate Covered Alternatives for Denied Medications
	809	Minimum Requirements for Medication Formularies
	810	Immediate Digital Access to Updated Medication Formulary for Patients and Their Physicians
	920	Revise FAA Regulations to Include Naloxone (Narcan) in the On-Board Medical Kit for Commercial Airlines flying within the Continental United States
New England	602	Delaying the ETF Endorsement Timeline Revision for Section IOP Revisions
	803	Healthcare Savings Account Reform
	804	Improving Public Assistance for People with Disabilities
New Jersey	218	Time Sensitive Credentialing of New Providers with an Insurance Carrier
	926	Development of Climate Health Education Tools for Physicians

SPONSOR	Reso #	TITLE
New York	219	Advocate to Continue Reimbursement for Telehealth / Telemedicine Visits Permanently
	220	MIPS Reform
	221	Medicare Coverage for Non-PAR Physicians
	222	Rollback on Physician Performance Measures
	223	Mandated Economic Escalators in Insurance Contracts
	305	Removing Board Certification as a Requirement for Billing for Home Sleep Studies
	604	Opposing Discrimination and Protecting Free Speech Among Member Organizations of Organized Medical Associations
	605	AMA House of Delegates Expenses
	606	Protecting Free Speech and Encouraging Respectful Discourse Among Member Organizations of Organized Medical Associations
	607	AMA House of Delegates Venues
	818	Payment for pre-certified/preauthorized procedures
	928	Public Safety Agencies Data Collection Enhancement
	929	Safety Concerns Regarding Inadequate Labeling of Food Products Upon Ingredient Changes with Known Major Food Allergens
North American Spine Society	202	Illicit Drugs: Calling for a Multifaceted Approach to the “Fentanyl” Crisis
Post-Acute and Long-Term Care Medical Association	217	Expand Access to Skilled Nursing Facility Services for Patients with Opioid Use Disorder
Renal Physicians Association	822	Resolution on Medicare Coverage for Non-Emergent Dialysis Transport
Resident and Fellow Section	216	Clearing Federal Obstacles for Supervised Injection Sites
	302	Strengthening Parental Leave Policies for Medical Trainees and Recent Graduates
	304	Payment and Benefit Parity for Fellows
	922	Advocating for the Regulation of Pink Peppercorn as a Tree Nut
	923	Updated Recommendations for Child Safety Seats
Senior Physicians Section	003	On the Ethics of Human Lifespan Prolongation
	208	Medicare Part B Enrollment and Penalty Awareness
	911	Adequate Masking and HPV Education for Health Care Workers (including those over age 45)
	912	Assuring Representation of Older Age Adults in Clinical Trials
	913	Sexually Transmitted Infections are on the Rise in the Senior Population

SPONSOR	Reso #	TITLE
Society for Cardiovascular Angiography and Interventions	819	Establishing a New Office-Based Facility Setting to Pay Separately from the Medicare Physician Fee Schedule for the Technical Reimbursement of Physician Services Using High-Cost Supplies
Society of Critical Care Medicine	815	Addressing the Crisis of Pediatric Hospital Closures and Impact on Care
Tennessee	201	Boarding Patients in the Emergency Room
	801	Reimbursement for Managing Portal Messages
Texas	601	Expanding AMA Meeting Venue Options
	802	Address Physician Burnout with Inbox Management Resources and Increased Payment
Women's Physician Section	001	Addressing Gender-Based Pricing Disparities
	002	Anti-Doxxing Data Privacy Protection
	206	Protect Infant and Young Child Feeding
	207	Accountability for G-605.009: Requesting A Task Force to Preserve the Patient-Physician Relationship Task Force Update and Guidance
	805	Coverage for Care for Sexual Assault Survivors
	902	Advancing Menopause Research and Care
	903	Improving the Identification of Intimate Partner Violence (IPV) in People with Disabilities
	904	Regulation of Ionized Radiation Exposure for Healthcare Workers
	905	Regulation and Transparency of Contaminants in Menstrual Hygiene Products

Reference Committee on Amendments to Constitution and Bylaws

Report(s) of the Board of Trustees

08 Increasing Access to Medical Care for People Seeking Asylum
14 Privacy Protection and Prevention of Further Trauma for Victims of Distribution of Intimate Videos and Images Without Consent
18 Expanding Protections of End-of-Life Care

Report(s) of the Council on Constitution and Bylaws

01 Resolution Deadline Clarification
02 Name Change for Reference Committee
03 Bylaw Amendments to Address Medical Student Leadership

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01 Expanding Access to Palliative Care
02 Protecting Physicians Who Engage in Contracts to Deliver Health Care Services

Resolutions

001 Addressing Gender-Based Pricing Disparities
002 Anti-Doxxing Data Privacy Protection
003 On the Ethics of Human Lifespan Prolongation
004 Improving Usability of Electronic Health Records for Transgender and Gender Diverse Patients
005 Updating the AMA Definition of Infertility
006 Opposition to the Deceptive Relocation of Migrants and Asylum Seekers
007 Supporting Diversity in Research
008 Missing and Murdered Black Women and Girls
009 Opposition to Creation or Enforcement of Civil Litigation, Commonly Referred to as Civil Causes of Action

REPORT OF THE BOARD OF TRUSTEES

B of T Report 08-I-24

Subject:	Increasing Access to Medical Care for People Seeking Asylum (Resolution 007-I-23)
Presented by:	Michael Suk, MD, JD, MPH, MBA, Chair
Referred to:	Reference Committee on Amendments to Constitution and Bylaws

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INTRODUCTION

At the 2023 Interim Meeting of the American Medical Association (AMA) House of Delegates (HOD), the Medical Student Section submitted Resolution 007 "Improving Access to Forensic Medical Evaluations and Legal Representation for Asylum Seekers" that asked the AMA to:

> Support public funding of legal representation for people seeking legal asylum (New HOD Policy); and be it further
>
> Support efforts to train and recruit physicians to conduct medical and psychiatric forensic evaluations for all asylum seekers through existing training resources, including, but not limited to, the Asylum Medicine Training Initiative.

Testimony was mixed. Concerns were raised about the first resolve clause, noting it may be outside the purview of the AMA. Also, testimony suggested deletion of "Asylum Medicine Training Initiative" from the second resolve to avoid endorsement of a specific program. The resolution was referred.

BACKGROUND

2022 data from the World Health Organization states that more than 1 billion people globally — or one in seven people — are refugees, immigrants, and migrants (RIM).[1] Such RIM communities often experience economic, educational, social, and health inequities.[2] Many have also been victims of great harms.

Definition of asylum seeker

To better understand the issues raised in this resolution, we must first be clear on the definitions of key terms. The U.S. Citizen and Immigration Services (USCIS) of the U.S. Department of Homeland Security (DHS) and the International Rescue Committee (IRC) provide such definitions. Key terms are defined and compared in Appendix A. This report will focus on the term "asylum seeker" since it is the one written in the resolution. An "asylum seeker" (or asylee) is a person who is "an alien in the U.S. or at a port of entry who is unable or unwilling to return to his or her country of nationality, or to seek the protection of that country because of persecution or a well-founded fear of persecution. Persecution or the fear thereof must be based on religion, nationality,

membership in a particular social group or political opinion."[1] They must arrive at or cross a border into the desired country and apply for protection. An asylum seeker's claim for refugee status has not yet been legally determined.[3]

According to the ICR, there were 6.9 million asylum seekers in 2023. The United States received the largest number of applications, followed by Germany. The most applications came from individuals departing Afghanistan, Colombia, Sudan, Syria, and Venezuela.[3] Many of these individuals, particularly women and children, report having fled their native country due to such atrocities as kidnappings, gender violence, forced gang recruitment, and even murder. Crossing an international border for asylum is legal, and the individual's case must be heard, per U.S. and international law.[3]

Applying for asylum

Asylum seekers must apply to the USCIS. To qualify, one must be physically present in the U.S. If one is eligible for asylum, then they may be permitted to remain in the U.S. Such persons must file a Form I-589 "Application for Asylum and for Withholding of Removal" within one year of arrival.[4] The DHS website provides further information on the ways to obtain asylum. The information is available in English and Spanish; they also offer a Multilingual Resource Center to assist those who read/speak other languages.

Legal representation

The U.S. Department of Justice provides lists of pro bono (free) legal service providers per state to help asylum seekers navigate the process. States themselves also provide resources to asylum seekers who have recently arrived. One such example is the Illinois Department of Human Services, which offers a list of community service agencies that provide a variety of services including legal aid.[5] Some cities have even established funding mechanisms to support such individuals. The city of Chicago invests in its Legal Protection Fund in partnership with the National Immigrant Justice Center (NIJC) and The Resurrection Project "to provide community-based outreach, education, legal consultations and courtroom representation for thousands of immigrants each year."[6] Various organizations work to ensure access to justice and human rights protections for asylum seekers (as well as immigrants and refugees). As mentioned, the NIJC advocates for policy reform and systems change while also offering legal services for said individuals. Such direct services generally involve volunteer attorneys providing pro bono services. The NIJC serves more than 10,000 asylum seekers each year with a 90 percent success rate in obtaining asylum.[7]

Medical evaluation

The Centers for Disease Control and Prevention (CDC), United States Public Health Service , is responsible for ensuring that noncitizens entering the U.S. do not pose a risk to the health of U.S. citizens and U.S. legal residents. Thus, each person is required to receive a medical (physical and mental) examination when applying for entry. Detailed information about the medical examination performed by designated physicians can be found on the CDC website. The Department of Health and Human Services (HHS) Office of Refugee Settlement also promotes the health, well-being, and stability of refugees, unaccompanied children, and other eligible individuals and families. For children, this office operates the Unaccompanied Refugee Minors Program and the Unaccompanied Children Program that provide health, dental, and mental health care.[8]

As mentioned, many asylum seekers claim to have undergone harms in their native country or may undergo harms if deported. A forensic medical evaluation is a specialized exam to document the physical or psychological consequences of such harms. Research indicates that "forensic medical evaluations can provide scientific evidence that a person has suffered persecution and harm, improving the likelihood that those who seek refuge in the United States will be granted asylum or other forms of life-saving immigration relief."[9]

Training for physicians

The CDC provides technical instructions for "panel physicians" who are medically trained, licensed, and experienced physicians practicing overseas and designated by the local U.S. consulate or embassy. These physicians "must follow specific identification procedures, prescribed by the U.S. Department of State, to ensure that the person appearing for the medical examination is the person who is actually applying. The panel physician is responsible for the entire examination, including the required chest radiograph and any necessary laboratory procedures. The panel physician is also responsible for reporting the results of all required tests and consultations on the prescribed forms and for ensuring that the completed medical report forms are sent directly to the consular officer. The panel physician is not responsible for determining whether an applicant is actually eligible to apply to enter the United States; that determination is made by the consular officer after reviewing all records, including the report of the medical examination."[10] Likewise, the CDC provides technical instructions for designated "civil surgeons" who perform such medical examinations inside the U.S. The CDC also provides Overseas Refugee Health Guidance to physicians to help promote healthy resettlement.[10]

Medical education

Standard 7 of the Liaison Committee on Medical Education (LCME), the organization that accredits medical schools, addresses "Curricular Content." Specifically, 7.1 addresses "Societal Problems" and 7.2 addresses "Structural Competence, Cultural Competence, and Health Inequities." However, LCME does not dictate how medical schools will interpret these standards nor if they will include information on the needs of asylum seekers. Likewise, the Accreditation Council on Graduate Medical Education's Common Program Requirement IV.A. on "Educational Components" states that training be "consistent with the sponsoring institution's mission, the needs of the community it serves, and the desired distinctive capabilities of its graduates, which must be made available to program applicants, residents, and faculty members" (but does not specify asylum seekers who may be part of the community).[11]

DISCUSSION

A study of U.S. medical students published in 2022 concluded that "medical students at schools with affiliated asylum clinics desire to care for asylum seeker patients but feel unprepared to do so, highlighting an unmet need for formal asylum education in U.S. medical schools."[12] This point was echoed in a 2024 study that assessed the current state of medical school curricula worldwide.[13]

Another study evaluated student-run clinics for asylum seekers, revealing "the burgeoning capability of student-run asylum clinics to provide evaluations, a trend that underscores medical students' ability to significantly impact human rights issues. Student-run asylum clinics are poised to fill an increasingly important role in supporting victims of torture and persecution."[14] These findings highlight the essential role of human rights and social justice in medical education.

Similarly, education is imperative for physicians to assist asylum seekers. A variety of resources and trainings are available for physician and non-physician health care professionals. For example,

- Physicians for Human Rights has galvanized an Asylum Network of physicians to provide forensic medical and psychological evaluations to support asylum seekers; training is required, and aids are available.
- Center for Health Care Strategies offers education on trauma-informed care.
- Center for Victims of Torture provides information about trauma-informed and culturally competent care and clinical interventions.
- Asylum Medicine Training Initiative prepares health care professionals in the forensic medical evaluation of persons seeking asylum in the U.S.

While payment for the provision of legal representation for asylum seekers is outside the scope of a physician, and therefore the AMA, the AMA is supportive of medical-legal partnerships (MLPs) and understands the large role that social resources have in health outcomes for patients. Policy H-265.986 is of relevance. The AMA Code of Medical Ethics does not provide a direct perspective on physician participation in MLPs, but recognizes they can help physicians carry out the responsibilities and principles articulated in Opinions 1.1.8, 8.5, 10.8, and 11.1.4. The AMA Journal of Ethics released information on this topic in August 2024.[15] Newly established immigration medical-legal partnerships are being implemented in some states to address the complex needs of asylum seekers; the results of the partnerships would be informative.

AMA efforts

AMA's Advocacy unit has been actively involved in communicating with the highest levels of government in support of the health and well-being of immigrants, refugees, and asylum seekers. In the last four years alone, letters to the following offices have been drafted and submitted (both alone and in collaboration with other organizations):

- March 28, 2024, letter to Centers for Medicare & Medicaid Services (CMS) asking to remove barriers to Medicaid and Children's Health Insurance Program (CHIP) coverage for immigrants.
- June 23, 2024, letter to HHS and CMS with comments on the proposed clarifications to eligibility criteria for Qualified Health Plans (QHP) through an Exchange, state-based Basic Health Programs (BHPs), and CHIP as well as some insurance affordability programs.
- March 16, 2023, letter to President of the United States and U.S. Department of Homeland Security (DHS) to raise concerns about the consideration of a harmful immigration policy — the reinstating of detention of immigrant families.
- October 10, 2022, letter to DHS and HHS to increase research and patient-centered mental health treatment for refugee and migrant populations and provide for safer medical practices and protections for migrant women.
- July 12, 2022, letter to U.S. Department of the Treasury and HHS with comment in support of Washington State's Section 1332 Waiver application to cover the uninsured and improve health insurance affordability.
- April 22, 2022 letter to DHS with comment on the Public Charge Ground of Inadmissibility proposed rule, opposing any regulations or policy that would deter immigrants and/or their dependents from utilizing non-cash public benefits, including but not limited to Medicaid, CHIP, Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), and Supplemental Nutrition Assistance Program (SNAP).
- February 2, 2022 letter to the Department of Justice and DHS in opposition to Docket Number USCIS 2020-0013 (Interim Final Rule) on the grounds that it will place asylum

seekers in even greater peril and provide DHS and border patrol agents with unwarranted and heightened authority that represents an ineffective way to protect public health while reducing barriers for noncitizens seeking protection in the U.S.

- January 13, 2022 letter to the Secretary of State with comment on "Visas: Ineligibility Based on Public Charge Grounds" Docket DOS-2021-0034 and RIN 1400-AE87.1 The AMA strongly opposed any rules, regulations, or policies that would deter immigrants, nonimmigrants, and their dependents from seeking visas or from utilizing noncash public benefits including, but not limited to, Medicaid, SNAP, and housing assistance.
- November 29, 2021, letter to DHS with comment on the USCIS proposed rule regarding Deferred Action for Childhood Arrivals (DACA) [DHS Docket No. USCIS–2021–0006]
- October 14, 2021, letter to DHS to provide information regarding the Public Charge Ground of Inadmissibility, as the AMA strongly opposed any rules, regulations, or policies that would deter immigrants/nonimmigrants seeking visas and/or their dependents from utilizing non-cash public benefits such as, but not limited to, Medicaid, SNAP, and housing assistance.
- September 23, 2021, letter to DHS urging them to ensure the health and well-being of all individuals and their families seeking asylum in the U.S., including the Haitian refugees that were at the U.S. southern border.
- September 23, 2020, letter to DHS urging DHS and the Office of the Inspector General (OIG) to thoroughly investigate complaints about detained immigrants' substandard living conditions and improper health care, including allegations of inadequate informed consent practices.
- September 22, 2020, letter to Customs and Border Protection to raise concerns regarding their expiring contract for medical services.
- July 16, 2020, letter to DHS to urge U.S. Immigration and Customs Enforcement (ICE) to release all children together with their parents and caregivers from ICE-run Family Residential Centers.

RELEVANT AMA POLICIES

AMA Policy H-350.957 "Addressing Immigrant Health Disparities" calls for:

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.

Additional policies that address asylum seekers are listed here and located in Appendix B:

- Opposition to Discriminatory Treatment of Haitian Asylum Seekers H-350.951
- Oppose Mandatory DNA Collection of Migrants H-65.955
- Care of Women and Children in Family Immigration Detention H-350.955

The AMA has many other policies regarding refugees and immigrants such as:

- Increasing Mental Health Screenings by Refugee Resettlement Agencies and Improving Mental Health Outcomes for Refugee Women D-345.982
- Increasing Access to Healthcare Insurance for Refugee Populations H-350.956
- Retraining Refugee Physicians H-200.950
- Immigration Status is a Public Health Issue D-350.975
- Opposition to Regulations That Penalize Immigrants for Accessing Health Care Services D-440.927
- Support of Health Care to Legal Immigrants H-290.983
- Medical Needs of Unaccompanied, Undocumented Immigrant Children D-65.992
- Improving Medical Care in Immigrant Detention Centers D-350.983
- Care of Women and Children in Family Immigration Detention H-350.955

CONCLUSION

The AMA recognizes that there are many facets to the legal U.S. immigration system, including medical evaluation. Asylum seekers are in need of care and assistance, and medical students, trainees, and physicians should play a role in this medical care. The AMA supports opportunities for interested physicians to gain further education and training to care for these patients.

The Board of Trustees therefore recommends that the following recommendations be adopted and the remainder of this report be filed.

That Policy H-350.957 be amended by addition and deletion to read as follows:

3. Our AMA ~~will~~ calls for asylum seekers to receive medically-appropriate care, including vaccinations, in a patient centered, language and culturally appropriate way upon presentation for asylum regardless of country of origin.
4. Our AMA supports efforts to train physicians to conduct medical and psychiatric forensic evaluations for asylum seekers.
5. Our AMA supports medical education that addresses the challenges of life-altering events experienced by asylum seekers.
6. Our AMA urges physicians to provide medically-appropriate care for asylum seekers.
7. Our AMA encourages physicians to seek out organizations or agencies in need of physicians to provide these services.
8. Our AMA encourages provision of resources to assist people seeking asylum.

Fiscal note: $1,000

APPENDIX A: GLOSSARY (in alphabetical order)

Alien/Non-citizen/Foreign National
A person who is "not a citizen or national of the United States as the term 'alien' is defined in section 101(a)(3) of the Immigration and Nationality Act (8 U.S.C. 1101(a)(3))." An alien is subject to the host country's law pertaining to non-citizens.[1]

Asylum Seeker/Asylee
A person who is "an alien in the U.S. or at a port of entry who is unable or unwilling to return to his or her country of nationality, or to seek the protection of that country because of persecution or a well-founded fear of persecution. Persecution or the fear thereof must be based on religion, nationality, membership in a particular social group or political opinion."[1] They must arrive at or cross a border into the desired country and apply for protection.[2] An asylum seeker's claim for refugee status has not yet been legally determined.

Immigrant
A person who "chooses to leave their home country and move to a foreign one to settle there."[2] While a "legal immigrant" is foreign-born and legally admitted to the U.S., an "undocumented immigrant" (also called an "illegal alien") is a foreign-born person who does not possess a valid visa or other immigration documentation.[2]

Migrant
A person who "is moving from place to place (within his or her country or across borders), usually for economic reasons such as seasonal work"[2]. Like immigrants, they are seeking better opportunities but were not forced to leave their native countries (due to persecution or violence).

Refugee
A person "outside his or her country of nationality who is unable or unwilling to return to that country because of persecution or a well-founded fear of persecution based on the person's race, religion, nationality, membership in a particular social group, or political opinion. For a legal definition of refugee, see section 101(a)(42) of the Immigration and Nationality Act." According to the International Rescue Committee (IRC), a government or the United Nations Refugee Agency determines whether a person seeking international protection meets the definition of a refugee. If one is granted refugee status, they are given protections under international laws and conventions and lifesaving support from aid agencies, including the IRC. Refugees in the U.S. also have the opportunity to become lawful permanent residents and eventually citizens.[2]

APPENDIX B: RELEVANT AMA POLICIES

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.

Opposition to Discriminatory Treatment of Haitian Asylum Seekers H-350.951
Our American Medical Association opposes discrimination against Haitian asylum seekers which denies them the same opportunity to attain asylum status as individuals from other nations.

Oppose Mandatory DNA Collection of Migrants H-65.955
Our American Medical Association opposes the collection and storage of the DNA of refugees, asylum seekers, and undocumented immigrants for nonviolent immigration-related crimes without non-coercive informed consent.

Care of Women and Children in Family Immigration Detention H-350.955
1. Our American Medical Association 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.

REFERENCES

1. World Health Organization. Refugee and migrant health. Accessed June 25, 2024. https://www.who.int/health-topics/refugee-and-migrant-health#tab=tab_1.

2. Centers for Disease Control and Prevention, Immigrant and Refugee Health. About Immigrants and Refugee Health. May 15, 2024. Accessed June 25, 2024. https://www.cdc.gov/immigrant-refugee-health/about/index.html.

3. International Rescue Committee. Migrants, asylum seekers, refugees and immigrants: What's the difference? June 22, 2018. Last updated June 17, 2024. Accessed June 25, 2024. https://www.rescue.org/article/migrants-asylum-seekers-refugees-and-immigrants-whats-difference.

4. U.S. Department of Homeland Security, U.S. Citizen and Immigration Services. Obtaining Asylum in the United States. Accessed June 25, 2024. https://www.uscis.gov/humanitarian/refugees-and-asylum/asylum/obtaining-asylum-in-the-united-states.

5. Illinois Department of Human Services, Refugee & Immigrant Serves. List of Community Service Agencies Serving Immigrants. Accessed June 24, 2024. https://www.dhs.state.il.us/page.aspx?item=117419.

6. City of Chicago, Office of the Mayor. Legal Protection Fund. Accessed June 25, 2024. https://www.chicago.gov/city/en/depts/mayor/supp_info/office-of-new-americans/legal-protection-fund.html.

7. National Immigrant Justice Center. About NIJC. Accessed June 25, 2024. https://immigrantjustice.org/about-nijc.

8. U.S. Department of Health & Human Services, Office of Refugee Resettlement. Unaccompanied Refugee Minors Program. March 14, 2024. Accessed June 26, 2024. https://www.acf.hhs.gov/orr/programs/refugees/urm.

9. Physicians for Human Rights. Immigrants Who Obtained Forensic Medical Evaluations Much More Likely to Be Granted Asylum or Other Relief in United States: Study. November 30, 2021. Accessed June 26, 2024. https://phr.org/news/immigrants-who-obtained-forensic-medical-evaluations-much-more-likely-to-be-granted-asylum-or-other-relief-in-united-states-study/.

10. U.S. Department of Homeland Security, U.S. Citizen and Immigration Services. Designated Civil Surgeons. Last updated December 6, 2023. Accessed June 25, 2024. https://www.uscis.gov/tools/designated-civil-surgeons.

11. Accreditation Council for Graduation Medical Education. Common Program Requirement (Residency). July 1, 2023. Accessed June 26, 2024. https://www.acgme.org/globalassets/pfassets/programrequirements/cprresidency_2023.pdf.

12. Das P, Sagal K, Blanton K, et al. U.S. medical student knowledge and interest in asylum seeker medical care. Education for Primary Care. November 2022. 33(6):364-368. Epub 2022 Oct 28. PMID: 36307973. DOI: 10.1080/14739879.2022.2137856.

13. Man J, Wright J. Framework for implementing asylum seekers and refugees' health into the undergraduate medical curriculum in the United Kingdom. Health Education Research. April 2024. 39(2):170–181. https://academic.oup.com/her/article/39/2/170/7595384?login=false.

14. Sharp M, Milewski A, Lamneck C, et al. Evaluating the Impact of Student-run Asylum Clinics in the US from 2016-2018. Health and Human Rights. December 2019. 21(2):309-323. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6927377/.

15. American Medical Association. Standards in Medical-Legal Partnerships. AMA Journal of Ethics. Aug 2024. 26(8):E591-664. https://journalofethics.ama-assn.org/issue/standards-medical-legal-partnerships.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 14-I-24

Subject:	Privacy Protection and Prevention of Further Trauma for Victims of Distribution of Intimate Videos and Images Without Consent (Resolution 009-A-22)
Presented by:	Michael Suk, MD, JD, MPH, MBA, Chair
Referred to:	Reference Committee on Amendments to Constitution and Bylaws

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At the 2022 Annual Meeting, the House of Delegates (HOD) adopted Resolution 009, "Privacy Protection and Prevention of Further Trauma for Victims of Distribution of Intimate Videos and Images Without Consent," which amended Policy H-515.967 as follows:

> Our American Medical Association 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.

And further asked our American Medical Association (AMA) to:

> Research issues related to the distribution of intimate videos and images without consent to find ways to protect these victims to prevent further harm to their mental health and overall well-being- (Policy D-515.975).

This report responds to the call for research.

BACKGROUND

The distribution of sexual or pornographic images and videos of individuals without their consent is a growing problem. Such acts include images taken without consent or images taken with consent but later distributed without consent, sometimes referred to as revenge porn, as well as sexually explicit deepfake images or videos of individuals created without their consent. The distribution of intimate videos and images without consent is known as image-based sexual abuse, which is also a form of gender-based violence, as it disproportionately affects women, and the impacts on victims often replicate those of sexual assault [1].

A 2020 report found that an estimated 1 in 12 adults in the U.S. have been victims of nonconsensual pornography, and that 1 in 20 adults in the U.S. have reported perpetuating such abuse [2]. Additionally, a 2016 report found that young people (ages 15 to 29), LGBTQ+ individuals, and those from low-income households are at greater risk of image-based sexual abuse [3]. Research published in 2020 also found that approximately 1 in 5 girls and 1 in 10 boys (ages 13 to 17) report sharing their own "nudes," and 1 in 3 underaged teens report having seen nonconsensual shared nudes of other minors, which legally qualifies as child pornography [4].

The development of generative AI has accelerated the proliferation of image-based sexual abuse. The creation of nonconsensual deepfake pornography of students by their peers has quickly become a nationwide crisis at schools across the country [5,6]. A 2023 report on the state of deepfakes found that 98 percent of all deepfake videos online were pornographic and that 99 percent of such videos were of women [7]. The same report also found a 550 percent rise in the prevalence of deepfakes from 2019 to 2023 and that "[i]t now takes less than 25 minutes and costs $0 to create a 60-second deepfake pornographic video of anyone using just one clear face image" [7].

ETHICAL CONCERNS

The nonconsensual creation and/or distribution of explicit images of a person is a form of sexual violence and is inherently unethical. Sexual violence, which disproportionately affects women and younger people (ages 18 to 34), can have lasting negative health impacts, including increased risk of Post Traumatic Stress Disorder (PTSD), substance abuse, and suicide [8]. In addition to the physical and mental harms, those who experience image-based sexual abuse may also suffer from social, emotional, and existential harms, such as social rupture, isolation, and constrained liberty [9,10]. In addition to the harms such acts of abuse may cause, they also constitute wrongs that violate individuals' rights to dignity, privacy, autonomy, and freedom of sexual expression [10].

DISCUSSION

Confidentiality laws, which protect individuals' choices about sharing information, and privilege laws, which prohibit the sharing of private information without an individual's consent, vary from state to state. As of May 2024, only 20 states have enacted laws addressing nonconsensual sexual deepfakes [11]. There is currently no federal law against image-based sexual abuse.

There is currently a lack of accountability when it comes to the regulation of nonconsensual sexually explicit images. The federal 1996 Communications Decency Act that regulates pornography on the internet protects websites and service providers from liability for content posted by users with whom they are not co-creators. According to Section 230 of the Act, operators of internet services and websites, including social media, are not considered publishers of content their users post, and as such, have no legal obligation to remove nonconsensual pornography unless it otherwise violates copyright or federal criminal laws [12].

On May 23, 2024, the White House released "A Call to Action to Combat Image-Based Sexual Abuse," calling on Congress and the technology sector to work to manage the risks of AI and to strengthen protections for survivors and victims of image-based sexual abuse, including those generated by AI [13]. One proposed approach to strengthen protections has been to craft an amendment to the Violence Against Women Act, which protects survivors of sexual assault and domestic violence, to give victims the right to sue in civil court those who create, solicit, possess, and distribute nonconsensual AI-generated pornography [14].

Technology Safety, a national network to end domestic violence, has created a Confidentiality Toolkit with resources such as survivor confidentiality releases, information on federal confidentiality laws, and access to online coordinated care networks and referral systems [15]. The National Network to End Domestic Violence has also created a series of educational tools and online toolkits that focus on the intersections of technology and domestic and sexual violence [16]. Similarly, Cyber Civil Rights Initiative (CCRI) is an online organization that provides support for revenge porn survivors, including resources such as attorney referrals, a crisis hotline, and a guide

for helping remove photos from the internet [17]. The Digital Millennium Copyright Act website also can help with taking down images [18].

The recent White House "Call to Action" lists actions that the private sector should take, such as disrupting the monetization of image-based sexual abuse by curbing access to payment services for the sites or apps that host such images, as well as encouraging institutional requirements for app developers to work towards preventing their creation in the first place. A 2020 international report found that men and young people are more commonly perpetrators of image-based sexual abuse, which suggests that targeted public health educational initiatives may be an effective tool to reduce such abuse [19].

RELEVANT AMA POLICY

Our AMA has several relevant policies including AMA *Code of Medical Ethics* Opinion 8.10, "Preventing, Identifying and Treating Violence and Abuse." Among the directives of the opinion, physicians are told that they should become familiar with how to detect violence or abuse and the resources available for abused or vulnerable persons; routinely inquire about physical, sexual, and psychological abuse as part of the medical history; not allow diagnosis or treatment to be influenced by misconceptions about abuse; and treat the immediate symptoms and sequalae of violence and abuse and provide ongoing care for patients to address long-term consequences that may arise. The 2023 AMA article "You suspect a patient is being abused. What should you do?" provides physicians with information and links to relevant resources, including information on the importance of providing trauma-informed care and recognizing that not all patients may choose to disclose abuse, even when screened [20].

AMA policies that address sexual assault include H-515.953, "Sexual Assault Education and Prevention in Public Schools," H-515.956, "Addressing Sexual Assault on College Campuses," H-515.967, "Protection of the Privacy of Sexual Assault Victims," and D-515.976, "Advocacy on the US Department of Education's Spring 2022 Title IX Rules on Sexual Harassment and Assault in Education Programs." These policies tend to focus on sexual assault rather than sexual violence, which is a more encompassing, non-legal term that covers sexual assault, harassment, and abuse. Our AMA may want to consider adopting the broader term "sexual violence" in place of "sexual assault" in most cases.

CONCLUSION

Advances in digital technologies including generative AI have facilitated the distribution of intimate videos and images without consent, and thus sexual violence overall. Physicians should be familiar with how to identify signs of sexual violence, how to treat the immediate and long-term consequences of sexual violence, and how to prevent further harm to their patients' mental and overall health. In addition, more public and private sector efforts to address image-based sexual violence are needed.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted and the remainder of the report be filed:

1. That our American Medical Association (AMA) encourage the development of public and private sector initiatives to prevent and address image-based sexual violence. (New HOD Policy)

2. That Policy D-515.975 be rescinded as having been accomplished by this report.

Fiscal Note: Minimal – less than $500

REFERENCES

1. Image-based sexual abuse: an introduction. End Cyber Abuse. 2022. https://endcyberabuse.org/law-intro/
2. Ruvalcaba, Y., & Eaton, A. A. Nonconsensual pornography among U.S. adults: A sexual scripts framework on victimization, perpetration, and health correlates for women and men. Psychology of Violence. 2020; 10(1), 68-78. doi:10.1037/vio0000233
3. Lenhart, A., Ybarra, M., & Price-Feeney, M. Nonconsensual image sharing: One in 25 Americans has been a victim of "revenge porn". Data & Society Research Institute. 2016. https://datasociety.net/pubs/oh/Nonconsensual_Image_Sharing_2016.pdf
4. Thorn research: Understanding sexually explicit images, self-produced by children. Thorn. 2020. https://www.thorn.org/blog/thorn-research-understanding-sexually-explicit-images-self-produced-by-children/
5. Kelly S. Students are Using AI to Generate Deepfake Pornographic Images, Schools' Lack of Discipline Exacerbating This Nationwide Problem. Fighting for Civil Rights. 2024. https://www.fightingforcivilrights.com/blog/students-are-using-ai-to-generate-deepfake-pornographic-images-schools-lack-of-discipline-exacerbating-this-nationwide-problem/
6. Singer N. Teen Girls Confront an Epidemic of Deepfake Nudes in Schools. NY Times. 2024. https://www.nytimes.com/2024/04/08/technology/deepfake-ai-nudes-westfield-high-school.html
7. 2023 state of deepfakes: Realities, threats, and impact. Home Security Heroes. 2023. https://www.homesecurityheroes.com/state-of-deepfakes/#key-findings
8. Victims of sexual violence: statistics. RAINN. 2024. https://rainn.org/statistics/victims-sexual-violence
9. Huber A. 'A shadow of me old self': The impact of image-based sexual abuse in a digital society. International Review of Victimology. 2023 May;29(2):199-216. https://journals.sagepub.com/doi/pdf/10.1177/02697580211063659
10. McGlynn C, Johnson K, Rackley E, Henry N, Gavey N, Flynn A, Powell A. 'It's torture for the soul': The harms of image-based sexual abuse. Social & legal studies. 2021 Aug;30(4):541-62. https://journals.sagepub.com/doi/full/10.1177/0964663920947791?utm_source=miragenews&utm_medium=miragenews&utm_campaign=news
11. Combating sexual deepfakes. Multistate.ai. 2023. https://www.multistate.ai/deepfakes-sexual
12. Nonconsensual pornography (revenge porn) laws in the United States. Ballotpedia. https://ballotpedia.org/Nonconsensual_pornography_(revenge_porn)_laws_in_the_United_States#cite_note-faq-1
13. Klein J and Prabhakar A. A Call to Action to Combat Image-Based Sexual Abuse. WhiteHouse.gov. 2024. https://www.whitehouse.gov/gpc/briefing-room/2024/05/23/a-call-to-action-to-combat-image-based-sexual-abuse/
14. Chatterjee M. Nonconsensual AI porn is hated on the left and right. Can Congress act on it? Politico. 2024. https://www.politico.com/news/2024/05/26/ai-deepfake-porn-congress-00158713
15. Confidentiality toolkit. Safety Net Project. https://www.techsafety.org/confidentiality
16. Technology safety. National Network to End Domestic Violence. https://nnedv.org/content/technology-safety/
17. Cyber Civil Rights Initiative. https://cybercivilrights.org/
18. Empowering Strategies to Protect Yourself from Revenge Porn. DMCA. 2023. https://www.dmca.com/faq/How-to-stop-from-being-a-victim-of-revenge-porn
19. Powell A, Scott AJ, Flynn A, Henry N. Image-based sexual abuse: An international study of victims and perpetrators–A Summary Report. 2020. https://research.monash.edu/files/319918063/ImageBasedSexualAbuseReport_170220_WEB_2.pdf

20. Henry, Tanya Alberta. You suspect a patient is being abused. What should you do? AMA. 20 October 2023. https://www.ama-assn.org/delivering-care/physician-patient-relationship/you-suspect-patient-being-abused-what-should-you-do

REPORT OF THE BOARD OF TRUSTEES

B of T Report 18-I-24

Subject:	Expanding Protections of End-of-Life Care (Resolution 722-A-23)
Presented by:	Michael Suk, MD, JD, MPH, MBA, Chair
Referred to:	Reference Committee on Amendments to Constitution and Bylaws

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At the 2023 Annual Meeting, the House of Delegates (HOD) referred Resolution 722, "Expanding Protections of End-of-Life Care," authored by the New York Delegation which asks our American Medical Association (AMA):

(1) recognizes that health care, including end of life care like hospice, is a human right,

(2) supports the education of medical students, residents and physicians about the need for physicians who provide end of life health care services,

(3) supports the medical and public health importance of access to safe end of life health care services and the medical, ethical, legal and psychological principles associated with end-of-life care,

(4) supports education of physicians and lay people about the importance of offering medications to treat distressing symptoms associated with end of life including dyspnea, air hunger, and pain,

(5) will work with interested state medical societies and medical specialty societies to vigorously advocate for broad, equitable access to end-of-life care,

(6) supports shared decision-making between patients and their physicians regarding end-of-life health care,

(7) opposes limitations on access to evidence-based end of life care services,

(8) opposes the imposition of criminal and civil penalties or other retaliatory efforts against physicians for receiving, assisting in, referring patients to, or providing end of life health care services.

This report provides relevant background, discussion, and recommendations.

BACKGROUND

The leading causes of death in the United States are associated with chronic illness in which the patient experiences long durations of symptom burden, medical treatments and interventions, and diminished quality of life [1]. As chronic illness progresses to serious and critical illness, death

may be anticipated; however, patients and their families are often unprepared for the emotional burden of making life-sustaining and/or prolonging medical decisions during treatment of serious and critical illness [2]. As a result, many patients experience physical suffering and receive life-sustaining and/or prolonging medical treatments and interventions that are not in accordance with their preferences, values, and goals [3]. Additionally, patients and their families commonly experience emotional suffering including anxiety and depression [2]. The health care team plays a crucial role in alleviating the burden of physical and existential suffering during serious and critical illness and end-of-life through the delivery of palliative care.

Palliative care is the comprehensive management and coordination of care for pain and other distressing symptoms, including physical, psychological, intellectual, social, psychosocial, spiritual, and existential consequences of a serious illness, which improves the quality of life of patients and their families/caregivers. Additionally, palliative care evaluation and treatments are patient-centered, with a focus on the central role of the family unit in shared decision-making according to the needs, values, beliefs, and culture or cultures of the patient and their family [4]. Importantly, palliative care can be offered in all care settings through a collaborative team approach involving all disciplines (e.g., physicians, nurses, social workers, spiritual care providers, therapists, pharmacists), should be available at any stage of illness from birth to advanced age, and may be offered simultaneously with disease-modifying interventions, including attempts for cure or remission [5, 6]. However, palliative care is especially suited for persons who have incurable, progressive illness and are facing end-of-life. Hospice, which is a part of palliative care, is offered when a patient is eminently dying [7].

Palliative care can be delivered by any physician, in any specialty; however, specialty palliative care can be provided by consultants when the patient and/or their family's needs are more complex [6]. Integration of palliative care into the patient's care plan has many well studied benefits including, improved quality of life, decreased symptom burden, increased goal-concordant care, increased caregiver support, reduced anxiety, decreased hospital mortality, and reductions in unnecessary medical costs [8]. Additionally, early integration of palliative care reduces unnecessary medications and procedures that have the potential to elicit unwanted side effects or complications and, in some cases, lengthens survival while also decreasing suffering [9,10]. Although palliative care is especially suited for persons who have incurable, progressive illness and are facing end-of-life, it is imperative to distinguish the delivery and purpose of palliative care from any action that intentionally causes death, including physician assisted suicide and euthanasia. While palliative care provides pain and symptom management as well as assistance with making difficult medical decisions and emotional support to patients during end-of-life, palliative care interventions never intentionally cause death.

Numerous AMA policies (H-295.875, Palliative Care and End-of-Life Care; H-70.915 Good Palliative Care; D-295.969, Geriatric and Palliative Care Training for Physicians) support the provision of palliative care for patients and the education on palliative care for physicians. The AMA is not alone in its support of palliative care. The World Health Assembly (WHA) declared that providing palliative care should be considered an ethical duty for health organizations [11]. Additionally, the World Health Organization (WHO) declared that palliative care is an ethical duty of health professionals, and, in 2012, the United Nations Office of the High Commissioner for Human Rights recognized that the failure to provide palliative care and end-of-life care to older persons is a human rights violation [11,12]. Furthermore, in 2011, the World Medical Association (WMA) adopted the *Declaration on End-of-life Medical Care* which declared that "The objective of palliative care is to achieve the best possible quality of life through appropriate palliation of pain and other distressing physical symptoms, and attention to the social, psychological and spiritual needs of the patient" and is part of good medical care [13]. Three years later, the WMA further

expanded their support of palliative care with the adoption of a resolution that called for the integration of palliative care in global disease control and health system plans. Additionally, major world religions also endorse palliative care [14].

The AMA recognizes the disparities in access to palliative care services, especially among racial, ethnic, and socioeconomically disadvantaged populations. Ensuring all patients, regardless of background or geography, receive equitable, culturally competent, and appropriate palliative care is essential.

DISCUSSION

Despite a strong evidence basis supporting the benefits of palliative care, and existing AMA and international medical policies supporting palliative care as an ethical and imperative part of high-quality medical care, millions of patients within the United States experience barriers to accessing palliative care due to misconceptions, misinformation, limited resource availability, and inaccurate stigma surrounding the definition of palliative care and its scope [5,11,15,16]. Additionally, due to these same misconceptions and stigma, physicians face barriers to receiving education and providing palliative care at all stages of the disease course [17,18].

While AMA Policy and the *Code of Medical Ethics* (Opinion 5.2: Advance Directives; Opinion 5.3: Withholding or Withdrawing Life-Sustaining Treatment) historically support addressing the palliative needs of patients and assert that clinicians have a duty to provide optimal palliative care to patients, our AMA has not provided specific guidance on the definition, delivery, and scope of high-quality palliative care.

First, although the concept of palliative care is referenced throughout AMA policy, it is often inaccurately labeled as end-of-life care and no specific definition is provided as to what the ethical provision of this care entails or the scope of this practice. Defining palliative care is essential given that palliative care is often misunderstood and misattributed. Second, expanding palliative care education and access is important for ensuring that patients are able to obtain these evidence-based health care interventions during any stage of their serious or critical illness, including end-of-life care. Palliative care should be offered concurrently with disease modifying interventions, including attempts for cure or remission. Thirdly, palliative care, which is an ethical duty, should be distinguished from other practices that are considered ethically questionable or unethical in the practice of medicine by the AMA *Code of Medical Ethics* (e.g., knowingly and intentionally hastening or causing death, physician assisted suicide, and euthanasia). Lastly, advocating for expanding access to palliative care, as well as legal protections for physicians who provide this essential component of high-quality patient care are important.

CONCLUSION

Palliative care is an evidence based, essential component of serious illness, critical illness, and end-of-life care that is often inaccurately defined, misrepresented, and neglected. As a result, patients and their families endure physical and existential suffering that could be mitigated or alleviated with palliative care intervention. Barriers to physicians providing, and patients receiving palliative care may be alleviated through reaffirming existing AMA policy on education and new AMA policy providing guidance on the definition, delivery, and scope of palliative care.

RECOMMENDATION

In light of these considerations, the Board of Trustees Report 18 reaffirms H-295.825, Palliative Care and End-of-Life Care; H-70.915, Good Palliative Care; D-295.969, Geriatric and Palliative Care Training for Physicians; and recommends that alternate Resolution 722, "Expanding Protection of End-of-Life Care," be adopted in lieu of Resolution 722 and this report be titled "Expanding Palliative Care" and the remainder of this report be filed:

Our American Medical Association:

(1) recognizes that access to palliative care, including hospice, is a human right.

(2) recognizes that palliative care is the comprehensive management and coordination of care for pain and other distressing symptoms, including physical, psychological, intellectual, social, psychosocial, spiritual, and the existential consequences of a serious illness, which improves the quality of life of patients and their families/caregivers and that palliative care evaluation and that palliative care treatments are patient-centered and family-oriented., emphasizing shared decision-making according to the needs, values, beliefs, and culture or cultures of the patient and their family or chosen family.

(3) recognizes that palliative care can be offered in all care settings through a collaborative team approach involving all disciplines (e.g., physicians, nurses, social workers, spiritual care providers, therapists, pharmacists) and should be available at any stage of a serious illness from birth to advanced age and may be offered simultaneously with disease modifying interventions.

(4) recognizes that hospice is a specific type of palliative care, reserved for individuals with a prognosis of six months or less who have chosen to forego most life-prolonging therapies, whereas palliative can be offered alongside curative or life-prolonging treatments at any stage of illness.

(5) recognizes that palliative care differs from physician assisted suicide in that palliative care does not intentionally cause death. In fact, palliative treatments that relieve symptom distress have been shown in numerous studies to prolong life.

(6) will work with interested state medical societies and medical specialty societies and vigorously advocate for broad, equitable access to palliative care, including hospice, to ensure that all populations, particularly those from underserved or marginalized communities have access to these essential services.

(7) opposes the imposition of criminal and civil penalties or other retaliatory efforts against physicians for assisting in, referring patients to, or providing palliative care services, including hospice.

(New HOD Policy)

Fiscal Note: Minimal – Less than $500

References

1. Non communicable diseases. Accessed August 7, 2024.https://www.who.int/news-room/fact-sheets/detail/noncommunicable-diseases.
2. Akdeniz M, Yardımcı B, Kavukcu E. Ethical considerations at the end-of-life care. *SAGE Open Med*. 2021;9:20503121211000918. doi:10.1177/20503121211000918.
3. Curtis JR, Lee RY, Brumback LC, et al. Intervention to Promote Communication About Goals of Care for Hospitalized Patients With Serious Illness: A Randomized Clinical Trial. *JAMA*. 2023;329(23):2028-2037. doi:10.1001/jama.2023.8812.
4. Wantonoro W, Suryaningsih EK, Anita DC, Nguyen TV. Palliative Care: A Concept Analysis Review. SAGE Open Nurs. 2022;8:23779608221117379. doi:10.1177/23779608221117379
5. Hawley P. Barriers to Access to Palliative Care. *Palliat Care*. 2017;10:1178224216688887. doi:10.1177/1178224216688887.
6. Quill TE, Abernethy AP. Generalist plus Specialist Palliative Care — Creating a More Sustainable Model. *N Engl J Med*. 2013;368(13):1173-1175. doi:10.1056/NEJMp1215620.
7. Bhatnagar M, Kempfer LA, Lagnese KR. Hospice Care. In: StatPearls. StatPearls Publishing; 2024. Accessed August 5, 2024. http://www.ncbi.nlm.nih.gov/books/NBK537296/.
8. Ferrell BR, Twaddle ML, Melnick A, Meier DE. National Consensus Project Clinical Practice Guidelines for Quality Palliative Care Guidelines, 4th Edition. *J Palliat Med*. 2018;21(12):1684-1689. doi:10.1089/jpm.2018.0431.
9. Choudhuri AH, Sharma A, Uppal R. Effects of Delayed Initiation of End-of-life Care in Terminally Ill Intensive Care Unit Patients. *Indian J Crit Care Med Peer-Rev Off Publ Indian Soc Crit Care Med*. 2020;24(6):404-408. doi:10.5005/jp-journals-10071-23454.
10. Buss MK, Rock LK, McCarthy EP. Understanding Palliative Care and Hospice: A Review for Primary Care Providers. *Mayo Clin Proc*. 2017;92(2):280-286. doi:10.1016/j.mayocp.2016.11.007.
11. Palliative care. World Health Organization. 2020. Accessed August 2, 2024. https://www.who.int/news-room/fact-sheets/detail/palliative-care.
12. UN, Office of the High Commissioner for Human Rights. Normative standards in international human rights law in relation to older persons, Analytical Outcome Paper. 2012. Accessed August 21, 2024. Available from http://social.un.org/ageing-working-group/documents/ohchr-outcome-paper-olderpersons12.pdf.
13. WMA Declaration on End-of-Life Medical Care. The World Medical Association, Inc.; 2011. Accessed August 21, 2024. https://www.wma.net/policies-post/wma-declaration-on-end-of-life-medical-care/.
14. Strengthening of palliative care as a component of comprehensive care throughout the life course. SIXTY-SEVENTH WORLD HEALTH ASSEMBLY.
15. Flieger SP, Chui K, Koch-Weser S. Lack of Awareness and Common Misconceptions About Palliative Care Among Adults: Insights from a National Survey. *J Gen Intern Med*. 2020;35(7):2059-2064. doi:10.1007/s11606-020-05730-4.
16. Shen MJ, Wellman JD. Evidence of Palliative Care Stigma: The Role of Negative Stereotypes in Preventing Willingness to Utilize Palliative Care. *Palliat Support Care*. 2019;17(4):374-380. doi:10.1017/S1478951518000834.
17. Donne J, Odrowaz T, Pike S, Youl B, Lo K. Teaching Palliative Care to Health Professional Students: A Systematic Review and Meta-Analysis of Randomized Controlled Trials. *Am J Hosp Palliat Med*. 2019;36(11):1026-1041. doi:10.1177/1049909119859521.
18. Head BA, Schapmire TJ, Earnshaw L, et al. Improving medical graduates' training in palliative care: advancing education and practice. *Adv Med Educ Pract*. 2016;7:99-113. doi:10.2147/AMEP.S94550.

REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 1-I-24

Subject: Resolution Deadline Clarification

Presented by: Jerry P. Abraham, MD, MPH, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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At the 2024 Annual Meeting of the American Medical Association (AMA) House of Delegates (HOD), the HOD adopted CCB Report 6 that included bylaw language to implement a change to resolution deadlines. CCB Report 6-A-24 derived from the adopted as amended recommendations in Speakers Report 1-A-24. The HOD voted to retain the existing exception for Section resolutions that was initially proposed for deletion. The adopted language is follows:

2.11.3 Introduction of Business.

2.11.3.1 Resolutions. To be considered as regular business, each resolution must be introduced by a delegate or organization represented in the House of Delegates and must have been submitted to the AMA not later than 45 days prior to the commencement of the meeting at which it is to be considered, with the following exceptions.

2.11.3.1.1 AMA Sections. Resolutions presented from the business meetings of the AMA Sections may be presented for consideration by the House of Delegates no later than the recess of the House of Delegates opening session to be accepted as regular business. Resolutions presented after the recess of the opening session of the House of Delegates will be accepted in accordance with Bylaw 2.11.3.1.3.

2.11.3.1.2 Late Resolutions. Late resolutions may be presented by a delegate any time after the 45-day resolution deadline until the opening session of the House of Delegates, and will be accepted as business of the House of Delegates only upon two-thirds vote of delegates present and voting.

2.11.3.1.3 Emergency Resolutions. Resolutions of an emergency nature may be presented by a delegate any time after the opening session of the House of Delegates. Emergency resolutions will be accepted as business only upon a three-fourths vote of delegates present and voting, and if accepted shall be presented to the House of Delegates without consideration by a reference committee. A simple majority vote of the delegates present and voting shall be required for adoption.

2.11.3.1.4 Withdrawal of Resolutions. A resolution may be withdrawn by its sponsor at any time prior to its acceptance as business by the House of Delegates.

2.11.3.1.5 Resolutions not Accepted. Late resolutions and emergency resolutions not accepted as business by the House of Delegates may be submitted for consideration at a future meeting in accordance with the procedure in Bylaw 2.11.3.

Following the A-24 HOD meeting, there were concerns raised about how the "section exception" in Bylaw 2.11.3.1.1 would be applied to those sections with resolution ratification processes not occurring immediately prior to the HOD meetings Therefore, the Council has prepared clarifying bylaw language for consideration by the HOD to include all section resolutions that are ratified prior to a HOD meeting and within the 45 day window in this singular exception to on-time resolutions. Additionally, the Council offers further clarifying edits to better delineate on-time, late and emergency resolutions.

RECOMMENDATIONS

The Council on Constitution and Bylaws recommends that the following recommendation be adopted, and that the balance of the report be filed. Adoption requires the affirmative vote of two-thirds of the members of the House of Delegates present and voting following a one-day layover.

1) That our AMA Bylaws be amended by insertion and deletion as follows:

2.11.3 Introduction of Business.

2.11.3.1 Resolutions.

2.11.3.1.1 On-Time Resolutions. To be considered as regular business, each resolution must be introduced by a delegate or organization represented in the House of Delegates and must have been submitted to the AMA not later than 45 days prior to the commencement of the meeting at which it is to be considered, with the following exceptions.

2.11.3.1.1.1 AMA Sections. Resolutions presented from ~~the business~~ meetings of the AMA Sections convened prior to the coinciding House of Delegates meeting but after the 45 day on-time deadline may be presented for consideration by the House of Delegates upon adoption by the Section and no later than the commencement ~~recess~~ of the House of Delegates opening session to be accepted as regular business. Section ~~R~~resolutions presented after the commencement ~~recess~~ of the opening session of the House of Delegates will be accepted in accordance with Bylaw 2.11.3.1.3.

2.11.3.1.2 **Late Resolutions.** Late resolutions may be presented by a delegate or organization represented in the House of Delegates any time after the 45-day resolution deadline until the commencement of the opening session of the House of Delegates, and will be accepted as business of the House of Delegates only upon two-thirds vote of delegates present and voting.

2.11.3.1.3 **Emergency Resolutions.** Resolutions of an emergency nature may be presented by a delegate any time after the commencement of the opening session of the House of Delegates. Emergency resolutions will be accepted as business only upon a three-fourths vote of delegates present and voting, and if accepted shall be ~~presented to~~ considered by the House of Delegates without ~~consideration~~ deliberation by a reference committee. ~~A simple majority vote of the delegates present and voting shall be required for adoption.~~

(Modify Bylaws)

Fiscal Note: Less than $500

REVISED

REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 2-I-24

Subject: Name Change for Reference Committee

Presented by: Jerry P. Abraham, MD, MPH, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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American Medical Association (AMA) Bylaw 2.13.1.1, Amendments to the Constitution and Bylaws. states that "All proposed amendments to the Constitution or Bylaws, and matters pertaining to the Principles of Medical Ethics of the AMA shall be referred to this committee." This is the only reference committee cited in the AMA Bylaws. Its name, however, when listed in the online reference committee, on resolutions and reports, or in the House of Delegates Handbook implies that that the reference committee focuses exclusively on items related to amendments to the Constitution or Bylaws.

To more appropriately convey the focus of this reference committee and minimize confusion about its purpose, the Speakers have requested the Council to consider proposing a name change. The Council considered this request, and has proposed a bylaw amendment to rename this committee more appropriately as the Reference Committee on Ethics and Bylaws. The Council believes this bylaw change will provide needed clarity to Delegates and reference committee members alike as to the scope of matters considered by this committee.

RECOMMENDATIONS

The Council on Constitution and Bylaws recommends that the following recommendation be adopted and that the remainder of this report be filed. Adoption requires the affirmative vote of two-thirds of the members of the House of Delegates present and voting following a one-day layover:

1) That our AMA Bylaws be amended by insertion and deletion as follows:

2.13 Committees of the House of Delegates.

2.13.1 Reference Committees of the House of Delegates.

2.13.1.1 Ethics and ~~Amendments to the Constitution and~~ Bylaws. All ~~proposed amendments to the Constitution or Bylaws, and~~ matters pertaining to ethics, the Principles of Medical Ethics of the AMA and to the AMA Constitution and Bylaws shall be referred to this committee.

(Modify Bylaws)

Fiscal Note: Less than $500

REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 3-I-24

Subject: Bylaw Amendments to Address Medical Student Leadership (Resolution 003-A-24)

Presented by: Jerry P. Abraham, MD, MPH, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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At the 2024 Annual Meeting of the House of Delegates (HOD) of the American Medical Association (AMA), the HOD adopted Resolution 3 as amended submitted by the Medical Student Section: "That our American Medical Association modify the current 90-day post-graduation eligibility provisions in AMA Bylaws 3.5.6.3, 6.11, 7.3.2, 7.7.3.1, and 7.10.3.1 to allow medical students to serve on the Medical Student Section Governing Council, on the AMA Board of Trustees, on AMA Councils, and as Section Representatives on other Governing Councils for up to 200 days after graduation and not extending past the Annual Meeting following graduation" (Policy D-605.985). The intent of the adopted language was to accommodate those medical students who graduate off-cycle.

The Council has prepared the appropriate bylaw amendments for HOD action. The Council has also added amended bylaw language to encompass the medical student member of the newly formed LGBTQ+ Section.

RECOMMENDATIONS

The Council on Constitution and Bylaws recommends that the following recommendation be adopted; that Policy D-605.985 be rescinded; and that the remainder of this report be filed. Adoption requires the affirmative vote of two-thirds of the members of the House of Delegates present and voting following a one-day layover:

1) That our AMA Bylaws be amended by insertion and deletion as follow:

3 Officers

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3.5.6 Medical Student Trustee. The Medical Student Section shall elect the medical student trustee annually. The medical student trustee shall have all of the rights of a trustee to participate fully in meetings of the Board, including the right to make motions and to vote on policy issues, intra-Board elections or other elections, appointments or nominations conducted by the Board of Trustees.

3.5.6.1 Term. The medical student trustee shall be elected at the Business Meeting of the Medical Student Section prior to the Interim Meeting for a term of one year beginning at the close of the next Annual Meeting and concluding at the

close of the second Annual Meeting following the meeting at which the trustee was elected.

3.5.6.2 Re-election. The medical student trustee shall be eligible for re-election as long as the trustee remains eligible for medical student membership in AMA.

3.5.6.3 Cessation of Enrollment. The term of the medical student trustee shall terminate and the position shall be declared vacant if the medical student trustee should cease to be eligible for medical student membership in the AMA by virtue of the termination of the trustee's enrollment in an educational program. If the medical student trustee graduates from an educational program during their term, ~~within 90 days prior to an Annual Meeting~~, the trustee shall be permitted to continue to serve on the Board of Trustees for up to 200 days after graduation but not extending past the Annual Meeting following graduation. ~~until completion of the Annual Meeting~~.

6 Councils

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6.11 Term of Resident/Fellow Physician or Medical Student Member. A resident/fellow physician ~~or medical student member~~ of a Council who completes residency or fellowship ~~or who graduates from an educational program within 90 days prior to an Annual Meeting~~ shall be permitted to serve on the Council until the completion of the Annual Meeting following completion. A medical student member of a Council who graduates from an educational program during their term ~~within 90 days prior to an A~~nnual Meeting shall be permitted to serve on the Council for up to 200 days after graduation but not extending past the completion of the Annual Meeting following graduation. Service on a Council as a resident/fellow physician and/or medical student member shall not be counted in determining maximum Council tenure.

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7 Sections

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7.3 Medical Student Section. The Medical Student Section is a fixed Section.

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7.3.1 Membership. All active medical student members of the AMA shall be members of the Medical Student Section.

7.3.2 Cessation of Eligibility. If any officer or Governing Council member ceases to meet the membership requirements of Bylaw 7.3.1 prior to the expiration of the term for which elected, the term of such officer or member shall terminate and the position shall be declared vacant. If the officer or member graduates from an educational program during their term ~~within 90 days prior to an Annual Meeting~~, the officer or member shall be permitted to continue to serve in office for up to 200 days after graduation but not extending past ~~until the completion of~~ the Annual Meeting following graduation.

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7.7 Minority Affairs Section. The Minority Affairs Section is a delineated Section.

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7.7.3.1 Section Representatives on the Governing Council. If a representative of the ~~Medical Student Section,~~ Resident and Fellow Section or Young Physicians Section ceases to meet the criteria for membership in the section from which elected within 90 days prior to the Annual Meeting, such member shall be permitted to serve in office until the conclusion of the Annual Meeting in the calendar year in which they cease to meet the membership requirement of the respective section. If a representative of the Medical Student Section graduates from an educational program during their governing council term, such medical student member shall be permitted to serve in office for up to 200 days after graduation but not extending past until the completion of the Annual Meeting following graduation.

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7.10 Women Physicians Section. The Women Physicians Section is a delineated Section.

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7.10.3.1 Section Representatives on the Governing Council. If a representative of the ~~Medical Student Section,~~ Resident and Fellow Section or Young Physicians Section ceases to meet the criteria for membership in the section from which elected within 90 days prior to the Annual Meeting, such member shall be permitted to serve in office until the conclusion of the Annual Meeting in the calendar year in which they cease to meet the membership requirement of the respective section. If any representative of the Medical Student Section graduates from an educational program during their governing council term, such medical student member shall be permitted to serve in office for up to 200 days after graduation but not extending past until the completion of the Annual Meeting following graduation.

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7.12 LGBTQ+ Section. The LGBTQ+ Section is a delineated Section.

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7.12.2.3 If any ~~medical student,~~ resident/fellow or young physician member of the governing council ceases to meet the criteria for membership in the section they represent within 90 days prior to the Annual Meeting they will be permitted to continue to serve in their position until the conclusion of the Annual Meeting in the calendar year in which they cease to meet the membership requirement of their section. If any medical student member graduates from an educational program during their governing council term, such medical student shall be permitted to serve in office for up to 200 days after graduation but not extending past the completion of the Annual Meeting following graduation.

(Modify Bylaws)

Fiscal Note: Less than $500

RELEVANT AMA POLICY

D-605.985, Amendments to AMA Bylaws to Enable Medical Student Leadership Continuity. Our American Medical Association will modify the current 90-day post-graduation eligibility provisions in AMA Bylaws 3.5.6.3, 6.11, 7.3.2, 7.7.3.1, and 7.10.3.1 to allow medical students to serve on the Medical Student Section Governing Council, on the AMA Board of Trustees, on AMA Councils, and as Section Representatives on other Governing Councils for up to 200 days after graduation and not extending past the Annual Meeting following graduation.

REPORT 1 OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS (I-24)
Expanding Access to Palliative Care
(Reference Committee on Amendments to Constitution and Bylaws)

EXECUTIVE SUMMARY

Palliative care focuses on improving quality of life by providing physical and emotional support to the patient and their family during serious and critical illness. Failure to provide palliative care is in direct conflict with the well-established ethical duty for physicians to relieve the pain and suffering of their patients. Although the term "palliative treatment" is referred to in both the *Code of Medical Ethics* (*Code*) *a*nd numerous House of Delegates policies, the ethical provision of this medical practice is neither discussed nor defined in house policies or in the *Code*. This Council on Ethical and Judicial Affairs (CEJA) report recommends the adoption of a new opinion in the *Code* which addresses the ethical provision of palliative care.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 1-I-24

Subject: Expanding Access to Palliative Care

Presented by: Jeremy A. Lazarus, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

BACKGROUND

The majority of deaths in the United States result after months to years of treating complications of underlying chronic illness and comorbidities, including cancer, heart disease, and stroke [1]. Although many deaths in America are anticipated, patient preferences, values, and goals for medical treatment during serious and critical illness are not often elicited prior to the initiation of life sustaining interventions including mechanical ventilation, artificial nutrition and hydration, and cardiopulmonary resuscitation [2]. The stress and uncertainty surrounding medical decisions during serious illness often results in patients and their families experiencing needless physical and emotional suffering such as anxiety, depression, and the prolonged use of unwanted or likely to be ineffective mechanical and pharmacological life sustaining interventions that cannot restore the patient to an acceptable level of health and function [3]. The patient and their family's experience of suffering during their serious illness is often avoidable or mitigatable by physicians through palliative care [3].

Palliative care focuses on improving quality of life by providing physical and emotional support to the patient and their family during serious and critical illness [4]. Palliative care can be provided at any point in the illness trajectory by any physician, in any specialty (a.k.a. primary palliative care) [5]. When the patient's and/or their family's needs are more complex, specialty palliative care can be consulted [5]. Opinion 5.3 of the *Code of Medical Ethics* (*Code*) calls for the provision of palliative care, which is appropriate when patient or family distress, physical and psychological symptom burden, uncertainty about what to expect in the future, or spiritual/existential distress is identified. Failure to provide palliative care is in direct conflict with the well-established ethical duty for physicians to address the pain and suffering of their patients [6]. Furthermore, American Medical Association (AMA) policy H-70.915 encourages the provision of "good palliative care" and "encourages all physicians to become skilled in palliative medicine." Opinion 5.3, "Withholding and Withdrawing Life-Sustaining Treatment," calls for the provision of palliative care when such transitions in care are considered. Additionally, a 1991 Council on Ethical and Judicial Affairs (CEJA) Report was adopted entitled "Decisions Near End of Life" which advocated for the use of palliative care [7].

Although there is a strong basis supporting the provision of palliative care for patients facing serious illness, the *Code* does not address the ethical provision of palliative care for serious or critical illness. This gap should be filled by the creation of a new opinion which describes the

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

ethical provision of "good palliative care" and provides ethical guidelines for implementing palliative care during clinical practice.

RELEVANT LAW(S)

There are several definitions of palliative care from the Centers for Medicare and Medicaid Services (CMS), the World Health Organization, the World Medical Association, and the Center to Advance Palliative Care. Common elements include physical and psychological symptom management, focusing on the patient and caregivers as the unit of care, provision throughout the course of the illness, and continuity of care across settings and over time. Reimbursement for palliative care is funded through the CMS as well as other insurers [8]. Also, the Palliative Care and Hospice Education Training Act (PCHETA) is under consideration in the Senate and has been introduced with bipartisan support and the official support of over 90 national and state organizations [9]. PCHETA would create and promote education programs, research programs, and public education programs to support and expand the palliative care workforce, delivery of palliative care, and public awareness about palliative care. In support of furthering the evidence base for palliative medicine, the National Institutes of Health recently established a Consortium for Palliative Care Research Across the Lifespan, a cross-institute funding initiative with an annual commitment of approximately $12 million [10].

RELEVANT POLICY PROVISION(S)

Numerous AMA policies support the provision of palliative care for patients and the education of palliative care for physicians. AMA policy H-140.966 states that "physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of patients in their care. Furthermore, policy encourages the provision of "good palliative care" and "encourages all physicians to become skilled in palliative medicine." H-295.875 encourages "the inclusion of palliative medicine in the core curriculum of undergraduate and graduate medical education" and the "use of palliative care techniques and interdisciplinary team care." D-295.969 "encourages palliative training for physicians caring for elderly and terminally ill patients in long-term care facilities." H-85.949 supports "increased access to comprehensive interdisciplinary palliative care services by Medicare patients." H-55.999 "supports palliative care procedures for cancer patients."

RELEVANT *CODE* PROVISION(S)

The *Code* references and supports the provision of palliative care numerous times. For example, Opinions 5.3 and 6.1.2 both require physicians to "ensure that relevant standards for good clinical practice and palliative care are followed when implementing any decision to withdraw a life-sustaining intervention" and Opinion 5.6 requires physicians to consult "an expert in the field of palliative care, to ensure that symptom-specific treatments have been sufficiently employed" prior to engaging in palliative sedation to unconsciousness. Additionally, Opinions 2.2.5 and 5.2 mention palliative interventions; however, the *Code* does not directly address what qualifies as palliative care, nor does it provide ethical guidance on the delivery of palliative care.

ETHICAL ISSUES

Delivering palliative care during clinical practice is inextricably linked with navigating ethical dilemmas. For example, physicians must balance the often-competing values, preferences, and goals of the patient, the health care entity, the clinical care team, the payer, and their surrogate or support persons while making complex medical decisions such as when to withhold or withdraw life sustaining interventions or when to counsel cessation of 'curative' treatments that become

ineffective or harmful [3,11]. These competing values, preferences, and goals arise from many sources including the profession itself, society, community, family, religious beliefs, and personal desires and experience. While navigating various perspectives and competing values during palliative care delivery, physicians must also balance complex ethical questions such as when it is ethically appropriate to withhold or withdrawal life sustaining interventions or provide sedation or analgesia to relieve symptom distress when the unintended potential effect is hastened death. The concept of double effect permits, under appropriate conditions medical treatments or interventions that could have the effect of hastening death so long as the primary intention of providing the medical treatment or intervention is not to hasten death but is for some other clinically and ethically appropriate reason such as pain and symptom management.

Many of the ethical complexities of palliative care are discussed in detail within the 1991 CEJA report entitled "Decisions Near End of Life"; however, guidance regarding ethical palliative care is absent within the *Code* [7]. This is problematic for several reasons. Importantly, palliative care as a discipline has substantially evolved since 1991 when it was first recognized as a medical specialty. Despite the rapid evolution of palliative care as a medical specialty, the ethical issues highlighted in the 1991 report remain; however, the understanding of palliative care and the role palliative care plays in resolving ethical dilemmas has evolved. Additionally, palliative care is often misunderstood as being limited to comfort care for patients imminently facing end of life. This misunderstanding often results in palliative care being initiated late in the disease course and typically only after the decision to discontinue curative or life prolonging interventions [12]. Additionally, this misunderstanding often results in palliative care not being offered concurrently with curative treatments, even for patients with substantial distress during a serious or complex critical illness. Furthermore, due to the underutilization of palliative care throughout the full course of the patient's illness trajectory, patients are too often referred for palliative care consultation prior to imminent death, and thus, often receive high burden life sustaining interventions where burden outweighs benefit [13,8]. This is problematic because delaying the provision of palliative care results in patients and their families facing unnecessary suffering which is in direct conflict with a physician's ethical duty to relieve pain and suffering. Providing ethical guidance in the *Code* will help alleviate misnomers and barriers to implementing and practicing ethical palliative care during clinical practice.

RELEVANT PRACTICAL MATTERS FOR CLINICAL PRACTICE

Amending the *Code* to include ethical guidance on providing palliative care for patients facing serious, chronic, complex, or critical illness will positively affect clinical practice. First, the benefits of palliative care have been well studied and include improved quality of life, decreased symptom burden, increased goal-concordant care, increased caregiver support, reduced anxiety, decreased hospital mortality, and reductions in unnecessary medical costs [14]. In some cases, it may even result in longer survival than those treated with chemotherapy [15]. Second, palliative care improves the quality of care the patient (and their care partners) receives, while providing support for the physician and their team and has been associated with both improved physician satisfaction and patient satisfaction. Third, serious and critical illness care is often a source of stress for physicians and has been associated with physician burn out [13]. Palliative care provides support to physicians in four important ways through the provision of: 1) dedicated time for intensive family meetings and goals of care conversations; 2) skilled communication over time to help patients and their families determine the medical treatment options that match their preferences, values, and goals as illness evolves; 3) expert pain and symptom management of both physical, emotional, social, and spiritual distress; and 4) comprehensive coordination of communication among all providers involved in the patients care [5,14,11].

REVIEW OF RELEVANT LITERATURE

Most people will experience death in a hospital or health care facility after suffering from a chronic serious illness, and one-in-three of the deaths that occur in the hospital will result from a decision to withdraw life-sustaining interventions [12,16-19]. Although it is common for Americans to die in a hospital or health care facility and receive life prolonging interventions at the end of life, this is not how most healthy Americans report that they want their lives to end. This is likely related to multiple factors: the aim of preserving life; the rational assumption that patients and families hold that doctors would not recommend treatments they did not believe to be helpful to the patient so they accede to the doctor's recommendations; and the fact that when death is imminent, patient (and caregiver) desire to hold on often strengthens (this is evident in the observation that despite presence of advance directives specifying comfort measures when recovery is not possible, they are seldom honored) [20]. Evidence is clear that regardless of prognosis and treatments, patients and caregivers living with serious, chronic, complex, and critical illness experience anxiety, depression, and physical and spiritual/existential suffering [11]. One way to remediate this experience is through the provision of palliative care, which is associated with improved quality of life, reduced suffering, and reduced hospital mortality [5,14].

Palliative care is the comprehensive management and coordination of care for pain and other distressing symptoms including physical, psychological, intellectual, social, psychosocial, spiritual, and existential consequences of a serious illness that improves the quality of life of patients and their families/caregivers [5]. The evaluation and treatment are patient-centered, with a focus on the central role of the family unit in decision-making according to the needs, values, beliefs, and culture of the patient and his or her family [14]. Palliative care can be offered in all care settings, by any physician, and at any stage in a serious illness. The provision of palliative care by physicians without subspecialty training in palliative medicine is known as primary palliative care [5]. When a patient and/or their family's needs become complex, specialty palliative care can be delivered through a collaborative team approach involving all disciplines optimally including physicians, nurses, social workers, spiritual care providers, therapists, and pharmacists. Specialist level palliative care teams work alongside the primary treating team as an added layer of support for all- patient, caregivers, and clinicians.

Hospice is a mode of palliative care for patients in their homes or long-term care facilities provided in the U.S. with a specific Medicare payment model. Eligible U.S. patients must have an expected prognostic life-expectancy of six months or less and agree to give up regular Medicare insurance coverage. Most private insurers in the U.S. follow the Medicare model for patients not on Medicare. Hospice care is predominantly provided at home or in nursing homes. In contrast, palliative care has no prognosis or treatment restrictions (delivered at any age, any stage, any setting and whether the illness is curable chronic or progressive) and is provided (depending on local capacity) in any setting- hospital, office, cancer center, dialysis unit, home, or long-term care facility [8]. While patients usually receive palliative care concurrently with traditional medical treatments, hospice care focuses on comfort measures for the patient and their family near the end of life. Comfort measures focus on relieving the stress, anxiety, and physical pain which often occurs during the dying process.

The use of complex disease-specific interventions at the end of life is associated with stress and uncertainty and often results in patients and their families experiencing physical and existential suffering such as intractable pain, anxiety, and depression [13]. The patients and their families' experience of suffering is often avoidable or mitigatable through palliative care [5,14,13]. Although the provision of palliative care is associated with improved quality of life, more days at home, and reduced suffering, palliative care is too often initiated as a last resort, after disease-specific

interventions have become ineffective (i.e. futile or unable to result in a beneficial outcome), and the decision to withdraw life sustaining interventions either needs to be made or has already been made [13]. Due to the underutilization of palliative care throughout the full course of the patient's illness trajectory, patients are too often referred for palliative care consultation prior to imminent death, and thus, often receive high burden life sustaining interventions where burden outweighs benefit [13,8].

ETHICAL ANALYSIS

Palliative Care is the Evidence Based Standard of Care for Patients with Serious and Critical Illness

The need to address palliative care in the *Code* is not a novel concept. At the 1991 Annual Meeting of the House of Delegates (HOD), CEJA Report was adopted entitled "Decisions Near End of Life" which addressed palliative care as an ethical medical intervention [7]. Since the adoption of the CEJA report "Decisions Near End of Life", the HOD passed policy H-70.915 entitled "Good Palliative Care" in 2014. This policy "encourages all physicians to become skilled in palliative medicine" and "encourages education programs . . . in care of the dying patient." Additionally, this policy advocates for reimbursement of palliative care services and research to improve the field of palliative medicine. This policy has been reaffirmed three times since it was originally passed showing the continued interest and support of palliative care in the AMA HOD. In addition to the HOD policy on Good Palliative Care, the HOD has passed eight other policies which have affirmatively advocated for providing palliative care.

The AMA HOD is not alone in its support of palliative care. The World Health Assembly (WHA) declared that providing palliative care should be considered an ethical duty for health organizations. Additionally, the World Health Organization declared that palliative care is an ethical duty of health professionals and, in 2012, the United Nations Office of the High Commissioner for Human Rights recognized that the failure to provide palliative care and end of life care to older persons is a human rights violation. Furthermore, in 2011, the World Medical Association (WMA) adopted the Declaration on End-of-Life Medical Care which declared that "The objective of palliative care is to achieve the best possible quality of life through appropriate palliation of pain and other distressing physical symptoms, and attention to the social, psychological and spiritual needs of the patient and is part of good medical care" [10]. Three years later, the WMA further expanded their support of palliative care with the adoption of a resolution which called for the integration of palliative care in global disease control and health system plans. Additionally, major world religions also endorse palliative care [21].

Despite the continued support for palliative care within the AMA HOD and from medical organizations across the globe, the *Code* remains silent on what constitutes the ethical provision of palliative care. Providing guidance on the ethical practice of palliative care in the *Code* is important because there is not one standard definition of palliative care and what it entails. Additionally, palliative care is often misattributed as being connected to physician assisted suicide or euthanasia. Misattribution and confusion about the scope of palliative care may be contributing to the underutilization of this high quality, evidence based, medical intervention. As there is an established ethical duty within the *Code* to provide palliative care and HOD policies which encourage the provision of palliative care, it is imperative to offer clinicians guidance on what the ethical delivery of high-quality palliative care entails. Additionally, it is imperative to distinguish palliative care, which is an ethical duty, from other practices which either straddle the line of ethical acceptability or are considered by the *Code* as unethical in the practice of medicine (e.g., knowingly and intentionally hastening death, physician assisted suicide, and euthanasia). Lastly,

given the rapid and vast evolution of palliative care as a medical discipline, it is important to update the 1991 CEJA report's understanding of the scope and way in which palliative care is ethically implemented during clinical practice.

The Aim of Palliative Care is Not Hastening Death

Providing palliative care is ethically distinguishable from physician assisted suicide and euthanasia, both of which are intended to cause death. It is important, however, to recognize that treatments for the relief of intractable pain/agitation/dyspnea may theoretically (and very rarely if the clinician is well trained in symptom management) result in the unintended consequence of hastening death. To the contrary, uncontrolled symptom distress, including moderate to severe pain, agitation, depression, and dyspnea, are all associated with a higher risk of death [21-25]. The ethical concept of "double effect" hinges on the intention of the medical intervention. It stipulates that an intervention is ethically permissible if it is provided with the intention of relieving pain or treating symptoms, even if the intervention has the foreseen but unintended side effect of hastening death, provided that the benefits outweigh the burdens and the relief of symptoms or suffering is not achieved by means of causing death [26]. Conversely, this same intervention would be deemed unethical if the primary intention was to hasten death. Patients and/or their surrogate medical decision makers should be provided informed consent which allows them to determine if the risk of intentionally hastening death is worth the relief of pain and/or suffering.

Palliative Care is Offered Concurrently with Curative Treatments

The *Code* contains many ethical opinions permitting the withholding or withdrawing of medical interventions for life-prolonging purposes. For example, patients with decision making capacity have the ethical right to decline or stop any medical intervention, even if this decision will result in their death (Opinion 5.3). Additionally, patients have the ethical right to refuse cardiopulmonary resuscitation attempts through the execution of a Do Not Resuscitate Order (Opinion 5.4). In addition to patients having the ethical right to determine if they want to start or continue an offered medical treatment, physicians also have an ethical duty to not provide interventions that, "in their best medical judgement, cannot reasonably be expected to yield the intended clinical benefit or achieve agreed-on goals for care" (Opinion 5.5).

Although there is a well-established ethical basis for medical interventions to be withheld or withdrawn from both the patient and physicians' perspective, there is also a well-established ethical "duty to relieve pain and suffering" that is "central to the physician's role as healer and is an obligation physicians have to their patients" (Opinion 5.6). Further, as noted above, symptom distress is consistently associated with a higher risk of death, adding to the professional obligation to ameliorate it. Additionally, physicians have an ethical duty to "respond to the needs of patients at the end of life", and they "should not abandon a patient once it is determined that a cure is impossible" (Opinion 5.8).

The provision of palliative care bridges these ethical obligations by providing physical and emotional support to patients and their family/ care partners during the entire illness trajectory. Palliative care is offered to patients concurrently with disease-directed treatments and interventions and, therefore, it is not necessary to decide between continued treatment and palliative care intervention because they are provided simultaneously. As the illness progresses and the patient's medical goals transition from cure or prolonging life towards making the life that remains as peaceful and functional as possible, hospice should be offered to the patient and their family. Although life prolonging interventions (for the terminal condition) are not offered as a Medicare

Condition of Participation in hospice during the provision of comfort care, the patient and their family are provided physical, emotional, spiritual, and practical support during the dying process.

CONCLUSION

Although our AMA adopted a CEJA report in 1991 which recommend "providing effective palliative treatment . . ." a *Code* opinion speaking to what it means to practice ethical and effective palliative care has never been adopted [7]. This is problematic because palliative care is an essential part of a patient's serious illness experience and provides beneficial outcomes in terms of symptom distress, patient and family understanding of what to expect and how to prepare for it, and reduction in use of Emergency Department and hospital admission for symptom crises. This is further problematic because the term "palliative treatment" is referred to in both the *Code* and numerous HOD policies; however, the ethical provision of this medical practice is neither discussed nor defined in house policies or in the *Code*.

RECOMMENDATION

Given both the AMA Policy and CEJA's historical support of addressing the palliative needs of patients and the duty of clinicians to provide optimal palliative care to patients, it is recommended that the *Code of Medical Ethics* be amended to include a new opinion on Palliative Care.

> Physicians have clinical ethical responsibilities to address the pain and suffering occasioned by illness and injury and to respect their patients as whole persons. These duties require physicians to assure the provision of effective palliative care whenever a patient is experiencing serious, chronic, complex, or critical illness, regardless of prognosis. Palliative care is sound medical treatment that includes the comprehensive management and coordination of care for pain and other distressing symptoms including physical, psychological, intellectual, social, spiritual, and existential distress from serious illness. Evaluation and treatment are patient-centered but with an additional focus on the needs, values, beliefs, and culture of patients and those who love and care for them in decision-making accordingly.
>
> Palliative care is widely acknowledged to be appropriate for patients who are close to death, but persons who have chronic, progressive, and/or eventually fatal illnesses often have symptoms and experience suffering early in the disease course. The clinical ethical responsibilities to address symptoms and suffering may therefore sometimes entail a need for palliative care before the terminal phase of disease. Moreover, the duty to respect patients as whole persons should lead physicians to encourage patients with chronic, progressive, and/or eventually fatal conditions to identify surrogate medical decision makers, given the likelihood of a loss of decisional capacity during medical treatment.
>
> When caring for patients' physicians should:
>
> (a) Integrate palliative care into treatment.
>
> (b) Seek and/or provide palliative care, as necessary, for the management of symptoms and suffering occasioned by any serious illness or condition, at any stage, and at any age throughout the course of illness.
>
> (c) Offer palliative care simultaneously with disease modifying interventions, including attempts for cure or remission.

(d) Be aware of, and where needed, engage palliative care expertise in care.

Physician as a profession should:

(e) Advocate that palliative care be accessible for all patients, as necessary, for the management of symptoms and suffering occasioned by any serious illness or condition, at any stage, and at any age throughout the course of illness.

(New Policy)

Fiscal Note: Less than $500

REFERENCES

1. FASTSTATS - Leading Causes of Death. Centers for Disease Control and Prevention, January 17, 2024. https://www.cdc.gov/nchs/fastats/leading-causes-of-death.htm.
2. Curtis JR, Lee RY, Brumback LC, Kross EK, Downey L, Torrence J, LeDuc N, Mallon Andrews K, Im J, Heywood J, Brown CE, Sibley J, Lober WB, Cohen T, Weiner BJ, Khandelwal N, Abedini NC, Engelberg RA. Intervention to Promote Communication About Goals of Care for Hospitalized Patients With Serious Illness: A Randomized Clinical Trial. JAMA. 2023 Jun 20;329(23):2028-2037.
3. Akdeniz M, Yardımcı B, Kavukcu E. Ethical considerations at the end-of-life care. SAGE Open Med. 2021 Mar 12;9:20503121211000918.
4. Wantonoro W, Suryaningsih EK, Anita DC, Nguyen TV. Palliative Care: A Concept Analysis Review. SAGE Open Nurs. 2022 Aug 8;8:237s79608221117379.
5. Quill TE, Abernethy AP. Generalist plus specialist palliative care — creating a more sustainable model. New England Journal of Medicine. 2013 Mar 28;368:1173–1175.
6. American Medical Association. Virtual Mentor. 2013;13(12):1038-1040.
7. Council on Ethical and Judicial Affairs. Report B-A-91: Decisions Near the End of Life. Adopted June 1991. Available at http://http://www.ama-assn.org/ama/pub/about-ama/our people/ama-councils/council-ethical-judicial-affairs/ceja-reports.page? Accessed Sep 5, 2024.
8. What are palliative care and hospice care. National Institute on Aging. https://www.nia.nih.gov/health/hospice-and-palliative-care/what-are-palliative-care-and-hospice-care. Accessed 27 Feb 20248.
9. Coalition T Coalition responds to Senate HELP committee hearing on health care workforce shortages. National Coalition For Hospice and Palliative Care. https://www.nationalcoalitionhpc.org/coalition-responds-to-senate-help-committee-hearing-on-health-care-workforce-shortages/. Accessed 27 Feb 2024
10. World Medical Association. WNA Declaration on End-of-Life Care. https://www.wma.net/policies-post/wma-declaration-on-end-of-life-medical-care/
11. Blinderman CD, Billings JA. Comfort care for patients dying in the hospital. New England Journal of Medicine. 2015 Dec 24;374:1692–1693.
12. Schofield G, Dittborn M, Huxtable R, et al. Real-world ethics in Palliative Care: A systematic review of the ethical challenges reported by specialist palliative care practitioners in their clinical practice. Palliative Medicine 2020 Dec 10;35:315–334.
13. Dijxhoorn A-FQ, Brom L, van der Linden YM, et al. Prevalence of burnout in healthcare professionals providing palliative care and the effect of interventions to reduce symptoms: A systematic literature review. Palliative Medicine. 2020 Oct 16;35:6–26.
14. Ferrell BR, Twaddle ML, Melnick A, et al. National consensus project clinical practice guidelines for quality palliative care guidelines, 4th edition. Journal of Palliative Medicine. 2018 Dec 14;21(12), 1684–1689.
15. Temel JS, Greer JA, Muzikansky A, Gallagher ER, et. al. Early Palliative Care for Patients with Metastatic Non-Small-Cell Lung Cancer. JAMA. 2010;363:733-742.
16. Rodriguez KL, Barnato AE, Arnold RM. Perceptions and utilization of palliative care services in Acute Care Hospitals. Journal of Palliative Medicine 2007 Feb 13;10:99–110.
17. Sabatino CP. The evolution of health care advance planning law and policy. Milbank Q. 2010 Jun;88(2):211-39.
18. QuickStats: Percentage of deaths, by place of death - national vital statistics system, United States, 2000–2018. In: Centers for Disease Control and Prevention. https://www.cdc.gov/mmwr/volumes/69/wr/mm6919a4.htm?s_cid=mm6919a4_w. Accessed 27 Feb 2024

19. Steinberg A, Abella BS, Gilmore EJ, et al (2021) Frequency of withdrawal of life-sustaining therapy for perceived poor neurologic prognosis. Critical Care Explorations. 2021 Jul;3(7):p e0487.
20. Morrison RS. Meier DE, Arnold RM. What's wrong with advance care planning? JAMA 2021;326(16):1575-1576.
21. Centeno C, Sitte T, de Lima L, Alsirafy S, Bruera E, Callaway M, Foley K, Luyirika E, Mosoiu D, Pettus K, Puchalski C, Rajagopal MR, Yong J, Garralda E, Rhee JY, Comoretto N. White Paper for Global Palliative Care Advocacy: Recommendations from a PAL-LIFE Expert Advisory Group of the Pontifical Academy for Life, Vatican City. J Palliat Med. 2018 Oct;21(10):1389-1397. doi: 10.1089/jpm.2018.0248.)"
22. Triplett DP, LeBrett WG, Bryant AK, Bruggeman AR, Matsuno RK, Hwang L, Boero IJ, Roeland EJ, Yeung HN, Murphy JD. Effect of Palliative Care on Aggressiveness of End-of-Life Care Among Patients With Advanced Cancer. J Oncol Pract. 2017 Sep;13(9):e760-e769.
23. National Palliative Care Research Center. http://www.npcrc.org/news-detail.aspx?id=150
24. Macfarlane GJ, Barnish MS, Jones GT. Ann Rheum Dis. 2017;76(11):1815-1822. https://pubmed.ncbi.nlm.nih.gov/28733474/
25. Zhang Z, Jackson SL, Gillespie C. JAMA Network Open. 2023;6(10):e2337011. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2810363
26. Sulmasy DP, Pellegrino ED. The rule of double effect: clearing up the double talk. Arch Intern Med. 1999 Mar 22;159(6):545-50. doi: 10.1001/archinte.159.6.545; Sulmasy DP. 'Re-inventing' the rule of double effect. In: The Oxford Handbook of Bioethics, ed. B Steinbock, Oxford: Oxford University Press, 2007, 114-149.).
27. Pesola GR. Ahsan H. Clin Respir J. 2016;10(2):142–152. https://onlinelibrary.wiley.com/doi/10.1111/crj.12191.

REPORT 2 OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS (I-24)
"Protecting Physicians Who Engage in Contracts to Deliver Health Care Services"
(D-140.951)

EXECUTIVE SUMMARY

In adopting policy D-140.951, "Establishing Ethical Principles for Physicians Involved in Private Equity Owned Practices," the House of Delegates directed the Council on Ethical and Judicial Affairs (CEJA) to "study and clarify the ethical challenges and considerations regarding physician professionalism raised by the advent and expansion of private equity ownership".

Increasing investments by private equity firms in health care raise ethical concerns regarding dual loyalties of physicians and competing interests between profits and patients. Private equity firms' incursion into health care raises several ethical concerns and warrants extreme caution. To respond to these issues, CEJA recommends amending Opinion 11.2.3, "Contracts to Deliver Health Care Services" to more clearly encompass partnerships with private equity firms and the ethical dilemmas and obligations that they raise for both physicians seeking capital to support their private practice as well as physicians entering into employment contracts with private equity-owned hospitals.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 2-I-24

Subject: Protecting Physicians Who Engage in Contracts to Deliver Health Care Services

Presented by: Jeremy A. Lazarus, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

In response to Policy D-140.951, "Establishing Ethical Principles for Physicians Involved in Private Equity Owned Practices," which instructs our American Medical Association (AMA) to "study and clarify the ethical challenges and considerations regarding physician professionalism raised by the advent and expansion of private equity ownership", the Council on Ethical and Judicial Affairs (CEJA) presented Report 02-A-23, and later a revised Report 03-A-24, which offered recommendations on amending Opinion 11.2.3, "Contracts to Deliver Health Care Services." The 2024 report was referred back to CEJA, with testimony expressing a desire that a stronger stance be taken against private equity's involvement in health care.

BACKGROUND

The past several decades have seen an increase in the corporatization, financialization, and commercialization of health care [1,2]. Since 2018, more physicians now work as employees of hospitals or health care systems rather than in private practice [3,4]. Our AMA reports that this trend is continuing: "[e]mployed physicians were 50.2 percent of all patient care physicians in 2020, up from 47.4 percent in 2018 and 41.8 percent in 2012. In contrast, self-employed physicians were 44 percent of all patient care physicians in 2020, down from 45.9 percent in 2018 and 53.2 percent in 2012" [4]. A major factor in these trends has been the incursion of private equity into health care. It is estimated that private equity capital investment between 2000 and 2018 grew from $5 billion to $100 billion [1]. Between 2016 and 2017 alone, the global value of private equity deals in health care increased 17 percent, with health care deals compromising 18 percent of all private equity deals in 2017 [5].

Private equity firms use capital from institutional investors to purchase private practices, typically utilizing a leveraged buy-out model that finances the majority of the purchase through loans for which the physician practice serves as security, with the goal of selling the investment within 3 to 7 years and yielding a return of 20-30 percent [1,5,6]. However, private equity investment broadly encompasses many types of investors and strategies, including venture capital firms that primarily invest in early-stage companies for a minority ownership, growth equity firms that tend to partner with promising later-stage ventures, and traditional private equity firms that borrow money through a leveraged buyout to take a controlling stake of mature companies [7].

When ownership shifts from physicians to private equity firms, the firms typically seek to invest resources to expand market share, increase revenue, and decrease costs to make the practice more

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

profitable before selling it to a large health care system, insurance company, another private equity firm (as a secondary buyout), or the public via an initial public offering (IPO) [8]. To expand market share, private equity typically employs a "platform and add-on" or "roll-up" approach in which smaller add-ons are acquired after the initial purchase of a large, established practice, allowing private equity firms to gain market power in a specific health care segment or sub-segment [1,9]. These practices by private equity appear to be driving mergers and acquisitions within health care, significantly contributing to the consolidation of the health care industry that has dramatically increased over the past decade [9].

Proponents of private equity investments in health care claim that private equity provides access to capital infusions, which may facilitate practice innovation and aid in the adoption of new technological infrastructure [6,8]. Proponents also advocate that private equity can bring "valuable managerial expertise, reduce operational inefficiencies, leverage economies of scale, and increase healthcare access by synergistically aligning profit incentives with high quality care provision" [10].

Critics argue that private equity's focus on generating large, short-term profits likely establishes an emphasis on profitability over patient care, which creates dual loyalties for physicians working as employees at private equity-owned practices [5,6]. Critics further assert that prioritizing profits likely jeopardizes patient outcomes, overburdens health care companies with debt, leads to an over-emphasis on profitable services, limits access to care for certain patient populations (such as uninsured individuals or individuals with lower rates of reimbursement such as Medicaid or Medicare patients), and fundamentally limits physician control over the practice and clinical decision making [5,8,10].

Despite strong opinions regarding private equity's incursion into medicine, empirical research on the effects of private equity investments in health care, and the impacts on patient outcomes, is currently limited [8]. Zhu and Polsky explain that this lack of research is primarily because "[p]rivate equity firms aren't required to publicly disclose acquisitions or sales, and the widespread use of nondisclosure agreements further contributes to opacity about practice ownership and the nature of transactions" [6]. More research is needed on the effects of private equity investment in the health care sector, as little empirical evidence exists on how private equity impacts utilization, spending, or patient outcomes. Of the empirical research that has been done, evidence on the effects of private equity acquisition of health care entities on patient outcomes has been mixed [10,13-15].

Regardless, there is widespread concern among physicians that private equity-controlled practices result in worse patient outcomes. This is particularly worrisome as private equity firms are emerging to be major employers of physicians. Currently, it is estimated that eight percent of all private hospitals in the U.S. and 22 percent of all proprietary for-profit hospitals are owned by private equity firms [11].

Relevant Laws

Fuse Brown and Hall write that despite the market consolidation that results from private equity acquisitions within health care, these acquisitions generally go unreported and unreviewed since they do not exceed the mandatory reporting threshold under the Hart-Scott-Rodino (HSR) Act and that there are currently no legal guidelines for assessing the collective market effects of add-on acquisitions. However, they do note:

> Under Section 7 of the Clayton Act, federal antitrust authorities—the Federal Trade Commission (FTC) and the Department of Justice (DOJ)—can sue to block mergers and acquisitions where the effect of the transaction may be "substantially to lessen competition, or to tend to create a monopoly." To determine whether a transaction may threaten competition, antitrust agencies analyze whether the transaction will enhance the market power of the transacting parties in a given geographic and product market. […] Typically, the FTC oversees health care acquisitions (other than insurance).[1]

To protect patients from harmful billing practices, the federal government has passed the No Surprises Act, the False Claims Act, Anti-Kickback Statute, and Stark Law. Additionally, most states have similar laws, such as those barring fee-splitting and self-referral, and several states have passed laws regulating or restricting the use of gag clauses in physician contracts. The FTC has also recently proposed a rule banning noncompete clauses in all employment contracts [1].

The federal Emergency Medical Treatment and Labor Act ensures that hospitals with an emergency department provide all patients access to emergency services regardless of their ability to pay. Similarly, federal law requires nonprofit hospitals, which account for 58 percent of community hospitals, provide some level of charity care as a condition for their tax-exempt status, which the Internal Revenue Service defines as "free or discounted health services provided to persons who meet the organization's eligibility criteria for financial assistance and are unable to pay for all or a portion of the services" [16].

Relevant AMA Policy Provisions

Council on Medical Service Report 11-A-10 reviewed the scope and impact of private equity and venture capital investment in health care, and its recommendations were adopted as Policy H-160.891, "Corporate Investors." This policy delineates 11 factors that physicians should consider before entering into partnership with corporate investors, including alignment of mission, vision, and goals; the degree to which corporate partners may require physicians to cede control over practice decision making; process for staff representation on the board of directors and medical leadership selection; and retaining medical authority in patient care and supervision of nonphysician practitioners.

Our AMA further developed and published materials to assist physicians contemplating partnering with private equity and venture capital firms:

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

Policy H-310.901, "The Impact of Private Equity on Medical Training," encourages GME training institutions and programs to "demonstrate transparency on mergers and closures, especially as it relates to private equity acquisition" and asserts that our AMA will "[s]upport publicly funded independent research on the impact that private equity has on graduate medical education."

Relevant AMA *Code Provisions*

Opinion 10.1.1, "Ethical Obligations of Medical Directors," states that physicians in administrative positions must uphold their core professional obligations to patients. The opinion mandates that physicians in their role as medical directors should help develop guidelines and policies that are

fair and equitable, and that they should always "[p]ut patient interests over personal interests (financial or other) created by the nonclinical role."

Opinion 11.2.1, "Professionalism in Health Care Systems," acknowledges that "[p]ayment models and financial incentives can create conflicts of interest among patients, health care organizations, and physicians" and offers recommendations for physicians within leadership positions regarding the ethical use of payment models that influence where and by whom care is delivered. Key elements include the need for transparency, fairness, a primary commitment to patient care, and avoiding overreliance on financial incentives that may undermine physician professionalism.

Opinion 11.2.2, "Conflicts of Interest in Patient Care," clearly states: "[t]he primary objective of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration. […] When the economic interests of the hospital, health care organization, or other entity are in conflict with patient welfare, patient welfare takes priority."

Opinion 11.2.3, "Contracts to Deliver Health Care Services," stipulates that physicians' fundamental ethical obligation to patient welfare requires physicians to carefully consider any contract to deliver health care services they may enter into to ensure they do not create untenable conflicts of interest. The opinion states that physicians should negotiate or remove "any terms that unduly compromise physicians' ability to uphold ethical standards." However, it should be acknowledged that physicians have little leverage in changing entire payment structures or reimbursement mechanisms when negotiating their contracts with hospitals. Similarly, physicians in private practice often feel that they have little leverage in negotiating the sale of their practice; they simply receive an offer and are told they can take it or leave it.

Opinion 11.2.3.1, "Restrictive Covenants," states: "[c]ovenants-not-to-compete restrict competition, can disrupt patient care, and may limit access to care" and that physicians should not enter into covenants that "[u]nreasonably restrict the right of a physician to practice medicine for a specified period of time or in a specified geographic area on termination of a contractual relationship". However, many hospitals and hospital systems today now routinely include noncompete clauses as part of their physician contracts. These clauses put physicians at risk of violation of professional obligations and their widespread use has the potential to undermine the integrity of the profession as a whole. While the FTC issued a rule in April 2024 banning most noncompete agreements, a Texas District Judge issued a preliminary injunction on July 3, 2024, halting the enforcement of the ban, with a final order on the merits due by August 30, 2024.

Ethical Analysis

The increasing corporatization and financialization of health care have generated legitimate concerns over ethical dilemmas they raise regarding a focus on profits at the expense of patient care. Because it is unethical to place profit motives above commitments to patient care and well-being, private equity firms' commitment to ensuring short-term, high returns on their investments creates a potential ethical dilemma when investing in health care. This report examines whether private equity investments in health care may be ethical, as well as how physicians may ethically navigate private equity buyouts and employment in today's rapidly evolving financial health care landscape.

A major concern of physicians regarding private equity investments in health care is the potential loss of autonomy, which physicians worry could translate into practice policies designed for profitability and that limit physicians' decision-making and their ability to care for patients [9]. Loss of autonomy is also associated with increased physician burnout [12]. There are also valid

concerns that private equity ownership leads to increased patient volumes and more expensive and potentially unnecessary procedures [9]. The debate over private equity's incursion into health care often regards private equity acquisitions through a lens of exceptionalism—either negatively or positively. However, although private equity-owned health care entities are different in their ownership structure and oversight compared to other traditional health care investors, private equity-acquired health care entities may not be substantively different from other for profit and non-profit health care entities in terms of their stated goals of both solvency and patient care. Zhu and Polsky argue that private equity is not inherently unethical and that there are likely good and bad actors as is the case in many sectors [6]. They add: "physicians should be aware that private equity's growth is emblematic of broader disruptions in the physician-practice ecosystem and is a symptom of medicine's transformation into a corporate enterprise" [6].

The corporatization of medicine comes with ethical and professional risks that are perhaps best exemplified by private equity but are not unique to private equity alone. One only needs to turn to the systemic failure of nonprofit hospitals to provide adequate charity care or how for-profit hospitals often reduce access to care (particularly for Medicaid recipients) to see examples of how the corporatization and financialization of medicine has increasingly come to treat health care as a mere commodity [17,18]. This is despite the fact that health care is inherently different from normal market goods because the demand for health care is substantially inelastic and nonfungible, and medical knowledge is a social good collectively produced by the work of generations of physicians, researchers, and patients. The real problem with private equity's involvement in health care is that it blatantly reveals that as a society, we have increasingly moved towards treating health care as a commodity when as a profession, we know this should not be the case.

While business ethics and medical ethics are not inherently antithetical, differences do clearly exist [19]. Many physicians are thus justly concerned about any removal of professional control that may accompany the increasing commercialization of the physician's role. Veatch points out that paradoxically, despite being open to the profit motive in the practice of medicine, the profession as a whole has shown strong resistance to the commercialization of medical practice. For Veatch, the crux of the issue is whether people perceive health care as a fundamental right or a commodity like any other, adding that the notion of health care as a right jeopardizes any profit motive in health care including traditional private practitioner fee-for-service models [19].

Pellegrino offers a similar analysis, arguing that health care is not a commodity but rather a human good that society has an obligation to provide in some measure to all citizens [20]. Pellegrino argues that health care is substantively different from traditional market goods—it is not fungible, cannot be proprietary because medical knowledge is possible only due to collective achievements, is realized in part through the patient's own body, and requires an intensely personal relationship—and thus cannot be a commodity. Pellegrino warns that the commodification of health and medicine turns any interaction between the patient and physician into a commercial transaction subject to the laws and ethics of business rather than to medical and professional ethics. "In this view," Pellegrino writes, "inequities are unfortunate but not unjust […]. In this view of health care, physicians and patients become commodities too" [20].

Rather than claiming that health care is a fundamental right, Pellegrino takes a position of distributive justice to argue that health care is a collective good. Because a good society is one in which each citizen is enabled to flourish, and good health is a condition of human flourishing, society has a moral responsibility to provide health care to all citizens. In this light, health care is both an individual and a social good. Pellegrino also refers to this view as one of "beneficent justice" and explains, "[t]reating health care as a common good implies a notion of solidarity of humanity, i.e., the linkage of humans to each other as social beings" [20]. Pellegrino concludes:

> Understanding health care to be a commodity takes one down one arm of a bifurcating pathway to the ethic of the marketplace and instrumental resolution of injustices. Taking health care as a human good takes us down a divergent pathway to the resolution of injustice through a moral ordering of societal and individual priorities [20].

Whether health care is understood as a commodity or a human good is of course not always so clear in policy and in practice. What is evident, however, is that as health care has become increasingly commodified, the ethical risks to patients and physicians are being realized as physicians find themselves increasingly working as employees and worrying about the impact that commercial enterprises—such as private equity investments—may be having on patients.

Private equity represents the latest and most extreme form of health care commercialization that has escalated over the past few decades. This is the very reason why private equity firms became interested in health care in the first place—they recognized that health care as a market was already ripe for investment and future profitability. Private equity firms use the same investment models in health care that they do in other industries—invest in fragmented markets, acquire the most promising targets as a platform, expand through add-on acquisitions, and exit the market once a significant consolidation of market share can secure a sale, secondary buyout, or IPO [9]. Each individual acquisition is typically too small to require review by anti-trust regulators at the Federal Trade Commission (FTC); at the same time, however, this practice is driving the trend of mergers and acquisitions in the health care sector [9].

Fuse Brown and Hall explain, "[private equity] functions as a divining rod for finding market failures—where PE has penetrated, there is likely a profit motive ripe for exploitation" [1]. They continue that private equity investments pose three primary risks:

> First, PE investment spurs health care consolidation, which increases prices and potentially reduces quality and access. Second, the pressure from PE investors to increase revenue can lead to exploitation of billing loopholes, overutilization, upcoding, aggressive risk-coding, harming patients through unnecessary care, excessive bills, and increasing overall health spending. Third, physicians acquired by PE companies may be subject to onerous employment terms and lose autonomy over clinical decisions [1].

While the profit motive of private equity firms may drive them to take part in less than scrupulous practices, such as private equity's exploitation of out-of-network surprise billing, there is also potential for private equity to play a more positive role in transforming health care practices [1,21]. Powers et al write:

> Ultimately, private equity—a financing mechanism—is not inherently good or bad. Instead, it acts to amplify the response to extant financial incentives. Within a fee-for-service construct, this is intrinsically problematic. But value-based payment models can serve as an important guardrail, helping to ensure that financial return to private equity investors are appropriately aligned with system goals of access, quality, equity, and affordability [21].

Private equity firms could help accelerate changes in health care payment and delivery towards value-based models. With such models, where financial performance is tied to quality and value, private equity may be incentivized to invest in changes that support better health and lower costs [21].

While more research is needed on the impacts of private equity investments in health care, private equity firms' involvement in health care does not appear to be exceptional within the current corporate transformation of the profession and thus is inherently no more or less ethical than this current trend that has penetrated health care and the practice of medicine far beyond interactions with private equity. As Fuse Brown and Hall point out, "PE investment in health care is just the latest manifestation of the long trend of increasing commercialization of medicine. And so long as the U.S. treats health care as a market commodity, profit-seeking will persist" [1]. Any financing model of health care that ignores patient care or puts profits over patient care should be considered unethical by physicians and the public.

Concerns over private equity's incursion into health care are clearly warranted. However, the financial and investment landscape of health care continues to evolve, and while private equity may be the latest trend it will not be the last version that emerges within the health care marketplace. Health care spending in the US continues to rise each year, with health spending increasing by 4.1percent in 2022 for a total of $4.5 trillion and accounting for roughly 17 percent of total gross domestic product [22]. With so much money involved in health care, it is bound to draw in investors; the involvement of investors from outside of health care, who may treat it as merely a market commodity and do not share physicians' overriding commitment to patient care and well-being, should be concerning. Such involvement by outside investors is likely to further transform health care, driving consolidation, commercialization, and de-professionalization.

In a practical approach to the current financial health care landscape, Ikrum et al offer some realistic recommendations for partnering with private equity in health care:

> While PE involvement in health care delivery invokes inherent concerns, it has provided much-needed capital for many primary care practices to mitigate the effects of the pandemic and to potentially undertake care delivery innovations such as population health management under value-based payment models. To make partnerships with private investors work, providers need to select the right investors, establish strategies upfront to address misaligned objectives, and define a successful partnership by setting goals for and transparently reporting on indicators that reflect both financial and clinical performance. Safeguards and regulations on sales may also protect patients and providers [7].

While private equity's overriding profit motive may be unethical in many instances, the reality is that private equity is already a large player in health care and physicians urgently need guidance on how to interact with private equity firms and private equity-owned health care entities. Keeping within its purview, the *Code* should offer guidance to physicians and to the practice of medicine on how to best interact with private equity and other outside forces that increasingly impact health care today. To support physicians as private equity continues to increase its market share of health care entities, practical guidance is needed related to both the sale of physician-owned practices to private equity as well as to those seeking employment by private equity-owned health care entities to help physicians navigate today's evolving financial health care landscape.

CONCLUSION

The ethical concerns raised by private equity investments in health care are not unique but instead represent ethical dilemmas that exist due to the very nature of treating health care as a commodity. Any decision to pursue financial incentives over and above patient care is unethical, and physicians' concerns regarding private equity's focus on short-term profits at the expense of patients' and their own well-being are justly warranted. Due to such concerns, physicians should

strongly consider whether they can sell their practice to private equity investors while also upholding their ethical and professional obligations to patients and to the profession as a whole.

It is therefore crucial that policy guidelines be developed to ensure that private equity-acquired hospitals, hospital systems, and physician practices function in an ethical manner that prioritizes patients and patient care over profits. Policies that require greater transparency and disclosure of data on private equity ownership, greater state regulatory control over private equity acquisitions, closing payment and billing loopholes, rules requiring an independent clinical director on the Board of private equity firms engaged in health care, and means for physicians to help set goals and measure outcomes to ensure the alignment of corporate and clinical values should be considered [7]. The growth of private equity investment within the health care marketplace is clearly concerning and is an urgent issue that needs greater regulatory oversight. Beyond established ethical and professional norms, new regulations must be developed to prevent private equity from negatively impacting patient care and the medical profession [6].

Though the current literature is conflicting, there are valid concerns that private equity investment in health care might negatively impact patient outcomes. Significantly, since serious potential risks and conflicts of interest do exist, it is essential for physicians considering entering into partnership with private equity firms to first reflect on their ethical and professional obligations. If they do decide to proceed, however, physicians have a duty to evaluate their contracts and require that the agreements are consistent with the norms of medical ethics. Likewise, physicians considering entering into a contractual relation as an employee—whether with a private equity-owned hospital or otherwise—should ensure that their contract does not place them in an untenable conflict of interest or compromise their ability to fulfill their ethical and professional obligations to patients [8]. While we must acknowledge that physicians often have little power in contract negotiations, their ethical obligation remains nonetheless to try to negotiate when contractual agreements are likely to lead to ethical dilemmas.

The Preamble to the *Code* stipulates that "[o]pinions of the AMA Council on Ethical and Judicial Affairs lay out the ethical responsibilities of physicians as members of the profession of medicine." Although some areas of concern therefore extend beyond what the *Code* may speak to, CEJA is currently studying the ethical obligations of health care entities that interact with physicians and is considering entering a report in the near future regarding the potential need for a new opinion to address additional stakeholders involved in our evolving health care landscape.

It is the conclusion of the Council on Ethical and Judicial Affairs that increasing investment by private equity firms in health care raises ethical concerns regarding dual loyalties of physicians and competing interests between profits and patients. To respond to these issues, CEJA recommends amending Opinion 11.2.3, "Contracts to Deliver Health Care Services," to more clearly address concerns raised by entering into partnerships with private equity firms and the ethical risks that may arise for both physicians seeking capital to support their private practice as well as physicians entering into employment contracts with private equity-owned health care entities.

RECOMMENDATION

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

While profitmaking is not inherently unethical, no part of the health care system that supports or delivers patient care should place profits over such care. Physicians have a fundamental ethical obligation to put the welfare of patients ahead of other considerations, including personal financial interests. This obligation requires ~~them to~~ that before entering into contracts to deliver health care services, physicians consider carefully the proposed contract to assure themselves that its terms and conditions ~~of contracts to deliver health care services before entering into such contracts to ensure that those contracts~~ do not create untenable conflicts of interest or compromise their ability to fulfill their ethical and professional obligations to patients.

Ongoing evolution in the health care system continues to bring changes to medicine, including changes in reimbursement mechanisms, models for health care delivery, restrictions on referral and use of services, clinical practice guidelines, and limitations on benefits packages. While these changes are intended to enhance quality, efficiency, and safety in health care, they can also put at risk physicians' ability to uphold professional ethical standards ~~of informed consent and fidelity to patients~~ and can impede physicians' freedom to exercise independent professional judgment and tailor care to meet the needs of individual patients.

As physicians seek capital to support their practices or enter into various differently structured contracts to deliver health care services—with group practices, hospitals, health plans, investment firms, or other entities—they should be mindful that while ~~many~~ some arrangements have the potential to promote desired improvements in care, ~~some~~ other arrangements ~~also~~ have the potential to ~~impede~~ put patients' interests at risk and to interfere with physician autonomy.

When contracting with entities, or having a representative do so on their behalf, to provide health care services, physicians should:

(a) Carefully review the terms of proposed contracts, preferably with the advice of legal and ethics counsel, ~~or have a representative do so on their behalf~~ to assure themselves that the arrangement:

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

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

    (iii) ~~allows~~ ensures the physician can ~~to~~ appropriately exercise professional judgment;

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

    (v) is transparent and permits disclosure to patients;

    (vi) enables physicians to have significant influence on, or preferably outright control of, decisions that impact practice staffing.

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

When entering into contracts as employees, preferably with the advice of legal and ethics counsel, physicians should:

(c) Advocate for contract provisions to specifically address and uphold physician ethics and professionalism.

(d) Advocate that contract provisions affecting practice align with the professional and ethical obligations of physicians and negotiate to ensure that alignment.

(e) Advocate that contracts do not require the physician to practice beyond their professional capacity and provide contractual avenues for addressing concerns related to good practice, including burnout or related issues.

(Modify HOD/CEJA Policy)

Fiscal Note: Less than $500

REFERENCES

1. Fuse Brown EC, Hall MA. Private Equity and the Corporatization of Health Care. Stanford Law Review 2024;76.
2. Crowley R, Atiq O, Hilden D, Health and Public Policy Committee of the American College of Physicians. Financial profit in medicine: A position paper from the American College of Physicians. Annals of Internal Medicine 2021;174(10):1447-9.
3. Moses MJ, Weiser LG, Bosco III JA. The corporate practice of medicine: Ethical implications of orthopaedic surgery practice ownership by non-physicians. JBJS 2020;102(11):e53.
4. AMA analysis shows most physicians work outside of private practice. In: American Medical Association. https://www.ama-assn.org/press-center/press-releases/ama-analysis-shows-most-physicians-work-outside-private-practice#:~:text=Employment%20status,2018%20and%2053.2%25%20in%202012.
5. Gondi S, Song Z. Potential implications of private equity investments in health care delivery. JAMA 2019;321(11):1047-8.
6. Zhu JM, Polsky D. Private equity and physician medical practices-navigating a changing ecosystem. NEJM 2021;384(11):981-3.
7. Ikram U, Aung KK, Song Z. Private equity and primary care: Lessons from the field. NEJM Catalyst Innovations in Care Delivery 2021;2(6).
8. DeCamp M, Snyder Sulmasy L, American College of Physicians Ethics, Professionalism and Human Rights Committee. Ethical and professionalism implications of physician employment and health care business practices: a policy paper from the American College of Physicians. Ann of Intern Med 2021;174(6):844-51.
9. Appelbaum E, Batt R. Private equity buyouts in healthcare: who wins, who loses? Institute for New Economic Thinking Working Paper Series 2020(118). doi.org/10.36687/inetwp118.
10. Borsa A, Bejarano G, Ellen M, Bruch JD. Evaluating trends in private equity ownership and impacts on health outcomes, costs, and quality: systematic review. BMJ 2023;382.
11. PESP Private Equity Hospital tracker. In: Private Equity Stakeholder Project PESP. https://pestakeholder.org/private-equity-hospital-tracker/.
12. Dillon EC, Tai-Seale M, Meehan A, Martin V, Nordgren R, Lee T, Nauenberg T, Frosch DL. Frontline perspectives on physician burnout and strategies to improve well-being: interviews with physicians and health system leaders. Journal of General Internal Medicine 2020;35:261-7.
13. Kannan S, Bruch JD, Song Z. Changes in Hospital Adverse Events and Patient Outcomes Associated With Private Equity Acquisition. JAMA. 2023;330(24):2365–2375. doi:10.1001/jama.2023.23147.
14. Singh Y, Song Z, Polsky D, Bruch JD, Zhu JM. Association of private equity acquisition of physician practices with changes in health care spending and utilization. JAMA Health Forum 2022;3(9):e222886-e222886.
15. Gao J, Sevilir M, Kim YS. Private equity in the hospital industry. European Corporate Governance Institute–Finance Working Paper 2021;787.
16. Levinson Z, Hulver S, Neuman T. Hospital charity care: how it works and why it matters. KFF 2022 Nov 3. https://www.kff.org/health-costs/issue-brief/hospital-charity-care-how-it-works-and-why-it-matters/.
17. 2024 fair share spending report: Are hospitals giving back as much as they take? Lown Institute, 2024 Hospitals Index. https://lownhospitalsindex.org/hospital-fair-share-spending-2024/.
18. Scott D. A worrisome trend in American hospitals is hurting poor patients. Vox 2023 Jan 13. https://www.vox.com/policy-and-politics/2023/1/13/23550067/us-hospitals-medicaid-patients-health-care-access.

19. Veatch RM. Ethical dilemmas of for-profit enterprise in health care. In *The New Health Care for Profit: Doctors and Hospitals in a Competitive Environment.* Gray BH, ed. National Academy Press, Washington DC, 1983.
20. Pellegrino ED. The commodification of medical and health care: the moral consequences of a paradigm shift from a professional to a market ethic. J Med Philos 1999;24(3):243-266. doi:10.1076/jmep.24.3.243.2523.
21. Powers BW, Shrank WH, Navathe AS. Private equity and health care delivery: value-based payment as a guardrail?. JAMA 2021;326(10):907-8.
22. Cox C, Ortaliza J, Wager E, Amin K. Health care costs and affordability. KFF 2024 May 28. https://www.kff.org/health-policy-101-health-care-costs-and-affordability/?entry=table-of-contents-introduction.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 001
(I-24)

Introduced by: Women Physicians Section

Subject: Addressing Gender-Based Pricing Disparities

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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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]; and

Whereas, a 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 consumers[2-4]; and

Whereas, a JAMA Dermatology study found that Minoxidil prescriptions were priced significantly more per volume for female patients compared to male patients[5]; and

Whereas, facial moisturizers marketed towards female consumers are on average $3.09 more per ounce than moisturizers marketed towards male consumers, despite no significant differences in the products' targeted skin-concerns[6]; and

Whereas, women spend more than 15 billion dollars annually more than men on healthcare costs, but they also pay 18% more on average for out-of-pocket medical expenses than men despite having similar insurance coverage[7]; and

Whereas, older women are disproportionately affected by gaps in coverage for long-term-care services and higher out-of-pocket expenses[8]; and

Whereas, menstrual products are a necessity, and past efforts have made these products tax-exempt in 24 states, but many women in non-tax-exempt states pay taxes ranging from 4-7% on menstrual products[9-11]; and

Whereas, lack of affordable access to menstrual products increases exposure to health risks such as urinary tract infection, candidiasis, and mental health disorders such as depression and anxiety[12-14]; and

Whereas, the compounding effects of increasing wage gap, gender pricing disparities, and sole household income earners result in negative overall effects on health and quality of life particularly for women[15-18]; and

Whereas, state and local jurisdictions have passed laws to prohibit gender-based price discrimination, and the Pink Tax Repeal Act has been introduced in Congress[4, 14, 19]; therefore be it

RESOLVED, that our American Medical Association support federal and state efforts to minimize gender-based pricing disparities in healthcare services and products. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Date Submitted: 9/19/2024

REFERENCES

1. Lankford K. The pink tax costs women thousands of dollars over their lifetimes. . April 28 2023. Available from: https://money.usnews.com/money/personal-finance/taxes/articles/the-pink-tax-costs-women-thousands-of-dollars-over-their-lifetimes.
2. Habbal HL, Lemke R, Felkey AJ, Long SM. *An economic analysis of the pink tax.* ; 2020.
3. Maloney C. The pink tax how gender-based pricing hurts women's buying power. . . 2016.
4. Cackley AP. Consumer protection: Gender-related price differences for goods and services. . 2019.
5. Wehner MR, Nead KT, Lipoff JB. Association between gender and drug cost for over-the-counter minoxidil. . 2017;153(8):825-826. http://dx.doi.org/10.1001/jamadermatol.2017.1394. doi: 10.1001/jamadermatol.2017.1394.
6. Manatis-Lornell AJ, Marks DH, Hagigeorges D, Okhovat J, Senna MM. Gender-related cost discrepancies in a cohort of 110 facial moisturizers. . 2019;18(6):1765-1766. https://onlinelibrary.wiley.com/doi/abs/10.1111/jocd.12954. doi: 10.1111/jocd.12954.
7. Bergh J, Sulzer K, Chock S, Buscemi B, Murray J. Hiding in plain sight: The health care gender toll. . 2023.
8. Salganicoff A. Women and medicare: An unfinished agenda. *Generations.* 2015;39(2):43-50. https://www.ingentaconnect.com/content/asag/gen/2015/00000039/00000002/art00008.
9. Why is the US "tampon tax" so hated? . September 14 2016. Available from: https://www.bbc.com/news/world-us-canada-37365286#:~:text=Necessities%20such%20as%20food%20and,are%20not%20considered%20a%20luxury.
10. Tampon tax . Alliance for Period Supplies Web site. https://allianceforperiodsupplies.org/tampon-tax/.
11. Alisha Haridasani Gupta. Texas is the latest state to drop the 'Tampon tax'. *NYTimes.com Feed*. Sep 1, 2023. Available from: https://global.factiva.com/en/du/article.asp?accessionno=NYTFEED020230901ej91001ry.
12. U by kotex period poverty awareness week.
13. Jaafar H, Ismail SY, Azzeri A. Period poverty: A neglected public health issue. . 2023;44(4):183-188. https://www.ncbi.nlm.nih.gov/pubmed/37189262. doi: 10.4082/kjfm.22.0206.
14. Rohatgi A, Dash S. Period poverty and mental health of menstruators during COVID-19 pandemic: Lessons and implications for the future. . 2023;4:1128169. https://www.ncbi.nlm.nih.gov/pubmed/36937043. doi: 10.3389/fgwh.2023.1128169.
15. Yearby R. When equal pay is not enough: The influence of employment discrimination on health disparities. *Public Health Rep*. 2019;134(4):447-450. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6598139/. Accessed Mar 31, 2024. doi: 10.1177/0033354919847743.
16. Southwick R. Women earn less than men, and their health suffers due to the pay gap. OncLive Web site. https://www.chiefhealthcareexecutive.com/view/women-earn-less-than-men-and-their-health-suffers-due-to-the-pay-gap. Updated 2022. Accessed Mar 31, 2024.
17. Costa T, Nguyen T(T. The gender pay gap and its effect on women's retirement savings | U.S. GAO. Office, U. S. Government Accountability Web site. https://www.gao.gov/blog/gender-pay-gap-and-its-effect-womens-retirement-savings. Updated 2021. Accessed Mar 31, 2024.
18. Adhikari J, Milli J, Buchanan MJ. The economic, educational, and health-related costs of being a woman .. 2022.
19. Governor cuomo reminds new yorkers "pink tax" ban goes into effect today. *States News Service*. Sep 30, 2020. Available from: https://dos.ny.gov/news/former-governor-cuomo-reminds-new-yorkers-pink-tax-ban-goes-effect-today.

RELEVANT AMA POLICY

Considering Feminine Hygiene Products as Medical Necessities H-525.974
Our AMA encourages the Internal Revenue Service to classify feminine hygiene products as medical necessities: (1) 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 (2) 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. [Res. 218, A-18; Modified: Res. 209, I-21]

Tax Exemptions for Feminine Hygiene Products H-270.953
Our AMA supports legislation to remove all sales tax on feminine hygiene products. [Res. 215, A-16]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 002
(I-24)

Introduced by: Women Physician Section

Subject: Anti-Doxxing Data Privacy Protection

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, the onus of advocacy burden is often placed on minorities themselves, such as in the context of abortion and gender-affirming healthcare advocacy, and thus harassment and doxxing over these issues also disproportionately affect women and minorities[2,3]; and

Whereas, doxxing refers to unconsented publishing of private information (such as name, home address, phone number, email address, school, and workplace) in public forums such as social media and the Internet to facilitate harassment or intimidation of victims[2]; and

Whereas, in June 2024 a doxxing list of individuals (name and city of residence) from Arkansas involved in a grassroots abortion rights ballot petition was circulated on the Internet by the Family Council, a conservative group that opposes the amendment. This doxxing resulted in death threats, harassment, and intimidation towards activists for medically underserved populations[4,5,6,7]; and

Whereas, a systematic review of information posted on an anti-abortion website indicated extensive personal information for 64 abortion providers in 24 states published on the website in an accessible and searchable format, violating personal privacy and representing a pattern of efforts to intimidate, threaten, and vilify providers[8]; and

Whereas, from 2021 to 2022, death threats and other threats of violence increased by 20%, including threats communicated on the Internet, threatening calls and mail to abortion clinics, and stalking incidents doubled. U.S. abortion rights campaigner Alison Dreith reported moving houses four times in the last five years due to fears to personal safety from threatening letters to her address[9,10,11,12]; and

Whereas, data broker companies profit off of selling information due to lack of industry regulation, and attempts to remove personal information from the internet are costly expenses[10,13]; and

Whereas, the politicization of gender-affirming care has also resulted in targeted harassment (threats of violence, doxxing, bomb threats) of adolescent gender-affirming care providers, with 70% sharing that either they, their practice, or their institution received threats specific to gender affirming care delivery and several receiving death threats[14]; and

Whereas, providers reported this harassment led to concerns about safety, emotional/psychological toll, limited access to care, and decreased ability to advocate for their patients due to fear for the safety of themselves, their colleagues, and family[14]; and

Whereas, providers expressed that large institutions, such as hospitals and professional organizations should show more public-facing support for issues that resulted in doxxing to support their providers in advocacy[14]; and

Whereas, a psychological study of how doxxing influences hiring-related decisions revealed that doxxing influenced suspicion of job applicants and expected retaliation from individuals outside the organization, and thus may induce employment bias and discrimination[15]; and

Whereas, in a survey of pediatric endocrinologists providing gender-affirming care in states where legislation banning gender-affirming care had been proposed or passed, respondents experienced threats to personal safety, concerns about their career (recommendation for promotion, job security, etc.), and institutional concerns about engagement with media[16]; and

Whereas, in 2020, 9-12% of public health officials reported receiving either individual or family threats, with their residential addresses, phone numbers, and emails doxxed through the Internet[17]; and

Whereas, many officials feared loss of their jobs or putting themselves at further risk, leaving them silent, isolated, and pressured to comply with public or political opinions rather than focusing on what is best for community health[17]; and

Whereas, H.R.2701 Online Privacy Act of 2023, which establishes online privacy rights for personal information, allowing individuals to access, correct, and request the deletion of their information, was introduced in April 2023 but has not yet passed the House[18,19,20]; and

Whereas, S.2121 DELETE Act was proposed to establish a centralized system to allow individuals to request the simultaneous deletion of their personal information across all data brokers[21]; and

Whereas, current AMA policy does not address the issue of doxxing and personal data privacy outside of the context of healthcare data, and bills listed above addressing the underlying data privacy rights issues have yet to be passed by Congress; therefore be it

RESOLVED, that our American Medical Association support physicians and healthcare providers that provide reproductive and gender-affirming care who experience doxxing, support nondiscrimination and privacy protection for employees, and availability of resources on doxing (New HOD Policy); and be it further

RESOLVED, that our AMA work with partners to support data privacy and anti-doxxing laws to prevent harassment, threats, and non-consensual publishing of information for physicians who provide reproductive and gender-affirming care (Directive to Take Action); and be it further

RESOLVED, that our AMA encourage institutions, employers, and state medical societies to provide legal resources and support for physicians who provide reproductive and gender-affirming care who are affected by doxing (New HOD Policy); and be it further

RESOLVED, that our AMA encourage institutions, employers, and medical societies to provide training and education on the issue of doxxing. (New HOD Policy)

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

Received: 9/19/2024

REFERENCES

1. About. American Medical Association. Accessed August 8, 2024. https://www.ama-assn.org/about
2. Eckert, S., & Metzger-Riftkin, J. (2020). Doxxing. In The International Encyclopedia of Gender, Media, and Communication (pp. 1–5). John Wiley & Sons, Ltd. https://doi.org/10.1002/9781119429128.iegmc009
3. Berg, S. For physician advocates, social media hate is nauseatingly normal. American Medical Association. Published September 28, 2023. https://www.ama-assn.org/practice-management/physician-health/physician-advocates-social-media-hate-nauseatingly-normal
4. Rodriguez, B & Panetta, G. 'They want us to be scared': Anti-abortion activists target ballot measure organizers in Arkansas. Published June 16, 2024. https://www.pbs.org/newshour/politics/they-want-us-to-be-scared-anti-abortion-activists-target-ballot-measure-organizers-in-arkansas
5. Vrbin, T. Publication of abortion amendment canvasser list is intimidation, ballot question committee says. Published June 7, 2024. https://arkansasadvocate.com/2024/06/07/publication-of-abortion-amendment-canvasser-list-is-intimidation-ballot-question-committee-says/
6. Family Council Action Committee. About the Abortion Amendment. https://www.familycouncilactioncommittee.com/about-ar-abortion-amendment
7. https://www.familycouncilactioncommittee.com/_files/ugd/449489_1a19040dbb544a17be11e7bfb9fb108b.pdf
8. Rosen JD, Ramirez JJ. When doctors are "doxxed:" An analysis of information posted on an antiabortion website. Contraception. 2022;115:1-5. doi:10.1016/j.contraception.2022.07.008
9. Asher-Schapiro, A & Moloney, A. US abortion advocates face doxxing as data scavenged online. Reuters. Published August 1, 2023. https://www.reuters.com/article/idUSL8N39E8D3/
10. Mithani, J. Personal data is easier to get than ever. Reproductive health workers are at risk. Published April 29, 2024. https://19thnews.org/2024/04/doxxing-personal-data-reproductive-health-care-workers/
11. Privacy breaches and reputation terrorism plague abortion providers. Published, January 1, 2022. Relias Media. https://www.reliasmedia.com/articles/148882-privacy-breaches-and-reputation-terrorism-plague-abortion-providers
12. Recent Cases on Violence Against Reproductive Health Care Providers. https://www.justice.gov/crt/recent-cases-violence-against-reproductive-health-care-providers
13. Mithani, J. Facing constant doxxing threats, reproductive health workers fear for their data. Published May 5, 2024. https://truthout.org/articles/facing-constant-doxxing-threats-reproductive-health-workers-fear-for-their-data/
14. Hughes LD, Gamarel KE, Restar AJ, et al. Adolescent Providers' Experiences of Harassment Related to Delivering Gender-Affirming Care. J Adolesc Health. 2023;73(4):672-678. doi:10.1016/j.jadohealth.2023.06.024
15. Roth PL, Bobko P, Shan GJ, Roth RW, Ferrise E, Thatcher JB. Doxing, political affiliation, and type of information: Effects on suspicion, perceived similarity, and hiring-related judgments. J Appl Psychol. 2024;109(5):730-754. doi:10.1037/apl0001153
16. Gupta P, Barrera E, Boskey ER, Kremen J, Roberts SA. Exploring the Impact of Legislation Aiming to Ban Gender-Affirming Care on Pediatric Endocrine Providers: A Mixed-Methods Analysis. J Endocr Soc. 2023;7(10):bvad111. Published 2023 Sep 19. doi:10.1210/jendso/bvad111
17. Mello MM, Greene JA, Sharfstein JM. Attacks on Public Health Officials During COVID-19. JAMA. 2020;324(8):741-742. doi:10.1001/jama.2020.14423
18. H.R.2701 Online Privacy Act of 2023. https://www.congress.gov/bill/118th-congress/house-bill/2701
19. H.R.8818 https://www.congress.gov/bill/118th-congress/house-bill/8818/text
20. The American Privacy Rights Act of 2024. https://www.commerce.senate.gov/services/files/E7D2864C-64C3-49D3-BC1E-6AB41DE863F5
21. S.2121 DELETE Act. https://www.congress.gov/bill/118th-congress/senate-bill/2121/text

RELEVANT AMA POLICY

Supporting Improvements to Patient Data Privacy D-315.968

1. Our AMA will strengthen patient and physician data privacy protections by advocating for legislation that reflects the AMA's Privacy Principles with particular focus on mobile health apps and other digital health tools, in addition to non-health apps and software capable of generating patient data.
2. Our AMA will work with appropriate stakeholders to oppose using any personally identifiable data to identify patients, potential patients who have yet to seek care, physicians, and any other healthcare providers who are providing or receiving healthcare that may be criminalized in a given jurisdiction
[Res. 227, A-22; Modified: Res. 230, I-22; Reaffirmation: A-23; Reaffirmed: CMS Rep. 07, A-24]

Anonymous Cyberspace Evaluations of Physicians D-478.980

Our AMA: (1) encourages physicians to take an active role in managing their online reputation in ways that can help them improve practice efficiency and patient care; (2) encourages physician practices and health care organizations to establish policies and procedures to address negative online complaints directly with patients that do not run afoul of federal and state privacy laws; (3) will develop and publish educational material to help guide physicians and their practices in managing their online reputation, including recommendations for responding to negative patient reviews and clarification about how federal privacy laws apply to online reviews; and (4) will work with appropriate stakeholders to (a) consider an outlet for physicians to share their experiences and (b) potentially consider a mechanism for recourse for physicians whose practices have been affected by negative online reviews, consistent with federal and state privacy laws.

[BOT action in response to referred for decision Res. 709, A-10, Res. 710, A-10, Res. 711, A-10 and BOT Rep. 17, A-10; Reaffirmed in lieu of Res. 717, A-12; Reaffirmation A-14; Consolidated with D-445.997: CCB/CLRPD Rep. 01, A-24]

National Provider Identification D-406.998
Our AMA will work closely in consultation with the Centers for Medicare and Medicaid Services to introduce safeguards and penalties surrounding the use of National Provider Identification to protect physicians' privacy, integrity, autonomy, and ability to care for patients.
[Res. 717, I-04; Reaffirmed: CMS Rep. 1, A-14; Reaffirmed: BOT Rep. 09, A-24]

Violence Against Medical Facilities and Health Care Practitioners and Their Families H-5.997
The AMA supports the right of access to medical care and opposes (1) violence and all acts of intimidation directed against physicians and other health care providers and their families and (2) violence directed against medical facilities, including abortion clinics and family planning centers, as an infringement of the individual's right of access to the services of such centers. [Res. 82, I-84; Reaffirmed by CLRPD Rep. 3 - I-94; Res. 422, A-95; Reaffirmation I-99; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed: CSAPH Rep. 01, A-19]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 003
(I-24)

Introduced by: Senior Physicians Section

Subject: On the Ethics of Human Lifespan Prolongation

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, modern medicine, particularly through advancements in public health, has progressively improved the human life expectancy from 45 to 75 years over the last century, with an apparent biologic limit to the human lifespan of around 120 years[1,2,3]; and

Whereas, the recent scientific advancements probing the aging process have raised the real possibility of significantly lengthening the human lifespan[4,5,6]; and

Whereas, this potential for prolonging the human lifespan raises a number of ethical issues including equitable access, distributive justice, allocation of limited resources, and potentiating healthcare disparities; and

Whereas, our American Medical Association has been traditionally a leader in medical ethics; therefore be it

RESOLVED, that our American Medical Association undertake an evaluation of the ethics of extension of the human lifespan, currently considered to be 120 years, with the goal of providing guidance and/or guidelines for clinical practice, research and potential regulatory challenges. (Directive to Take Action)

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

Received: 9/23/2024

REFERENCES

1. Macedo, J. C. G. M. (2022). Ethical and legal issues in end-of-life care: the case of life prolongation.
2. Dong, X., Milholland, B., & Vijg, J. (2016). Evidence for a limit to human lifespan. *Nature, 538*(7624), 257-259.
3. Kyriazis, M. (2020). Ageing throughout history: the evolution of human lifespan. *Journal of molecular evolution, 88*(1), 57-65.
4. de Beer, J., Bardoutsos, A., & Janssen, F. (2017). Maximum human lifespan may increase to 125 years. *Nature, 546*(7660), E16-E17.
5. Carr, G. (2023, September 25) Some claim human lifespans can be lengthened indefinitely. *The Economist Technology Quarterly*. https://www.economist.com/technology-quarterly/2023-09-30
6. Milholland, B., & Vijg, J. (2022). Why Gilgamesh failed: the mechanistic basis of the limits to human lifespan. *Nature Aging*, *2*(10), 878-884.

RELEVANT AMA POLICY

D-85.993 Increased Death Rate and Decreased Life Expectancy in the United States

Our AMA: (1) will raise awareness of the recent reversals in the improvement of overall death rates and life expectancy with the message that these new problems in the United States are different from all other developed countries and that these trends need to be reversed promptly; (2) will call on the legislative and executive branches of the Federal Government to fund and carry out investigations into the causes of these very unusual decreases in life expectancy and increases in death rates in order to design multi-

disciplinary interventions to reverse these troubling changes; and (3) encourages state and local medical societies to raise awareness of the new problems of decreasing life expectancy and increasing population death rates as indicators of major public health problems and advocate for local investigation of the causes and remedies for these disturbing problems.
[Citation: Res. 913, I-17]

H-25.998 Policy Recommendations in the Field of Aging

1. It is the policy of our American Medical Association that:

    a. Older individuals should not be isolated.
    b. A health maintenance program is necessary for every individual.
    c. More persons interested in working with the older people in medical and other professional fields are needed.
    d. More adequate nursing home facilities are an urgent health need for some older people in many communities.
    e. Further development of service and facilities is required.
    f. Extension of research on both medical and socioeconomic aspects of aging is vital.
    g. Local programs for older persons, especially those which emphasize the importance of self-help and independence by the senior citizen, should be a major concern of medicine, both collectively and individually.
    h. Local medical society committees along with other leaders in community service, should be equipped to appraise the advantage or disadvantage of proposed housing for older people.
2. Our AMA support initiatives by the American Bar Association Commission on Law and Aging and other associations and agencies of the federal government to address elder abuse and to ensure consistent protection of elders' rights in all states.

[Citation: CMS Rep. A, I-60; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmed: CMS Rep.01, A-18; Appended: BOT Rep.11, I-21]

AMERICAN MEDICAL ASSOCIATION LGBTQ+ SECTION ASSEMBLY

Resolution: 004
(I-24)

Introduced by: LGBTQ Section

Subject: Improving Usability of Electronic Health Records for Transgender and Gender Diverse Patients

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, Electronic Health Record (EHR) systems play a vital role in helping physicians track patient demographics, clinical notes, diagnoses, and test results[1]; and

Whereas, EHR systems reflect an assumption that everyone is cisgender, and many EHRs do not provide sufficient flexibility or inclusivity for transgender and gender diverse (TGD) patients who do not fit into the traditional binary of sex and gender[2-4]; and

Whereas, sex assigned at birth may inadequately describe current clinical sex for transgender patients whose gender-affirming care alters secondary sex characteristics, hormone levels, or genitals[4]; and

Whereas, multiple studies have demonstrated that the changes in chemistry and hematology parameters from masculinizing and feminizing hormone therapies overall show good correlation with cisgender male and female reference values[5,6]; and

Whereas, the legal sex found on identity documents should not be used as a proxy for current sex because it can be clinically misleading in many circumstances[7]; and

Whereas, both sex assigned at birth and current anatomy are needed to inform clinical decisions, while legal sex may be required for billing and insurance purposes[8,9]; and

Whereas, due to a variety of financial and institutional barriers, many TGD people may not be able to formally change their legal name to reflect their chosen name; thus, their chosen name may not appear on insurance and medical documentation[10;] and

Whereas, in TGD patient chart notes, the correct pronouns are used less than 40% of the time, assigned sex at birth is recorded accurately less than 54% of the time and only 46% of TGD patients were recorded with the proper ICD codes[8]; and

Whereas, gender identity data includes chosen name, pronouns, current gender identity, and sex listed on original birth certificate[11]; and

Whereas, the term "sexual preference" suggests that an individual's sexual orientation is a choice[12-14]; and

Whereas, the term "preferred name" and "preferred pronouns" imply optional use by providers as opposed to the term "chosen name" which removes the implication of elective use[12-14]; and

Whereas, the term “preferred name” is a broad term which can be applied to any patient (i.e. Sue vs Susan) and is not specific to the “chosen name” associated with some gender-diverse individuals leading to the patient’s chosen name being documented in quotes or parentheses alongside their legal deadname (i.e. Mark “Mary” Moore)[15]; and

Whereas, in most EMR a space for documenting “preferred name” exists alongside documenting “legal name”, no such separate space exists to document a patient’s chosen name in a way that minimizes appearance of legal names inconsistent with chosen name in documents presented to the patient[15]; and

Whereas, the Office of the National Coordinator for Health Information Technology’s (ONC) sets “preferred name” as standard and the AMA advocates for “preferred name” in communications with ONC as opposed to chosen name[16]; and

Whereas, 40% of TGD people attempt suicide within their lifetime, with young people being most likely to do so, and TGD youth who addressed by their chosen name experience lower rates of depression, suicidal ideation, and suicidal behavior[11,17]; and

Whereas, misgendering is when a person is addressed or described with pronouns that do not reflect their gender identity[11], and is associated with experiences of depression, stress, and stigma[18,19]; and

Whereas, deadnaming is a form of misgendering that often occurs in healthcare settings in which a transgender person is inadvertently addressed by their birth name which they no longer use, often triggering gender dysphoria[20]; and

Whereas, storing gender identity data in inconsistent locations across EHR platforms and institutions adds further confusion to what is already a challenging topic for healthcare workers to understand[21]; and

Whereas, twenty-three percent of TGD people have avoided necessary medical care due to fear of being disrespected or mistreated, with misnaming and misgendering cited as common reasons for doing so[10]; and

Whereas, automated cancer screening reminders for TGD patients may cause discomfort and increased mistrust in medical professionals when the screening reminders are linked to sex assigned at birth instead of the patient's present organs; this can be prevented by organ inventories, which list the patient's present organs, and are recommended by the World Professional Association for Transgender Healthcare[2,8,22-24]; and

Whereas, many TGD people undergo medical and surgical gender-affirming interventions including hormone replacement therapy, masculinizing chest surgery, breast augmentation, hysterectomy, and genital surgeries, which may lead to an organ inventory that does not align with the binary view of sex and gender upon which EHRs are structured[25]; and

Whereas, patient sex as recorded in EHRs is used to generate health screenings, medication dosages, and laboratory test ranges by taking into account assumed hormonal history and anatomy typical for the specified sex[26]; and

Whereas, TGD people with a uterus have a 37% lower odds of being up to date on their Pap testing compared with cisgender people[27-30]; and

Whereas, incorrect application of sex-based risk stratification tools for bone health[31] and cardiovascular disease[32], predicting hypoxemia in anesthetized patients during surgery[4], and estimated glomerular filtration rate[33] further compound poor TGD health outcomes[10]; and

Whereas, over half of healthcare professionals reported their EHRs have one field for both sexual orientation and gender identity rather than separate fields for each, only 27% had the ability to record patient pronouns, and 55% had the ability to record chosen name[21]; and when EHRs have inclusive options, these features are often hidden behind a paywall or only available through opting in to turn the features on[34]; and

Whereas, only 10-20% of customers utilize trans-inclusive options in EHRs that have them, and only a quarter of all patients have their gender identity listed in the EHR[9,35]; and

Whereas, our AMA policy D-478.995 urges EHR vendors to adopt social determinants of health templates without adding further cost to medical providers; and

Whereas, our AMA policy H-315.967 advocates for the inclusion of gender identity-related demographics in medical documentation and incorporation of recommended best practices into electronic health records; however, the suggestions for what to include leave an incomplete picture of transgender patients' medical history, leading to unhelpful ambiguity of advocacy efforts; therefore be it

RESOLVED, that our American Medical Association amend policy H-315.967 "Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation" by addition and deletion to read as follows:

Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation, H315.967

Our AMA: (1) supports the voluntary inclusion of a patient's ~~biological sex~~current clinical sex, sex assigned at birth, current gender identity, legal sex on identification documents, sexual orientation, ~~preferred~~ gender pronoun(s), ~~preferred~~ chosen name, and clinically relevant, sex specific anatomy in medical documentation, and related forms, including in electronic health records, in a culturally-sensitive and voluntary manner, with efforts to improve visibility and awareness of transgender and gender diverse patients' chosen name and pronouns in all relevant EHR screens and to de-emphasize or conceal legal name except when required for insurance and billing purposes; (2) Will advocate for the inclusion of an organ inventory encompassing medical transition history and a list of current present organs in EHRs, with efforts to link organ-specific examinations and cancer screenings to the current organ inventory rather than sex or gender identity; (~~2~~3). Will advocate for collection of patient data in medical documentation and in medical research studies, according to current best practices, that is inclusive of sexual orientation, gender identity, and other sexual and gender minority traits for the purposes of research into patient and population health; (~~3~~4) Will research the problems related to the handling of sex and gender within health information technology (HIT) products and how to best work with vendors so their HIT products treat patients equally and appropriately, regardless of sexual or gender identity; (4~~5~~) Will investigate the use of personal health records to reduce physician burden in maintaining accurate patient information instead of having to query each patient regarding sexual orientation and gender identity at each encounter; and (~~5~~6) Will advocate for the incorporation of recommended best practices into electronic health records and other HIT products at no additional

cost to physicians automatically. (7) Will advocate for patient informed consent regarding how gender identity and related data will be used with the ability to opt out of recording aforementioned data without compromising patient care; (Modify Current HOD Policy); and be it further

RESOLVED, that our AMA supports the use of the term “chosen name” over “preferred name,” recognizing the value of the term “chosen name” to transgender and gender-diverse patients (New HOD Policy).

Fiscal Note: Minimal – less than $1,000

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REFERENCES

1. HealthIT.gov. What is an electronic health record (EHR)? Healthit.gov. Published September 10, 2019. https://www.healthit.gov/faq/what-electronic-health-record-ehr Accessed April 8, 2023
2. Grasso C, Goldhammer H, Thompson J, Keuroghlian AS. Optimizing gender-affirming medical care through anatomical inventories, clinical decision support, and population health management in electronic health record systems. J Am Med Inform Assoc. 2021;28(11):2531-2535. doi:10.1093/jamia/ocab080
3. McClure RC, Macumber CL, Kronk C, et al. Gender harmony: improved standards to support affirmative care of gender-marginalized people through inclusive gender and sex representation [published correction appears in J Am Med Inform Assoc. 2021 Nov 25;]. J Am Med Inform Assoc. 2022;29(2):354-363. doi:10.1093/jamia/ocab196
4. Albert K, Delano M. Sex trouble: Sex/gender slippage, sex confusion, and sex obsession in machine learning using electronic health records. Patterns. 2022;3(8):100534. doi:https://doi.org/10.1016/j.patter.2022.100534
5. Krasowski M, Imborek K, Nisly N, et al. Preferred names, preferred pronouns, and gender identity in the electronic medical record and laboratory information system: Is pathology ready? Journal of Pathology Informatics. 2017;8(1):42. doi:https://doi.org/10.4103/jpi.jpi_52_17
6. Aquino AC. Transgender adult reference intervals taking shape. CAP TODAY: Pathology, Laboratory Medicine, Laboratory Management https://www.captodayonline.com/transgender-adult-reference-intervals-taking- shape/ Published December 18, 2019. Accessed April 9, 2023.
7. Patel, K., Lyon, M. E., & Luu, H. S. Providing Inclusive Care for Transgender Patients: Capturing Sex and Gender in the Electronic Medical Record. The Journal of Applied Laboratory Medicine. 2021; 6(1), 210-218. https://doi.org/10.1093/jalm/jfaa214
8. Kronk CA, Everhart AR, Ashley F, et al. Transgender data collection in the electronic health record: Current concepts and issues. J Am Med Inform Assoc. 2022;29(2):271- 284. doi:10.1093/jamia/ocab136
9. Grasso C., McDowell MJ., Goldhammer H., Keuroghlian AS. Planning and implementing sexual orientation and gender identity data collection in electronic health records. J Am Med Inform Assoc 2019; 26:66-70 doi:10.1093/jamia/ocy137
10. James SE, Herman JL, Rankin S, Keisling M, Mottet L, Anafi M.The Report of the 2015 U.S. Transgender Survey. https://transequality.org/sites/default/files/docs/usts/USTS- Full-Report-Dec17.pdf. Published 2016. Accessed March 8, 2023.
11. Dolan IJ, Strauss P, Winter S, Lin A. Misgendering and experiences of stigma in health care settings for transgender people. Med J Aust. 2020;212(4):150-151.e1. doi:10.5694/mja2.50497
12. GLAAD Media Reference Guide - LGBTQ terms. GLAAD. https://www.glaad.org/reference/terms. Published March 15, 2022. Accessed April 9, 2023.
13. Fowlkes AC. Why you should not say 'preferred gender pronouns'. Forbes. https://www.forbes.com/sites/ashleefowlkes/2020/02/27/why-you-should-not-say-preferred-gender-pronouns/?sh=7b6a64e11bd6. Published October 12, 2022. Accessed April 9, 2023.
14. Levin RN. Why asking students their preferred pronoun is not a good idea. Inside Higher Ed | Higher Education News, Events and Jobs. https://www.insidehighered.com/views/2018/09/19/why-asking-students-their-preferred-pronoun-not-good-idea-opinion. Accessed April 9, 2023.
15. Grutman AJ. Use of chosen names in electronic health records to promote transgender inclusivity. *J Am Med Inform Assoc*. 2023;30(6):1219-1221. doi:10.1093/jamia/ocad047
16. Madara JL. Health Data, Technology, and Interoperability: Certification Program Updates, Algorithm Transparency, and Information Sharing (HTI-1) proposed rule. Sent June 2023. Accessed April 6, 2024. https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Flfonc.zip%2F2023-6-20-Letter-to-Tripathi-re-ONC-NRPM-template-v2.pdf#page=30
17. Russell ST, Pollitt AM, Li G, Grossman AH. Chosen Name Use Is Linked to Reduced Depressive Symptoms, Suicidal Ideation, and Suicidal Behavior Among Transgender Youth. J Adolesc Health. 2018;63(4):503-505. doi:10.1016/j.jadohealth.2018.02.003
18. Pollitt AM, Ioverno S, Russell ST, Li G, Grossman AH. Predictors and Mental Health Benefits of Chosen Name Use among Transgender Youth. Youth Soc. 2019;2019:10.1177/0044118X19855898. doi:10.1177/0044118X19855898
19. McLemore KA. A minority stress perspective on transgender individuals’ experiences with misgendering. A minority stress perspective on transgender individuals’ experiences with misgendering. 2018;3(1):53-64. doi:10.1037/sah0000070
20. Sinclair-Palm J. “it’s non-existent”: Haunting in trans youth narratives about naming. Occasional Paper Series. 2017;2017(37). doi:10.58295/2375-3668.1102

21. Deutsch MB, Keatley J, Sevelius J, Shade SB. Collection of gender identity data using electronic medical records: survey of current end-user practices. J Assoc Nurses AIDS Care. 2014;25(6):657-663. doi:10.1016/j.jana.2014.04.001
22. Deutsch MB. Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People | Transgender Care. Ucsf.edu. Published 2019. https://transcare.ucsf.edu/guidelines Accessed April 8, 2023
23. New Paper Provides Strategies for Optimizing Gender-Affirming Medical Care By Changing Electronic Health Records - Fenway Health: Health Care Is A Right, Not A Privilege. fenwayhealth.org. Published July 7, 2021.https://fenwayhealth.org/new-paper-provides-strategies-for-optimizing-gender-affirming-medical-care-by-changing-electronic-health-records/ Accessed April 9, 2023.
24. Deutsch MB, Green J, Keatley JA, et al. Electronic medical records and the Transgender Patient: Recommendations from the World Professional Association for Transgender Health EMR Working Group. Journal of the American Medical Informatics Association : JAMIA. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3721165/. Published 2013. Accessed April 9, 2023.
25. Deutsch MB. Overview of gender-affirming treatments and procedures. Overview of gender-affirming treatments and procedures | Gender Affirming Health Program. https://transcare.ucsf.edu/guidelines/overview. Published June 17, 2016. Accessed April 9, 2023.
26. Burgess C, Kauth MR, Klemt C, Shanawani H, Shipherd JC. Evolving Sex and Gender in Electronic Health Records. Fed Pract. 2019;36(6):271-277.
27. Peitzmeier SM, Khullar K, Reisner SL, Potter J. Pap test use is lower among female-to-male patients than non-transgender women. Am J Prev Med. 2014;47(6):808-812. doi:10.1016/j.amepre.2014.07.031
28. Gatos KC. A Literature Review of Cervical Cancer Screening in Transgender Men. Nurse Womens Health. 2018;22(1):52-62. doi:10.1016/j.nwh.2017.12.008
29. Streed CG, Grasso C, Reisner SL, Mayer KH. Sexual orientation and gender identity data collection: Clinical and public health importance. American Journal of Public Health. 2020;110(7):991-993. doi:10.2105/ajph.2020.305722
30. Grasso C, Goldhammer H, Brown RJ, Furness BW. Using sexual orientation and gender identity data in electronic health records to assess for disparities in preventive health screening services. Int J Med Inform. 2020;142:104245. doi:10.1016/j.ijmedinf.2020.104245
31. Walcott Q, Dallman J, Crow H, Graves L, Marsh C. DXA Scan Variants in Transgender Patients. J Clin Densitom. 2022;25(4):615-621. doi:10.1016/j.jocd.2022.02.004
32. Streed, C. G., Jr, Beach, L. B., Caceres, B. A., Dowshen, N. L., Moreau, K. L., Mukherjee, M., Poteat, T., Radix, A., Reisner, S. L., Singh, V., & American Heart Association Council on Peripheral Vascular Disease; Council on Arteriosclerosis, Thrombosis and Vascular Biology; Council on Cardiovascular and Stroke Nursing; Council on Cardiovascular Radiology and Intervention; Council on Hypertension; and Stroke Council. Assessing and Addressing Cardiovascular Health in People Who Are Transgender and Gender Diverse: A Scientific Statement From the American Heart Association. Circulation. 2021;144(6), e136–e148. https://doi.org/10.1161/CIR.0000000000001003
33. Whitley CT, Greene DN. Transgender Man Being Evaluated for a Kidney Transplant. Clin Chem. 2017;63(11):1680-1683. doi:10.1373/clinchem.2016.268839
34. Leventhal R. The many layers of healthcare's EHR Gender Identity problem. Healthcare Innovation. https://www.hcinnovationgroup.com/clinical-it/article/13029566/the-many-layers-of-healthcares-ehr-gender-identity-problem. Published March 14, 2018. Accessed April 10, 2023.
35. Landman K. The Battle to Get Gender Identity Into Your Health Records. Wired. Published June 30, 2017. https://www.wired.com/story/the-battle-to-get-gender-identity-into-your-health-records/

RELEVANT AMA 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.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 005
(I-24)

Introduced by: American Society for Reproductive Medicine

Subject: Updating the American Medical Association Definition of Infertility

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, the World Health Organization defines infertility as "a disease of the male or female reproductive system defined by the failure to achieve a pregnancy after 12 months or more of regular unprotected sexual intercourse;" [1] and

Whereas, this definition excludes people with infertility who do not have heterosexual intercourse, who are interested in parenting alone, or who have clear and immediate medical or physiologic indications for fertility treatment; and

Whereas, AMA Code of Medical Ethics 4.2.1 on "Assisted Reproductive Technology" states in part that "Physicians who offer assisted reproductive services should… not discriminate against patients who have difficult-to-treat conditions, whose infertility has multiple causes, or on the basis of race, socioeconomic status, or sexual orientation or gender identity;" [3] and

Whereas, AMA policy H-510.984 on "Infertility Benefits for Veterans" states in part that "7. Our AMA supports expansion of reproductive health insurance coverage to all active-duty service members and veterans eligible for medical care regardless of service-connected disability, marital status, gender or sexual orientation;" [4] and

Whereas, AMA policy H-185.926 also "supports: (1) insurance coverage for fertility treatments regardless of marital status or sexual orientation when insurance provides coverage for fertility treatments; and (2) local and state efforts to promote reproductive health insurance coverage regardless of marital status or sexual orientation when insurance provides coverage for fertility treatments;" [5] therefore be it

RESOLVED, that our American Medical Association amend policy H-420.952 "Recognition of Infertility as a Disease" by addition, to state:

1. Our AMA supports the World Health Organization's designation of infertility as a disease state with multiple etiologies requiring a range of interventions to advance fertility treatment and prevention.
2. Our AMA also supports the American Society for Reproductive Medicine's definition of infertility as (a) the inability to achieve a successful pregnancy based on a patient's medical, sexual, and reproductive history, age, physical findings, diagnostic testing, or any combination of those factors; (b) the need for medical intervention, including, but not limited to, the use of donor gametes or donor embryos in order to achieve a successful pregnancy either as an individual or with a partner; and (c) in patients having regular unprotected intercourse and without any known etiology for either partner suggestive of impaired reproductive ability, evaluation should be evaluated at 12 months when the female partner is under 35 years of age and at 6 months when the female partner is 35 years of age or older. Nothing in this definition

shall be used to deny or delay treatment to any individual, regardless of relationship status or sexual orientation. (Modify Current HOD Policy); and be it further

RESOLVED, that our AMA work with other interested organizations to communicate with third-party payers that discrimination in coverage of fertility services on the basis of marital status or sexual orientation cannot be justified (Directive to Take Action); and be it further

RESOLVED, that our AMA reaffirm policy H-510.984 "Infertility Benefits for Veterans," (Reaffirm HOD Policy); and be it further

RESOLVED, that our AMA report back on this issue at I-25. (Directive to Take Action)

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

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REFERENCES

1. "Definition of Infertility" by the World Health Organization, at https://www.who.int/news-room/fact-sheets/detail/infertility#:~:text=Infertility%20is%20a%20disease%20of%20the%20male%20or,months%20or%20more%20of%20regular%20unprotected%20sexual%20intercourse, accessed 2/18/24
2. "Birth Rate by Country 2024" by World Population Review, at https://worldpopulationreview.com/country-rankings/birth-rate-by-country, accessed 2/18/24
3. "Assisted Reproductive Technology" from AMA Code of Medical Ethics 4.2.1, at https://policysearch.ama-assn.org/policyfinder/detail/Assisted%20Reproductive%20Technology?uri=%2FAMADoc%2FEthics.xml-E-4.2.1.xml, accessed 2/18/24
4. AMA policy H-510.984 on "Infertility Benefits for Veterans" at https://policysearch.ama-assn.org/policyfinder/detail/Infertility%20Benefits%20for%20Veterans?uri=%2FAMADoc%2FHOD-510.984.xml, accessed 2/18/24
5. AMA policy H-185.926 on "Reproductive Health Insurance Coverage" at https://policysearch.ama-assn.org/policyfinder/detail/Reproductive%20Health%20Insurance%20Coverage?uri=%2FAMADoc%2FHOD-185.926.xml, accessed 2/18/24
6. Hamai CJ, Groves SD, Kostandinis T, Girald-Berlingeri S, Simon KE, Christy AY, **Hsu AL**. "Helping Military Families Grow": Increasing Infertility Coverage for Active-duty Servicemembers and Veterans. *Fertil Steril Dialog*. Published online 7 Mar 2022
7. Veterans Health Administration (VHA) Directive 1334 Assisted Reproductive Technology (ART) Services, including IN Vitro Fertilization (IVF) for the Benefit of Veterans with Service-Connected Illness or Injury Resulting in Infertility – Frequently Asked Questions (12 February 2018), accessible at: <https://www.fertstertdialog.com/documents/vha-directive-1334-bb1012b6-de5f-4626-a161-4e1a76b93f04>, accessed 2/18/24
8. DoD Policy for Assisted Reproductive Services for the Benefit of Seriously or Severely Ill/Injured (Category II or III) Active Duty Service Members (ADSMs), accessible at <https://www.fertstertdialog.com/documents/dod-policy-guidance>, , accessed 2/18/24
9. "Definition of Infertility: A Committee Opinion (2023)" by the American Society for Reproductive Medicine Practice Committee, at https://www.asrm.org/practice-guidance/practice-committee-documents/denitions-of-infertility/?_t_id=p0bbIaqP-Lj2gUYT3tL14g%3d%3d&_t_uuid=QmmAeVJaTxSm4c5c5CBsCg&_t_q=infertility+definition&_t_tags=siteid%3a01216f06-3dc9-4ac9-96da-555740dd020c%2clanguage%3aen%2candquerymatch&_t_hit.id=ASRM_Models_Pages_ContentPage/_1bd481cd-5547-4afe-a440-d6651a17391f_en&_t_hit.pos=1, accessed 2/18/24
10. "Access to fertility treatment by gays, lesbians, and unmarried persons: a committee opinion. Ethics Committee of the American Society for Reproductive Medicine. Fertil Steril 2013; 100: 1524-7.

RELEVANT AMA POLICY

Recognition of Infertility as a Disease H-420.952
Our AMA supports the World Health Organization's designation **of infertility** as a disease state with multiple etiologies requiring a range **of** interventions to advance fertility treatment and prevention. [Res. 518, A-17]

AMA Code of Medical Ethics 4.2.1 Assisted Reproductive Technology
Assisted reproduction offers hope to patients who want children but are unable to have a child without medical assistance. In many cases, patients who seek assistance have been repeatedly frustrated in their attempts to have a child and are psychologically very vulnerable. Patients whose health insurance does not cover **assisted reproductive** services may also be financially vulnerable. Candor and respect are thus essential for ethical practice.

"**Assisted reproductive technology**" is understood as all treatments or procedures that include the handling of human oocytes or embryos. It encompasses an increasingly complex range of interventions—such as therapeutic donor insemination, ovarian stimulation, ova and sperm retrieval, in vitro fertilization, gamete intrafallopian transfer—and may involve multiple participants.

Physicians should increase their awareness of infertility treatments and options for their patients. Physicians who offer **assisted reproductive** services should:

(a) Value the well-being of the patient and potential offspring as paramount.
(b) Ensure that all advertising for services and promotional materials are accurate and not misleading.
(c) Provide patients with all of the information they need to make an informed decision, including investigational techniques to be used (if any); risks, benefits, and limitations of treatment options and alternatives, for the patient and potential offspring; accurate, clinic-specific success rates; and costs.
(d) Provide patients with psychological assessment, support and counseling or a referral to such services.
(e) Base fees on the value of the service provided. Physicians may enter into agreements with patients to refund all or a portion of fees if the patient does not conceive where such agreements are legally permitted.
(f) Not discriminate against patients who have difficult-to-treat conditions, whose infertility has multiple causes, or on the basis of race, socioeconomic status, or sexual orientation or gender identity.
(g) Participate in the development of peer-established guidelines and self-regulation.

AMA Principles of Medical Ethics: I,V,VII
The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.
[Issued: 2016]

Infertility Benefits for Veterans H-510.984

1. Our AMA supports lifting the congressional ban on the Department of **Veterans** Affairs (VA) from covering in vitro fertilization (IVF) costs **for veterans** who have become infertile due to service-related injuries.
2. Our AMA encourages interested stakeholders to collaborate in lifting the congressional ban on the VA from covering IVF costs **for veterans** who have become infertile due to service-related injuries.
3. Our AMA encourages the Department of Defense (DOD) to offer service members fertility counseling and information on relevant health care **benefits** provided through TRICARE and the VA at pre-deployment and during the medical discharge process.
4. Our AMA supports efforts by the DOD and VA to offer service members comprehensive health care services to preserve their ability to conceive a child and provide treatment within the standard of care to address **infertility** due to service-related injuries.
5. Our AMA supports additional research to better understand whether higher rates of **infertility** in servicewomen may be linked to military service, and which approaches might reduce the burden of **infertility** among service women.
6. Our AMA will work with interested organizations to encourage TRICARE to cover: (1) fertility preservation procedures (cryopreservation of sperm, oocytes, or embryos) **for** medical indications, **for** active-duty military personnel and other individuals covered by TRICARE; and (2) gamete preservation **for** active-duty military personnel and activated reservist military personnel.
7. Our AMA supports expansion of reproductive health insurance coverage to all active-duty service members and **veterans** eligible **for** medical care regardless of service-connected disability, marital status, gender or sexual orientation.

[CMS Rep.01, I-16; Appended: Res. 513, A-19; Appended: Res. 101, A-22; Appended: Res.801, I-22]

Reproductive Health Insurance Coverage H-185.926
Our AMA supports: (1) **insurance coverage** for fertility treatments regardless of marital status or sexual orientation when **insurance** provides **coverage** for fertility treatments; and (2) local and state efforts to promote **reproductive health insurance coverage** regardless of marital status or sexual orientation when **insurance** provides **coverage** for fertility treatments. [Res. 804, I-16]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 006
(I-24)

Introduced by: Minority Affairs Section

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

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, state governors have spent billions to inappropriately relocate over 100,000 migrants out of state without food, housing, or other basic necessities and without accounting for health needs or weather conditions, raising major humanitarian concerns[1-2]; and

Whereas, migrants report being falsely promised expedited work papers, job offers, free housing, education for their children, and free legal assistance, while others have been manipulated due to their fear of deportation and been either incorrectly informed or completely uninformed where they are being relocated[3]; and

Whereas, a child relocated from Texas to Chicago died en route due to previous illness, despite claims that “no passenger presented with medical concerns”[4]; and

Whereas, a security employee monitoring buses transporting migrants called their conditions “disgusting” and “inhumane”, describing lack of facilities for disposal of menstrual products, diapers, and human waste[5]; and

Whereas, a migrant unknowingly bussed to Philadelphia from Texas reported that her 10 year-old daughter had to be hospitalized for acute dehydration and high fever after the journey[6]; and

Whereas, despite inadequate funds and personnel, volunteer physicians and medical students serving thousands of bussed migrants in Chicago have treated a wide range of medical emergencies, including infected skin lacerations, stabbings, and miscarriages[7]; therefore be it

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

RESOLVED, that our AMA support state and federal efforts to protect the health and safety of traveling migrants and asylum-seekers and investigate possible abuse and human rights violations. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

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REFERENCES

1. Molestina K. Governor Abbott’s Operation Lone Star touts thousands of arrests, $10 billion cost - CBS Texas. www.cbsnews.com. Published January 22, 2024. https://www.cbsnews.com/texas/news/governor-abbotts-operation-lone-star-touts-thousands-of-arrests-10-billion-cost/
2. Clemens L. Migrants on Martha’s Vineyard flight say they were told they were going to Boston. NPR. Published September 15, 2022. Accessed March 4, 2024. https://www.npr.org/2022/09/15/1123109768/migrants-sent-to-marthas-vineyard6.

3. Tom Mockaitis opinion contributor. Busing migrants to sanctuary cities looks a lot like human trafficking. The Hill. Published September 18, 2022. https://thehill.com/opinion/immigration/3646647-bussing-migrants-to-sanctuary-cities-looks-a-lot-like-human-trafficking/
4. Jervis R. Migrant child who died on Texas bus trip had fever before she boarded, coroner says. USA TODAY. Published September 7, 2023. https://www.usatoday.com/story/news/investigations/2023/09/07/texas-migrant-bus-death-coroners-report/70786395007/
5. News ABC. Migrant bus conditions "disgusting and inhuman," says former veteran who escorted convoys. ABC News. Published October 24, 2023. Accessed March 4, 2024. https://abcnews.go.com/US/migrant-bus-conditions-disgusting-inhuman-former-vet-escorted/story?id=104038204
6. "Texas Sent a Migrant Woman and Her Sick Daughter Nearly 2,000 Miles Away: 'I Was Afraid.'" The Guardian, Guardian News and Media, 15 Jan. 2023, www.theguardian.com/us-news/2023/jan/15/us-mexico-border-texas-philadelphia-bus.
7. "'We Need Help': Chicago Medical Students Are Serving the Migrants Texas Is Sending by Bus." The Guardian, Guardian News and Media, 22 Nov. 2023, www.theguardian.com/us-news/2023/nov/22/we-need-help-chicago-medical-students-are-serving-the-migrants-texas-is-sending-by-bus.

RELEVANT AMA POLICY

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]

Opposing the Detention of Migrant Children H-60.906
1. Our American Medical Association 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. Our AMA 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.
3. Our AMA urges continuity of care for migrant children released from detention facilities. [Res. 004, I-18; Reaffirmed: Res. 234, A-22]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 007
(I-24)

Introduced by: Minority Affairs Section

Subject: Supporting Diversity in Research

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, 25 million Americans with low English proficiency (LEP) are regularly excluded from medical research, limiting sample diversity and generalizability of results[1-37]; and

Whereas, 20% of all clinical trials require English proficiency[33]; and

Whereas, barriers to greater participation of patients with LEP in medical research include unclear, outdated, and inconsistent federal and institutional guidance, differences in certification of non-medical interpreters and use of uncertified interpreters leading to errors and downstream costs, and time and funds required for translated consent forms and interpretation during study visits[33-51]; and

Whereas, patients who are Deaf and Hard of Hearing are frequently excluded from clinical trials and report that their greatest barrier to recruitment and participation is the lack of communication accessibility[53,54]; and

Whereas, federal agencies oversee 2,300 Institutional Review Boards (IRBs) at 1,800 institutions and organizations nationwide[43]; and

Whereas, recent federal efforts have focused on improving diversity in clinical research but have not yet addressed the use of interpretation[52]; and

Whereas, the U.S. Department of Health & Human Services Office of Human Research Protection's (OHRP) guidance on "Informed Consent of Subjects Who Do Not Speak English" has not been updated in nearly 30 years[52]; therefore be it

RESOLVED, that our American Medical Association support the use of language interpreters and translators in clinical and medical research participation to promote equitable data collection and outcomes (New HOD Policy); and be it further

RESOLVED, that our AMA encourage all Institutional and Research Review Boards (IRBs) to develop and publish transparent guidelines for interpreter services to ensure appropriate enrollment and ongoing participation of medical and clinical research participants with Limited English Proficiency and Deaf or Hard of Hearing people (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for the Department of Health and Human Services and Office for Human Research Protections (OHRP) to update their guidance on "Informed Consent of Subjects Who Do Not Speak English (1995)" (Directive to Take Action); and be it further

RESOLVED, that our AMA support the creation of a federal standard upon which individual Institutional Review Boards (IRBs) may base their recommendations. (New HOD Policy)

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

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REFERENCES

1. Definition: Limited English proficiency from 20 CFR § 641.140 | LII / Legal Information Institute. Accessed April 9, 2023. https://www.law.cornell.edu/definitions/index.php?width=840&height=800&iframe=true&def_id=ccb84f811e7e2c5cef1099322abf98dd&term_occur=999&term_src=Title:20:Chap%20ter:V:Part:641:Subpart:E:641.520.%20Accessed%20April%209,%20202 3
2. Detailed Languages Spoken at Home and Ability to Speak English. United States Census Bureau. Published 2015. Accessed March 1, 2023. https://www.census.gov/data/tables/2013/demo/2009-2013-lang-tables.html
3. S0201: SELECTED POPULATION PROFILE ... - Census Bureau Table. United States Census Bureau. Published 2021. Accessed April 2, 2023. https://data.census.gov/table/ACSSPP1Y2021.S0201?q=Language+Spoken+at+Home&t=Race+and+Ethnicity
4. Zong JB Jie Zong Jeanne Batalova and Jie. Language Diversity and English Proficiency in the United States. migrationpolicy.org. Published November 10, 2016. Accessed April 2, 2023. https://www.migrationpolicy.org/article/language-diversity-and-english-proficiency-united-states
5. Foiles Sifuentes AM, Robledo Cornejo M, Li NC, Castaneda-Avila MA, Tjia J, Lapane KL. The Role of Limited English Proficiency and Access to Health Insurance and Health Care in the Affordable Care Act Era. *Health Equity*. 2020;4(1):509-517. doi:10.1089/heq.2020.0057
6. Gulati RK, Hur K. Association Between Limited English Proficiency and Healthcare Access and Utilization in California. *J Immigr Minor Health*. 2022;24(1):95-101. doi:10.1007/s10903-021-01224-5
7. How Should Clinicians Respond to Language Barriers That Exacerbate Health Inequity? *AMA J Ethics*. 2021;23(2):E109-116. doi:10.1001/amajethics.2021.109
8. Kim J, Ford KL, Kim G. Geographic Disparities in the Relation between English Proficiency and Health Insurance Status among Older Latino and Asian Immigrants. *J Cross-Cult Gerontol*. 2019;34(1):1-13. doi:10.1007/s10823-019-09366-8
9. Waibel S, Wong ST, Katz A, Levesque JF, Nibber R, Haggerty J. The influence of patient–clinician ethnocultural and language concordance on continuity and quality of care: a cross-sectional analysis. *CMAJ Open*. 2018;6(3):E276-E284. doi:10.9778/cmajo.20170160
10. Parker MM, Fernández A, Moffet HH, Grant RW, Torreblanca A, Karter AJ. Association of Patient-Physician Language Concordance and Glycemic Control for Limited–English Proficiency Latinos With Type 2 Diabetes. *JAMA Intern Med*. 2017;177(3):380. doi:10.1001/jamainternmed.2016.8648
11. Lor M, Martinez GA. Scoping review: Definitions and outcomes of patient-provider language concordance in healthcare. *Patient Educ Couns*. 2020;103(10):1883-1901. doi:10.1016/j.pec.2020.05.025
12. Diamond L, Izquierdo K, Canfield D, Matsoukas K, Gany F. A Systematic Review of the Impact of Patient–Physician Non-English Language Concordance on Quality of Care and Outcomes. *J Gen Intern Med*. 2019;34(8):1591-1606. doi:10.1007/s11606-019-04847-5
13. Flores G. The Impact of Medical Interpreter Services on the Quality of Health Care: A Systematic Review. *Med Care Res Rev*. 2005;62(3):255-299. doi:10.1177/1077558705275416
14. Karliner LS, Jacobs EA, Chen AH, Mutha S. Do Professional Interpreters Improve Clinical Care for Patients with Limited English Proficiency? A Systematic Review of the Literature. *Health Serv Res*. 2007;42(2):727-754. doi:10.1111/j.1475-6773.2006.00629.x
15. Hsueh L, Hirsh AT, Maupomé G, Stewart JC. Patient–Provider Language Concordance and Health Outcomes: A Systematic Review, Evidence Map, and Research Agenda. *Med Care Res Rev*. 2021;78(1):3-23. doi:10.1177/1077558719860708
16. Jaeger FN, Pellaud N, Laville B, Klauser P. Barriers to and solutions for addressing insufficient professional interpreter use in primary healthcare. *BMC Health Serv Res*. 2019;19(1):753. doi:10.1186/s12913-019-4628-6
17. Karliner LS, Pérez-Stable EJ, Gregorich SE. Convenient Access to Professional Interpreters in the Hospital Decreases Readmission Rates and Estimated Hospital Expenditures for Patients With Limited English Proficiency. *Med Care*. 2017;55(3):199-206. doi:10.1097/MLR.0000000000000643
18. Rajbhandari P, Keith MF, Braidy R, Gunkelman SM, Smith E. Interpreter Use for Limited English Proficiency Patients/Families: A QI Study. *Hosp Pediatr*. 2021;11(7):718-726. doi:10.1542/hpeds.2020-003889
19. Heath M, Hvass AMF, Wejse CM. Interpreter services and effect on healthcare - a systematic review of the impact of different types of interpreters on patient outcome. *J Migr Health*. 2023;7:100162. doi:10.1016/j.jmh.2023.100162
20. Staples JN, Lester J, Li A, et al. Language as a barrier to cancer clinical trial accrual: assessing consenting team knowledge and practices for cancer clinical trial consent among low English fluency patients. *Appl Cancer Res*. 2018;38(1):14. doi:10.1186/s41241-018-0065-9
21. Rights (OCR) O for C. Civil Rights Requirements- A. Title VI of the Civil Rights Act of 1964, 42 U.S.C. 2000d et seq. (“Title VI”). Published January 15, 2009. Accessed March 1, 2023. https://www.hhs.gov/civil-rights/for-individuals/special-topics/needy-families/civil-rights-requirements/index.html
22. Rights (OCR) O for C. Section 1557: Frequently Asked Questions. Published August 25, 2016. Accessed February 18, 2024. https://www.hhs.gov/civil-rights/for-individuals/section-1557/1557faqs/index.html
23. HHS Office for Civil Rights HHS Language Access Statement. Published online 2023. https://www.hhs.gov/sites/default/files/language-access-report-2023.pdf
24. FAQ - Translators and Interpreters. National Council on Interpreting in Health Care. Published 2024. Accessed February 18, 2024. https://www.ncihc.org/faq-translators-and-interpreters
25. Debra Wood, RN, contributor. National Certification for Medical Interpreters | AMN Healthcare Language Services. AMN Healthcare. Published November 27, 2023. Accessed February 18, 2024. https://www.amnhealthcare.com/amn-insights/language-services/blog/national-certification-for-medical-interpreters/
26. Martinez-Morales C. Home. The National Board of Certification for Medical Interpreters. Published January 26, 2024. Accessed

February 18, 2024. https://www.certifiedmedicalinterpreters.org/
27. Interpreters and Translators : Occupational Outlook Handbook: : U.S. Bureau of Labor Statistics. Published 2023. Accessed February 5, 2024. https://www.bls.gov/ooh/media-and-communication/interpreters-and-translators.htm#tab-4
28. Ji M, Laviosa S, eds. *The Oxford Handbook of Translation and Social Practices*. Oxford University Press; 2021.
29. Guerrero S, López-Cortés A, Indacochea A, et al. Analysis of Racial/Ethnic Representation in Select Basic and Applied Cancer Research Studies. *Sci Rep*. 2018;8(1):13978. doi:10.1038/s41598-018-32264-x
30. Charrow A, Xia FD, Joyce C, Mostaghimi A. Diversity in Dermatology Clinical Trials: A Systematic Review. *JAMA Dermatol*. 2017;153(2):193. doi:10.1001/jamadermatol.2016.4129
31. How Should Representation of Subjects With LEP Become More Equitable in Clinical Trials? *AMA J Ethics*. 2022;24(4):E319-325. doi:10.1001/amajethics.2022.319
32. Egleston BL, Pedraza O, Wong YN, et al. Characteristics of clinical trials that require participants to be fluent in English. *Clin Trials*. 2015;12(6):618-626. doi:10.1177/1740774515592881
33. Muthukumar AV, Morrell W, Bierer BE. Evaluating the frequency of English language requirements in clinical trial eligibility criteria: A systematic analysis using ClinicalTrials.gov. Kruk ME, ed. *PLOS Med*. 2021;18(9):e1003758. doi:10.1371/journal.pmed.1003758
34. Jorge S, Masshoor S, Gray HJ, Swisher EM, Doll KM. Participation of Patients With Limited English Proficiency in Gynecologic Oncology Clinical Trials. *J Natl Compr Canc Netw*. 2023;21(1):27-32.e2. doi:10.6004/jnccn.2022.7068
35. Agarwal P, Ray S, Burdick D, Griffith A. Clinical Research Participation: Trials And Tribulations of The Limited English Proficiency Patient Volunteer in Parkinson's Disease Clinical Trials. (P5.071). *Neurology*. 2018;90(15_supplement):P5.071. doi:10.1212/WNL.90.15_supplement.P5.071
36. Roy M, Purington N, Liu M, Blayney DW, Kurian AW, Schapira L. Limited English Proficiency and Disparities in Health Care Engagement Among Patients With Breast Cancer. *JCO Oncol Pract*. 2021;17(12):e1837-e1845. doi:10.1200/OP.20.01093
37. Brodeur M, Herrick J, Guardioloa J, Richman P. Exclusion of Non-English Speakers in Published Emergency Medicine Research - A Comparison of 2004 and 2014. *Acta Inform Medica*. 2017;25(2):112. doi:10.5455/aim.2017.25.112-115
38. Manti S, Licari A. How to obtain informed consent for research. *Breathe*. 2018;14(2):145-152. doi:10.1183/20734735.001918
39. Peled Y. Language barriers and epistemic injustice in healthcare settings. *Bioethics*. 2018;32(6):360-367. doi:10.1111/bioe.12435
40. 45 CFR 46.116 -- General requirements for informed consent. Accessed February 17, 2024. https://www.ecfr.gov/current/title-45/part-46/section-46.116
41. Squires A, Sadarangani T, Jones S. Strategies for overcoming language barriers in research. *J Adv Nurs*. 2020;76(2):706-714. doi:10.1111/jan.14007
42. Velez MA, Lindenbaum M, Hegde M, et al. Cost of consent document (CD) translation is a potential barrier to consenting limited English-proficient participants (LEPPs) in non-industry–sponsored studies (NISS). *J Clin Oncol*. 2022;40(16_suppl):6533-6533. doi:10.1200/JCO.2022.40.16_suppl.6533
43. Office USGA. Institutional Review Boards: Actions Needed to Improve Federal Oversight and Examine Effectiveness | U.S. GAO. Accessed February 17, 2024. https://www.gao.gov/products/gao-23-104721
44. Grady C. Institutional Review Boards: Purpose and Challenges. *Chest*. 2015;148(5):1148-1155. doi:10.1378/chest.15-0706
45. McMillan G. IRB Policies for Obtaining Informed Consent from Non-English-Speaking People. *Ethics Hum Res*. 2020;42(3):21-29. doi:10.1002/eahr.500050
46. Perry KH. Ethics, Vulnerability, and Speakers of Other Languages: How University IRBs (Do Not) Speak to Research Involving Refugee Participants. *Qual Inq*. 2011;17(10):899-912. doi:10.1177/1077800411425006
47. Resnik DB, Jones CW. Research subjects with limited English proficiency: ethical and legal issues. *Account Res*. 2006;13(2):157-177. doi:10.1080/08989620600654043
48. Rights (OCR) O for C. Section 1557: Ensuring Meaningful Access for Individuals with Limited English Proficiency. Published August 25, 2016. Accessed February 17, 2024. https://www.hhs.gov/civil-rights/for-individuals/section-1557/fs-limited-english-proficiency/index.html
49. Jacobs B, Ryan AM, Henrichs KS, Weiss BD. Medical Interpreters in Outpatient Practice. *Ann Fam Med*. 2018;16(1):70-76. doi:10.1370/afm.2154
50. Brandl EJ, Schreiter S, Schouler-Ocak M. Are Trained Medical Interpreters Worth the Cost? A Review of the Current Literature on Cost and Cost-Effectiveness. *J Immigr Minor Health*. 2020;22(1):175-181. doi:10.1007/s10903-019-00915-4
51. Hendrickson SG, Harrison TC, Lopez NA, Zegarra-Coronado AG, Ricks T. Translation Cost, Quality, and Adequacy. *J Nurs Scholarsh*. 2013;45(2):185-191. doi:10.1111/jnu.12021
52. Committee on Improving the Representation of Women and Underrepresented Minorities in Clinical Trials and Research, Committee on Women in Science, Engineering, and Medicine, Policy and Global Affairs, National Academies of Sciences, Engineering, and Medicine. *Improving Representation in Clinical Trials and Research: Building Research Equity for Women and Underrepresented Groups*. (Bibbins-Domingo K, Helman A, eds.). National Academies Press; 2022:26479. doi:10.17226/26479
Kushalnagar P, Nicolarakis O, Mirus G, Anderson M, Burke T, Kushalnagar R. Barriers and Facilitators to the Inclusion of Deaf People in Clinical Trials. *Clin Trials Lond Engl*. 2023;20(5):576-580. doi:10.1177/17407745231177376
53. DeCormier Plosky W, Ne'eman A, Silverman BC, et al. Excluding People With Disabilities From Clinical Research: Eligibility Criteria Lack Clarity And Justification. *Health Aff (Millwood)*. 2022;41(10):1423-1432. doi:10.1377/hlthaff.2022.00520

RELEVANT AMA POLICY

Allergen Labeling on Food Packaging H-150.924
Our AMA encourages food manufacturers to pursue more obvious packaging distinctions between products that contain the most common food allergens identified in the Food Allergen Labeling and Consumer Protection Act and products that do not contain these allergens. [Res. 918, I-18]

Preventing Allergic Reactions in Food Service Establishments D-440.932
Our American Medical Association will pursue federal legislation requiring restaurants and food establishments to: (1) include a notice in menus reminding customers to let the staff know of any food allergies; (2) educate their staff regarding common food allergens and the need to remind customers to inform wait staff of any allergies; and (3) identify menu items which contain any of the major food allergens identified by the FDA (in the Food Allergen Labeling and Consumer Protection Act of 2004) and which allergens the menu item contains.[Res. 416, A-15]

Increasing Awareness of Nutritional Information and Ingredient Lists H-150.948
Our American Medical Association supports legislation or rules requiring restaurants, retail food establishments, and vending machine operators that have menu items common to multiple locations, as well as all school and workplace cafeterias, especially those located in health care facilities, to have available for public viewing ingredient lists, nutritional information, and standard nutrition labels for all menu items. [Sub. Res. 411, A-04; Reaffirmation A-07; Reaffirmed in lieu of Res. 413, A-09, Res. 416, A-09 and Res. 418, A-09; Modified: BOT Rep. 1, A-14; Modified: CSAPH Rep. 01, A-24]

Product Date Labels H-150.926
Our AMA will support federal standardization of date labels on food products to ensure that the labels address safety concerns. [Res. 421, A-18]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 008
(I-24)

Introduced by: American Psychiatric Association, Minority Affairs Section, Oklahoma

Subject: Missing and Murdered Black Women and Girls

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, in the United States, Black people comprise 13 percent of the population, but represent more than 33 percent of the nearly 550,000 people who were reported missing in 2022; and

Whereas, Black women comprise 7 percent of the US population yet nearly 20 percent of all missing persons cases; and

Whereas, Black women and girls less than 20 years of age comprise up to 2% of the population but represent more than 15 percent of missing persons; and

Whereas, in 2022, the National Crime Information Center reported more than 140,000 Black children age 17 and younger went missing for at least some period, including more than 77,000 girls, approximately 39% of missing children in the U.S. that year; and

Whereas, Black women making up 40 percent of sex trafficking survivors; and

Whereas, more than 40 percent of Black women have experienced intimate partner violence in their lifetimes and are nearly three times as likely than white women to be killed by an intimate partner; and

Whereas, the homicide rates among Black women in the U.S. are disproportionately high compared to their peers and Black women are murdered at younger ages and higher rates; and

Whereas, the number of unsolved homicides of Black women and girls rose by 89% in 2020 and 2021 compared with 2018 and 2019, a far bigger increase than any other demographic group according to a survey of 21 U.S. cities by the Wall Street Journal; and

Whereas, missing person cases involving Black women and girls stay open four times longer than their white peers; and

Whereas, all studies demonstrate that Black women and girls receive significantly less media attention at the outset to garner media coverage; and

Whereas, Black women and girls are less likely to be the subject of a single news story and a high-profile case that dominates the news, or receive extensive news coverage referred to as a “signal crime”; and

Whereas, signal crimes are much more visible than cases that only receive a news story or two, and thus are likely to have a greater influence on the perceptions and beliefs of viewers and readers; and

Whereas, Scripps Howard News Service analyzed CNN and Associated Press (AP) news reports pertaining to child abductions from 2000 to 2004. The study found that the 162 AP stories and 43 CNN reports dramatically overrepresented white children; and

Whereas, Seong-Jae Min and John C. Feaster found that missing black children were underrepresented in their sample of 161 nationally broadcast television news segments when compared to the racial composition of the overall missing children population; and

Whereas, the Black and Missing Foundation reports that missing minority children are often initially classified as “runaways” — which prevents them from being eligible for an Amber Alert — and minority adults who go missing are often associated with “criminal involvement,” including gangs and drugs, thus lowering the odds of a successful outcome; and

Whereas, in 2023, Minnesota became the first state to create an Office of Missing and Murdered Black Women and Girls, which will receive annual state funding to support families and communities and help solve open and cold missing persons cases among Black women and girls; and

Whereas, Illinois followed Minnesota in implementing a task force to look into disparities around violence against Black women and girls; and

Whereas, Wisconsin and Missouri have followed Minnesota in introducing legislation to create a Task Force on Missing and Murdered Black Women and Girls Office; and

Whereas, in 2024 California enacted an Ebony Alert, an emergency alert system, upon request from local law enforcement when a Black youth or young Black woman, between the ages of 12 and 25, is reported missing “under unexplained or suspicious circumstances,” is considered “at risk, developmentally disabled, or cognitively impaired” or has been abducted; and

Whereas, members of the United States House of Representatives have followed Minnesota’s blueprint and introduced legislation to create a National Office on Missing and Murdered Black Women and Girls; therefore be it

RESOLVED, that our American Medical Association advocate that the United States Department of Justice collect data on missing persons and homicide cases involving Black women and girls, including the total number of cases, the rate at which the cases are solved, the length of time the cases remain open, and a comparison to similar cases involving different demographic groups (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for the United States Department of Justice, legislators, and other stakeholders to collect data on Amber Alerts, including the total number of Amber Alerts issued, aggregated by the child's race and sex (Directive to Take Action); and be it further

RESOLVED, that our AMA encourage state medical societies to work with legislators, advocates, and other stakeholders to establish equity in policy and practices related to missing and murdered black women and girls. (New HOD Policy)

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

Received: 9/24/2024

REFERENCES

1. 2022 NCIC missing person and unidentified person statistics. FBI. February 10, 2023. Accessed September 24, 2024. https://www.fbi.gov/file-repository/2022-ncic-missing-person-and-unidentified-person-statistics.pdf/view.
2. House Judiciary; House Education and the Workforce; House Energy and Commerce; House Financial Services, Rep. Kelly RL. U.S. Government Publishing Office; 2024:1-18.
3. Alexander KA, Willie TC. An epidemic of missing black women has been ignored for too long. The Hill. October 10, 2023. Accessed September 24, 2024. https://thehill.com/opinion/criminal-justice/4246039-an-epidemic-of-missing-black-women-has-been-ignored-for-too-long/.
4. Buchholz K, Richter F. Infographic: Young, black, female persons more likely to be missing. Statista Daily Data. July 26, 2023. Accessed September 24, 2024. https://www.statista.com/chart/30487/missing-persons-age-race-sex/.
5. Boogie A. The epidemic very few are talking about: Missing black women and girls. REVOLT. October 9, 2023. Accessed September 24, 2024. https://www.revolt.tv/article/2023-10-09/329319/the-epidemic-very-few-are-talking-about-missing-black-women-girls.
6. Buchholz K, Richter F. Infographic: Black people overrepresented among America's missing. Statista Daily Data. July 26, 2023. Accessed September 24, 2024. https://www.statista.com/chart/30486/race-of-missing-persons-us-population/.
7. Sommers Z. Missing White Woman Syndrome: An Empirical Analysis of Race and Gender Disparities in Online News Coverage of Missing Persons. *Journal of Criminal Law and Criminology*. 2016;106(2):1-41. doi:10.2139/ssrn.4897756

RELEVANT AMA POLICY

Missing and Murdered Indigenous Persons H-350.938

Our American Medical Association supports emergency alert systems for American Indian and Alaska Native tribal members reported missing on tribal reservations and elsewhere. [Res. 411, A-24]

Missing Children Identification H-60.996

1. Our American Medical Association supports development of a means of identifying children.
2. Our AMA supports education of the public and parents on the fingerprinting and documentation of characteristic identifying marks as a matter of record, should it be necessary to assist officials in locating a missing child.[Res. 98, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: CSA Rep. 6, A-04; Reaffirmed: CSAPH Rep. 1, A-14; Reaffirmed: CSAPH Rep. 01, A-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 009
(I-24)

Introduced by: Kansas

Subject: Opposition to Creation or Enforcement of Civil Litigation, Commonly Referred to as Civil Causes of Action

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, civil causes of action removed from allegations of breach in standard of care can drive a wedge between patient and physicians, increase costs, and fail to yield improved care and outcomes for patients; and

Whereas, adding new civil causes of actions against physicians to enforce legislative policy may conflict with a physician's duty to make treatment decisions that meet the accepted standard of care for each individual patient and their specific needs; and

Whereas, utilizing the threat of civil lawsuits as an enhanced enforcement mechanism for legislative policy is unnecessary and encourages more costly litigation, which has significant emotional, financial, and relational consequences for patients, physicians, and the healthcare system as a whole; and

Whereas, adequate remedies already exist to hold physicians accountable for actions that fall below the standard of care; and

Whereas, the American Medical Association is committed to advocating for the best interests of patients and physicians; state law provides a cause of action for patients to obtain compensation for injuries caused by medical negligence, and physicians are subject to significant consequences for failure to comply with statutory requirements, including loss of license to practice; therefore be it

RESOLVED, that our American Medical Association affirms that civil causes of action in healthcare should be limited to causes of action that address alleged violations of a physician's duty to meet the standard of care in the treatment of patients. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 9/24/2024

Reference Committee B

Report(s) of the Board of Trustees

01 Augmented Intelligence Development, Deployment, and Use in Health Care
02 On-Site Physician Requirements for Emergency Departments
03 Stark Law Self-Referral Ban
04 Addressing Work Requirements For J-1 Visa Waiver Physicians
06 Health Technology Accessibility for Aging Patients
09 Corporate Practice of Medicine Prohibition

Resolutions

201 Boarding Patients in the Emergency Room
202 Illicit Drugs: Calling for a Multifaceted Approach to the "Fentanyl" Crisis
204 Support for Physician-Supervised Community Paramedicine Programs
205 Native American Medical Debt
206 Protect Infant and Young Child Feeding
207 Accountability for G-605.009: Requesting A Task Force to Preserve the Patient-Physician Relationship Task Force Update and Guidance
208 Medicare Part B Enrollment and Penalty Awareness
210 Laser Surgery
211 Water Bead Injuries
212 Addressing the Unregulated Body Brokerage Industry
213 Sustainable Long-term Funding for Child Psychiatry Access Programs
214 Advocating for Evidence-Based Strategies to Improve Rural Obstetric Health Care and Access
215 Advocating for Federal and State Incentives for Recruitment and Retention of Physicians to Practice in Rural Areas
216 Clearing Federal Obstacles for Supervised Injection Sites
217 Expand Access to Skilled Nursing Facility Services for Patients with Opioid Use Disorder
218 Time Sensitive Credentialing of New Providers with an Insurance Carrier
219 Advocate to Continue Reimbursement for Telehealth / Telemedicine Visits Permanently
220 MIPS Reform
221 Medicare Coverage for Non-PAR Physicians
222 Rollback on Physician Performance Measures
223 Mandated Economic Escalators in Insurance Contracts
225 Elimination of Medicare 14-Day Rule
226 Information Blocking Rule
227 Medicare Payment Parity for Telemedicine Services

REPORT 01 OF THE BOARD OF TRUSTEES (I-24)
Augmented Intelligence Development, Deployment, and Use in Health Care
(Resolution 247-A-23) (Resolution 206-I-23) (BOT Report 15-A-24)
(Reference Committee B)

EXECUTIVE SUMMARY

At the 2023 Annual Meeting, the American Medical Association (AMA) House of Delegates (HOD) adopted Policy H-480-935, "Assessing the Potentially Dangerous Intersection Between AI and Misinformation." This policy calls on the AMA to "study and develop recommendations on the benefits and unforeseen consequences to the medical profession of large language models (LLM) such as, generative pretrained transformers (GPTs), and other augmented intelligence-generated medical advice or content, and that our AMA propose appropriate state and federal regulations with a report back at A-24." Additionally, at the 2023 Interim Meeting, the HOD referred Resolution 206-I-23, "The Influence of Large Language Models (LLMs) on Health Policy Formation and Scope of Practice." Resolution 206-I-23 asked, "that our American Medical Association encourage physicians to educate our patients, the public, and policymakers about the benefits and risks of facing LLMs including GPTs for advice on health policy, information on health care issues influencing the legislative and regulatory process, and for information on scope of practice that may influence decisions by patients and policymakers." At the 2024 Annual Meeting, a previous version of this report (BOT Report 15-A-24) was referred by the HOD for further consideration of testimony received from the online forum and during the Reference Committee B hearing.

Generative augmented intelligence (AI) is a type of AI that can recognize, summarize, translate, predict, and generate text and other content based on knowledge gained from large datasets. There has been increasing discussion about clinical applications of generative AI, including use as clinical decision support to provide differential diagnoses, early detection and intervention, and to assist in treatment planning. Generative AI tools are also being developed to assist with administrative functions, such as generating office notes, responding to documentation requests, and generating patient messages. While generative AI tools show tremendous promise to make a significant contribution to health care, there are a number of risks and limitations to consider when using these tools in a clinical setting or for direct patient care.

As the number of AI-enabled health care tools and systems continues to grow, these technologies must be designed, developed, and deployed in a manner that is ethical, equitable, responsible, accurate, and transparent. With a lagging effort towards adoption of national governance policies or oversight of AI, it is critical that the AMA and the physician community engage in the development of policies to help inform patient and physician education, help guide development of these tools in a way that best meets both patient and physician needs, and advocate for governance policies to help ensure that risks arising from AI are mitigated to the greatest extent possible.

This report highlights the AMA's recognition of the issues raised at the A-23, I-23, and A-24 HOD meetings, introduces and explains major themes of the report's recommendations, and provides background information on the evolution of AI policy in health care and the direction that policy appears to be headed.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 01-I-24

Subject:	Augmented Intelligence Development, Deployment, and Use in Health Care (Resolution 247-A-23) (Resolution 206-I-23) (BOT Report 15-A-24)
Presented by:	Michael Suk, MD, JD, MPH, MBA, Chair
Referred to:	Reference Committee B

INTRODUCTION

At the 2023 Annual Meeting, the American Medical Association (AMA) House of Delegates (HOD) adopted Policy H-480-935, "Assessing the Potentially Dangerous Intersection Between AI and Misinformation." This policy calls on the AMA to "study and develop recommendations on the benefits and unforeseen consequences to the medical profession of large language models (LLM) such as, generative pretrained transformers (GPTs), and other augmented intelligence-generated medical advice or content, and that our AMA propose appropriate state and federal regulations with a report back at A-24." This policy reflects the intense interest and activity in augmented intelligence (AI) prompted by the arrival of OpenAI's ChatGPT and other LLMs/generative AI.

Additionally, at the 2023 Interim Meeting, the AMA HOD referred Resolution 206-I-23, "The Influence of Large Language Models (LLMs) on Health Policy Formation and Scope of Practice." Resolution 206-I-23 asked, "that our American Medical Association encourage physicians to educate our patients, the public, and policymakers about the benefits and risks of facing LLMs including GPTs for advice on health policy, information on health care issues influencing the legislative and regulatory process, and for information on scope of practice that may influence decisions by patients and policymakers."

Testimony on Resolution 206-I-23 highlighted the importance of physician understanding of LLMs and the ability to weigh the benefits and risks of these tools as the excitement and eagerness to implement them in everyday practice increases. Testimony emphasized that our AMA is currently in the process of fulfilling the directive in Policy H-480-935 (adopted at A-23) that directs our AMA to study and develop recommendations on the benefits and unforeseen consequences to the medical profession of LLMs, such as GPTs, and other augmented intelligence-generated medical advice or content. The HOD referred Resolution 206 so that the issues raised in this resolution could be considered along with the issues in Policy H-480.935.

At the 2024 Annual Meeting, a previous version of this report (BOT Report 15-A-24) was referred by the HOD for further consideration of testimony received from the online forum and during the Reference Committee B hearing. Some of those who testified expressed concern over omissions in the report regarding the use of AI in the development of scientific literature and its ability to propagate health care misinformation. Others expressed concern over the feasibility of some recommendations relating to transparency and disclosure of the use of AI, primarily that it may add additional burden on health systems, hospitals, and physicians. These issues are addressed in this report.

BACKGROUND

The issue of AI first presented itself as an area of potential interest to AMA physicians and medical students that necessitated creation of AMA policy in 2018. At that time, physicians and medical students primarily considered AI-enabled technologies within the context of medical device and clinical decision support, although administrative applications of AI began to grow exponentially and started to gain traction in the hospital, health system, and insurer space. Since the development of the AMA's foundational AI policy in 2018 and subsequent policy on coverage and payment for AI in 2019, the number of AI-enabled medical devices approved by the U.S. Food and Drug Administration (FDA) has grown to over 800. In 2022, the concept of "generative AI" and what it can do became better understood to the public. Generative AI is a broad term used to describe any type of artificial intelligence that can be used to create new text, images, video, audio, code, or synthetic data. Generative AI and LLMs have rapidly transformed the use cases and policy considerations for AI within health care, necessitating updated AMA policy that reflects the rapidly evolving state of the technologies.

AMA policy adopted in 2018 and 2019 enabled the AMA to be a strong advocate on behalf of patients and physicians and has been the bedrock of AMA's advocacy on AI in the form of lobbying key congressional committees, participating in expert panel discussions, creating educational resources, and working with our Federation colleagues at the federal and state levels. However, as AI has rapidly developed beyond AI-enabled medical devices and into LLMs/generative AI, new policy and guidance are needed to ensure that they are designed, developed, and deployed in a manner that is ethical, equitable, responsible, accurate, and transparent.

As an initial step, in November 2023, the AMA Board of Trustees approved a set of advocacy principles developed by the Council on Legislation (COL) that serve as the framework of this Board report. The main topics addressed in the principles include AI oversight, disclosure requirements, liability, data privacy and security, and payor use of AI. In addition to the COL, these principles have been vetted among multiple AMA business units, and AMA staff has worked with several medical specialty societies that have an expertise in AI and has received additional guidance and input from outside experts that have further refined these principles. These principles build upon and are supplemental to the AMA's existing AI policy, especially Policy H-480.940, "Augmented Intelligence in Health Care," Policy H-480.939, "Augmented Intelligence in Health Care," and Policy D-480.956, "Use of Augmented Intelligence for Prior Authorization," as well as the AMA's Privacy Principles. The Board recommends adoption of these principles as AMA policy to guide our AMA's advocacy and educational efforts on LLM/generative AI issues.

This report highlights the AMA's recognition of the issues raised at the A-23 and I-23 HOD meetings, as well as the comments heard during the A-24 HOD meeting regarding BOT Report 15-A-24. It also introduces and explains major themes of the report's recommendations and provides background information on the evolution of AI policy in health care and the direction that policy appears to be headed.

Current Status of Oversight of Augmented Intelligence-Enabled Technologies

There is currently no whole-of-government strategy for oversight and regulation of AI. The U.S. Department of Health and Human Services (HHS) did establish an AI Office in March 2021 and developed a general strategy to promote the use of trustworthy AI but has not produced a department-wide plan for the oversight of AI. While many other federal departments and agencies also have some authority to regulate health care AI, many regulatory gaps exist. The Assistant

Secretary for Technology Policy/Office of the National Coordinator for Health Information Technology (ASTP/ONC) recently created a position for a Chief AI Officer. However, the job role is targeted at the internal use of AI within HHS and less about public policy. To address the lack of a national strategy and national governance policies directing the development and deployment of AI, the federal government has largely defaulted to public "agreements" representing promises by large AI developers and technology companies to be good actors in their development of AI-enabled technologies.

In December 2023, the Biden Administration released a reasonably comprehensive executive order on the "Safe, Secure, and Trustworthy Development and Use of Artificial Intelligence." While the executive order does not create new statutory or regulatory requirements, it does serve to direct federal departments and agencies to take action to provide guidance, complete studies, identify opportunities, etc. on AI across several sectors, including HHS. The AMA was pleased to see close alignment between the executive order's direction and AMA principles. However, executive orders do not represent binding policy, so the regulatory status quo remains unchanged at present.

The Biden Administration had also previously released a "Blueprint for an AI Bill of Rights," setting forth five principles that should guide the design, use, and deployment of AI. Those include recommendations for creating safe and effective systems; algorithmic discrimination protections; data privacy; notice and explanation; and human alternatives, considerations, and fallback. Like executive orders, this blueprint does not create new or binding policy with the force of law.

There have been few, but notable, additional actions by federal agencies that may serve to impact patient and physician interaction with AI-enabled technologies. In 2022, the Centers for Medicare & Medicaid Services (CMS) and HHS Office for Civil Rights (OCR) introduced a sweeping liability proposal within its Section 1557 Non-Discrimination in Health Programs and Activities proposed rule. The AMA submitted detailed comments opposing this section of the proposed rule. OCR ultimately finalized the rule, including the new section prohibiting discrimination by clinical algorithms. The final rule requires physicians to make "reasonable efforts" at identifying and mitigating discriminatory harms from algorithms, including AI.

In addition, the ASTP/ONC* proposed and finalized, with some modifications, polices that will require electronic health record (EHR) technology developers to make certain information about AI used in EHRs available to physicians and other users. ASTP/ONC refers to these AI tools as Predictive Decision Support Interventions (Predictive DSI). Starting in 2025, EHR developers that supply Predictive DSIs as part of the developer's EHR offering must disclose specific attributes and inform users if patient demographic, social determinants of health, or health assessment data are used in the Predictive DSI. EHRs will be subject to regulatory requirements regarding the design, development, training, and evaluation of Predictive DSIs along with mandated risk management practices. ASTP/ONC's stated goal is to ensure that physicians understand how these tools work, how data are used, the potential for bias, and any known limitations.

FDA Approved AI-Enabled Medical Devices

The FDA continues to rapidly approve AI-enabled medical devices. While FDA approval and clearance of algorithmic-based devices date back to 1995, clearance and approval of these devices has rapidly accelerated in the last several years. As of May 2024, 882 devices that FDA classifies as Artificial Intelligence/Machine Learning (AI/ML) devices have been approved for marketing.

* On July 25, 2024, HHS announced that ONC will be renamed the Assistant Secretary for Technology Policy and Office of the National Coordinator for Health Information Technology (ASTP/ONC).

The overwhelming number of these devices are classified as radiology devices and this category of devices has seen the steadiest increases in the number of applications for FDA approval. However, the number of applications is increasing in several specialties, including cardiology, neurology, hematology, gastroenterology, urology, anesthesiology, otolaryngology, ophthalmology, and pathology. A significant number of cleared or approved devices are considered diagnostic in nature and many currently support screening or triage functions.

In 2017, the FDA announced that it was evaluating a potentially new regulatory approach towards Software as a Medical Device, which would include AI/ML technologies. The so-called Pre-Certification program, or "Pre-Cert," progressed to an initial pilot program involving nine manufacturer applicants. The program proposed to pre-certify manufacturers of software-based medical devices. Devices developed by pre-certified manufacturers would be subject to varying levels of FDA review based on risk to patients, including potentially being exempt from review if the risk is low. However, the Pre-Cert program has been tabled and the pilot dismantled for the time being, leaving FDA to utilize traditional review pathways for AI-enabled medical devices. In the absence of new regulatory strategies tailored to Software as a Medical Device (SaMD) and AI/ML, FDA has issued some proposed guidance for developers of these devices but has not yet moved forward with additional guidance for important, physician-facing topics, such as transparency and labeling requirements. In June 2024, the FDA released a set of "guiding principles" for AI transparency in conjunction with Health Canada and the Medicines and Healthcare Products Regulatory Agency of the United Kingdom. However, these guiding principles do not represent official FDA guidance nor are they mandatory requirements of applicants for FDA review. The continued lack of transparency mandates leaves a critical gap in the oversight of AI-enabled medical devices.

Data Privacy and Cybersecurity Considerations in Health Care AI

The integration of AI into health care signifies a transformative era, with potential to greatly enhance patient care and operational efficiency. However, this advancement also introduces considerable challenges, particularly in data privacy and cybersecurity. As health care facilities, technology vendors, clinicians, and users increasingly adopt AI, it is vital to focus on protecting patient and user data and securing AI systems against cyber threats. Handling vast amounts of sensitive data raises critical questions about privacy and security. Survey data has shown that nine out of 10 patients believe privacy is a right and nearly 75 percent of people are concerned about protecting the privacy of their health data.[1] Addressing these concerns necessitates a multifaceted approach that includes advanced data privacy techniques, data use transparency, robust cybersecurity strategies, and compliance with regulatory standards.

Ensuring the protection of patient data in the context of AI requires sophisticated privacy techniques. Key methods such as anonymization and pseudonymization can remove or replace personal identifiers in data sets and significantly reduce the risk of re-identification. Additionally, implementing a robust data management system empowers patients by providing clear ways to grant, deny, or revoke consent for the use of their data, enhancing patient trust and ensuring compliance with global data protection regulations such as the General Data Protection Regulation and the Health Insurance Portability and Accountability Act (HIPAA). Moreover, the collection of data should be kept to a minimum. By collecting only the data necessary for the intended purpose, AI systems can mitigate the risks associated with data breaches and misuse.

Cybersecurity plays a crucial role in health care, especially in the context of the increasing digitalization of medical records, patient data, and health care services. The health care sector is a prime target for cyber-attacks due to the sensitivity and value of the data it handles, including

personal health information (PHI), financial data, and intellectual property related to medical research. The integration of technology in health care has undoubtedly brought significant benefits such as improved patient care, streamlined operations, and enhanced data analytics. However, it also introduces vulnerabilities. These include potential unauthorized access, data breaches, and disruptions to health care services, which can have dire consequences for patient privacy and safety. In 2017, 83 percent of surveyed physicians had already experienced a cyberattack and 85 percent stated that they want to share electronic PHI but were concerned about the data security necessary to protect it.[2] This risk is amplified by the recent increased use of interconnected devices and systems, such as EHRs, telemedicine platforms, and mobile health applications.

The attack on Change Healthcare in February 2024 is a stark reminder of the critical importance of cybersecurity in health care. Change Healthcare, a division of UnitedHealth Group, was struck by a ransomware attack that significantly disrupted the largest health care payment and operations system in the United States. This incident led to widespread disruptions, affecting thousands of medical practices, hospitals, pharmacies, and others. The attack was attributed to ransomware. Despite efforts to recover from this attack, the impact on health care operations was profound, including the disruption of claims processing, payments, and electronic prescriptions leading to financial strain on physicians and delays in patient care. The health care sector's reliance on interconnected digital systems for patient records, billing, and payments, means that the impact of a cyberattack can be both immediate and widespread, affecting patient care and operational continuity.

The implications of cybersecurity in health care AI are multifaceted. AI in health care, encompassing machine learning algorithms, predictive analytics, and robotic process automation, holds immense potential for diagnostic accuracy, personalized medicine, and operational efficiency. However, the deployment of AI in health care settings creates unique cybersecurity challenges. AI systems require large datasets to train and operate effectively, increasing the risk of large-scale data breaches. Additionally, the complexity of AI algorithms can make them opaque and vulnerable to manipulation, such as adversarial attacks that can lead to misdiagnoses or inappropriate treatment recommendations. AI-driven health care solutions often rely on continuous data exchange across networks, escalating the risk of cyber-attacks that can compromise both the integrity and availability of critical health care services.

A model stealing attack represents a significant cybersecurity threat in the realm of AI, where a malicious actor systematically queries an AI system to understand its behavior and subsequently replicates its functionality. This form of intellectual property theft is particularly alarming due to the substantial resources and time required to develop sophisticated AI models. An example of this issue involves a health care organization that has invested heavily in an AI model designed to predict patient health outcomes based on a wide range of variables. If a malicious entity were to engage in model stealing by extensively querying this predictive model, it could essentially duplicate the original model's predictive capabilities along with capitalizing on sensitive health care information and physicians, users, or the entity's intellectual property. Absent strong protections against input manipulation and malicious attacks, AI can become a new conduit for bad actors to compromise health care organizations and harm patients. This not only undermines the original investment but also poses a direct threat to the competitive advantage of the innovating organization.

Moreover, the risk extends beyond intellectual property theft to encompass serious privacy concerns. This is exemplified by incidents where generative AI models, trained on vast datasets, inadvertently reveal sensitive information contained within their training data in response to certain prompts. In the health care sector, where models are often trained on highly sensitive patient data,

including personally identifiable information, the unauthorized extraction of this data can lead to significant breaches of patient confidentiality. The dual threat of intellectual property theft and data privacy breaches underscores the critical need for robust cybersecurity measures in safeguarding AI models, particularly those developed and utilized within the health care industry, to maintain the integrity of both their intellectual property and the confidentiality of the sensitive data they handle.

While there are new federal policies to increase data transparency when AI is used in conjunction with health information technology, such as those issued by ASTP/ONC, these new policies only cover the certified EHR developer and stop short of holding AI developers accountable for robust data governance or data security and privacy practices.[3]

Generative AI

The broad introduction of generative AI into the public sphere in 2022 saw a paradigm shift in how physicians contemplated AI. Open-source LLM Chat GPT presented a new, easily accessible AI-enabled technology with significant capabilities to generate new content and provide readily available access to information from a huge number of sources. Generative AI tools have significant potential to relieve physician administrative burdens by helping to address actions such as in-box management, patient messages, and prior authorization requests. They also show promise in providing clinical decision support and highly personalized treatment recommendations.

However, these generative AI tools can also pose significant risk, particularly for clinical applications. As these LLMs are constantly evolving, they run the risk of providing inconsistent responses on the same fact pattern on potentially a daily, weekly, monthly, or yearly basis. The risks of these tools fabricating content are well known and could serve to propagate the spread of medical misinformation as content fabricated by the AI technologies is more broadly disseminated. They also pose potentially significant data privacy concerns.

At the present time, these technologies are largely unregulated, as there is no current regulatory structure for generative AI clinical decision support tools unless they meet the definition of a medical device regulated by the FDA. The U.S. Federal Trade Commission (FTC) has limited authority to regulate data privacy issues that may be associated with generative AI. The FTC does have some authority to regulate activities considered to be an unfair, deceptive, or abusive business practice and can enforce laws for consumer protection. However, these authorities are not specific to AI and the agency is generally under-resourced in this area. CMS has some authority to regulate use of AI by entities receiving funds from Medicare and Medicaid, including use by Medicare Advantage plans. OCR has some additional authorities to regulate data privacy and nondiscrimination.

While some federal agencies may have oversight and authorities to regulate some aspects of AI, there are many regulatory gaps. These regulatory gaps are particularly significant when considering generative AI, as tools like ChatGPT and others currently fall well outside the definition of a regulated medical device. While generative AI use for clinical applications is relatively limited currently, it is expected to grow and patients and physicians will need assurances that it is providing safe, accurate, non-discriminatory answers to the full extent possible, whether through regulation or generally accepted standards for design, development, and deployment.

Physician Liability for Use of AI

One of the most significant concerns raised by physicians regarding the use of AI in clinical practice is concern over potential liability for use of AI that ultimately performs poorly. The

question of liability for the use of AI is novel and complex given that the use of AI for activities, such as clinical decision making and treatment recommendations, introduces an element of shared decision making between the patient, physician, and now the machine. While it is likely that liability will mostly be determined by the legal system through decisions in courts of law, some federal agencies have considered the idea of physician liability in these instances. Notably, the HHS Office of Civil Rights has finalized a rule creating new liability for physicians utilizing AI that results in discriminatory harms to patients. This could include, for example AI that utilizes algorithms with race adjustments or returns otherwise biased results to physicians and patients. The final rule prohibits discrimination by clinical algorithms and requires physicians, hospitals, health systems, and others to use "reasonable efforts" to both identify algorithmic discrimination and to mitigate resulting harms. While the AMA supports a prohibition on discrimination by clinical algorithms, the AMA strongly opposed efforts to create new physician liability for the use of AI.

Use of AI By Payors

There have been numerous reports recently regarding the use of what has been termed "automated decision-making tools" by payors to process claims. However, numerous reports regarding the use of these tools show a growing tendency toward inappropriate denials of care or other limitations on coverage. Reporting by ProPublica claims that tools used by Cigna denied 300,000 claims in two months, with claims receiving an average of 1.2 seconds of review.[4] Two class action lawsuits were filed during 2023, charging both United Health Care and Humana with inappropriate claims denials resulting from use of the nHPredict AI model, a product of United Health Care subsidiary NaviHealth. Plaintiffs in those suits claim the AI model wrongfully denied care to elderly and disabled patients enrolled in Medicare Advantage (MA) plans with both companies. Plaintiffs also claim that payors used the model despite knowing that 90 percent of the tool's denials were faulty.

There is growing concern among patients and physicians about what they perceive as increasing and inappropriate denials of care resulting from the use of these automated decision-making tools. In his recent Executive Order on AI, President Biden addressed this issue as an area of concern, directing HHS to identify guidance and resources for the use of predictive and generative AI in many areas, including benefits administration, stating that it must take into account considerations such as appropriate human oversight of the application of the output from AI.

There are currently no statutory and only limited regulatory requirements addressing the use of AI and other automated decision-making tools by payors. States are beginning to look more closely at this issue given the significant negative reporting in recent months and are a likely place for near-term action on this issue. Congress has also shown increasing concern and has convened hearings for testimony on the issue; however, there has been no further Congressional action or legislation to pursue further limitations on use of these algorithms. Additionally, CMS has not taken broad regulatory action to limit the use of these algorithms by entities administering Medicare and Medicaid benefits.

AMA POLICY

The AMA has existing policies, H-480.940 and H-480.939 both titled "Augmented Intelligence in Health Care," which stem from a 2018 and 2019 Board report and cover an array of areas related to the consequences and benefits of AI use in the physician's practice. In pertinent part to this discussion, AMA Policy H-480.940 seeks to "promote development of thoughtfully designed, high-quality, clinically validated health care AI, encourage education for patients, physicians, medical students, other health care professionals, and health administrators to promote greater understanding of the promise and limitations of health care AI, and explore the legal implications

of health care AI, such as issues of liability or intellectual property, and advocate for appropriate professional and governmental oversight for safe, effective, and equitable use of and access to health care AI." This policy reflects not only the significance of attribution on the part of the developer, but furthermore emphasizes that physicians and other end users also play a role in understanding the technology and the risks involved with its use.

AMA Policy H.480.939 also addresses key aspects of accountability and liability by stating that "oversight and regulation of health care AI systems must be based on risk of harm and benefit accounting for a host of factors, including but not limited to: intended and reasonably expected use(s); evidence of safety, efficacy, and equity including addressing bias; AI system methods; level of automation; transparency; and, conditions of deployment." Furthermore, this policy asserts that "liability and incentives should be aligned so that the individual(s) or entity(ies) best positioned to know the AI system risks and best positioned to avert or mitigate harm do so through design, development, validation, and implementation. Specifically, developers of autonomous AI systems with clinical applications (screening, diagnosis, treatment) are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users."

AMA Policy D-480.956 supports "greater regulatory oversight of the use of augmented intelligence for review of patient claims and prior authorization requests, including whether insurers are using a thorough and fair process that: (1) is based on accurate and up-to-date clinical criteria derived from national medical specialty society guidelines and peer reviewed clinical literature; (2) includes reviews by doctors and other health care professionals who are not incentivized to deny care and with expertise for the service under review; and (3) requires such reviews include human examination of patient records prior to a care denial."

AMA Policy H-480.935 directs our AMA to study and develop recommendations on the benefits and unforeseen consequences to the medical profession of LLMs such as generative pretrained transformers (GPTs), and other augmented intelligence-generated medical advice or content. In addition to a report back to the HOD, this policy directs AMA to work with the federal government and other appropriate organizations to protect patients from false or misleading AI-generated medical advice; encourage physicians to educate patients about the benefits and risks of consumers facing LLMs including GPTs; and support publishing groups and scientific journals in efforts to ensure transparency and accountability of authors in the use and validation of text generated by augmented intelligence.

DISCUSSION

As the number of AI-enabled health care tools and systems continues to grow, these technologies must be designed, developed, and deployed in a manner that is ethical, equitable, responsible, accurate, and transparent. With a lagging effort towards adoption of national governance policies or oversight of AI, it is critical that the physician community engage in development of policies to help drive advocacy, inform patient and physician education, and guide engagement with these new technologies. It is also important that the physician community help guide development of these tools in a way that best meets both patient and physician needs, and help define their own organization's risk tolerance, particularly where AI impacts direct patient care. AI has significant potential to advance clinical care, reduce administrative burdens, and improve clinician well-being. This may only be accomplished by ensuring that physicians engage only with AI that satisfies rigorous, clearly defined standards to meet the goals of the quadruple aim,[5] advance health equity, prioritize patient safety, and limit risks to both patients and physicians.

Oversight of Health Care Augmented Intelligence

There is currently no national policy or governance structure in place to guide the development and adoption of non-medical device AI. As discussed above, the FDA regulates AI-enabled medical devices, but many types of AI-enabled technologies fall outside the scope of FDA oversight.[6] This potentially includes AI that may have clinical applications, such as some generative AI technologies serving clinical decision support functions. While the FTC and OCR have oversight over some aspects of AI, their authorities are limited and not adequate to ensure appropriate development and deployment of AI generally, and specifically in the health care space. Likewise, ASTP/ONC's enforcement is limited and focused on EHR developers' use and integration of AI within their federally certified EHRs. While this is a major first step in requiring AI transparency, it is still the EHR developer that is regulated with few requirements on the AI developer itself. Encouragement of a whole-of-government approach to implement governance policies will help to ensure that risks to consumers and patients arising from AI are mitigated to the greatest extent possible.

In addition to the government, health care institutions, practices, and professional societies share some responsibility for appropriate oversight and governance of AI-enabled systems and technologies. Beyond government oversight or regulation, purchasers and users of these technologies should have appropriate and sufficient policies in place to ensure they are acting in accordance with the current standard of care. Similarly, clinical experts are best positioned to determine whether AI applications are high quality, appropriate, and whether the AI tools are valid from a clinical perspective. Clinical experts can best validate the clinical knowledge, clinical pathways, and standards of care used in the design of AI-enabled tools and can monitor the technology for clinical validity as it evolves over time.

Transparency in Use of Augmented Intelligence-Enabled Systems and Technologies

As implementation of AI-enabled tools and systems increases, it is essential that use of AI in health care be transparent to both patients and physicians. Transparency requirements should be tailored in a way that best suits the needs of the end users. Care must be taken to preserve the integrity of data sets used in health care such that individual choice and data privacy are balanced with preserving algorithms that remain as pristine as possible to avoid exacerbating health care inequities. Disclosure should contribute to patient and physician knowledge without increasing administrative burden. When AI is utilized in health care decision-making at the point of care, that use should be disclosed and documented to limit risks to, and mitigate inequities for, both patients and physicians, and to allow each to understand how decisions impacting patient care or access to care are made. While transparency does not necessarily ensure AI-enabled tools are accurate, secure, or fair, it is difficult to establish trust if certain characteristics are hidden.

Heightened attention to transparency and additional transparency requirements serve several purposes. They help to ensure that the best possible decisions are made about a patient's health care and help patients and physicians identify critical decision points and possible points of error. They can also serve as mechanisms to help shield physicians from liability so that potential issues related to use of AI-enabled technologies can be isolated and accountability apportioned appropriately.

There are currently few federal requirements for transparency regarding AI. The FDA requires product labeling to provide certain information to physicians and other users, but requirements for device labeling are generally considered to be less stringent and have more leeway than drug product labeling. While FDA has stated that transparency is a key priority for the agency to address, they have not taken any additional action to update the labeling requirements for

AI-enabled medical devices or put into place additional transparency requirements for AI-enabled devices. As discussed above, ASTP/ONC also has new transparency requirements applicable to the use of AI within EHRs; however, again, those requirements are limited to AI within an EHR or other applications integrated and made available through the EHR. They will not apply to AI-enabled tools accessible through the Internet, cellular phones, etc. There is an urgent need for additional federal action to ensure AI transparency.

Transparency: Attributes and the Importance of Disclosure

During consideration of an earlier version of this report at the 2024 Annual Meeting, comments were heard during the online forum and Reference Committee B hearing regarding the recommendations on disclosure of use of AI to physicians and, ultimately, to patients. Commentors raised concerns that transparency regarding the use of AI would be overly burdensome to health systems and hospitals deploying AI and that transparency would entail disclosure of use of algorithms in any instance, including those used in EHRs, those for administrative purposes, and others that do not directly impact physician and patient decision-making. There were also concerns that the recommendations around transparency were akin to calling for burdensome informed consent for the use of AI and that disclosure of the use of AI to patients risks damaging the patient-physician relationship.

For the purposes of this report and its recommendations, "disclosure" should be understood to mean communicating to physicians or patients about the use of AI-enabled systems or technologies that directly impact medical decision making and treatment recommendations at the point of care.

Documentation involves recording of an AI system's design, development, and decision-making processes. This is primarily intended for internal teams, regulators, and researchers, and to enhance understanding, maintenance, and improvement of AI systems. Disclosure, on the other hand, refers to communicating essential information about AI systems to external stakeholders, e.g., end users. Disclosure focuses on essential aspects and, in this context, denotes the "when" and not the "what" to disclose. Concise and targeted disclosure is easier to disseminate and understand than comprehensive and nuanced details. It is important to note that disclosure should not be confused with informed consent. Informed consent is multifaceted, including benefits and drawbacks depending on its implementation and context of use. It can introduce burdens such as time-consuming paperwork, complex legal language, and potential delays in receiving care or participating in research. These burdens can deter individuals from providing their medical information or utilizing AI. Disclosure, on the other hand, is a form of transparency that builds trust, ensures accountability, supports risk management efforts, and informs users about the AI system's behavior without adding undue burden. Together, documentation and disclosure foster a comprehensive approach to AI transparency, addressing both internal and external needs.

The National Institute of Standards and Technology (NIST) frames AI risk management as a path to minimize potential negative impacts of AI systems, such as threats to civil liberties and rights, while also providing opportunities to maximize positive impacts. NIST adopted the International Organization for Standardization's (ISO) position that transparency and ethical behavior are a social responsibility when decisions and activities impact society and the environment (ISO 26000:2010).[7] NIST further states that addressing, documenting, disclosing, and managing AI risks and potential negative impacts effectively can lead to more trustworthy AI systems.[8] Moreover, multiple medical specialty organizations, including the American College of Radiology (ACR) and the American College of Physicians (ACP) support disclosure.

ACR's *Ethics of AI in Radiology* states that, for a model to be transparent, it must be both visible and understandable to outsiders, including patients. A practical approach to achieving transparency is through clear disclosure. Further, when AI is the main point of contact in health care, it is ACR's position that patients should be clearly informed that they are interacting with an AI tool. In its 2024 position paper *AI in the Provision of Health Care,* ACP emphasizes that AI transparency is important for patients as well as physicians and other clinicians. Even if patients are not, at present, explicitly informed of all the ways technology is involved in their care—for example, they may or may not be told about computer-assisted electrocardiogram or mammography interpretation—ACP asserts that, due to the novelty of AI and its potential for significant clinical impacts, honesty and transparency about its use are crucial. [9,10]

Given that transparency and disclosure are not static, their practicality or applicability are dependent on the situation and environment. ACP, for example, recognizes that transparency with patients about the integration of AI into certain devices may be reasonably feasible. In these cases, disclosure is more attuned to AI used in medical treatment and decision making and not the underlying algorithm, which could be overly burdensome. Algorithms are not new in health care; they are widely used, and many have become the standard of care. On the other hand, transparency with patients about AI integration into EHR systems and other common sources of information may be less feasible, especially given that physicians are often not made aware of the integration.

Nevertheless, as NIST notes, meaningful transparency should provide access to appropriate levels of information based on the stage of the AI lifecycle and tailored to the role or knowledge of individuals interacting with or using the AI system.

Ethical Considerations for Disclosure of the Use of AI that Impacts Clinical Decision Making

The AMA was founded in part to establish the world's first national code of medical ethics. Opinions included in the AMA Code of Medical Ethics aim to address issues and challenges confronting the medical profession and represent AMA policy. Promoting adherence to the professional standards promulgated in the Code is essential to preserving patient trust and public confidence in the medical profession.

Included as part of the Code are the ethical responsibilities of physicians as they relate to transparency in health care.[11] The Code states that "[p]atients must rely on their physicians to provide information that patients reasonably would want to know to make informed, well-considered decisions about their health care," and that "physicians have an obligation to inform patients about…tools that influence treatment recommendations and care." The Code additionally states that, where treatment recommendations are concerned, "[p]atients 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."[12]

Physician use of AI is not an exception to the Code, nor is there separate ethical guidance for the use of AI at this time. The Code suggests that communication to physicians and patients about the use of AI that may directly impact medical decision making and treatment recommendations is in line with prevailing ethical principles. It may be particularly important seeing that, at this time, patients are expressing broad discomfort with the notion of their physicians relying on AI in their own health care.[13] To best foster trust, both between physicians and developers/deployers, and between physicians and patients, use of AI that may directly impact medical decision making should be communicated to parties involved in that decision making.

Intersections between Physician Liability and Disclosure of the Use of AI in Clinical Practice

AI transparency, both in disclosing use to physicians and to patients as well as disclosure of key information to physicians regarding the tools by AI developers and deployers, is an essential component to managing risk and potentially reducing physician liability resulting from the use of AI. As with hardware devices and other medical products, physicians are ultimately responsible for the appropriate selection and use of devices, diagnostics, and other products in clinical practice. Claims of lack of knowledge or understanding of the system in question will likely weaken a defense in any medical liability case involving AI-enabled technology. Therefore, it is essential that both physicians and patients are aware when AI impacts clinical decision-making and understand how it factors into the process. This ensures that accountability and liability can be appropriately assigned when poor AI performance leads to poor patient outcomes, or where the AI-technology is itself defective (similar to when a device or diagnostic product is defective).

Required Disclosures by Health Care Augmented Intelligence-Enabled Systems and Technologies

Along with significant opportunity to improve patient care, all new technologies in health care will likely present certain risks and limitations that physicians must carefully navigate during the early stages of clinical implementation of these new systems and tools. AI-enabled tools are no different and are perhaps more challenging than other advances as they present novel and complex questions and risks. To best mitigate these risks, it is critical that physicians understand AI-driven technologies and have access to certain information about the AI tool or system being considered, including how it was trained and validated, so that they can assess the quality, performance, equity, and utility of the tool to the best of their ability. This information may also establish a set of baseline metrics for comparing AI tools. Transparency and explainability regarding the design, development, and deployment processes should be mandated by law where feasible, including potential sources of inequity in problem formulation, inputs, and implementation. Additionally, sufficient detail should be disclosed to allow physicians to determine whether a given AI-enabled tool would reasonably apply to the individual patient they are treating.

Physicians should be aware and understand that, where they utilize AI-enabled tools and systems without transparency provided by the AI developer, their risks of liability for reliance on that AI will likely increase. The need for full transparency is greatest where AI-enabled systems have greater impact on direct patient care, such as by AI-enabled medical devices, clinical decision support, and interaction with AI-driven chatbots. Transparency needs may be somewhat lower where AI is utilized for primarily administrative, practice-management functions.

While some of this information may be provided in labeling for FDA cleared and approved medical devices, the labeling requirements for such devices have not been specifically tailored to clearly convey information about these new types of devices. Updated guidance for FDA-regulated medical devices is needed to provide this critical information. Congress should consider actions to ensure appropriate authorities exist to require appropriate information to be provided to users of AI so that they can best evaluate the technology to determine reported performance, intended use, intended population, and appropriateness for the task. Developers and vendors should provide this information about their products, and physicians and other purchasers should consider this information when selecting the AI tools they use.

Generative AI

Generative AI is a type of AI that can recognize, summarize, translate, predict, and generate text and other content based on knowledge gained from large datasets. Generative AI tools are finding

an increasing number of uses in health care, including assistance with administrative functions, such as generating office notes, responding to documentation requests, and generating patient messages. Additionally, there has been increasing discussion about clinical applications of generative AI, including use as clinical decision support to provide differential diagnoses, early detection and intervention, and to assist in treatment planning. While generative AI tools show tremendous promise to make a significant contribution to health care, there are a number of risks and limitations to consider when using these tools in a clinical setting or for direct patient care. These risks are especially important to consider for clinical applications that may impact clinical decision-making and treatment planning where risks to patients are higher.

Given that there are no regulations or generally accepted standards or frameworks to govern the design, development, and deployment of generative AI, consideration and mitigation of the significant risks are paramount. To manage risk, health care organizations should develop and adopt appropriate polices that anticipate and minimize negative impacts. Physicians who consider utilizing a generative AI-based tool in their practice should ensure that all practice staff are educated on the risks and limitations, including patient privacy concerns, and should have appropriate governance policies in place for its use prior to adoption. Also, as raised in Resolution 206-I-23, physicians should be encouraged to educate their patients about the benefits and risks of using AI-based tools, such as LLMs, for information about health care conditions, treatment options, or the type of health care professionals who have the education, training, and qualifications to treat a particular condition. Patients and physicians should be aware that chatbots powered by LLMs/generative AI could provide inaccurate, misleading, or unreliable information and recommendations. This principle is incorporated in the recommendations in this report and current AMA Policy H-480.940, "Augmented Intelligence in Health Care."

Liability

The question of physician liability for use of AI-enabled technologies presents novel and complex legal questions and poses risks to the successful clinical integration of AI-enabled technologies. It is also one of the most serious concerns for physicians when considering integration of AI into their practice. Concerns also arise for employed physicians who feel they may have no choice but to utilize the AI, should hospitals or health systems mandate its use or utilize an EHR system that incorporates AI-based applications as standard.

The challenge for physicians regarding questions of liability for use of AI is that there is not yet any clear legal standard for determining liability. While there are clear standards for physician liability generally and for medical device liability, AI presents novel and potentially complex legal questions. When AI has suggested a diagnosis, the question of how appropriate it is for a physician to rely on that result is yet to be determined and will likely continue to evolve as AI improves. Ultimately the "standard of care" will help guide physician liability. It is expected that, as it improves over time, AI will be incorporated into what is likely to be specialty-specific standards of care. However, until that occurs, AI-transparency is of critical importance and physicians will need to be diligent in ensuring that they engage with AI tools where performance has been validated in their practice setting.

As AI continues to evolve, there may ultimately be questions regarding liability when physicians fail to use AI and rely only on their professional judgment. Again, this question may ultimately turn on what evolves to be considered the standard of care.

It should be noted that, when using AI, physicians will still be subject to general legal theories regarding medical liability. Negligent selection of an AI tool, including using tools outside their

intended use or intended population, or choosing a tool where there is no evidence of clinical validation, could be decisions that expose a physician to a liability claim.

Data Privacy and Augmented Intelligence

Data privacy is highly relevant to AI development, implementation, and use. The AMA is deeply invested in ensuring individual patient rights and protections from discrimination remain intact, that these assurances are guaranteed, and that the responsibility rests with the data holders. AI development, training, and use requires assembling large collections of health data. AI machine learning is data hungry; it requires massive amounts of data to function properly. Increasingly, more electronic health records are interoperable across the health care system and, therefore, are accessible by AI trained or deployed in medical settings. AI developers may enter into legal arrangements (e.g., business associate agreements) that bring them under the HIPAA Privacy and Security Rules. However, physicians and medical providers are often seen as the sole responsible parties, expected to bear the burden of data protection. This position is not sustainable. Given the newness of AI and its potential for clinically significant effects on care, equitable accountability must be established. While some uses of AI in health care, such as research, are not allowed by HIPAA absent patient authorization, the applicability of other HIPAA privacy protections to AI use is not as clear and HIPAA cannot protect patients from the "black box" nature of AI which makes the use of data opaque. AI system outputs may also include inferences that reveal personal data or previously confidential details about individuals. This can result in a lack of accountability and trust and exacerbate data privacy concerns. Often, AI developers and implementers are themselves unaware of exactly how their products use information to make recommendations.

It is unlikely that physicians or patients will have any clear insight into a generative AI tool's conformance to state or federal data privacy laws. LLMs are trained on data scraped from the web and other digital sources, including one well-documented instance where HIPAA privacy protections were violated.[14] Few, if any, controls are available to help users protect the data they voluntarily enter in a chatbot query. For instance, there are often no mechanisms in place for users to request data deletion or ensure that their inputs are not stored or used for future model training. While tools designed for medical use should align with HIPAA, many "HIPAA-compliant" generative tools rely on antiquated notions of deidentification, i.e., stripping data of personal information. With today's advances in computing power, data can easily be reidentified. Rather than aiming to make LLMs compliant with HIPAA, all health care AI-powered generative tools should be designed from the ground up with data privacy in mind. Additionally, some companies have intentionally misled the public and end-users by labeling their software tools as "HIPAA compliant", when the entity itself was not a covered entity or business associate and therefore not subject to HIPAA Privacy Rules.

The AMA's Privacy Principles were designed to provide individuals with rights and protections and shift the responsibility for privacy to third-party data holders. While the Principles are broadly applicable to all AI developers, e.g., entities should only collect the minimum amount of information needed for a particular purpose, the unique nature of LLMs and generative AI warrant special emphasis on entity responsibility and user education.

Augmented Intelligence Cybersecurity

Data privacy relies on strong data security measures. There is growing concern that cyber criminals will use AI to attack health care organizations. AI poses new threats to health IT operations. AI-operated ransomware and AI-operated malware can be targeted to infiltrate health IT systems and automatically exploit vulnerabilities. Attackers using ChatGPT can craft convincing or authentic

emails and use phishing techniques that entice people to click on links—giving them access to the entire electronic health record system.

AI is particularly sensitive to the quality of data. Data poisoning is the introduction of "bad" data into an AI training set, affecting the model's output. AI requires large sets of data to build logic and patterns used in clinical decision-making. Protecting this source data is critical. Threat actors could also introduce input data that compromises the overall function of the AI tool. Failure to secure and validate these inputs, and corresponding data, can contaminate AI models—resulting in patient harm.

Because stringent privacy protections and higher data quality standards might slow model development, there could be a tendency to forgo essential data privacy and security precautions. However, strengthening AI systems against cybersecurity threats is crucial to their reliability, resiliency, and safety.

Mis- and Disinformation Propagated by AI

Health mis- and disinformation poses a serious threat to public health. It can cause significant confusion among patients, increase patient mistrust in science and in physicians, result in patients making decisions that cause themselves harm, and undermine the ability to manage public health threats. The dissemination of mis- and disinformation in health care significantly increased during the COVID-19 pandemic and shows no signs of abating. Whether intentionally or unintentionally, AI, in particular generative AI, runs the risk of contributing to the creation and dissemination of scientific and medical mis- and disinformation. Physicians, staff, and patients must all be aware of the risks of mis- and disinformation when engaging with generative and other forms of AI. Generative AI can propagate mis- and disinformation in several ways. It can engage in the unintentional or intentional creation of incorrect information on its own. The risk of generative AI "hallucinating," "confabulating," or otherwise fabricating information in response to a user-generated query has been well documented.[15,16] Notably, tools such as ChatGPT have shown a not-uncommon tendency to falsify references cited in response to these queries. Generative AI tools have demonstrated the ability to generate fraudulent scientific/medical literature.[17] They are also capable of plagiarizing, falsifying, or misrepresenting data in ways that could compromise research integrity. Additionally, retracted papers may have the ability to continue to impact the content generated by LLM-based tools, potentially leading to dissemination or inaccurate or otherwise discredited information.

AI can also be responsible for intentionally or unintentionally disseminating false information or intentional misinformation, which can happen when that information is used as part of the training data set for the model, used as a reference in a response to a query, or otherwise presented to a user in a query response. Information presented to users by generative AI models can be extremely convincing, with the users potentially having little reason to doubt what is presented.

There is little opportunity currently to regulate AI's role in propagation of health mis- and disinformation under current oversight structures. The FTC is the most likely agency to take action against mis- and disinformation, as it has broad authorities to regulate unfair and deceptive business practices. However, as discussed above, the FTC will require additional resources to appropriately regulate the role of AI in propagating mis- and disinformation. Regulation of mis- and disinformation is further complicated by the intersection of false and misleading information with free speech rights guaranteed by the First Amendment.

It is critical that the health care industry and health care stakeholders broadly take action to limit AI's ability to create or disseminate mis- or disinformation. Developers of AI should be accountable for their product creating or disseminating false information and should have mechanisms in place to allow for reporting of mis- and disinformation. Federal regulations should seek to eliminate the propagation of mis- and disinformation by AI-enabled tools. Ethical principles for use of AI in medical and scientific research should be in place to ensure continued research integrity. Journals should ensure that they have clear guidelines in place to regulate the use of AI in scientific publications that include documenting and detailing the use of AI in research and to exclude the use of AI systems as authors. Policies should also detail the responsibility of authors to validate the veracity of any text generated by AI. (See Policy H-480.935, Assessing the Potentially Dangerous Intersection Between AI and Misinformation).

Payor Use of Augmented Intelligence in Automated Decision-Making

Payors and health plans are increasingly using AI and algorithm-based decision-making in an automated fashion to determine coverage limits, make claim determinations, and engage in benefit design. Payors should leverage automated decision-making systems that improve or enhance efficiencies in coverage and payment automation, facilitate administrative simplification, and reduce workflow burdens. While the use of these systems can create efficiencies such as speeding up prior authorization and cutting down on paperwork, there is concern these systems are not being designed or supervised effectively creating access barriers for patients and limiting essential benefits.

Increasingly, evidence indicates that payors are using automated decision-making systems to deny care more rapidly, often with little or no human review. This manifests in the form of increased denials, stricter coverage limitations, and constrained benefit offerings. For example, a payor allowed an automated system to cut off insurance payments for Medicare Advantage patients struggling to recover from severe diseases, forcing them to forgo care or pay out of pocket. In some instances, payors instantly reject claims on medical grounds without opening or reviewing the patient's medical record. There is also a lack of transparency in the development of automated decision-making systems. Rather than payors making determinations based on individualized patient care needs, reports show that decisions are based on algorithms developed using average or "similar patients" pulled from a database. Models that rely on generalized, historical data can also perpetuate biases leading to discriminatory practices or less inclusive coverage.[18,19,20,21]

While AI can be used inappropriately by payors with severe detrimental outcomes to patients, it can also serve to reduce administrative burdens on physicians, providing the ability to more easily submit prior authorization and documentation requests in standardized forms that require less physician and staff time. Given the significant burden placed on physicians and administrative staff by prior authorization requests, AI could provide much needed relief and help to increase professional satisfaction among health care professionals. With clear guidelines, AI-enabled decision-making systems may also be appropriate for use in some lower-risk, less complex care decisions.

While payor use of AI in well-defined situations with clear guidelines has the potential to reduce burdens and benefit physician practices, new regulatory or legislative action is necessary to ensure that automated decision-making systems do not reduce needed care, nor systematically withhold care from specific groups. Steps should be taken to ensure that these systems do not override clinical judgment. Patients and physicians should be informed and empowered to question a payor's automated decision-making. There should be stronger regulatory oversight, transparency, and audits when payors use these systems for coverage, claim determinations, and benefit design.

[See Policy D-480.956, "Use of Augmented Intelligence for Prior Authorization;" and Policy H-320.939, "Prior Authorization and Utilization Management Reform"]

CONCLUSION

As the number of AI-enabled health care tools and systems continue to grow, these technologies must be designed, developed, and deployed in a manner that is ethical, equitable, responsible, accurate, and transparent. In line with AMA Policy H-480-935 and Resolution 206-I-23, this report highlights some of the potential benefits and risks to the medical profession and patients of LLMs (e.g., GPTs) and other AI-generated medical decision-making tools, and recommends adoption of policy to help inform patient and physician education and guide engagement with this new technology, as well as position the AMA to advocate for governance policies that help to ensure that risks arising from AI are mitigated to the greatest extent possible.

RECOMMENDATION

The Board of Trustees recommends that the following be adopted as new policy in lieu of Resolution 206-I-23 and that the remainder of the report be filed:

AUGMENTED INTELLIGENCE DEVELOPMENT, DEPLOYMENT, AND USE IN HEALTH CARE

1) General Governance
    a) Health care AI must be designed, developed, and deployed in a manner which is ethical, equitable, responsible, accurate, and transparent.
    b) Use of AI in health care delivery requires clear national governance policies to regulate its adoption and utilization, ensuring patient safety, and mitigating inequities. Development of national governance policies should include interdepartmental and interagency collaboration.
    c) Compliance with national governance policies is necessary to develop AI in an ethical and responsible manner to ensure patient safety, quality, and continued access to care. Voluntary agreements or voluntary compliance is not sufficient.
    d) AI systems should be developed and evaluated with a specific focus on mitigating bias and promoting health equity, ensuring that the deployment of these technologies does not exacerbate existing disparities in health care access, treatment, or outcomes.
    e) Health care AI requires a risk-based approach where the level of scrutiny, validation, and oversight should be proportionate to the overall potential of disparate harm and consequences the AI system might introduce. [See also Augmented Intelligence in Health Care H-480.939 at (1)]
    f) AI risk management should minimize potential negative impacts of health care AI systems while providing opportunities to maximize positive impacts.
    g) Clinical decisions influenced by AI must be made with specified human intervention points during the decision-making process. As the potential for patient harm increases, the point in time when a physician should utilize their clinical judgment to interpret or act on an AI recommendation should occur earlier in the care plan. With few exceptions, there generally should be a human in the loop when it comes to medical decision making capable of intervening or overriding the output of an AI model.
    h) Health care practices and institutions should not utilize AI systems or technologies that introduce overall or disparate risk that is beyond their capabilities to mitigate. Implementation and utilization of AI should avoid exacerbating clinician burden and should be designed and deployed in harmony with the clinical workflow and, in

institutional settings, consistent with AMA Policy H-225.940 - Augmented Intelligence and Organized Medical Staff.

i) Medical specialty societies, clinical experts, and informaticists are best positioned and should identify the most appropriate uses of AI-enabled technologies relevant to their clinical expertise and set the standards for AI use in their specific domain. [See Augmented Intelligence in Health Care H-480.940 at (2)]

2) When to Disclose: Transparency in Use of Augmented Intelligence-Enabled Systems and Technologies That Impact Medical Decision Making at the Point of Care
   a) Decisions regarding transparency and disclosure of the use of AI should be based upon a risk- and impact-based approach that considers the unique circumstance of AI and its use case. The need for transparency and disclosure is greater where the performance of an AI-enabled technology has a greater risk of causing harm to a patient.
      i) AI disclosure should align and meet ethical standards or norms.
      ii) Transparency requirements should be designed to meet the needs of the end users. Documentation and disclosure should enhance patient and physician knowledge without increasing administrative burden.
      iii) When AI is used in a manner which impacts access to care or impacts medical decision making at the point of care, that use of AI should be disclosed and documented to both physicians and/or patients in a culturally and linguistically appropriate manner. The opportunity for a patient or their caregiver to request additional review from a licensed clinician should be made available upon request.
      iv) When AI is used in a manner which directly impacts patient care, access to care, medical decision making, or the medical record, that use of AI should be documented in the medical record.
   b) AI tools or systems cannot augment, create, or otherwise generate records, communications, or other content on behalf of a physician without that physician's consent and final review.
   c) When AI or other algorithmic-based systems or programs are utilized in ways that impact patient access to care, such as by payors to make claims determinations or set coverage limitations, use of those systems or programs must be disclosed to impacted parties.
   d) The use of AI-enabled technologies by hospitals, health systems, physician practices, or other entities, where patients engage directly with AI, should be clearly disclosed to patients at the beginning of the encounter or interaction with the AI-enabled technology. Where patient-facing content is generated by AI, the use of AI in generating that content should be disclosed or otherwise noted within the content.

3) What to Disclose: Required Disclosures by Health Care Augmented Intelligence-Enabled Systems and Technologies
   a) When AI-enabled systems and technologies are utilized in health care, the following information should be disclosed by the AI developer to allow the purchaser and/or user (physician) to appropriately evaluate the system or technology prior to purchase or utilization:
      i) Regulatory approval status.
      ii) Applicable consensus standards and clinical guidelines utilized in design, development, deployment, and continued use of the technology.
      iii) Clear description of problem formulation and intended use accompanied by clear and detailed instructions for use.
      iv) Intended population and intended practice setting.
      v) Clear description of any limitations or risks for use, including possible disparate impact.

vi) Description of how impacted populations were engaged during the AI lifecycle.
vii) Detailed information regarding data used to train the model:
(1) Data provenance.
(2) Data size and completeness.
(3) Data timeframes.
(4) Data diversity.
(5) Data labeling accuracy.
viii) Validation Data/Information and evidence of:
(1) Clinical expert validation in intended population and practice setting and intended clinical outcomes.
(2) Constraint to evidence-based outcomes and mitigation of "hallucination"/"confabulation" or other output error.
(3) Algorithmic validation.
(4) External validation processes for ongoing evaluation of the model performance, e.g., accounting for AI model drift and degradation.
(5) Comprehensiveness of data and steps taken to mitigate biased outcomes.
(6) Other relevant performance characteristics, including but not limited to performance characteristics at peer institutions/similar practice settings.
(7) Post-market surveillance activities aimed at ensuring continued safety, performance, and equity.
ix) Data Use Policy:
(1) Privacy.
(2) Security.
(3) Special considerations for protected populations or groups put at increased risk.
x) Information regarding maintenance of the algorithm, including any use of active patient data for ongoing training.
xi) Disclosures regarding the composition of design and development team, including diversity and conflicts of interest, and points of physician involvement and review.

b) Purchasers and/or users (physicians) should carefully consider whether or not to engage with AI-enabled health care technologies if this information is not disclosed by the developer. As the risk of AI being incorrect increases risks to patients (such as with clinical applications of AI that impact medical decision making), disclosure of this information becomes increasingly important. [See also Augmented Intelligence in Health Care H-480.939]

4) Generative Augmented Intelligence

a) Generative AI should: (a) only be used where appropriate policies are in place within the practice or other health care organization to govern its use and help mitigate associated risks; and (b) follow applicable state and federal laws and regulations (e.g., HIPAA-compliant Business Associate Agreement).

b) Appropriate governance policies should be developed by health care organizations and account for and mitigate risks of:
i) Incorrect or falsified responses; lack of ability to readily verify the accuracy of responses or the sources used to generate the response.
ii) Training data set limitations that could result in responses that are out of date or otherwise incomplete or inaccurate for all patients or specific populations.
iii) Lack of regulatory or clinical oversight to ensure performance of the tool.
iv) Bias, discrimination, promotion of stereotypes, and disparate impacts on access or outcomes.
v) Data privacy.
vi) Cybersecurity.

vii) Physician liability associated with the use of generative AI tools.

c) Health care organizations should work with their AI and other health information technology (health IT) system developers to implement rigorous data validation and verification protocols to ensure that only accurate, comprehensive, and bias managed datasets inform generative AI models, thereby safeguarding equitable patient care and medical outcomes. [See Augmented Intelligence in Health Care H-480.940 at (3)(d)]

d) Use of generative AI should incorporate physician and staff education about the appropriate use, risks, and benefits of engaging with generative AI. Additionally, physicians should engage with generative AI tools only when adequate information regarding the product is provided to physicians and other users by the developers of those tools.

e) Clinicians should be aware of the risks of patients engaging with generative AI products that produce inaccurate or harmful medical information (e.g., patients asking chatbots about symptoms) and should be prepared to counsel patients on the limitations of AI-driven medical advice.

f) Governance policies should prohibit the use of confidential, regulated, or proprietary information as prompts for generative AI to generate content.

g) Data and prompts contributed by users should primarily be used by developers to improve the user experience and AI tool quality and not simply increase the AI tool's market value or revenue generating potential.

5) Physician Liability for Use of Augmented Intelligence-Enabled Technologies

a) Current AMA policy states that liability and incentives should be aligned so that the individual(s) or entity(ies) best positioned to know the AI system risks and best positioned to avert or mitigate harm do so through design, development, validation, and implementation. [See Augmented Intelligence in Health Care H-480.939]

i) Where a mandated use of AI systems prevents mitigation of risk and harm, the individual or entity issuing the mandate must be assigned all applicable liability.

ii) Developers of autonomous AI systems with clinical applications (screening, diagnosis, treatment) are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.

iii) Health care AI systems that are subject to non-disclosure agreements concerning flaws, malfunctions, or patient harm (referred to as gag clauses) must not be covered or paid and the party initiating or enforcing the gag clause assumes liability for any harm.

b) When physicians do not know or have reason to know that there are concerns about the quality and safety of an AI-enabled technology, they should not be held liable for the performance of the technology in question.

6) Data Privacy and Augmented Intelligence

a) Entity Responsibility:

i) Entities, e.g., AI developers, should make information available about the intended use of generative AI in health care and identify the purpose of its use. Individuals should know how their data will be used or reused, and the potential risks and benefits.

ii) Individuals should have the right to opt-out, update, or request deletion of their data from generative AI tools. These rights should encompass AI training data and disclosure to other users of the tool.

iii) Generative AI tools should not reverse engineer, reconstruct, or reidentify an individual's originally identifiable data or use identifiable data for nonpermitted uses, e.g., when data are permitted to conduct quality and safety evaluations. Preventive

measures should include both legal frameworks and data model protections, e.g., secure enclaves, federated learning, and differential privacy.

b) User Education:
   i) Users should be provided with training specifically on generative AI. Education should address:
      (1) Legal, ethical, and equity considerations.
      (2) Risks such as data breaches and re-identification.
      (3) Potential pitfalls of inputting sensitive and personal data.
      (4) The importance of transparency with patients regarding the use of generative AI and their data.

[See H-480.940, Augmented Intelligence in Health Care, at (4) and (5)]

7) Augmented Intelligence Cybersecurity
   a) AI systems must have strong protections against input manipulation and malicious attacks.
   b) Entities developing or deploying health care AI should regularly monitor for anomalies or performance deviations, comparing AI outputs against known and normal behavior.
   c) Independent of an entity's legal responsibility to notify a health care provider or organization of a data breach, that entity should also act diligently in identifying and notifying the individuals themselves of breaches that impact their personal information.
   d) Users should be provided education on AI cybersecurity fundamentals, including specific cybersecurity risks that AI systems can face, evolving tactics of AI cyber attackers, and the user's role in mitigating threats and reporting suspicious AI behavior or outputs.

8) Mitigating Misinformation in AI-Enabled Technologies
   a) AI developers should ensure transparency and accountability by disclosing how their models are trained and the sources of their training data. Clear disclosures are necessary to build trust in the accuracy and reliability of the information produced by AI systems.
   b) Algorithms should be developed to detect and flag potentially false and misleading content before it is widely disseminated.
   c) Developers of AI should have mechanisms in place to allow for reporting of mis- and disinformation generated or propagated by AI-enabled systems.
   d) Developers of AI systems should be guided by policies that emphasize rigorous validation and accountability for the content their tools generate, and, consistent with AMA Policy H-480.939(7), are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.
   e) Academic publications and journals should establish clear guidelines to regulate the use of AI in manuscript submissions. These guidelines should include requiring the disclosure that AI was used in research methods and data collection, requiring the exclusion of AI systems as authors, and should outline the responsibility of the authors to validate the veracity of any referenced content generated by AI.
   f) Education programs are needed to enhance digital literacy, helping individuals critically assess the information they encounter online, particularly in the medical field where mis- and disinformation can have severe consequences.

9) Payor Use of Augmented Intelligence and Automated Decision-Making Systems
   a) Use of automated decision-making systems that determine coverage limits, make claim determinations, and engage in benefit design should be publicly reported, based on easily accessible evidence-based clinical guidelines (as opposed to proprietary payor criteria), and disclosed to both patients and their physician in a way that is easy to understand.

b) Payors should only use automated decision-making systems to improve or enhance efficiencies in coverage and payment automation, facilitate administrative simplification, and reduce workflow burdens. Automated decision-making systems should never create or exacerbate overall or disparate access barriers to needed benefits by increasing denials, coverage limitations, or limiting benefit offerings. Use of automated decision-making systems should not replace the individualized assessment of a patient's specific medical and social circumstances and payors' use of such systems should allow for flexibility to override automated decisions. Payors should always make determinations based on particular patient care needs and not base decisions on algorithms developed on "similar" or "like" patients.

c) Payors using automated decision-making systems should disclose information about any algorithm training and reference data, including where data were sourced and attributes about individuals contained within the training data set (e.g., age, race, gender). Payors should provide clear evidence that their systems do not discriminate, increase inequities, and that protections are in place to mitigate bias.

d) Payors using automated decision-making systems should identify and cite peer-reviewed studies assessing the system's accuracy measured against the outcomes of patients and the validity of the system's predictions.

e) Any automated decision-making system recommendation that indicates limitations or denials of care, at both the initial review and appeal levels, should be automatically referred for review to a physician (a) possessing a current and valid non-restricted license to practice medicine in the state in which the proposed services would be provided if authorized and (b) be of the same specialty as the physician who typically manages the medical condition or disease or provides the health care service involved in the request prior to issuance of any final determination. Prior to issuing an adverse determination, the treating physician must have the opportunity to discuss the medical necessity of the care directly with the physician who will be responsible for determining if the care is authorized.

f) Individuals impacted by a payor's automated decision-making system, including patients and their physicians, must have access to all relevant information (including the coverage criteria, results that led to the coverage determination, and clinical guidelines used).

g) Payors using automated decision-making systems should be required to engage in regular system audits to ensure use of the system is not increasing overall or disparate claims denials or coverage limitations, or otherwise decreasing access to care. Payors using automated decision-making systems should make statistics regarding systems' approval, denial, and appeal rates available on their website (or another publicly available website) in a readily accessible format with patient population demographics to report and contextualize equity implications of automated decisions. Insurance regulators should consider requiring reporting of payor use of automated decision-making systems so that they can be monitored for negative and disparate impacts on access to care. Payor use of automated decision-making systems must conform to all relevant state and federal laws.

(New HOD Policy)

Fiscal Note: Less than $500.

REFERENCES

[1] https://www.ama-assn.org/system/files/ama-patient-data-privacy-survey-results.pdf.
[2] https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/government/advocacy/medical-cybersecurity-findings.pdf.
[3] https://www.healthit.gov/sites/default/files/page/2024-01/DSI_HTI1%20Final%20Rule%20Presentation_508.pdf.
[4] https://www.propublica.org/article/cigna-health-insurance-denials-pxdx-congress-investigation#:~:text=The%20letter%20follows%20an%20investigation,PXDX%20system%2C%20spending%20an%20average.
[5] AI systems should enhance the patient experience of care and outcomes, improve population health, reduce overall costs for the health care system while increasing value, and support the professional satisfaction of physicians and the health care team.
6 For example, the 21st Century Cures Act includes several exemptions to FDA's oversight, such as software intended for administrative support of a health care facility, maintaining or encouraging a healthy lifestyle (and is unrelated to the diagnosis, cure, mitigation, prevention, or treatment of a disease or condition), is intended to be used as electronic patient records, is intended for transferring, storing, converting formats, or displaying data or results, and otherwise does not meet the definition of a medical device under the Federal Food, Drug, and Cosmetic Act.
[7] https://www.iso.org/obp/ui/en/#iso:std:iso:26000:ed-1:v1:en.
[8] https://nvlpubs.nist.gov/nistpubs/ai/NIST.AI.100-1.pdf.
[9] https://www.acr.org/-/media/ACR/Files/Informatics/Ethics-of-AI-in-Radiology-European-and-North-American-Multisociety-Statement--6-13-2019.pdf
[10] https://www.acpjournals.org/doi/10.7326/M24-0146?_gl=1*e8j406*_gcl_au*MzQ3MzI3OTcuMTcyMTY1OTI1Mw..*_ga*NzM2MjYxNTIxLjE3MjE2NTkyNTM.*_ga_PM4F5HBGFQ*MTcyMTY1OTI1Mi4xLjAuMTcyMTY1OTI1Mi42MC4wLjA.&_ga=2.223886232.2016482322.1721659253-736261521.1721659253.
[11] https://code-medical-ethics.ama-assn.org/ethics-opinions/transparency-health-care#:~:text=Respect%20for%20patients'%20autonomy%20is,influence%20treatment%20recommendations%20and%20care.
[12] https://code-medical-ethics.ama-assn.org/chapters/consent-communication-decision-making.
[13] https://www.pewresearch.org/science/2023/02/22/60-of-americans-would-be-uncomfortable-with-provider-relying-on-ai-in-their-own-health-care/.
[14] Feathers, T., et al. "Facebook is receiving sensitive medical information from hospital websites. The Markup. June 16, 2022." https://themarkup.org/pixel-hunt/2022/06/16/facebook-is-receiving-sensitive-medical-information-from-hospital-websites.
[15] https://www.cnet.com/tech/hallucinations-why-ai-makes-stuff-up-and-whats-being-done-about-it/.
[16] https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2808091.
[17] https://www.jmir.org/2023/1/e46924/.
[18] Obermeyer, Ziad, et al. "Dissecting racial bias in an algorithm used to manage the health of populations." Science 366.6464 (2019): 447-453. https://www.science.org/doi/10.1126/science.aax2342.
[19] Ross, C., Herman, B. (2023) "Medicare Advantage Plans' Use of Artificial Intelligence Leads to More Denials." https://www.statnews.com/2023/03/13/medicare-advantage-plans-denial-artificial-intelligence/ (Accessed September 14, 2023).
[20] Rucker, P., Miller, M., Armstrong, D. (2023). "Cigna and Its Algorithm Deny Some Claims for Genetic Testing, ProPublica Finds." https://www.propublica.org/article/cigna-pxdx-medical-health-insurance-rejection-claims (Accessed September 14, 2023).
[21] Ross, C., Herman, B. (2023). "Medicare Advantage Algorithms Lead to Coverage Denials, With Big Implications for Patients." https://www.statnews.com/2023/07/11/medicare-advantage-algorithm-navihealth-unitedhealth-insurance-coverage/ (Accessed September 14, 2023).

REPORT 02 OF THE BOARD OF TRUSTEES (I-24)
On-Site Physician Requirements for Emergency Departments (Resolution 207-I-23)
Reference Committee B

EXECUTIVE SUMMARY

This American Medical Association (AMA) Board of Trustees report considers the appropriateness and scope of "limited rural exceptions" to proposed policy requiring the real-time, on-site presence of a qualified physician in the emergency department (ED) at all times, whose primary duty is to treat patients seeking care in that ED.

AMA policy broadly supports physician-led care in all health care settings. It also promotes physician supervision of care in the ED and supports a requirement that a physician must always "staff" the ED. Existing policy does not, however, address whether a 24/7 staffing requirement always implies the on-site presence of the physician in the ED.

Rural EDs—particularly smaller EDs in remote areas—face a different operational situation than those located in urban areas. Physicians report, and the literature supports, that these realities may make a 24/7 on-site physician requirement impracticable for certain rural EDs. While many rural EDs across the country are at risk of closure, hurdles associated with such a requirement are not primarily financial. Problems recruiting and retaining physicians to staff the ED 24/7 in some rural facilities are reported to be a challenge. Further, low census in many rural EDs may warrant different approaches to resource utilization than those pursued by larger metropolitan institutions, which may see higher patient volume.

Assessment, stabilization, and arranging appropriate transfer of high-acuity rural ED patients is critical. Physicians are best equipped to provide this type of emergency care. As such, an ideal ED staffing model will require the presence of a physician to provide care to high-acuity patients who present to the ED. Still, some physician-led care models may appropriately allow a physician to be always staffed in a rural ED 24/7, not necessarily physically present in that ED, but proximate in location and present on-site promptly. Rural hospital staffing challenges due to physician workforce limitations may necessitate limited adoption of specified alternative supervision models. These models include allowing the physician to provide care outside the ED while being on duty in the ED, requiring that the physician be available to be physically present in the ED within a specified timeframe, and certain uses of telehealth.

The application of any rural exception that would allow for this type of extended supervision likely most appropriately applied to the subset of rural EDs located in the country's most remote areas, which are most likely to face insurmountable barriers to adherence to a 24/7 on-site physician policy. However, making proper delineations when it comes to the exception's applicability is difficult, in part because there is no widely agreed-upon definition of rurality, and in part because additional factors, such as patient volume, are relevant. The unique needs of each state should be considered when determining how to apply any rural exceptions.

This report makes a concerted effort to pay due respect to the unique operational realities faced by rural EDs, while balancing the integrity of AMA policy on physician-led care. Ultimately, the recommendations proffered aim both to preserve physician supervision in the ED and to account for the needs of rural EDs—especially those in very remote areas.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 02-I-24

Subject: On-Site Physician Requirements for Emergency Departments (RES 207-I-23)

Presented by: Michael Suk, MD, JD, MPH, MBA, Chair,

Referred to: Reference Committee B

INTRODUCTION

This American Medical Association (AMA) Board of Trustees report arises from Resolution 207-I-23, "On-Site Physician Requirement for EDs." As introduced by the Michigan Delegation. Resolution 207 called upon the AMA to develop model legislation and support requirements for the real-time, on-site presence of a physician in the emergency department (ED), whose primary duty is to treat patients seeking care in that ED.

The AMA House of Delegates (HOD) referred the following language for study (Resolution 207-I-23) (emphasis in original):

> RESOLVED, that our American Medical Association develop model state legislation and support federal and state legislation or regulation, **with appropriate consideration for limited rural exceptions**, requiring all facilities that imply the provision of emergency medical care have the real-time, on-site presence of a physician, and on-site supervision of non-physician practitioners (e.g., physician assistants and advanced practice nurses) by a licensed physician with training and experience in emergency medical care whose primary duty is dedicated to patients seeking emergency medical care in that ED. (Directive to Take Action)

Testimony in favor of Resolution 207 suggested that the AMA should take a firm stance on physician supervision in the ED based on existing AMA policy related to physician-led team-based care and as part of AMA's robust campaign promoting physician-led care. At the same time, robust testimony was heard against this resolution—exclusively from physicians representing rural delegations—expressing that the proposed requirement would be untenable for many rural hospitals and could lead to closures, ultimately depriving patients access to emergency care.

BACKGROUND

Brief Overview of Relevant AMA Policy

AMA policy that pre-dated this resolution, as well as policy that was passed concurrent with the drafting of this report, provides necessary context for the referred language. AMA has extensive policy promoting physician-led care. For example, AMA Policy H-160.949, "Practicing Medicine by Non-Physicians," provides that the AMA vigorously supports appropriate physician supervision of non-physician clinical staff in all areas of medicine, and AMA Policy H-160.947, "Physician

Assistants and Nurse Practitioners," establishes that the physician should be responsible for managing the health care of patients in all settings.

More specifically to care provided in EDs, AMA Policy D-35.976, "Promoting Supervision of Emergency Care Services in Emergency Departments by Physicians," establishes AMA's support for laws that "ensure only physicians supervise the provision of emergency care services in an ED."[1] On top of that, after the referral of Resolution 207 at the AMA 2023 Interim Meeting and concurrent with the drafting of this report, the HOD at the 2024 Annual Meeting adopted new policy stating that, "AMA will support that all EDs be staffed 24/7 by a qualified physician."[2] Altogether, AMA policy promotes physician supervision of care in the ED and supports a requirement that a physician must staff the ED at all times. Notably, however, policy does not address whether a 24/7 staffing requirement always implies the real-time, on-site presence of the physician in the ED as suggested by Resolution 207.

Scope of This Report

Given the purview of the referred language and the strength of existing policy addressing physician-led care in the ED and in all health care settings, this report is narrow in scope and specific in focus. It considers the possibility of limited rural exceptions to potential legislation or regulation that would require the real-time, on-site presence of a physician in the ED, whose primary duty is to treat patients in that ED. In so doing, this report explores challenges faced by rural EDs that may impact their staffing decisions. It gives special consideration to the operational realities experienced by EDs in the country's most remote rural areas, and takes care to appreciate concerns, expressed by physicians with lived experience in rural areas, that a round-the-clock, on-site physician supervision requirement would be untenable and possibly devastating for many rural hospitals, many of which are at risk of closure.

The aforementioned AMA policies guide the Board's approach to this report. To summarize, existing AMA policy demands that any rural exceptions to a requirement that the ED be supervised by an on-site physician who is primarily responsible for care in that ED must (a) preserve physician-led care and (b) ensure that the ED remains "staffed 24/7" by a physician. To evaluate the appropriateness of limited rural exceptions to the requirement proposed by the resolution, the Board is therefore called to consider models of physician supervision that ensure the ED is adequately "staffed 24/7" by a physician and address the challenges rural EDs face in implementing the proposed model. In so doing, this report takes very seriously the concerns raised by rural physicians. It strives to pay due respect to these considerations while preserving the integrity of AMA policy on care in the ED. Ultimately, the recommendations proffered in this report aim to address the most salient challenges faced by rural EDs surrounding the proposed requirement (for the real-time, on-site presence of a physician in the ED whose primary duty is to provide care in that ED), while maintaining alignment with relevant AMA policy.

Laws Related to Physician-led Care in EDs

While federal law requires hospitals to maintain a list of physicians who are on call to provide treatment necessary to stabilize an individual with an emergency medical condition,[3] there is no requirement that care in an ED be led by a physician. Under the relevant federal regulations, the "qualified member of the medical staff" who must supervise an ED may be a non-physician practitioner such as a physician assistant or a nurse practitioner where state law allows.[4] As such, federal law does not demand that EDs be supervised by a physician.

Governance of this issue is therefore left to the states. While most states do not have laws that expressly require physician supervision of emergency care services provided in the ED, there are a few notable exceptions. In the past two years, Indiana and Virginia have each passed state legislation requiring the on-site presence of a physician in the ED. Indiana enacted legislation in 2023 requiring that an ED must have at least one physician on site and on duty who is responsible for the ED whenever the ED is open.[5] Similarly, Virginia's 2024 law requires at least one physician who is primarily responsible for the ED to be on duty and physically present at all times at each hospital that operates or holds itself out as operating an emergency service.[6] Neither of these laws includes a rural exception. Comparable legislation has been considered but not yet enacted in a handful of additional states.

California and New Jersey also have in place longstanding regulations that promote physician-led care in the ED. California requires that a trained physician have overall responsibility for a hospital's emergency services and makes this physician responsible for ensuring that emergency services are staffed 24 hours a day by an experienced physician.[7] New Jersey's regulations around ED staffing require that at least one licensed physician be present in the ED to attend to all emergencies.[8] Both of these regulatory approaches effectively require "24/7 staffing" by a physician in the ED, with New Jersey specifically requiring the on-site presence of a physician in the ED.

State laws governing the scope of practice of non-physicians also influence the use of non-physicians in EDs. Hospitals or EDs in states where physician assistants or nurse practitioners are permitted to practice without physician supervision are more likely to employ a non-physician to supervise an ED in lieu of a physician. EDs in states that do require physician involvement in the practice of non-physicians are more likely to leverage non-physicians under some kind of physician supervision or collaboration model pursuant to state law—these models may or may not require the 24/7 on-site presence of a physician.

American College of Emergency Physicians Campaign

In June 2023, the American College of Emergency Physicians (ACEP) issued a policy statement on the role of nurse practitioners and physician assistants in emergency departments,[9] in which ACEP advocates for physician-led care teams in all EDs. As part of this campaign, ACEP has developed model legislative and regulatory language for use by states interested in advocating for on-site physician supervision in EDs. ACEP's model legislation requires that "[a] hospital with an emergency department must have a physician onsite and on duty who is primarily responsible for the emergency department at all times the emergency department is open."[10] Further, ACEP policy would require that the physician on duty in the ED solely determine what level of supervision is appropriate for patients being cared for by a nurse practitioner or a physician assistant in the ED. However, ACEP's policy statement on care in EDs also acknowledges the workforce limitations faced by certain rural hospitals and provides for the limited adoption of specified alternative supervision models where necessary in those rural hospitals facing staffing challenges.

Current ED Staffing Practices

EDs across the country are staffed by physicians from varying specialties as well as non-physicians such as nurse practitioners or physician assistants. A 2020 study found that of 48,835 clinically active emergency physicians, 92 percent were in urban areas, 6 percent were in large rural areas, and two percent were in small rural areas.[11] Those emergency physicians in urban areas were substantially younger than rural emergency physicians.[12] International medical graduates (IMGs) also make up a sizeable portion—about nine percent—of the emergency medicine workforce.

About 20 percent of these IMGs are trained in specialties other than emergency medicine, and eight percent work in small rural areas.[13] Further, a 2018 study found that of all emergency medicine clinicians (i.e., inclusive of both physicians and non-physician practitioners), about 61.1 percent were physicians residency-trained in emergency medicine and about 14.3 percent were physicians trained in other specialties such as family practice or internal medicine.[14] Non-physician practitioners such as physician assistants or nurse practitioners made up about 24.5 percent of the total emergency medicine workforce.[15]

Rural EDs may directly employ physicians or other clinicians, or they may contract with management groups or individual clinicians to meet all or part of their staffing needs. In any case, the role each practitioner plays on the care team in the ED varies depending on state law and institutional policy. As this report will explore, rural EDs often face unique challenges that impact staffing decisions.

While some EDs only staff physicians who are residency-trained and board certified in emergency medicine, it is also common for EDs to staff physicians from other specialties. A 2020 study on the emergency physician workforce found that 81 percent of practicing emergency medicine physicians were residency trained or board certified in emergency medicine, while 19 percent were trained in other specialties such as family medicine, internal medicine, or surgery.[16] There is evidence that physicians trained in specialties outside of emergency medicine are more prevalent in rural EDs than in urban ones.[17] Both literature and anecdote suggest that the staffing of these physicians may be crucial to the success of some rural EDs. The option to staff physicians from specialties outside emergency medicine emergency allows rural EDs to overcome recruitment hurdles and keep their doors open while preserving physician-led emergency care.[18] AMA policy supports all care in the ED that is physician-led and does not specify that a physician be board certified in emergency medicine or residency-trained in emergency medicine to be qualified to supervise an ED.[19]

That said, the unfortunate reality is that physician-led care in the ED is not guaranteed. Some EDs are run by nurse practitioners or physician assistants rather than by physicians. To indicate, a study of Iowa EDs found that nurse practitioners or physician assistants provided solo coverage for at least part of the week in 60 percent of the state's EDs in 2012—a number that jumped from about 39 percent in 2008.[20] More recent national research found that nearly a quarter of clinicians in EDs across the country were non-physicians (over two-thirds of whom were physician assistants and the rest nurse practitioners),[21] but notably, this study did not capture whether these non-physicians worked on physician-led teams or whether they worked in a supervisory role over the ED; other research suggests that physicians were involved with nearly 90 percent of ED visits between 2010 and 2017.[22] Still, there is speculation that use of non-physicians as a replacement for physicians in EDs is increasing,[23] and ongoing and anticipated physician shortages in rural areas support this hypothesis.[24]

Several factors may contribute to the replacement of physicians with non-physicians in both urban and rural EDs nationally, including private equity's increasing influence on health care.[25] However, there is a body of evidence that EDs in rural areas are more likely to be staffed by a non-physician than EDs in urban areas.[26] This includes workforce studies showing that urban counties have a higher proportion of emergency physicians compared with rural counties,[27] and research finding that physician assistants in rural areas are more likely to work without on-site physician supervision and to have a broader scope of practice in the ED than their urban counterparts.[28] Physicians who work in rural areas also report that recruitment challenges create the need to staff non-physicians instead of physicians in the ED, which may contribute to a trend toward use of non-physicians in rural EDs.

Rural Hospitals

Rural EDs—especially small institutions in very remote areas—face a different financial and operational situation than most EDs associated with larger metropolitan hospitals or otherwise located in urban areas. The realities associated with these differences may make a 24/7 on-site physician requirement impracticable for certain rural EDs.

Financial Vulnerability and Risk of Closure

Rural hospitals serve communities outside metropolitan areas and are often geographically isolated. EDs in these rural hospitals can be a keystone of the health care infrastructure in some areas—for example, especially in areas that are particularly remote, a single ED may serve as the sole health care safety net for patients experiencing medical emergencies. And yet, despite their role as a crucial health care resource, rural hospitals across the country are struggling to keep their doors open. Some research estimates that more than 30 percent of all rural hospitals in the U.S. are at risk of closing, and a third of those hospitals face risk of immediate closure.[29] Government Accountability Office data from 2020 reveals that more than 4 percent of rural hospitals closed from 2013 through 2020. [30] Closures have a serious impact on access to emergency services in rural areas, including by increasing the time and distance patients must travel to reach an ED. The closure of a rural ED raises grave concerns for the surrounding community's patients, as rural hospital closures have been linked to greater patient mortality.[31]

Rural hospitals confront a unique financial situation that often makes them more vulnerable than hospitals in metropolitan areas. In short, many insurers simply do not pay rural hospitals enough to cover the cost of providing services in low-population and rural communities,[32] which directly threatens the viability of many rural hospitals and EDs. Financial vulnerability and challenges covering the cost of round-the-clock physician services may play some role in a rural hospital's ability to staff a physician 24/7 in the ED, at least insofar as it can be more cost-effective for a rural hospital to use a physician's services somewhere outside the ED for higher reimbursement than in the ED.

However, while the cost associated with hiring physicians to be on-site in the ED 24/7 could contribute to a rural ED's financial vulnerability, the hurdles associated with such a requirement are not primarily financial. These organizations also experience challenges with recruitment and retention of qualified physicians to staff an ED 24/7. On top of that, low census and low patient acuity in many rural EDs may warrant different approaches to resource utilization than those pursued by larger metropolitan EDs, which may see higher patient volumes.

Physician Recruitment and Retention Issues

Rural hospitals offering emergency services grapple with workforce challenges. Because a relatively small percentage of physicians choose to practice in rural communities, the workforce inherently differs in rural areas from that of more metropolitan areas.[33] Physicians who work in rural areas report that they struggle to attract and retain physicians to staff the ED, and workforce data tends to support this. As mentioned above, a 2020 study found that only eight percent of emergency physicians were located in rural areas, with a mere two percent located in small rural areas.[34] Physicians in rural areas were also, on average, significantly older than their urban counterparts and nearing the retirement age, with most having completed their training at least 20 years prior to 2020.[35] And despite the fact that rural EDs may be more likely to staff physicians who are not specialty trained in emergency medicine, workforce research shows that less than a quarter of clinically active family medicine-trained emergency physicians practice in rural areas.[36]

Physicians who work in rural areas report that staffing challenges sometimes compound on themselves: for example, rural hospitals may require new physicians to help meet ED staffing needs as a condition of employment—such as by requiring that the physician staff the ED multiple nights per week—which may be unattractive to physicians not keen on providing emergency medical services or keeping nighttime hours.

The density of physicians providing care in EDs decreased in both large and small rural areas between 2008 and 2020.[37] One group of researchers identified a band of underserved states from North Dakota to Texas with particularly bad shortages of emergency physicians (both residency-trained in emergency medicine and in other specialties). These shortage areas are represented in white and light green on the map below (Figure A).

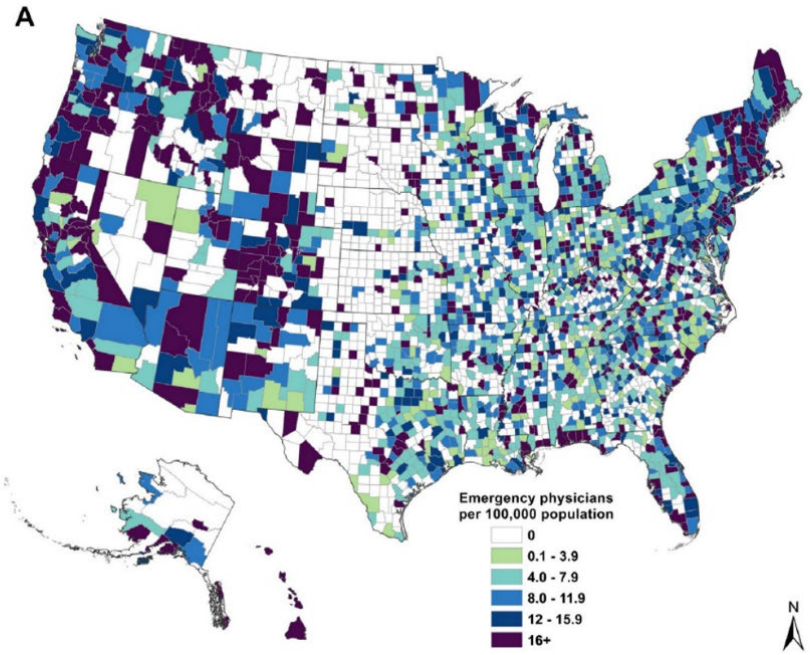

Figure A: density of emergency physicians across the country—emergency physicians per 100,000 population—includes physicians who are residency-trained or certified in emergency medicine and physicians trained in a non-emergency specialty. [38]

As a consequence of the physician shortage in rural areas—especially small rural areas—problems recruiting and retaining physicians to staff the ED emerge as a primary barrier to the ability of some rural hospitals to adhere to a 24/7 on-site physician requirement. Anecdotally, physicians on the ground in Nebraska, where at least 29 rural hospitals are at risk of closure,[39] report that "finances are not the problem"—rather, staffing is, and mention that a job listing seeking a physician to staff one ED in a remote area has been open for more than 18 months.[40] There is a concern that the inability to attract or retain a sufficient number of physicians to staff the ED on-site 24/7 in severe rural areas could result in ED closure should the proposed requirement be implemented. Further, the AMA Health Workforce Mapper and Geographic Mapping Initiative demonstrate that non-physician health care providers do not gravitate to rural areas even in states without a requirement for physician supervision or collaboration—as such, non-physicians cannot be assumed to be a robust workforce alternative to physicians.

Low Patient Volume and Low Acuity

Patient volume impacts the viability of rural hospitals and plays a role in staffing decisions. The patient volume of rural hospitals and affiliated EDs might vary significantly for several reasons, including the population of the community, the age and health status of the population, the availability of primary care options, and the accessibility of the hospital. However, rural physicians report that for many EDs—particularly ones in very remote areas—census is consistently low. Low census impacts the hospital's financial viability, in part due to a lack of service-based revenue, and because many commonly used quality measures cannot be employed when there are too few patients to reliably measure performance.[41] Patient volume also complicates decision-making around staffing models. EDs in remote areas may see lighter patient volume than urban EDs. Even though there are higher-volume EDs in some rural areas, and lower-volume EDs in some urban areas, one study found that a full 79 percentage of lower-volume EDs were located in rural areas.[42]

Survey data by non-medical chart reviewers using "a five-point scale, based on the immediacy with which the patient should be seen" provides some evidence that while visits to rural EDs have, on the whole, risen in the past 10 years, lower-acuity ED visits in rural areas may also be increasing.[43] However, that data contrasts with reports from the Emergency Department Benchmarking Alliance utilizing clinician determinations for ED patients' CPT codes that show an increase in acuity.[44] Rural physicians report that in the case of low-volume, low-acuity EDs—that is, where the ED sees light patient volume and where true emergencies are few and far between—it might become inefficient to staff the ED 24/7 with an on-site physician whose only duty is to see patients in the ED. Tending to support this, one study found that the presence of non-physician practitioners is higher among EDs that see fewer than 5,000 visits annually.[45] As discussed in more detail below, physician-led care that allows supervising physicians to provide services in areas of the hospital beyond just the ED may be appropriate for rural EDs with these characteristics.

The Importance of a Physician in Rural EDs

Even where patient volume is generally low, it is expected that patients facing life-threatening medical emergencies will present to the ED. When they do, it is critical that a physician be available to be on-site to provide care. A nurse practitioner or a physician assistant is not an adequate substitute for a physician in the ED: only physicians have the requisite training and experience to lead patient care. This remains true in rural hospitals. In rural hospitals—where there may be a dearth of community-based physicians in certain specialties that may be necessary to provide care for very high-acuity patients—assessment, stabilization, and arranging appropriate transfer of high acuity ED patients becomes critical. Physicians, who are trained in performing differential diagnosis and experienced in treating a broad range of acute illness and injury, are best equipped to provide this type of emergency care. As such, ideal rural ED staffing models will require the physical presence of a physician who might directly provide care to high-acuity patients.

24/7 Staffing Models and the On-site Presence of a Physician

As referenced in the Introduction to this report, AMA policy requires that all EDs be "staffed 24/7 by a qualified physician." This language does not necessarily imply the round-the-clock physical presence of a qualified physician. While the on-site presence of a qualified physician solely responsible for the ED is the preferred model for providing emergency medical services, some appropriate physician-led care models may allow a physician to be always staffed in certain rural EDs 24/7 but not necessarily physically present in that ED round the clock. This report explores three types of extended supervision models that require the staffing of and supervision by a

physician in the ED (in alignment with AMA policy) but forego requirements that the physician be physically on-site in the ED 24/7 or primarily responsible for care in that ED. Approaches like these may be appropriate for limited application in certain rural EDs, such as those facing the threat of closure or experiencing consistently low patient volume.

AMA policy supports physician-led care in all health care settings.[46] To be clear, for all the staffing models mentioned below, in any instance where a non-physician practitioner is on-site in the ED, that non-physician practitioner should be working as part of a physician-led care team under an appropriate collaboration or supervision agreement.

Permit Physicians to Perform Duties Beyond Staffing the ED

The proposed requirement would demand that an on-site physician in the ED be primarily responsible for supervising care in that ED. However, policies that allow supervising physicians to perform other duties in the hospital or health system beyond just staffing the ED may help rural EDs overcome staffing challenges and more efficiently leverage physician resources. This approach—sometimes called the "upstairs physician" model—may allow a physician who is supervising an especially low volume ED to perform rounds at the hospital or see patients at an outpatient clinic nearby to the ED (i.e., across the street or next door) in addition to seeing patients who present to the ED. Extending the reach of the ED physician in this way may make particular sense for rural EDs with low census.

Require that Supervising Physicians be Available but not Necessarily Physically Present

Some rural EDs currently require the *availability* of a supervising physician rather than the on-site physical presence of a physician. Under these staffing models, a supervising physician must be available to be physically present in the ED within a reasonable timeframe upon noticing that their services are necessary, for example within 20 minutes. These models work particularly well when emergency medical services are able to contact the ED or the supervising physician directly to inform them that a patient will be arriving by ambulance, thereby allowing the physician to meet the patient at the ED to provide emergency care. For lower-acuity patients, these physicians provide supervision under a supervision agreement.

Incorporation of Telehealth

Other models of extended supervision allow a physician to provide a degree of supervision via telehealth. Most recent research around telehealth use in the ED focuses on Tele-ED, a model that connects practitioners at rural or remote EDs, which may lack emergency medicine physicians or other specialists, to physicians at a well-resourced central hub ED through video technology. Literature suggests that most implementations of Tele-ED involve the connection of rural EDs to physicians who are "on call" for the rural ED (i.e., enlisted to provide consultation to fulfill the ED's obligations under the Emergency Medical Treatment and Active Labor Act) but they are often not supervising operations in that ED.[47] This is a great approach for bringing specialty expertise to under-resourced rural areas.

However, utilizing telehealth to supervise non-physicians in an ED raises other challenges. AMA Policy H-160.937, "The Promotion of Quality Telemedicine," supports the supervision of non-physicians via telehealth within certain parameters, recognizing that the physician retains the authority for, and safety and quality of services provided by the non-physician. The supervising physician must also be immediately available for consultation with ED non-physician staff and patients via telehealth. Importantly, AMA's Code of Medical Ethics 1.2.12, "Ethical Practice in Telemedicine" and other AMA policy on telehealth states that physicians have an obligation to

ensure that the use of telehealth as a modality is appropriate for the type of medical care sought and individual patient needs. In other words, as a modality, telehealth must be medically appropriate for the care provided and needs of the individual patient, as well as aligned with clinical guidelines.

Real-time telehealth consultation may be part of an extended model of physician supervision of non-physicians in the ED. However, a telehealth-only supervision model does not allow for the physician to perform a physical examination or necessary interventions which may be crucial for high-acuity patients in an ED setting. Given the type of life saving, high-acuity care that may need to be provided in an ED and which necessitates the physical presence of a physician, a telehealth-only option may be inappropriate. Consequentially, telehealth-based supervision models may be best leveraged with local physicians and combined with other extended supervision models—for example, a requirement that a physician supervising via telehealth also be in close proximity and available in-person on-site promptly to provide emergency care when needed.

Defining the Applicability of "Limited Rural Exceptions" to a 24/7 On-Site Physician Requirement

The preferred model of physician-led care in the ED is the full-time, on-site presence of a physician. However, "limited rural exceptions" to this ideal may be appropriate given the operational realities faced by certain rural EDs. The notion of "limited rural exceptions" to an on-site physician requirement calls for criteria to determine which rural EDs would qualify for such an exception. A blanket exception applicable to any ED located in a rural area may be so sweeping in breadth as to defeat the purpose of the requirement. This is supported by data from the American Hospital Association which suggests that a full 35 percent of American hospitals are located in rural areas,[48] as well as older research specific to emergency care finding that approximately 42 percent of American EDs are located in rural counties and estimating that these rural EDs see about 17 percent of all ED visits.[49] Further, not every rural hospital faces the challenges that make an on-site physician requirement impractical. Differences in EDs across the spectrum of rurality call for some nuance in determining which rural EDs might be most appropriately subject to an exception.

Likely, it is most appropriate to apply any exception to the subset of rural EDs located in the country's most remote areas that are likely to face insurmountable barriers to adherence to a 24/7 on-site physician policy. However, making proper delineations when it comes to the exception's applicability is difficult because there is no widely agreed-upon definition of "rural" or concrete spectrum of rurality. Also, rurality itself may not be determinative of the challenges most salient to the on-site supervision issue, such as low patient volume. Determinations made based on an EDs patient volume may therefore be worth considering; however, even low volume EDs may still see high acuity patients.

This report provides a few imperfect options for defining "rurality" and determining the subset of rural EDs that may most appropriately qualify for the exception at issue. Ultimately, there is no single best apparent one-size-fits-all approach; the characteristics and unique needs of each state will need to be considered when determining the scope of "limited rural exceptions" to a requirement that a physician always be on-site in the ED and primarily responsible for care in that ED.

<u>Critical Access Hospital or Rural Emergency Hospital Status</u>

One approach might base applicability of an exception on the U.S. Centers for Medicare & Medicaid Services' Critical Access Hospital (CAH) or Rural Emergency Hospital (REH) designation.

Hospitals classified as CAHs receive certain benefits that aim to reduce financial vulnerabilities, including cost-based reimbursement for Medicare services. A hospital's designation as a CAH would seem to imply a degree of rurality and the existence of an ED. Among other requirements, to become a CAH, a hospital must provide 24/7 emergency care and be located more than 35 miles from the nearest hospital (or 15 miles in mountainous terrain). Qualifying hospitals are also relatively small, maintaining 25 or fewer inpatient beds.[50] Given the ease of determining whether an ED is part of a CAH, and the fact that CAH designation would largely implicate small rural EDs, using CAH status as a basis for an exception to the on-site physician requirement might be an attractive option to policymakers. However, whether this approach would be adequately narrow in scope is worth considering. CAHs make up a sizeable portion of total hospitals across the country—about 22 percent of American hospitals (1,368 of the 6,120 hospitals in the United States). [51,52] Further, not all CAHs are in true rural areas; certain CAHs located within urban areas are "treated as being located in a rural area" for purposes of CAH designation.[53] As such, basing eligibility on CAH status alone may be overly inclusive.

Effective January 2023, CAHs and other small rural hospitals became eligible to apply for REH status in order to receive special Medicare payment for providing emergency services. Conversion to an REH is thought to prevent rural hospital closures.[54] To qualify for REH status, a hospital must be an acute care hospital with 50 or fewer inpatient beds, located in a rural area, and provide 24-hour emergency services as well as laboratory services, diagnostic radiologic services, and a pharmacy.[55] REHs generally provide outpatient care and cannot exceed an annual length of stay of 24 hours per patient. While REH status may indicate a degree of rurality and a small hospital size, the designation is quite new and not yet broadly utilized; further, not every state has passed legislation required to support REH status, and REH conversion may not be appropriate or feasible for all small rural hospitals.

U.S. Department of Agriculture Urban Influence Codes

The U.S. Department of Agriculture's (USDA) Urban Influence Codes (the Codes), which are applied at the county level, were developed to capture differences in economic opportunities among U.S. counties. The Codes distinguish metropolitan and nonmetropolitan areas, using population size of a metro area or the size of the largest city and proximity to both metro- and micropolitan areas.[56] The Codes are divided into a 12-part county classification made up of two metro and 10 nonmetro categories. Micropolitan and "noncore nonmetro" counties are classified by adjacency to and population of the county's largest town, which allows for a relatively fine rural-urban gradation that can be used by policy makers. [57] In short, the Codes may be useful in identifying rural counties, including remote areas—to indicate, Code 12 captures 182 "noncore" counties that are "not adjacent to [a] metro or micro area and [do not] contain a town of at least 2,500 residents."[58] As such, the Codes may be a feasible basis for determining rurality for the purpose of the limited rural exception at issue here. However, some concerns have been raised about the appropriateness of county-level determinations, both because there may be some very remote EDs on the outskirts of counties that are not considered remote under the Codes, and similarly, there may be non-remote EDs on the outskirts of counties that are generally considered very rural by the Urban Influence Code classification system.

Rural Urban Commuting Areas

The Economic Research Service (ERS) has established Rural Urban Commuting Areas (RUCA) codes using population data from the U.S. Census, urban area delineations from the U.S. Census Bureau, and commuting data from the American Community Survey. These codes apply to census tracts and make classifications using population density, urbanization, and daily commuting

measures. USDA has published a version of the RUCA classifications that makes delineations by ZIP code, which makes it easy to determine a rural hospital's classification. RUCA classification contains 10 primary and 21 secondary codes. The primary codes reflect a spectrum of metropolitan and nonmetropolitan areas, with levels 4-10 loosely indicating a rural area. Notably, the U.S. Veteran's Health Administration relies on RUCA codes to determine rurality, making designations for urban, rural, and highly rural areas, whereby highly rural areas are tracts with a RUCA score of 10, (meaning that less than 10 percentage of workers travel to urbanized areas).[59] Importantly, though, these codes are not designed to represent a continuum of rurality—rather, each code has a specific meaning, and RUCA codes are interpreted and applied differently for every purpose for which they are used, which adds a layer of complication to the application of RUCA codes for the purpose considered here. Finally, there is some concern about the fact that some census tracts and ZIP codes are geographically very large, meaning that certain classifications may seem inappropriate.

Frontier and Remote Area Codes

Frontier and Remote Area (FAR) Codes were developed by USDA Economic Research Service and the Federal Office of Rural Health Policy to assist in policy-related considerations related to isolated areas of country, that is, areas with low population size and high geographic remoteness.[60] FAR codes were specifically designed to classify frontier and remote areas.[61] They apply at the zip-code level, are determined based on the time it takes to travel by car to nearby urban areas, and are assigned based on population size and travel time. FAR designations reflect a range of degree of remoteness, distributed from Level 1 to 4, with Level 4 being the most remote. While these codes uniquely reflect a spectrum of rurality that identifies frontier and remote areas, they have not been updated since 2010 and the literature suggests they are not widely used. Some research, however, determines that the FAR definition may work well for considerations of access to health care resources,[62] which may make them a viable option for determining rurality for purposes of an exception.

AMA POLICY

As mentioned in the Introduction to this report, AMA has extensive policy supporting physician-led care in all health care settings in addition to policy specific to physician-led care in EDs.

AMA policy supports physician-led, team-based care in all health care settings and covers the appropriate supervision of nurse practitioners and physician assistants. Relevant AMA polices include the following: Support for Physician Led, Team Based Care (D-35.985); Practicing Medicine by Non-Physicians (H-160.949); Scopes of Practice of Physician Extenders (H-35.973); Supervision of Non-Physician Practitioners by Physicians (D-35.978); Physician Assistants (H-35.989); Physician Assistants and Nurse Practitioners (H-160.947); and Guidelines for Integrated Practice of Physician and Nurse Practitioner (H-160.950).

AMA policy specific to care in EDs establishes AMA's support for legislation and regulation requiring physician-led care in the ED as well as AMA's support for "24/7 staffing" of EDs by physicians. See the following policies: On-Site Emergency Care (H-130.976) and Promoting Supervision of Emergency Care Services in EDs by Physicians (D-35.976).

Regarding telehealth, AMA Policy H-160.937 supports the supervision of non-physicians via telehealth within certain parameters.

DISCUSSION

The Board of Trustees is tasked with considering "limited rural exceptions" to a requirement, to be included in model legislation, that a physician always be on-site at the ED and primarily responsible for care in that ED always. To address this question, existing AMA policy and operational realities of rural EDs which may make the proposed requirement difficult to meet must be meaningfully examined.

AMA policy on this issue is robust and cannot be ignored. Our AMA has extensive policy supporting physician-led care in all health care settings, including the ED. AMA policy specific to care provided in EDs provides that only physicians should supervise care provided in EDs—this means that according to AMA policy, care should not be provided by non-physicians such as physician assistants or nurse practitioners in the absence of adequate physician supervision. On top of that, a new policy passed at the AMA 2024 Annual Meeting calls for "24/7 staffing" of the ED by a physician. In its consideration of possible rural exceptions to the proposed requirement, the Board must honor this codified AMA policy.

At the same time, it is clear that certain rural hospitals and EDs experience different financial and workforce challenges than those faced by EDs in metropolitan areas. This is evident based on a review of relevant literature as well as a series of focus-group style conversations with physicians and experts who work in very rural areas. Even though rural EDs are a key lifeline for patients in their communities, many are at risk of closure. Even so, while financial challenges are salient, physician recruitment and retention issues emerge as the most pressing barrier standing in the way of staffing certain EDs with an on-site, full-time physician. Further, if there is low patient volume and low patient acuity, this can make it inefficient to staff the ED with a physician who is only responsible for care in that ED—sometimes the physician's services may be most effectively put to use in other areas of the hospital or health system, even while that physician is supervising the ED. Altogether, the proposed requirement for an on-site, round the clock physician who is primarily responsible for care in the ED emerges as unfeasible for certain EDs, namely those in very remote rural areas which face both recruitment challenges and low patient volume. Indeed, should such a requirement be implemented in these very remote rural areas, EDs may face closure that would deprive local patients of access to emergency care.

The preferred model of physician-led care is the full-time, on-site presence of a physician. This is due to the nature of emergency medicine, in which, as articulated by ACEP, "patients present with a broad spectrum of acute, undifferentiated illness and injury, including critical life-threatening conditions."[63] As such, the on-site presence of a physician should be pursued in all cases and required wherever feasible. Model legislation developed by ACEP may be used in advocacy toward this objective. However, given the vulnerabilities and workforce limitations experienced by certain rural hospitals, "limited rural exceptions" to this preferred model may be acceptable if necessary. Round-the-clock physician-led care in the ED may still exist even in the absence of the on-site, full-time presence of a physician in the ED who is primarily responsible for care in that ED. It may be appropriate for the AMA to aid state medical associations who, based on the needs of the state, may choose to pursue certain alternative supervision models for care provided in EDs in remote rural areas, which may constitute a "limited rural exception" to the proposed requirement.

Possible supervision models may include requirements that a supervising physician be at all times available to be physically present in the ED within a reasonable amount of time, or they may include arrangements that allow a supervising physician to provide care in other, nearby areas of the hospital or health system in addition to managing care in the ED. Telehealth, when used

appropriately, may also be incorporated into an appropriate alternative supervision model. In all cases, however, it is important that a physician maintain supervision of the ED and to ensure that a physician can be present to assess, stabilize, and manage high-acuity patients presenting to the ED. Without the availability of a physician's expertise, patient safety is put at risk.

While researchers have identified a band of localities—primarily rural—that face extreme emergency physician shortages, developing hard-and-fast criteria for the proper applicability of these rural exceptions is difficult to do at the national level. The composition of each state is highly variable, and the spectrum of rurality across the United States is broad. In any case, these rural exceptions likely most appropriately apply in very remote rural areas that face consistently low patient volume.

The recommendations provided herein aim to adhere to existing AMA policy while addressing the unique needs of rural EDs.

RECOMMENDATIONS

The AMA Board of Trustees recommends that the following be adopted in lieu of Resolution 207-I-23 entitled, "On-Site Physician Requirement for EDs," and the remainder of the report be filed:

1. That our American Medical Association recognize that the preferred model of emergency care is the on-site presence of a physician in the emergency department (ED) whose primary duty is to provide care in that ED, and support state and federal legislation or regulation requiring that a hospital with an ED must have a physician on-site and on duty who is primarily responsible for the emergency department at all times the emergency department is open. (New HOD Policy)

2. That our AMA, in the pursuit of any legislation or regulation requiring the on-site presence of a physician who is primarily responsible for care in the emergency department (ED), will support state medical associations in developing appropriate rural exceptions to such a requirement if, based on the needs of their states, the association chooses to pursue certain alternative supervision models for care provided in EDs in remote rural areas that cannot meet such a requirement due to workforce limitations, ensuring that exceptions only apply where needed. These exceptions shall preserve 24/7 physician supervision of the ED and provide for the availability of a physician to provide on-site care. (New HOD Policy)

Fiscal Note: Less than $500

REFERENCES

[1] AMA Policy D-35.976, Promoting Supervision of Emergency Care Services in EDs by Physicians. https://policysearch.ama-assn.org/policyfinder/detail/supervision?uri= percentage2FAMADoc percentage2Fdirectives.xml-D-35.976.xml
[2] AMA Annual Meeting 2024. Resolution 204. *See* Report of Reference Committee B (annotated), American Medical Association House of Delegates (A-24). https://www.ama-assn.org/system/files/a24-refcomm-b-annotated.pdf
[3] 42 U.S. CODE § 1395CC(I)(III)
[4] 42 CFR § 482.22 - CONDITION OF PARTICIPATION: MEDICAL STAFF.
[5] IN SB 400 (2023). Full text available at: https://iga.in.gov/pdf-documents/123/2023/senate/bills/SB0400/SB0400.08.ENRH.pdf
[6] VA SB 392 (2024). Approved April 4, 2024. https://s3.amazonaws.com/fn-document-service/file-by-sha384/f7f5c2b73556546f411ff52fa9df6413b17fe54e7b49002a32faa65b1b2f8feec1842beb27c658549f2bd5f9ca5ed8a3
[7] Cal. Code Regs. tit. 22 § 70415
[8] N.J. Admin. Code § 8:43G-12.5
[9] American College of Emergency Physicians. Policy Statement – Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in Emergency Departments. June 2023. Available at https://www.acep.org/siteassets/new-pdfs/policy-statements/guidelines-reg-the-role-of-physician-assistants-and-nurse-practitioners-in-the-ed.pdf.
[10] American College of Emergency Physicians. Physician Staff Requirement in Emergency Departments – Model Legislation and Toolkit.
[11] Bennett CL, Sullivan AF, Ginde AA, Rogers J, Espinola JA, Clay CE, Camargo CA Jr. National Study of the Emergency Physician Workforce, 2020. Ann Emerg Med. 2020 Dec;76(6):695-708. doi: 10.1016/j.annemergmed.2020.06.039. Epub 2020 Aug 1. PMID: 32747085
[12] *Id.*
[13] *Id.*
[14] M. Kennedy Hall, MD, MHS; Kevin Burns, EMT-P, PA-C; Michael Carius, MD; Mitchel Erickson, MSN, ACNP-C; Jane Hall, PhD; Arjun Venkatesh, MD, MBA. State of the National ED Workforce: Who Provides Care Where? THE PRACTICE OF EMERGENCY MEDICINE/BRIEF RESEARCH REPORT. 2018 American College of Emergency Physicians. doi: https://doi.org/10.1016/j.annemergmed.2018.03.032.
[15] *Id*.
[16] *Id.*
[17] Physicians in rural EDs are also less likely than their urban counterparts to have emergency medicine training. *See id. See also,* M. Kennedy Hall, MD, MHS; Kevin Burns, EMT-P, PA-C; Michael Carius, MD; Mitchel Erickson, MSN, ACNP-C; Jane Hall, PhD; Arjun Venkatesh, MD, MBA. *State of the National ED Workforce: Who Provides Care Where?* THE PRACTICE OF EMERGENCY MEDICINE/BRIEF RESEARCH REPORT. 2018 American College of Emergency Physicians. doi: https://doi.org/10.1016/j.annemergmed.2018.03.032.
[18] *Supra* note 14.
[19] AMA policy does not specify that a physician must be residency-trained or certified in emergency medicine to be qualified to lead care in the ED; on the contrary, AMA policy leaves room for a physician trained in family medicine or another specialty to supervise the ED. This policy decision was made intentionally as a result of extensive discussions on the floor of the HOD on this issue. *See* AMA Policy D-35.976, Promoting Supervision of Emergency Care Services in EDs by Physicians. https://policysearch.ama-assn.org/policyfinder/detail/supervision?uri= percentage2FAMADoc percentage2Fdirectives.xml-D-35.976.xml
[20] House H, Young R, DeRoo E. Penetration of board certified emergency physicians into rural EDs in Iowa. Ann Emerg Med. 2009;54:S64.
[21] *Supra* note 11.
[22] Fred Wu, Michael A Darracq, Physician Assistant and Nurse Practitioner Utilization in U.S. EDs, 2010 To 2017, The American Journal Of Emergency Medicine Volume 38, Issue 10, 2020, Pages 2060-2064, Issn 0735-6757, https://doi.org/10.1016/j.ajem.2020.06.032.
[23] *See, e.g.* Brett Kelman and Blake Farmer, *Doctors are Disappearing from Emergency Rooms as Hospitals Look to Cut Costs*, KFF Health News. February 13, 2023. Available at:

https://kffhealthnews.org/news/article/doctors-are-disappearing-from-emergency-rooms-as-hospitals-look-to-cut-costs/ (last accessed June 24, 2024); *see also* Jamie Reno, *Why You Might See A Nurse Practitioner and Not a Doctor at Your Urgent Care Clinic*, Healthline. Available at: https://www.healthline.com/health-news/nurse-practitioner-no-doctor-urgent-care-center (last accessed June 24, 2024).

[24] *Supra* note 11.

[25] *See, e.g.*, Kelman and Farmer, *supra* note xxii.

[26] *Supra* note 14.

[27] *Id.*

[28]Brandon T. Sawyer, Adit A. Ginde MD, MPH. Scope of Practice and Autonomy of Physician Assistants in Rural Versus Urban EDs. *Academic Emergency Medicine* 2014; 21: 520–525 © 2014 by the Society for Academic Emergency Medicine. doi: https://doi.org/10.1111/acem.12367

[29] Rural Hospitals at Risk of Closing. Center for Healthcare Quality & Payment Reform. April 2024. Available at: https://chqpr.org/downloads/Rural_Hospitals_at_Risk_of_Closing.pdf.

[30] Rural Hospital Closures – Affected Residents Had Reduced Access to Health Care Services. Report to the Ranking Member, Committee on Homeland Security and Governmental Affairs, United States Senate. U.S. GOVERNMENT ACCOUNTABILITY OFFICE. Dec. 2020. Available at: https://www.gao.gov/assets/gao-21-93.pdf

[31] *See, e.g.,* Gujral K, Basu A. *Impact of Rural and Urban Hospital Closures on Inpatient Mortality.* National Bureau of Economic Research Working Paper 26182; 2019. doi:10.3386/w26182

[32] Payment & Delivery in Rural Hospitals. AMA Issue Brief. 2024. Available at: https://www.ama-assn.org/system/files/issue-brief-rural-hospital.pdf.

[33] Delivery of Emergency Care in Rural Settings - An Information Paper. American College of Emergency Physicians. 2017. Available at: https://www.acep.org/siteassets/sites/acep/blocks/section-blocks/rural/delivery-of-emergency-care-in-rural--settings.pdf

[34] *Supra* note 11.

[35] *Id*.

[36] Christopher L. Bennett, W. Anthony Gerard, John S. Cullen, Janice A. Espinola, Ashley F. Sullivan, Carson E. Clay, Carlos A. Camargo. National Study on the Contribution of Family Physicians to the US Emergency Physician Workforce in 2020. The Journal of the American Board of Family Medicine Nov 2021, 34 (6) 1221 1228; DOI: 10.3122/jabfm.2021.06.210166

[37] *Supra* note 11.

[38] *Id.*.

[39] See Laura Dyrda, 418 rural hospitals at risk of closure, breakdown by state, Becker's Hospital Review, Feb. 14, 2024. Available at: https://www.beckershospitalreview.com/finance/418-rural-hospitals-at-risk-of-closure-breakdown-by-state.html

[40] Testimony of a physician from Nebraska at the 2024 AMA Annual Meeting's Reference Committee B Hearing.

[41] Miller, H. Saving Rural Hospitals and Sustaining Rural Healthcare. Center for Healthcare Quality & Payment Reform. Available at: https://www.chqpr.org/downloads/Saving_Rural_Hospitals.pdf

[42] Lower-volume is defined as EDs with fewer than 10,000 visits yearly. *See* Muelleman, R.L., Sullivan, A.F., Espinola, J.A., Ginde, A.A., Wadman, M.C. and Camargo Jr., C.A. (2010), Distribution of EDs According to Annual Visit Volume and Urban–Rural Status: Implications for Access and Staffing. Academic Emergency Medicine, 17: 1390-1397. https://doi.org/10.1111/j.1553-2712.2010.00924.x

[43] Greenwood-Ericksen M, Kamdar N, Lin P, et al. Association of Rural and Critical Access Hospital Status With Patient Outcomes After ED Visits Among Medicare Beneficiaries. JAMA Netw Open. 2021;4(11):e2134980. doi:10.1001/jamanetworkopen.2021.34980. *See also*, Greenwood-Ericksen MB, Kocher K. Trends in ED Use by Rural and Urban Populations in the United States. JAMA Netw Open. 2019;2(4):e191919. doi:10.1001/jamanetworkopen.2019.1919

[44] Personal communication. *See* Emergency Medicine Benchmarking Alliance Data. Available at www.edbenchmarking.com.

[45] Casey MM, Wholey D, Moscovice IS. Rural ED staffing and participation in emergency certification and training programs. *J Rural Health.* 2008; 24: 253–62.

[46] AMA policy supporting physician-led care in settings non-specific to EDs includes: Practicing Medicine by Non-Physicians H-160.949, Physician Assistants and Nurse Practitioners H-160.947, Guidelines for Integrated Practice of Physician and Nurse Practitioner H-160.950

[47] Use Of Telemedicine For ED Physician Coverage In Critical Access Hospitals Increased After CMS Policy Clarification. Marcia M. Ward, Kimberly A. S. Merchant, Knute D. Carter, Xi Zhu, Fred

Ullrich, Amy Wittrock, and Amanda Bell. Health Affairs 2018 37:12, 2037-2044. doi: https://doi.org/10.1377/hlthaff.2018.05103

[48] American Hospital Association. Fast Facts on U.S. Hospitals, 2024. Available at: https://www.aha.org/system/files/media/file/2024/01/Fast-Facts-on-US-Hospitals-2024-Infographics-20240112.pdf (last accessed July 9, 2024).

[49] Macht M, Mackenzie A, Ginde A. The rural emergency physician workforce. JREM. June 2014;1(1):3- 8

[50] Critical Access Hospitals. Centers for Medicare & Medicaid Services. Available at: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/CAHs

[51] *Supra* note xliii.

[52] Rural Health Information Hub, Critical Access Hospitals (using 2024 HRSA data), https://www.ruralhealthinfo.org/topics/critical-access-hospitals#how-many (last accessed July 9, 2024); *See also* Flex Monitoring Team (University of Minnesota, University of North Carolina at Chapel Hill, University of Southern Maine) Critical Access Hospitals Location List, Available at: https://www.flexmonitoring.org/critical-access-hospital-locations-list (last accessed July 9, 2024)

[53] Centers for Medicare and Medicaid Services, State Operations Manual Appendix W - Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAHs) and Swing-Beds in CAHs, §485.610(b). Available at: https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/som107ap_w_cah.pdf

[54] *See* Charts. Rural Health Safety Net Under Renewed Pressure as Pandemic Fades. Available at https://email.chartis.com/hubfs/CCRH/2023%20Policy%20Institute/Chartis%20Study_Rural%20Health%20Safety%20Net%20Under%20Renewed%20Pressure%20as%20Pandemic%20Fades_Feb%202023%20FNL.pdf?hsLang=en

[55] *See* 42 U.S.C. §1395x.

[56] USDA Economic Research Service. Urban Influence Codes. https://www.ers.usda.gov/data-products/urban-influence-codes/ (last accessed July 10, 2024).

[57] USDA Economic Research Service. Urban Influence Codes – Documentation. https://www.ers.usda.gov/data-products/urban-influence-codes/documentation/ (last accessed July 10, 2024)

[58] *Id.*

[59] *See* U.S. Department of Veterans Affairs. Fact Sheet – How to Define Rurality. Rev. December 2023. Available at: https://www.ruralhealth.va.gov/docs/ORH_RuralityFactSheet_508.pdf

[60] USDA Economic Research Service. Frontier and Remote Area Codes. https://www.ers.usda.gov/data-products/frontier-and-remote-area-codes/ (last accessed July 10, 2024)

[61] Mueller, K., Coburn, A., et al. Considerations for Defining Rural Places in Health Policies and Programs. Rural Policy Research Institute. May 2020. Available at: https://rupri.public-ealth.uiowa.edu/publications/policypapers/Considerations percentage20For percentage20Defining percentage20Rural percentage20Places.pdf

[62] Long, Julianna C. BSPH; Delamater, Paul L. PhD; Holmes, George M. PhD. Which Definition of Rurality Should I Use? The Relative Performance of 8 Federal Rural Definitions in Identifying Rural-Urban Disparities. Medical Care 59(): p S413-S419, October 2021. DOI: 10.1097/MLR.0000000000001612. Available at: https://journals.lww.com/lww-medicalcare/fulltext/2021/10001/which_definition_of_rurality_should_i_use___the.4.aspx

[63] *Supra* note ix.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 03-I-24

Subject: Stark Law Self-Referral Ban
(Res. 227-I-23)

Presented by: Michael Suk, MD, JD, MPH, MBA, Chair

Referred to: Reference Committee B

At the 2023 Interim Meeting, the House of Delegates referred Resolution 227-I-23, sponsored by the Private Practice Physicians Section. Resolution 227-I-23 asks the American Medical Association (AMA) to: 1) recognize the substantial impact of the Stark law's unequal restrictions on independent physicians; 2) support comprehensive Stark law reform aimed at rectifying the disparities by ending the ban on self-referral practices; and 3) advocate for equitable and balanced Stark law reform that fosters fair competition, incentivizes innovation, and facilitates the delivery of high-quality, patient-centered care.

The Reference Committee heard mixed testimony concerning Resolution 227. Some testimony stated that the Stark law has contributed to health care market consolidation. Other testimony noted that AMA policy opposes and calls on the AMA to continue to advocate against the misuse of the Stark law and regulations to cap or control physician compensation. Testimony highlighted that the Stark law includes an exception (the in-office ancillary services exception) that allows physicians in independent practices to self-refer Medicare and Medicaid patients, subject to certain requirements. For these reasons, the HOD referred Resolution 227 for a report to be considered at the 2024 Interim Meeting.

BACKGROUND

The Physician Self-Referral Law, commonly referred to as the Stark law, prohibits physicians from referring patients to receive "designated health services" payable by Medicare or Medicaid from entities with which the physician or an immediate family member has a financial relationship, unless an exception applies. Financial relationships include both ownership/investment interests and compensation arrangements. For example, if a physician invests in an imaging center, the Stark law requires the resulting financial relationship to fit within an exception or the physician may not refer patients to the facility and the entity may not bill for the referred imaging services.

"Designated health services" are:

- clinical laboratory services;
- physical therapy, occupational therapy, and outpatient speech-language pathology services;
- radiology and certain other imaging services;
- radiation therapy services and supplies;
- DME and supplies;
- parenteral and enteral nutrients, equipment, and supplies;
- prosthetics, orthotics, and prosthetic devices and supplies;

- home health services;
- outpatient prescription drugs; and
- inpatient and outpatient hospital services.

The Stark law is a strict liability statute, which means proof of specific intent to violate the law is not required. The Stark law prohibits the submission, or causing the submission, of claims in violation of the law's restrictions on referrals. Penalties for physicians who violate the Stark law include fines as well as exclusion from participation in federal health care programs.

AMA POLICY AND ADVOCACY

The AMA has longstanding policy on the issue of self-referral by physicians. AMA Policy H-140.861, "Physicians' Self-Referral," states that physicians should not refer patients to a health care facility that is outside their office practice and at which they do not directly provide care or services, when they have a financial interest in that facility.

In a similar vein, the AMA has well developed policy regarding physician ownership and referral for imaging services. AMA Policy D-270.995, "Physician Ownership and Referral for Imaging Services," states that the AMA will work collaboratively with state medical societies and specialty societies to actively oppose any and all federal and state legislative and regulatory efforts to repeal the in-office ancillary services exception to physician self-referral laws, including as they apply to imaging services.

In addition, the AMA has adopted principles emphasizing that, in regard to their involvement with Accountable Care Organizations (ACOs), the physician's primary ethical and professional obligation is the well-being and safety of the patient. AMA Policy H-160.915, "Accountable Care Organization Principles," emphasizes in Clause 5 that federal and state anti-kickback and self-referral laws and the federal Civil Monetary Penalties statute (which prohibits payments by hospitals to physicians to reduce or limit care) should be sufficiently flexible to allow physicians to collaborate with hospitals in forming ACOs without being employed by the hospitals or ACOs.

Also, H-385.914, "Stark Law and Physician Compensation," calls on the AMA to oppose and continue to advocate against the misuse of the Stark law and regulations to cap or control physician compensation.

Finally, AMA Code of Medical Ethics 9.6.9, "Physician Self-Referral," states that, in general, physicians should not refer patients to a health care facility that is outside their office practice and at which they do not directly provide care or services when they have a financial interest in that facility.

DISCUSSION

The Board understands and recognizes the challenges the Stark law may pose on many physician practices. The Board also recognizes that restrictions on self-referral may be a contributing factor to market consolidation. Some Stark waivers for integrated systems may put independent physicians at a disadvantage and thus contribute to consolidation. Although there is some overlap between the Anti-Kickback Statute and the False Claims Act, without an increase in Stark law waivers independent physicians are not on an even playing field. An additional waiver to allow hospitals to support independent physicians in quality improvement initiatives could lead to better care coordination and efficiency. The Stark law also includes a physician-owned hospital exception for existing physician owned hospitals. H.R. 1330 specifically targets the Stark law prohibition on

physician ownership of hospitals. Current AMA policy, however, generally addresses the concerns expressed in this resolution. For example, AMA policy opposes and advocates against the misuse of the Stark law and regulations to cap or control physician compensation. Resolution 227 indicates that the Stark law provides a "blanket ban on self-referral practices." This, however, is not the case. The Stark law contains numerous exceptions, which if met, allow physicians to self-refer, e.g., when physicians self-refer to risk-bearing arrangements. Most importantly for the purposes of this report, the Stark law has a broad exception for both ownership interests and compensation arrangements that applies specifically to physician practices—the in-office ancillary services exception. Regarding any contributing factor the Stark law may have on consolidation, the AMA has extensive policy addressing issues raised by consolidated hospital markets and advocates aggressively with the goal of preventing further consolidation in those markets and restoring competition in those markets. If the Stark law were repealed, then the consolidated systems would have even less restriction, which may disadvantage the independent physician even more. Thus, a more focused approach may be better in addressing specific issues. The AMA supports the development of additional Stark law waivers that allow independent physicians, in addition to employed or affiliated physicians, to work with hospitals or health entities on quality improvement initiatives which may address issues including care coordination and efficiency.

RECOMMENDATION

The Board of Trustees recommends that the following policy be adopted in lieu of Resolution 227-I-23, and the remainder of the report be filed.

1. That our American Medical Association reaffirm AMA Policies H-140.861, "Physicians Self-Referral," D-270.995, "Physician Ownership and Referral for Imaging Services," and H-385.914, "Stark Law and Physician Compensation," be reaffirmed. (Reaffirm HOD Policy)

2. That our American Medical Association supports initiatives to expand Stark law waivers to allow independent physicians, in addition to employed or affiliated physicians, to work with hospitals or health entities on quality improvement initiatives to address issues including care coordination and efficiency. (New HOD Policy)

Fiscal Note: Less than $500.

APPENDIX AMA POLICY

H-140.861, Physicians' Self-Referral
Business arrangements among physicians in the health care marketplace have the potential to benefit patients by enhancing quality of care and access to health care services. However, these arrangements can also be ethically challenging when they create opportunities for self-referral in which patients' medical interests can be in tension with physicians' financial interests. Such arrangements can undermine a robust commitment to professionalism in medicine as well as trust in the profession.

In general, physicians should not refer patients to a health care facility that is outside their office practice and at which they do not directly provide care or services when they have a financial interest in that facility. Physicians who enter into legally permissible contractual relationships--including acquisition of ownership or investment interests in health facilities, products, or equipment; or contracts for service in group practices--are expected to uphold their responsibilities to patients first. When physicians enter into arrangements that provide opportunities for self-referral they must:
(1) Ensure that referrals are based on objective, medically relevant criteria.
(2) Ensure that the arrangement:
(a) is structured to enhance access to appropriate, high quality health care services or products;
(b) within the constraints of applicable law:
(i) does not require physician-owners/investors to make referrals to the entity or otherwise generate revenues as a condition of participation;
(ii) does not prohibit physician-owners/investors from participating in or referring patients to competing facilities or services; and
(iii) adheres to fair business practices vis-a-vis the medical professional community--for example, by ensuring that the arrangement does not prohibit investment by nonreferring physicians.
(3) Take steps to mitigate conflicts of interest, including:
(a) ensuring that financial benefit is not dependent on the physician-owner/investor's volume of referrals for services or sales of products;
(b) establishing mechanisms for utilization review to monitor referral practices; and
(c) identifying or if possible making alternate arrangements for care of the patient when conflicts cannot be appropriately managed/mitigated.
(4) Disclose their financial interest in the facility, product, or equipment to patients; inform them of available alternatives for referral; and assure them that their ongoing care is not conditioned on accepting the recommended referral.

D-270.995, Physician Ownership and Referral for Imaging Services
Our AMA will work collaboratively with state medical societies and specialty societies to actively oppose any and all federal and state legislative and regulatory efforts to repeal the in-office ancillary exception to physician self-referral laws, including as they apply to imaging services.

H-385.914, Stark Law and Physician Compensation
Our AMA opposes and continues to advocate against the misuse of the Stark Law and regulations to cap or control physician compensation.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 04-I-24

Subject:	Addressing Work Requirements For J-1 Visa Waiver Physicians (Resolution 217-I-23)
Presented by:	Michael Suk, MD, JD, MPH, MBA Chair
Referred to:	Reference Committee B

INTRODUCTION

At the 2023 Interim Meeting of the American Medical Association (AMA) House of Delegates (HOD), Resolution 217 entitled, "Addressing Work Requirements for J-1 Visa Waiver Physicians," was introduced by the International Medical Graduates Section and called on the AMA to:

- Acknowledge that the requirement of 40-hours of direct patient care could impose a burden on IMG physicians and may hinder opportunities for professional growth; and
- Advocate for a revision in the J-1 waiver physician's requirement, proposing a transition to a comprehensive 40-hour work requirement that encompasses both direct clinical responsibilities and other professional activities.

Resolution 217 was referred to the Board of Trustees. One of the primary reasons for referral was the need for additional information concerning the accuracy of the 40-hours of direct patient care requirement as it relates to J-1 visa waivers.

BACKGROUND

J-1 Visas

A J-1 visa is a nonimmigrant exchange visitor visa that allows an individual to participate in an exchange visitor program in the United States.[1] In order to receive a J-1 visa there is a significant process that takes place that includes (but is not limited to) applying for the visa, participating in a visa interview, being accepted into a qualifying program, demonstrating certain competencies, providing a statement of need from the country of last permanent residence, and, except in very limited circumstances, being sponsored by the Educational Commission for Foreign Medical Graduates (ECFMG).[2] Once a J-1visa is acquired, the physician is expected to advance through training in the U.S. for up to seven years, though the length of the visa is usually limited to the time typically required to complete a program per the Accreditation Council of Graduate Medical Education (ACGME) and/or the American Board of Medical Specialties (ABMS).[3]

As part of these requirements, an individual who is in the U.S. on a J-1 visa must be enrolled in a "full course of study." For international medical graduates (IMGs), this means that they must participate "in a program in which a foreign medical school graduate will receive graduate medical education or training, which generally consists of a residency or fellowship program involving

health care services to patients, but does not include programs involving observation, consultation, teaching or research in which there is no or only incidental patient care. This program may consist of a medical specialty, a directly related medical subspecialty, or both."[4] No specific hour requirements are given in the definition of a "full course of study." However, per ACGME, the clinical and educational work hours of residents "must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home, and all moonlighting."[5]

H-1B Visa

An H-1B visa is a nonimmigrant visa for individuals who want to perform a specialty occupation in the U.S.[6] In order to qualify for an H-1B visa the individual must engage in an occupation that requires the "theoretical and practical application of a body of highly specialized knowledge," attain a bachelor's degree or higher, and must engage in a job that requires the individual to have a bachelor's degree or higher.[7] For an H-1B worker, full-time employment is defined as 40 hours per week unless the employer can demonstrate that less than 40 hours per week is the regular course of business for the profession. However, full-time work may not drop below 35 hours of work per week.[8] Moreover, the statutes do not define what tasks the H-1B visa holder must undertake during the 35-to-40-hour work week.

J-1 Visa Waiver

If an individual participates in the J-1 visa program, and is in graduate medical education or training, a strict two-year home country physical presence requirement attaches to the individual per section 212(e) of the Immigration and Nationality Act.[9,10] This requirement is commonly referred to as the "home country return requirement" and means that the individual must return to their home country for a total of at least two years before they can change status, adjust status, receive an immigrant visa, or receive a temporary worker visa.[11]

To forgo the home country return requirement, some IMGs choose to participate in a waiver program. The waiver programs require that IMGs:

- Have been admitted to the U.S. in J-1 visa status to receive graduate medical training.
- Obtain a statement of "no objection" from their home country.
- Demonstrate a bona fide offer of full-time employment at an accepted facility.
- Begin employment within 90 days of receiving the waiver.
- Agree to work for not less than three years in that position.
- Upon acceptance into a waiver program, the Attorney General will change the IMG's visa status from J-1 to H-1B.

The U.S. Department of State (DOS) considers full-time employment to be 40 hours per week.[12] Additionally, U.S. Citizen and Immigration Services has noted that if a noncitizen physician averages, or will average, 40 hours per week, while working a minimum of 35 hours per week, that individual may be considered to have met the full time employment requirement.[13] However, these requirements do not specify what type of work must be undertaken within those hours.

Federal Government Agency Waivers

Any U.S. federal government agency can request a J-1 waiver for a physician.[14] However, at the federal level these requests are most frequently made for IMGs by the U.S. Department of Health and Human Services (HHS) and the U.S. Department of Veterans Affairs (VA).

HHS has its own U.S. Exchange Visitor Program related to health research and clinical care. HHS can submit a waiver request to DOS on behalf of a physician that either preforms research in an area of priority or significant interest to the agency or provides health care services for a minimum of three years in a mental health or primary care Health Professional Shortage Area (HPSA).[15] To qualify for an HHS waiver, the physician must have completed their residency training no more than 12 months before the start of their employment through HHS.[16] Moreover, through the HHS waiver the physician must agree to work 40 hours per week providing primary care (family practice, general internal medicine, general pediatrics, or obstetrics/gynecology) or general psychiatric services.[17] This requirement does not specify that the services rendered must include 40 hours of direct patient care.[18]

The VA can also request visa waivers on behalf of physicians. For physicians that work for the VA the VA hospital that they work at does not have to be in an underserved area and instead of a three-year contract, the physicians must have a signed memorandum of agreement between themselves and the hospital.[19] Through the VA waiver the physician must agree to work 40 hours per week fulfilling the duties of the position including using 51 percent or more of their time engaging in patient care duties at the Veterans Health Administration (VHA).[20] Again, this requirement does not specify that the services rendered must include 40 hours of direct patient care.

Conrad 30 Waiver Work Hour Requirements

One of the main waiver programs is the Conrad 30 Waiver Program, which is run through Regional Commissions and State Departments of Public Health or their equivalent.[21] In order to be eligible for the Conrad 30 Waiver Program, the physician must:

- Hold a J-1 visa.
- Have a bona fide full-time employment contract to practice medicine in H-1B nonimmigrant status for at least 3 years at a health care facility located in an area designated by HHS as a HPSA, Medically Underserved Area (MUA), or Medically Underserved Population (MUP) or serving patients who reside in a HPSA, MUA, or MUP geography.
- Have a "no objection" statement from their home country.
- Begin working at the approved health care facility within 90 days of receiving the waiver.[22]

Conrad 30 waiver recipients are required to work full time, which is defined as 40 hours per week.[23] There are no statutory requirements that these 40 hours must be comprised solely of direct patient care. However, individual states can set work hour requirements in their Conrad 30 waiver employment contracts.

As shown in Appendix A, the work hour requirements of individual states and regional commissions varies. While most states only require 40 hours of work per week in their Conrad 30 waiver contracts, without noting specific requirements about how that time must be spent, there are several states that do require a minimum number of hours of direct patient care (e.g., 32 hours, 40 hours).

Also, there are other federal programs intended to encourage physicians to practice in underserved areas, similar to the J-1 waiver program, that do require a minimum number of hours of direct patient care. For example, the National Health Service Corps requires physicians that are accepted to the program to work full-time which is defined as working "a minimum of 40 hours per week in a clinical practice, for a minimum of 45 weeks per service year, in a National Health Service Corps approved service site."[24] Of those 40 hours at least 36 hours each week must be spent providing direct patient care.[25] Other federal programs specify clinical practice hours without specifying direct patient care hours. The Indian Health Service Loan Repayment Program requires physicians to engage in full-time clinical practice which is defined "as working a minimum of 80 hours every two-week period for an average of at least 40 hours per week."[26] Moreover, for those physicians engaging in the Public Service Loan Forgiveness Program, they must work full-time which is defined as meeting the employer's definition of "full-time" or working at least 30 hours per week, whichever is greater.[27]

DISCUSSION

One of the whereas clauses in Resolution 217 states that "for a waiver application, physicians must possess a full-time employment contract, involving at least 40 hours of work per week as a direct care physician." This, however, is inaccurate. Though all J-1 waivers require IMGs to engage in full-time employment, which is considered to be an average of 40 hours per week, there is no statutory requirement that an IMG provide 40 hours of "direct" patient care per week. Instead, as noted in Appendix A, the work hour requirements that apply to J-1 waivers vary by state, regional commission, and federal agency. Moreover, the majority of states do not specify that an IMG utilizing a waiver must engage in 40 hours of direct patient care a week. Since the federal statutes that govern J-1 waivers do not have a requirement that IMGs must provide 40 hours of direct patient care each week, there is no need to advocate for a revision in the J-1 waiver requirements. Instead, it is up to the states to decide if they will require their J-1 waiver recipients to provide direct patient care or not.

It is important to acknowledge, however, the burden that IMGs experience when they do provide 40 hours of direct patient care per week, including having trouble balancing administrative tasks and not having opportunities for professional growth. Testimony from the 2023 Interim Meeting noted that physicians who are required to provide 40 hours of direct patient care a week find it difficult to navigate the complexities of continuous patient care while also aiming to dedicate time to administrative responsibilities and pursue non-clinical leadership roles. Testimony noted that this rigid structure hampers IMGs' abilities to effectively deliver high-quality medical services while fostering their own professional progress.

CONCLUSION

Given that there is no federal statutory requirement for physicians utilizing J-1 visa waivers to provide direct patient care, the Board believes that Resolution 217-I-23 should not be adopted. However, as discussed above, some states and federal programs have established minimal direct patient care requirements. IMGs in these states may experience challenges balancing administrative tasks and may not have the same opportunities for professional growth as IMGs in other states. The Board is not in a position to determine where the balance lies, but believes that, generally, J-1 visa waiver recipients should have time within their 40-hour work week to provide direct patient care, engage in administrative duties, participate in professional development opportunities, and undertake other professional responsibilities. The Board therefore recommends adoption of policy consistent with this goal.

RECOMMENDATIONS

The Board of Trustees recommends that the following policy be adopted in lieu of Resolution 217-I-23, and the remainder of the report be filed:

> Our American Medical Association supports federal visa and visa waiver policies that include time within the federally mandated work week requirements for direct patient care, administrative tasks, professional development opportunities, and other professional responsibilities. (New HOD Policy)

Fiscal Note: Less than $500.

APPENDIX A: STATE WORK REQUIREMENTS FOR J-1VISA WAIVER RECIPIENTS

State	Work Hour Requirements
States With 40 Hour Direct Patient Care Requirement	
Alabama	Primary care and mental health physicians must engage in direct patient care at least 40 hours per week (exclusive of hospital rounds and inpatient care).[28]
Florida	The physician will practice a minimum of 40 hours per week of direct patient care.[29]
Iowa	Direct care services must be provided for a minimum 3-year term and not less than forty (40) hours per week starting the first day of employment.[30]
Kansas	The physician must serve in the clinical practice of his/her profession full time, a minimum of 40 hours per week providing direct patient care at the approved practice site(s).[31]
New Mexico	Physicians must provide direct patient care services 40 hours per week.[32]
Ohio	The physician must spend a minimum of 40 hours per week in direct clinical care.[33]
Pennsylvania	The physician must practice a minimum of 40 clinical hours in direct patient care per week.[34]
South Carolina	The physician must spend a minimum of 40 hours weekly to provide care only.[35]
Utah	Physicians must provide direct patient care services 40 hours per week.[36]
Vermont	Physicians must work a minimum of 40 hours weekly to provide patient care only.[37]
Virginia	The physician will provide direct patient care for at least 40 hours per week.[38]
Washington	The physician will work not fewer than 40 hours per week providing direct clinical patient services.[39]
West Virginia	Full-time practice means providing hands-on, direct patient care for a minimum of 40 hours per week.[40]
Appalachian Regional Commission	The physician must agree to provide direct patient care for at least forty (40) hours a week.[41]
Delta Regional Authority	The physician must agree to provide 40 hours per week or 160 hours per month of direct patient care.[42]
Southeast Crescent Regional Commission	The physician must agree to provide 40 hours per week or 160 hours per month of direct patient care.[43]
States with 32 Hour Direct Patient Care Requirement	
Louisiana	The contract must state that the physician is a full-time employee working a minimum of 40 hours per week or 160 hours per month. The hours may include 8 hours of administrative time per week. This will not include hours in teaching settings, supervising residents, fellows, or students, supervising a clinic, or other administrative work.[44]
Maine	The physician must be employed full-time with the facility with 32 of the 40 hours spent providing direct patient care.[45]
Maryland	The physician must practice a minimum of 40 hours per week (at least 32 of the required 40 hours must be in direct patient care).[46]
New Hampshire	Physicians must work a minimum of 40 hours per week in an outpatient, clinical setting. At least 32 hours of the required 40 hours per week must be

	spent providing direct patient care in the outpatient ambulatory care setting at the approved service site. The remaining eight (8) hours must be spent providing clinical services for patients in the approved service site(s), in alternative settings (e.g., hospitals, nursing homes, shelters, etc.) as directed by the approved site(s), or in administrative activities. OB/GYN physicians, Family Practice physicians (who practice obstetrics on a regular basis) and Psychiatrists: the majority of the 40 hours per week (no less than 21 hours per week) is expected to be spent providing direct patient care. The remaining 19 hours must be spent providing inpatient care at the approved service site; providing clinical services in alternative settings (e.g., hospitals, nursing homes, shelters, etc.), as directed by the approved practice site(s); or performing practice related administration. Practice–related administrative activities shall not exceed 8 hours of the minimum 40 hours per week.[47]
North Carolina	The physician will provide at least forty (40) hours per week of clinic time that includes at least 32 hours per week in direct face-to-face patient care.[48]
South Dakota	The physician will perform an average of 40 hours of medical practice per week, meaning a four-week minimum of 128 hours seeing patients on an ambulatory or in-patient basis and 32 hours of administrative work for at least 48 weeks per year. Subject to approval by the Department, the physician may opt to practice down to a minimum of 64 hours per four-week period of direct patient care within the shortage area identified in the contract. In such instances, the J-1 physician will provide up to 96 additional hours per week under any of the following conditions: providing care to patients in either the hospital inpatient or outpatient department if the hospital is shown to serve a significant portion of shortage area residents; clinical outreach to underserved populations residing in a shortage area, whether directly in person or by electronic means; public health services if approved by the department; or direct patient care in a facility or setting that serves the underserved.[49]
Wisconsin	The physician must agree to work full-time (40 hours per week), with at least 32 hours per week spent in direct patient care.[50]
States With No Specific Direct Patient Care Requirement	
Alaska	Physicians will work for no less than 40 hours a week for three years.[51]
Arizona	Physicians must work 40 hours per week at an eligible service site.[52]
Arkansas	Physicians must provide primary or specialty medical care to patients for a minimum of 40 hours per week.[53]
California	The physician must practice medicine full-time.[54]
Colorado	The physician must practice full time in an underserved area for three years.[55]
Connecticut	The Physician Applicant will commit to three (3) years of full-time employment.[56]
Delaware	The site will employ the physician on a full-time basis (minimum of 40 hours per week).[57]
Georgia	The physician will practice medicine at least 40 hours per week (or at least 80 hours per two-week period) at the approved practice site(s) in the approved discipline for a minimum of three years.[58]
Hawaii	The physician must secure an employment contract to provide patient care for at least 40 hours per week.[59]
Idaho	The physician will engage in full-time (40 hours) employment at a health facility.[60]

Illinois	The physician will engage in full-time (40 hours) employment at a health care facility.[61]
Indiana	The physician will engage in full-time employment (at least 40 hours per week) at one or more eligible service sites.[62]
Kentucky	Physicians must work full-time (at least 40 hours per week at the approved worksite).[63]
Massachusetts	The physician must agree to practice medicine for a minimum of 40 hours per week providing clinical care only. Clinical care can include paperwork and phone calls related to patient care.[64]
Michigan	The physician will practice medicine (as defined by the signed contract with employer) for at least 40 hours per week.[65]
Minnesota	The physician must agree to work at the health care facility for at least 40 hours per week. Contracts that include protected time for activities other than patient care, such as research or teaching, must specify how many hours per week will be dedicated to those activities and how many hours per week will be dedicated to patient care.[66]
Mississippi	The physician must have an employment contract indicating full-time (40 hours per week) employment with the sponsoring medical facility.[67]
New Jersey	The physician must work for a minimum of forty (40) hours per week.[68]
New York	The physician will practice on a full-time basis providing patient care for a minimum of 40 hours per week.[69]
North Dakota	The physician will work full time (40 hours per week).[70]
Oklahoma	Full-time employment is defined as an average of 40 hours per week.[71]
Oregon	The physician will provide not less than 40 hours per week of patient services.[72]
Rhode Island	The physician must have a 40-hour, three-year position in a job consistent with the Department's mission.[73]
Tennessee	Each physician specialist must agree to practice his or her specialty in affiliation with the hospital for a minimum of forty (40) hours per week.[74]
Texas	The physician will provide patient care for a minimum of 40 hours per week.[75]
Wyoming	The physician must practice medicine a minimum of 40 hours per week.[76]
Northern Border Regional Commission	The physician must agree to practice primary medical care at least forty (40) hours a week.[77]

APPENDIX B: AMA POLICY

The following AMA policy is relevant to this Board Report:

J-1 Visas and Waivers D-255.993

1. Our AMA shall encourage HHS and other interested government agencies to continue sponsorship of the J-1 visa waiver program.

2. If the USDA does not continue in its role as an interested government agency (IGA), the AMA encourage HHS to expand its J-1 visa waiver program.

3. Our AMA will work with federal agencies to ensure better coordination of federal, state, and local agencies in monitoring the placement and enforcement of physicians service requirements through the J-1 waiver and Conrad-30 programs with a report back at A-03.

4. Our AMA will work towards regulation and/or legislation to allow physicians on H-1B visas for their J-1 visa waiver, who are limited to serving in medically underserved areas, to continue to care for their patients who require hospitalization in the closest appropriate medical facility which may not be in the underserved area.

5. Our AMA will work with state medical societies to study and report back on the feasibility of having a national data repository of J-1 Visa Waiver statistics so that J-1 Visa Waiver unoffered positions can be transferred to states as needed to treat underserved communities and to monitor the success of this program.

Conrad 30 - J-1 Visa Waivers D-255.985

1. Our AMA will:

    a. lobby for the reauthorization of the Conrad 30 J-1 Visa Waiver Program;
    b. advocate that the J-1 Visa waiver slots be increased from 30 to 50 per state;
    c. advocate for expansion of the J-1 Visa Waiver Program to allow IMGs to serve on the faculty of medical schools and residency programs in geographic areas or specialties with workforce shortages;
    d. publish on its website J-1 visa waiver (Conrad 30) statistics and information provided by state Conrad 30 administrators along with a frequently asked questions (FAQs) document about the Conrad 30 program;
    e. advocate for solutions to expand the J-1 Visa Waiver Program to increase the overall number of waiver positions in the US in order to increase the number of IMGs who are willing to work in underserved areas to alleviate the physician workforce shortage;
    f. work with the Educational Commission for Foreign Medical Graduates and other stakeholders to facilitate better communication and information sharing among Conrad 30 administrators, IMGs, US Citizenship and Immigration Services and the State Department; and
    g. continue to communicate with the Conrad 30 administrators and IMGS members to share information and best practices in order to fully utilize and expand the Conrad 30 program.

2. Our AMA will continue to monitor legislation and provide support for improvements to the J-1 Visa Waiver program.

3. Our AMA will continue to promote its educational or other relevant resources to IMGs participating or considering participating in J-1 Visa waiver programs.

4. As a benefit of membership, our AMA will provide advice and information on Federation and other resources (but not legal opinions or representation), as appropriate to IMGs in matters pertaining to work-related abuses.

5. Our AMA encourages IMGs to consult with their state medical society and consider requesting that their state society ask for assistance by the AMA Litigation Center, if it meets the Litigation Center's established case selection criteria.

Expedited Immigrant Green Card Visa for J-1 Visa Waiver Physicians Serving in Underserved Areas D-255.976

Our American Medical Association will advocate that physicians who are on J-1 visas be granted a waiver and H-1B status for serving in underserved areas, be given highest priority in visa conversion to green cards upon completion of their service commitment, and be exempt from the per country limitation of H-1B visa to green card conversion.

J-1 Exchange Visitor Program (J-1 Visa) H-255.975

1. Policy of the AMA states: the purpose of the physician J-1 Visa Exchange Program is to ameliorate physician specialty shortages in other countries; and the AMA will work to correct the problems of inconsistency, lack of accountability, and non-compliance in the administration of the physician J-1 Visa Exchange Program.

2. Our AMA supports a model employment contract specific to J-1 Visa Waiver physicians.

AMA Principles on International Medical Graduates H-255.988

Our AMA supports:

1. Current U.S. visa and immigration requirements applicable to foreign national physicians who are graduates of medical schools other than those in the United States and Canada.

2. Current regulations governing the issuance of exchange visitor visas to foreign national IMGs, including the requirements for successful completion of the USMLE.

3. The AMA reaffirms its policy that the U.S. and Canada medical schools be accredited by a nongovernmental accrediting body.

4. Cooperation in the collection and analysis of information on medical schools in nations other than the U.S. and Canada.

5. Continued cooperation with the ECFMG and other appropriate organizations to disseminate information to prospective and current students in foreign medical schools. An AMA member, who is an IMG, should be appointed regularly as one of the AMA's representatives to the ECFMG Board of Trustees.

6. Working with the Accreditation Council for Graduate Medical Education (ACGME) and the Federation of State Medical Boards (FSMB) to assure that institutions offering accredited residencies, residency program directors, and U.S. licensing authorities do not deviate from established standards when evaluating graduates of foreign medical schools.

7. In cooperation with the ACGME and the FSMB, supports only those modifications in established graduate medical education or licensing standards designed to enhance the quality of medical education and patient care.

8. The AMA continues to support the activities of the ECFMG related to verification of education credentials and testing of IMGs.

9. That special consideration be given to the limited number of IMGs who are refugees from foreign governments that refuse to provide pertinent information usually required to establish eligibility for residency training or licensure.

10. That accreditation standards enhance the quality of patient care and medical education and not be used for purposes of regulating physician manpower.

11. That AMA representatives to the ACGME, residency review committees and to the ECFMG should support AMA policy opposing discrimination. Medical school admissions officers and directors of residency programs should select applicants on the basis of merit, without considering status as an IMG or an ethnic name as a negative factor.

12. The requirement that all medical school graduates complete at least one year of graduate medical education in an accredited U.S. program in order to qualify for full and unrestricted licensure. State medical licensing boards are encouraged to allow an alternate set of criteria for granting licensure in lieu of this requirement: (a) completion of medical school and residency training outside the U.S.; (b) extensive U.S. medical practice; and (c) evidence of good standing within the local medical community.

13. Publicizing existing policy concerning the granting of staff and clinical privileges in hospitals and other health facilities.

14. The participation of all physicians, including graduates of foreign as well as U.S. and Canadian medical schools, in organized medicine. The AMA offers encouragement and assistance to state, county, and specialty medical societies in fostering greater membership among IMGs and their participation in leadership positions at all levels of organized medicine, including AMA committees and councils, the Accreditation Council for Graduate Medical Education and its review committees, the American Board of Medical Specialties and its specialty boards, and state boards of medicine, by providing guidelines and non-financial incentives, such as recognition for outstanding achievements by either individuals or organizations in promoting leadership among IMGs.

15. Support studying the feasibility of conducting peer-to-peer membership recruitment efforts aimed at IMGs who are not AMA members.

16. AMA membership outreach to IMGs, to include a) using its existing publications to highlight policies and activities of interest to IMGs, stressing the common concerns of all physicians; b) publicizing its many relevant resources to all physicians, especially to nonmember IMGs; c) identifying and publicizing AMA resources to respond to inquiries

from IMGs; and d) expansion of its efforts to prepare and disseminate information about requirements for admission to accredited residency programs, the availability of positions, and the problems of becoming licensed and entering full and unrestricted medical practice in the U.S. that face IMGs. This information should be addressed to college students, high school and college advisors, and students in foreign medical schools.

17. Recognition of the common aims and goals of all physicians, particularly those practicing in the U.S., and support for including all physicians who are permanent residents of the U.S. in the mainstream of American medicine.

18. Its leadership role to promote the international exchange of medical knowledge as well as cultural understanding between the U.S. and other nations.

19. Institutions that sponsor exchange visitor programs in medical education, clinical medicine and public health to tailor programs for the individual visiting scholar that will meet the needs of the scholar, the institution, and the nation to which he will return.

20. Informing foreign national IMGs that the availability of training and practice opportunities in the U.S. is limited by the availability of fiscal and human resources to maintain the quality of medical education and patient care in the U.S., and that those IMGs who plan to return to their country of origin have the opportunity to obtain GME in the United States.

21. U.S. medical schools offering admission with advanced standing, within the capabilities determined by each institution, to international medical students who satisfy the requirements of the institution for matriculation.

22. The Federation of State Medical Boards, its member boards, and the ECFMG in their willingness to adjust their administrative procedures in processing IMG applications so that original documents do not have to be recertified in home countries when physicians apply for licenses in a second state.

23. Continued efforts to protect the rights and privileges of all physicians duly licensed in the U.S. regardless of ethnic or educational background and opposes any legislative efforts to discriminate against duly licensed physicians on the basis of ethnic or educational background.

24. Continued study of challenges and issues pertinent to IMGs as they affect our country's health care system and our physician workforce.

25. Advocacy to Congress to fund studies through appropriate agencies, such as the Department of Health and Human Services, to examine issues and experiences of IMGs and make recommendations for improvements.

Visa Complications for IMGs in GME D-255.991

1. Our AMA will:

    a. work with the ECFMG to minimize delays in the visa process for International Medical Graduates applying for visas to enter the US for postgraduate medical training and/or medical practice;

b. promote regular communication between the Department of Homeland Security and AMA IMG representatives to address and discuss existing and evolving issues related to the immigration and registration process required for International Medical Graduates; and
c. work through the appropriate channels to assist residency program directors, as a group or individually, to establish effective contacts with the State Department and the Department of Homeland Security, in order to prioritize and expedite the necessary procedures for qualified residency applicants to reduce the uncertainty associated with considering a non-citizen or permanent resident IMG for a residency position.

2. Our AMA International Medical Graduates Section will continue to monitor any H-1B visa denials as they relate to IMGs inability to complete accredited GME programs.

3. Our AMA will study, in collaboration with the Educational Commission on Foreign Medical Graduates and the Accreditation Council for Graduate Medical Education, the frequency of such J-1 Visa reentry denials and its impact on patient care and residency training.

4. Our AMA will, in collaboration with other stakeholders, advocate for unfettered travel for IMGs for the duration of their legal stay in the US in order to complete their residency or fellowship training to prevent disruption of patient care.

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

1. Our American Medical Association recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine.

2. Our AMA will oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion.

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

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

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

6. Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S.

APPENDIX C: REFERENCES

[1] https://travel.state.gov/content/travel/en/us-visas/study/exchange.html.
[2] https://www.law.cornell.edu/cfr/text/22/62.27.
[3] https://www.ecfmg.org/evsp/applying-general.html.
[4] https://j1visa.state.gov/wp-content/uploads/2014/10/Subpart-A-Federal-Register-publication-8893_PublishedFR_10-6-2014.pdf.
[5] https://www.acgme.org/globalassets/PFAssets/ProgramRequirements/CPRResidency_2022v2.pdf.
[6] https://www.uscis.gov/working-in-the-united-states/h-1b-specialty-occupations.
[7] https://www.uscis.gov/working-in-the-united-states/h-1b-specialty-occupations.
[8] https://www.dol.gov/agencies/whd/fact-sheets/68-h1b-fulltime-employee#:~:text=A%20full%2Dtime%20week%20is,to%20be%20full%2Dtime%20employment.
[9] https://travel.state.gov/content/travel/en/us-visas/study/exchange.html.
[10] https://www.law.cornell.edu/cfr/text/22/62.27.
[11] https://travel.state.gov/content/travel/en/us-visas/study/exchange.html.
[12] https://www.uscis.gov/working-in-the-united-states/students-and-exchange-visitors/conrad-30-waiver-program.
[13] https://www.uscis.gov/policy-manual/volume-2-part-d-chapter-4.
[14] https://travel.state.gov/content/travel/en/us-visas/study/exchange/waiver-of-the-exchange-visitor/eligibility.html.
[15] https://www.hhs.gov/about/agencies/oga/about-oga/what-we-do/exchange-visitor-program/index.html.
[16] https://www.law.cornell.edu/cfr/text/45/50.5.
[17] https://www.hhs.gov/about/agencies/oga/about-oga/what-we-do/visitor-exchange-program/supplementary-b-clinical-care.html.
[18] https://www.law.cornell.edu/cfr/text/45/50.5.
[19] https://travel.state.gov/content/travel/en/us-visas/study/exchange/waiver-of-the-exchange-visitor/how-to-apply-waiver.html.
[20] https://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=10033.
[21] https://www.law.cornell.edu/cfr/text/22/41.63#:~:text=(3)%20An%20exchange%20visitor%20who,objection%20from%20his%20or%20her.
[22] https://www.uscis.gov/working-in-the-united-states/students-and-exchange-visitors/conrad-30-waiver-program.
[23] https://www.uscis.gov/working-in-the-united-states/students-and-exchange-visitors/conrad-30-waiver-program.
[24] https://nhsc.hrsa.gov/sites/default/files/nhsc/scholarships/scholarship-guidance-definitions.pdf.
[25] https://nhsc.hrsa.gov/scholarships/requirements-compliance.
[26] https://www.ihs.gov/loanrepayment/policiesandprocedures/employmentrequirements/.
[27] https://studentaid.gov/manage-loans/forgiveness-cancellation/public-service#full-time-employment.
[28] https://www.alabamapublichealth.gov/ruralhealth/j1visa.html.
[29] https://www.floridahealth.gov/provider-and-partner-resources/community-health-workers/HealthResourcesandAccess/conrad-30-program-j-1-visa/index.html.
[30] https://hhs.iowa.gov/media/2849/download?inline=.
[31] https://www.kdhe.ks.gov/DocumentCenter/View/640/Kansas-Conrad-State-30-J-1-Visa-Waiver-Program-KDHE-PDF.
[32] https://www.nmhealth.org/publication/view/form/7707/.
[33] https://odh.ohio.gov/wps/wcm/connect/gov/4a0f8ba1-68fd-4916-9c00-ec74598d87ef/OPHE_2024+State+30+Application+Packet_02122024.pdf?MOD=AJPERES&CONVERT_TO=url&CACHEID=ROOTWORKSPACE.Z18_79GCH8013HMOA06A2E16IV2082-4a0f8ba1-68fd-4916-9c00-ec74598d87ef-oSEiFyt.
[34] https://www.health.pa.gov/topics/Documents/Health%20Planning/J-1VisaWaiverProgram%20Revised%20Policy.pdf.
[35] https://scdhec.gov/sites/default/files/media/document/J-1-Application-Components.pdf.
[36] https://ruralhealth.utah.gov/j-1-visa-waivers/.
[37] https://www.healthvermont.gov/sites/default/files/documents/pdf/ADM_J-1_Application_Checklist.pdf.
[38] https://www.vdh.virginia.gov/content/uploads/sites/76/2023/08/2023-2025-Conrad-30-Waiver-Program-Guidelines-Updated-February-2023.pdf.

[39] https://doh.wa.gov/sites/default/files/legacy/Documents/Pubs/346003.pdf.
[40] https://dhhr.wv.gov/ruralhealth/j1conrad30arc/Documents/J1%20DOS%20%20Packet%201-2024.pdf.
[41] https://www.arc.gov/j-1-visa-waivers/.
[42] https://dra.gov/wp-content/uploads/2023/03/J-1_Visa_Waiver_Application_Requirements_-_2022.pdf.
[43] https://scrc.gov/sites/default/files/2024-04/j-1-waiver-application-requirements.pdf.
[44] https://wellaheadla.com/healthcare-access/louisiana-primary-care-office/louisiana-conrad-30-j-1-visa-waiver-program/#.
[45] https://www.maine.gov/dhhs/mecdc/public-health-systems/rhpc/documents/J1Guide.pdf.
[46] https://health.maryland.gov/pophealth/Documents/J1%20Visa%20Waiver/Maryland%20J-1%20Policy%20and%20Procedures%20Updated%202022.pdf.
[47] https://www.dhhs.nh.gov/sites/g/files/ehbemt476/files/inline-documents/sonh/j1waiver_0.pdf.
[48] https://www.ncdhhs.gov/j-1-visa-waiver-2022-2023-guidelines-final/download?attachment.
[49] https://doh.sd.gov/healthcare-professionals/rural-health/j-1-waiver-program/j-1-visa-waiver-application-content/.
[50] https://www.dhs.wisconsin.gov/primarycare/j-1visa/description.htm.
[51] https://health.alaska.gov/dph/Emergency/Documents/healthcare/workforce/AK%20J-1%20Guidelines.pdf.
[52] https://www.azdhs.gov/documents/prevention/health-systems-development/workforce-programs/j-1-visa-waiver/j1-visa-waiver.pdf?v=20240513.
[53] https://www.healthy.arkansas.gov/images/uploads/pdf/J-1_visa_waiver_application.pdf.
[54] https://hcai.ca.gov/workforce/health-workforce/california-primary-care-office/j-1-visa-waiver-program/.
[55] https://cdphe.colorado.gov/prevention-and-wellness/health-access/international-medical-graduates/j-1-visa-waiver-program.
[56] https://portal.ct.gov/-/media/dph/conrad-30--j-1-visa-waiver-program/2023-24-conrad-30-waiver-application-packet.pdf.
[57] https://dhss.delaware.gov/dph/hsm/files/j1visaregs.pdf.
[58] https://dch.georgia.gov/georgias-j-1-visa-waiver-program.
[59] https://www.3rnet.org/Locations/Hawaii.
[60] https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=3210&dbid=0&repo=PUBLIC-DOCUMENTS.
[61] https://dph.illinois.gov/content/dam/soi/en/web/idph/publications/idph/topics-and-services/life-stages-populations/rural-underserved-populations/j1-waiver-program/j1-waiver-application-2023.pdf.
[62] https://www.in.gov/health/cdpc/files/IN-J-1-Visa-Waiver-2020-Program-Guidlines_8.27.2020.pdf.
[63] https://www.chfs.ky.gov/agencies/dph/dpqi/hcab/hcabdocs/J1%20Guidelines%20Revised%204.9.24.pdf.
[64] https://www.mass.gov/doc/massachusetts-conrad-30-j-1-visa-waiver-program-policy-0/download.
[65] https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Doing-Business-with-MDHHS/Health-Care-Providers/Conrad-30/Michigan_Conrad_30_Application_Guidelines.pdf?rev=377b7e91739d4fac9ba8ea6ba3ac8ca7&hash=3061555762D062C8E0CA6F7A5B3B5E41.
[66] https://www.health.state.mn.us/facilities/ruralhealth/j1/docs/j1appguide.pdf.
[67] https://msdh.ms.gov/page/resources/4254.pdf.
[68] https://healthapps.state.nj.us/forms/subforms.aspx?pro=fhs/j1&_gl=1*18jw46d*_ga*MTQ1MjMzOTA3Ny4xNzIxNjc2Njg0*_ga_5PWJJG6642*MTcyMTY3NjY4My4xLjAuMTcyMTY3NjY4My4wLjAuMA.
[69] https://www.health.ny.gov/professionals/j-1_visa_waivers/.
[70] https://www.hhs.nd.gov/sites/www/files/documents/DOH%20Legacy/Primary%20Care%20Office/nd-j1-policy-and-guidelines.pdf.
[71] https://oklahoma.gov/content/dam/ok/en/health/health2/aem-documents/organization/center-for-health-innovation-and-effectiveness/J12023-24pkg2.pdf.
[72] https://www.oregon.gov/oha/HPA/HP-PCO/J1VisaWaiverProgram/J1-Application.pdf.
[73] https://health.ri.gov/publications/requirements/PhysicianVisaWaiver.pdf.
[74] https://www.tn.gov/content/dam/tn/health/documents/1200-20-11.pdf.
[75] https://www.dshs.state.tx.us/sites/default/files/STATEEPI-TPCO/Documents/FY25%20Conrad30%20J1%20Visa%20Policy%20Manual%20-%20Final.pdf.
[76] https://health.wyo.gov/wp-content/uploads/2016/04/53-13067_Wyoming_Conrad_30_J-1_Visa_Waiver_Program_Guidelines_and_Application_Information_October_2012-1.pdf.
[77] https://www.nbrc.gov/userfiles/files/J%201-Visa/Link%205%20-%20J-1%20Waiver%20Employer%20Letter%20Outline.pdf.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 06-I-24

Subject:	Health Technology Accessibility for Aging Patients (Resolution 213-I-23)
Presented by:	Michael Suk, MD, JD, MPH, MBA, Chair
Referred to:	Reference Committee B

INTRODUCTION

At the 2023 Interim Meeting, the House of Delegates (HOD) referred Resolution 213-I-23, "Health Technology Accessibility for Aging Patients," sponsored by the Medical Student Section (MSS). Resolution 213-I-23 asked our American Medical Association (AMA) to:

> "support the development of a standardized definition of 'age-friendliness' in health information technology (HIT) advancements; encourage appropriate parties to identify best practices to set expectations of HIT developers to ensure that they create devices and technology applicable to and easily accessible by older adults; work with relevant organizations to encourage the utilization of industry standards of web content accessibility to make electronic health record software accessible for patients with visual impairments without requiring them to use third-party programs; and require EHR providers to provide standardized, easily accessible digital storage space for advanced care paperwork."

Testimony was largely in support for the spirit of this resolution. Testimony highlighted the need for electronic health record (EHR) vendors to design applications that better assist the needs of aging patient populations to enable them to fully realize the potential of evolving devices and technologies. Others expressed that, while specific standards for EHR functionalities aimed at older adults is desired, a more holistic approach to addressing issues that affect a broader population, including underserved and marginalized patients and their barriers to fully utilizing health information technology, may be a more effective route for AMA advocacy.

BACKGROUND

The COVID-19 public health emergency (PHE) was the catalyst to a seismic shift in the way technology to deliver and receive care is utilized. With telehealth visits being the only mechanism to continue receiving most forms of care during the PHE, it was essential that patients could connect to their physician through video or audio technology. Aside from the known issues stemming from lack of access to a quality broadband connection for some, a separate issue persists pertaining to whether a patient has the technical ability or familiarity to successfully access an online portal, operate and troubleshoot audiovisual equipment, and communicate without the cues available during an in-person visit.[1] This is a major obstacle to achieving equitable access to telehealth and the optimal use of ancillary digital services such as a patient portal application to view clinical care summaries.

Disparities surrounding the use and adoption of technology in health care are varied and multidimensional and range from issues such as patients being unable to navigate the health care system to physician-patient communication difficulties, which are sometimes exacerbated despite implementation of new technologies.[2,3] Digital health literacy limitations as one example, create foundational barriers that are hard to overcome without the help from a physician or caretaker. Enhancements in technology may be extremely helpful in streamlining communications and other administrative functions; however, patients of any age with a mental or physical disability may be unable to experience the benefits because of that disability. More broadly, patients may have limitations due to inexperience with technology. Telehealth and other forms of health information technology (health IT) have proven to be essential tools for physicians but, the breadth of those who benefit is limited since it is not always designed in a way that is accessible to all.

AMA POLICY

Existing AMA policy encourages telehealth solution and service providers to implement design functionality, content, user interface, and service access best practices with and for historically minoritized and marginalized communities, including addressing culture, language, technology accessibility, and digital literacy within these populations (H-480.937).[4] Additionally, this policy supports efforts to design telehealth technology, including voice-activated technology, with and for those with difficulty accessing technology, such as older adults, individuals with vision impairment, and individuals with disabilities.

AMA Code of Medical Ethics (Code) recognizes that "[i]nnovation in technology, including information technology, is redefining how people perceive time and distance. It is reshaping how individuals interact with and relate to others, including when, where, and how patients and physicians engage with one another." The Code states that collectively, through their professional organizations and health care institutions, physicians should:

(i) Support ongoing refinement of telehealth/telemedicine technologies, and the development and implementation of clinical and technical standards to ensure the safety and quality of care.
(j) Advocate for policies and initiatives to promote access to telehealth/telemedicine services for all patients who could benefit from receiving care electronically.
(k) Routinely monitor the telehealth/telemedicine landscape to:
    (i) identify and address adverse consequences as technologies and activities evolve; and
    (ii) identify and encourage dissemination of both positive and negative outcomes.

Policy H-480.937, however, does not explicitly address the needs for electronic structured advance care planning or adequate space to be available in the EHR to be accessible quickly. The Code states that physicians should routinely engage their patients in advance care planning in keeping with the following guidelines including incorporating notes from the advance care planning discussion into the medical record.[5]

DISCUSSION

<u>Addressing Equity in Telehealth and Health IT</u>

Access to telehealth services can be a lifeline to patients across the country and facilitates unprecedented expansion in access to crucial health care services. Also, telehealth and the use of other digital modalities will continue to be integrated into the health care system framework for treating patients and managing their care. Unfortunately, using technology to access care does not

come easily for all older adults. In a 2020 *JAMA* study measuring the prevalence of telemedicine unreadiness among older adults, the authors found that in 2018 an estimated 13 million of all older adults in the United States were not ready for video visits, predominantly owing to inexperience with technology.[6] The authors defined "unreadiness" as meeting any of the following criteria for disabilities or inexperience with technology: (1) difficulty hearing well enough to use a telephone, (2) problems speaking or making oneself understood, (3) possible or probable dementia, (4) difficulty seeing well enough, (5) owning no internet-enabled devices or being unaware of how to use them, or (6) no use of email, texting, or internet.[7] In policy H-480.937, Addressing Equity in Telehealth, our AMA supports efforts to design telehealth technology, including voice-activated technology, with and for those with difficulty accessing technology, such as older adults, individuals with vision impairment and individuals with disabilities. Telehealth must address a broad spectrum of patients with both physical and mental disabilities, of all ages and backgrounds. To help ensure equitable access including appointment scheduling, patients who are without technological proficiency or access may require a method other than electronic communication.

Electronic Advanced Care Planning

In emergent situations, the patient's EHR information may be the only means of getting physicians and the care team advanced care planning (ACP) information in the event the patient is incapacitated or when there is no family or caregiver to ensure that the patient's wishes are respected in an imminent situation. Relying on a system where ACP documentation standards are low may expose physicians to unnecessary liability with the risk of incomplete or inaccurate forms that purport to officially represent patient's preferences when in fact the information may be inaccurate or out of date.[8] One challenging aspect of ACP documentation is the non-standardized nature of documentation methods. However, there is a movement to promote structured advance care planning (S-ACP) documentation within the EHR that better facilitates the transition of most medical documentation to the EHR and allows for ACP documentation to be rapidly disseminated across diverse ambulatory settings.[9] S-ACP may provide important advantages to free-text ACP documentation, including standardization, ease-of-access, lower provider-level variability, and auditability; recognizing that it is of value to maintain a level of flexibility to capture unique, patient-centered details.[10]

CONCLUSION

The Board of Trustees (Board) recognizes that the need for accessibility considerations for health IT tools is critically important to achieve equity among aging populations, as well as underserved, marginalized, and disabled populations. The Board shares the goal of supporting efforts aimed at addressing telehealth and equity, as well as associated barriers to patients being able to fully realize the potential of technology that can increase access to care and promote better health outcomes. Resolution 213-I-23 provides an example of one population, namely the aging population, that can benefit from stronger considerations being given to developers of health IT. As discussed above, the AMA has existing policy that more broadly addresses the issue of equity and telehealth but welcomes the opportunity to further refine and enhance existing policy to be aligned with the spirit of this resolution. The Board recognizes the importance of ensuring safeguards for those who are without technological access or access. The Board, therefore, recommends amending existing policy H-480.937 in lieu of Resolution 213-I-23.

RECOMMENDATIONS

The Board of Trustees recommends that the following recommendations be adopted in lieu of Resolution 213-I-23, and the remainder of the report be filed.:

That our American Medical Association amend Policy H-480-937 by addition and the title be changed by addition.

Policy H-480-937, ADDRESSING EQUITY IN TELEHEALTH AND HEALTH TECHNOLOGY

(1) Our American Medical Association recognizes access to broadband internet as a social determinant of health.
(2) Our AMA encourages initiatives to measure and strengthen digital literacy, with appropriate education programs, and with an emphasis on programs designed with and for historically marginalized and minoritized populations.
(3) Our AMA encourages telehealth solution and service providers to implement design functionality, content, user interface, and service access best practices with and for historically minoritized and marginalized communities, including addressing culture, language, technology accessibility, and digital literacy within these populations.
(4) Our AMA supports efforts to design and to improve the usability of existing electronic health record (EHR) and telehealth technology, including voice-activated technology, with and for those with difficulty accessing technology, such as older adults, individuals with vision impairment and individuals with other mental or physical disabilities.
(5) Our AMA encourages hospitals, health systems and health plans to invest in initiatives aimed at designing access to care via telehealth with and for historically marginalized and minoritized communities, including improving physician and non-physician provider diversity, offering training and technology support for equity-centered participatory design, and launching new and innovative outreach campaigns to inform and educate communities about telehealth.
(6) Our AMA supports expanding physician practice eligibility for programs that assist qualifying health care entities, including physician practices, in purchasing necessary services and equipment in order to provide telehealth services to augment the broadband infrastructure for, and increase connected device use among historically marginalized, minoritized and underserved populations.
(7) Our AMA supports efforts to ensure payers allow all contracted physicians to provide care via telehealth.
(8) Our AMA opposes efforts by health plans to use cost-sharing as a means to incentivize or require the use of telehealth or in-person care or incentivize care from a separate or preferred telehealth network over the patient's current physicians.
(9) Our AMA will advocate that physician payments should be fair and equitable, regardless of whether the service is performed via audio-only, two-way audio-video, or in-person.
(10) Our AMA encourages the development of improved solutions to incorporate structured advance care planning (ACP) documentation standards that best meet the requisite needs for patients and physicians to easily store and access in the EHR complete and accurate ACP documentation that maintains the flexibility to capture unique, patient-centered details.
(11) Our AMA encourages hospitals, health systems, and physician practices to provide a method other than electronic communication for patients who are without technological proficiency or access. (Modify Current HOD Policy)

Fiscal Note Less than $500

REFERENCES

[1] Lam K, Lu AD, Shi Y, Covinsky KE. Assessing Telemedicine Unreadiness Among Older Adults in the United States During the COVID-19 Pandemic. JAMA Intern Med. 2020;180(10):1389–1391. doi:10.1001/jamainternmed.2020.2671.
[2] Saeed SA, Masters RM. Disparities in Health Care and the Digital Divide. Curr Psychiatry Rep. 2021 Jul 23;23(9):61. doi: 10.1007/s11920-021-01274-4. PMID: 34297202; PMCID: PMC8300069.
[3] Cosco TD, Fortuna K, Wister A, Riadi I, Wagner K, Sixsmith A
COVID-19, Social Isolation, and Mental Health Among Older Adults: A Digital Catch-22
J Med Internet Res 2021;23(5): e21864.
[4] Addressing Equity in Telehealth H-480.937
[5] 5.1 Advance Care Planning.
[6] Lam K, *supra* note 1.
[7] Id.
[8] Lakin JR, Gundersen DA, Lindvall C, Paasche-Orlow MK, Tulsky JA, Brannen EN, Pollak KI, Kennedy D, McLeggon JA, Stout JJ, Volandes A; ACP-PEACE Investigators. A Yet Unrealized Promise: Structured Advance Care Planning Elements in the Electronic Health Record. J Palliat Med. 2021 Aug;24(8):1221-1225. doi: 10.1089/jpm.2020.0774. Epub 2021 Apr 7. PMID: 33826860; PMCID: PMC8309417.
[9] Wu, A., Huang, R.J., Colón, G.R. et al. Low rates of structured advance care planning documentation in electronic health records: results of a single-center observational study. BMC Palliat Care 21, 203 (2022). https://doi.org/10.1186/s12904-022-01099-9
[10] Id.

REPORT 09 OF THE BOARD OF TRUSTEES (I-24)
Corporate Practice of Medicine Prohibition (Resolution 233-I-23)
Reference Committee B

EXECUTIVE SUMMARY

At the American Medical Association (AMA) 2023 Interim Meeting, the House of Delegates (HOD) referred Resolution 233 entitled, "Corporate Practice of Medicine Prohibition." Resolution 233 was introduced by the Private Practice Physicians Section and the Organized Medical Staff Section. The HOD referred the following amendment to existing AMA Policy H-215.981 entitled, "Corporate Practice of Medicine:"

> Our AMA ~~vigorously opposes any effort to pass~~ will seek federal legislation to ~~preempting state laws~~ prohibit~~ing~~ the corporate practice of medicine by limiting ownership and corporate control of physician medical practices to physicians or physician-owned groups only and ensure private equity/non-medical groups do not have a controlling interest.

This report begins by discussing: (1) the different perspectives that physicians may have regarding corporate investment in physician practices; (2) the purpose of the corporate practice of medicine prohibition; and (3) the proposals that some state legislatures are considering, including corporate practice of medicine prohibitions, to restrict and scrutinize corporate investors' influence on physician practices and health care generally.

This report then examines the prospects for the federal legislation called for by Resolution 233. The Board of Trustees (Board) describes its concerns and the unintended consequences that might be the result of the AMA developing federal legislation.

Critically, however, the Board believes that the AMA should be heavily engaged in fighting the negative influence that private equity and other corporate investors are having on the practice of medicine, and that this engagement should include influencing federal legislative proposals and continuing to work closely with state medical associations in the state advocacy arena.

To this end, the Board recommends that, in lieu of adopting Resolution 233, the AMA HOD amend AMA Policy H-215.981 by: (1) adding new policy to vigorously oppose any effort to pass legislation or regulation that removes or weakens state laws prohibiting the corporate practice of medicine; (2) adding new policy that AMA opposes the corporate practice of medicine and supports the restriction of ownership and operational authority of physician medical practices to physicians or physician-owned groups; (3) amending existing policy so that AMA will work with interested state medical associations the federal government and other interested parties to develop and advocate for regulations and appropriate legislation pertaining to corporate control of practices in the health care sector such that physician clinical autonomy and operational authority are preserved and protected; and (4) adding new policy that directs the AMA to create a state corporate practice of medicine template to assist the Federation on these issues.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 09-I-24

Subject: Corporate Practice of Medicine Prohibition (RES 233-I-23)

Presented by: Michael Suk, JD, MPH, MBA, MD, Chair

Referred to: Reference Committee B

INTRODUCTION

This American Medical Association (AMA) Board of Trustees report arises from Resolution 233"Corporate Practice of Medicine Prohibition", introduced at the 2023 Interim Meeting by the Private Practice Physicians Section (PPPS) and the Organized Medical Staff Section (OMSS). The AMA House of Delegates (HOD) referred the following amendments to existing policy:

RESOLVED, That our American Medical Association amend policy H-215.981, Corporate Practice of Medicine, by deletion and substitution to read as follows:

1. Our AMA ~~vigorously opposes any effort to pass~~ will seek federal legislation to ~~preempting state laws~~ prohibit~~ing~~ the corporate practice of medicine by limiting ownership and corporate control of physician medical practices to physicians or physician-owned groups only and ensure private equity/non-medical groups do not have a controlling interest.

2. At the request of state medical associations, our AMA will provide guidance, consultation, and model legislation regarding the corporate practice of medicine, to ensure the autonomy of hospital medical staffs, employed physicians in non-hospital settings, and physicians contracting with corporately owned management service organizations.

3. Our AMA will continue to monitor the evolving corporate practice of medicine with respect to its effect on the patient-physician relationship, financial conflicts of interest, patient centered care and other relevant issues. (Directive to Take Action).

Testimony was largely supportive of the resolution's underlying objectives to: (1) strengthen corporate practice of medicine prohibitions and (2) limit the controlling influence of corporate investors in health care. Much of the debate centered on the appropriateness of federal legislation to achieve this goal, in part because corporate practice of medicine (CPOM) prohibitions is governed at the state level.

BACKGROUND

The health care sector has become attractive to corporate investors. Private equity (PE) and other corporate investors are well-positioned to capitalize on the vulnerability of independent physician

practices. At the same time, an array of factors related to the complexity of care delivery—including changes in payment and delivery models, physician payment challenges, and increased administrative and regulatory burdens, health care consolidation, etc. (all of which contribute to physician practice instability and physician burnout)—drive some physicians toward corporate investment to remain independent. For many, the only other option is employment with a hospital, health insurer, etc.

Physicians are on Both Sides of this Issue

Reasons Why Physicians May Value Corporate Investment in Medical Practices

Physicians may find value in corporate investment for several reasons. Some physicians consider corporate investment as the only way to stay independent. A corporate investor may be able to manage the financial and administrative aspects of practice operations, leaving more time for physicians to focus on patient care. Other benefits may include financially attractive deals for physicians looking to exit ownership of their practices; access to capital for practice expenses or expansions; potentially reduced medical liability costs; and centralized resources for certain functions such as information technology, marketing, or human resources. To this end, some physician practices have invited corporate investors into their practices.

Reasons Why Physicians May Oppose Corporate Investment in Medical Practices

On the other hand, some physicians oppose corporate investment in physician practices because in some cases corporate investors have taken control over physician practices and exerted undue influence over clinical matters that should be reserved exclusively to the physicians. Furthermore, some investors employ a short-term business model whereby once they invest in and/or start managing a practice, they make drastic cost-cutting changes to both the practice's business operations and clinical operations. Examples of these changes include hiring non-physician practitioners to replace physicians, altering physician working conditions for the worse, and forcing physicians to do more with less. Moreover, it is not unusual for physicians to be bound by physician noncompete agreements that hinder their ability to leave the practice. There are also instances where, after the investor has extracted all profits that it can from the practice, the investor may exit and leave the practice in debt if not bankruptcy. All of this has the potential to create uncertainties for non-owner early- and mid-career physicians, placing physicians under inordinate stress and further contributing to physician burnout.

Purpose of the CPOM

To date, CPOM prohibitions have been governed at the state level—as states use their police power to protect the health and welfare of their citizens by preventing the commercialization of medicine. One of the common ways states have tried to limit lay control over physicians is by restricting lay entity or non-physician ownership in physician practices, a strategy recognized by Resolution 233. The majority of states take this approach.

For example, some of these states prohibit lay entities or non-physician practitioners from having any ownership in a practice, meaning that the practice must be wholly owned by physicians. Other states allow lay entities or individuals to own part of the practice but require that physicians must have a majority interest in the practice. In California, for example, at least 51 percent of the shares of a physician practice must be owned by a licensed physician or surgeon.

From what has been stated, it is clear that some states do not prohibit corporate investors from owning a physician practice. It is important to note, however, that these states often have in place other requirements that are designed to prohibit those investors from controlling the practice of medicine, e.g., actively enforcing fee-splitting prohibitions.

In states that prohibit or limit corporate investors from owning physician practices (in whole or in part), the only corporations that are permitted to practice medicine are physician-owned legal entities, typically known as a professional corporation or professional medical corporation (PC). States have specific requirements regarding how a PC can be structured, including but not limited to, who can serve as shareholders or owners and the composition of the board of directors.

Use of the "Friendly PC" or "Friendly Physician" Model in States that Prohibit or Limit Non-Physician Ownership in a PC

In the states that do not permit corporate investors from having a controlling interest in a PC, investors typically use an arrangement often referred to as the "friendly physician" model to invest indirectly in the practice. This is done through forming a corporation often referred to as a "management services organization" (MSO). Here the PC is frequently consolidated into one (or a small number) of the designated physician owners, some of whom will serve as "friendly physicians," i.e., sympathetic to the MSO (such that they will effectively control the PC entity on the MSO's behalf). The MSO may designate a "friendly physician" owner with whom it has a prior relationship, and who may be totally unknown to the PC's current owner physicians. Further, the MSO may have the right to replace the physician owners either at will or based upon the occurrence of a variety of events (e.g., incurrence of additional debt, initiating bankruptcy proceedings, etc.). Finally, the PC pays the MSO for providing administrative services and oftentimes, the MSO buys the practice's nonclinical assets, e.g., the office building, real estate, furniture, computers and other IT—and then leases those back to the practice. Unfortunately, as noted by the California Medical Association in an amicus brief submitted in a lawsuit filed by the American Academy of Emergency Medicine Physician Group (*American Academy of Emergency Medicine Physician Group (AAEMPG) v. Envision Healthcare Corp.*),

> Such "friendly" medical corporation arrangements are common, and in many cases can be desirable because they enable medical corporations to access and take advantage of needed capital and market resources. However, in some instances the "friendly" alignment between a lay entity and a medical corporation can cross over into prohibited territory, wherein the lay entity gains undue influence or control over the medical corporation.

Notably, the American College of Emergency Physicians also filed an amicus brief in this case.

Recent State Legislative Activity

While it is widely recognized that in many states the CPOM has been underenforced, the situation is rapidly changing. States are very aware of the harm that some PE and corporate investors have wrought in health care. State legislatures are closely scrutinizing the role of corporate interests in health care and considering diverse legislative proposals to limit the control that corporate investors have with respect to the practice of medicine, hospitals, and health care generally. What follows is a brief description, for illustrative purposes, of three state legislative strategies from 2024—strategies that other states are considering, including but not limited to strengthening the CPOM doctrine.

California AB 3129, which is currently being considered by the state senate (as of the writing of this report), would require a PE group or a hedge fund to notify and obtain the consent of the California attorney general before a transaction between the PE group or hedge fund and a health care facility, provider, or provider group, and any of those entities under common control or affiliated with a payer, can be completed. (AB 3129 amends a current prenotification law to include PE groups and hedge funds.) These notice and consent requirements, combined with a description of specific practices over which corporate interests may not intrude, may bolster the CPOM ban in California. Specifically, they call attention to transactions that may pose a threat to independent practice of medicine by physicians and provide a clearer basis for a stronger exercise of state enforcement authority. At least 10 states have enacted similar prior notice laws.

Further, per AB 3129, a PE group or hedge fund would be prohibited from interfering with the professional judgment of physicians in making health care decisions, including but not limited to: (1) determining what diagnostic tests are appropriate for a particular condition; (2) determining the need for referrals to, or consultation with, another physician; (3) being responsible for the ultimate overall care of the patient, including treatment options available to the patient; and (4) determining how many patients a physician shall see in a given period of time or how many hours a physician shall work.

Massachusetts has also been considering different bills that would help the state impose greater scrutiny and control over PE and corporate investors in the state, e.g., H 4620. As of the writing of this report, among many other provisions, H 4620, like California AB 3129, would impose notice and reporting requirements for PE acquisitions, including the size and market share of any significant equity investor in a physician practice. It also would authorize the state attorney general to collect information from PE groups and MSOs (the bill has other requirements specific to MSOs). Finally, H 4620 would also require practices to provide notice of "significant transfers of assets including, but not limited to, real estate sale lease-back arrangements," and would ban the future leasing of land from real estate investment trusts for the operation of a hospital's in-patient facilities. It would also require increased disclosure of other lease arrangements.

Finally, Oregon considered HB 4130. HB 4130 attracted much attention, and refiling is expected next session. HB 4130 would prohibit a shareholder, director or officer of a PC from participating in managing the PC or having voting shares in the corporate action that bears on the ownership, management, or governance of the PC, if the shareholder, etc., is simultaneously a shareholder, director, member, officer or employee of an MSO serving the PC. HB 4130 provides that a PC cannot remove a director or an officer by means other than majority vote of directors or officers, as appropriate, who are licensed Oregon physicians. Physician noncompete clauses would be banned except in limited circumstances by enactment of HB 4130. Further, the bill prohibits an MSO from disciplining a physician for violating a non-competition, non-disclosure, or non-disparagement agreement or for disclosing or reporting information that the physician in good faith believes is a violation of federal or state law, rules, or regulations.

As stated, while the CPOM doctrine may have historically been unenforced in many states, things are rapidly changing. State legislatures are greatly concerned about the negative impact that some corporate investors have caused in health care markets, and there is a revived interest in enforcing existing CPOM prohibitions, strengthening prohibitions, and utilizing other legislative strategies to increase corporate oversight and scrutiny of corporate investors. The AMA's state Advocacy Resource Center is closely monitoring this legislative activity and is working closely with interested state medical associations and national medical specialty societies on addressing their concerns, as they arise.

Prospects for Federal Legislation

Resolution 233 raises the issue of AMA advocating for federal legislation to prohibit CPOM. There are several concerns about "federalizing" this issue.

As noted above, historically, CPOM has been a state issue—with state legislatures working on solutions that reflect their unique health care environments. For example, while some states mandate that PCs be wholly physician owned or restrict non-physician ownership to not more than 49 percent, other states have determined that it is best not to prohibit corporate investors from owning physician practices and instead place appropriate requirements and limitations on said models. A concern with advocating for federal legislation any time there are existing variations at the state level is that the new federal legislation that is passed may supersede an existing state protection that is stronger. Thus, depending on the nature of the federal legislation, some physicians may oppose weaker federal legislation, and unfortunately the federal legislative and subsequent regulatory processes leave no guarantee as to the strength of the final version of the federal legislation.

With respect to authority over practice operations, i.e., how a practice is "run," as was just mentioned above, the Board recommends that AMA policy distinguish between corporate investment, corporate ownership, and corporate control in physician practices. A corporate entity may invest in a practice but not have ownership nor operational control of the practice. Thus, a corporate investor may offer financing without physician practices giving up clinical autonomy or operational authority. On the other hand, a corporate entity may not technically own a practice but effectively exercises corporate control of the physician practice. The previous discussion concerning the "friendly physician" model illustrates this point—under that model the desire for corporate profits may interfere with clinical decision-making and physician autonomy even though technically corporate investors' ownership interests are limited or prohibited outright. To clarify, retaining operation authority does not stop a practice from outsourcing or delegating its management or even day-to-day operations. However, management would be a contracted service or some other structure in which, if there is a conflict, the physician or designated physician partners have the final authority. Importantly, most of the time a controlling interest by a corporate entity will confer operational authority of a practice either directly or indirectly.

Obviously, while lay entities must not—under any circumstances—control the practice of medicine, the Board believes that decisions made by a corporate investor on matters often characterized as operational or administrative may in some cases intrude on clinical decision-making and physician autonomy, as well as affect quality of care and patient outcomes. This is not simply in cases where the difference may be blurred—even matters that may be typically characterized as operational, e.g., coding, billing and collections, administration and non-clinical management; risk managements, etc., may themselves be implemented in ways that interfere with clinical decision-making and physician autonomy and/or expose physicians to liability. Thus, the Board also believes that regardless of a physician practice's ownership structure, physician clinical autonomy and operational authority must be preserved and protected. The Board further recognizes that beyond patient care and physician autonomy at the practice level, allowing the corporatization of medicine has led to further consolidation of healthcare, increased costs, and siphoning of health care dollars to shareholders and non-health care entities in the larger health care system. Notably, allowing the corporate ownership of a medical practice also has implication for scope of practice issues—both in the supervision of non-physician practitioners (NPP) in the practice, as well as the potential conflict if an NPP has an ownership in the practice.

While the Board does not recommend developing federal legislation called for by Resolution 233 given the potential pitfall of initiating federal legislation as discussed above, the Board does believe that the AMA should be heavily engaged in fighting the negative influence that PE and other corporate investors are having on the practice of medicine. The Board also believes that the AMA must vigorously oppose any removal or weakening of existing state laws prohibiting the corporate practice of medicine legislation or regulation. This advocacy should include closely monitoring federal legislative proposals and engaging where appropriate, as well as continuing to work closely with state medical associations and national medical specialty societies in the state advocacy arena.

In this regard, it must be noted that at the AMA 2024 Annual Meeting, the HOD amended AMA Policy H-215.981 "Corporate Practice of Medicine," that directs AMA Advocacy as follows: "Our AMA will work with the state and federal government and other interested parties to develop and advocate for regulations pertaining to corporate control of practices in the health care sector such that physician autonomy in clinical care is preserved and protected." Importantly, the AMA was already engaged in federal advocacy, as well as advocacy at the state level—as directed by Resolution 710 (A-24). For example, prior to the AMA 2024 Annual Meeting on June 5, 2024, the AMA sent an extensive letter to the Federal Trade Commission (FTC), U.S. Department of Justice (DOJ), and the U.S. Department of Health and Human Services, expressing its concerns about PE, its impact on physicians, and how PE is exacerbating consolidation in health care markets generally. Given the current political environment, the Board believes that continued federal regulatory advocacy is much more likely to be successful (as compared to federal legislative advocacy). Both the FTC and DOJ are subjecting PE in health care to unprecedented scrutiny, including "strip and flip" tactics. The Board supports the preservation of the restrictions of ownership and operational authority of physician medical practices to physicians or physician owned groups. and expects AMA Advocacy to seek every opportunity to advocate consistent with our HOD policy at the federal level, as well as in the states.

With regard to AMA state level advocacy, the Board strongly recommends that the AMA's state government affairs team, the Advocacy Resource Center, develop a comprehensive corporate investor state legislative template modeled after the Advocacy Resource Center's "Legislative Template: Covenants not-to-Compete in Physician Contracts"—to advance AMA engagement at the state level on CPOM issues. State medical associations and national medical specialty societies interested in seeing how the corporate investor template will be structured can view the Advocacy Resource Center's covenant not-to-compete template here.

Notably, the AMA has also developed a number of excellent resources to help physicians understand and negotiate contracts with PE and venture capital firms, including, but not limited to, sample contract language. Finally, the Board would like to note that during its 2024 Annual Meeting, the HOD amended existing AMA Policy D-215.982 entitled, "The Corporate Practice of Medicine, Revisited" which calls on the AMA to create a new report that will study and report back by AMA 2025 Annual Meeting with recommendations on how to increase competition, increase transparency, support physicians and physician autonomy, protect patients, and control costs in already consolidated health care markets. This report is just one example of continuing studies that the AMA is conducting regarding the negative impact that corporate interests are having on the practice of medicine, and the Board expects that AMA Advocacy will take full advantage of new findings to prohibit corporate investors' intrusion into the practice of medicine, in its federal and state level work.

AMA POLICY

The following AMA policy is relevant to this Board Report:

Policy D-160-904 entitled, "The Regulation of Private Equity in the Healthcare Sector," which states that: Our American Medical Association will propose appropriate guidelines for the use of private equity in healthcare, ensuring that physician autonomy and operational authority in clinical care is preserved and protected.

Policy H-160.891 entitled, "Corporate Investors," which states that:
(1) Our American Medical Association 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 council should be obtained to advise during the exploration and negotiation of corporate investor transactions.
(d) Retaining negotiators to advocate for the 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 physicians 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.
(l) Our AMA supports improved transparency regarding corporate investment in physician practices and subsequent changes in health care prices.
(m) 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.
(n) Our AMA supports consideration of options for gathering information on the impact of private equity and corporate investors on the practice of medicine.
AMA Policy H-160.887 entitled "Corporate Practice of Medicine"
(1) Our American Medical Association acknowledges that the corporate practice of medicine:
(a) has the potential to erode the patient-physician relationship.
(b) may create a conflict of interest between profit and best practices in residency and fellowship training.

Policy H-215.981 entitled. "Corporate Practice of Medicine," which states that:
(1) Our American Medical Association vigorously opposes any effort to pass federal legislation preempting state laws prohibiting the corporate practice of medicine.

(2) At the request of state medical associations, our AMA will provide guidance, consultation, and model legislation regarding the corporate practice of medicine, to ensure the autonomy of hospital medical staffs, employed physicians in non-hospital settings, and physicians contracting with corporately owned management service organizations.
(3) Our AMA will continue to monitor the evolving corporate practice of medicine with respect to its effect on the patient-physician relationship, financial conflicts of interest, patient-centered care and other relevant issues.
(4) Our AMA will work with state and federal government and other interested parties to develop and advocate for regulations pertaining to corporate control of practices in the healthcare sector such that physician autonomy in clinical care is preserved and protected.

Policy D-215.982 entitled, "The Corporate Practice of Medicine, Revisited" which states that: Our American Medical Association will revisit the concept of restrictions on the corporate practice of medicine, including, but not limited to, private equities, hedge funds and similar entities, review existing state laws and study needed revisions and qualifications of such restrictions and/or allowances, in a new report that will study and report back by Annual 2025 with recommendations on how to increase competition, increase transparency, support physicians and physician autonomy, protect patients, and control costs in already consolidated health care markets; and to inform advocacy to protect the autonomy of physician-directed care, patient protections, medical staff employment and contract conflicts, and access of the public to quality health care, while containing health care costs.

Policy H-310.904 entitled, "Graduate Medical Education and the Corporate Practice of Medicine," which states that:
(1) Our American Medical Association recognizes and supports that the environment for education of residents and fellows must be free of the conflict of interest created between a training site's fiduciary responsibility to shareholders and the educational mission of residency or fellowship training programs.
(2) Our AMA encourages the Accreditation Council for Graduate Medical Education (ACGME) to update its "Principles to Guide the Relationship between Graduate Medical Education, Industry, and Other Funding Sources for Programs and Sponsoring Institutions Accredited by the ACGME" to include corporate-owned lay entity funding sources.
(3) Our AMA will continue to monitor issues, including waiver of due process requirements, created by corporate control of graduate medical education sites.

RECOMMENDATIONS:

The Board of Trustees recommends that in lieu of Resolution 233-I-23, existing AMA Policy H-215.981 entitled, "Corporate Practice of Medicine," be amended by addition and the remainder of the report be filed:

1. Our American Medical Association vigorously opposes any effort to pass federal legislation or regulation preempting state laws prohibiting the corporate practice of medicine. (Reaffirm HOD Policy)

2. Our AMA vigorously opposes any effort to pass legislation or regulation that removes or weakens state laws prohibiting the corporate practice of medicine. (New HOD Policy)

3. Our AMA opposes the corporate practice of medicine and supports the restriction of ownership and operational authority of physician medical practices to physicians or physician-owned groups. (New HOD Policy)

4. At the request of state medical associations, our AMA will provide guidance, consultation, and model legislation regarding the corporate practice of medicine, to ensure the autonomy of hospital medical staffs, employed physicians in non-hospital settings, and physicians contracting with corporately owned management service organizations. (Reaffirm HOD Policy)

5. Our AMA will continue to monitor the evolving corporate practice of medicine with respect to its effect on the patient-physician relationship, financial conflicts of interest, patient centered care and other relevant issues. (Directive to take action)

6. Our AMA will work with interested state medical associations, the federal government, and other interested parties to develop and advocate for regulations and appropriate legislation pertaining to corporate control of practices in the healthcare sector such that physician clinical autonomy ~~in clinical care~~ and operational authority ~~is~~ are preserved and protected. (Modify Current HOD Policy)

7. Our AMA will create a state corporate practice of medicine template to assist state medical associations and national medical specialty societies as they navigate the intricacies of corporate investment in physician practices and health care generally at the state level and develop the most effective means of prohibiting the corporate practice of medicine in ways that are not detrimental to the sustainability of physician practices. (New HOD Policy)

Fiscal note: Less than $500.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 201
(I-24)

Introduced by: Tennessee

Subject: Boarding Patients in the Emergency Room

Referred to: Reference Committee B

Whereas, due to multiple issues including staffing shortages it has become common practice to board admitted patients for extended periods of time in the emergency room; and

Whereas, boarding of admitted patients in the emergency room greatly increases demands on the emergency room staff and physicians; and

Whereas, burnout is a very real complication of a medical system that allows staffing ratios to be bypassed in an emergency room setting; and

Whereas, this overcrowding of and boarding within the emergency room has created a public health crisis; and

Whereas, patient safety and HIPAA compliance are secondary goals in an overcrowded emergency room with admitted patients boarding in the halls; therefore be it

RESOLVED, that our American Medical Association immediately collaborate with stakeholders such as hospitals, insurance companies, CMS, and joint commission to resolve this issue (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate strongly for appropriate staffing ratios and appropriate care for patients and the emergency room and those admitted but still physically located in the emergency room to decrease patient harm and physician and nurse burnout. (Directive to Take Action)

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

Received: 9/3/2024

REFERENCES

1. “Clinicians’ Insights on Emergency Department Boarding: An Explanatory Mixed Methods Study Evaluating Patient Care and Clinician Well-Being,” by Dana E. Loke, MD, MS; Kelsey A. Green, MD; Emily G. Wessling, MD; Elizabeth T. Stulpin, MD; and Abra L. Fant, MD, MS. The article appears in The Joint Commission Journal on Quality and Patient Safety (JQPS), volume 49, number 12 (December 2023)
2. American College of Emergency Physicians/Morning Consult poll October 2023.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 202
(I-24)

Introduced by: North American Spine Society

Subject: Illicit Drugs: Calling for a Multifaceted Approach to the “Fentanyl” Crisis

Referred to: Reference Committee B

Whereas, there is an illicit opioid crisis in the United States (U.S.) with an escalating number of drug-related illnesses, overdoses, and deaths, placing a growing burden on patients, families, medical professionals and our society; and

Whereas, these illicit drugs serve no legitimate medical purpose, endanger the lives of first responders and healthcare workers, put a drain on our medical system and the medical resources needed to treat victims, including people with a substance use disorder (SUD); and

Whereas, the shift from plant-based drugs, like marijuana, heroin and cocaine, to synthetic, chemical-based drugs, like fentanyl and carfentanil is much easier and less costly to manufacture and easier to distribute, has resulted in the most dangerous and lethal drug crisis U.S. history; and

Whereas, illicit fentanyl is a highly potent synthetic opioid that has resulted in the overdose deaths of infants, children and adults of all ages, especially those who suffer from SUD; and

Whereas, the total number of illicit fentanyl seizures by law enforcement surged by more than 1700% between 2017 and 2023, enough to the kill the entire American population many times over; and

Whereas, overdose deaths exceed 100,000 U.S. citizens/year, a vast majority due to illicit fentanyl which is now the number one killer of all adults ages 18-45, including 20 high school deaths/week; and

Whereas, this illicit-drug crisis has rapidly evolved to include many chemical compounds beyond fentanyl, such as 3-methylfentanyl and carfentanil which are 6,000-to-10,000-times more potent than morphine, respectively, making it difficult for our government agencies and healthcare systems to adapt to; and

Whereas, at least one third of illegally manufactured recreational pills are laced with fentanyl and/or carfentanil and are pressed to resemble legal prescription drugs (e.g. oxycodone, Xanax, Adderall), they create a significant risk of accidental overdose for users who are unaware of the laced drugs; and

Whereas, these illicit drugs, undetectable by sight, smell or taste, are on the black market in various forms, including liquid, powder and/or aerosolized, have been found in vape pens, nasal sprays, eye drops, gummies, small candies and paper; and

Whereas, the Public Health Security and Bioterrorism Preparedness and Response Act of 2002 criminalizes the use of a biological agent to cause death, disease (e.g. addiction), or other harm; and

Whereas, the Chemical Weapons Convention defines chemical weapons as a toxic chemical or its precursors specifically designed to cause death or other harm (e.g., addiction) through toxic properties; and

Whereas, according to the Department of Homeland Security (DHS), “a weapon of mass destruction (WMD) is a nuclear, radiological, biological or chemical (e.g. illicit fentanyl, carfentanil), intended to harm a large number of people”, and many organizations have called for illicit fentanyl and similar illicit drugs to be classified as WMDs; and

Whereas, carfentanil has been used as a WMD and in 2018, the Federal Bureau of Investigation's Weapons of Mass Destruction Directorate assessed that fentanyl’s highly toxic properties, make it a “very viable option for a chemical weapon attack”; and subsequently the Department of Defense proposed that fentanyl receive a WMD designation; therefore be it

RESOLVED, that our American Medical Association advocate for public education and awareness about the rapidly evolving US illicit drug crisis due to dangers of fentanyl and carfentanil-laced products (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that federal, state and local government officials and agencies implement measures to curb and/or stop the manufacturing, importation, and distribution of illicit drugs and related chemical compounds (Directive to Take Action); and be it further

RESOLVED, that our AMA support federal legislation that would help Customs and Border Protection (CBP) stop the flow of illicit goods, including fentanyl and counterfeit medications (New HOD Policy); and be it further

RESOLVED, that our AMA, based on the Public Health Security and Bioterrorism Preparedness and Response Act of 2002 (which criminalizes the use of a biological agents to cause death, disease, or other harm), request our government to determine if expansion should include illicit chemicals and drugs such as fentanyl, carfentanil, 3-methylfentanyl, Xylazine, etc. (Directive to Take Action); and be it further

RESOLVED, that our AMA encourage our government to clarify if, and in what circumstances, these types of illicit drugs (e.g. fentanyl, carfentanil, etc.), or their precursors, should be considered chemical weapons as defined by The Chemical Weapons Convention and/or a WMD as defined by the DHS (New HOD Policy); and be it further

RESOLVED, that our AMA assess the likelihood that illicit drugs such as carfentanil may be used as a WMD and what steps healthcare workers, hospital systems and first-responders should take to prepare for such an event. (Directive to Take Action)

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

Received: 9/18/2024

REFERENCES

1. Weapons of Mass Destruction https://www.dhs.gov/topics/weapons-mass-destruction
2. Demand to classify illicit fentanyl a weapon of mass destruction. July 2018. Department of Homeland Security. https://www.myfloridalegal.com/newsrelease/demand-classify-illicit-fentanyl
3. DHS Considering Classifying Fentanyl as Weapon of Mass Destruction: An internal memo from the Department of Homeland Security states that Fentanyl is a likely option for a chemical weapon attack. By Alexa Lardieri, April 16, 2019 https://www.usnews.com/news/politics/articles/2019-04-16/report-dhs-considering-classifying-fentanyl-as-weapon-of-massdestruction
4. State of Florida letter. Declare of Fentanyl a Weapon of Mass Destruction. https://www.myfloridalegal.com/files/pdf/page/63B8F1A56E1BE00A85258880
5. A bipartisan U.S. congressional report warned in February that the flow of precursors to Mexico "remains almost unabated." https://www.rand.org/pubs/external_publications/EP68838.html?itid=lk_inline_enhanced-template
6. US House Code, Title18 https://uscode.house.gov/view.xhtml?path=/prelim@title18/part1/chapter11B&edition=prelim#:~:text=%C2%A7229A.&text=)%20Cri minal%20Penalties.%E2%80%94,(1)%20In%20general%20.,(2)%20Death%20penalty%20
7. China is doing this for political reasons to disrupt the USA. Code of Federal Regulation Section 719.4. Cornell Law School. https://www.law.cornell.edu/cfr/text/15/719.4
8. A Reuters Investigation. https://www.reuters.com/investigates/special-report/drugsfentanylsupplychain/#:~:text=At%20the%20tap%20of%20a,trade%20behind%20the%20fentanyl%20crisis
9. Illicit Fentanyl Seizures Increased Nearly 2000% Within 7-Year Period in US. By Lauren Massaro, May 13, 2024. https://www.cbp.gov/newsroom/stats/cbp-public-data-portal
10. Palamar JP, Fitzgerald N, Carr TH, Cottler LB, Ciccarone D. National and regional trends in fentanyl seizures in the United States, 2017-2023. Int J Drug Policy. Published online May 13, 2024. Doi.org/10.1016/j.drugpo.2024
11. Dramatic increase in fentanyl seized by authorities in last six years. New release. EurekAlert. May 13, 2024. Accessed May 13. 2024. https://www.eurekalert.org/news-releases/1044110
12. Tanz LJ, Gladden RM, Dinwiddie AT, et al. Routes of drug use among drug overdose deaths—United States, 2020-2022. MMWR Surveill Summ2024;73(6):124-130. doi: 10.15585/mmwr.mm7306a2
13. Inside the daunting hunt for the ingredients for fentanyl and meth. The Washington Post. Mary Beth Sheridan. December 13, 2022. https://www.washingtonpost.com/investigations/interactive/2022/precursor chemicals-fentanyl-meth/
14. Commission on Combating Synthetic Opioid Trafficking. Final Report. https://www.rand.org/pubs/external_publications/EP68838.html?itid=lk online enhanced-template
15. About 22 high school age adolescents died each week from overdoses in 2022, driven by fentanyl-laced prescription pills. UCLA Health. January, 2024. https://www.uclahealth.org/news/release/about-22-high-school-age-adolescents-died-each-week
16. DEA Releases 2024 Drug Threat Assessment. United States Drug Enforcement Agency. May 9, 2024. https://www.dea.gov/press-releases/2024/05/09/dea-releases-2024-national-drug-threat-assessment
17. United States Drug Enforcement Agency: Public Safety Alert. DEA Reports Widespread Threat of Fentanyl Mixed with Xylazine. https://www.dea.gov/alert/dea-reports-widespread-threat-fentanyl-mixed-xylazine
18. US committee finds China is subsidizing American fentanyl crisis. By. Michael Martina. April 16, 2024. https://www.reuters.com/world/us/us-committee-finds-china-is-subsidizing american-fentanyl-crisis-2024-04-16/
19. Select Committee Unveils Fentanyl Policy Working Group. June 20, 2024. https://selectcommitteeontheccp.house.gov/media/press-releases/select-committee-unveils-fentanyl-policy-working-group
20. House select committee on China role on fentanyl crisis- House non-partisan working committee. https://www.youtube.com/watch?v=DSSrdfqyOpI
21. The Fentanyl/China Threat: a Conversation with Ray Donovan and Paul Martin https://www.youtube.com/watch?v=K2dVIs_-CoM
22. As more teens overdose on fentanyl, schools face a drug crisis like no other. Special Series. Schools and the Fentanyl Crisis. NPR. August 2023. https://www.npr.org/2023/08/30/1196343448/fentanyl-deaths-teens-schools-overdose
23. Why Is Fentanyl Driving Overdose Deaths? https://www.yalemedicine.org/news/fentanyl-driving-overdoses
24. Inside Fentanyl's Mounting Death Toll: "This Is Poison". New York Times. 11/12/2023. https://www.nytimes.com/2021/11/20/nyregion/fentanyl-opioid-deaths.html
25. How Opioids Were Used as Weapons During the 2002 Moscow Theater hostage Crisis. https://www.history.com/news/opioid-chemical-weapons-moscow-theater-hostage-crisis
26. DEA Releases 2024 National Dug Threat Assessment https://www.dea.gov/sites/default/files/2024-05/5.23.2024%20NDTAupdated.pdf
27. Fentanyl and it's derivatives: Pain-killers or man-killers? https://www.cell.com/heliyon/pdf/S2405-8440(24)04826-6.pdf
28. European Union Drugs Agency: Fentanyl Drug Profile. https://www.euda.europa.eu/publications/drug-profiles/fentanyl_en
29. Fighting for America Act of 2024 https://www.finance.senate.gov/chairmans-news/wyden-lummis-brown-collins-and-casey-release-bipartisan-legislation-to-halt-theflood-of-illicit-packages-into-the-united-states

RELEVANT AMA POLICY

Addressing Emerging Trends in Illicit Drug Use H-95.940

1. Our American Medical Association recognizes that emerging drugs of abuse, especially new psychoactive substances (NPS), are a public health threat.
2. Our AMA supports ongoing efforts of the National Institute on Drug Abuse, the Drug Enforcement Administration, the Centers for Disease Control and Prevention, the Department of Justice, the Department of Homeland Security, state departments of health, and poison control centers to assess and monitor emerging trends in illicit drug use, and to develop and disseminate fact sheets, other educational materials, and public awareness campaigns.
3. Our AMA supports a collaborative, multiagency approach to addressing emerging drugs of abuse, including information and data sharing, increased epidemiological surveillance, early warning systems informed by laboratories and epidemiologic surveillance tools, and population driven real-time social media resulting in actionable information to reach stakeholders.
4. Our AMA encourages adequate federal and state funding of agencies tasked with addressing the emerging drugs of abuse health threat.
5. Our AMA encourages the development of continuing medical education on emerging trends in illicit drug use.
6. Our AMA supports efforts by federal, state, and local government agencies to identify new drugs of abuse and to institute the necessary administrative or legislative actions to deem such drugs illegal in an expedited manner.
Sub. Res. 901, I-14 Modified: CSAPH Rep. 02, A-17 Reaffirmed: Res. 503, A-18 Reaffirmed in lieu of: Res. 512, A-18 Reaffirmation I-22

Drug Policy Reform H-95.901

1. Our American Medical Association supports elimination of criminal penalties for drug possession for personal use as part of a larger set of related public health and legal reforms designed to improve carefully selected outcomes.
2. Our AMA supports federal and state efforts to automatically expunge, at no cost to the individual, criminal records for drug possession for personal use upon completion of a sentence or penalty
3. 3Our AMA supports programs that provide comprehensive substance use disorder treatment and social support to people who use or possess illicit drugs for personal use as an alternative to incarceration-based penalties, including for persons under parole, probation, pre-trial, or other civic, criminal, or judicial supervision.
4. Our AMA, concurrently, supports robust policies and funding that facilitate people's access to evidence-based prevention, early intervention, treatment, harm reduction, and other supportive services – with an emphasis on youth and racially and ethnically minoritized people – based on individualized needs and with availability in all communities.
BOT Rep. 17, A-24

Increasing Availability of Naloxone and Other Safe and Effective Overdose Reversal Medications H-95.932

1. Our American Medical Association supports legislative, regulatory, and national advocacy efforts to increase access to affordable naloxone and other safe and effective overdose reversal medications, including but not limited to collaborative practice agreements with pharmacists and standing orders for pharmacies and, where permitted by law, community-based organizations, law enforcement agencies, correctional settings, schools, and other locations that do not restrict the route of administration for naloxone and other safe and effective overdose reversal medications delivery.
2. Our AMA supports efforts that enable law enforcement agencies to carry and administer naloxone and other safe and effective overdose reversal medications .

3. Our AMA encourages physicians to co-prescribe naloxone and other safe and effective overdose reversal medications to patients at risk of overdose and, where permitted by law, to the friends and family members of such patients.
4. Our AMA encourages private and public payers to include all forms of naloxone and other safe and effective overdose reversal medications on their preferred drug lists and formularies with minimal or no cost sharing.
5. Our AMA supports liability protections for physicians and other healthcare professionals and others who are authorized to prescribe, dispense and/or administer naloxone and other safe and effective overdose reversal medications pursuant to state law.
6. Our AMA supports efforts to encourage individuals who are authorized to administer naloxone and other safe and effective overdose reversal medications to receive appropriate education to enable them to do so effectively.
7. Our AMA encourages manufacturers or other qualified sponsors to pursue the application process for over the counter approval of naloxone and other safe and effective overdose reversal medications with the Food and Drug Administration.
8. Our AMA supports the widespread implementation of easily accessible naloxone and other safe and effective overdose reversal medications rescue stations (public availability of naloxone and other safe and effective overdose reversal medications through wall-mounted display/storage units that also include instructions) throughout the country following distribution and legislative edicts similar to those for Automated External Defibrillators.
9. Our AMA supports the legal access to and use of naloxone and other safe and effective overdose reversal medications in all public spaces regardless of whether the individual holds a prescription.
10. Our AMA supports efforts to increase the availability, delivery, possession and use of mail-order overdose reversal medications, including naloxone, to help prevent opioid-related overdose, especially in vulnerable populations, including but not limited to underserved communities and American Indian reservation populations.
11. Our AMA supports the expansion of naloxone availability through colocation of intranasal naloxone with AEDs in public locations.
BOT Rep. 22, A-16 Modified: Res. 231, A-17 Modified: Speakers Rep. 01, A-17 Appended: Res. 909, I-17 Reaffirmed: BOT Rep. 17, A-18 Modified: Res. 524, A-19 Reaffirmed: BOT 09, I-19 Reaffirmed: Res. 219, A-21 Modified: Res. 505, A-23 Reaffirmed: BOT Rep. 11, A-24 Modified: Res. 512, A-24

Prevention of Drug-Related Overdose D-95.987

1. Our American Medical Association:
    a. recognizes the great burden that substance use disorders (SUDs) and drug-related overdoses and death places on patients and society alike and reaffirms its support for the compassionate treatment of patients with a SUD and people who use drugs.
    b. urges that community-based programs offering naloxone and other safe and effective overdose reversal medications and other opioid overdose and drug safety and prevention services continue to be implemented in order to further develop best practices in this area.
    c. encourages the education of health care workers and people who use drugs about the use of naloxone and other safe and effective overdose reversal medications and other harm reduction measures in preventing opioid and other drug related overdose fatalities.
    d. will continue to monitor the progress of such initiatives and respond as appropriate.

2. Our AMA will: advocate for the removal of **fentanyl** test strips (FTS) and other testing strips, devices or testing equipment used in identifying or analyzing whether a substance contains **fentanyl** or other adulterants from the legal definition of drug paraphernalia.
3. Our AMA will:
    a. advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of a drug- related overdose.
    b. support the development of adjuncts and alternatives to naloxone to combat synthetic opioid-induced respiratory depression and overdose.
    c. encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for a drug-related overdose.
4. Our AMA will support the development and implementation of appropriate education programs for persons receiving treatment for a SUD or in recovery from a SUD and their friends/families that address harm reduction measures.
5. Our AMA will advocate for and encourage state and county medical societies to advocate for harm reduction policies that provide civil and criminal immunity for the possession, distribution, and use of “drug paraphernalia” designed for harm reduction from drug use, including but not limited to drug contamination testing and injection drug preparation, use, and disposal supplies.
6. Our AMA will implement an education program for patients with substance use disorder and their family/caregivers to increase understanding of the increased risk of adverse outcomes associated with having a substance use disorder and a serious respiratory illness such as COVID-19.
7. Our AMA supports efforts to increase access to **fentanyl** test strips and other drug checking supplies for purposes of harm reduction.

Res. 526, A-06 Modified in lieu of Res. 503, A-12 Appended: Res. 909, I-12 Reaffirmed: BOT Rep. 22, A-16 Modified: Res. 511, A-18 Reaffirmed: Res. 235, I-18 Modified: Res. 506, I-21Appended: Res. 513, A-22 Modified: Res. 211, I-22 Appended: Res. 221, A-23 Reaffirmation: A-23 Modified: Res. 505, A-23 Reaffirmed: BOT Rep. 18, A-24

Chemical and Biological Weapons H-520.992

Our AMA condemns the use of chemical and biologic weapons.
Res. 175, I-89 Reaffirmed: Sunset Report, A-00 Reaffirmed: CSAPH Rep. 1, A-10 Reaffirmed: CSAPH Rep. 01, A-20

Federal Drug Policy in the United States H-95.981

The AMA, in an effort to reduce personal and public health risks of drug abuse, urges the formulation of a comprehensive national policy on drug abuse, specifically advising that the federal government and the nation should: (1) acknowledge that federal efforts to address illicit drug use via supply reduction and enforcement have been ineffective (2) expand the availability and reduce the cost of treatment programs for substance use disorders, including addiction; (3) lead a coordinated approach to adolescent drug education; (4) develop community-based prevention programs for youth at risk; (5) continue to fund the Office of National Drug Control Policy to coordinate federal drug policy; (6) extend greater protection against discrimination in the employment and provision of services to drug abusers; (7) make a long-term commitment to expanded research and data collection; (8) broaden the focus of national and local policy from drug abuse to substance abuse; and (9) recognize the complexity of the problem of substance abuse and oppose drug legalization. BOT Rep. NNN, A-88 Reaffirmed: CLRPD 1, I-98 Reaffirmed: CSAPH Rep. 2, A-08 Modified: CSAPH Rep. 2, I-13 Reaffirmed: BOT Rep. 14, I-20

Altered Illicit Substances D-95.997

Our AMA will pursue appropriate revisions of the relevant federal laws and regulations as a means of interdicting the manufacture, distribution or sale of such **substances**. Sub. Res. 401, I-99Reaffirmed: CSAPH Rep. 1, A-09 Reaffirmed: CSAPH Rep. 01, A-19

Substance Use Disorders as a Public Health Hazard H-95.975

Our AMA: (1) recognizes that **substance use disorders** are **a** major **public health** problem in the United States today and that its solution requires **a** multifaceted approach;
(2) declares **substance use disorders** are **a public health** priority;
(3) supports taking **a** positive stance **as** the leader in matters concerning **substance use disorders**, including addiction;
(4) supports studying innovative approaches to the elimination of **substance use disorders** and their resultant street crime, including approaches which have been used in other nations; and
(5) opposes the manufacture, distribution, and sale of substances created by chemical alteration of illicit substances, herbal remedies, and over-the-counter drugs with the intent of circumventing laws prohibiting possession or **use** of such substances.
Res. 7, I-89 Appended: Sub. Res. 401, Reaffirmed: Sunset Rep., I-99 Reaffirmed: CSAPH Rep. 1, A-09 Modified and Reaffirmed: CSAPH Rep. 1, A-09 Reaffirmed: CSAPH Rep. 01, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 204
(I-24)

Introduced by: Medical Student Section and American College of Emergency Physicians

Subject: Support for Physician-Supervised Community Paramedicine Programs

Referred to: Reference Committee B

Whereas, physician-supervised community paramedicine programs send paramedics on home visits to patients recently discharged from emergency departments (ED) to assist with remote patient monitoring and video support, coordinating with primary care and specialist physicians and pharmacies, and arranging transportation[1-6]; and

Whereas, community paramedicine pilots in several states address geographic barriers physicians, especially in rural areas, that lead to delayed care and ED overcrowding[1-4]; and

Whereas, a rural Ontario program showed a 24% reduction in 911 calls, 20% reduction in ED visits, and 55% reduction in hospitalizations after 1 year[7]; and

Whereas, a Minnesota study showed decreases in readmissions and ED visits, savings of over $400,000, and higher reported quality of life[8,9]; and

Whereas, an Abbeville County (population 25,000) program showed a nearly 60% decrease in ED visits and nearly 70% decrease in admissions over 4 years, while also reducing blood pressure and blood glucose[10]; and

Whereas, community paramedicine is funded by public and private grants, partnerships with hospitals and nursing homes to share savings, Medicare's Emergency Triage, Treat, and Transport (ET3) alternative payment model, and Medicaid in some states including Arizona, Georgia, Minnesota, Nevada, and Wyoming[11-12]; therefore be it

RESOLVED, that our American Medical Association support federal and state efforts to establish, expand, and provide coverage for community paramedicine programs supervised by physicians, especially in rural areas. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Date Received: 09/19/2024

REFERENCES

1. 1.Riley WJ. Health disparities: gaps in access, quality and affordability of medical care. Trans Am Clin Climatol Assoc. 2012;123:167-172; discussion 172-174.
2. 2.Labban M, Chen CR, Frego N, et al. Disparities in Travel-Related Barriers to Accessing Health Care From the 2017 National Household Travel Survey. JAMA Netw Open. 2023;6(7):e2325291. doi:10.1001/jamanetworkopen.2023.25291
3. 3.Savioli G, Ceresa IF, Gri N, et al. Emergency Department Overcrowding: Understanding the Factors to Find Corresponding Solutions. J Pers Med. 2022;12(2):279. doi:10.3390/jpm12020279
4. 4.Kruk ME, Gage AD, Joseph NT, Danaei G, García-Saisó S, Salomon JA. Mortality due to low-quality health systems in the universal health coverage era: a systematic analysis of amenable deaths in 137 countries. Lancet Lond Engl. 2018;392(10160):2203-2212. doi:10.1016/S0140-6736(18)31668-4

5. 5.Guo X, Wang XF. Signaling cross-talk between TGF-beta/BMP and other pathways. Cell Res. 2009;19(1):71-88. doi:10.1038/cr.2008.302
6. 6.Okoh CM, Moczygemba LR, Thurman W, Brown C, Hanson C, Baffoe JO. An examination of the emerging field of community paramedicine: a national cross-sectional survey of community paramedics. BMC Health Serv Res. 2023;23(1):516. doi:10.1186/s12913-023-09537-x
7. 7.Ruest MR, Ashton CW, Millar J. Community Health Evaluations Completed Using Paramedic Service (CHECUPS): design and implementation of a new community-based health program. J Health Hum Serv Adm.
8. 8.Burnett A, Wewerka S, Miller P, et al. Community Paramedicine Intervention Reduces Hospital Readmission and Emergency Department Utilization for Patients with Cardiopulmonary Conditions. West J Emerg Med. 2023;24(4):786-792. doi:10.5811/westjem.57862
9. 9.Nolan MJ, Nolan KE, Sinha SK. Community paramedicine is growing in impact and potential. CMAJ Can Med Assoc J J Assoc Medicale Can. 2018;190(21):E636-E637. doi:10.1503/cmaj.180642
10. 10.Bennett KJ, Yuen MW, Merrell MA. Community Paramedicine Applied in a Rural Community. J Rural Health. 2018;34(S1). doi:10.1111/jrh.12233
11. 12.Centers for Medicare & Medicaid Services. (2023, September 6). Emergency triage, treat, and transport (ET3) model - frequently asked questions. CMS.gov. https://www.cms.gov/priorities/innovation/innovation-models/et3/faq.
12. 13.Spencer, A. (2024, March 14). Making A case for community paramedicine: Evidence roundup. Playbook. https://bettercareplaybook.org/_blog/2024/12/making-case-community-paramedicine-evidence-roundup

RELEVANT AMA POLICY

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]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 205
(I-24)

Introduced by: Medical Student Section

Subject: Native American Medical Debt

Referred to: Reference Committee B

Whereas, the Indian Health Service (IHS) Purchased and Referred Care (PRC) program pays for services for American Indian and Alaska Native (AI/AN) patients provided at non-IHS facilities[1]; and

Whereas, limited PRC funds often result in denial or deferral of payments until the next fiscal year, making IHS patients pay out-of-pocket[2]; and

Whereas, unpaid and late PRC payments result in IHS patients being sent to collections and paying debts to avoid impacting their credit[2]; and

Whereas, since 2016, IHS has declined PRC payments for over 500,000 patients, saddling them with over $2 billion in debt[2-3]; and

Whereas, medical debt-related collection adversely impacts AI/AN patients' credit scores, which results in higher interest rates for mortgages and consumer loans and, in some cases, the inability to obtain credit or financing altogether[4]; and

Whereas, medical debt is linked to increased financial vulnerability, delayed or foregone treatment due to cost, use of high-risk short-term loans, and costly overdraft and late payment fees[5]; and

Whereas, the 2018 National Financial Capability Study found that AI/AN patients are more likely to have medical debt and not fill prescriptions due to cost than non-Hispanic whites [6]; and

Whereas, the Protecting Veterans Credit Act of 2017 requires credit agencies to remove debt and collections activity from veterans' credit reports for medical bills that should have been paid by the Department of Veterans Affairs[7]; and

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

Whereas, currently, two bipartisan bills are under consideration to hold the IHS accountable for unpaid bills and protect Native Americans' credit from unpaid bills under PRC[8]; therefore be it

RESOLVED, that our American Medical Association support federal legislation requiring credit reporting agencies to remove information on the credit reports of Indian Health Service (IHS)

beneficiaries that relate to debts or collections activities for medical services that should have been paid by the IHS. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Date Received: 09/19/2024

REFERENCES

1. Purchased and Referred Care. Indian Health Service. Accessed March 31, 2024. https://www.ihs.gov/prc/
2. Legislative Hearing on H.R., to Amend the Indian Health Care Improvement Act to Improve the Recruitment and Retention of Employees in the Indian Health Service, Restore Accountability in the Indian Health Service, Improve Health Services, and for Other Purposes. "Restoring Accountability in the Indian Health Service Act of 2023." Available at: https://www.congress.gov/event/118th-congress/house-event/LC70802/text
3. Fed Up With Deaths, Native Americans Want to Run Their Own Health Care." The New York Times. Published 2019-10-15. Available at: https://www.nytimes.com/2019/10/15/us/politics/native-americans-health-care.html.
4. National Consumer Law Center, Community Catalyst. Medical Debt Crisis: Impact on Native and Indigenous Families. Webinar. February 9, 2023. Available at: https://www.nclc.org/event/medical-debt-crisis-impact-on-native-and-indigenous-families/.
5. "How financially vulnerable are people with medical debt?" Peterson-KFF Health System Tracker. Published 2024-02-12. Available at: https://www.healthsystemtracker.org/brief/how-financially-vulnerable-are-people-with-medical-debt/#Share%20of%20adults%20with%20different%20measures%20of%20financial%20conditions,%202021
6. Hubbard S, Chen PM. Falling Short: Examining Medical Debt and Cost Avoidance in American Indian and Alaska Native Households. J Health Care Poor Underserved. 2022;33(4):1757-1771. doi:10.1353/hpu.2022.0136
7. Protecting Veterans Credit Act of 2017. Congress.gov. Available at: https://www.congress.gov/bill/115th-congress/senate-bill/744/all-info?r=99&s=1.
8. Johnson Introduces Bills to Reform IHS, Protect Native Americans' Credit. Press Release. Published online March 1, 2024. https://dustyjohnson.house.gov/media/press-releases/johnson-introduces-bills-reform-ihs-protect-native-americans-credit

RELEVANT AMA POLICY

Indian Health Service H-350.977
The policy of the American Medical Association 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. Our 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. Personnel:
    a. Compensation scales 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 specialty and primary care service in remote areas;

   c. In conjunction with improvement of Service facilities, efforts should be made to establish closer ties with teaching centers and other federal health agencies, thus increasing both the available staffing 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 without detracting from physician compensation;
   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 burnout; 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 supports 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.
8. Our AMA will call for an immediate change in the Public Service Loan Forgiveness Program to allow physicians to receive immediate, but incremental, loan forgiveness when they practice in an Indian Health Service, Tribal, or Urban Indian Health Program.
9. Our AMA supports reform of the Indian Health Service (IHS) Loan Repayment Program eligibility for repayment with either a part-time or full-time employment commitment to IHS and Tribal 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; Reaffirmed: CMS Rep. 03, A-24; Reaffirmed: Res. 244, A-24; Reaffirmed: BOT Rep. 31, A-24; Modified: CMS Res. 305, A-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 206
(I-24)

Introduced by: Women Physicians Section

Subject: Protect Infant and Young Child Feeding

Referred to: Reference Committee B

Whereas, more than half of all infants in the United States consume formula, either exclusively or as a supplement, by three months of life;[1] and

Whereas, a recent investigation into Nestlé identified nutritional discrepancies between the infant formula sold in high-income countries and low- and middle-income countries, specifically elevated levels of sugar in formula sold in low- and middle-income countries;[2] and

Whereas, within the United States, infant formula is advertised as similar to breast milk, but research has identified up to 7.7 g/100 kcal of added sugars in certain formulas which could prime the developing brain's reward circuit to prefer high-sugary foods and contribute to the significant rates of obesity in pediatric populations;[3,4] and

Whereas, numerous structural and systemic barriers prevent caregivers from pursuing breastfeeding, and disproportionately affect marginalized groups;[5] and

Whereas, donor breast milk costs $14.37/100 mL and formula costs $3.30/100 mL, making donor milk prohibitively expensive;[6,7] and

Whereas, in 2021, 16% of children in the United States lived below the poverty line, thus making purchase of donor breast milk a nonviable option for many families;[8] and

Whereas, the use of donor breast milk is associated with decreased risk of early childhood pathology and increased likelihood of continuation of breastfeeding relative to infant formula;[9] and

Whereas, premature infants that are exclusively fed human breast milk have significantly reduced rates of necrotizing enterocolitis, one of the leading causes of death in premature infants;[27] and

Whereas, research conducted in Florida determined that, in addition to avoiding more infant deaths, using pasteurized donor human milk in neonatal intensive care units would avoid an estimated $4 million in annual health care expenditures;[28] and

Whereas, seventeen states and the District of Columbia have passed legislation that requires Medicaid coverage of donor human milk;[7] and

Whereas, birthing parents who undergo chemotherapy, and those who have certain infections, are not able to breastfeed due to the impact of radiation and the risk of transmitting diseases to the infant;[10,11] and

Whereas, thousands of infants, older children, and adults with metabolic, gastrointestinal and allergic disorders rely on specialty formulas to meet their nutritional needs;[12] and

Whereas, four companies: Abbott Nutrition, Nestle, Mead Johnson, and Perrigo control nearly 90% of the infant formula market in the United States;[13] and

Whereas, the dominant formula companies have further consolidated an already concentrated market by relying on just a few manufacturing facilities to produce the majority of their products;[14] and

Whereas, reports of bacterial contamination in the manufacturing facility responsible for producing 40% of Abbott Nutrition's products led to a mass formula recall and subsequent plant closure in 2022;[15] and

Whereas, Abbott Nutrition's 2022 formula recall and plant closure caused a mass shortage with the national out-of-stock rate for infant formula spiking to 74%;[16] and

Whereas, on average, formula companies with sole-source WIC contracts hold 84% of the market share in each of their respective states, resulting in highly concentrated individual state formula markets that are particularly vulnerable to supply disruptions and shortages;[17] and

Whereas, unsafe infant feeding practices including rationing, diluting, and using homemade formula rose from 8% to 48.5% during the 2022 formula shortage;[18] and

Whereas, despite introducing several bills that would address the underlying causes of the formula recall and subsequent shortage, the federal government's lack of action left the nation vulnerable and susceptible to future formula crises;[19] and

Whereas, the U.S. Food and Drug Administration (FDA) and the U.S. Department of Agriculture (USDA) announced plans to enhance inspections of formula production facilities, promote new market entry, and support WIC agencies in the event of future formula crises but failed to address the issue of sole-source WIC contracts exacerbating market concentration;[14] and

Whereas, infant formula tariff rates reaching 17.5% serve as significant barriers to entry into the U.S. formula market for foreign manufacturers and further reduce healthy competition;[20] and

Whereas, the bipartisan "Formula Act" (H.R. 8351) that waived tariffs on imported infant formulas through January 1, 2023 helped replenish the national supply and doubled the number of manufacturers selling baby formula in the United States before expiring;[21] and

Whereas, the expiration of the "Formula Act" (H.R. 8351) and the return of import tariffs caused formula supply to drop again and led to price increases of as much as $8.00 per can;[22] and

Whereas, competition and market diversity benefit consumers by keeping costs low, increasing the quality of goods, providing consumers with greater variety, and ensuring a reliable and sustainable infant formula supply for American families;[23, 24, 25] and

Whereas, the short-term solutions enacted in 2022, such as tariff reductions and amended regulatory requirements for imported formulas, alleviated the strain of the infant formula shortage but did not solve the underlying structural issues of limited suppliers, thus demonstrating the need for long-term solutions in order to prevent future formula crises;[26] therefore be it

RESOLVED, that our American Medical Association support Medicaid coverage of donor human breast milk (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for an adequate supply and consistent sources of infant milk formula. (Directive to Take Action)

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

Received: 09/19/2024

REFERENCES

1. CDC Breastfeeding Facts. Centers for Disease Control and Prevention. July 31, 2024. Accessed August 7, 2024. https://www.cdc.gov/breastfeeding/data/facts.html.
2. Rundall P, Gaberell L. How Nestlé Gets Children Hooked on Sugar in Lower-Income Countries. Die neusten Public Eye Reportagen. June 6, 2024. Accessed August 7, 2024. https://stories.publiceye.ch/nestle-babies/.
3. Kong KL, Burgess B, Morris KS, et al. Association between added sugars from infant formulas and rapid weight gain in US infants and toddlers. The Journal of Nutrition. June 1, 2021. Accessed August 7, 2024. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8169810/.
4. Fazzino TL, Kong KL. A new paradigm for investigating the etiology of obesity in early childhood: Exposure to added sugars and hyper-palatable foods in infancy and dysregulation of food reinforcement processes. Obesity Reviews. 2022;24(2). doi:10.1111/obr.13526
5. Barriers to breastfeeding: Supporting initiation and continuation of breastfeeding. ACOG. February 2021. Accessed August 7, 2024. https://www.acog.org/clinical/ clinical-guidance/committee-opinion/articles/2021/02/barriers-to-breastfeeding-supporting-initiation-and-continuation-of-breastfeeding.
6. Johnson T, Berenz A, Wicks J. The economic impact of donor milk in the neonatal intensive ... The Journal of Pediatrics. July 15, 2020. Accessed August 7, 2024. https://www.jpeds.com/article/S0022-3476(20)30523-0/abstract#.
7. Speer K. Donor human milk: More valuable than gold? National Conference of State Legislatures. November 21, 2022. Accessed August 7, 2024. https://www.ncsl.org/state-legislatures-news/details/donor-human-milk-more-valuable-than-gold.
8. Poverty Status of Children by Family structure. Office of Juvenile Justice and Delinquency Prevention. Accessed August 7, 2024. https://ojjdp.ojp.gov/statistical-briefing-book/population/faqs/qa01203.
9. Tran HT, Nguyen TT, Mathisen R. The Use of Human Donor Milk. The BMJ. November 17, 2020. Accessed August 7, 2024. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7673198/.
10. Peirce A. Can I breast-feed during cancer treatment? Memorial Sloan Kettering Cancer Center. August 2, 2016. Accessed August 7, 2024. https://www.mskcc.org/news/can-breast-feed-during-cancer-treatment.
11. Lawrence R. Transmission of infectious diseases through breast milk and breastfeeding. Breastfeeding (Ninth Edition). June 4, 2021. Accessed August 7, 2024. https://www.sciencedirect.com/science/article/abs/pii/B9780323680134000122?via%3Dihub.
12. Stead Sellers F. Baby Formula Shortage Life-Threatening for Some Older Kids and Adults. The Washington Post. June 3, 2022. Accessed August 7, 2024. https://www.washingtonpost.com/health/2022/06/03/baby-formula-shortage-metabolic-disorder/.
13. Bottemiller Evich H. Duckworth asks FTC to examine formula market. Politico. May 13, 2022. Accessed August 7, 2024. https://www.politico.com/news/2022/05/13/duckworth-ftc-examine-formula-market-00032283.
14. The U.S. Food and Drug Administration's Immediate National Strategy to Increase the Resiliency of the U.S. Infant Formula Market. U.S. Food and Drug Administration. March 2023. Accessed August 7, 2024.https://www.fda.gov/media/166520/download?attachment.
15. Kimball S. Abbott Baby Formula Plant had "egregiously unsanitary" conditions, FDA chief says in scathing testimony to Congress. CNBC. June 1, 2022. Accessed August 7, 2024.https://www.cnbc.com/2022/05/25/watch-live-house-grills-fda-commissioner-abbott-executive-on-baby-formula-shortage.html.
16. Paris M. One in Five US States Is 90% Out of Baby Formula. Bloomberg. June 2, 2022. Accessed August 7, 2024. https://www.bloomberg.com/news/articles/2022-06-02/us-baby-formula-shortages-hit-74-despite-biden-action.
17. Market Factors Relevant to Infant Formula Supply Disruptions. A Report of the Federal Trade Commission. March 13, 2024. Accessed August 7, 2024. https://www.ftc.gov/system/files/ftc_gov/pdf/infant_formula_report_final.pdf.
18. Cernioglo K, Smilowitz JT. Infant feeding practices and parental perceptions during the 2022 United States infant formula shortage crisis. BMC Pediatrics. 2023;23(1). doi:https://doi.org/10.1186/s12887-023-04132-9
19. Modi L. Why the infant formula shortage is still a concern. Fast Company. Published February 28, 2024. https://www.fastcompany.com/91042983/why-the- infant-formula-shortage-is-still-a-concern
20. Tariffs and the Infant Formula Shortage: How Are Imports of Infant Formula Classified?; 2022. https://crsreports.congress.gov/product/pdf/IN/IN11932
21. Essley Whyte L, Peterson K, Newman J. Baby-Formula Imports to Face Tariffs Again in 2023. WSJ. Published December 28, 2022. https://www.wsj.com/ articles/baby-formula-imports-to-face-tariffs-again-in-2023-11672233735
22. Murray C. Enfamil Infant Formula Price Spikes: Frustrated Consumers Cry, "Robbery!" As Shortages Persist. Forbes. Published March 22, 2023. Accessed March 4, 2024.https://www.forbes.com/sites/conormurray/2023/03/21/enfamil-infant-formula-price-spikes-frustrated-consumers-cry-robbery-as-shortages- persist/?sh=376af89c61a2
23. Competition Counts. Federal Trade Commission https://www.ftc.gov/sites/default/files/attachments/competition-counts/zgen01.pdf
24. Neuberger Z, Bergh K, Hall L. Infant Formula Shortage Highlights WIC's Critical Role in Feeding Babies. Center on Budget and Policy Priorities. Published June 22, 2022. https://www.cbpp.org/research/food-assistance/infant-formula-shortage-highlights-wics-critical-role-in-feeding-babies#_ftnref18
25. Torres Cabrera M. Vulnerabilities in the US Baby Formula Market Post-2022. Euromonitor. Published May 12, 2023. Accessed March 4, 2024. https:// www.euromonitor.com/article/vulnerabilities-in-the-us-baby-formula-market-post-2022

26. Abrams SA. Making Sense of the Infant Formula Shortage: Moving From Short-term Blame to Long-term Solutions. Nutrition Today. 2023;58(5):195. doi:https:// doi.org/10.1097/NT.0000000000000645
27. Sullivan, S. An Exclusively Human Milk-Based Diet Is Associated with a Lower Rate of Necrotizing Enterocolitis than a Diet of Human Milk and Bovine Milk-Based Products. The Journal of Pediatrics. December 28, 2009. Accessed August 16, 2024. http://www.jpeds.com/article/S0022-3476(09)01085-3/abstract.
28. Donor Human Milk Legislative Report. The Florida Senate. November 1, 2021. Accessed August 16, 2024.https://www.flsenate.gov/Committees/Show/HP/MeetingPacket/5435/9764_MeetingPacket_5435.01.26%20-%20Post%20Meeting%20Packet.pdf.

RELEVANT AMA POLICY

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]

Adequate Funding of the WIC Program H-245.989

Our AMA urges the U.S. Congress to investigate recent increases in the cost of infant formula, as well as insure that WIC programs receive adequate funds to provide infant formula and foods for eligible children. [Res. 269, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 207
(I-24)

Introduced by: Women Physicians Section

Subject: Accountability for G-605.009: Requesting A Task Force to Preserve the Patient-Physician Relationship Task Force Update and Guidance

Referred to: Reference Committee B

Whereas, a task force to preserve the patient-physician relationship when evidence-based, appropriate care is banned or restricted was established at A-22 by policy G-605.009; and

Whereas, the G-605.009 created a task force to help guide organized medicine's response to bans and restrictions on abortion, prepare for widespread criminalization of other evidence-based care, implement relevant AMA policies, and identify and create implementation-focused practice and advocacy resources; and

Whereas, the G-605.009 created an ad hoc committee or task force to identify issues with physician payment and reimbursement for gender-affirming care and recommend solutions to address these barriers to care; and

Whereas, this G-605.009 task force was established in 2022, but there have been no updates delivered to the AMA membership on its progress; and

Whereas, the lack of updates impedes further AMA HOD advocacy due to lack of findings and recommendations from the task force; and

Whereas, in many states in the U.S. with restrictive abortion laws, many physicians and other clinicians face confusion around what is legally permissible[1]; and

Whereas, some states have proposed legislation, for example South Dakota House Bill 1224, which requires the creation of an informational video and other materials describing the state's abortion law and medical care for a pregnant woman experiencing life-threatening or health-threatening medical conditions[2]; and

Whereas, the infant mortality rate in Texas increased to a greater degree than in the rest of the United States following the introduction of strict abortion restrictions[3]; therefore be it

RESOLVED, that our American Medical Association's Task Force to Preserve the Patient-Physician Relationship will present annual updates on their findings at AMA Annual Meetings until the objectives have been completed (Directive to Take Action); and be it further

RESOLVED, that our AMA's work on the Task Force continues for a minimum of three years with reevaluation of need and relevance at I-29 (Directive to Take Action); and be it further

RESOLVED, that our AMA amend G-605.009 with the addition of text as follows:

2h. Work with interested parties to publish public-facing guidance for what is medically allowable for physicians practicing in states with

restrictions potentially impeding on the patient-physician relationship.
(Modify Current HOD Policy)

Fiscal Note: To Be Determined

Received: 09/19/2024

REFERENCES
1. Zionts A. What counts as an exception to South Dakota's abortion ban? A video may soon explain. NPR [Internet]. KFF Health News; 2024 Feb 27 [cited 2024 Aug 11]; Available from: https://www.npr.org/sections/health-shots/2024/02/27/1234056635/abortion-ban-south-dakota-ectopic-pregnancy-miscarriage-life-of-mother
2. 2024 House Bill 1224 [Internet]. South Dakota Legislature. [cited 2024 Aug 11]. Available from: https://sdlegislature.gov/Session/Bill/24959
3. Gemmill A, Margerison CE, Stuart EA, Bell SO. Infant Deaths After Texas' 2021 Ban on Abortion in Early Pregnancy. JAMA Pediatr. 2024;178(8):784–791. doi:10.1001/jamapediatrics.2024.0885

RELEVANT AMA POLICY

Establishing A Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care is Banned or Restricted G-605.009

1. Our American Medical Association will convene a task force of appropriate AMA councils and interested state and medical specialty societies, in conjunction with the AMA Center for Health Equity, and in consultation with relevant organizations, practices, government bodies, and impacted communities for the purpose of preserving the patient-physician relationship.
2. This task force, which will serve at the direction of our AMA Board of Trustees, will inform the Board to help guide organized medicine's response to bans and restrictions on abortion, prepare for widespread criminalization of other evidence-based care, implement relevant AMA policies, and identify and create implementation-focused practice and advocacy resources on issues including but not limited to:
    a. Health equity impact, including monitoring and evaluating the consequences of abortion bans and restrictions for public health and the physician workforce and including making actionable recommendations to mitigate harm, with a focus on the disproportionate impact on under-resourced, marginalized, and minoritized communities.
    b. Practice management, including developing recommendations and educational materials for addressing reimbursement, uncompensated care, interstate licensure, and provision of care, including telehealth and care provided across state lines.
    c. Training, including collaborating with interested medical schools, residency and fellowship programs, academic centers, and clinicians to mitigate radically diminished training opportunities.
    d. Privacy protections, including best practice support for maintaining medical records privacy and confidentiality, including under HIPAA, for strengthening physician, patient, and clinic security measures, and countering law enforcement reporting requirements.
    e. Patient triage and care coordination, including identifying and publicizing resources for physicians and patients to connect with referrals, practical support, and legal assistance.
    f. Coordinating implementation of pertinent AMA policies, including any actions to protect against civil, criminal, and professional liability and retaliation, including criminalizing and penalizing physicians for referring patients to the care they need.
    g. Anticipation and preparation, including assessing information and resource gaps and creating a blueprint for preventing or mitigating bans on other appropriate health care, such as gender affirming care, contraceptive care, sterilization, infertility care, and management of ectopic pregnancy and spontaneous pregnancy loss and pregnancy complications.
3. Our American Medical Association will appoint an ad hoc committee or task force, composed of physicians from specialties who routinely provide gender-affirming care, payers, community advocates, and state Medicaid directors and/or insurance commissioners, to identify issues with physician payment and reimbursement for gender-affirming care and recommend solutions to address these barriers to care. [Res. 621, A-22; Appended: Res. 816, I-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 208
(I-24)

Introduced by: Senior Physicians Section

Subject: Medicare Part B Enrollment and Penalty Awareness

Referred to: Reference Committee B

Whereas, Medicare provides essential health insurance for those aged 65 and older, as well as for those receiving Social Security disability benefits[1]; and

Whereas, individuals aged 65 or older already receiving Social Security have the option to either enroll in or refuse Medicare Part B coverage; and

Whereas, individuals working past age 65 who are offered COBRA coverage upon retirement or dismissal may find the cost prohibitive, thereby affecting their Medicare enrollment decisions; and

Whereas, Medicare allows for re-enrollment in Part B, but will incur a late enrollment penalty that will apply for as long as they retain Part B coverage[1]; and

Whereas, many seniors approaching retirement may be unaware of Medicare's sign-up rules, which can result in significant penalties if they do not enroll during the Initial Enrollment Period (IEP)—a seven-month window beginning three months prior to their 65th birthday and ending three months after[1]; and

Whereas, seniors may incur a late enrollment penalty (LEP) of 10% of the standard Part B premium for each 12-month period they were not enrolled, which will be added to their monthly premium for the duration of their life[2]; and

Whereas, a straightforward checklist could help clarify the lifelong penalties associated with late Medicare enrollment and provide a smoother transition into Medicare Part B, addressing issues such as (1) failure to enroll when first eligible; (2) missing the special enrollment period and (3) switching from Medicare Advantage to traditional Medicare; and

Whereas, physicians and their patients must be well-informed about Medicare sign-up rules to ensure timely and affordable coverage for all eligible individuals; and

Whereas, these penalties are not sufficiently advertised to seniors, leading to potential financial hardship; therefore be it

RESOLVED, that our American Medical Association review the current penalties for declining Medicare Part B coverage with the Centers for Medicare and Medicaid Services (CMS), and advocate for changes to improve awareness of the risk and financial burdens associated with discontinuing coverage before reaching age 65 (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate to CMS for the creation of a comprehensive checklist for seniors approaching age 65 to facilitate Medicare enrollment and avoid gaps in insurance

coverage or permanent increases in Part B premiums (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for enhanced public awareness regarding the risks of not enrolling in Medicare Part B, and support making information about these risks more accessible and widely available to prevent lifetime penalties (Directive to Take Action); and be it further

RESOLVED, that our AMA explore with AARP and other interested organizations a mechanism for auto enrollment in Medicare Part B for those who take Social Security benefits before age 65 that would include additional premium support for those making less than $1,000 in monthly Social Security benefits. (Directive to Take Action)

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

Received: 9/23/2024

REFERENCES

1. The Centers for Medicare and Medicaid Services (CMS). Medicare 2024 Website, https://www.ssa.gov/pubs/EN-05-10043.pdf (accessed July 20, 2024).
2. The Centers for Medicare and Medicaid Services (CMS). Avoid late enrollment penalties Medicare 2023 Website, https://www.medicare.gov/basics/costs/medicare-costs/avoid-penalties (accessed August 19, 2024).

RELEVANT AMA POLICY

H-330.924 Changes In COBRA Federal Regulations

(1) The AMA, in cooperation with other organizations interested in the welfare of seniors, urge Congress to change existing law to allow COBRA coverage for employed seniors changing employment, irrespective of Medicare eligibility. (2) That for this population (i.e., persons still employed at the time of attaining age 65, who have no need, to enroll in Medicare Part B), an elimination of the 90-day waiting period for eligibility for Medicare Part B, together with an elimination of the penalties applied for a delayed application, be sought.
[Res.144, A-98; Reaffirmed: BoT Rep. 23, A-09; Reaffirmed: CMS Rep. 01, A-19]

D-330.925 Medicare Enrollment and Re-enrollment Delays

Our AMA will seek legislation mandating that the Centers for Medicare and Medicaid Services impose a requirement on its carriers and Medicare administrative contractors (MACs) that enrollment and re-enrollment applications must be processed within thirty days of receipt with appropriate feedback to the applicant, and that financial penalties be imposed on carriers and MACs for unjustified delays in enrollment and re-enrollment.
[Res. 205, I-08; Reaffirmed: BoT Rep. 09, A-18]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 210
(I-24)

Introduced by: American Academy of Ophthalmology

Subject: Laser Surgery

Referred to: Reference Committee B

Whereas, American Medical Association policy defines surgery as "the diagnostic or therapeutic treatment of conditions or disease processes by any instruments causing localized alteration or transposition of live human tissue which include lasers, ultrasound, ionizing radiation, scalpels, probes, and needles[1]"; and

Whereas, AMA policy calls on our AMA to support legislation prohibiting optometrists from performing surgical procedures and encourages state medical associations to support state legislation and rulemaking prohibiting optometrists from performing surgical procedures[2]; and

Whereas, AMA policy states that laser surgery should be performed only by individuals licensed to practice medicine and surgery or by those categories of practitioners currently licensed by the state to perform surgical services and calls on our AMA to encourage state medical associations to support state legislation and rulemaking in support of this policy[3]; and

Whereas, optometrists in 9 states are currently licensed to perform laser surgery; and

Whereas, optometry's laser surgery training consists of a 16 hour didactic course with no training on live patients; and

Whereas, H-475.980, Addressing Surgery Performed by Optometrists cross-references an incorrect section of AMA Policy and should instead cross-reference H-475.989, Laser Surgery[2]; therefore be it

RESOLVED, that our American Medical Association amend policy H-475.989, "Laser Surgery" to read that laser surgery should be performed only by individuals licensed to practice medicine and surgery or by those categories of practitioners <u>appropriately trained</u> and currently licensed by the state to perform surgical services (Modify Current HOD Policy); and be it further

RESOLVED, that our AMA amend policy H-475.980 Addressing Surgery Performed by Optometrists to read:
1. Our AMA will support legislation prohibiting optometrists from performing surgical procedures as defined by AMA policies H-475.983, "Definition of Surgery," and <u>H-475.989</u>~~H-475.988~~, "Laser Surgery." 2. Our AMA encourages state medical associations to support state legislation and rulemaking prohibiting optometrists from performing surgical procedures as defined by AMA policies H-475.983, "Definition of Surgery," and <u>H-475.989</u>~~H-475.988~~, "Laser Surgery". (Modify Current HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 9/23/2024

References
1. H-475.983 Definition of Surgery
2. H-475.980 Addressing Surgery Performed by Optometrists
3. H-475.989 Laser Surgery

Relevant AMA Policy

H-475.980 Addressing Surgery Performed by Optometrists
1. Our AMA will support legislation prohibiting optometrists from performing surgical procedures as defined by AMA policies H-475.983, “Definition of Surgery,” and H-475.988, “Laser Surgery.”
2. Our AMA encourages state medical associations to support state legislation and rulemaking prohibiting optometrists from performing surgical procedures as defined by AMA policies H-475.983, “Definition of Surgery,” and H-475.988, “Laser Surgery”. (Res. 229, I-18)

H-475.983 Definition of Surgery
Our American Medical Association adopts the following definition of 'surgery' from American College of Surgeons Statement ST-11:
Surgery is performed for the purpose of structurally altering the human body by the incision or destruction of tissues and is part of the practice of medicine. Surgery also is the diagnostic or therapeutic treatment of conditions or disease processes by any instruments causing localized alteration or transposition of live human tissue which include lasers, ultrasound, ionizing radiation, scalpels, probes, and needles. The tissue can be cut, burned, vaporized, frozen, sutured, probed, or manipulated by closed reductions for major dislocations or fractures, or otherwise altered by mechanical, thermal, light-based, electromagnetic, or chemical means. Injection of diagnostic or therapeutic substances into body cavities, internal organs, joints, sensory organs, and the central nervous system also is considered to be surgery (this does not include the administration by nursing personnel of some injections, subcutaneous, intramuscular, and intravenous, when ordered by a physician). All of these surgical procedures are invasive, including those that are performed with lasers, and the risks of any surgical procedure are not eliminated by using a light knife or laser in place of a metal knife, or scalpel.

Patient safety and quality of care are paramount and, therefore, patients should be assured that individuals who perform these types of surgery are licensed physicians (defined as doctors of medicine or osteopathy) who meet appropriate professional standards. (Res. 212 A-07 Reaffirmed: BOT Rep. 16, A-13 Reaffirmed: CCB/CLRPD Rep. 01, A-23)

H-475.989 Laser Surgery
Our American Medical Association adopts the policy that laser surgery should be performed only by individuals licensed to practice medicine and surgery or by those categories of practitioners currently licensed by the state to perform surgical services. Our AMA encourages state medical associations to support state legislation and rulemaking in support of this policy. (Sub. Res. 39, I-90 Reaffirmed: Sunset Report, I-00 Reaffirmed: CMS Rep. 6, A-10 Reaffirmed: BOT Rep. 16, A-13 Reaffirmed: BOT Rep. 09, A-23)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 211
(I-24)

Introduced by: American Academy of Ophthalmology

Subject: Water Bead Injuries

Referred to: Reference Committee B

Whereas, from January 1, 2007, through December 31, 2022, there were 8,159 U.S. emergency room visits reported in the National Electronic Injury Surveillance System by individuals under 20 years old associated with water beads, of which ingestion was the most common mechanism of injury (45.9%), followed by ear canal insertion (32.6%), nasal insertion (11.7%), and eye injury (8.8%)[1]; and

Whereas, H.R. 6468 (Pallone), currently pending in the Subcommittee on Innovation, Data, and Commerce of the House Energy and Commerce Committee, would classify a water bead product as a banned hazardous product, regardless of the date of manufacture or importation [2]; and

Whereas, H.R. 6468 would define a water bead product as any item designed, intended, or marketed as a toy, educational material, or art material [2]; and

Whereas, the U.S. Consumer Product Safety Commission (CPSC) established ASTM F963-23, the Standard Consumer Safety Specification for Toy Safety, as the mandatory consumer product safety standard for toys[3]; and

Whereas, Section 4.40 of ASTM F963-23 includes specific requirements for toys made of 'Expanding Materials,' including, but not limited to, water beads[3]; and

Whereas, on November 8, 2024, the comment period ended for a Notice of Proposed Rulemaking (NPR) by the CPSC to establish additional performance and labeling requirements for water bead toys and toys containing water beads to address all known associated hazards[4]; and

Whereas, the NPR would also require the CPSC to publish a Notice of Requirement (NOR) for the accreditation of third-party conformity assessment bodies (laboratories) to assess compliance with children's product safety rules applicable to water bead toys and toys containing water beads[4]; and

Whereas, the estimated injuries cited in the NPR excluded incidents involving water bead gel blaster projectiles, which commonly result in eye injuries and may include products that are not classified as children's toys under the scope of the proposed rule[4]; and

Whereas, ocular injury resulting from gel pellet projectiles can result in serious visual impairment and may require surgical intervention, most commonly for uncontrolled intraocular pressure (IOP) in the setting of hyphema[5,6]; therefore be it

RESOLVED, that our American Medical Association urge the U.S. Consumer Product Safety Commission (CPSC) to promptly promulgate and enforce stringent performance and labeling requirements for water bead toys and toys containing water beads to effectively mitigate associated health hazards (New HOD Policy); and be it further

RESOLVED, that our AMA continue to urge Congress to enact legislation to classify water bead products as banned hazardous items to protect consumers, particularly children, from associated risks (New HOD Policy); and be it further

RESOLVED, that our AMA encourage businesses that sell gel blasters to make appropriate and safe protective eye wear available and encourage its use to their customers and to distribute educational materials on the safe use of gel guns (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for the development of national safety standards for gel blasters that include requirements for product design modifications such as lower velocity limits, safer projectile designs, or integrated safety mechanisms to reduce the risk of eye injuries. (Directive to Take Action)

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

Received: 9/23/2024

References:

1. Joynes HJ, Kistamgari S, Casavant MJ, Smith GA. Pediatric water bead-related visits to United States emergency departments. Am J Emerg Med. 2024 Jul 28;84:81-86. doi: 10.1016/j.ajem.2024.07.048. Epub ahead of print. PMID: 39096713.
2. H.R.6468 - Ban Water Beads Act (https://www.congress.gov/bill/118th-congress/house-bill/6468/text)
3. 16 CFR Parts 1112 and 1250 (https://www.federalregister.gov/documents/2024/01/18/2024-00741/safety-standard-mandating-astm-f963-for-toys)
4. Safety Standard for Toys: Requirements for Water Beads, 89 Fed. Reg. 73024, (September 9, 2024), Notice of Proposed Rulemaking, (https://www.federalregister.gov/documents/2024/09/09/2024-19286/safety-standard-for-toys-requirements-for-water-beads)
5. Lin BR, Al-Khersan H, Rowsey T, West M, Lin A, Qu P, Bitrian E, Hudson J, Venincasa M, Fan J, Gutkind N, Diaz JD, Parekh P, Sultan H, Yannuzzi NA. Clinical Outcomes after Ocular Trauma with Orbeez Gel Pellet Projectiles. Ophthalmology. 2023 May;130(5):553-555. doi: 10.1016/j.ophtha.2023.01.013. Epub 2023 Jan 28. PMID: 36717000.
6. Hayes R, Dai S. Ocular injuries from gel blasters: not just a harmless toy. BMJ Case Rep. 2019 Jun 9;12(6):e229629. doi: 10.1136/bcr-2019-229629. PMID: 31178435; PMCID: PMC6557336.

Relevant AMA Policy

D-60.967 Support for Detergent Poisoning and Child Safety Act
1. Our AMA will advocate to the state and federal authorities for laws that would protect children from poisoning by detergent packet products by requiring that these products meet child-resistant packaging requirements and that these products are manufactured to be less attractive to children in color and in design and to include conspicuous warning labels.
2. Our AMA will advocate that the detergent product package labeling be constructed in a clear and obvious method so children know that the product is dangerous to ingest.
3. Our AMA encourages the Consumer Product Safety Commission in conjunction with the American Association of Poison Control Centers to study the impact of “F3159-15 - Consumer Safety Specification for Liquid Laundry Packets” to ensure that the voluntary ASTM standard adequately protects children from injury, including eye injury. (Res. 430, A-16 Appended: Res. 413, A-17)

H-145.982 Prevention of Ocular Injuries from BB and Air Guns
The AMA encourages businesses that sell BB and air guns to make appropriate and safe protective eye wear available and encourages its use to their customers and to distribute educational materials on the safe use of non-powder guns. Res. 416, I-96 Reaffirmed: CSAPH Rep. 3, A-06 Reaffirmed: CSAPH Rep. 01, A-16

H-245.985 Mandatory Labeling for Waterbeds and Beanbag Furniture
Our American Medical Association urges the Consumer Product Safety Commission to require waterbed manufacturers and manufacturers of similar type furnishings to affix a permanent label and to distribute warning materials on each waterbed and other furnishings sold concerning the risks of leaving an infant or handicapped child, who lacks the ability to roll over, unattended on a waterbed or beanbag. Res. 414, A-92 Reaffirmed: CSA Rep. 8, A-03 Modified: CSAPH Rep. 1, A-13 Reaffirmed: CSAPH Rep. 08, A-23

H-470.974 Athletic Helmets
1. Our AMA urges the Consumer Product Safety Commission and other appropriate agencies and organizations to establish standards to ensure that athletic and recreational equipment produced or sold in the United States provide protection against head and facial injury.
2. Our AMA: (a) supports requiring the use of head and facial protection by children and adolescents while engaged in potentially dangerous athletic and recreational activities; (b) encourages the use of head and facial protection for adults while engaged in potentially dangerous athletic and recreational activities; (c) encourages physicians to educate their patients about the importance of head and facial protection while engaged in potentially dangerous athletic and recreational activities; and (d) encourages the availability of rental helmets at all commercial settings where potentially dangerous athletic and recreational activities take place. (Sub. Res. 16, I-88 Res. 419, A-93 Reaffirmed: CSA Rep. 8, A-03 Appended: Sub Res. 911, I-10 Modified: Res. 404, A-12 Reaffirmed: CSAPH Rep. 3, A-15)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 212
(I-24)

Introduced by: Michigan

Subject: Addressing the Unregulated Body Brokerage Industry

Referred to: Reference Committee B

Whereas, the for-profit body broker industry's (a.k.a., non-transplant tissue banks) lack of regulation gives rise to significant ethical dilemmas and public health hazards; and

Whereas, body brokers are firms or individuals that acquire whole bodies/cadavers donated to science, for the purpose of dissecting them to sell or lease the parts for profit; and

Whereas, brokers make money - anywhere from $5,000 to $10,000 - by providing bodies and dissected parts to companies and institutions that specialize in advancing medicine and other trades through training, education, and research; and

Whereas, a Reuters review of court, police, and internal broker records and interviews identified more than 2,357 body parts obtained by brokers from at least 1,638 people that were misused, abused, or defiled; and

Whereas, in 2017, a Midwest couple was charged with defrauding customers by selling body parts infected with hepatitis and HIV; and

Whereas, in 2016, more than 20 bodies donated to an Arizona broker were used in United States Army blast experiments, without the consent of the deceased or next of kin; and

Whereas, body brokers are known to prey on underserved and minoritized populations, profiting on exploitation while demand for organs, skeletons, and tissues unceasingly rise; and

Whereas, the Uniform Anatomical Gift Act (1967) is a federal framework that specifies how organ donations can be made and aims to maintain the current organ donation and transplantation systems in the U.S.; and

Whereas, current regulations only cover body parts intended for transplant, such as hearts, livers, and tissue; and

Whereas, no such regulatory body exists for the body broker industry; and

Whereas, only ten states provide any oversight, and only some require licensing or disclosure of body brokers; therefore be it

RESOLVED, that our American Medical Association amend existing policy H-460.890, "Improving Body Donation Regulation," by addition to read as follows:

Our AMA: (1) recognizes the need for ethical, transparent, and consistent body and body part donation regulations~~.~~; (2) will collaborate with interested organizations to actively advocate for

the passage of federal legislation to provide necessary minimum standards, oversight, and authority over body broker entities that receive donated human bodies and body parts for education and research; (3) will develop model state legislation to provide necessary minimum standards, oversight, and authority over body broker entities that receive donated human bodies and body parts for education and research; and (4) encourages state medical societies to advocate legislation or regulations in their state that are consistent with the AMA model state legislation. (Modify Current HOD Policy)

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

Received: 9/23/2024

REFERENCES

1. In a warehouse of horrors, a body broker allegedly stacked human heads (reuters.com)
2. Murphy, Tillis, Bilirakis, Fletcher Introduce Bipartisan, Bicameral Bill To Stop The Brokering Of Body Parts, Preserve Integrity Of Organ Donation Process (senate.gov)
3. Body Broker Bill Introduced in the Senate > National Funeral Directors Association (NFDA)
4. For Congress - CDRI Info 12-6-2023.pdf (nfda.org)
5. uaga_final_aug09.pdf (pitt.edu)
6. https://www.uniformlaws.org/committees/community-home?CommunityKey=015e18ad-4806-4dff-b011-8e1ebc0d1d0f

RELEVANT AMA POLICY

Improving Body Donation Regulation H-460.890
Our AMA recognizes the need for ethical, transparent, and consistent body and body part donation regulations.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 213
(I-24)

Introduced by: American Academy of Child and Adolescent Psychiatry

Subject: Sustainable Long-term Funding for Child Psychiatry Access Programs

Referred to: Reference Committee B

Whereas, there is a shortage of child psychiatrists in the United States[1]; and

Whereas, primary care physicians (PCPs), such as pediatricians and family physicians, may manage mental health conditions in primary care settings[2,3]; and

Whereas, Child Psychiatry Access Programs (CPAPs) are centralized coordinated-care programs that provide quick remote pediatric psychiatry mental health consultations to PCPs[4]; and

Whereas, CPAPs are promising in addressing the shortage of child and adolescent psychiatrists in the United States by leveraging the existing child and adolescent psychiatry workforce and enhancing PCPs' ability to manage psychiatric conditions in primary care settings[5]; and

Whereas, at the time of a 2022 paper by Lee et al., CPAPs exist in 46 states and can be funded by multiple entities, including federal grants, Medicare, state funding, and commercial insurance[4]; and

Whereas, the federal Health Resources and Services Administration funds CPAPs in 46 states, the District of Columbia, the U.S. Virgin Islands, the Republic of Palau, the Chickasaw Nation, the Red Lake Band of Chippewa Indians, the Federated States of Micronesia, the Commonwealth of Northern Mariana Islands, and Guam, through its Pediatric Mental Healthcare Access Program; and

Whereas, few CPAPs have permanent sustainable funding[4]; and

Whereas, CPAPs are temporarily funded and vulnerable to budget cuts and could benefit from some federal oversight[5]; and

Whereas, federal involvement in the Child Nutrition and WIC Reauthorization Act of 2004 successfully mandated School Wellness Programs in all states[5]; and

Whereas, the federal government has the authority to enact legislation encouraging states to develop and fund CPAP programs[5]; therefore be it

RESOLVED, that our American Medical Association advocate that the federal government work to achieve adequate sustained funding of child psychiatry consultation programs,

such as Child Psychiatry Access Programs and Pediatric Mental Health Care Access Program. (Directive to Take Action)

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

Received: 9/23/2024

REFERENCES

1. AACAP. Workforce Maps by State. Accessed August 6, 2023. https://www.aacap.org/aacap/Advocacy/Federal_and_State_Initiatives/Workforce_Maps/Home.aspx
2. Whitney DG, Peterson MD. US National and State-Level Prevalence of Mental Health Disorders and Disparities of Mental Health Care Use in Children. JAMA Pediatr. 2019;173(4):389-391. doi:10.1001/jamapediatrics.2018.5399
3. Patel A, Medhekar R, Ochoa-Perez M, et al. Care Provision and Prescribing Practices of Physicians Treating Children and Adolescents With ADHD. Psychiatr Serv. Published online February 15, 2017. doi:10.1176/appi.ps.201600130
4. Lee CM, Yonek J, Lin B, et al. Systematic Review: Child Psychiatry Access Program Outcomes. JAACAP Open. Published online August 1, 2023. doi:10.1016/j.jaacop.2023.07.003
5. Addressing National Workforce Shortages by Funding Child Psychiatry Access Programs | Pediatrics | American Academy of Pediatrics. Accessed September 12, 2023. https://publications.aap.org/pediatrics/article/147/1/e20194012/33432/Addressing-National-Workforce-Shortages-by-Funding?autologincheck=redirected

RELEVANT AMA POLICY

H-345.981 Access to Mental Health Services
Our AMA advocates the following steps to remove barriers that keep Americans from seeking and obtaining treatment for mental illness: (1) reducing the stigma of mental illness by dispelling myths and providing accurate knowledge to ensure a more informed public; (2) improving public awareness of effective treatment for mental illness; (3) ensuring the supply of psychiatrists and other well trained mental health professionals, especially in rural areas and those serving children and adolescents; (4) tailoring diagnosis and treatment of mental illness to age, gender, race, culture and other characteristics that shape a person's identity; (5) facilitating entry into treatment by first-line contacts recognizing mental illness, and making proper referrals and/or to addressing problems effectively themselves; and (6) reducing financial barriers to treatment. [CMS Rep. 9, A-01; Reaffirmation A-11; Reaffirmed: CMS Rep. 7, A-11; Reaffirmed: BOT action in response to referred for decision Res. 403, A-12; Reaffirmed in lieu of Res. 804, I-13; Reaffirmed in lieu of Res. 808, I-14; Reaffirmed: Res. 503, A-17; Reaffirmation: I-18; Reaffirmed: CSAPH Rep. 07, A-24]

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

H-345.975 Maintaining Mental Health Services by States
Our American Medical Association supports maintaining essential mental health services at the state level, to include maintaining state inpatient and outpatient mental hospitals, community mental health centers, addiction treatment centers, and other state-supported psychiatric services. Our AMA supports state responsibility to develop programs that rapidly identify and refer individuals with significant mental illness for treatment, to avoid repeated psychiatric hospitalizations and repeated interactions with the law, primarily as a result of untreated mental conditions. Our AMA supports increased funding for state Mobile Crisis Teams to locate and treat homeless individuals with mental illness. Our AMA supports enforcement of the Mental Health Parity Act at the federal and state level. Our AMA will take these resolves into consideration when developing policy on essential benefit services. [Res. 116, A-12; Reaffirmation A-15; Reaffirmed: Res. 414, A-22]

D-345.972 Mental Health Crisis
Our American Medical Association will work expediently with all interested national medical organizations, national mental health organizations, and appropriate federal government entities to convene a federally-sponsored blue ribbon panel and develop a widely disseminated report on mental health treatment availability and suicide prevention in order to: Improve suicide prevention efforts, through support, payment and insurance coverage for mental and behavioral health and suicide prevention services, including, but not limited to, the National Suicide Prevention Lifeline. Increase access to affordable and effective mental health care through expanding and diversifying the mental and behavioral health workforce. Expand research into the disparities in youth suicide prevention. Address inequities in suicide risk and rate through education, policies and development of suicide prevention programs that are culturally and linguistically appropriate. Develop and support resources and programs that foster and strengthen healthy mental health development. Develop best practices for minimizing emergency department delays in obtaining appropriate mental health care for patients who are in mental health crisis. Our AMA supports physician acquisition of emergency mental health response skills by promoting education courses for physicians, fellows, residents, and medical students including, but not limited to, mental health first aid training.
Our AMA along with other interested parties will advocate that children's mental health and barriers to mental health care access for children represent a national emergency that requires urgent attention from all interested parties.
Our AMA will join with other interested parties to advocate for efforts to increase the mental health workforce to address the increasing shortfall in access to appropriate mental health care for children. [Res. 425, A-22; Appended: Res. 422, A-23]

H-60.929 National Child Traumatic Stress Network
Our American Medical Association recognizes the importance of and support the widespread integration of evidence-based pediatric trauma services with appropriate post-traumatic mental and physical care, such as those developed and implemented by the National Child Traumatic Stress Initiative. Our AMA will work with mental health organizations and relevant health care organizations to support full funding of the National Child Traumatic Stress Initiative. [Res. 419, A-11; Modified: CSAPH Rep. 1, A-21]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 214
(I-24)

Introduced by: American College of Obstetricians and Gynecologists, South Dakota

Subject: Advocating for Evidence-Based Strategies to Improve Rural Obstetric Health Care and Access

Referred to: Reference Committee B

Whereas, rural Americans experience significant health disparities, with mortality rates 20% higher and preventable hospitalizations 57% higher compared to urban populations, and disproportionately higher rates of cardiovascular disease, stroke, cancer, diabetes and respiratory illness;[1] and

Whereas, the risk of pregnancy-related mortality is highest for rural populations in the United States (US) compared to micropolitan or metropolitan populations, and rural women have a consistently higher probability of severe maternal morbidity;[2] and

Whereas, 6.9 million women in the US live in areas with limited or no access to maternity care services, and 36% of all US counties are designated as maternity care deserts, and 61% of those are rural counties;[3] and

Whereas, closure of rural maternity units is associated with longer driving distances to maternity care, with half of rural women living more than a thirty-minute drive to a maternity unit, with higher rates of preterm birth, births outside of hospitals and births in hospital emergency rooms;[4] and

Whereas, physicians and personnel in hospitals without maternity units often do not have the training and infrastructure to recognize, stabilize, obtain consultation, and safely transfer a patient with pregnancy-related complications;[5] and

Whereas, the Alliance for Innovation on Maternal Health (AIM) program is a national data-driven maternal safety and quality improvement initiative based on interdisciplinary consensus-based algorithms to improve maternal safety and outcomes, through implementation and data support of evidence-based and evidence-informed patient safety bundles, funded by the United States Department of Health and Human Services Administration (HRSA) Maternal and Child Health Bureau (MCHB);[6] and

Whereas, there are existing telemedicine programs around the US that have shown success in providing training and infrastructure for community physicians to deliver best-practice care for patients with complex conditions, and improve health outcomes such as Project ECHO (Extension for Community Healthcare Outcomes)[7] Project ANGELS (Antenatal & Neonatal Guidelines, Education and Learning System);[8] therefore be it

RESOLVED, that our American Medical Association strongly supports federal legislation that provides funding for the creation and implementation of a national obstetric emergency training program for rural health care facilities with and without a dedicated labor and delivery unit (New HOD Policy); and be it further

RESOLVED, that our AMA supports the expansion and implementation of innovative obstetric telementoring/teleconsultation models to address perinatal health disparities and improve access to evidence-informed perinatal care in rural communities (New HOD Policy); and be it further

RESOLVED, that our AMA encourages academic medical centers and health systems to actively participate in obstetric telementoring/teleconsultation models to support rural physicians and advanced practice providers and improve perinatal health outcomes in rural communities (New HOD Policy); and be it further

RESOLVED, that our AMA supports ongoing research to evaluate the effectiveness of national implementation of obstetric telementoring/teleconsultation models to improve rural perinatal health outcomes and reduce rural-urban health disparities (New HOD Policy).

Fiscal Note: Minimal – less than $1,000

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REFERENCES

1. Statistical Brief #178. Healthcare Cost and Utilization Project (HCUP). September 2014. Agency for Healthcare Research and Quality, Rockville, MD. Retrieved from www.hcup-us.ahrq.gov/reports/statbriefs/sb178-Preventable-Hospitalizations-by-Region.jsp.
2. Rural Health Information Hub. Rural Maternal Health. Retrieved from https://www.ruralhealthinfo.org/topics/maternal-health#:~:text=According%20to%20the%20Pregnancy%20Mortality,per%20100%2C000%20in%20micropolitan%20areas.
3. Stoneburner A, Lucas R, Fontenot J, Brigance C, Jones E, DeMaria AL. Nowhere to Go: Maternity Care Deserts Across the US. (Report No 4). March of Dimes. 2024. https://www.marchofdimes.org/maternity-care-deserts-report.
4. Minion SC, Krans EE, Brooks MM, Mendez DD, Haggerty CL. Association of Driving Distance to Maternity Hospitals and Maternal and Perinatal Outcomes. Obstet Gynecol. 2022 Nov 1;140(5):812-819. doi: 10.1097/AOG.0000000000004960.
5. American College of Obstetricians and Gynecologists. Identifying and Managing Obstetric Emergencies in Nonobstetric Settings. Retrieved from https://www.acog.org/programs/obstetric-emergencies-in-nonobstetric-settings.
6. Alliance for Innovation on Maternal Health. About Us. Retrieved from Initiatives to Reduce Maternal Mortality | AIM (saferbirth.org).
7. Arora S, Thornton K, Murata G, Deming P, Kalishman S, Dion D, Parish B, Burke T, Pak W, Dunkelberg J, Kistin M, Brown J, Jenkusky S, Komaromy M, Qualls C. Outcomes of treatment for hepatitis C virus infection by primary care providers. N Engl J Med. 2011 Jun 9;364(23):2199-207. doi: 10.1056/NEJMoa1009370.
8. Lowery C, et al. ANGELS and University of Arkansas for Medical Sciences paradigm for distant obstetrical care delivery. *Am J Obstet Gynecol*. 2007; 196:534.e1-534.e9.

RELEVANT AMA POLICY

H-478.980 Increasing Access to Broadband Internet to Reduce Health Disparities
Our AMA will advocate for the expansion of broadband and wireless connectivity to all rural and underserved areas of the United States while at all times taking care to protecting existing federally licensed radio services from harmful interference that can be caused by broadband and wireless services.

H-480.937 Addressing Equity in Telehealth
(1) Our American Medical Association recognizes access to broadband internet as a social determinant of health.
(2) Our AMA encourages initiatives to measure and strengthen digital literacy, with an emphasis on programs designed with and for historically marginalized and minoritized populations.
(3) Our AMA encourages telehealth solution and service providers to implement design functionality, content, user interface, and service access best practices with and for historically minoritized and marginalized communities, including addressing culture, language, technology accessibility, and digital literacy within these populations.
(4) Our AMA supports efforts to design telehealth technology, including voice-activated technology, with and for those with difficulty accessing technology, such as older adults, individuals with vision impairment and individuals with disabilities.

(5) Our AMA encourages hospitals, health systems and health plans to invest in initiatives aimed at designing access to care via telehealth with and for historically marginalized and minoritized communities, including improving physician and non-physician provider diversity, offering training and technology support for equity-centered participatory design, and launching new and innovative outreach campaigns to inform and educate communities about telehealth.
(6) Our AMA supports expanding physician practice eligibility for programs that assist qualifying health care entities, including physician practices, in purchasing necessary services and equipment in order to provide telehealth services to augment the broadband infrastructure for, and increase connected device use among historically marginalized, minoritized and underserved populations.
(7) Our AMA supports efforts to ensure payers allow all contracted physicians to provide care via telehealth.
(8) Our AMA opposes efforts by health plans to use cost-sharing as a means to incentivize or require the use of telehealth or in-person care or incentivize care from a separate or preferred telehealth network over the patient's current physicians.
(9) Our AMA will advocate that physician payments should be fair and equitable, regardless of whether the service is performed via audio-only, two-way audio-video, or in-person.

H-185.917 Reducing Inequities and Improving Access to Insurance for Maternal Health Care
(1) Our American Medical Association acknowledges that structural racism and bias negatively impact the ability to provide optimal health care, including maternity care, for people of color.
(2) Our AMA encourages physicians to raise awareness among colleagues, residents and fellows, staff, and hospital administrators about the prevalence of racial and ethnic inequities and the effect on health outcomes, work to eliminate these inequities, and promote an environment of trust.
(3) Our AMA encourages physicians to pursue educational opportunities focused on embedding equitable, patient-centered care for patients who are pregnant and/or within 12 months postpartum into their clinical practices and encourages physician leaders of health care teams to support similar appropriate professional education for all members of their teams.
(4) Our AMA will continue to monitor and promote ongoing research regarding the impacts of societal (e.g., racism or unaffordable health insurance), geographical, facility-level (e.g., hospital quality), clinician-level (e.g., implicit bias), and patient-level (e.g., comorbidities, chronic stress or lack of transportation) barriers to optimal care that contribute to adverse and disparate maternal health outcomes, as well as research testing the effectiveness of interventions to address each of these barriers.
(5) Our AMA will promote the adoption of federal standards for clinician collection of patient-identified race and ethnicity information in clinical and administrative data to better identify inequities. The federal data collection standards should be:
    a. Informed by research (including real-world testing of technical standards and standardized definitions of race and ethnicity terms to ensure that the data collected accurately reflect diverse populations and highlight, rather than obscure, critical distinctions that may exist within broad racial or ethnic categories),
    b. Carefully crafted in conjunction with clinician and patient input to protect patient privacy and provide non-discrimination protections.
(6) Lead to the dissemination of best practices to guide respectful and non-coercive collection of accurate, standardized data relevant to maternal health outcomes.
(7) Our AMA supports the development of a standardized definition of maternal mortality and the allocation of resources to states and Tribes to collect and analyze maternal mortality data (i.e., Maternal Mortality Review Committees and vital statistics) to enable stakeholders to better understand the underlying causes of maternal deaths and to inform evidence-based policies to improve maternal health outcomes and promote health equity.
(8) Our AMA encourages hospitals, health systems, and state medical associations and national medical specialty societies to collaborate with non-clinical community organizations with close ties to minoritized and other at-risk populations to identify opportunities to best support pregnant persons and new families.
(9) Our AMA encourages the development and funding of resources and outreach initiatives to help pregnant individuals, their families, their communities, and their workplaces to recognize the value of comprehensive prepregnancy, prenatal, peripartum, and postpartum care. These resources and initiatives should encourage patients to pursue both physical and behavioral health care, strive to reduce barriers to pursuing care, and highlight care that is available at little or no cost to the patient.

(10)Our AMA supports adequate payment from all payers for the full spectrum of evidence-based prepregnancy, prenatal, peripartum, and postpartum physical and behavioral health care.
(11)Our AMA encourages hospitals, health systems, and states to participate in maternal safety and quality improvement initiatives such as the Alliance for Innovation on Maternal Health program and state perinatal quality collaboratives.
(12)Our AMA will advocate for increased access to risk-appropriate care by encouraging hospitals, health systems, and states to adopt verified, evidence-based levels of maternal care.

H-130.976 On-Site Emergency Care
(1) The AMA reaffirms its policy endorsing the concept of appropriate medical direction of all prehospital emergency medical services. (2) The following factors should be considered by prehospital personnel in making the decision either to provide extended care in the field or to evacuate the trauma victim rapidly: (a) the type, severity and anatomic location of the injury; (b) the proximity and capabilities of the receiving hospital; (c) the efficiency and skill of the paramedic team; and (d) the nature of the environment (e.g., rural or urban). (3) Because of the variability of these factors, no single methodology or standard can be applied to all accident situations. Trauma management differs markedly between locales, settings, and types of patients receiving care. For these reasons, physician supervision of prehospital services is essential to ensure that the critical decision to resuscitate in the field or to transfer the patient rapidly is made swiftly and correctly.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 215
(I-24)

Introduced by: American College of Obstetricians and Gynecologists, South Dakota, American Academy of Dermatology Association, American Society for Dermatologic Surgery Association

Subject: Advocating for Federal and State Incentives for Recruitment and Retention of Physicians to Practice in Rural Areas

Referred to: Reference Committee B

Whereas, rural residents of the United States (US) often have higher rates of chronic disease and die younger than their urban counterparts, with significant health disparities and reduced access to care; and

Whereas, there is a projected shortage of up to 87,000 physicians by 2036, with rural areas disproportionately affected; and

Whereas, the number of medical school graduates from rural areas declined by 28% between 2002 and 2017, with only 4-5% of incoming medical students now from rural backgrounds;[1] and

Whereas, rural communities face significant challenges in attracting and retaining physicians due to financial constraints, professional isolation, and lack of resources;[2] and

Whereas, the ability to obtain care in rural America is complicated by scarce medical facilities, disproportionately lower health insurance coverage rates, and a higher proportion of Medicaid/CHIP clients than in urban areas;[3] and

Whereas, rural areas tend to have higher proportions of elderly residents, who typically require more care;[4] and

Whereas, reimbursement for health care services as well as low patient volume in rural areas may not be sufficient for a physician practice to be financially viable; and

Whereas, medical training is long and expensive, with significant student debt incurred; and

Whereas, physicians may choose practice opportunities which offer maximum opportunity to pay off student debt; and

Whereas, urban facilities and practices may offer higher salaries, more benefits, and better working conditions;[5] and

Whereas, our American Medical Association supports educational and recruiting strategies to encourage physicians choose and be prepared for rural practice, including recruitment of students from rural backgrounds;[6] and

Whereas, individuals from rural backgrounds may incur substantial student debt;[7] and

Whereas, our AMA supports Medicare bonus payments for physicians practicing in rural areas regardless of Health Professional Shortage Area (HPSA) status, low interest government business loans, and exemption from some business regulatory requirements in order to enhance recruitment and retention of physicians in rural areas;[8] therefore be it

RESOLVED, that our American Medical Association advocate for increased federal and state funding for loan forgiveness for physicians who commit to practice and reside in rural and underserved areas for a meaningful period of time (Directive to Take Action); and be it further

RESOLVED, that our AMA urge Congress and State legislatures to establish retention bonus programs for physicians who maintain practice in rural areas for extended periods, with increasing bonuses for longer commitments (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for the expansion and sustainable funding of residency and graduate medical education slots in rural areas, as well as opportunities for exposure to rural health care such as through clinical rotations in rural areas, to increase the likelihood of physicians practicing in these communities after training. (Directive to Take Action)

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

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REFERENCES

1. Henry, Tanya Albert. AMA outlines 5 keys to fixing America's rural health crisis. American Medical Association. June 6, 2024. Retrieved from https://www.ama-assn.org/delivering-care/population-care/ama-outlines-5-keys-fixing-america-s-rural-health-crisis?&utm_source=BulletinHealthCare&utm_medium=email&utm_term=062824&utm_content=MEMBER&utm_campaign=article_alert-morning_rounds_daily&utm_uid=2029008&utm_effort=MRNRD0.
2. Rural Health Information Hub. Recruitment and Retention for Rural Health Facilities. Retrieved from https://www.ruralhealthinfo.org/topics/rural-health-recruitment-retention.
3. Medicaid and CHIP Payment and Access Commission. Issue Brief: Medicaid and Rural Health. April 2021. Retrieved from https://www.macpac.gov/wp-content/uploads/2021/04/Medicaid-and-Rural-Health.pdf.
4. U.S. Government Accountability Office. Watchblog: Why Health Care Is Harder to Access in Rural America. May 16, 2023. Retrieved from https://www.gao.gov/blog/why-health-care-harder-access-rural-america.
5. Rural Health Information Hub. Rural Healthcare Workforce. Retrieved from https://www.ruralhealthinfo.org/topics/health-care-workforce#:~:text=Urban%20facilities%20and%20practices%20may,less%20affordable%20for%20rural%20students.
6. AMA Policy H-465.988,2023
7. Zimmerschied, Caleb. How med student loan burdens can deepen health disparities. American Medical Association. April 27, 2017. Retrieved fromhttps://www.ama-assn.org/education/medical-school-diversity/how-med-student-loan-burdens-can-deepen-health-disparities
8. AMA Policy H-465.981, 2023

RELEVANT AMA POLICY

H-465.988 Educational Strategies for Meeting Rural Health Physician Shortage

(1) In light of the data available from the current literature as well as ongoing studies being conducted by staff, our American Medical Association recommends that:
   a. Our AMA encourage medical schools and residency programs to develop educationally sound rural clinical preceptorships and rotations consistent with educational and training requirements, and to provide early and continuing exposure to those programs for medical students and residents.
   b. Our AMA encourage medical schools to develop educationally sound primary care residencies in smaller communities with the goal of educating and recruiting more rural physicians.
   c. Our AMA encourage state and county medical societies to support state legislative efforts toward developing scholarship and loan programs for future rural physicians.

d. Our AMA encourage state and county medical societies and local medical schools to develop outreach and recruitment programs in rural counties to attract promising high school and college students to medicine and the other health professions.
e. Our AMA urge continued federal and state legislative support for funding of Area Health Education Centers (AHECs) for rural and other underserved areas.
f. Our AMA continue to support full appropriation for the National Health Service Corps Scholarship Program, with the proviso that medical schools serving states with large rural underserved populations have a priority and significant voice in the selection of recipients for those scholarships.
g. Our AMA support full funding of the new federal National Health Service Corps loan repayment program.
h. Our AMA encourage continued legislative support of the research studies being conducted by the Rural Health Research Centers funded by the National Office of Rural Health in the Department of Health and Human Services.
i. Our AMA continue its research investigation into the impact of educational programs on the supply of rural physicians.
j. Our AMA continue to conduct research and monitor other progress in development of educational strategies for alleviating rural physician shortages.
k. Our AMA reaffirm its support for legislation making interest payments on student debt tax deductible.
l. Our AMA encourage state and county medical societies to develop programs to enhance work opportunities and social support systems for spouses of rural practitioners.

(2) Our AMA will work with state and specialty societies, medical schools, teaching hospitals, the Accreditation Council for Graduate Medical Education (ACGME), the Centers for Medicare and Medicaid Services (CMS) and other interested stakeholders to identify, encourage and incentivize qualified rural physicians to serve as preceptors and volunteer faculty for rural rotations in residency.
(3) Our AMA will:
a. work with interested stakeholders to identify strategies to increase residency training opportunities in rural areas with a report back to the House of Delegates; and
b. work with interested stakeholders to formulate an actionable plan of advocacy with the goal of increasing residency training in rural areas.
(4) Our AMA will encourage ACGME review committees to consider adding exposure to rural medicine as appropriate, to encourage the development of rural program tracks in training programs and increase physician awareness of the conditions that pose challenges and lack of resources in rural areas.
(5) Our AMA will encourage adding educational webinars, workshops and other didactics via remote learning formats to enhance the educational needs of smaller training programs.

D-465.998 Addressing Payment and Delivery in Rural Hospitals

(1) Our American Medical Association will advocate that public and private payers take the following actions to ensure payment to rural hospitals is adequate and appropriate:
a. Create a capacity payment to support the minimum fixed costs of essential services, including surge capacity, regardless of volume.
b. Provide adequate service-based payments to cover the costs of services delivered in small communities.
c. Adequately compensate physicians for standby and on-call time to enable very small rural hospitals to deliver quality services in a timely manner.
d. Use only relevant quality measures for rural hospitals and set minimum volume thresholds for measures to ensure statistical reliability.
e. Hold rural hospitals harmless from financial penalties for quality metrics that cannot be assessed due to low statistical reliability.
f. Create voluntary monthly payments for primary care that would give physicians the flexibility to deliver services in the most effective manner with an expectation that some services will be provided via telehealth or telephone.
(2) Our AMA encourages transparency among rural hospitals regarding their costs and quality outcomes.
(3) Our AMA supports better coordination of care between rural hospitals and networks of providers where services are not able to be appropriately provided at a particular rural hospital.

(4) Our AMA encourages employers and rural residents to choose health plans that adequately and appropriately reimburse rural hospitals and physicians.

H-465.981 Enhancing Rural Physician Practices

(1) Our AMA supports legislation to extend the 10% Medicare payment bonus to physicians practicing in rural counties and other areas where the poverty rate exceeds a certain threshold, regardless of the areas' Health Professional Shortage Area (HPSA) status.
(2) Our AMA encourages federal and state governments to make available low interest loans and other financial assistance to assist physicians with shortage area practices in defraying their costs of compliance with requirements of the Occupational Safety and Health Administration, Americans with Disabilities Act and other national or state regulatory requirements.
(3) Our AMA will explore the feasibility of supporting the legislative and/or regulatory changes necessary to establish a waiver process through which shortage area practices can seek exemption from specific elements of regulatory requirements when improved access, without significant detriment to quality, will result.
(4) Our AMA supports legislation that would allow shortage area physician practices to qualify as Rural Health Clinics without the need to employ one or more physician extenders.
(5) Our AMA will undertake a study of structural urbanism, federal payment polices, and the impact on rural workforce disparities.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 216
(I-24)

Introduced by: Resident and Fellow Section, American Academy of Addiction Psychiatry

Subject: Clearing Federal Obstacles for Supervised Injection Sites

Referred to: Reference Committee B

Whereas, the Anti-Drug Abuse Act of 1986 (commonly known as the “crack house statute”) outlawed the operation of houses and buildings where crack cocaine and other drugs are made or used;[1] and

Whereas, the Anti-Drug Abuse Act led to an increased disparity in prison sentencing between Black and white populations;[2-4] and

Whereas, Supervised injection facilities (SIFs), also known as overdose prevention centers, have been linked to reduction in public injection, improperly-disposed syringes, and drug-related crime;[5-7] and

Whereas, SIFs have been estimated to result in significant net cost savings to communities based on reduction of transmissible diseases and wound infections;[8] and

Whereas, fentanyl overdose is the number one cause of death for Americans aged 18-45, and the rate of overdose deaths continues to rise;[9-10] and

Whereas, SIFs have a proven record of preventing fatal overdoses and increasing enrollment in detoxification services;[11-13] and

Whereas, the immediate success of two SIFs in New York City has demonstrated that SIFs in the United States can be an effective tool in the battle to curb overdose deaths;[14] and

Whereas, there is demonstrated interest from a number of states to support state-sanctioned SIFs;[15] and

Whereas, the legality of SIFs is directly threatened by the Anti-Drug Abuse Act, which has been used to shut down operations of some of these programs, and continues to be the major barrier to their implementation in the United States;[16-18] and

Whereas, our American Medical Association supports the development and implementation of pilot SIFs to generate data to inform policymakers on the feasibility, effectiveness, and legal aspects of SIFs in reducing harms and healthcare costs related to injection drug use (AMA policy H-95.925); therefore be it

RESOLVED, that our American Medical Association advocate for federal policies that empower states to determine the legality of supervised injection facilities (SIFs). (Directive to Take Action)

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

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REFERENCES:

1. Anti-Drug Abuse Act of 1986, Public Law No: 99-570. U.S. Statutes at Large
2. "Oct. 27, 1986: Anti-Drug Abuse Act Creates Racially Biased 100 to 1 Crack/Powder Disparity." *Calendar.Eji.Org*, calendar.eji.org/racial-injustice/oct/27.
3. Vagins, Deborah., Jesselyn McCurdy. "Cracks in the System: Twenty Years of the Unjust Federal Crack Cocaine Law," *American Civil Liberties Union* (2006). https://www.aclu.org/sites/default/files/pdfs/drugpolicy/cracksinsystem_20061025.pdf
4. Milloy MJ, Kerr T, Tyndall M, Montaner J, Wood E. Estimated drug overdose deaths averted by North America's first medically-supervised safer injection facility. PLoS One. 2008;3(10):e3351. https://doi.org/10.1371/journal.pone.0003351.
5. Wood E, Kerr T, Small W, et al. Changes in public order after the opening of a medically supervised safer injecting facility for illicit injection drug users. CMAJ. Stoltz JA,Wood E, SmallW, et al. Changes in injecting practices associated with the use of a medically supervised safer injection facility. J Public Health (Oxf). 2007;29(1):35–39. https://doi.org/10.1093/pubmed/fdl090.
6. Stoltz JA, Wood E, SmallW, et al. Changes in injecting practices associated with the use of a medically supervised safer injection facility. J Public Health (Oxf). 2007;29(1):35–39. https://doi.org/10.1093/pubmed/fdl090.
7. Wood E, Tyndall MW, Lai C, Montaner JS, Kerr T. Impact of a medically supervised safer injecting facility on drug dealing and other drug-related crime. Subst Abuse Treat Prev Policy. 2006;1:13. https://doi.org/10.1186/1747-597X-1-13.https://doi.org /10.1503/cmaj.1040774.
8. Irwin A, Jozaghi E, Bluthenthal RN, Kral AH. A Cost-Benefit Analysis of a Potential Supervised Injection Facility in San Francisco, California, USA. J Drug Issues. 2017;47(2):164–184. https://doi.org/10.1177/0022042616679829.
9. "Drug Overdose Deaths | Drug Overdose | CDC Injury Center," August 22, 2023. https://www.cdc.gov/drugoverdose/deaths/index.html.
10. "DEA Administrator on Record Fentanyl Overdose Deaths | Get Smart About Drugs." Accessed April 14, 2024. https://www.getsmartaboutdrugs.gov/media/dea-administrator-record-fentanyl-overdose-deaths.
11. Wood E, Tyndall MW, Zhang R, Montaner JS, Kerr T. Rate of detoxification service use and its impact among a cohort of supervised injecting facility users. Addiction. 2007;102(6):916–919. https://doi.org/10.1111/j.1360-0443.2007.01818.x.
12. DeBeck K, Kerr T, Bird L, et al. Injection drug use cessation and use of North America's first medically supervised safer injecting facility. Drug Alcohol Depend. 2011;113(2–3):172–176. https://doi.org/10.1016/j.drugalcdep.2010.07.023.
13. Small W, Van Borek N, Fairbairn N, Wood E, Kerr T. Access to health and social services for IDU: the impact of a medically supervised injection facility. Drug Alcohol Rev. 2009;28(4):341–346. https://doi.org/10.1111/j.1465-3362.2009.00025.x.
14. OnPoint NYC. "Baseline Annual Report 2023." Accessed April 14, 2024. https://onpointnyc.org/baseline-annual-report-2023/.
15. Cato Institute. "New York City, Rhode Island, and Now Minnesota Defy the 'Crack House Statute,'" May 24, 2023. https://www.cato.org/blog/new-york-city-rhode-island-now-minnesota-defy-crack-house-statute.
16. Beletsky L, Davis CS, Anderson E, Burris S. The law (and politics) of safe injection facilities in the United States. Am J Public Health. 2008; 98(2):231–237. https://doi.org/10.2105/AJPH.2006.103747.
17. Otterman, Sharon. "Federal Officials May Shut Down Overdose Prevention Centers in Manhattan." *The New York Times*, August 8, 2023, sec. New York. https://www.nytimes.com/2023/08/08/nyregion/drug-overdoses-supervised-consumption-nyc.html.
18. Ovalle, David. "Philadelphia Nonprofit Loses Latest Bid to Open Supervised Drug-Use Center." *Washington Post*, April 4, 2024. https://www.washingtonpost.com/health/2024/04/03/drug-use-center-philadelphia-justice-department/.

RELEVANT AMA POLICY:

H-95.925 Pilot Implementation of Supervised Injection Facilities
Our AMA supports the development and implementation of pilot **supervised injection** facilities (SIFs) in the United States that are designed, monitored, and evaluated to generate data to inform policymakers on the feasibility, effectiveness, and legal aspects of SIFs in reducing harms and health care costs related to **injection** drug use. [Res. 513, A-17; Reaffirmation A-23]

H-95.978 Harmful Drug Use in the United States - Strategies for Prevention
Our AMA: (1) Urges the Substance Abuse and Mental Health Administration to support research into special risks and vulnerabilities, behavioral and biochemical assessments and intervention methodologies most useful in identifying persons at special risk and the behavioral and biochemical strategies that are most effective in ameliorating risk factors.
(2) Urges the Center for Substance Abuse Prevention to continue to support community-based prevention strategies which include: (a) Special attention to children and adolescents, particularly in schools, beginning at the pre-kindergarten level. (b) Changes in the social climate (i.e., attitudes of community leaders and the public), to reflect support of harmful drug and alcohol use prevention and treatment, eliminating past imbalances in allocation of resources to supply and demand reduction. (c) Development

of innovative programs that train and involve parents, educators, physicians, and other community leaders in "state of the art" prevention approaches and skills.
(3) Urges major media programming and advertising agencies to encourage the development of more accurate and prevention-oriented messages about the effects of harmful drug and alcohol use.
(4) Supports the development of advanced educational programs to produce qualified prevention specialists, particularly those who relate well to the needs of economically disadvantaged, ethnic, racial, and other special populations.
(5) Supports investigating the feasibility of developing a knowledge base of comprehensive, timely and accurate concepts and information as the "core curriculum" in support of prevention activities.
(6) Urges federal, state, and local government agencies and private sector organizations to accelerate their collaborative efforts to develop a national consensus on prevention and eradication of harmful alcohol and drug use.
[BOT Rep. H, A-89; Reaffirmed: CSA Rep. 12, A-99; Reaffirmation I-01; Reaffirmed: CSAPH Rep. 1, A-11; Modified: CSAPH Rep. 1, A-21; Reaffirmed: Res. 523, A-23]

D-95.987 Prevention of Drug-Related Overdose
1. Our AMA: (a) recognizes the great burden that substance use disorders (SUDs) and drug-related overdoses and death places on patients and society alike and reaffirms its support for the compassionate treatment of patients with a SUD and people who use drugs; (b) urges that community-based programs offering naloxone and other opioid overdose and drug safety and prevention services continue to be implemented in order to further develop best practices in this area; (c) encourages the education of health care workers and people who use drugs about the use of naloxone and other harm reduction measures in preventing opioid and other drug-related overdose fatalities; and (d) will continue to monitor the progress of such initiatives and respond as appropriate.
2.Our AMA will: (a) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of a drug-related overdose; and (b) encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for a drug-related overdose.
3. Our AMA will support the development and implementation of appropriate education programs for persons receiving treatment for a SUD or in recovery from a SUD and their friends/families that address harm reduction measures.
4. Our AMA will advocate for and encourage state and county medical societies to advocate for harm reduction policies that provide civil and criminal immunity for the use of “drug paraphernalia” designed for harm reduction from drug use, including but not limited to drug contamination testing and injection drug preparation, use, and disposal supplies.
[Res. 526, A-06; Modified in lieu of Res. 503, A-12; Appended: Res. 909, I-12; Reaffirmed: BOT Rep. 22, A-16; Modified: Res. 511, A-18; Reaffirmed: Res. 235, I-18; Modified: Res. 506, I-21; Appended: Res. 513, A-22; Modified: Res. 211, I-22; Appended: Res. 221, A-23; Reaffirmation: A-23; Modified: Res. 505, A-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 217
(I-24)

Introduced by: Post-Acute and Long-Term Care Medical Association

Subject: Expand Access to Skilled Nursing Facility Services for Patients with Opioid Use Disorder

Referred to: Reference Committee B

Whereas, opioid use disorder (OUD) in older adults is one of the fastest growing health problems that continues to go underrecognized and undertreated; and

Whereas, there is an increasing number of older adults with a history of OUD or on medications for OUD (Medication-Assisted Treatment [MAT] or MOUD; i.e., methadone, buprenorphine, and naltrexone) who are hospitalized and require discharge to skilled nursing facilities (SNFs) for skilled nursing and rehabilitation, but face disproportionate harms if they are unable to access SNF care; and

Whereas, there is a pervasive practice of screening patients for admission to SNFs (i.e., 80% of referrals being denied and 40% of patients being denied SNF admission) leading to longer hospital lengths of stay awaiting disposition, and/or discharge to self-care in the community despite being medically appropriate and referred for SNF level of care; and

Whereas, there are significant barriers and delays in many SNFs to obtain medications for the treatment of OUD; therefore be it

RESOLVED, that our American Medical Association advocate for legislative and regulatory action to ensure patients are not being denied appropriate admission to skilled nursing facilities based on practices of denying admission solely on the diagnosis of opioid use disorder or prescriptions for active medications for opioid use disorder (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for and support legislation and regulatory action to ensure adequate reimbursement of skilled nursing facilities that recognizes the complexity of care, treatment and resources required for opioid use disorder treatment (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for increased access to medications for opioid use disorder in long-term care pharmacies and address the barriers to access to methadone in long-term care for use in the treatment of opioid use disorder. (Directive to Take Action)

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

Received: 9/24/2024

RELEVANT AMA POLICY

D-95.961 Enabling Methadone Treatment of Opioid Use Disorder in Primary Care Settings
Our AMA: (1) will research current best practices and support pilot programs and other evidence-based efforts to expand and integrate primary care services for patients receiving methadone maintenance treatment; (2) supports further research to help define the population of patients who may be safely treated with methadone maintenance treatment via office-based treatment, including primary care; and (3) urges all payers, including health insurance companies, pharmacy benefit management companies, and state and federal agencies, to reduce prior authorization and other administrative burdens and to enhance the provision of primary care, counseling, and other medically necessary services for patients being treated with methadone maintenance treatment. [BOT Rep. 16, 1-20]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 218
(I-24)

Introduced by: New Jersey

Subject: Time Sensitive Credentialing of New Providers with an Insurance Carrier

Referred to: Reference Committee B

Whereas, a health care provider is a physician or a non-physician health care practitioner, or group of health care practitioners, or a healthcare organization who are licensed, certified, or otherwise authorized by law to provide health care services; and

Whereas, a health care provider needs to be “credentialed” into an insurance carrier to create a financial relationship for reimbursement of services provided to patients insured by that insurance carrier (even though they have been licensed and board certified); and

Whereas, the requirements for the application process used by a carrier to credential a provider into the carrier’s network are individually created by the insurance carrier and the insurance carrier must provide a credentialing application to the provider for participation if the provider is part of an existing group or if the carrier has an open network, in order to get paid; and

Whereas, the application process in the current advanced technological era is quite simple, as the necessary segments are filled out correctly, they turn green if acceptable and the areas needing to be modified remain red or yellow, and they can be rectified within 24-48 hour so that the successfully completed application turns all green; and

Whereas, the ERISA plans need to be regulated Federally; and

Whereas, currently each carrier has “their own policies” and create unnecessary delays to the extent of several months, in some cases 8 to 9 months despite submitting all necessary supporting documents thus causing undue burden and roadblocks in providing essential medical care to their patients; and

Whereas, the carriers standard answer when enquired about the status of the applicant is” the application is in process”; therefore be it

RESOLVED, that our American Medical Association urge the US Department of Labor to establish uniform provider credentialing standards for Third Party Administrator’s (TPA's) serving ERISA Plans to include the following : that when a credentialing application is submitted, the insurance carrier must respond in writing within five business days whether the application is complete and acceptable, and if incomplete the carrier must send notice to the provider indicating what additional information is needed for completion of the process, and acknowledge the completion of a successfully completed application within ten business (Directive to Take Action); and be it further

RESOLVED, that our AMA urge the US Department of Labor to require Third Party Administrators to send a written notice to applicants within 45 days, regarding their credentialing decision and after 45 days, an applicant is deemed to have been automatically credentialled

and enrolled to be eligible for payment of services, even if the payer fails to acknowledge the applicant. (Directive to Take Action)

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

Received: 9/24/2024

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 219
(I-24)

Introduced by: New York

Subject: Advocate to Continue Reimbursement for Telehealth / Telemedicine Visits Permanently

Referred to: Reference Committee B

Whereas, Medicare is set to end reimbursement for telehealth on 12/31/24; and

Whereas, the decision for a telehealth type visit should be made between a doctor and a patient and not determined by a third-party insurance payor; and

Whereas, “Telehealth offers patients and providers significant benefits as a lower cost, easier way to access quality care”[1]; and

Whereas, the COVID-19 health pandemic heightened awareness and dramatically increased the need for use of telehealth; and

Whereas, telehealth has been shown in surveys to benefit both physicians and patients and physicians would be able to maintain continuity of care to those patients who are unable to make in-person visits; and

Whereas, licensed health care professionals in the VA system can practice their profession “using telemedicine at any location in any state regardless of where the professional or patient is located if the covered health care professional is using telemedicine to provide VA [Department of Veterans Affairs (VA)] medical or health services”[2]; and

Whereas, physicians would be able to render care to those patients seeking their follow-up medical care and expert opinion without the need to travel to the physician;[3,4] and

Whereas, telehealth would benefit patients as it would increase patient access to a greater number of physicians particularly for the homebound, increase choice of patients for their physicians and has been shown to increase patient satisfaction;[3,4] and

Whereas, “The rise of telehealth during pandemic boosted mental health treatment rates”[5] in a society where “90% of US adults say the U.S. is experiencing a mental health crisis”;[6] and

Whereas, “An American Medical Association (AMA) survey released shows physicians have enthusiastically embraced telehealth and expect to use it even more in the future and “Nearly 85% of physician respondents indicated they are currently using telehealth to care for patients, and nearly 70% report their organization is motivated to continue using telehealth in their practice”;[3,4] therefore be it

RESOLVED, that our American Medical Association advocate for making telehealth reimbursement permanent for Medicare and for all health insurance providers. (Directive to Take Action)

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

Received: 9/24/2024

References:

1. Manocchia A. Telehealth: Enhancing Care through Technology. RI Med J; 2020; 103(1):18-20. Available at: https://pubmed.ncbi.nlm.nih.gov/32013298/

2. H.R.2123 - Veterans E-Health and Telemedicine Support Act of 2017. Bill Summary available at: https://www.congress.gov/bill/115th-congress/house-bill/2123?s=1&r=7

3. Kelly, S. Rise of telehealth during pandemic boosted mental health treatment rates. Available at: https://www.healthcaredive.com/news/telehealth-mental-health-JAMA-pandemic/639905/

4. McPhillips, D. 90% of US adults say the United States is experiencing a mental health crisis, CNN/KFF poll finds. Available at: https://www.cnn.com/2022/10/05/health/cnn-kff-mental-health-poll-wellness/index.html

5. AMA Telehealth Survey report. Available at: https://www.ama-assn.org/system/files/telehealth-survey-report.pdf

6. AMA survey shows widespread enthusiasm for telehealth. Available at: https://www.ama-assn.org/press-center/press-releases/ama-survey-shows-widespread-enthusiasm-telehealth

RELEVANT AMA POLICY

COVID-19 Emergency and Expanded Telemedicine Regulations - D-480.963

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

2)
In 2019, prior to the pandemic, the AMA developed the policy below on telehealth reimbursement and then reaffirmed it in 2022. However, the AMA does not request that coverage and reimbursement for telehealth be made **permanently or indefinitely.**

Reimbursement for Telehealth - D-480.965
Our AMA will work with third-party payers, the Centers for Medicare and Medicaid Services, Congress and interested state medical associations to provide coverage and reimbursement for telehealth to ensure increased access and use of these services by patients and physicians."

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 220
(I-24)

Introduced by: New York

Subject: MIPS Reform

Referred to: Reference Committee B

Whereas, MIPS is an administratively costly program that has failed as a strategy to improve the quality of care and has had many negative unintended consequences; and

Whereas, Based on 2019 data, before full program implementation, MIPS required a considerable investment in time and financial capital -- approximately 200 hours and $12,811 (IQR, $2,861-$17,715) annually per physician; thus, this is likely an underestimate of today's costs[1]; and

Whereas, a November 2023, JAMA study of 49,901 surgeons revealed that 78% of surgeons participating in MIPS in 2021 received quality scores qualifying them for a median positive payment adjustment of $1,341 (IQR, $210-$3120).[2] These adjustments do not compensate for the financial costs of participation and the significant diversion of physicians from patient care; and

Whereas, independently practicing physicians had significantly lower MIPS performance scores than physicians affiliated with better resourced health systems[3]; and

Whereas, physicians caring for more medically and socially vulnerable patients received significantly lower MIPS scores despite providing high-quality care, punishing them for factors outside of their control.[4] Thus, MIPS will serve to increase healthcare disparities by transferring resources from poorer patients to the most affluent; and

Whereas, a 2022 study demonstrated that the MIPS program is ineffective at measuring and incentivizing quality improvement[5]; and

Whereas, MIPS is inconsistent with physician professionalism, is perceived as manipulative and fails to harness what motivates physicians most – mastery, purpose and autonomy;[6] therefore be it

RESOLVED, that our American Medical Association advocate for the repeal of the Medicare Merit-Based Incentive Payment System (MIPS) and replacement with 1) a practicing physician-designed program that has far less administrative burdens and 2) only adopts measures that have been shown to measurably improve patient outcomes. (Directive to Take Action)

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

Received: 9/24/2024

REFERENCES

1. Khullar D, Bond AM, O'Donnell EM, Qian Y, Gans DN, Casalino LP. Time and Financial Costs for Physician Practices to Participate in the Medicare Merit-based Incentive Payment System: A Qualitative Study. JAMA Health Forum. May 2021;2(5):e210527. doi:10.1001/jamahealthforum.2021.0527

2. Maganty A, Shah AA, Hill D, Golla V. Financial Implications of the Merit-Based Incentive Payment System for Surgical Health Care Professionals. JAMA Surg. Published online November 22, 2023. doi:10.1001/jamasurg.2023.5638

3. Johnston KJ, Wiemken TL, Hockenberry JM, Figueroa JF, Joynt Maddox KE. Association of Clinician Health System Affiliation With Outpatient Performance Ratings in the Medicare Merit-based Incentive Payment System. JAMA. 2020;324(10):984–992. doi:10.1001/jama.2020.13136

4. Khullar D, Schpero WL, Bond AM, Qian Y, Casalino LP. Association Between Patient Social Risk and Physician Performance Scores in the First Year of the Merit-based Incentive Payment System. JAMA. Sep 8 2020;324(10):975-983. doi:10.1001/jama.2020.13129

5. Bond AM, Schpero WL, Casalino LP, Zhang M, Khullar D. Association Between Individual Primary Care Physician Merit-based Incentive Payment System Score and Measures of Process and Patient Outcomes. *JAMA*. 2022;328(21):2136–2146. doi:10.1001/jama.2022.20619

6. Khullar D, Wolfson D, Casalino LP. Professionalism, Performance, and the Future of Physician Incentives. JAMA. 2018;320(23):2419-2420. doi:10.1001/jama.2018.17719

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 221
(I-24)

Introduced by: New York

Subject: Medicare Coverage for Non-PAR Physicians

Referred to: Reference Committee B

Whereas, not all physicians participate in the Medicare program; and

Whereas, certain specialties as well as physicians in certain geographic regions have opted out of CMS insurance products due to reimbursement rates well below the level needed to provide adequate care; and

Whereas, traditional Medicare provides freedom of physician choice for its insured; and

Whereas, many non-governmental insurance products exist that provide out of network benefits albeit at some potential cost to the insured beyond the level of reimbursement; and

Whereas, certain services such as mental health care are critical to good health and covered under Medicare; and

Whereas, these services are difficult, if not impossible, to find within the participating provider panels; therefore be it

RESOLVED, that our American Medical Association support federal legislation that would provide Medicare enrollees with the ability to receive partial reimbursement towards the cost of receiving treatment from the physician of their choice, regardless of whether that physician participates in Medicare. (New HOD Policy)

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

Received: 9/24/2024

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 222
(I-24)

Introduced by: New York State

Subject: Rollback on Physician Performance Measures

Referred to: Reference Committee B

Whereas, there are increasing Initiatives from public and private payers that feature incentives purportedly aimed at “elevated performance standards” for physicians and facilitating public reporting; and

Whereas, this increased emphasis on “elevated performance standards” affects physicians’ pay, reputation, and job satisfaction, despite such measures being largely unproven; and

Whereas, the prioritization of such purported quality improvement measures places a financial and temporal strain on hospitals and administrators, and too often raises tensions between hospital administrators and physicians; and

Whereas, on average, physicians spend about 2.6 hours per week on quality improvement documentation, time that could be better utilized in patient care; and (NEJM)

Whereas, because of technological limitations, there is an omission of many aspects of quality that cannot be measured and claims data do not reliably capture many of the factors included in performance measurement, a problem compounded by variability in coding habits among physicians and institutions; and

Whereas, the reliability, validity, evidence, attribution, and meaningfulness of performance measures have been questioned; and (time out article)

Whereas, these largely unproven performance measures are a major driver of the systemic stressors that are resulting in moral injury and demoralization amongst physicians while also resulting in more patient dissatisfaction and destroying the patient-physician relationship; therefore be it

RESOLVED, that our American Medical Association will make public statements calling for a removal of any/all unproven outcomes measures and associated mandates placed on physicians, practices, licensed clinics, nursing homes, hospitals and other places of healthcare (Directive to Take Action); and be it further

RESOLVED**,** that our AMA will seek legislation or regulation removing any/all unproven outcomes measures and associated mandates placed on physicians, practices, licensed clinics, nursing homes, hospitals and other places of healthcare (Directive to Take Action); and be it further

RESOLVED**,** that our AMA will include the following action on a national level, including but not limited to:

-AMA statements calling for a removal of any/all unproven outcomes measures and associated mandates placed on physicians, practices, licensed clinics, nursing homes, hospitals and other places of healthcare; and legislation and regulation seeking the same, and

-AMA seeking legislation or regulation mandating the removal of any/all unproven outcomes measures and associated mandates placed on physicians, practices, licensed clinics, nursing homes, hospitals and other places of healthcare. (Directive to Take Action)

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

Received: 9/24/2024

RELATED AMA POLICIES

Opposed Replacement of the Merit-Based Incentive Payment System with the Voluntary Value Program D-395.998
1. Our AMA will oppose the replacement of the Merit-Based Incentive Payment System (MIPS) with the Voluntary Value Program (VVP) as currently defined.
2. Our AMA will study the criticisms of the Merit-Based Incentive Payment System (MIPS) program as offered by proponents of the VVP to determine where improvement in the MIPS program needs to be made.
3. Our AMA will continue its advocacy efforts to improve the MIPS program, specifically requesting: (a) true EHR data transparency, as the free flow of information is vital to the development of meaningful outcome measures; (b) safe harbor protections for entities providing clinical data for use in the MIPS program; (c) continued infrastructure support for smaller practices that find participation particularly burdensome; (d) adequate recognition of and adjustments for socioeconomic and demographic factors that contribute to variation in patient outcomes as well as geographic variation; and (e) limiting public reporting of physician performance to those measures used for scoring in the MIPS program.
4. Our AMA will determine if population measures are appropriate and fair for measuring physician performance.
Policy Timeline
Res. 247, A-18 Reaffirmed: BOT Rep. 13, I-20

Merit-based Incentive Payment System (MIPS) Update H-385.905
Our AMA supports legislation that ensures Medicare physician payment is sufficient to safeguard beneficiary access to care, replaces or supplements budget neutrality in MIPS with incentive payments, or implements positive annual physician payment updates.
Policy Timeline
BOT Rep. 13, I-20 Reaffirmed: Res. 212, I-21

Reducing MIPS Reporting Burden D-395.999
Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) to advocate for improvements to Merit-Based Incentive Payment System (**MIPS**) that have significant input from practicing physicians and reduce regulatory and paperwork burdens on physicians. In the interim, our AMA will work with CMS to shorten the yearly MIPS data reporting period from one-year to a minimum of 90-days (of the physician's choosing) within the calendar year.
Policy Timeline
Res. 236, A-18 Reaffirmation: A-19 Reaffirmed: BOT Rep. 13, I-20

MIPS and MACRA Exemption H-390.838
Our AMA will advocate for an exemption from the Merit-Based Incentive Payment System (MIPS) and Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) for small practices.
Policy Timeline
Res. 208, I-16 Reaffirmation: A-17 Reaffirmation: I-17 Reaffirmation: A-18 Reaffirmed: BOT

Preserving a Period of Stability in Implementation of the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act (MACRA) D-390.950
1. Our AMA will advocate that Centers for Medicare and Medicaid Services (CMS) implement the Merit-Based Payment Incentive Payment System (MIPS) and Alternative Payment Models (APMs) as is consistent with congressional intent when the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act (MACRA) was enacted.
2. Our AMA will advocate that CMS provide for a stable transition period for the implementation of MACRA, which includes assurances that CMS has conducted appropriate testing, including physicians' ability to participate and validation of accuracy of scores or ratings, and has necessary resources to implement provisions regarding MIPS and APMs.
3. Our AMA will advocate that CMS provide for a stable transition period for the implementation of MACRA that includes a suitable reporting period.
Policy Timeline
Res. 242, A-16 Reaffirmed: BOT Rep. 13, I-20

Measurement of Drug Costs to Assess Resource Use Under MACRA H-385.911
1. Our AMA will work with Congress and the Centers for Medicare and Medicaid Services to exempt all Medicare Part B and Part D drug costs from any current and future resource use measurement mechanisms, including those that are implemented as part of the Merit-Based Incentive Payment System (**MIPS**) or resource use measurement used by an Alternative Payment Model to assess payments or penalties based on the physician's performance and assumption of financial risk, unless a Physician Focused Alternative Payment Model (incorporating such costs) is proposed by a stakeholder organization and participation in the model is not mandatory.
2. Our AMA will continue work with impacted specialties to actively lobby the federal government to exclude Medicare Part B drug reimbursement from the **MIPS** payment adjustment as part of the Quality Payment Program (QPP).
Policy Timeline Res. 218, A-16Appended: Res. 225, I-17

Support for the Quadruple Aim H-405.955
1. Our AMA supports that the "Triple Aim"□ be expanded to the Quadruple Aim, adding the goal of improving the work-life balance of physicians and other health care providers.
2. Our AMA will advocate that addressing physician satisfaction count as a Clinical Practice Improvement Activity under the Merit-Based Incentive Payment System (**MIPS**).
Policy Timeline
Res. 104, A-16 Reaffirmation: A-22

Preserving Patient Access to Small Practices Under MACRA D-390.949
1. Our AMA will urge the Centers for Medicare and Medicaid Services to protect access to care by significantly increasing the low volume threshold to expand the MACRA **MIPS** exemptions for small practices (on a voluntary basis), and to further reduce the MACRA requirements for ALL physicians' practices to provide additional flexibility, reduce the reporting burdens and administrative hassles and costs.
2. Our AMA will advocate for additional exemptions or flexibilities for physicians who practice in health professional shortage areas.
3. Our AMA will determine if there are other fragile practices that are threatened by MACRA and seek additional exemptions or flexibilities for those practices.
Policy Timeline
Res. 243, A-16 Reaffirmation: I-17 Reaffirmation: A-18 Reaffirmed: BOT Rep. 13, I-20

Opposition to Mandatory Licensing Requirements for Qualified Clinical Data Registries H-180.943
1. Our AMA will oppose any Centers for Medicare and Medicaid Services (CMS) proposal that would require Qualified Clinical Data Registries (QCDR) measure owners, as a condition of measure approval for reporting in Merit-based Incentive Payment System (**MIPS**) and other Medicare quality payment programs, to enter into a free license agreement with CMS that would allow other QCDRs to use the owner's measures without a direct license with the measure owner.
2. Our AMA will oppose any CMS proposal that would require inclusion of CMS as a party in a QCDR measure licensing agreement between the QCDR measure owner and another.

3. Our AMA will support in situations where QCDR measures are shared between the original measure owner and another QCDR, that the latter QCDR:
A. must adhere to certain standards and terms set out by the QCDR measure owner on measure implementation and data capture, including data validity and reliability, plus fair remuneration for measure development and ongoing measure stewardship.
B. must have demonstrated clinical expertise in medicine, quality measure development and improvement by providing methods to ensure data quality, routine metric reporting, and quality improvement consultation.
Policy Timeline
Res. 232, I-18

Sequestration D-390.946
Our AMA will: (a) continue to prioritize and actively pursue vigorous and strategic advocacy to prevent sequester and other cuts in Medicare payments due to take effect on January 1, 2022; (b) seek positive inflation-adjusted annual physician payment updates that keep pace with rising practice costs; (c) ensure Medicare physician payments are sufficient to safeguard beneficiary access to care; (d) work towards the elimination of budget neutrality requirements within Medicare Part B; (e) eliminate, replace, or supplement budget neutrality in **MIPS** with positive incentive payments; (f) advocate strongly to the current administration and Congress that additional funds must be put into the Medicare physician payment system to address increasing costs of physician practices, and that continued budget neutrality is not an option; and (g) advocate for payment policies that allow the Centers for Medicare & Medicaid Services to retroactively adjust overestimates of volume of services.
Policy Timeline
Res. 212, I-21 Reaffirmed: Res. 240, A-22 Reaffirmed: CMS Rep. 02, A-23 Reaffirmed: Res. 214, A-23

Pay-for-Performance Principles and Guidelines H-450.947
1. The following *Principles for Pay-for-Performance and Guidelines for Pay-for-Performance* are the official policy of our AMA.

PRINCIPLES FOR PAY-FOR-PERFORMANCE PROGRAMS H-450.947
Physician pay-for-performance (PFP) programs that are designed primarily to improve the effectiveness and safety of patient care may serve as a positive force in our health care system. Fair and ethical PFP programs are patient-centered and link evidence-based performance measures to financial incentives. Such PFP programs are in alignment with the following five AMA principles:
. Ensure quality of care - Fair and ethical PFP programs are committed to improved patient care as their most important mission. Evidence-based **quality** of care measures, created by physicians across appropriate specialties, are the measures used in the programs. Variations in an individual patient care regimen are permitted based on a physician's sound clinical judgment and should not adversely affect PFP program rewards.
2. Foster the patient/physician relationship - Fair and ethical PFP programs support the patient/physician relationship and overcome obstacles to physicians treating patients, regardless of patients' health conditions, ethnicity, economic circumstances, demographics, or treatment compliance patterns.
3. Offer voluntary physician participation - Fair and ethical PFP programs offer voluntary physician participation, and do not undermine the economic viability of non-participating physician practices. These programs support participation by physicians in all practice settings by minimizing potential financial and technological barriers including costs of start-up.
4. Use accurate data and fair reporting - Fair and ethical PFP programs use accurate data and scientifically valid analytical methods. Physicians are allowed to review, comment and appeal results prior to the use of the results for programmatic reasons and any type of reporting.
5. Provide fair and equitable program incentives - Fair and ethical PFP programs provide new funds for positive incentives to physicians for their participation, progressive **quality** improvement, or attainment of goals within the program. The eligibility criteria for the incentives are fully explained to participating physicians. These programs support the goal of **quality** improvement across all participating physicians.

GUIDELINES FOR PAY-FOR-PERFORMANCE PROGRAMS

Safe, effective, and affordable health care for all Americans is the AMA's goal for our health care delivery system. The AMA presents the following guidelines regarding the formation and implementation of fair and ethical pay-for-performance (PFP) programs. These guidelines augment the AMA's "Principles for Pay-for-Performance Programs" and provide AMA leaders, staff and members with operational boundaries that can be used in an assessment of specific PFP programs.

Quality of Care

- The primary goal of any PFP program must be to promote **quality** patient care that is safe and effective across the health care delivery system, rather than to achieve monetary savings.

- Evidence-based **quality** of care measures must be the primary measures used in any program.

1. All performance measures used in the program must be prospectively defined and developed collaboratively across physician specialties.
2. Practicing physicians with expertise in the area of care in question must be integrally involved in the design, implementation, and evaluation of any program.
3. All performance measures must be developed and maintained by appropriate professional organizations that periodically review and update these measures with evidence-based information in a process open to the medical profession.
4. Performance measures should be scored against both absolute values and relative improvement in those values.
5. Performance measures must be subject to the best-available risk- adjustment for patient demographics, severity of illness, and co-morbidities.
6. Performance measures must be kept current and reflect changes in clinical practice. Except for evidence-based updates, program measures must be stable for two years.
7. Performance measures must be selected for clinical areas that have significant promise for improvement.

- Physician adherence to PFP program requirements must conform with improved patient care **quality** and safety.
- Programs should allow for variance from specific performance measures that are in conflict with sound clinical judgment and, in so doing, require minimal, but appropriate, documentation.
- PFP programs must be able to demonstrate improved **quality** patient care that is safer and more effective as the result of program implementation.
- PFP programs help to ensure **quality** by encouraging collaborative efforts across all members of the health care team.
- Prior to implementation, pay-for-performance programs must be successfully pilot-tested for a sufficient duration to obtain valid data in a variety of practice settings and across all affected medical specialties. Pilot testing should also analyze for patient de-selection. If implemented, the program must be phased-in over an appropriate period of time to enable participation by any willing physician in affected specialties.
- Plans that sponsor PFP programs must prospectively explain these programs to the patients and communities covered by them.

Patient/Physician Relationship

- Programs must be designed to support the patient/physician relationship and recognize that physicians are ethically required to use sound medical judgment, holding the best interests of the patient as paramount.
- Programs must not create conditions that limit access to improved care.

1. Programs must not directly or indirectly disadvantage patients from ethnic, cultural, and socio-economic groups, as well as those with specific medical conditions, or the physicians who serve these patients.
2. Programs must neither directly nor indirectly disadvantage patients and their physicians, based on the setting where care is delivered or the location of populations served (such as inner city or rural areas).

- Programs must neither directly nor indirectly encourage patient de-selection.
- Programs must recognize outcome limitations caused by patient non-adherence, and sponsors of PFP programs should attempt to minimize non-adherence through plan design.

Physician Participation

Physician participation in any PFP program must be completely voluntary.

- Sponsors of PFP programs must notify physicians of PFP program implementation and offer physicians the opportunity to opt in or out of the PFP program without affecting the existing or offered contract provisions from the sponsoring health plan or employer.

- Programs must be designed so that physician nonparticipation does not threaten the economic viability of physician practices.
- Programs should be available to any physicians and specialties who wish to participate and must not favor one specialty over another. Programs must be designed to encourage broad physician participation across all modes of practice.
- Programs must not favor physician practices by size (large, small, or solo) or by capabilities in information technology (IT).
1. Programs should provide physicians with tools to facilitate participation.
2. Programs should be designed to minimize financial and technological barriers to physician participation.
- Although some IT systems and software may facilitate improved patient management, programs must avoid implementation plans that require physician practices to purchase health-plan specific IT capabilities.
- Physician participation in a particular PFP program must not be linked to participation in other health plan or government programs.
- Programs must educate physicians about the potential risks and rewards inherent in program participation, and immediately notify participating physicians of newly identified risks and rewards.
physician participants must be notified in writing about any changes in program requirements and evaluation methods. Such changes must occur at most on an annual basis.

Physician Data and Reporting

Patient privacy must be protected in all data collection, analysis, and reporting. Data collection must be administratively simple and consistent with the Health Insurance Portability and Accountability Act (HIPAA).

The **quality** of data collection and analysis must be scientifically valid. Collecting and reporting of data must be reliable and easy for physicians and should not create financial or other burdens on physicians and/or their practices. Audit systems should be designed to ensure the accuracy of data in a non-punitive manner.
1. Programs should use accurate administrative data and data abstracted from medical records.
2. Medical record data should be collected in a manner that is not burdensome and disruptive to physician practices.
3. Program results must be based on data collected over a significant period of time and relate care delivered (numerator) to a statistically valid population of patients in the denominator.
- Physicians must be reimbursed for any added administrative costs incurred as a result of collecting and reporting data to the program.
- Physicians should be assessed in groups and/or across health care systems, rather than individually, when feasible.
- Physicians must have the ability to review and comment on data and analysis used to construct any performance ratings prior to the use of such ratings to determine physician payment or for public reporting.
1. Physicians must be able to see preliminary ratings and be given the opportunity to adjust practice patterns over a reasonable period of time to more closely meet **quality** objectives.
2. Prior to release of any physician ratings, programs must have a mechanism for physicians to see and appeal their ratings in writing. If requested by the physician, physician comments must be included adjacent to any ratings.
- If PFP programs identify physicians with exceptional performance in providing effective and safe patient care, the reasons for such performance should be shared with physician program participants and widely promulgated.

The results of PFP programs must not be used against physicians in health plan credentialing, licensure, and certification. Individual physician **quality** performance information and data must remain confidential and not subject to discovery in legal or other proceedings.

PFP programs must have defined security measures to prevent the unauthorized release of physician ratings.

Program Rewards

- Programs must be based on rewards and not on penalties.
- Program incentives must be sufficient in scope to cover any additional work and practice expense incurred by physicians as a result of program participation.
- Programs must offer financial support to physician practices that implement IT systems or software that interact with aspects of the PFP program.
- Programs must finance bonus payments based on specified performance measures with supplemental funds.

- Programs must reward all physicians who actively participate in the program and who achieve pre-specified absolute program goals or demonstrate pre-specified relative improvement toward program goals.
- Programs must not reward physicians based on ranking compared with other physicians in the program.
- Programs must provide to all eligible physicians and practices a complete explanation of all program facets, to include the methods and performance measures used to determine incentive eligibility and incentive amounts, prior to program implementation.
- Programs must not financially penalize physicians based on factors outside of the physician's control.
- Programs utilizing bonus payments must be designed to protect patient access and must not financially disadvantage physicians who serve minority or uninsured patients.
- Programs must not financially penalize physicians when they follow current, accepted clinical guidelines that are different from measures adopted by payers, especially when measures have not been updated to meet currently accepted guidelines.

2. Our AMA opposes private payer, Congressional, or Centers for Medicare and Medicaid Services pay-for-performance initiatives if they do not meet the AMA's "Principles and Guidelines for Pay-for-Performance."

Policy Timeline

BOT Rep. 5, A-05 Reaffirmation A-06 Reaffirmed: Res. 210, A-06 Reaffirmed in lieu of Res. 215, A-06 Reaffirmed in lieu of Res. 226, A-06 Reaffirmation I-06 Reaffirmation A-07 Reaffirmation A-09 Reaffirmed: BOT Rep. 18, A-09 Reaffirmed in lieu of Res. 808, I-10 Modified: BOT Rep. 8, I-11 Reaffirmed: Sub. Res. 226, I-13 Appended: BOT Rep. 1, I-14 Reaffirmed in lieu of Res. 203, I-15 Reaffirmed in lieu of Res. 216, I-15 Reaffirmation I-15 Reaffirmed: BOT Rep. 20, A-16 Reaffirmed in lieu of: Res. 712, A-17 Reaffirmation: A-18 Reaffirmation: A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 223
(I-24)

Introduced by: New York

Subject: Mandated Economic Escalators in Insurance Contracts

Referred to: Reference Committee B

Whereas, our American Medical Association is committed to advocating for the best interests of its members and ensuring access to quality healthcare for all patients; and

Whereas, the ever-changing landscape of healthcare economics poses challenges to sustaining the financial viability of medical practices; and

Whereas, adequate payment for medical care provided through commercial insurance contracts are integral to the financial well-being of healthcare providers; and

Whereas, the US Congress has directed CMS to repeatedly lowered the conversion factor utilized in the Medicare Physician Fee Schedule (PFS) resulting in significant decline in payment rates under traditional Medicare; and

Whereas, most commercial insurance contracts are based on a multiple of Medicare Payment rate for a specified service resulting in a potential decline in commercial reimbursement rates over time; and

Whereas, healthcare providers face increased costs of operation due to inflation in various aspects of practice, including but not limited to personnel, supplies, and overhead expenses; and

Whereas, the absence of an economic escalator in insurance contracts fails to account for the economic realities faced by medical practices, thereby hindering their ability to provide quality care to patients; therefore be it

RESOLVED, that our American Medical Association advocates through legislation or regulation for the mandatory insertion of an economic escalator provision in all commercial insurance contracts to account for economic inflation or a decline in Medicare Physician Fee Schedule (PFS). (Directive to Take Action)

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

Received: 9/24/2024

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 225
(I-24)

Introduced by: Association for Clinical Oncology

Subject: Elimination of Medicare 14-Day Rule

Referred to: Reference Committee B

Whereas, our American Medical Association adopted D-330.903 at I-17, which asks our AMA "actively lobby the federal government to change laboratory Date of Service rules under Medicare such that complex diagnostic laboratory services performed on pathologic specimens collected from a hospital procedure be paid separately from inpatient and outpatient bundled payments"; and

Whereas, AMA advocacy on the CY 2018 Medicare Outpatient Prospective Payment System Rule was successful in getting complex molecular testing unbundled from outpatient diagnostic procedures – such as outpatient interventional radiology biopsies; and

Whereas, the Medicare 14-Day Laboratory Date of Service Rule (Medicare 14-Day Rule) provides billing requirements for diagnostic tests ordered for Medicare patients and determines whether the clinical laboratory performing the tests will directly bill Medicare or bill the hospital where the specimen was collected; and

Whereas, the Medicare 14-Day Rule was not changed for specimens collected during an inpatient encounter, with complex molecular tests ordered within 14 days of hospital discharge continuing to be bundled into inpatient Medicare payments; and

Whereas, performing complex molecular tests on inpatient samples parallel the criteria established for unbundling testing of outpatient samples: including it being medically appropriate to have been collected during the hospital inpatient encounter, the results of the test not guiding treatment during the hospital inpatient encounter, and the test being reasonable and medically necessary for the treatment of an illness; and

Whereas, the real-world effect of an inpatient Medicare 14-Day Rule is to routinely delay the initiation, until 14 days after discharge, of complex molecular tests on pathologic samples collected during an acute hospitalization, such as cytology from an inpatient thoracentesis for a new diagnosis of lung cancer; and

Whereas, diagnostic delay of pivotal molecular data due to the inpatient Medicare 14-Day Rule causes harm to patients, such as forcing an initial round of an inferior cytotoxic chemotherapy on newly diagnosed lung cancer patients while awaiting candidacy for a more efficacious targeted agent; therefore be it

RESOLVED, that our American Medical Association actively lobby the federal government to readdress and change laboratory date of service rules under Medicare, e.g. the Medicare 14-Day Laboratory Date of Service Rule (Medicare 14-Day Rule), such that complex laboratory services performed on pathologic specimens collected from an inpatient hospital procedure be

paid separately from inpatient bundled payments, consistent with Outpatient rules. (Directive to Take Action).

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

Received: 9/24/2024

REFERENCES

1. American Medical Association. Follow-Up on Implementation of Resolutions and Report Recommendations, AMA House of Delegates Interim Meeting - November 8-11, 2017. https://www.ama-assn.org/system/files/2018-11/i17-followup-status-report_0.pdf
2. Centers for Medicare & Medicaid Services. Laboratory Date of Service Policy. https://www.cms.gov/medicare/payment/fee-schedules/clinical-laboratory-fee-schedule-clfs/date-service-policy
3. Foundation Medicine. 14-Day Rule Billing Requirements for Foundation Medicine Tests. https://www.foundationmedicine.com/sites/default/files/media/documents/2024-08/14%20Day%20Medicaid%20Rule_One%20Pager_LaboratoryDateOfService_June%202024_US-PF-2200092_R4.pdf

RELEVANT AMA POLICY

Elimination of Laboratory 14-Day Rules Under Medicare D-330.903
Our AMA will actively lobby the federal government to change laboratory Date of Service rules under Medicare such that complex diagnostic laboratory services performed on pathologic specimens collected from a hospital procedure be paid separately from inpatient and outpatient bundled payments.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 226
(I-24)

Introduced by: Association for Clinical Oncology, American Society of Hematology

Subject: Information Blocking Rule

Referred to: Reference Committee B

Whereas, the 21st Century Cures Act contained the Information Blocking Rule as a provision, requiring that patients be given immediate access to their medical records, including clinical notes, radiology and pathology reports and laboratory results; and

Whereas, since enforcement of the Information Blocking Rule began in April 2021, patients have increasingly received sensitive and distressing information and diagnoses from their patient portal first rather than from the treating physician, thereby causing undue distress, confusion and compromising the patient-physician relationship; and

Whereas, after elimination of a 36-hour embargo on release of radiology reports to patient portals to comply with the 21st Century Cures Act; and

Whereas, these reports were accessed first by the patient in 44% of cases compared to 18.2% of cases prior to the change, and the median time from report finalization to first patient access decreased from 45 hours during the embargo period to 5.5 hours following the change; and

Whereas, our American Medical Association supports revising the definition of harm exception to the Information Blocking Rule to include mental and emotional distress [D-315.972] but does not include an exception for harassment or potential harm of medical staff or others; and

Whereas, a short-term embargo of reports or results associated with sensitive information would give the treating physician the opportunity to act on new information and thereby reduce distress and confusion without restricting the patient's ultimate access to information; and

Whereas, the Information Blocking Rule does not allow patients to tailor their preferred way of receiving information, such as requesting that the ordering or treating physician review the report or results before its release to the portal; and

Whereas, the ordering physician no longer has the ability to review a report or result prior to release to the patient to verify its accuracy or add clinical context to the findings, thereby giving the patient the false impression that the information is absolute; therefore be it

RESOLVED, that our American Medical Association supports the use of short-term embargo of reports or results and individual tailoring of preferences for release of information as part of the harm exception to the Information Blocking Rule (New HOD Policy); and be it further

RESOLVED, that our AMA supports the requirement of review of report and result information by the ordering physician or physician surrogate prior to release of medical information to the patient (New HOD Policy); and be it further

RESOLVED, that our AMA supports expansion of the harm exception to the Information Blocking Rule to include harassment or potential harm of medical staff or others (New HOD Policy); and be it further

RESOLVED, that our AMA advocates for expansions to the harm exception to the Information Blocking Rule and for the requirement of review by the ordering physician or surrogate prior to the application of the Information Blocking Rule provisions. (Directive to Take Action).

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

Received: 9/24/2024

REFERENCES

1. Pollock JR, Petty SAB, Schmitz JJ, Varner J, Metcalfe AM, Tan N. Patient Access of Their Radiology Reports Before and After Implementation of 21st Century Cures Act Information-Blocking Provisions at a Large Multicampus Health System. AJR Am J Roentgenol. 2024 Jun;222(6):e2330343. doi: 10.2214/AJR.23.30343. Epub 2024 Mar 27. PMID: 38534191.

RELEVANT AMA POLICY

Redefining the Definition of Harm D-315.972
Our AMA will: (1) advocate to the Office for Civil Rights to revise the definition of harm to include mental and emotional distress. Such a revision would allow additional flexibility for clinicians under the Preventing Harm Exception, based on their professional judgement, to withhold sensitive information they believe could cause physical, mental or emotional harm to the patient; (2) advocate that the Office for Civil Rights assemble a commission of medical professionals to help the office review the definition of harm and provide scientific evidence demonstrating that mental and emotional health is intertwined with physical health; (3) continue to urge the Department of Health and Human Services (HHS)'s Office of the National Coordinator for Health Information Technology (ONC) and its Office of Inspector General (OIG) to leverage their enforcement discretion that would afford medical practices additional compliance flexibilities; and (4) urge the ONC to earnestly consult with relevant stakeholders about unintended or unforeseen consequences that may arise from the information blocking regulations.
Policy Timeline
Res. 206, A-21
UPDATE 2022: Our AMA has written to the Office for Civil Rights (OCR) and spoken to National Coordinator for Health Information Technology (ONC) about this issue multiple times. As of October, we have met with both OCR and ONC to clarify that emotional and psychological harm are encompassed in the "substantial harm" prong of HIPAA that should be better publicized to clinicians to help them comply with information blocking and HIPAA alike.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 227
(I-24)

Introduced by: American College of Rheumatology

Subject: Medicare Payment Parity for Telemedicine Services

Referred to: Reference Committee B

Whereas, as a care delivery strategy, telemedicine holds huge potential to overcome certain limitations of our current health care system with its focus on fee-for-service environment; and

Whereas, considerable growth was seen in telemedicine delivery as the system adjusted to pandemic circumstances and the presence of telehealth flexibilities made available during the public health emergency declared by the federal government; and

Whereas, the rapid adoption of telemedicine during the public health emergency helped to combat the financial strain associated with a reduction of in-person visits for many practices during the pandemic; and

Whereas, from the onset of the public health emergency through the end of 2023, Medicare reimbursed for telemedicine services at the same rate as if the services were performed in person; and

Whereas, as of July 2024, 24 states require private payers to reimburse for telemedicine services at the same rate as if the services were provided in-person; and

Whereas, telemedicine visits are costly to set up and consume the same amount of resources as in-person visits; and

Whereas, providers are having to see a higher percentage of Medicare patients via telemedicine while experiencing workforce shortages, high inflation, higher costs for procuring drugs and medical supplies, and other economic burdens associated with running a medical practice; and

Whereas, payment parity for Medicare telemedicine services would provide resources for providers to cover these costs; therefore be it

RESOLVED, that our American Medical Association advocate for Medicare to reimburse providers for telemedicine-provided services at an equal rate as if the services were provided in-person. (Directive to Take Action)

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

Received: 9/24/2024

RELEVANT AMA POLICY

Insurance Coverage Parity for Telemedicine Service D-480.969
Our AMA will: 1) advocate for telemedicine parity laws that require private insurers to cover telemedicine-provided services comparable to that of in-person services, and not limit coverage only to services provided by select corporate telemedicine providers; and 2) develop model legislation to support states' efforts to achieve parity in telemedicine coverage policies; and
3) work with the Federation of State Medical Boards to draft model state legislation to ensure telemedicine is appropriately defined in each state's medical practice statutes and its regulation falls under the jurisdiction of the state medical board.
Policy Timeline
Res. 233, A-16, Reaffirmed: CMS Rep. 1, I-19, Reaffirmed: CMS Rep. 7, A-21, Reaffirmed: Res. 239, A-22, Reaffirmed: CMS Rep. 2, A-22

Coverage of and Payment for Telemedicine H-480.946
Our American Medical Association believes that **telemedicine** services should be covered and paid for if they abide by the following principles:

a. A valid patient-physician relationship must be established before the provision of telemedicine services, through:
- A face-to-face examination, if a face-to-face encounter would otherwise be required in the provision of the same service not delivered via telemedicine.
- A consultation with another physician who has an ongoing patient-physician relationship with the patient. The physician who has established a valid physician-patient relationship must agree to supervise the patient's care.
- Meeting standards of establishing a patient-physician relationship included as part of evidence-based clinical practice guidelines on telemedicine developed by major medical specialty societies, such as those of radiology and pathology.

Exceptions to the foregoing include on-call, cross coverage situations; emergency medical treatment; and other exceptions that become recognized as meeting or improving the standard of care. If a medical home does not exist, telemedicine providers should facilitate the identification of medical homes and treating physicians where in-person services can be delivered in coordination with the telemedicine services.

a. Physicians and other health practitioners delivering telemedicine services must abide by state licensure laws and state medical practice laws and requirements in the state in which the patient receives services.
b. Physicians and other health practitioners delivering telemedicine services must be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state's medical board.
c. Patients seeking care delivered via telemedicine must have a choice of provider, as required for all medical services.
d. The delivery of telemedicine services must be consistent with state scope of practice laws.
e. Patients receiving telemedicine services must have access to the licensure and board certification qualifications of the health care practitioners who are providing the care in advance of their visit.
f. The standards and scope of telemedicine services should be consistent with related in-person services.
g. The delivery of telemedicine services must follow evidence-based practice guidelines, to the degree they are available, to ensure patient safety, quality of care and positive health outcomes.
h. The telemedicine service must be delivered in a transparent manner, to include but not be limited to, the identification of the patient and physician in advance of the delivery of the service, as well as patient cost-sharing responsibilities and any limitations in drugs that can be prescribed via telemedicine.
i. The patient's medical history must be collected as part of the provision of any telemedicine service.
j. The provision of telemedicine services must be properly documented and should include providing a visit summary to the patient.

k. The provision of telemedicine services must include care coordination with the patient's medical home and/or existing treating physicians, which includes at a minimum identifying the patient's existing medical home and treating physicians and providing to the latter a copy of the medical record.
l. Physicians, health professionals and entities that deliver telemedicine services must establish protocols for referrals for emergency services.

2. Our AMA believes that delivery of telemedicine services must abide by laws addressing the privacy and security of patients' medical information.

3. Our AMA encourages additional research to develop a stronger evidence base for telemedicine.

4. Our AMA supports additional pilot programs in the Medicare program to enable coverage of telemedicine services, including, but not limited to store-and-forward telemedicine.

5. Our AMA supports demonstration projects under the auspices of the Center for Medicare and Medicaid Innovation to address how telemedicine can be integrated into new payment and delivery models.

6. Our AMA encourages physicians to verify that their medical liability insurance policy covers telemedicine services, including telemedicine services provided across state lines if applicable, prior to the delivery of any telemedicine service.

7. Our AMA encourages national medical specialty societies to leverage and potentially collaborate in the work of national telemedicine organizations, such as the American Telemedicine Association, in the area of telemedicine technical standards, to the extent practicable, and to take the lead in the development of telemedicine clinical practice guidelines.

Policy Timeline

CMS Rep. 7, A-14 Reaffirmed: BOT Rep. 3, I-14 Reaffirmed in lieu of Res. 815, I-15 Reaffirmed: CME Rep. 06, A-16 Reaffirmed: CMS Rep. 06, I-16 Reaffirmed: Res. 111, A-17 Reaffirmation: A-18 Reaffirmed: CMS Rep. 1, I-19 Reaffirmed: CMS Rep. 8, A-21 Reaffirmed: Res. 239, A-22 Reaffirmed: CMS Rep. 2, A-22 Reaffirmed: Res. 213, A-23

Reference Committee C

Report(s) of the Council on Medical Education

01 Medication Reconciliation Education
02 Updates to Recommendations for Future Directions for Medical Education

Resolutions

302 Strengthening Parental Leave Policies for Medical Trainees and Recent Graduates
304 Payment and Benefit Parity for Fellows
305 Removing Board Certification as a Requirement for Billing for Home Sleep Studies
306 Streamlining Continuing Medical Education Across States and Medical Specialties

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 1-I-24

Subject: Medication Reconciliation Education (Resolution 805-I-23, Resolved 2)

Presented by: Krystal Tomei, MD, MPH, Chair

Referred to: Reference Committee C

Resolution 805-I-23, "Medication Reconciliation Education," was introduced by the Michigan delegation at the 2023 Interim Meeting of the American Medical Association (AMA). While Resolve 1 was adopted into AMA Policy D-300.973, Medication Reconciliation Education, thus encouraging external parties to more broadly study medication reconciliation separate from this report, the language of Resolve 2 was referred for study. The referred clause asked that our AMA:

> work with other appropriate organizations to determine whether education for physicians-in-training is sufficient to attain the medication reconciliation core competencies necessary to reduce medical errors and ensure patient safety and quality of care and provide recommendations for action as applicable. (Directive to Take Action)

Testimony within Reference Committee J emphasized the importance of the spirit of the resolution and how vital appropriate medication reconciliation is to patient safety. Additionally, testimony indicated that this is not an issue around the education of physicians, but rather the other challenges that can occur even for well-trained physicians working toward medication reconciliation, such as the burdens of dissimilar electronic health records (EHR). The testimony discussed the involvement of many non-physicians in medication reconciliation as well. Council on Medical Education testimony also noted that the AMA as an organization does not make determinations of the adequacy of training as this lies solely with the accrediting body and as such the original language would be inappropriate. Reference Committee J proposed amending language to offer generalized educational support for all relevant health care providers.

The House of Delegates (HOD) rejected this proposed wording. Testimony at full HOD deliberations centered around differing opinions on the adequacy of existing training for medical learners: some academic physicians felt training was sufficient, while some residency program educators felt training was not effective. Other concerns included differing opinions about the potential impacts of additional EHR and medication reconciliation regulations on physicians and patients and uncertainty regarding who bears the responsibility for medication reconciliation. Due to varying and sometimes contradictory concerns, the HOD felt that the language of the directive warranted further study before a decision was made. This report is in response to this referral.

BACKGROUND

Medication Reconciliation: Definitions, Importance, and Existing Policy

The Centers for Medicare & Medicaid Services (CMS) define medication reconciliation as follows: "The process of identifying the most accurate list of all medications that the patient is taking, including name, dosage, frequency, and route, by comparing the medical record to an external list

of medications obtained from a patient, hospital, or other provider."[1] Adverse drug events are a leading cause of injury and death for patients,[2] and medication reconciliation is one intervention intended to alleviate some of the risks of this potential harm. Medication reconciliation, when compared to usual care, has the potential to reduce dangerous discrepancies, although it is likely insufficient on its own[3] and creates inconsistent results due to being subject to a variety of barriers in resource-limited settings.[4] A reconciled list may also not necessarily be the correct medication list, and understandings of what constitute medication reconciliation and when it has been achieved vary.[5] Though important, evidence indicates medication reconciliation must be paired with a larger set of interventions to improve safety.[6] However, the correct medication list, when achieved, significantly improves patient outcomes.[5]

Existing AMA policy supports medication reconciliation as a means to improve patient safety (Pharmacy Review of First Dose Medication D-120.965), supports implementation of medication reconciliation as part of the hospital discharge process (Hospital Discharge Communications H-160.902), and offers suggestions within these policies to optimize medication reconciliation. AMA also "supports medication reconciliation processes that include confirmation that prescribed discharge medications will be covered by a patient's health plan and resolution of potential coverage and/or prior authorization (PA) issues prior to hospital discharge" (Continuity of Care for Patients Discharged from Hospital Settings H-125.974) and encourages further study of a broad number of issues related to medication reconciliation (Medication Reconciliation Education D-300.973).

Nationally, other major groups incorporate medication reconciliation guidance into their own policies. CMS, a federal agency, provides, regulates, and/or facilitates health coverage through Medicare, Medicaid, the Children's Health Insurance Program, and the Health Insurance Marketplace. They describe medication reconciliation within their Electronic Health Record Incentive Program documentation on Eligible Professional (EP) Meaningful Use Menu Set Measures,[1] with an objective of "The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation" and the qualifying measure of "The EP performs medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP." Medication reconciliation is also part of CMS' Merit-Based Incentive Payment System (MIPS) measures for clinicians, listed as high priority under Quality ID #130, "Documentation of Current Medications in the Medical Record."[7] The Joint Commission, a non-profit organization that accredits more than 20,000 health care programs and organizations in the United States,[8] also provides newsletters and National Patient Safety Goals (NPSG) related to medication reconciliation. NPSG.03.06.01 states: "There is evidence that medication discrepancies can affect patient outcomes. Medication reconciliation is intended to identify and resolve discrepancies—it is a process of comparing the medications a patient is taking (or should be taking) with newly ordered medications. The comparison addresses duplications, omissions, and interactions, and the need to continue current medications. The types of information that clinicians use to reconcile medications include (among others) medication name, dose, frequency, route, and purpose. Organizations should identify the information that needs to be collected in order to reconcile current and newly ordered medications and to safely prescribe medications in the future"[9] and lists several elements of performance in this safety goal, including obtaining, documenting, and defining patient medications, comparing other lists and resolving discrepancies, providing appropriate parties with written medication information, and explaining the importance of medication management to patients/caregivers. The Agency for Healthcare Research and Quality also released a toolkit for medical reconciliation with tools for designing or redesigning the process.[10] Finally, globally, the World Health Organization provides a Standard Operating Protocol for "Assuring Medication Accuracy at Transitions in Care: Medication Reconciliation."[2]

Responsibility

Significant disagreement exists about who is responsible for each role within medication reconciliation, and workflow processes vary depending on the setting.[11] Although physicians are ultimately held legally accountable in the United States for medication and medication management[12] and AMA policy advocates that prescriptive authority include the responsibility to monitor the effects of the medication and to attend to problems associated with the use of the medication, including liability (Non-Physician Prescribing H-120.955), medication reconciliation, while physician-led, is a team-based interprofessional process, with an absence of shared understanding about the roles physicians, pharmacists, pharmacy technicians, nurses, and other professionals play to reconcile medication lists in any given setting.[13] In fact, pharmacist-based interventions may have a significant positive impact in preventing hospital readmissions.[14] Physician trainees rotate through many different clinical settings during their medical education making the trainees' roles in multiple medical reconciliation processes as transient care team members challenging in many circumstances. The perspectives of the patient and the patient's family also impact the practice of medication reconciliation.[5]

Responsibility for ensuring medication reconciliation takes place within health care is typically enforced via hospital accreditation bodies, although challenges such as difficulty demonstrating tangible positive outcomes and complexities and costs of the process have led to lack of standardization and scaling back of some requirements.[15]

The Role of Technology

Although EHR use can reduce medication errors,[7] EHR systems have interoperability gaps across different clinical settings that create additional conditions for errors.[5] AMA policy currently involves working with EHR vendors and other vendors to improve medication reconciliation within the systems (Reducing Polypharmacy as a Significant Contributor to Senior Morbidity D-120.928). Other existing and emerging technologies also impact medication reconciliation—for instance, The Joint Commission warned of the potential dangers of voice recognition technology to patient safety within medication reconciliation.[16]

Medical Education Core Competencies and Specialty-Specific Competencies

The Accreditation Council for Graduate Medical Education (ACGME) endorses six core competencies expected of all residents. These are patient care, medical knowledge, professionalism, interpersonal and communication skills, practice-based learning and improvement, and systems-based practice.[17] Though medical reconciliation is not specifically delineated for all specialties in these broad categories, it applies to the requirements within several categories, including patient care, systems-based practice, and the interpersonal and communication skills requirement of communicating effectively with patients and other professionals as well as the need to "maintain comprehensive, timely, and legible medical records."[18] In addition, several specific specialties discuss medication reconciliation within their ACGME Milestones, including within "Patient Care 3: Assessing and Optimizing of Pharmacotherapy" in the Geriatric Medicine Milestones[19] and within "Patient Care 1: History" in the Internal Medicine Milestones.[20]

At the time of this writing, the ACGME, the Association of American Medical Colleges, and the American Association of Colleges of Osteopathic Medicine are engaged in a multi-year initiative to develop a common set of foundational competencies for use in undergraduate medical education programs.[21]

DISCUSSION

The Agency for Healthcare Research and Quality offers a toolkit for medication reconciliation training,[22] emphasizing a multidisciplinary approach to education, as a multiplicity of disciplines are involved in the medication use process, including physicians, nurses, pharmacists, medical assistants, and others, and therefore, robust communication and cooperation across the continuum of care is required.[23] This multidisciplinary approach is especially highlighted by research that indicates involvement of pharmacists in medication reconciliation tends to lead to better patient outcomes and should therefore not be exclusively related to physician training.[24]

Current research[25] emphasizes the efficacy of using simulation, roleplay, and interactive, skills-based training in teaching interdisciplinary medication reconciliation skills.[26] One interprofessional education session including both pharmacy students and medical students from neighboring institutions elicited themes of: "1) increased awareness of barriers to medication adherence, (2) increased empathy towards adults with polypharmacy, (3) appreciation for the interprofessional team, and (4) realization of the importance of medication reconciliation and patient understanding of their medications."[27] One study found that even PowerPoint-based instruction within grand rounds improved perceived, self-reported knowledge of medication reconciliation among medical learners, though actual practices and patient outcomes were not assessed.[28]

One 2021 study of pediatric resident physicians in Canada revealed incomplete documentation for 40% of patient charts, with no reason for the incompleteness documented in 68% of these cases. Improved resident education at the institution level was one of the recommended quality improvement strategies, in addition to improved patient education and increased collaboration with pharmacy services.[29] A twice-monthly interactive educational intervention took place among internal medicine residents at the Washington DC VA Medical Center and significantly reduced medication discrepancies when compared to a control group not receiving the educational intervention, although there was no statistical difference between the amount of medication omissions across the two groups.[30] Most studied and effective interventions regarding medication reconciliation education for health care professionals take place at site-specific levels with the entire care team, such as nursing homes in a specific region.[31] Some sites also recommended urgent suggestions for improvement that were not focused around physician training on medication reconciliation specifically, but on improving communication mechanisms between staff and the need for pharmacy involvement, again emphasizing the interdisciplinary nature of the work.[15]

More broadly, away from local contexts, in addition to AMA policy related to medication reconciliation, the AMA also offers continuing medical education in medication reconciliation on the AMA Ed Hub, offering 36 modules at the time of this writing that incorporate mentions of medication reconciliation improvements.

There is an underlying infrastructure for medical learner training within medication reconciliation in several ACGME-accredited specialties, hospital system quality metrics, and wider medical education competencies. The AMA as an organization does not make determinations of the adequacy of training as this lies solely with the accrediting body, but AMA policy does provide robust support for medication reconciliation, including the possibility of additional training. In addition, as discussed above, physician training is only one component of medication reconciliation education, and medication reconciliation itself, though important, is insufficient for patient safety on its own. Each care setting has a unique context, and interventions are often conducted most effectively in the care setting with the entire interdisciplinary team and with the overall promotion of interprofessional communication, as well as improvement of EHR systems. Interventions must also focus on improvements to actual patient outcomes and receiving the correct medications,

rather than simply to the completion of medication reconciliation, which may or may not be correct or helpful to the patient, even if accurately reconciled across multiple sources: "Primary care clinicians and hospitalists currently must attest that medication reconciliation has been completed, but this does not measure accuracy. Currently, no validated measures are available to assess the quality of medication reconciliation. More meaningful measures are needed, and studies can be built upon these measures to assess the value of medication reconciliation across a gradient of how comprehensively it was performed."[5] AMA policy D-300.973 already advocates toward this goal.

RELEVANT AMA POLICY

The AMA has extensive policy related to medication reconciliation and physicians-in-training. Some examples are as follows:

- D-300.973, "Medication Reconciliation Education," encourages the study of current medication reconciliation practices across transitions of care to evaluate the impact on patient safety and quality of care, including when there are dissimilar electronic health records, and to develop strategies, including the potential need for additional training, to reduce medical errors and ensure patient safety and quality of care.
- D-120.965, "Pharmacy Review of First Dose Medication," supports medication reconciliation as a means to improve patient safety and indicates that (a) systems be established to support physicians in medication reconciliation, and (b) medication reconciliation requirements should be at a level appropriate for a particular episode of care and setting.
- H-160.902, "Hospital Discharge Communications," supports implementation of medication reconciliation as part of the hospital discharge process.
- D-120.928, "Reducing Polypharmacy as a Significant Contributor to Senior Morbidity," works with other stakeholders and EHR vendors to address the continuing problem of inaccuracies in medication reconciliation and propagation of such inaccuracies in electronic health records.
- H-125.974, "Continuity of Care for Patients Discharged from Hospital Settings," supports medication reconciliation processes that include confirmation that prescribed discharge medications will be covered by a patient's health plan and resolution of potential coverage and/or prior authorization issues prior to hospital discharge.
- H-120.968, "Medication (Drug) Errors in Hospitals," encourages individual physicians to minimize medication errors by adhering to the following guidelines when prescribing medications: (a) Physicians should stay abreast of the current state of knowledge regarding optimal prescribing through literature review, use of consultations with other physicians and pharmacists, participation in continuing medical education programs, and other means.
- H-120.955, "Non-Physician Prescribing," advocates that prescriptive authority include the responsibility to monitor the effects of the medication and to attend to problems associated with the use of the medication. This responsibility includes the liability for such actions.
- H-310.929, "Principles for Graduate Medical Education," states there must be objectives for residency education in each specialty that promote the development of the knowledge, skills, attitudes, and behavior necessary to become a competent practitioner in a recognized medical specialty. Institutions sponsoring residency programs and the director of each program must assure the highest quality of care

for patients and the attainment of the program's educational objectives for the residents.

- D-295.934, "Encouragement of Interprofessional Education Among Health Care Professions Students," recognizes that interprofessional education and partnerships are a priority of the American medical education system and encourages the development of skills for interprofessional education that are applicable to and appropriate for each group of learners.

These policies are listed in full detail in Appendix A.

SUMMARY AND RECOMMENDATIONS

While support and ongoing improvement can and should be ongoing in the education of physicians-in-training, aligned with the overall goal to reduce errors and improve patient safety, issues associated with medication reconciliation far exceed the domain of education for physicians-in-training, and even appropriate medication reconciliation practices alone[3] do not necessarily improve certain patient outcomes,[6] requiring attention to the full spectrum of medication-related practices. Accrediting bodies for both physician trainees and for hospitals and health systems currently provide guidance and frameworks around medication reconciliation as appropriate for each clinical setting and specialty. The AMA already works to remedy EHR-related medication reconciliation issues via D-120.928 and encourages additional study of medication reconciliation issues via D-300.973, which includes encouraging research on additional training opportunities. Current evidence suggests this training is best done in an interdisciplinary context, which D-295.934 also provides support and guidance for.

The Council on Medical Education therefore recommends that the following recommendations be adopted in lieu of Resolution 805-I-23, Resolve 2, and the remainder of this report be filed:

That our AMA:

1. Amend AMA Policy D-120.965 "Pharmacy Review of First Dose Medication" by addition of a new third clause to read as follows:
   3. Our AMA a) recognizes that medication reconciliation is a multidisciplinary process and b) supports education of physicians-in-training about the physician's role and responsibilities in medication reconciliation and management within a physician-led team in relevant clinical settings, to minimize medical errors and promote patient safety and quality of care.
2. Amend AMA Policy D-120.965 with a change in title to read as follows:
   Medication Reconciliation to Improve Patient Safety
3. Reaffirm AMA Policy H-160.902 "Hospital Discharge Communications"

Fiscal note: $1,000

APPENDIX A: RELEVANT AMA POLICY

Medication Reconciliation Education D-300.973
Our American Medical Association encourages the study of current medication reconciliation practices across transitions of care to evaluate the impact on patient safety and quality of care, including when there are dissimilar electronic health records, and to develop strategies, including the potential need for additional training, to reduce medical errors and ensure patient safety and quality of care.

Pharmacy Review of First Dose Medication D-120.965
1. Our AMA supports medication reconciliation as a means to improve patient safety.
2. It is AMA policy that (a) systems be established to support physicians in medication reconciliation, and (b) medication reconciliation requirements should be at a level appropriate for a particular episode of care and setting.

Hospital Discharge Communications H-160.902
1. Our AMA encourages the initiation of the discharge planning process, whenever possible, at the time patients are admitted for inpatient or observation services and, for surgical patients, prior to hospitalization.
2. Our AMA encourages the development of discharge summaries that are presented to physicians in a meaningful format that prominently highlight salient patient information, such as the discharging physician's narrative and recommendations for ongoing care.
3. Our AMA encourages hospital engagement of patients and their families/caregivers in the discharge process, using the following guidelines:
a. Information from patients and families/caregivers is solicited during discharge planning, so that discharge plans are tailored to each patient's needs, goals of care and treatment preferences.
b. Patient language proficiency, literacy levels, cognitive abilities and communication impairments (e.g., hearing loss) are assessed during discharge planning. Particular attention is paid to the abilities and limitations of patients and their families/caregivers.
c. Specific discharge instructions are provided to patients and families or others responsible for providing continuing care both verbally and in writing. Instructions are provided to patients in layman's terms, and whenever possible, using the patient's preferred language.
d. Key discharge instructions are highlighted for patients to maximize compliance with the most critical orders.
e. Understanding of discharge instructions and post-discharge care, including warning signs and symptoms to look for and when to seek follow-up care, is confirmed with patients and their families/caregiver(s) prior to discharge from the hospital.
4. Our AMA supports making hospital discharge instructions available to patients in both printed and electronic form, and specifically via online portals accessible to patients and their designated caregivers.
5. Our AMA supports implementation of medication reconciliation as part of the hospital discharge process. The following strategies are suggested to optimize medication reconciliation and help ensure that patients take medications correctly after they are discharged:
a. All discharge medications, including prescribed and over-the-counter medications, should be reconciled with medications taken pre-hospitalization.
b. An accurate list of medications, including those to be discontinued as well as medications to be taken after hospital discharge, and the dosage and duration of each drug, should be communicated to patients.
c. Medication instructions should be communicated to patients and their families/caregivers verbally and in writing.

d. For patients with complex medication schedules, the involvement of physician-led multidisciplinary teams in medication reconciliation including, where feasible, pharmacists should be encouraged.
6. Our AMA encourages patient follow-up in the early time period after discharge as part of the hospital discharge process, particularly for medically complex patients who are at high-risk of re-hospitalization.
7. Our AMA encourages hospitals to review early readmissions and modify their discharge processes accordingly.

Reducing Polypharmacy as a Significant Contributor to Senior Morbidity D-120.928
1. Our AMA will work with other organizations e.g., AARP, other medical specialty societies, PhRMA, and pharmacists to educate patients about the significant effects of all medications and most supplements, and to encourage physicians to teach patients to bring all medications and supplements or accurate, updated lists including current dosage to each encounter.
2. Our AMA along with other appropriate organizations encourages physicians and ancillary staff if available to initiate discussions with patients on improving their medical care through the use of only the minimal number of medications (including prescribed or over-the-counter, including vitamins and supplements) needed to optimize their health.
3. Our AMA will work with other stakeholders and EHR vendors to address the continuing problem of inaccuracies in medication reconciliation and propagation of such inaccuracies in electronic health records.
4. Our AMA will work with other stakeholders and EHR vendors to include non-prescription medicines and supplements in medication lists and compatibility screens.

Continuity of Care for Patients Discharged from Hospital Settings H-125.974
Our AMA:
(1) will advocate for protections of continuity of care for medical services and medications that are prescribed during patient hospitalizations, including when there are formulary or treatment coverage changes that have the potential to disrupt therapy following discharge;
(2) supports medication reconciliation processes that include confirmation that prescribed discharge medications will be covered by a patient's health plan and resolution of potential coverage and/or prior authorization (PA) issues prior to hospital discharge;
(3) supports strategies that address coverage barriers and facilitate patient access to prescribed discharge medications, such as hospital bedside medication delivery services and the provision of transitional supplies of discharge medications to patients;
(4) will advocate to the Office of the National Coordinator for Health Information Technology (ONC) and the Centers for Medicare & Medicaid Services (CMS) to work with physician and hospital organizations, and health information technology developers, in identifying real-time pharmacy benefit implementations and published standards that provide real-time or near-time formulary information across all prescription drug plans, patient portals and other viewing applications, and electronic health record (EHR) vendors;
(5) will advocate to the ONC to include proven and established real-time pharmacy benefit criteria within its certification program;
(6) will advocate to the ONC and the CMS that any policies requiring health information technology developers to integrate real-time pharmacy benefit systems (RTPB) within their products do so without disruption to EHR usability and minimal to no cost to physicians and hospitals, providing financial support if necessary; and
(7) supports alignment and real-time accuracy between the prescription drug data offered in physician-facing and consumer-facing RTPB tools.

Medication (Drug) Errors in Hospitals H-120.968

(1) Our AMA encourages individual physicians to minimize medication errors by adhering to the following guidelines when prescribing medications:

(a) Physicians should stay abreast of the current state of knowledge regarding optimal prescribing through literature review, use of consultations with other physicians and pharmacists, participation in continuing medical education programs, and other means.

(b) Physicians should evaluate the patient's total status and review all existing drug therapy before prescribing new or additional medications (e.g., to ascertain possible antagonistic drug interactions).

(c) Physicians should evaluate and optimize patient response to drug therapy by appropriately monitoring clinical signs and symptoms and relevant laboratory data; follow-up and periodically reevaluate the need for continued drug therapy.

(d) Physicians should be familiar with the hospital's medication-ordering system, including the formulary system; the drug use review (DUR) program; allowable delegation of authority; procedures to alert nurses and others to new drug orders that need to be processed; standard medication administration times; and approved abbreviations.

(e) Written drug or prescription orders (including signatures) should be legible. Physicians with poor handwriting should print or type medication orders if direct order entry capabilities for computerized systems are unavailable.

(f) Medication orders should be complete and should include patient name; drug name (generic drug name or trademarked name if a specific product is required); route and site of administration; dosage form (if applicable); dose; strength; quantity; frequency of administration; and prescriber's name. In some cases, a dilution, rate, and time of administration should be specified. Physicians should review all drug orders for accuracy and legibility immediately after they have prescribed them.

(g) Medication orders should be clear and unambiguous. Physicians should: (i) write out instructions rather than use nonstandard or ambiguous abbreviations (e.g., write "daily" rather than "qd" which could be misinterpreted as "qid" or "od"); (ii) not use vague instructions, such as "take as directed"; (iii) specify exact dosage strengths (such as milligrams) rather than dosage form units (such as one vial) (an exception would be combination products, for which the number of dosage form units should be specified); (iv) prescribe by standard nomenclature, using the United States Adopted Names (USAN)-approved generic drug name, official name, or trademarked name (if a specific product is required) and avoid locally coined names, chemical names, unestablished abbreviated drug names (e.g., AZT), acronyms, and apothecary or chemical symbols; (v) always use a leading "0" to precede a decimal expression of less than one (e.g., 0.5 ml), but never use a terminal "0" (e.g., 5.0 ml); (vi) avoid the use of decimals when possible (e.g., prescribe 500 mg instead of 0.5 g); (vii) spell out the word "units" rather than writing "u"; (viii) and use the metric system. Instructions with respect to "hold" orders for medications should be clear.

(h) Verbal medication orders should be reserved only for those situations in which it is impossible or impractical for the prescriber to write the order or enter it in a computer. Verbal orders should be dictated slowly, clearly, and articulately to avoid confusion. The order should be read back to the prescriber by the recipient (e.g., nurse, pharmacist); when read back, the recipient should spell the drug name and avoid abbreviations when repeating the directions. A written copy of the verbal order should be placed in the patient's medical record and later confirmed by the prescriber in accordance with applicable state regulations and hospital policies.

(2) Our AMA encourages the hospital medical staff to take a leadership role in their hospital, and in collaboration with pharmacy, nursing, administration, and others, to develop and improve organizational systems for monitoring, reviewing, and reporting medication errors and, after identification, to eliminate their cause and prevent their recurrence.

Non-Physician Prescribing H-120.955
1. Our AMA advocates that prescriptive authority include the responsibility to monitor the effects of the medication and to attend to problems associated with the use of the medication. This responsibility includes the liability for such actions.
2. Our AMA supports the development of methodologically valid research on the relative impact of non-physician prescribing on the quality of health care.

Principles for Graduate Medical Education H-310.929
Our American Medical Association urges the Accreditation Council for Graduate Medical Education (ACGME) to incorporate these principles in its Institutional Requirements, if they are not already present.
PURPOSE OF GRADUATE MEDICAL EDUCATION AND ITS RELATIONSHIP TO PATIENT CARE. There must be objectives for residency education in each specialty that promote the development of the knowledge, skills, attitudes, and behavior necessary to become a competent practitioner in a recognized medical specialty. Exemplary patient care is a vital component for any residency/fellowship program. Graduate medical education enhances the quality of patient care in the institution sponsoring an accredited program. Graduate medical education must never compromise the quality of patient care. Institutions sponsoring residency programs and the director of each program must assure the highest quality of care for patients and the attainment of the program's educational objectives for the residents.
RELATION OF ACCREDITATION TO THE PURPOSE OF RESIDENCY TRAINING. Accreditation requirements should relate to the stated purpose of a residency program and to the knowledge, skills, attitudes, and behaviors that a resident physician should have on completing residency education.
EDUCATION IN THE BROAD FIELD OF MEDICINE. GME should provide a resident physician with broad clinical experiences that address the general competencies and professionalism expected of all physicians, adding depth as well as breadth to the competencies introduced in medical school.
SCHOLARLY ACTIVITIES FOR RESIDENTS. Graduate medical education should always occur in a milieu that includes scholarship. Resident physicians should learn to appreciate the importance of scholarly activities and should be knowledgeable about scientific method. However, the accreditation requirements, the structure, and the content of graduate medical education should be directed toward preparing physicians to practice in a medical specialty. Individual educational opportunities beyond the residency program should be provided for resident physicians who have an interest in, and show an aptitude for, academic and research pursuits. The continued development of evidence-based medicine in the graduate medical education curriculum reinforces the integrity of the scientific method in the everyday practice of clinical medicine.
FACULTY SCHOLARSHIP. All residency faculty members must engage in scholarly activities and/or scientific inquiry. Suitable examples of this work must not be limited to basic biomedical research. Faculty can comply with this principle through participation in scholarly meetings, journal club, lectures, and similar academic pursuits.
INSTITUTIONAL RESPONSIBILITY FOR PROGRAMS. Specialty-specific GME must operate under a system of institutional governance responsible for the development and implementation of policies regarding the following; the initial authorization of programs, the appointment of program directors, compliance with the accreditation requirements of the ACGME, the advancement of resident physicians, the disciplining of resident physicians when this is appropriate, the maintenance of permanent records, and the credentialing of resident physicians who successfully complete the program. If an institution closes or has to reduce the size of a residency program, the institution must inform the residents as soon as possible. Institutions must make every effort to allow residents already in the program to complete their education in the affected program. When this is not possible, institutions must assist residents to enroll in another program in which they can

continue their education. Programs must also make arrangements, when necessary, for the disposition of program files so that future confirmation of the completion of residency education is possible. Institutions should allow residents to form housestaff organizations, or similar organizations, to address patient care and resident work environment concerns. Institutional committees should include resident members.

COMPENSATION OF RESIDENT PHYSICIANS. All residents should be compensated. Residents should receive fringe benefits, including, but not limited to, health, disability, and professional liability insurance and parental leave and should have access to other benefits offered by the institution. Residents must be informed of employment policies and fringe benefits, and their access to them. Restrictive covenants must not be required of residents or applicants for residency education.

LENGTH OF TRAINING. The usual duration of an accredited residency in a specialty should be defined in the "Program Requirements." The required minimum duration should be the same for all programs in a specialty and should be sufficient to meet the stated objectives of residency education for the specialty and to cover the course content specified in the Program Requirements. The time required for an individual resident physician's education might be modified depending on the aptitude of the resident physician and the availability of required clinical experiences.

PROVISION OF FORMAL EDUCATIONAL EXPERIENCES. Graduate medical education must include a formal educational component in addition to supervised clinical experience. This component should assist resident physicians in acquiring the knowledge and skill base required for practice in the specialty. The assignment of clinical responsibility to resident physicians must permit time for study of the basic sciences and clinical pathophysiology related to the specialty.

INNOVATION OF GRADUATE MEDICAL EDUCATION. The requirements for accreditation of residency training should encourage educational innovation and continual improvement. New topic areas such as continuous quality improvement (CQI), outcome management, informatics and information systems, and population-based medicine should be included as appropriate to the specialty.

THE ENVIRONMENT OF GRADUATE MEDICAL EDUCATION. Sponsoring organizations and other GME programs must create an environment that is conducive to learning. There must be an appropriate balance between education and service. Resident physicians must be treated as colleagues.

SUPERVISION OF RESIDENT PHYSICIANS. Program directors must supervise and evaluate the clinical performance of resident physicians. The policies of the sponsoring institution, as enforced by the program director, and specified in the ACGME Institutional Requirements and related accreditation documents, must ensure that the clinical activities of each resident physician are supervised to a degree that reflects the ability of the resident physician and the level of responsibility for the care of patients that may be safely delegated to the resident. The sponsoring institution's GME Committee must monitor programs' supervision of residents and ensure that supervision is consistent with:

(A) Provision of safe and effective patient care;

(B) Educational needs of residents;

(C) Progressive responsibility appropriate to residents' level of education, competence, and experience; and

(D) Other applicable Common and specialty/subspecialty specific Program Requirements. The program director, in cooperation with the institution, is responsible for maintaining work schedules for each resident based on the intensity and variability of assignments in conformity with ACGME Review Committee recommendations, and in compliance with the ACGME clinical and educational work hour standards. Integral to resident supervision is the necessity for frequent evaluation of residents by faculty, with discussion between faculty and resident. It is a cardinal principle that responsibility for the treatment of each patient and the education of resident and fellow physicians lies with the physician/faculty to whom the patient is assigned and who

supervises all care rendered to the patient by residents and fellows. Each patient's attending physician must decide, within guidelines established by the program director, the extent to which responsibility may be delegated to the resident, and the appropriate degree of supervision of the resident's participation in the care of the patient. The attending physician, or designate, must be available to the resident for consultation at all times.

EVALUATION OF RESIDENTS AND SPECIALTY BOARD CERTIFICATION. Residency program directors and faculty are responsible for evaluating and documenting the continuing development and competency of residents, as well as the readiness of residents to enter independent clinical practice upon completion of training. Program directors should also document any deficiency or concern that could interfere with the practice of medicine and which requires remediation, treatment, or removal from training. Inherent within the concept of specialty board certification is the necessity for the residency program to attest and affirm to the competence of the residents completing their training program and being recommended to the specialty board as candidates for examination. This attestation of competency should be accepted by specialty boards as fulfilling the educational and training requirements allowing candidates to sit for the certifying examination of each member board of the ABMS.

GRADUATE MEDICAL EDUCATION IN THE AMBULATORY SETTING. Graduate medical education programs must provide educational experiences to residents in the broadest possible range of educational sites, so that residents are trained in the same types of sites in which they may practice after completing GME. It should include experiences in a variety of ambulatory settings, in addition to the traditional inpatient experience. The amount and types of ambulatory training is a function of the given specialty.

VERIFICATION OF RESIDENT PHYSICIAN EXPERIENCE. The program director must document a resident physician's specific experiences and demonstrated knowledge, skills, attitudes, and behavior, and a record must be maintained within the institution.

Encouragement of Interprofessional Education Among Health Care Professions Students D-295.934

1. Our American Medical Association recognizes that interprofessional education and partnerships are a priority of the American medical education system.
2. Our AMA supports the concept that medical education should prepare students for practice in, and leadership of, physician-led interprofessional health care teams.
3. Our AMA will encourage health care organizations that engage in a collaborative care model to provide access to an appropriate mix of role models and learners.
4. Our AMA will encourage the development of skills for interprofessional education that are applicable to and appropriate for each group of learners.
5. Our AMA supports the concept that interprofessional education include a mechanism by which members of interdisciplinary teams learn about, with, and from each other; and that this education include learning about differences in the depth and breadth of their educational backgrounds, experiences, and knowledge and the impact these differences may have on patient care.
6. Our AMA supports a clear mechanism for medical school and appropriate institutional leaders to intervene when undergraduate and graduate medical education is being adversely impacted by undergraduate, graduate, and postgraduate clinical training programs of non-physicians.

1 REFERENCES

[1] Eligible Professional Meaningful Use Menu Set Measures Measure 6 of 9. Centers for Medicare & Medicaid Services. May 2014. Accessed July 5, 2024. https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downloads/7_Medication_Reconciliation.pdf.

[2] The High 5s Project Standard Operating Protocol Assuring Medication Accuracy at Transitions in Care: Medication Reconciliation. World Health Organization. September 2014. Accessed June 1, 2024. https://cdn.who.int/media/docs/default-source/integrated-health-services-(ihs)/psf/high5s/h5s-sop.pdf.

[3] Ciapponi A, Fernandez Nievas SE, Seijo M, et al. Reducing medication errors for adults in hospital settings. *Cochrane Libr*. 2021;2021(11). doi:10.1002/14651858.cd009985.pub2

[4] Presley CA, Wooldridge KT, Byerly SH, et al. The rural VA multi-center medication reconciliation quality improvement study (R-VA-MARQUIS). *Am J Health Syst Pharm*. 2020;77(2):128-137. doi:10.1093/ajhp/zxz275

[5] Rose AJ, Fischer SH, Paasche-Orlow MK. Beyond medication reconciliation: The correct medication list. *JAMA*. 2017;317(20):2057. doi:10.1001/jama.2017.4628

[6] Schnipper JL. Medication reconciliation—too much or not enough? *JAMA Netw Open*. 2021;4(9):e2125272. doi:10.1001/jamanetworkopen.2021.25272

[7] Quality ID #130: Documentation of Current Medications in the Medical Record. Centers for Medicare & Medicaid Services. December 2023. Accessed July 5, 2024. https://qpp.cms.gov/docs/QPP_quality_measure_specifications/CQM-Measures/2024_Measure_130_MIPSCQM.pdf.

[8] Wadhwa R, Boehning AP. *The Joint Commission*. StatPearls Publishing; 2023.

[9] National Patient Safety Goals® Effective January 2023 for the Hospital Program. The Joint Commission. October 2022. Accessed July 5, 2024. https://www.jointcommission.org/-/media/tjc/documents/standards/national-patient-safety-goals/2023/npsg_chapter_hap_jan2023.pdf.

[10] Medications at Transitions and Clinical Handoffs (MATCH) Toolkit for Medication Reconciliation. Chapter 3. Developing Change: Designing the Medication Reconciliation Process. Agency for Healthcare Research and Quality. July 2022. Accessed July 5, 2024. https://www.ahrq.gov/patient-safety/settings/hospital/match/chapter-3.html.

[11] Lee KP, Hartridge C, Corbett K, Vittinghoff E, Auerbach AD. "Whose job is it, really?" physicians', nurses', and pharmacists' perspectives on completing inpatient medication reconciliation: Medication Reconciliation Perspectives. *J Hosp Med*. 2015;10(3):184-186. doi:10.1002/jhm.2289

[12] The physician's role in medication reconciliation: Issues, strategies, and safety principles. American Medical Association. 2007. Accessed July 5, 2024. https://brucelambert.soc.northwestern.edu/book_reviews/med-rec-monograph.pdf.

[13] Rangachari P, Dellsperger KC, Fallaw D, et al. A Mixed-Method Study of Practitioners' Perspectives on Issues Related to EHR Medication Reconciliation at a Health System. Quality Management in Health. April/June 2019;28(2):84-95. doi:10.1097/QMH.0000000000000208

[14] Harris M, Moore V, Barnes M, Persha H, Reed J, Zillich A. Effect of pharmacy-led interventions during care transitions on patient hospital readmission: A systematic review. *J Am Pharm Assoc*. 2022;62(5):1477-1498.e8. doi:10.1016/j.japh.2022.05.017

[15] Holbrook A, Bowen JM, Patel H, et al. Process mapping evaluation of medication reconciliation in academic teaching hospitals: a critical step in quality improvement. *BMJ Open*. 2016;6(12):e013663. doi:10.1136/bmjopen-2016-013663

[16] Quick Safety Issue 12: Speech recognition technology translates to patient risk. The Joint Commission. May 2022. Accessed July 5, 2024. https://www.jointcommission.org/resources/news-and-multimedia/newsletters/newsletters/quick-safety/quick-safety--issue-12-transcription-translates-to-patient-risk/.

[17] Edgar L, McLean S, Hogan SO, Hamstra S, Holmboe ES. *The Milestones Guidebook*. Accreditation Council for Graduate Medical Education; 2020. https://www.acgme.org/globalassets/milestonesguidebook.pdf

[18] IVA5d. Accreditation Council for Graduate Medical Education Competencies. May 2008. Accessed July 5, 2024. https://www.acgme.org/globalassets/PDFs/commonguide/IVA5d_EducationalProgram_ACGMECompetencies_IPCS_Explanation.pdf.

[19] Geriatric Medicine Milestones. Accreditation Council for Graduate Medical Education. July 1, 2021. Accessed July 5, 2024. https://www.acgme.org/globalassets/pdfs/milestones/geriatricmedicinemilestones.pdf.

[20] Internal Medicine Milestones. Accreditation Councl for Graduate Medical Education. July 1, 2021. Accessed July 5, 2024. https://www.acgme.org/globalassets/pdfs/milestones/internalmedicinemilestones.pdf.

[21] Request for Input on First Draft of the Foundational Competencies for Undergraduate Medical Education. Accreditation Council for Graduate Medical Education. January 23, 2024. Accessed July 5, 2024. https://www.acgme.org/newsroom/2024/1/request-for-input-on-first-draft-of-the-foundational-competencies-for-undergraduate-medical-education/.

[22] Medications at Transitions and Clinical Handoffs (MATCH) Toolkit for Medication Reconciliation. Chapter 5. Education and Training. Agency for Healthcare Research and Quality. July 2022. Accessed July 5, 2024. https://www.ahrq.gov/patient-safety/settings/hospital/match/chapter-5.html.

[23] Poon EG. Medication Reconciliation: Whose Job Is It? Agency for Healthcare Research and Quality. September 1, 2007. Accessed July 5, 2024. https://psnet.ahrq.gov/web-mm/medication-reconciliation-whose-job-it.

[24] Splawski J, Minger H. Value of the pharmacist in the medication reconciliation process. *P T*. 2016;41(3):176-178.

[25] Hawley CE, Triantafylidis LK, Phillips SC, Schwartz AW. Brown bag simulation to improve medication management in older adults. *MedEdPORTAL*. 2019;15. doi:10.15766/mep_2374-8265.10857

[26] Stansell P, Paris D, Clark R, Morgan V. Using simulation to teach medication reconciliation and translate didactic to clinical. *Nurse Educ*. 2022;47(1):61-61. doi:10.1097/nne.0000000000001053

[27] Sehgal M, Nassetta KR, Bamdas JAM, Sourial M. First do no 'pharm': Educating medical and pharmacy students on the essentials of medication management. *Curr Pharm Teach Learn*. 2019;11(9):920-927. doi:10.1016/j.cptl.2019.05.006

[28] Lester PE, Sahansra S, Shen M, Becker M, Islam S. Medication reconciliation: An educational module. *MedEdPORTAL*. 2019;15. doi:10.15766/mep_2374-8265.10852

[29] Martin A, McDonald J, Holland J. Completeness of medication reconciliation performed by pediatric resident physicians at hospital admission for asthma. *Can J Hosp Pharm*. 2021;74(1):30-35. Accessed July 5, 2024. https://pubmed.ncbi.nlm.nih.gov/33487652/

[30] Arundel C, Logan J, Ayana R, Gannuscio J, Kerns J, Swenson R. Safe medication reconciliation: An intervention to improve residents' medication reconciliation skills. *J Grad Med Educ*. 2015;7(3):407-411. doi:10.4300/jgme-d-14-00565.1

[31] Mahlknecht A, Krisch L, Nestler N, et al. Impact of training and structured medication review on medication appropriateness and patient-related outcomes in nursing homes: results from the interventional study InTherAKT. *BMC Geriatr*. 2019;19(1). doi:10.1186/s12877-019-1263-3

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 2-I-24

Subject: Updates to Recommendations for Future Directions for Medical Education

Presented by: Krystal Tomei, MD, MPH, Chair

Referred to: Reference Committee C

"Updates to Recommendations for Future Directions for Medical Education" is a self-initiated report by the Council on Medical Education.

BACKGROUND

Report Origins and Process

In July 1980, the AMA House of Delegates (HOD) authorized the establishment of six task forces to review then-current and predicted future issues within medical education. At the 1982 Annual Meeting, the Council on Medical Education released recommendations on "Future Directions for Medical Education," with the following stated purpose: "This report expresses the continual interest of the Council on Medical Education, consistent with its function within the AMA, 'to elevate medical education'."[1] These recommendations are AMA Policy H-295.995, Recommendations for Future Directions for Medical Education, and were last amended by the Council in 2017 with CME Report 1-I-17, Promoting and Reaffirming Domestic Medical School Clerkship Education (Resolution 308-I-16). Most of the current 37 recommendations retain the original language from 1982, despite more than 40 years of changes to medical education.

For this reason, the Council on Medical Education voted in favor of proposing a series of self-initiated reports to reassess and modernize the policy's recommendations, including, when relevant, consolidating some of AMA's other policies on medical education topics. The goal of this self-initiated process is to establish an updated framework for understanding the future of medical education, as well as potentially incorporating innovations and newer understandings from the last several decades of collaboration with medical education stakeholders. This first report seeks to describe a brief history of the important changes in medical education since 1982 and proposes sunsetting out-of-date recommendations within AMA Policy H-295.995. This report also describes a proposed framework for reassessing AMA Policy H-295.995, with the subcategories of 1) mission of medical education, 2) professional regulation, 3) entry into and transition through the medical education continuum, 4) medical education curricula, 5) physician as medical professional, 6) medical education systems, and 7) obligation to students and trainees. This initial report then proposes that the Council conduct future studies in following years based around each of the new framework's categories to overhaul and modernize these aspects of AMA medical education policy. Beyond deleting irrelevant and out-of-date recommendations in AMA Policy H-295.995, this initial report will continue current AMA policies on medical education without revision or reorganization—and will offer these new categories with examples of where the existing recommendations may fit in the body of future reports, with the intention of future restructuring. In future studies, if approved, policy consolidation and/or new policy recommendations will then take place under each of the adopted subcategories.

40 Years of Changes in Medical Education

A detailed historical account of all major changes in medical education across more than 40 years is outside the scope of this report; however, major examples of changes include but are not limited to the following.

Mission of medical education

Medical education's mission is to train a competent physician workforce that meets the needs of patients and populations. Though efforts by groups and individuals have been made throughout history to improve conditions for the most marginalized, a heightened awareness of equity concerns within medical education has emerged over the past few decades. In the context of the AMA, since the original 1982 Council report on the future of medical education, the Minority Affairs Consortium was created in 1992, the Commission to End Health Care Disparities began in 2004, and in 2008, the AMA officially apologized for its history of harms against Black physicians and patients.[2] The AMA's Center for Health Equity was launched in 2019, with the AMA's strategic plan to embed racial justice and advance health equity released in 2021.[3] Council on Medical Education Report 05-J-21, "Promising Practices Among Pathway Programs to Increase Diversity in Medicine"[4] discussed the harms of the 1910 Flexner Report and called for an external study focused on reimagining the future of health equity and racial justice in medical education, which was published in 2024.[5] In the greater U.S., milestones such as the 1990 Americans with Disabilities Act (ADA), the 2008 ADA Amendments Act, and the 2015 legalization of same-sex marriage via the *Obergefell v. Hodges* Supreme Court decision have also drawn attention to disability and lesbian, gay, bisexual, transgender, queer, and more (LGBTQ+) rights within medical education.[6]

In recent years, there is an unprecedented demand for health care, with increasing physician workforce shortages nationally as well as in certain underserved areas.[7] There are also current and pending shortages in specific specialties, such as urology.[8] Many of these shortages may be attributed to maldistribution, rather than purely insufficient numbers of physicians nationwide, with certain areas remaining underserved, particularly rural areas, with medical education playing a major role in influencing physicians to meet these needs.[9] The transition toward competency-based medical education (CBME) is one of the most pivotal shifts in medical education in recent years[10] and one of AMA's ChangeMedEd 2023 areas of strategic focus, alongside equity, diversity, and belonging; precision education; and transitions across the continuum.[11]

Professional regulation

Medical education maintains commitment to the concept that the regulation of the medical profession should be guided by physicians. A 2015 memorandum of understanding between the Accreditation Council for Graduate Medical Education (ACGME), American Osteopathic Association, and American Association of Colleges of Osteopathic Medicine began a five-year transition to single U.S. graduate medical education (GME) accreditation, which finalized in 2020,[12] though some express concerns.[13] AMA policy currently supports work toward a single licensure exam (Single Licensing Exam Series for Osteopathic and Allopathic Medical Students D-275.947), and inequities between Doctors of Osteopathic Medicine (DOs) and Doctors of Medicine (MDs) continue to be addressed.[14]

Significant overall shifts in how standardized assessments are designed and discussed have also taken place since the 1980s. This includes the notion of competence as actual competencies linked to patient outcomes rather than personality traits, an understanding that did not develop until the

late 1990s and early 2000s, with awareness of assessor bias and the limitations of assessments emerging in scholarly literature even later.[15] In 2021, the United States Medical Licensing Examination (USMLE) Step 2 Clinical Skills (CS) was permanently discontinued after a COVID-19 related 2020 suspension.[16] In 2022, the USMLE Step 1 exam converted from numeric to pass-fail.[17]

Entry into and transition through the medical education continuum

Application and selection processes have also changed over time. In 1995, the Association of American Medical Colleges (AAMC) developed the Electronic Residency Application Service (ERAS), replacing cumbersome paper mail residency applications with newer technology—first floppy disks, followed by web-based services.[18] In more recent years, specialties have considered and tested alternatives to ERAS, such as the obstetrics and gynecology (OB/GYN) specialty's shift to the Residency Centralized Application Service in 2024.[19] This new platform will still work in conjunction with the National Resident Matching Program (NRMP) for the Match. Although the NRMP was established in 1952,[20] significant changes have also taken place over the years to modernize infrastructure and shift strategic priorities in response to modern needs.[21] The NRMP formalized its Specialty Matching Service and conducted its first fellowship Match in 1984.[22] A single Match for DOs and MDs began in 2020.[6]

The COVID-19 pandemic, declared officially in 2020, sparked both a major crisis within medical education and devastation for many within society at large, prompting opportunities for transformations of existing systems[23] in both education and patient care.[24] AAMC now recommends virtual interviewing for all residency and fellowship programs.[25] On the heels of COVID-19 related upheaval, the Coalition for Physician Accountability commissioned an independent body to review the UME-to-GME transition and provide recommendations. The Undergraduate Medical Education to Graduate Medical Education Review Committee (UGRC) released a report with 34 recommendations in August 2021.[26]

For international medical graduates, the Educational Commission for Foreign Medical Graduates (ECFMG) established the Foundation for Advancement of International Medical Education and Research (FAIMER) in 2000,[27] launched electronic verification of medical credentials in 2012,[28] developed certification Pathways in 2020 following the suspension of USMLE Step 2,[29] and in 2023, ECFMG and FAIMER became divisions of a private nonprofit organization, Intealth.[29] In 2024, the Federation of State Medical Boards (FSMB), Intealth, and the ACGME established an Advisory Commission on Alternate Licensing Models to "provide guidance on alternative pathways for state licensure of physicians who have completed training and/or practiced outside of the United States," with work in progress at the time of this writing.[30]

Medical education curricula

A vast number of technological changes have occurred since 1982, including but not limited to the advent of widely available internet access in the 1990s[31] in addition to more specific technological shifts in medical education over time.[32] Virtual education is now prominent.[33] More recently, the increasing attention to generative artificial intelligence or augmented intelligence (AI) prompted the AMA to release "Principles for Augmented Intelligence Development, Deployment, and Use" in November 2023.[34] AI technology and its opportunities and challenges are increasingly woven into the field of medical education.[35]

From 2013-2022, the AMA's Accelerating Change in Medical Education Consortium[36] made $30 million in grants to 32 medical schools to jumpstart curricular and process changes and disseminate

ideas,[37] and in 2019, AMA launched the Reimagining Residency initiative to support innovations to transform residency training.[38] The consortium became ChangeMedEd in 2023, and lessons from ChangeMedEd are informing ideas on future directions in medical education as intended. Curricular innovations include health systems science,[39] the Master Adaptive Learner model,[40] and a renewed emphasis on equity and social determinants of health.[41]

Physician as medical professional

Due in part to the rapid growth of managed care in health insurance in the late 1980s and early 1990s, a much larger proportion of physicians began seeking board certification.[42] Rapid changes in medicine and the exponential growth of medical knowledge also caused shifts in patient and payer concerns about physician knowledge.[43] In 1990, internal medicine board certification became time-limited rather than one-time, and in 2002, all member boards of the American Board of Medical Specialties agreed on recertification requirements and evaluation of performance in practice.[42] These changes led to continuous assessment programs called maintenance of certification (MOC)[43] in the early 2000s, which offered both benefits and challenges, and translated to varying options for continuing board certification depending on specialty, such as a longitudinal knowledge assessment pathway for the American Board of Internal Medicine (ABIM) in 2022.[43]

With regard to physician lifelong learning, the Accreditation Council for Continuing Medical Education was still new when the 1982 report was written, having been established in 1981, and has evolved over time.[44] AMA's own Physician Recognition Award (PRA) Credit System also shifted over time, including official booklet updates in 2017 and in-progress changes since then.[45] Many factors related to lifelong learning have also emerged into greater awareness, such as ageism and principles to guide physician competence assessment at any age[46] and substance use disorder destigmatization and interventions.[47]

Medical education systems

The overall role of the physician and the practice of medicine in U.S. society has shifted. There has been a shift away from independent practice, influenced by economic, administrative, and regulatory burdens.[48] Due to the increasing complexity of health systems, in 1999, systems-based practice was introduced as one of the core competencies[49] endorsed by the ACGME and the ABMS, with Milestones introduced in 2013 as a developmental framework related to competencies and harmonized across specialties in 2017. There have been other updates since then.[49] Challenges continue to emerge in the clinical learning environment, requiring new approaches.[40] There are increasing concerns about the impact of corporate interests and private equity, as discussed in Council on Medical Education Reports 01-I-22, "The Impact of Private Equity on Medical Training,"[50] and 01-I-20, "Graduate Medical Education and the Corporate Practice of Medicine."[51] Other systems factors also influence medical education, such as high demand for clinical placements,[52] physician workforce disparities,[53] and scope of practice concerns, the latter of which led to the formation of the AMA's Scope of Practice Partnership in 2006.[54]

Obligation to students and trainees

Since 1982, there has been increased attention to the needs of students and trainees, in a variety of forms. Student well-being is now better researched, and a variety of interventions have been tested and implemented on an ongoing basis.[55] Resident working conditions and duty hours have become major issues in GME, particularly after the Libby Zion case in 1984[56] and adoption of ACGME duty hour standards.[57] In 2011, the AMA released the Residents and Fellows' Bill of Rights H-

31.912, last updated in 2023, and there is increasing awareness of the need to address growing stressors and burnout within medical education, both for learners[58] and faculty.[59]

Research is ongoing on how other aspects of the medical education field have shifted over time and how these changes may impact learners and public health.[60]

Proposal for a New Medical Education Policy Framework

Given the substantial evolution in medical education over the last 40+ years, the Council on Medical Education proposes, over a series of future reports, to systematically re-evaluate Policy H-295.995 recommendations and other relevant AMA medical education policy to: a) reframe existing policies to match the current context, b) consolidate duplicate or overlapping policies, c) remove outdated policies, and d) propose new policies to address identified gaps. The proposed framework for this project is discussed below.

DISCUSSION

In the Council's original 1982 report, medical education topics were divided into the following 10 categories: 1) generalism and specialism, 2) preparation for and admission to medical school, 3) medical schools and undergraduate medical education, 4) evaluation, 5) the transition from undergraduate to graduate medical education, 6) specialism, graduate medical education, and specialty boards, 7) licensure for the practice of medicine, 8) continuing medical education, 9) graduates of foreign medical schools, and 10) the AMA and medical education. To modernize this policy, the Council on Medical Education recommends establishing a new framework with the following seven categories: 1) mission of medical education, 2) professional regulation, 3) entry into and transition through the medical education continuum, 4) medical education curricula, 5) physician as medical professional, 6) medical education systems, and 7) obligations to students and trainees. After receiving input from the House on this report, the Council intends to develop future reports based on a framework as adopted by the House of Delegates.

The Council on Medical Education also recommends sunsetting four out-of-date subsections of H-295.995, seen below.

RELEVANT AMA POLICY

The current, full text of Recommendations for Future Directions for Medical Education H-295.995 is listed in the Appendix A of this report.

SUMMARY AND RECOMMENDATIONS

Substantial changes have taken place in medical education since 1982, and AMA Policy H-295.995, "Recommendations for Future Directions for Medical Education," has not been comprehensively reviewed in over 40 years. The Council on Medical Education proposes a future series of self-initiated reports to modernize AMA medical education policy and consolidate relevant medical education policies.

The Council on Medical Education therefore recommends that the following recommendations be adopted, and the remainder of this report be filed:

That our American Medical Association (AMA):

1. Study the restructuring of AMA Policy H-295.995, "Recommendations for Future Directions for Medical Education" in a series of seven future reports based on the topics of 1) mission of medical education, 2) professional regulation, 3) entry into and transition through the medical education continuum, 4) medical education curricula, 5) physician as medical professional, 6) medical education systems, and 7) obligations to students and trainees, to consolidate existing AMA policies in these areas where appropriate and to recommend new language for the future of medical education. (Directive to Take Action)

2. Policy H-295.995, "Recommendations for Future Directions for Medical Education," be amended by deletion of items 19, 20, 31 and 33 and appropriately renumbered to read as follows (Modify Current HOD Policy):

(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.~~

(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.~~

(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.~~

Fiscal note: $7,000

APPENDIX A: RELEVANT 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.

1 REFERENCES

[1] AMA House of Delegates Proceedings, Annual Convention 1982. American Medical Association. Accessed July 11, 2024. https://ama.nmtvault.com/jsp/PsImageViewer.jsp?doc_id=1ee24daa-2768-4bff-b792-e4859988fe94%2Fama_arch%2FHOD00001%2F00000114

[2] Washington H. Apology Shines Light on Racial Schism in Medicine. *The New York Times*. Published July 29, 2008. Accessed July 11, 2024. https://www.nytimes.com/2008/07/29/health/views/29essa.html

[3] The history of African Americans and organized medicine. American Medical Association. Published February 2, 2024. Accessed July 11, 2024. https://www.ama-assn.org/about/ama-history/history-african-americans-and-organized-medicine

[4] Council on Medical Education Report 5-J-21, Promising Practices Among Pathway Programs to Increase Diversity in Medicine. American Medical Association. Published June 2021. Accessed July 11, 2024. https://www.ama-assn.org/system/files/2021-05/j21-cme05.pdf

[5] Bonilla-Silva E, Haozous EA, Kayingo G, McDade W, Meeks L, Núñez A, Oyeyemi T, Southerland J, Sukhera J. *Reimagining Medical Education: The Future of Health Equity and Social Justice.* Elsevier; 2024.

[6] Edje L, Casillas C, O'Toole JK. Strategies to counteract impact of harmful bias in selection of medical residents. *Acad Med*. 2023;98(8S):S75-S85. doi:10.1097/acm.0000000000005258

[7] Zhang X, Lin D, Pforsich H, Lin VW. Physician workforce in the United States of America: forecasting nationwide shortages. *Hum Resour Health*. 2020;18(1). doi:10.1186/s12960-020-0448-3

[8] Goroll AH. The future of the US physician workforce—challenges and opportunities. *JAMA Netw Open*. 2021;4(11):e2134464. doi:10.1001/jamanetworkopen.2021.34464

[9] Elma A, Nasser M, Yang L, Chang I, Bakker D, Grierson L. Medical education interventions influencing physician distribution into underserved communities: a scoping review. *Hum Resour Health*. 2022;20(1). doi:10.1186/s12960-022-00726-z

[10] Majumder MAA, Haque M, Razzaque MS. Editorial: Trends and challenges of medical education in the changing academic and public health environment of the 21st century. *Front Commun*. 2023;8. doi:10.3389/fcomm.2023.1153764

[11] Catalyzing change in medical education. American Medical Association. Published March 4, 2024. Accessed July 11, 2024. https://www.ama-assn.org/education/changemeded-initiative/catalyzing-change-medical-education

[12] Transition to a single GME accreditation system history. Accreditation Council for Graduate Medical Education. Accessed July 11, 2024. https://www.acgme.org/about/transition-to-a-single-gme-accreditation-system-history/

[13] Cummings M. The Single Accreditation System: Risks to the osteopathic profession. *Acad Med*. 2021;96(8):1108-1114. doi:10.1097/acm.0000000000004109

[14] Discrimination Against DO Students in Medical Residency. American Medical Association. Published June 2022. Accessed July 11, 2024. https://www.ama-assn.org/system/files/cme-issue-brief-discrimination-against-DO-students-in-medical-residency.pdf

[15] Schuwirth LWT, van der Vleuten CPM. A history of assessment in medical education. *Adv Health Sci Educ Theory Pract*. 2020;25(5):1045-1056. doi:10.1007/s10459-020-10003-0

[16] Work to relaunch USMLE Step 2 CS discontinued. United States Medical Licensing Examination. Published January 26, 2021. Accessed July 11, 2024. https://www.usmle.org/work-relaunch-usmle-step-2-cs-discontinued

[17] Murphy B. How the switch to pass-fail scoring for USMLE Step 1 is going. American Medical Association. Published April 5, 2023. Accessed July 11, 2024. https://www.ama-assn.org/medical-students/usmle-step-1-2/how-switch-pass-fail-scoring-usmle-step-1-going

[18] AAMC history. Association of American Medical Colleges. Accessed July 11, 2024. https://www.aamc.org/who-we-are/aamc-history

[19] Murphy B. What to know about the new ob-gyn physician residency application. American Medical Association. Published February 8, 2024. Accessed July 11, 2024. https://www.ama-assn.org/medical-students/preparing-residency/what-know-about-new-ob-gyn-physician-residency-application

[20] About the National Resident Matching Program. National Resident Matching Program. Accessed July 11, 2024. https://www.nrmp.org/about/

[21] Annual Report 2022-2023. National Resident Matching Program. Accessed July 11, 2024. https://annualreport.nrmp.org/#strategicpriorities

[22] NRMP® Publishes Comprehensive Data Book for Fellowship Matches. National Resident Matching Program. Published April 5, 2023. Accessed August 8, 2024. https://www.nrmp.org/about/news/2023/04/nrmp-publishes-comprehensive-data-book-for-fellowship-matches/

[23] Lucey CR, Davis JA, Green MM. We have no choice but to transform: The future of medical education after the COVID-19 pandemic. *Acad Med*. 2022;97(3S):S71-S81. doi:10.1097/acm.0000000000004526

[24] Guo MZ, Allen J, Sakumoto M, Pahwa A, Santhosh L. Reimagining undergraduate medical education in a post-COVID-19 landscape. *J Gen Intern Med*. 2022;37(9):2297-2301. doi:10.1007/s11606-022-07503-7

[25] Interviews in GME: Where do we go from here? Association of American Medical Colleges. Accessed July 11, 2024. https://www.aamc.org/about-us/mission-areas/medical-education/interviews-gme-where-do-we-go-here

[26] Knickrehm J. Coalition for Physician Accountability Accepts Report and Recommendations from UME-to-GME Review Committee. Coalition for Physician Accountability. Published August 26, 2021. Accessed July 11, 2024. https://physicianaccountability.org/wp-content/uploads/2021/08/UGRC-Submits-Final-Report-and-Recommendations.pdf

[27] History. Educational Commission for Foreign Medical Graduates. Published February 10, 2023. Accessed August 13, 2024. https://www.ecfmg.org/about/history.html

[28] Kelly, B. ECFMG® Launches Electronic Verification of Medical Credentials. Educational Commission for Foreign Medical Graduates. Published February 28, 2012. Accessed August 13, 2024. https://www.ecfmg.org/annc/ECFMG-release-Feb-28-2012.pdf

[29] About Us. Intealth. Published June 24, 2024. Accessed August 13, 2024. https://www.intealth.org/about-us/

[30] FSMB, Intealth, ACGME Establish Advisory Commission to Guide Alternate Pathways for State Licensure of International Medical Graduates. Intealth. Published March 27, 2024. Accessed August 13, 2024. https://www.intealth.org/news/2024/03/27/fsmb-intealth-acgme-establish-advisory-commission-to-guide-alternate-pathways-for-state-licensure-of-international-medical-graduates/

[31] A short history of the internet. National Science and Media Museum. Published December 3, 2020. Accessed July 11, 2024. https://www.scienceandmediamuseum.org.uk/objects-and-stories/short-history-internet

[32] Tokuç B, Varol G. Medical education in the era of advancing technology. *Balkan Med J*. 2023;40(6):395-399. doi:10.4274/balkanmedj.galenos.2023.2023-7-79

[33] Park A, Awan OA. COVID-19 and virtual medical student education. *Acad Radiol*. 2023;30(4):773-775. doi:10.1016/j.acra.2022.04.011

[34] AMA issues new principles for AI development, deployment & use. American Medical Association. Published November 28, 2023. Accessed July 11, 2024. https://www.ama-assn.org/press-center/press-releases/ama-issues-new-principles-ai-development-deployment-use

[35] Nagi F, Salih R, Alzubaidi M, et al. Applications of artificial Intelligence (AI) in medical education: A scoping review. In: *Studies in Health Technology and Informatics*. Vol 305. IOS Press; 2023.

[36] Accelerating change in medical education consortium: 2013-2022. American Medical Association. Published May 18, 2023. Accessed July 11, 2024. https://www.ama-assn.org/education/changemeded-initiative/accelerating-change-medical-education-consortium-2013-2022

[37] Smith, TM. Medical education in 2020: How we got here, where we're headed. American Medical Association. Published March 17, 2020. Accessed July 11, 2024. https://www.ama-assn.org/education/changemeded-initiative/medical-education-2020-how-we-got-here-where-we-re-headed

[38] AMA Reimagining Residency initiative. American Medical Association. Published April 26, 2024. Accessed July 11, 2024. https://www.ama-assn.org/education/changemeded-initiative/ama-reimagining-residency-initiative

[39] Richardson J, Gordon M, Pacis R, Wurster C, Hammoud MM. Health systems science: Insights from 155 U.S. allopathic medical schools, 2020–2021. Acad Med. 2023;98(11S):S214-S215. doi:10.1097/acm.0000000000005416

[40] Smith, TM. Why the physician of the future is a master adaptive learner. American Medical Association. Published October 5, 2020. Accessed August 13, 2024. https://www.ama-assn.org/education/changemeded-initiative/why-physician-future-master-adaptive-learner

[41] Onchonga D, Abdalla ME. Integrating social determinants of health in medical education: a bibliometric analysis study. *Public Health*. 2023;224:203-208. doi:10.1016/j.puhe.2023.09.005

[42] Cassel CK, Holmboe ES. Professionalism and accountability: the role of specialty board certification. *Trans Am Clin Climatol Assoc*. 2008;119:295-303; discussion 303-4.

[43] Cuenca AE. Board certification maintenance: History and evolution. *Fam Pract Manag*. 2022;29(5):6-11. Accessed July 11, 2024. https://www.aafp.org/pubs/fpm/issues/2022/0900/board-recertification.html

[44] History. Accreditation Council for Continuing Medical Education. Accessed July 11, 2024. https://www.accme.org/history

[45] The AMA PRA Credit System. American Medical Association. Published November 2023. Accessed July 11, 2024. https://www.ama-assn.org/system/files/cme-issue-brief-pra-credit-system.pdf

[46] Smith TM. 9 principles to guide physician competence assessment at all ages. American Medical Association. Published March 15, 2022. Accessed July 11, 2024. https://www.ama-assn.org/delivering-care/health-equity/9-principles-guide-physician-competence-assessment-all-ages

[47] Oreskovich MR, Shanafelt T, Dyrbye LN, et al. The prevalence of substance use disorders in American physicians. *Am J Addict*. 2015;24(1):30-38. doi:10.1111/ajad.12173

[48] AMA examines decade of change in physician practice ownership and organization. American Medical Association. Published July 12, 2023. Accessed July 11, 2024. https://www.ama-assn.org/press-center/press-releases/ama-examines-decade-change-physician-practice-ownership-and

[49] Edgar L, Hogan SO, Yamazaki K, Nasca TJ, Holmboe ES. Systems-based practice 20 years on: Navigating the system for better care. *Acad Med*. 2024;99(4):351-356. doi:10.1097/acm.0000000000005640

[50] Council on Medical Education Report 1-I-22, The Impact of Private Equity on Medical Training. American Medical Association. Published November 2022. Accessed July 11, 2024. https://councilreports.ama-assn.org/councilreports/downloadreport?uri=/councilreports/CME_01_I_22_final_annotated.pdf

[51] Council on Medical Education Report 2-N-20, Graduate Medical Education and the Corporate Practice of Medicine. American Medical Association. Published November 2020. Accessed July 11, 2024. https://councilreports.ama-assn.org/councilreports/downloadreport?uri=/councilreports/CME_02_I_20_annotated.pdf

[52] Nyoni CN, Dyk LHV, Botma Y. Clinical placement models for undergraduate health professions students: a scoping review. *BMC Med Educ*. 2021;21(1). doi:10.1186/s12909-021-03023-w

[53] Silver JK, Bean AC, Slocum C, et al. Physician workforce disparities and patient care: A narrative review. *Health Equity*. 2019;3(1):360-377. doi:10.1089/heq.2019.0040

[54] AMA successfully fights scope of practice expansions that threaten patient safety. American Medical Association. Published May 15, 2023. Accessed August 13, 2024. https://www.ama-assn.org/practice-management/scope-practice/ama-successfully-fights-scope-practice-expansions-threaten

[55] Klein HJ, McCarthy SM. Student wellness trends and interventions in medical education: a narrative review. *Humanit Soc Sci Commun*. 2022;9(1):1-8. doi:10.1057/s41599-022-01105-8

[56] Patel N. Learning lessons. *J Am Coll Cardiol*. 2014;64(25):2802-2804. doi:10.1016/j.jacc.2014.11.007

[57] Imrie KR, Frank JR, Parshuram CS. Resident duty hours: past, present, and future. *BMC Med Educ*. 2014;14(S1):S1. doi:10.1186/1472-6920-14-s1-s1

[58] Amir M, Dahye K, Duane C, Wendy L W. Medical student and resident burnout: A review of causes, effects, and prevention. *J Fam Med Dis Prev*. 2018;4(4). doi:10.23937/2469-5793/1510094

[59] Ko S, Guck A, Williamson M, Buck K, Young R. Family medicine faculty time allocation and burnout: A residency research network of Texas study. *J Grad Med Educ*. 2020;12(5):620-623. doi:10.4300/jgme-d-19-00930.1

[60] Buja LM. Medical education today: all that glitters is not gold. *BMC Med Educ*. 2019;19(1). doi:10.1186/s12909-019-1535-9

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 302
(I-24)

Introduced by: Resident and Fellow Section, LGBTQ+ Section, Minority Affairs Section

Subject: Strengthening Parental Leave Policies for Medical Trainees and Recent Graduates

Referred to: Reference Committee C

Whereas, supporting trainees with adequate parental leave is associated with improved resident wellness and productivity, as well as long-term maternal and child health outcomes;[1-3] and

Whereas, as of October 2020, all federal employees including members of the military are eligible for 12 weeks of paid parental leave for the birth or adoption of a child;[4] and

Whereas, both the American Academy of Pediatrics (AAP) and the American Academy of Family Physicians (AAFP) recommend that up to 12 weeks of paid parental leave should be available during residency training;[8] and

Whereas, a study of top-ranked hospitals and cancer centers found that the mean paid maternity and parental leave is 7.8 and 3.6 weeks, respectively, well below the 12-week paid family leave recommendation of the American Academy of Pediatrics and the mean of 18.6 weeks afforded by other Organization for Economic Co-operation and Development countries;[5] and

Whereas, the Family and Medical Leave Act of 1993 gives “eligible” employees of large employers and all government agencies regardless of size to take unpaid leave if it has been earned (defined as after 12 months of work) for a period of up to 12 weeks in any 12 month period;[6] and

Whereas, there are state-based parental leave laws that also require employees to have worked at least 12 months, which poses a burden for new graduates from residency and fellowship;[7] and

Whereas, in survey responses many residents do not feel supported in taking parental leave due to perceived or actual lack of support from faculty/peers, strain on residency program, and lack of flexibility of programs;[8] and

Whereas, in one survey, ⅔ of medical trainees who were parents felt that childcare contributed to their burnout especially when compounded by short parental leave and the difficulties of a relatively low trainee salary;[9] and

Whereas, in one survey of trainees in an institution and state offering only unpaid parental leave, the leading factor influencing length of parental leave time was financial;[10] and

Whereas, in one survey, nearly 40% of surgical trainees reported considering leaving residency during or after pregnancy for reasons including dissatisfaction with leave options;[11] and

Whereas, many women physicians delay childbearing until after training which often overlaps with periods of peak fertility such that approximately ¼ of women physicians report infertility, up to double the rate of the general US population;[12-14] and

Whereas, even if residencies and fellowships support paid leave, there is limited flexibility to support residents finishing residency on time, including limited board licensing exam dates; therefore be it

RESOLVED, that our American Medical Association amend Policies for Parental, Family and Medical Necessity Leave H-405.960 by addition to read as follows:

5. Our AMA recommends that medical practices, departments and training programs strive to provide 12 weeks of paid parental, family and medical necessity leave in a 12-month period for their attending and trainee physicians as needed with eligibility beginning at the start of employment without a waiting period. (Modify Current HOD Policy)

Fiscal Note: Minimal – less than $1,000

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REFERENCES:

1. Stack SW, McKinney CM, Spiekerman C, Best JA. Childbearing and maternity leave in residency: determinants and well-being outcomes. Postgrad Med J. 2018;94(1118):694-699. doi:10.1136/postgradmedj-2018-135960PubMedGoogle ScholarCrossref
2. Avendano M, Berkman LF, Brugiavini A, Pasini G. The long-run effect of maternity leave benefits on mental health: evidence from European countries. Soc Sci Med. 2015;132:45-53. doi:10.1016/j.socscimed.2015.02.037PubMedGoogle ScholarCrossref
3. Staehelin K, Bertea PC, Stutz EZ. Length of maternity leave and health of mother and child—a review. Int J Public Health. 2007;52(4):202-209. doi:10.1007/s00038-007-5122-1PubMedGoogle ScholarCrossref
4. Paid Parental Leave for Federal Employees. https://www.commerce.gov/hr/paid-parental-leave-federal-employees
5. Lu DJ, King BK, Sandler HM, Tarbell NJ, Kamrava M, Atkins KM. Paid parental leave policies among U.S. News & World Report 2020-2021 best hospitals and best hospitals for cancer. JAMA Netw Open 2021;4:e218518.Google Scholar
6. Code of Federal Regulations. https://www.ecfr.gov/current/title-29/subtitle-B/chapter-V/subchapter-C/part-825
7. Expanded Family and Medical Leave in California. https://calcivilrights.ca.gov/wp-content/uploads/sites/32/2023/02/Expanded-Family-And-Medical-Leave_ENG.pdf
8. Tobin-Tyler, Elizabeth, and Eli Y. Adashi. "The ACGME's new paid family and medical leave policy: just the beginning." *The Journal of the American Board of Family Medicine* 36.1 (2023): 190-192.
9. Marguerite W Spruce, Alicia A Gingrich, Amanda Phares, Carl A Beyer, Edgardo S Salcedo, Susan Guralnick, Margaret M Rea, Child-rearing During Postgraduate Medical Training and Its Relation to Stress and Burnout: Results From a Single-institution Multispecialty Survey, Military Medicine, Volume 187, Issue 3-4, March/April 2022, Pages e518–e526, https://doi.org/10.1093/milmed/usab029
10. Shobha W Stack, Christy M McKinney, Charles Spiekerman, Jennifer A Best, Childbearing and maternity leave in residency: determinants and well-being outcomes, Postgraduate Medical Journal, Volume 94, Issue 1118, December 2018, Pages 694–699, https://doi.org/10.1136/postgradmedj-2018-135960
11. Rangel EL, Smink DS, Castillo-Angeles M, Kwakye G, Changala M, Haider AH, Doherty GM. Pregnancy and Motherhood During Surgical Training. JAMA Surg. 2018 Jul 1;153(7):644-652. doi: 10.1001/jamasurg.2018.0153. PMID: 29562068; PMCID: PMC5875346.
12. Willett, Lisa L., et al. "Do women residents delay childbearing due to perceived career threats?." Academic Medicine 85.4 (2010): 640-646.
13. Natalie Clark Stentz, Kent A. Griffith, Elena Perkins, Rochelle DeCastro Jones, and Reshma Jagsi. Fertility and Childbearing Among American Female Physicians. Journal of Women's Health.Oct 2016.1059-1065.http://doi.org/10.1089/jwh.2015.5638
14. Carson SA, Kallen AN. Diagnosis and Management of Infertility: A Review. JAMA. 2021 Jul 6;326(1):65-76. doi: 10.1001/jama.2021.4788. PMID: 34228062; PMCID: PMC9302705.

RELEVANT AMA POLICY:

Policies for Parental, Family and Medical Necessity Leave H-405.960
AMA adopts as policy the following guidelines for, and encourages the implementation of, Parental, Family and Medical Necessity Leave for Medical Students and Physicians:
1. Our AMA urges residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement.
2. Recommended components of parental leave policies for physicians include: (a) duration of leave allowed before and after delivery; (b) category of leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for continuation of insurance benefits during leave, and who pays the premium; (e) whether sick leave and vacation time may be accrued from year to year or used in advance; (f) how much time must be made up in order to be considered board eligible; (g) whether make-up time will be paid; (h) whether schedule accommodations are allowed; and (i) leave policy for adoption.
3. AMA policy is expanded to include physicians in practice, reading as follows: (a) residency program directors and group practice administrators should review federal law concerning maternity leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled; (b) staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other physicians' workloads, particularly in residency programs; and (c) physicians should be able to return to their practices or training programs after taking parental leave without the loss of status.
4. Our AMA will study the impact on and feasibility of medical schools, residency programs, specialty boards, and medical group practices incorporating into their parental leave policies a 12-week minimum leave allowance, with the understanding that no parent be required to take a minimum leave.
5. Our AMA recommends that medical practices, departments and training programs strive to provide 12 weeks of paid parental, family and medical necessity leave in a 12-month period for their attending and trainee physicians as needed.
6. Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave.
7. Medical students and physicians who are unable to work because of pregnancy, childbirth, abortion or stillbirth, and other related medical conditions should be entitled to such leave and other benefits on the same basis as other physicians who are temporarily unable to work for other medical reasons.
8. Residency programs should develop written policies on leave for physicians. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) duration of leave allowed after abortion or stillbirth; (d) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); (e) whether leave is paid or unpaid; (f) whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (g) whether sick leave and vacation time may be accrued from year to year or used in advance; (h) extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (i) how time can be made up in order for a resident physician to be considered board eligible; (j) what period of leave would result in a resident physician being required to complete an extra or delayed year of training; (k) whether time spent in making up a leave will be paid; and (l) whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling.
9. Medical schools should develop written policies on parental leave, family leave, and medical leave for medical students. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) extended leave for medical students with extraordinary and long-term personal or family medical tragedies, without loss of previously accepted medical school seats, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (d) how time can be made up in order for a medical students to be eligible for graduation with minimal or no delays; (e) what period of leave would result in a medical student being required to complete an extra or delayed year of training; and (f) whether schedule accommodations are allowed, such as modified rotation schedules, no night duties, and flexibility with academic testing schedules.

10. Our AMA endorses the concept of equal parental leave for birth and adoption as a benefit for resident physicians, medical students, and physicians in practice regardless of gender or gender identity.
11. Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs.
12. Physicians should be able to return to their practices or training programs after taking parental leave, family leave, or medical leave without the loss of status.
13. Residency program directors must assist residents in identifying their specific requirements (for example, the number of months to be made up) because of leave for eligibility for board certification and must notify residents on leave if they are in danger of falling below minimal requirements for board eligibility. Program directors must give these residents a complete list of requirements to be completed in order to retain board eligibility.
14. Our AMA encourages flexibility in residency programs and medical schools incorporating parental leave and alternative schedules for pregnant trainees.
15. In order to accommodate leave protected by the federal Family and Medical Leave Act, our AMA encourages all specialties within the American Board of Medical Specialties to allow graduating residents to extend training up to 12 weeks after the traditional residency completion date while still maintaining board eligibility in that year.
16. Our AMA will work with appropriate stakeholders to encourage that residency programs annually publish and share with FREIDA and other appropriate stakeholders, self-identified and other demographic data, including but not limited to the composition of their program over the last 5 years by age; historically marginalized, minoritized, or excluded status; sexual orientation and gender identity.
17. Our AMA will encourage the Accreditation Council for Graduate Medical Education and other relevant stakeholders to annually collect data on childbirth and parenthood from all accredited US residency programs and publish this data with disaggregation by gender identity and specialty.
18. These policies as above should be freely available online through FREIDA and in writing to all current trainees and applicants to medical school, residency or fellowship. [CCB/CLRPD Rep. 4, A-13; Modified: Res. 305, A-14; Modified: Res. 904, I-14; Modified: Res. 307, A-22; Modified: Res. 302, I-22; Modified: Res. 312, I-22; Modified: CME Rep. 01 and Res. 306, I-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 304
(I-24)

Introduced by: Resident and Fellow Section, LGBTQ+ Section, Minority Affairs Section

Subject: Payment and Benefit Parity for Fellows

Referred to: Reference Committee C

Whereas, Graduate Medical Education (GME) is funded through both private and public sources[1-4]; and

Whereas, the largest source of funding for GME, specifically for residency positions, is through Medicare, both through direct (DGME) and indirect (IME) payments[1-4]; and

Whereas, additional federal funding comes from HRSA grants, the VA, and Department of Defense[1-4]; and

Whereas, Medicare payments cover residents in approved programs, accredited by the Accreditation Council on Graduate Medical Education (ACGME), the American Osteopathic Association (AOA), the American Dental Association (ADA), or the American Podiatric Medical Association (APMA)[3,5]; and

Whereas, Medicare will pay 1.0 FTE for each resident within their initial residency period, or the minimum number of years required for a resident to become board eligible in the specialty in which the resident first begins training, as determined by the ACGME[3,6]; and

Whereas, Medicare GME may have indirect effects on fellowship funding through various mechanisms such as hospital budget allocation, and contributing to infrastructure, resources and workforce development initiatives that can then support fellowship training[3,4]; and

Whereas, fellowships rely on private foundations, direct funding from the institution, government grants, endowments and donations, and/or other funding sources (often a combination of funding sources) to fund the fellowship[3,4]; and

Whereas, this difference in funding structure or pool can allow institutions to provide inferior benefits and salaries for fellows as compared to residents; and

Whereas, one can complete residency at an institution and have fringe benefits such as having subsidized parking, a 403b match, and/or gym membership, only to lose those benefits once they transition to fellowship at the same institution; and

Whereas, fellows often are older, carry more clinical responsibility, and may be more likely to have dependents compared to residents, and despite this, may receive fewer/inferior benefits compared to residents at the same institution; and

Whereas, all resident and fellow trainees deserve to be eligible for the same benefits, no matter what the funding source is for their program; therefore be it

RESOLVED, that our American Medical Association amend Residents and Fellows' Bill of Rights H-310.912 by addition to read as follows:

5. Our AMA will partner with ACGME and other relevant stakeholders to encourage training programs to reduce financial burdens on residents and fellows by providing employee benefits including, but not limited to, on-call meal allowances, transportation support, relocation stipends, and childcare services, and will encourage institutions to provide parity in salary and benefits between residents and fellows at a level that is at minimum commensurate with their postgraduate year. (Modify Current HOD Policy)

Fiscal Note: Minimal – less than $1,000

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REFERENCES:

1. ACGME. Funding for Graduate Medical Education. 2022. https://www.acgme.org/globalassets/pdfs/funding-for-graduate-medical-education-5.3.2022.pdf
2. Heisler, E., Mendez, B., Mitchell, A., Panangala, S.V, Villagrana, M. (2018) Federal Support for Graduate Medical Education: An Overview (CRS Report No. R44376) Retrieved from Congressional Research Service Website: Federal Support for Graduate Medical Education: An Overview (congress.gov)
3. AAMC. Medicare Payments for Graduate Medical Education: What Every Medical Student, Resident and Advisor needs to know. 2019. https://www.aamc.org/media/71701/download?attachment
4. Committee on the Governance and Financing of Graduate Medical Education; Board on Health Care Services; Institute of Medicine; Eden J, Berwick D, Wilensky G, editors. Graduate Medical Education That Meets the Nation's Health Needs. Washington (DC): National Academies Press (US); 2014 Sep 30. 3, GME Financing. Available from: https://www.ncbi.nlm.nih.gov/books/NBK248024/
5. 42 CFR 413.78 Direct GME payments: Determination of the total number of FTE residents; 42 CFR 413.75(b) Direct GME payments: General requirements.
6. 42 CFR 413.75(b) Direct GME payments: General requirements

RELEVANT AMA POLICY:

Onsite and Subsidized Childcare for Medical Students, Residents and Fellows H-200.948
Our AMA recognizes: (1) the unique childcare challenges faced by medical students, residents and fellows, which result from a combination of limited negotiating ability (given the matching process into residency), non-traditional work hours, extended or unpredictable shifts, and minimal autonomy in selecting their work schedules; and (2) the fiscal challenges faced by medical schools and graduate medical education institutions in providing onsite and/or subsidized childcare to students and employees, including residents and fellows. [CME Rep. 3, A-22]

Medical and Mental Health Services for Medical Students and Resident and Fellow Physicians H-345.973
Our AMA promotes the availability of timely, confidential, accessible, and affordable medical and mental health services for medical students and resident and fellow physicians, to include needed diagnostic, preventive, and therapeutic services. Information on where and how to access these services should be readily available at all education/training sites, and these services should be provided at sites in reasonable proximity to the sites where the education/training takes place. [Res. 915, I-15; Revised: CME Rep. 01, I-16]

Financial Protections for Doctors in Training H-310.903
Our AMA supports the availability of retirement plans for residents and fellows at all teaching institutions that are no less favorable than those offered to other institution employees. [BOT Rep. 18, I-21]

Residents and Fellows' Bill of Rights H-310.912
1. Our AMA continues to advocate for improvements in the ACGME Institutional and Common Program Requirements that support AMA policies as follows: a) adequate financial support for and guaranteed leave to attend professional meetings; b) submission of training verification information to requesting agencies within 30 days of the request; c) adequate compensation with consideration to local cost-of-living factors and years of training, and to include the orientation period; d) health insurance benefits to

include dental and vision services; e) paid leave for all purposes (family, educational, vacation, sick) to be no less than six weeks per year; and f) stronger due process guidelines.
2. Our AMA encourages the ACGME to ensure access to educational programs and curricula as necessary to facilitate a deeper understanding by resident physicians of the US health care system and to increase their communication skills.
3. Our AMA regularly communicates to residency and fellowship programs and other GME stakeholders in this Resident/Fellows Physicians' Bill of Rights.
4. Our AMA: a) will promote residency and fellowship training programs to evaluate their own institution's process for repayment and develop a leaner approach. This includes disbursement of funds by direct deposit as opposed to a paper check and an online system of applying for funds; b) encourages a system of expedited repayment for purchases of $200 or less (or an equivalent institutional threshold), for example through payment directly from their residency and fellowship programs (in contrast to following traditional workflow for reimbursement); and c) encourages training programs to develop a budget and strategy for planned expenses versus unplanned expenses, where planned expenses should be estimated using historical data, and should include trainee reimbursements for items such as educational materials, attendance at conferences, and entertaining applicants. Payment in advance or within one month of document submission is strongly recommended.
5. Our AMA will partner with ACGME and other relevant stakeholders to encourage training programs to reduce financial burdens on residents and fellows by providing employee benefits including, but not limited to, on-call meal allowances, transportation support, relocation stipends, and childcare services.
6. Our AMA will work with the Accreditation Council for Graduate Medical Education (ACGME) and other relevant stakeholders to amend the ACGME Common Program Requirements to allow flexibility in the specialty-specific ACGME program requirements enabling specialties to require salary reimbursement or "protected time" for resident and fellow education by "core faculty," program directors, and assistant/associate program directors.
7. Our AMA encourages teaching institutions to offer retirement plan options, retirement plan matching, financial advising and personal finance education.
8. Our AMA adopts the following "Residents and Fellows' Bill of Rights" as applicable to all resident and fellow physicians in ACGME-accredited training programs:
RESIDENT/FELLOW PHYSICIANS' BILL OF RIGHTS
Residents and fellows have a right to:
A. An education that fosters professional development, takes priority over service, and leads to independent practice.
With regard to education, residents and fellows should expect: (1) A graduate medical education experience that facilitates their professional and ethical development, to include regularly scheduled didactics for which they are released from clinical duties. Service obligations should not interfere with educational opportunities and clinical education should be given priority over service obligations; (2) Faculty who devote sufficient time to the educational program to fulfill their teaching and supervisory responsibilities; (3) Adequate clerical and clinical support services that minimize the extraneous, time-consuming work that draws attention from patient care issues and offers no educational value; (4) 24-hour per day access to information resources to educate themselves further about appropriate patient care; and (5) Resources that will allow them to pursue scholarly activities to include financial support and education leave to attend professional meetings.
B. Appropriate supervision by qualified physician faculty with progressive resident responsibility toward independent practice.
With regard to supervision, residents and fellows must be ultimately supervised by physicians who are adequately qualified and allow them to assume progressive responsibility appropriate to their level of education, competence, and experience. In instances where clinical education is provided by non-physicians, there must be an identified physician supervisor providing indirect supervision, along with mechanisms for reporting inappropriate, non-physician supervision to the training program, sponsoring institution or ACGME as appropriate.
C. Regular and timely feedback and evaluation based on valid assessments of resident performance.
With regard to evaluation and assessment processes, residents and fellows should expect: (1) Timely and substantive evaluations during each rotation in which their competence is objectively assessed by faculty who have directly supervised their work; (2) To evaluate the faculty and the program confidentially and in writing at least once annually and expect that the training program will address deficiencies revealed by these evaluations in a timely fashion; (3) Access to their training file and to be made aware of the contents of their file on an annual basis; and (4) Training programs to complete primary

verification/credentialing forms and recredentialing forms, apply all required signatures to the forms, and then have the forms permanently secured in their educational files at the completion of training or a period of training and, when requested by any organization involved in credentialing process, ensure the submission of those documents to the requesting organization within thirty days of the request.
D. A safe and supportive workplace with appropriate facilities.
With regard to the workplace, residents and fellows should have access to: (1) A safe workplace that enables them to fulfill their clinical duties and educational obligations; (2) Secure, clean, and comfortable on-call rooms and parking facilities which are secure and well-lit; (3) Opportunities to participate on committees whose actions may affect their education, patient care, workplace, or contract.
E. Adequate compensation and benefits that provide for resident well-being and health.
(1) With regard to contracts, residents and fellows should receive: a. Information about the interviewing residency or fellowship program including a copy of the currently used contract clearly outlining the conditions for (re)appointment, details of remuneration, specific responsibilities including call obligations, and a detailed protocol for handling any grievance; and b. At least four months advance notice of contract non-renewal and the reason for non-renewal.
(2) With regard to compensation, residents and fellows should receive: a. Compensation for time at orientation; and b. Salaries commensurate with their level of training and experience. Compensation should reflect cost of living differences based on local economic factors, such as housing, transportation, and energy costs (which affect the purchasing power of wages), and include appropriate adjustments for changes in the cost of living.
(3) With regard to benefits, residents and fellows must be fully informed of and should receive: a. Quality and affordable comprehensive medical, mental health, dental, and vision care for residents and their families, as well as retirement plan options, professional liability insurance and disability insurance to all residents for disabilities resulting from activities that are part of the educational program; b. An institutional written policy on and education in the signs of excessive fatigue, clinical depression, substance abuse and dependence, and other physician impairment issues; c. Confidential access to mental health and substance abuse services; d. A guaranteed, predetermined amount of paid vacation leave, sick leave, family and medical leave and educational/professional leave during each year in their training program, the total amount of which should not be less than six weeks; e. Leave in compliance with the Family and Medical Leave Act; and f. The conditions under which sleeping quarters, meals and laundry or their equivalent are to be provided.
F. Clinical and educational work hours that protect patient safety and facilitate resident well-being and education.
With regard to clinical and educational work hours, residents and fellows should experience: (1) A reasonable work schedule that is in compliance with clinical and educational work hour requirements set forth by the ACGME; and (2) At-home call that is not so frequent or demanding such that rest periods are significantly diminished or that clinical and educational work hour requirements are effectively circumvented. Refer to AMA Policy H-310.907, “Resident/Fellow Clinical and Educational Work Hours,” for more information.
G. Due process in cases of allegations of misconduct or poor performance.
With regard to the complaints and appeals process, residents and fellows should have the opportunity to defend themselves against any allegations presented against them by a patient, health professional, or training program in accordance with the due process guidelines established by the AMA.
H. Access to and protection by institutional and accreditation authorities when reporting violations.
With regard to reporting violations to the ACGME, residents and fellows should: (1) Be informed by their program at the beginning of their training and again at each semi-annual review of the resources and processes available within the residency program for addressing resident concerns or complaints, including the program director, Residency Training Committee, and the designated institutional official; (2) Be able to file a formal complaint with the ACGME to address program violations of residency training requirements without fear of recrimination and with the guarantee of due process; and (3) Have the opportunity to address their concerns about the training program through confidential channels, including the ACGME concern process and/or the annual ACGME Resident Survey.
9. Our AMA will work with the ACGME and other relevant stakeholders to advocate for ways to defray additional costs related to residency and fellowship training, including essential amenities and/or high cost specialty-specific equipment required to perform clinical duties.
10. Our AMA believes that healthcare trainee salary, benefits, and overall compensation should, at minimum, reflect length of pre-training education, hours worked, and level of independence and

complexity of care allowed by an individual's training program (for example when comparing physicians in training and midlevel providers at equal postgraduate training levels).
11.The Residents and Fellows' Bill of Rights will be prominently published online on the AMA website and disseminated to residency and fellowship programs.
12. Our AMA will distribute and promote the Residents and Fellows' Bill of Rights online and individually to residency and fellowship training programs and encourage changes to institutional processes that embody these principles, including resident/fellow empowerment and peer-selected representation in institutional leadership.
13. Our AMA encourages development of accreditation standards and institutional policies designed to facilitate and protect residents/fellows who seek to exercise their rights.
14. Our AMA encourages the formation of peer-led resident/fellow organizations that can advocate for trainees' interests, as outlined by the AMA's Residents and Fellows' Bill of Rights, at sponsoring institutions. [CME Rep. 8, A-11; Appended: Res. 303, A-14; Reaffirmed: Res. 915, I-15; Appended: CME Rep. 04, A-16; Modified: CME Rep. 06, I-18; Appended: Res. 324, A-19; Modified: Res. 304, A-21; Modified: Res. 305, A-21; Modified: BOT Rep. 18, I-21; Reaffirmation: A-22; Reaffirmed in lieu of: Res. 307, I-22; Modified: CME Rep. 05, I-23]

Resident and Fellow Access to Fertility Preservation H-310.902
Our AMA: (1) encourages insurance coverage for fertility preservation and infertility treatment within health insurance benefits for residents and fellows offered through graduate medical education programs; and (2) supports the accommodation of residents and fellows who elect to pursue fertility preservation and infertility treatment, including but not limited to, the need to attend medical visits to complete the gamete preservation process and to administer medications in a time-sensitive fashion. [Res. 302, A-22]

The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education D-305.967
1. Our AMA will actively collaborate with appropriate stakeholder organizations, (including Association of American Medical Colleges, American Hospital Association, state medical societies, medical specialty societies/associations) to advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions from all existing sources (e.g. Medicare, Medicaid, Veterans Administration, CDC and others).
2. Our AMA will actively advocate for the stable provision of matching federal funds for state Medicaid programs that fund GME positions.
3. Our AMA will actively seek congressional action to remove the caps on Medicare funding of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 (BBA-1997).
4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation.
5. Our AMA will oppose efforts to move federal funding of GME positions to the annual appropriations process that is subject to instability and uncertainty.
6. Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.).
7. Our AMA will actively explore additional sources of GME funding and their potential impact on the quality of residency training and on patient care.
8. Our AMA will vigorously advocate for the continued and expanded contribution by all payers for health care (including the federal government, the states, and local and private sources) to fund both the direct and indirect costs of GME.
9. Our AMA will work, in collaboration with other stakeholders, to improve the awareness of the general public that GME is a public good that provides essential services as part of the training process and serves as a necessary component of physician preparation to provide patient care that is safe, effective and of high quality.
10. Our AMA staff and governance will continuously monitor federal, state and private proposals for health care reform for their potential impact on the preservation, stability and expansion of full funding for the direct and indirect costs of GME.
11. Our AMA: (a) recognizes that funding for and distribution of positions for GME are in crisis in the United States and that meaningful and comprehensive reform is urgently needed; (b) will immediately

work with Congress to expand medical residencies in a balanced fashion based on expected specialty needs throughout our nation to produce a geographically distributed and appropriately sized physician workforce; and to make increasing support and funding for GME programs and residencies a top priority of the AMA in its national political agenda; and (c) will continue to work closely with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, American Osteopathic Association, and other key stakeholders to raise awareness among policymakers and the public about the importance of expanded GME funding to meet the nation's current and anticipated medical workforce needs.
12. Our AMA will collaborate with other organizations to explore evidence-based approaches to quality and accountability in residency education to support enhanced funding of GME.
13. Our AMA will continue to strongly advocate that Congress fund additional graduate medical education (GME) positions for the most critical workforce needs, especially considering the current and worsening maldistribution of physicians.
14. Our AMA will advocate that the Centers for Medicare and Medicaid Services allow for rural and other underserved rotations in Accreditation Council for Graduate Medical Education (ACGME)-accredited residency programs, in disciplines of particular local/regional need, to occur in the offices of physicians who meet the qualifications for adjunct faculty of the residency program's sponsoring institution.
15. Our AMA encourages the ACGME to reduce barriers to rural and other underserved community experiences for graduate medical education programs that choose to provide such training, by adjusting as needed its program requirements, such as continuity requirements or limitations on time spent away from the primary residency site.
16. Our AMA encourages the ACGME and the American Osteopathic Association (AOA) to continue to develop and disseminate innovative methods of training physicians efficiently that foster the skills and inclinations to practice in a health care system that rewards team-based care and social accountability.
17. Our AMA will work with interested state and national medical specialty societies and other appropriate stakeholders to share and support legislation to increase GME funding, enabling a state to accomplish one or more of the following: (a) train more physicians to meet state and regional workforce needs; (b) train physicians who will practice in physician shortage/underserved areas; or (c) train physicians in undersupplied specialties and subspecialties in the state/region.
18. Our AMA supports the ongoing efforts by states to identify and address changing physician workforce needs within the GME landscape and continue to broadly advocate for innovative pilot programs that will increase the number of positions and create enhanced accountability of GME programs for quality outcomes.
19. Our AMA will continue to work with stakeholders such as Association of American Medical Colleges (AAMC), ACGME, AOA, American Academy of Family Physicians, American College of Physicians, and other specialty organizations to analyze the changing landscape of future physician workforce needs as well as the number and variety of GME positions necessary to provide that workforce.
20. Our AMA will explore innovative funding models for incremental increases in funded residency positions related to quality of resident education and provision of patient care as evaluated by appropriate medical education organizations such as the Accreditation Council for Graduate Medical Education.
21. Our AMA will utilize its resources to share its content expertise with policymakers and the public to ensure greater awareness of the significant societal value of graduate medical education (GME) in terms of patient care, particularly for underserved and at-risk populations, as well as global health, research and education.
22. Our AMA will advocate for the appropriation of Congressional funding in support of the National Healthcare Workforce Commission, established under section 5101 of the Affordable Care Act, to provide data and healthcare workforce policy and advice to the nation and provide data that support the value of GME to the nation.
23. Our AMA supports recommendations to increase the accountability for and transparency of GME funding and continue to monitor data and peer-reviewed studies that contribute to further assess the value of GME.
24. Our AMA will explore various models of all-payer funding for GME, especially as the Institute of Medicine (now a program unit of the National Academy of Medicine) did not examine those options in its 2014 report on GME governance and financing.
25. Our AMA encourages organizations with successful existing models to publicize and share strategies, outcomes and costs.
26. Our AMA encourages insurance payers and foundations to enter into partnerships with state and local agencies as well as academic medical centers and community hospitals seeking to expand GME.

27. Our AMA will develop, along with other interested stakeholders, a national campaign to educate the public on the definition and importance of graduate medical education, student debt and the state of the medical profession today and in the future.
28. Our AMA will collaborate with other stakeholder organizations to evaluate and work to establish consensus regarding the appropriate economic value of resident and fellow services.
29. Our AMA will monitor ongoing pilots and demonstration projects, and explore the feasibility of broader implementation of proposals that show promise as alternative means for funding physician education and training while providing appropriate compensation for residents and fellows.
30. Our AMA will monitor the status of the House Energy and Commerce Committee's response to public comments solicited regarding the 2014 IOM report, Graduate Medical Education That Meets the Nation's Health Needs, as well as results of ongoing studies, including that requested of the GAO, in order to formulate new advocacy strategy for GME funding, and will report back to the House of Delegates regularly on important changes in the landscape of GME funding.
31. Our AMA will advocate to the Centers for Medicare & Medicaid Services to adopt the concept of “Cap-Flexibility” and allow new and current Graduate Medical Education teaching institutions to extend their cap-building window for up to an additional five years beyond the current window (for a total of up to ten years), giving priority to new residency programs in underserved areas and/or economically depressed areas.
32. Our AMA will: (a) encourage all existing and planned allopathic and osteopathic medical schools to thoroughly research match statistics and other career placement metrics when developing career guidance plans; (b) strongly advocate for and work with legislators, private sector partnerships, and existing and planned osteopathic and allopathic medical schools to create and fund graduate medical education (GME) programs that can accommodate the equivalent number of additional medical school graduates consistent with the workforce needs of our nation; and (c) encourage the Liaison Committee on Medical Education (LCME), the Commission on Osteopathic College Accreditation (COCA), and other accrediting bodies, as part of accreditation of allopathic and osteopathic medical schools, to prospectively and retrospectively monitor medical school graduates’ rates of placement into GME as well as GME completion.
33. Our AMA encourages the Secretary of the U.S. Department of Health and Human Services to coordinate with federal agencies that fund GME training to identify and collect information needed to effectively evaluate how hospitals, health systems, and health centers with residency programs are utilizing these financial resources to meet the nation’s health care workforce needs. This includes information on payment amounts by the type of training programs supported, resident training costs and revenue generation, output or outcomes related to health workforce planning (i.e., percentage of primary care residents that went on to practice in rural or medically underserved areas), and measures related to resident competency and educational quality offered by GME training programs.
34. Our AMA will publicize best practice examples of state-funded Graduate Medical Education positions and develop model state legislation where appropriate.
[Appended: Res. 202, I-22]

Insurance Coverage for Medical Students and Resident Physicians H-295.942
1. Our AMA urges (1) all medical schools to pay for or offer affordable policy options and, assuming the rates are appropriate, require enrollment in disability insurance plans by all medical students; (2) all residency programs to pay for or offer affordable policy options for disability insurance, and strongly encourage the enrollment of all residents in such plans; (3) medical schools and residency training programs to pay for or offer comprehensive and affordable health insurance coverage, including but not limited to medical, dental, and vision care, to medical students and residents which provides no less than the minimum benefits currently recommended by the AMA for employer-provided health insurance and to require enrollment in such insurance; (4) carriers offering disability insurance to: (a) offer a range of disability policies for medical students and residents that provide sufficient monthly disability benefits to defray any educational loan repayments, other living expenses, and an amount sufficient to continue payment for health insurance providing the minimum benefits recommended by the AMA for employer-provided health insurance; and (b) include in all such policies a rollover provision allowing continuation of student disability coverage into the residency period without medical underwriting. (5) Our AMA: (a) actively encourages medical schools, residency programs, and fellowship programs to provide access to portable group health and disability insurance, including human immunodeficiency virus positive indemnity insurance, for all medical students and resident and fellow physicians; (b) will work with the ACGME and the LCME, and other interested state medical societies or specialty organizations, to

develop strategies and policies to ensure access to the provision of portable health and disability insurance coverage, including human immunodeficiency virus positive indemnity insurance, for all medical students, resident and fellow physicians; and (c) will prepare informational material designed to inform medical students and residents concerning the need for both disability and health insurance and describing the available coverage and characteristics of such insurance.

2. Our AMA encourages medical schools to allow students and their families who qualify for and enroll in health insurance plans other than the institutionally offered health insurance plans, to be exempt from an otherwise mandatory student health insurance plan requirement, provided that the alternative plan has comparable care coverage and is accepted at the primary geographic locations of training.

3. Our AMA supports the continuation of comprehensive medical insurance benefits for inactive students taking an approved leave of absence during their time of degree completion and encourage medical schools to publicize their policies regarding the continuation of insurance benefits during leaves of absence. [Appended: Res. 304, I-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 305
(I-24)

Introduced by: New York

Subject: Removing Board Certification as a Requirement for Billing for Home Sleep Studies

Referred to: Reference Committee C

Whereas, 25-30% of men at 9-13% of women in the United States suffer from sleep apnea; and

Whereas, there is a shortage of board certified Sleep physicians to address this unmet public health threat; and

Whereas, the Center for Medicare and Medicaid Services (CMS) require onerous requirements for centers and physicians to even provide basic at home sleep testing[1]; and

Whereas, the American Academy of Sleep Medicine offers an alternative pathway for cardiologists not board certified in Sleep Medicine to seek accreditation in sleep apnea screening for OSA for $4500 for 5 years[2]; and

Whereas, this pathway is not offered to other licensed physicians and pathways for grandfathering of sleep certification were closed years ago and no post graduate pathway has been made available except leaving practice for a one year fellowship; and

Whereas, it has never been demonstrated that board certification in sleep apnea results in improved outcomes; therefore be it

RESOLVED, that our American Medical Association advocate that the appropriate bodies in United States government to remove Sleep Board Certification and facility accreditation as a requirement for the approval of and payment for home sleep studies. (Directive to Take Action)

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

Received: 9/24/2024

REFERENCES

1. https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=34040
Physician and Technician Requirements for Sleep Studies and Polysomnography Testing:
1. The physician performing the service must meet one of the following:
be a diplomate of the American Board of Sleep Medicine (ABSM);
OR
has a Sleep Certification issued by ONE of the following Boards:
American Board of Internal Medicine (ABIM),
American Board of Family Medicine (ABFM),
American Board of Pediatrics (ABP),
American Board of Psychiatry and Neurology (ABPN),
American Board of Otolaryngology (ABOto),
American Osteopathic Board of Neurology and Psychiatry (AOBNP),
American Osteopathic Board of Family Medicine, (AOBFP)
American Osteopathic Board of Internal Medicine, (AOBIM)
American Osteopathic Board of Ophthalmology and
Otorhinolaryngology (AOBOO);
OR
be an active physician staff member of a credentialed sleep center or laboratory that have active physician staff members meeting the criteria above in a or b.
2. Technician Credentials
The technician performing the service must meet one of the following:
American Board of Sleep Medicine (ABSM),
Registered Sleep Technologist (RST);
Board of Registered Polysomnographic Technologists (BRPT),
Registered Polysomnographic Technologist (RPSGT)
National Board for Respiratory Care (NBRC)
Certified Pulmonary Function Technologist (CPFT)
Registered Pulmonary Function Technologist (RPFT)
Certified Respiratory Therapist (CRT)
Registered Respiratory Therapist (RRT)

2. https://aasm.org/cardiology-practice-accreditation/

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 306
(I-24)

Introduced by: American College of Surgeons

Subject: Streamlining Continuing Medical Education Across States and Medical Specialties

Referred to: Reference Committee C

Whereas, continuing medical education (CME) is a requirement for maintaining licensure in almost every state and for maintenance of certification (MOC), Continuing Certification, or Continuous Certification across multiple medical and surgical specialty boards; and

Whereas, state medical licensing boards have differing CME requirements for licensure—without a common standard—while over 1 in 5 physicians hold an active license in more than one state; and

Whereas, federal entities, states, and medical specialty boards may require overlapping CME (e.g., U.S. Drug Enforcement Administration (DEA) opioid education along with state-specific opioid education mandates); and

Whereas, state and medical specialty boards may additionally require a proportion of CME to be of a specific type (e.g., contain a self-assessment component or be category 1 or 2); and

Whereas, CME across multiple state or medical specialty boards may require individual entry for each board, which can be repetitive, time consuming, and come at the expense of losing licensure; and

Whereas, simplified and central reporting of CME exists, such as the Program and Activity Reporting System (PARS) administered by the Accreditation Council for Continuing Medical Education (ACCME); and

Whereas, central reporting of CME is not universally implemented across all states and medical specialties requiring CME; therefore be it

RESOLVED, that our American Medical Association work with relevant stakeholders to minimize the financial and time burden of reporting continuing medical education, including but not limited to participation in a common reporting standard (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for medical specialty and state medical boards to continue to allow manual entry of continuing medical education until all boards and continuing medical education providers participate in a common reporting standard (Directive to Take Action); and be it further

RESOLVED, that our AMA work with relevant stakeholders to examine the feasibility of a single common continuing medical education requirement for maintaining state licensure (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate any continuing medical education that requires answering questions to be categorized as “Self-Assessment continuing medical education.” (Directive to Take Action

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

Received: 9/19/2024

References:
Young A., Chaudhry H.J., Pei A., Arnhart K., Dugan M., Simons K.B., (2021) “FSMB Census of Licensed Physicians in the United States, 2020” Journal of Medical Regulation 107(2), 58–59. N

Relevant AMA Policy:

H-300.969 Uniform Standards for Continuing Medical Education
The AMA (1) will continue its efforts to develop uniform standards for continuing medical education, and (2) will solicit input from all state medical associations, medical licensure boards, and national specialty organizations concerning the development of the most appropriate uniform standards for continuing medical education. [Res. 313, A-92; Reaffirmed: CME Rep. 2, A-03; Reaffirmed in lieu of Res. 901, I-05; Reaffirmed: CME Rep. 1, A-15]

An Update on Maintenance of Licensure D-275.957
Our American Medical Association will: 1. Continue to monitor the evolution of Maintenance of Licensure (MOL), continue its active engagement in discussions regarding MOL implementation, and report back to the House of Delegates on this issue.
2. Continue to review, through its Council on Medical Education, published literature and emerging data as part of the Council's ongoing efforts to critically review MOL issues.
3. Work with the Federation of State Medical Boards (FSMB) to study whether the principles of MOL are important factors in a physician's decision to retire or have a direct impact on the U.S. physician workforce.
4. Work with interested state medical societies and support collaboration with state specialty medical societies and state medical boards on establishing criteria and regulations for the implementation of MOL that reflect AMA guidelines for implementation of state MOL programs and the FSMB's Guiding Principles for MOL.
5. Explore the feasibility of developing, in collaboration with other stakeholders, AMA products and services that may help shape and support MOL for physicians.
6. Encourage the FSMB to continue to work with state medical boards to accept physician participation in the American Board of Medical Specialties maintenance of certification (MOC) and the American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) osteopathic continuous certification (OCC) as meeting the requirements for MOL and to develop alternatives for physicians who are not certified/recertified, and advocate that MOC or OCC not be the only pathway to MOL for physicians.
7. Continue to work with the FSMB to establish and assess MOL principles, with the AMA to assess the impact of MOL on the practicing physician and the FSMB to study its impact on state medical boards.
8. Encourage rigorous evaluation of the impact on physicians of any future proposed changes to MOL processes, including cost, staffing, and time. [CME Rep. 3, A-15 Modified: CME Rep. 2, I-15]

An Update on Maintenance of Licensure H-275.917
AMA Principles on Maintenance of Licensure (MOL):
1. Our American Medical Association (AMA) established the following guidelines for implementation of state MOL programs:
A. Any MOL activity should be able to be integrated into the existing infrastructure of the health care environment.
B. Any MOL educational activity under consideration should be developed in collaboration with physicians, should be evidence-based and should be practice-specific. Accountability for physicians should be led by physicians.

C. Any proposed MOL activity should undergo an in-depth analysis of the direct and indirect costs, including physicians' time and the impact on patient access to care, as well as a risk/benefit analysis, with particular attention to unintended consequences.
D. Any MOL activity should be flexible and offer a variety of compliance options for all physicians, practicing or non-practicing, which may vary depending on their roles (e.g., clinical care, research, administration, education).
E. Any MOL activity should be designed for quality improvement and lifelong learning.
F. Participation in quality improvement activities, such as chart review, should be an option as an MOL activity.

2. Our AMA supports the Federation of State Medical Boards Guiding Principles for MOL (current as of June 2015), which state that:
A. Maintenance of licensure should support physicians' commitment to lifelong learning and facilitate improvement in physician practice.
B. Maintenance of licensure systems should be administratively feasible and should be developed in collaboration with other stakeholders. The authority for establishing MOL requirements should remain within the purview of state medical boards.
C. Maintenance of licensure should not compromise patient care or create barriers to physician practice.
D. The infrastructure to support physician compliance with MOL requirements must be flexible and offer a choice of options for meeting requirements.
E. Maintenance of licensure processes should balance transparency with privacy protections (e.g., should capture what most physicians are already doing, not be onerous, etc.).

3. Our AMA will:
A. Continue to support and promote the AMA Physician's Recognition Award (PRA) Credit system as one of the three major CME credit systems that comprise the foundation for continuing medical education in the U.S., including the Performance Improvement CME (PICME) format, and continue to develop relationships and agreements that may lead to standards accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies, and other entities requiring evidence of physician CME as part of the process for MOL.
B. Advocate that if state medical boards move forward with a more intense or rigorous MOL program, each state medical board be required to accept evidence of successful ongoing participation in the ABMS MOC and AOA-Bureau of Osteopathic Specialists Osteopathic Continuous Certification to have fulfilled all three components of the MOL, if performed,
C. Advocate that state medical boards accept programs created by specialty societies as evidence that the physician is participating in continuous lifelong learning and allow physicians to choose which programs they participate in to fulfill their MOL criteria.
D. Oppose any MOL initiative that creates barriers to practice, is administratively unfeasible, is inflexible with regard to how physicians practice (clinically or not), does not protect physician privacy, or is used to promote policy initiatives about physician competence. [CME Rep. 3, A-15Modified: CME Rep. 2, I-15]

Continuing Board Certification D-275.954
1. Our American Medical Association will continue to monitor the evolution of Continuing Board Certification (CBC), continue its active engagement in discussions regarding their implementation, encourage specialty boards to investigate and/or establish alternative approaches for CBC, and prepare a report regarding the CBC process at the request of the House of Delegates or when deemed necessary by the Council on Medical Education.
2. Our AMA will continue to review, through its Council on Medical Education, published literature and emerging data as part of the Council’s ongoing efforts to critically review CBC issues.
3. Our AMA will continue to monitor the progress by the American Board of Medical Specialties (ABMS) and its member boards on implementation of CBC, and encourage the ABMS to report its research findings on the issues surrounding certification and CBC on a periodic basis.
4. Our AMA will encourage the ABMS and its member boards to continue to explore other ways to measure the ability of physicians to access and apply knowledge to care for patients, and to continue to examine the evidence supporting the value of specialty board certification and CBC.
5. Our AMA will work with the ABMS to streamline and improve the Cognitive Expertise (Part III) component of CBC, including the exploration of alternative formats, in ways that effectively evaluate acquisition of new knowledge while reducing or eliminating the burden of a high-stakes examination.

6. Our AMA will work with interested parties to ensure that CBC uses more than one pathway to assess accurately the competence of practicing physicians, to monitor for exam relevance and to ensure that CBC does not lead to unintended economic hardship such as hospital de-credentialing of practicing physicians.
7. Our AMA will recommend that the ABMS not introduce additional assessment modalities that have not been validated to show improvement in physician performance and/or patient safety.
8. Our AMA will work with the ABMS to eliminate practice performance assessment modules, as currently written, from CBC requirements.
9. Our AMA will encourage the ABMS to ensure that all ABMS member boards provide full transparency related to the costs of preparing, administering, scoring and reporting CBC and certifying examinations.
10. Our AMA will encourage the ABMS to ensure that CBC and certifying examinations do not result in substantial financial gain to ABMS member boards, and advocate that the ABMS develop fiduciary standards for its member boards that are consistent with this principle.
11. Our AMA will work with the ABMS to lessen the burden of CBC on physicians with multiple board certifications, particularly to ensure that CBC is specifically relevant to the physician's current practice.
12. Our AMA will work with key stakeholders to
a. support ongoing ABMS member board efforts to allow multiple and diverse physician educational and quality improvement activities to qualify for CBC.
b. support ABMS member board activities in facilitating the use of CBC quality improvement activities to count for other accountability requirements or programs, such as pay for quality/performance or PQRS reimbursement.
c. encourage ABMS member boards to enhance the consistency of quality improvement programs across all boards.
d. work with specialty societies and ABMS member boards to develop tools and services that help physicians meet CBC requirements.
13. Our AMA will work with the ABMS and its member boards to collect data on why physicians choose to maintain or discontinue their board certification.
14. Our AMA will work with the ABMS to study whether CBC is an important factor in a physician's decision to retire and to determine its impact on the US physician workforce.
15. Our AMA will encourage the ABMS to use data from CBC to track whether physicians are maintaining certification and share this data with the AMA.
16. Our AMA will encourage AMA members to be proactive in shaping CBC by seeking leadership positions on the ABMS member boards, American Osteopathic Association (AOA) specialty certifying boards, and CBC Committees.
17. Our AMA will continue to monitor the actions of professional societies regarding recommendations for modification of CBC.
18. Our AMA will encourage medical specialty societies' leadership to work with the ABMS, and its member boards, to identify those specialty organizations that have developed an appropriate and relevant CBC process for its members.
19. Our AMA will continue to work with the ABMS to ensure that physicians are clearly informed of the CBC requirements for their specific board and the timelines for accomplishing those requirements.
20. Our AMA will encourage the ABMS and its member boards to develop a system to actively alert physicians of the due dates of the multi-stage requirements of continuous professional development and performance in practice, thereby assisting them with maintaining their board certification.
21. Our AMA will recommend to the ABMS that all physician members of those boards governing the CBC process be required to participate in CBC.
22. Our AMA will continue to participate in the Coalition for Physician Accountability, formerly known as the National Alliance for Physician Competence forums.
23. Our AMA will encourage the PCPI Foundation, the ABMS, and the Council of Medical Specialty Societies to work together toward utilizing Consortium performance measures in Part IV of CBC.
24. Our AMA will continue to assist physicians in practice performance improvement.
25. Our AMA encourage all specialty societies to grant certified CME credit for activities that they offer to fulfill requirements of their respective specialty board's CBC and associated processes.
26. Our AMA will support the American College of Physicians as well as other professional societies in their efforts to work with the American Board of Internal Medicine (ABIM) to improve the CBC program.
27. Our AMA will oppose those maintenance of certification programs administered by the specialty boards of the ABMS, or of any other similar physician certifying organization, which do not appropriately adhere to the principles codified as AMA Policy on Continuing Board Certification.

28. Our AMA will ask the ABMS to encourage its member boards to review their maintenance of certification policies regarding the requirements for maintaining underlying primary or initial specialty board certification in addition to subspecialty board certification, if they have not yet done so, to allow physicians the option to focus on continuing board certification activities relevant to their practice.
29. Our AMA will call for the immediate end of any mandatory, secured recertifying examination by the ABMS or other certifying organizations as part of the recertification process for all those specialties that still require a secure, high-stakes recertification examination.
30. Our AMA will support a recertification process based on high quality, appropriate Continuing Medical Education (CME) material directed by the AMA recognized specialty societies covering the physician's practice area, in cooperation with other willing stakeholders, that would be completed on a regular basis as determined by the individual medical specialty, to ensure lifelong learning.
31. Our AMA will continue to work with the ABMS to encourage the development by and the sharing between specialty boards of alternative ways to assess medical knowledge other than by a secure high stakes exam.
32. Our AMA will continue to support the requirement of CME and ongoing, quality assessments of physicians, where such CME is proven to be cost-effective and shown by evidence to improve quality of care for patients.
33. Our AMA , through legislative, regulatory, or collaborative efforts, will work with interested state medical societies and other interested parties by creating model state legislation and model medical staff bylaws while advocating that Continuing Board Certification not be a requirement for:
a. medical staff membership, privileging, credentialing, or recredentialing.
b. insurance panel participation.
c. state medical licensure.
34. Our AMA will increase its efforts to work with the insurance industry to ensure that continuing board certification does not become a requirement for insurance panel participation.
35. Our AMA will advocate that physicians who participate in programs related to quality improvement and/or patient safety receive credit for CBC Part IV.
36. Our AMA will continue to work with the medical societies and the American Board of Medical Specialties (ABMS) member boards that have not yet moved to a process to improve the Part III secure, high-stakes examination to encourage them to do so.
37. Our AMA, through its Council on Medical Education, will continue to work with the American Board of Medical Specialties (ABMS), ABMS Committee on Continuing Certification (3C), and ABMS Stakeholder Council to pursue opportunities to implement the recommendations of the Continuing Board Certification: Vision for the Future Commission and AMA policies related to continuing board certification.
38. Our AMA, through its Council on Medical Education, will continue to work with the American Board of Medical Specialties (ABMS) and ABMS member boards to implement key recommendations outlined by the Continuing Board Certification: Vision for the Future Commission in its final report, including the development and release of new, integrated standards for continuing certification programs that will address the Commission's recommendations for flexibility in knowledge assessment and advancing practice, feedback to diplomates, and consistency.
39. Our AMA will work with the ABMS and its member boards to reduce financial burdens for physicians holding multiple certificates who are actively participating in continuing certification through an ABMS member board, by developing opportunities for reciprocity for certification requirements as well as consideration of reduced or waived fee structures.
40. Our AMA will continue to publicly report its work on enforcing AMA Principles on Continuing Board Certification.[CME Rep. 2, I-15 Appended: Res. 911, I-15 Appended: Res. 309, A-16 Appended: CME Rep. 02, A-16 Appended: Res. 307, I-16 Appended: Res. 310, I-16 Modified: CME Rep. 02, A-17 Reaffirmed: Res. 316, A-17 Reaffirmed in lieu of: Res. 322, A-17 Appended: CME Rep. 02, A-18 Appended: Res. 320, A-18 Appended: Res. 957, I-18 Reaffirmation: A-19 Modified: CME Rep. 02, A-19 Appended: CME Rep. 1, I-20 Appended: Res. 310, A-21 Modified: CME Rep. 2, A-22 Appended: Res. 310, I-22 Reaffirmed in lieu of: Res. 302, A-24 Reaffirmed in lieu of: Res. 316, A-24]

Reference Committee F

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607 AMA House of Delegates Venues

REPORT OF THE BOARD OF TRUSTEES

B of T Report 16-I-24

Subject: AMA Reimbursement of Necessary HOD Business Meeting Expenses for Delegates and Alternates (Resolution 606-A-23)

Presented by: Michael Suk, MD, JD, MPH, MBA, Chair

Referred to: Reference Committee F

At the 2023 Annual Meeting of the American Medical Association (AMA) House of Delegates (HOD) Resolution 606, "AMA Reimbursement of Necessary HOD Business Meeting Expenses for Delegates and Alternates" was referred to the Board of Trustees for a report back to the HOD. The Reference Committee heard mixed testimony, including compelling testimony from the Board of Trustees regarding their fiduciary responsibility to our AMA and the need to allow sufficient time to identify and fully assess the impact on our AMA. An informational report was provided at the 2024 Annual Meeting.

Resolution 606-A-23 asked:

> That our American Medical Association develop a reimbursement policy consistent with established AMA travel policies for reasonable travel expenses that any state or national specialty society is eligible to receive reimbursement for its delegate's and alternate delegate's actual expenses directly related to the necessary business functions required of its AMA delegates and alternate delegates in service to the AMA at HOD meetings, including travel, lodging, and meals; and
>
> That each state or national specialty society requesting such reimbursement for its delegate's and alternate delegate's reasonable travel expenses will submit its own aggregated documentation to the AMA in whatever form is requested by the AMA.

BACKGROUND

Resolution 606-A-23 highlighted the significance of the AMA HOD as a policy-making body with diverse voices being represented through the delegations. The resolution focuses on the costs that are incurred by the organizations sending delegates and alternates to the meetings without discussing the costs of the meeting to the AMA. The resolution pointed out that several state and specialty medical societies are facing financial hardships due to several factors, including declining membership. As these organizations are looking to cut costs, not sending their full complement of delegates and alternate delegates to the AMA HOD meetings could be seen as a savings. In some instances, delegates pay their own expenses to attend AMA HOD meetings so they can be a part of the robust policy-making process.

Your AMA Board is acutely aware of the high cost to the Federation of attending AMA HOD meetings as the AMA is already spending approximately $12 million annually to host these meetings. If the AMA were to adopt this resolution, an estimated $8.1 million would be added to the cost for our governance meetings. An expenditure of this magnitude annually needs careful

consideration including all factors that would contribute to this expenditure with feasible options for reducing the overall costs, while maintaining the fiduciary responsibility of the Board and protecting the governance of the association.

LISTENING SESSIONS

Following the 2024 Annual HOD meeting, the Board of Trustees hosted three listening sessions with members of the HOD and Federation staff. Over 100 state and specialty society delegates and executives participated. The purpose of the calls was to gather information and assess recommendations or other options for mitigating the costs of the HOD meetings.

It is understood that sending a delegation to an AMA HOD meeting can be seen as a financial burden for state and specialty societies that are experiencing financial strains. It was also expressed that certain societies have chosen to prioritize other activities or programs within their society over sending a full delegation to an AMA HOD meeting.

The decline in professional medical society membership can be attributed to several environmental factors, including a rapidly evolving health care landscape, shifts in professional priorities among younger physicians, and challenges in adapting to modern business models. Many medical societies rely on traditional membership-based revenue models, which may not align with the expectations of younger physicians who seek more immediate, tangible benefits from their affiliations, such as digital resources, networking opportunities, and career support or alternatively find most of their needs met through their employers. Additionally, younger physicians are often burdened with substantial student debt and face time constraints due to demanding work schedules, making them less willing to pay for memberships that do not provide clear value. Resistance to generational change within these societies can further exacerbate the decline, as established leaders may be hesitant to embrace new technologies, flexible engagement methods, and innovative services that appeal to younger members. Furthermore, the rise of online communities and free educational resources has diminished the perceived need for traditional society memberships, as physicians can access information and professional networks more conveniently and cost-effectively through digital platforms and their employers.

The following categories of costs associated with attending AMA HOD meetings and potential ways to mitigate their costs were raised during the listening sessions.

Costs associated with On-site Meetings

1) Travel-Associated Costs

   Cost mitigation strategies for hosting large medical conferences at hotels that focused on optimizing expenditures without compromising the quality and impact of the event.

   a. Negotiating contracts with venues to include discounts on food and beverage services, such as opting for buffet-style meals or selecting less expensive menu options that still cater to dietary needs and preferences. Since meeting venues negotiate an overall package, this may simply shift current discounts from one category to another.
   b. Choosing venues in less expensive cities or during off-peak seasons can also result in significant savings. This item was raised by multiple participants over all three days. It was recognized that current AMA policy G-630.140, Lodging, Meeting Venues, and Social Functions, limits options for venues and can only be changed through affirmative action of the House of Delegates.

c. Utilizing convention centers, which may offer more flexible pricing and amenities tailored for large events, may help reduce venue costs compared to traditional hotel settings. However, these cost savings may be offset by losing discounts attained when meeting rooms and hotel sleeping rooms are reserved at the same facility and additional transportation costs to move between hotel and convention center. In addition, this option could impose challenges to those who have impaired mobility or other disabilities.
d. Leveraging technology to provide virtual participation options can lower the need for physical space and associated expenses.
e. Partnering with local vendors and suppliers can further decrease costs, while consolidating event components such as audiovisual services through bundled packages can lead to better pricing.

2) Time commitment

In addition to the financial concerns, the time spent preparing and attending HOD meetings was given as an added challenge for delegates and alternates, particularly those in private practice. Extended time away from family and patients was a repeated concern. It was conveyed that not only are the costs of the meeting, but also the time spent preparing and attending the meeting are major concerns that the Board of Trustees must consider. Several delegates voiced support for shortening the meeting and revisiting the elimination and/or structure of the Interim meeting. The suggestions included changing one or both HOD meetings to a fully or partially virtual format or hybrid meeting, shortening the meetings, and eliminating one meeting a year. There is the potential for many delegates and alternates to benefit by attending shorter meetings and having less time away from their practices.

3) Corporate Sponsorship

Medical specialty organizations employ a variety of strategies to finance their annual meetings and conferences, balancing income streams from corporate sponsorships, registration fees, and educational grants. Corporate sponsorships often represent a significant portion of funding, with companies in the pharmaceutical, medical device, and technology sectors contributing funds in exchange for opportunities to showcase their products and services. These sponsorships can include exhibitor booths, branded sessions, or other promotional activities. Payment for educational sessions is another revenue stream, where attendees pay to participate in workshops, seminars, or continuing medical education activities. Organizations may also receive educational grants from industry partners, which are typically earmarked for specific educational content and must adhere to guidelines to maintain educational integrity and independence. Additional funds may come from advertising in conference materials and ancillary events like social gatherings or fundraising dinners. The strategic flow of these funds is carefully managed to cover the costs of venue rental, speaker fees, technology, and logistics, ensuring that the event provides value to both attendees and sponsors while aligning with the organization's mission and educational goals. However AMA policy G-630.040, Principles on Corporate Relationships, addresses situations where our AMA cannot utilize external funding and states “Funding core governance activities from corporate sponsors, i.e., the financial support for conduct of the House of Delegates…could make our AMA become dependent on external funding for its existence or could allow a supporter, or group of supporters, to have undue influence on the affairs of the AMA.”

4) Financial Assistance

While listening session participants suggested a variety of approaches, overall financial assistance to support delegates and alternates attending the meetings was the most mentioned option, pointing to the resolution's original language as a "quick fix" to a complex situation, while recognizing that the complexity indicates a need for a multi-phase solution. Resolution 606-A-23 called for each state or national specialty society to request reimbursement for its delegates' and alternate delegates' reasonable travel expenses by submitting aggregated documentation to the AMA in whatever form is requested by the AMA. Alternatively, a grant program or request for support, was suggested as an option for those organizations who need assistance as a temporary support mechanism to maintain participation in the HOD.

Based on a financial analysis of 178 constituent and specialty societies, the AMA understands the financial landscape of the Federation. There appears to be an immediate need to provide support for some delegations if the AMA is to maintain the strong policy making process that is currently in place. At the same time, and before attempting to solve the problem, a deeper understanding of the issue needs to be obtained. There are extenuating factors that should be examined:(1) societies with a financial challenge who need to direct their resources internally; and (2) societies with resources available who are deciding not to fund AMA delegations. Without some understanding of each individual situation, it is difficult to determine a solution that is appropriate for all situations over the long term, while still maintaining AMA's fiduciary obligations. A temporary solution could solve the immediate need of delegations in societies facing financial pressure to maintain an active presence at AMA HOD meetings. Support for those delegations in need of additional assistance could provide emergency relief while providing time to find a long-term solution that supports the sustainability of the AMA HOD while also acting as a responsible fiduciary for the AMA. Your Board needs to examine all aspects of the current HOD meeting and find areas that can be refined to offer increased value and lower costs for all participants.

Implementation of newly adopted changes on Introducing Business to the AMA House, G-600.060, may also yield savings yet-to-be realized.

OTHER CONSIDERATIONS

Further considerations must be made about the financial implications of comprehensively implementing a policy such as Resolution 606-A-23 calls for, including the financial status of the AMA and the Federation organizations that would be impacted by such a policy. While funding delegate/alternate travel to AMA meetings would not immediately threaten the AMA's financial standing, it would adversely affect the AMA's efforts in other key areas that support physician practices. It is crucial to understand that AMA financial policy provides for ongoing sustainable operations and programmatic activities for both the short- and long-term. By policy, any expenditures above the current budget levels will require reducing expenses from other areas of the annual budget. Such expenditures would reduce financial allocations that support other programmatic activities such as advocacy, health equity, improving health outcomes, public health. If this resolution were adopted, that would result in an ongoing annual $8.1 million cost reduction in other programs, which at the current rate of inflation would cost almost $100 million over the next ten years.

<u>Tax Implications</u>

AMA's tax-exempt status and the regulations under which it operates to maintain that status is a key consideration when determining if or how to provide benefits or contributions to individuals or organizations. AMA's tax counsel has advised that generally the IRS has found that the provision

of financial benefits to members in certain situations will constitute private inurement which will result in the loss of tax-exempt status. Counsel did advise that the IRS has consistently viewed paying the reasonable travel expenses of volunteers, particularly those who have a defined role in governance, as being acceptable and not treated as compensation which in this case would cover those attendees with an official role, delegates and alternate delegates, and thus led to the language of the resolution submitted to the HOD.

Further discussions with tax counsel have resulted in another potential alternative to direct reimbursement: providing travel grants to societies in the HOD to cover or partially cover direct out-of-pocket expenses for delegates and alternate delegates based on financial need of the organization they represent in the HOD. Under this alternative, counsel recommended the following criteria:1) the travel grants be limited to societies that demonstrate financial need; 2) the travel grants be specifically identified as grants to cover travel reimbursement only for voting delegates and alternate delegates who participate in the HOD meetings, enabling delegates to participate in discussions regarding important issues affecting AMA and the medical profession; 3) the grant agreement between AMA and the society require that the funds are for reimbursement of incurred travel expenses in a manner that is consistent with 501(c)(6) purposes; and 4) that AMA establish a cap on the amount that any one society can receive for reimbursement of travel expenses.

DISCUSSION

Your Board of Trustees has approached this report with two elements weighing heavily: (1) the fiduciary responsibility of the Board of Trustees to make sound, reasonable and prudent financial decisions and (2) the need to have a policy-making process that includes representatives from across the Federation. With myriad issues influencing AMA HOD participation, your Board of Trustees has determined that one report cannot address all the issues that are contributing to the current financial situation across the Federation that limit or threaten to limit participation in the policy-making process. However, the Board recognizes that there is an immediate need to provide relief to several societies to maintain a vibrant HOD and is committed to providing that relief in a temporary emergency assistance program. At the same time, your Board of Trustees also recognizes the need for further examination of the factors that are creating the current situation and will form an ad hoc work group of the Board to continue to look at ways to mitigate costs, explore solutions, and maintain participation in order to reduce the financial burden on all parties over the long term.

Emergency Assistance Program: In the near term, your Board of Trustees will establish an emergency assistance program that will be funded at no more than $1 million per year for two years, to be discontinued after I-26. The purpose of this temporary assistance program will be to offer financial relief to Federation organizations to support the funding of delegates and alternates to attend the AMA Annual and Interim HOD meetings. The funding will be made available as a grant to societies who are deemed to spend a greater percentage of their annual revenue to support their AMA delegation than the AMA spends on the Annual and Interim meetings (based on an average cost estimate per delegate for all societies and using the most recent Form 990 available). The AMA will provide the society $300 per day per delegate and alternate delegate that will be required to be used for expenses related to the AMA HOD meetings. This amount was based on Internal Revenue Service guidelines for allowable per diem amounts to eliminate the need for documentation of expenses and avoid any tax issues. Each society that is deemed eligible to receive assistance will need to provide a formal request to the AMA to receive funding. The funds will be paid directly to the society, not to the individual delegates and alternates, but will be limited to use for defraying the costs for delegates and alternate delegates to attend the AMA HOD meetings.

Shorter Meetings: Additionally, to defray costs, the AMA will compress the schedule of both the Annual and Interim Meetings by eliminating one day from each meeting, thereby ending each meeting a day earlier. This schedule will be implemented at the Annual 2025 meeting of the HOD. It is estimated that this will reduce the cost to societies by a minimum of $1.4 million per year and benefit many delegates and alternates by requiring less time away from their practices.

Ongoing Efforts to Mitigate Costs: Finally, the Board of Trustees will continue to examine all aspects of our policy-making process to determine efficiencies, which will result in cost mitigations for all who participate. As part of this examination, the Board ad hoc committee will evaluate meeting venues, locations, options for methods of participation, economies of scale related to food and beverage and audio-visual costs, and all other aspects that contribute to the cost of the meetings and report back at I-25 and I-26 at the conclusion of the program.

RECOMMENDATIONS

The AMA recognizes that engagement by the organizations who send representatives to our HOD meetings to participate in the policy-making process is essential to the strength of organized medicine. Your Board of Trustees is committed to supporting attendance at AMA HOD meetings, providing immediate financial relief on a short-term emergency basis, and developing a plan for long-term sustainable participation. Therefore, your Board of Trustees recommends that Resolution 606-A-23 not be adopted and the remainder of this report be filed.

Fiscal Note: $2 million

REPORT OF THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

CLRPD Report 1-I-24

Subject: Academic Physicians Section Five-Year Review

Presented by: Michelle Berger, MD, Chair

Referred to: Reference Committee F
(Rebecca L. Johnson, MD, Chair)

American Medical Association (AMA) Bylaw 7.0.9 states, "A delineated section must reconfirm its qualifications for continued delineated section status and associated representation in the House of Delegates by demonstrating at least every 5 years that it continues to meet the criteria adopted by the House of Delegates." AMA Bylaw 6.6.1.5 states that one function of the Council on Long Range Planning and Development (CLRPD) is "to evaluate and make recommendations to the House of Delegates, through the Board of Trustees, with respect to the formation and/or change in status of any section. The Council will apply criteria adopted by the House of Delegates."

APPLICATION OF CRITERIA

The Council analyzed information from a letter of application submitted in November 2023 from the Academic Physicians Section (APS) for renewal of delineated section status and continued representation in the AMA House of Delegates (HOD). APS leadership also responded to a follow-up query from the Council, providing further details on several points. This portion of the report presents each criterion and related information provided by the Section. The information in this report focuses on activities beginning in June 2019.

Criterion 1: Issue of Concern - Focus will relate to concerns that are distinctive to the subset within the broader, general issues that face medicine. A demonstrated need exists to deal with these matters, as they are not currently being addressed through an existing AMA group.

The APS remains the only AMA constituent group focused specifically on the perspectives of academic physicians. Following an administrative move from Medical Education to Governance/Marketing and Member Experience, the APS began an annual strategic planning process along with all other AMA sections. This process includes APS Governing Council (GC) attendance at the annual Sections Leadership Retreat, leading to greater awareness of the work of the APS and increased opportunities for strategic alliances with other sections.

The APS identified the following issues/concerns on which the Section is currently prioritizing and on which the Section has focused over the last five years:

1. Payment and reimbursement issues specific to academic physicians graduate medical education funding and sustainability
2. Workforce and the "physician supply chain"
3. Diversity, equity, inclusion, and belonging (DEIB)
4. Physician wellness
5. Scope of practice

The APS, often in collaboration with other AMA constituent groups, hosts many educational programs to address their prioritized issues of concern.

At the 2019 Annual Meeting of the HOD, the APS collaborated with the Medical Student Section (MSS) to host an educational session, "Connecting the dots: Unprofessional behavior, mistreatment, impairment, and their impact on burnout in education and practice." At its I-19 meeting, the APS held an educational session, "Recruiting, Retaining, 'Retraining,' and Rewarding Community Physicians." At the November 2020 and 2021 meetings, respectively, the APS convened the educational sessions, "Impacts on the medical education 'supply chain' in the residency program application and selection process" and "Racial diversity in the academic physician 'supply chain'." In May 2021, the APS developed a webinar, "Scope of practice issues that will impact current trainees' practice environment," in collaboration with the Medical Student Section and Resident and Fellow Section. At the June 2021 meeting, the APS partnered with the AMA Minority Affairs Section (MAS) on the educational session "African, Black, and Caribbean Voices: Patient narratives as a means to counter racism and unconscious bias in medicine." In April 2022, the APS presented a webinar on wellness specific to academic physicians, featuring lead AMA staff from Professional Satisfaction and Practice Sustainability and the Center for Health Equity, and the June 2022 APS meeting featured a talk on AMA medical education support for equity, diversity, and belonging by lead medical education staff involved in DEIB. Two APS education sessions were held at the Section's 2023 Annual and Interim meetings: "Career Threats in an RVU-Driven World" and "Show Them What You're Worth: Educational Value Units (EVUs) in Academic Medical Practice." In addition, the APS presented a webinar in October 2023, "How to recruit, orient, and retain community preceptors."

Attendee evaluations have shown these sessions to be consistently well received. The sessions have helped provide strategies to aid academic physicians and their respective institutions. The Section intends to use both educational and policy development tactics to enhance the focus on their prioritized issues. The APS stated its intention to apply a DEIB perspective to all its educational programming and will work to ensure that any resolutions that come from the Section reflect the principles of DEIB where appropriate and applicable. The APS has collaborated with other sections (e.g., the MAS and MSS as exemplified above) as well as AMA business units, including Improving Health Outcomes, the Center for Health Equity, and Professional Satisfaction and Practice Sustainability to convene internal AMA experts on relevant subjects and provide the highest quality of continuing medical education (CME) content.

The issues listed above reflect many of the overarching concerns expressed by physicians and verified through member and nonmember surveys and feedback. Through attention to and awareness of the AMA's strategic priorities and objectives, the APS acts on issues most relevant to medical education and academic physician practice. Such work helps extend awareness of the AMA's mission to a larger audience and leads to increased participation in the APS (and the AMA) among academic physicians.

Criterion 2: Consistency - Objectives and activities of the group are consistent with those of the AMA. Activities make good use of available resources and are not duplicative.

The APS has been intentional in its efforts to reflect AMA strategic objectives throughout its educational and policy development processes. Addressing large-scale AMA issues such as scope of practice, physician wellness, and health equity to its academic physician members helps expand the AMA message and its Recovery Plan for America's Physicians to core APS members. Specifically, the Section has been involved with the ChangeMedEd initiative, the activities of which are promoted directly to core APS members. In September 2023, the APS partnered with the

Medical Education unit to feature APS as part of the AMA exhibit at ChangeMedEd 2023, a national conference bringing together leaders and innovators in medical education and related health care fields to accelerate change in medical education across the continuum and transform the way future physicians and residents are trained.

Section leadership and staff are in discussion with AMA membership staff (Health System Partners program) to determine how APS and its engagement and policymaking opportunities might be presented as part of the value proposition for group membership for academic institutions.

Criterion 3: Appropriateness - The structure of the group will be consistent with its objectives and activities.

The primary opportunity for APS members to participate in APS activities occurs during the Section's twice-annual meetings in June and November. The institution of twice-annual webinars has helped to extend awareness of and engagement with the APS in the interim between the two face-to-face meetings. These sessions also create additional opportunities for sharing topics and information outside the June and November meetings. Participation in the nine-member GC of APS provides a pathway for professional development and leadership, and the structure of the Section provides for a bridge of information, awareness, and knowledge to and from the AMA to leadership and faculty at academic medical centers. The Section's recently developed the Resolutions/Policy Committee and Medical Education Committee that have created additional opportunities for engagement of APS members and have helped reduce the workload on the GC, allowing a more strategic approach to the Section's goals.

Email communications to the APS listserv provide news and updates on key APS and AMA activities. The academic physician segment of AMA MedEd Update is the de facto newsletter for the Section, unlike other sections that have their own dedicated communications. The APS noted this as a possible area of improvement, to ensure more standardized and predictable email communications to APS members, versus the ad hoc emails to the APS listserv.

Other opportunities for participation include:

- Engaging in the APS Resolutions/Policy Committee and CME Committee
- Informing Section policies, products, and services through participation in surveys and focus groups
- Participating as a student in educational programming tailored to develop the knowledge, skills, and attitudes that faculty physicians need to effectively prepare the next generation of physicians
- Networking and interacting with peers who have similar interests at other institutions, multiplying the prospects for success beyond what any one individual or institution could achieve on its own
- Involvement and engagement with the ChangeMedEd initiative, through participation in its webinars and other meetings

Criterion 4: Representation Threshold - Members of the formal group would be based on identifiable segments of the physician population and AMA membership. The formal group would be a clearly identifiable segment of AMA membership and the general physician population. A substantial number of members would be represented by this formal group. At minimum, this group would be able to represent 1,000 AMA members. It is important to note this threshold will

not be used to determine representation as each new group will be allocated only one delegate and one alternate delegate.

AMA Bylaws specify three avenues for APS membership among active physician members of the AMA: appointment by the dean of any United States medical school with an educational program; elective membership of those with a faculty appointment at a United States medical school with an educational program; elective membership of those who have an active role in undergraduate, graduate or CME or who serve in a clinical/research capacity with an academic medical center, community hospital, or other health care setting. Previous attempts to quantify academic physicians using available AMA data concluded that there were approximately 20,000 physicians engaged in "medical teaching" and/or employed by a medical school, with approximately 2,500 AMA members among them. Given the more expansive definition of potential APS membership as defined by AMA Bylaws, it is estimated that there may be as many as 80,000 academic physicians in the United States, and as many as 10,000 AMA members among them.

Criterion 5: Stability - The group has a demonstrated history of continuity. This segment can demonstrate an ongoing and viable group of physicians will be represented by this section and both the segment and the AMA will benefit from an increased voice within the policymaking body.

APS membership has grown from 513 to 573 since the Section's 2019 renewal of delineated section status, an increase of 11.7 percent. Between 35 and 263 APS members have attended each of the Section's meetings since A-19, with a median attendance of 52.5 members per meeting. The APS webinars implemented in 2022 have seen an average of 35 participants per session.

The APS has instituted a periodic new member orientation and networking session at recent meetings to ensure that new meeting attendees and new members feel welcome and gain an understanding of the Section's role within the AMA. The Section has developed an updated member application to help make membership operations more efficient and effective. The APS has also engaged in numerous discussions and collaborative activities with other sections, such as the Young Physicians Section (YPS), Organized Medical Staff Section, and Senior Physicians Section, to raise awareness of the opportunities for cross-memberships across different sections. In a positive sign of change, a growing number of YPS members are seeking to "graduate" from the YPS to the APS as they transition out of eligibility for YPS membership.

The Section has seen strong interest in GC positions and has been mindful of situations in which GC members are elected to new positions in lieu of new GC members. Collaboration with other sections has helped increase opportunities for joint work on, when appropriate, policy issues and educational topics. An additional venue for leadership opportunities for GC members is through serving as an APS liaison to the Council on Medical Education. One individual on the GC is elected as APS liaison to the Council and three other GC members are appointed to serve as ex officio liaisons to the undergraduate, graduate, and CME committees of the Council. These individuals report back to the APS as to the activities of the Council and work to ensure that the APS perspective is reflected in Council on Medical Education reports as they are being drafted.

Criterion 6: Accessibility - Provides opportunity for members of the constituency who are otherwise under-represented to introduce issues of concern and to be able to participate in the policymaking process within the AMA House of Delegates (HOD).

As the only AMA component group that represents the perspectives of academic physicians, the APS ensures that the AMA carries on its historic role in medical education standards and excellence, which was a catalyst for the AMA's founding in 1847. The AMA Section on Medical

Schools (now APS) was established in 1976 to "allow more direct participation in the AMA by physician members who are active in medical school administration." (AMA Board of Trustees Report P C-76). A 1979 AMA brochure noted that "The purpose of the Section is to provide a formal structure for medical educators to participate directly in the deliberation of the AMA House of Delegates; and to provide a forum for review, discussion, and development of recommendations and policies on national medical education and health care issues."

The APS, through the genesis of its Resolutions/Policy Committee, has taken a more active role in policy development in the HOD, and has sent six resolutions to the HOD since the 2020 Interim Meeting of the HOD. The APS also contributes to HOD reports—reports of the Council on Medical Education in particular—through the work of the APS liaison to the Council on Medical Education and GC members who are appointed to serve as ex officio liaisons to the undergraduate, graduate, and CME committees of the Council. The APS has worked to focus on issues affecting medical education and academic physicians. The GC carefully reviews potential policy and curates what is sent forward to the HOD. During the Section's twice-annual meetings members are invited to take part in the review of medical education reports/resolutions, voice opinions during debate and vote on the recommended APS action. At its meeting on the Friday prior to HOD meetings, the APS GC reviews all relevant HOD business items and develops a consent calendar for consideration by the entire APS membership. These recommendations are shared with APS members during the APS business meeting, with sufficient time for review, deliberation, dialogue, and voting. Members are also invited to join the Resolutions/Policy Committee. In addition, the APS reviews and assesses testimony on a wide variety of reports and resolutions that are considered by the HOD at its annual and interim meetings.

The Section previously formed the Academic Medicine Caucus, which from 2011 to 2019 helped reach a broader swath of current and potential members (i.e., those who attend the AMA HOD meeting on behalf of their state or specialty delegation but may not be involved in AMA sections) and reviewed proposed AMA policy (including the positions of the APS on the various HOD items). The integrated relationship between the two bodies helped ensure a more encompassing and holistic front for all academic physicians in the HOD and AMA policymaking processes. The Section noted that it was considering the possible reintroduction of this caucus.

DISCUSSION

The APS is the only section that represents the perspectives of academic physicians and focuses on issues that are significant and not currently being addressed through another existing AMA group. Since its previous five-year review, the Section has enhanced its strategic planning process in collaboration with the other AMA sections. This has facilitated collaboration and the selection of areas of focus and initiatives that align with the AMA's strategic direction. The Section's participation in the ChangeMedEd initiative, among other collaborations with other AMA groups and business units, demonstrates the APS's desire to contribute to and work towards the broader goals of the Association.

The structure of the APS allows members to participate in the deliberations and pursue the objectives of the Section, and the APS Listserv provides news and updates on key APS and AMA activities and provides networking and leadership opportunities for Section members. The Section has made strides to expand its membership through thoughtful collaborations with other AMA sections, in particular the MSS and YPS. The APS maintains regular communication with medical student leadership by including the chair of the MSS GC in monthly APS GC meetings. This relationship has increased awareness of and participation in APS events among medical students. The APS has worked with MSS leadership to change the perception of AMA among medical

school leadership and faculty, thereby increasing the likelihood of these leaders supporting their students' participation in AMA activities. For example, with support from APS, MSS and student membership staff now host a quarterly "faculty advisor training" to provide information about AMA initiatives and discuss how faculty advisors can best support MSS members/chapters at their institutions. The APS and MSS have discussed how the sections might work together to provide mentorship opportunities for medical students. These efforts demonstrate not only a desire to expand the scope of APS, but also to provide support to medical students and amplify the work of the AMA to the overall health care community.

The Section has demonstrated a desire to self-assess and has thoughtfully considered possible improvements that could be made to its current communications and governance strategies including the possible implementation of section-specific communications and the reorganization of the Academic Medicine Caucus.

The APS has a history of more than 40 years at the AMA and has introduced or significantly contributed to resolutions and reports that resulted in new policies that have benefitted both the AMA HOD, academic physicians and the entire health care community The Section provides numerous ways for its constituents to speak on issues and business items relevant to the work of the Section, and allows more direct participation in the AMA by physician members.

The Council appreciates the thorough work of APS leadership and staff in completing this letter of application and follow up communications, as well as the deliberation of the Section as it looks to improve upon its already commendable work in the future.

CONCLUSION

The CLRPD has determined that the APS meets all required criteria, and it is therefore appropriate to renew the delineated section status of the APS.

RECOMMENDATIONS

The Council on Long Range Planning and Development recommends that our American Medical Association renew delineated section status for the Academic Physicians Section through 2029 with the next review no later than the 2029 Interim Meeting. (Directive to Take Action)

Fiscal Note: Within current budget

REVISED

REPORT OF THE HOUSE OF DELEGATES COMMITTEE ON THE COMPENSATION OF THE OFFICERS

Compensation Committee Report, I-2024

Subject: REPORT OF THE HOUSE OF DELEGATES COMMITTEE ON THE COMPENSATION OF THE OFFICERS

Presented by: Evelyn Lewis, MD, Chair

Referred to: Reference Committee F

This report by the committee at the November 2024 Interim Meeting includes several recommendations and documents the compensation paid to Officers for the period July 1,2023 through June 30, 2024, including 2023 calendar year IRS reported taxable value of benefits, perquisites, services, and in-kind payments for all Officers.

BACKGROUND

At the 1998 Interim Meeting, the House of Delegates (HOD) established a House Committee on Trustee Compensation, currently named the Committee on Compensation of the Officers, (the "Committee"). The Officers are defined in the American Medical Association's (AMA) Constitution and Bylaws. (Note: under changes to the Constitution previously approved by the HOD, Article V refers simply to "Officer," which includes all 21 members of the Board among whom are President, President-Elect, Immediate Past President, Secretary, Speaker and Vice Speaker of the HOD, collectively referred to in this report as Officers.) The composition, appointment, tenure, vacancy process and reporting requirements for the Committee are covered under the AMA Bylaws. Bylaws 2.13.4.5 provides:

> The Committee shall present an annual report to the House of Delegates recommending the level of total compensation for the Officers for the following year. The recommendations of the report may be adopted, not adopted, or referred back to the Committee, and may be amended for clarification only with the concurrence of the Committee.

At A-00, the Committee and the Board jointly adopted the American Compensation Association's definition of total compensation which was added to the Glossary of the AMA Constitution and Bylaws. Total compensation is defined as the complete reward/recognition package awarded to an individual for work performance, including: (a) all forms of money or cash compensation; (b) benefits; (c) perquisites; (d) services; and (e) in-kind payments.

Since the inception of this Committee, its reports document the process the Committee follows to ensure that current or recommended Officer compensation is based on sound, fair, cost-effective compensation practices as derived from research and use of independent external consultants, expert in Board compensation. Reports beginning in December 2002 documented the principles the Committee followed in creating its recommendations for Officer compensation.

CASH COMPENSATION SUMMARY

The cash compensation of the Officers shown in the following table will not be the same as compensation reported annually on the AMA's IRS Form 990s because Form 990s are based on a calendar year. The total cash compensation in the summary is compensation for the days these officers spent away from home on AMA business approved by the Board Chair. The total cash compensation in the summary includes work as defined by the Governance Honorarium, Per Diem for Representation and Telephone Per Diem for External Representation. Detailed definitions are in the Appendix.

The summary covers July 1, 2023 to June 30, 2024.

AMA Officers	Position	Total Compensation	Total Days
David H Aizuss, MD	Secretary	$ 72,600	61
Toluwalase A Ajayi, MD	Officer	$ 71,900	55
John H. Armstrong, MD	Vice Speaker, House of Delegates	$ 80,300	59.5
Geralyn R. Breig	Officer	-	2
Madelyn E. Butler, MD	Officer	$ 81,000	55
Alex Ding, MD, MS, MBA	Officer	$ 90,100	70
Willarda V Edwards, MD, MBA	Officer	$ 85,900	52.5
Lisa Bohman Egbert, MD	Speaker, House of Delegates	$ 119,500	91
Jesse M Ehrenfeld, MD, MPH	President	$ 290,160	194
Scott Ferguson, MD	Officer	$ 76,100	50
Sandra Adamson Fryhofer, MD	Immediate Past Chair	$ 115,300	87
Melissa J. Garretson, MD	Officer	-	2.5
Marilyn Heine, MD	Officer	$ 76,800	58
Lynn Jeffers, MD, MBA	Officer	-	3
Pratistha Koirala, MD	Officer	$ 71,900	41.5
Ilse R Levin, DO, MPH & TM	Officer	$ 81,700	50.5
Thomas J Madejski, MD	Officer	$ 91,500	61
Bobby Mukkamala, MD	Officer	$ 89,400	61.5
Harris Pastides, PhD, MPH	Officer	$ 67,000	40
Jack Resneck, Jr, MD	Immediate Past President	$ 284,960	134
Bruce A Scott, MD	President-Elect	$ 289,160	113.5
Aliya Siddiqui, MS	Officer	$ 106,200	88.5
Michael Suk, MD, JD, MPH, MBA	Chair-Elect	$ 207,480	83
Willie Underwood, III, MD, MSc, MPH	Chair	$ 280,280	134.5
David Welsh, MD, MBA	Officer	-	2

President, President-Elect, Immediate Past President, and Chair
In 2023-2024, each of these positions received an annual Governance Honorarium which was paid in monthly increments. These four positions spent a total of 576 days on approved Assignment and Travel, or on average, 144 days each.

Chair-Elect
This position received a Governance Honorarium of approximately 75% of the Governance Honorarium provided to the Chair.

All Other Officers
All other Officers received cash compensation, which included a Governance Honorarium of $67,000 paid in monthly installments.

Assignment and Travel Days
As defined, these are Travel Days that are approved by the Board Chair to externally represent the AMA and for Internal Representation above 11 days. These days were compensated at a per diem rate of $1,400. The total Assignment and Travel Days for all Officers (excluding the President, President-Elect, Immediate Past President and Chair) were 1,074.5.

EXPENSES

Total expenses paid for period, July 1, 2023 – June 30, 2024, was $1,131,759, without use of upgrade allowance of $5,000 for Presidents and $2,500 all other Officers per position per term. Total upgrade allowances used for the period were $32,741.

BENEFITS, PERQUISITES, SERVICES, AND IN-KIND PAYMENTS

Officers are able to request benefits, perquisites, services, and in-kind payments, as defined in the "AMA Board of Trustees Standing Rules on Travel Expenses." These non-taxable business expense items are provided to assist the Officers in performing their duties.

- AMA Standard laptop computer or iPad
- American Express card (for AMA business use)
- Combination fax/printer/scanner (reimbursable up to $250)
- An annual membership to the airline club of choice offered each year during the Board member's tenure
- Personalized AMA stationery, business cards, and biographical data for official use

Additionally, all Officers are eligible for $305,000 term life insurance and are covered under the AMA's $500,000 travel accident policy and $10,000 individual policy for medical costs arising out of any accident while traveling on official business for the AMA. Life insurance premiums paid by the AMA are reported as taxable income. Also, travel assistance is available to all Officers when traveling more than 100 miles from home or internationally.

Secretarial support, other than that provided by the AMA's Board office, is available up to defined annual limits as follows: President, during the Presidential year, $15,000, and $5,000 each for the President-Elect, Chair, Chair-Elect, and Immediate Past President per year. Secretarial expenses incurred by other Officers in conjunction with their official duties are paid up to $750 per year per Officer. This is reported as taxable income. Calendar year taxable life insurance and taxable secretarial fee reported to the IRS totaled $28,914 and $28,875 respectively for 2023. An additional $16,625 was paid to third parties for secretarial services during 2023.

Officers are also eligible to participate in a service provided to AMA employees by Care@Work through Care.com. This service offers referral services at no cost and back-up care for children and adults up to 10 days a calendar year at a subsidized rate. If a Board member uses back-up care, it will be reported to the IRS as taxable income.

METHODOLOGY

In June 2024, the Committee commissioned Ms. Becky Glantz Huddleston, a consultant expert in board compensation with WTW, to update the 2019 research on compensation of non-leadership Officers. The purpose of the review was to ensure our non-leadership roles are compensated appropriately for their work performed on behalf of the AMA.

The Committee's review and subsequent recommendations for non-leadership compensation are based on the principle of the value of the work performed as affirmed by the HOD. In addition, the following additional guidelines were followed:

- Compensation should take into account that the AMA is a complex organization when comparing compensation provided to Board members by for-profit and by complex not-for-profit of similar size and complexity.
- Compensation should be aligned with long term interests of AMA members and fulfillment of the fiduciary responsibilities of the Officers.
- Officers should be adequately compensated for their value, time and effort.
- Compensation should reinforce choices and behaviors that enhance effectiveness.

The process the Committee followed along with the principles previously noted, is consistent with IRS recommended guidelines for determining reasonable and competitive levels of compensation.

The Committee, with the assistance of Ms. Huddleston developed their recommendations based on:

- The current compensation structure.
- Review and analysis of non-leadership compensation for the past two terms so that the data reflects more of a 'normal' post-Covid schedule.
- Pay practices for non-leadership positions at for-profit and not-for-profit organizations similar to the AMA who pay and their Board members.
- A collaborative, deliberative and objective review process.

FINDINGS

The Committee notes that Officers continue to make significant time commitments in supporting our AMA in governance and representation functions. Given the amount of time required of Board members, it is important that individuals seeking a position on the Board be aware of the scope of the commitment and the related compensation.

To assess the current compensation structure, the consultant reviewed the time commitment of Officers during the 2023/24 term and found that the time commitment for honorarium days is generally consistent with the number of internal representation days being more variable and external representation the most variable. The Per Diem addresses this variability for both Internal and External Representation days. Internal Representation days greater than 11 are compensated via the Per Diem. External Representation reflects the unique skillset and expertise of each Officer. Officers are compensated for each External Representation Day via the Per Diem. The current structure continues to be an appropriate approach to compensating Officers.

However, modest increases are recommended to both the Honorarium and Per Diem considering the last adjustment was in 2019 and the compensation for not-for-profit boards has increased 4.8% at the median. As such, the Committee is recommending increasing the Honorarium by $1500, increasing the Per Diem by $150 and increasing the telephonic per diem by $75.

RECOMMENDATIONS

The Committee on Compensation of the Officers recommends the following recommendations be adopted and the remainder of this report be filed:

1. That there be no change to the current Definitions effective July 1, 2018 as they appear in the Travel and Expenses Standing Rules for AMA Officers for the Governance Honorarium, Per Diem for Representation and Telephonic Per Diem except for the Governance Honorarium and Per Diem amounts as recommended in 2, 3 and 4 below.

- Definition of Governance Honorarium effective July 1, 2017:

The purpose of this payment is to compensate Officers, excluding Board Chair, Chair-Elect and Presidents, for all Chair-assigned internal AMA work and related travel. This payment is intended to cover all currently scheduled Board meetings, special Board or Board committee, subcommittee and task force meetings, Board orientation, Board development and media training, and Board conference calls, and any associated review or preparatory work, and all travel days related to all such meetings. The Governance Honorarium also covers Internal Representation, such as section and council liaison meetings (and associated travel) or calls, up to eleven (11) Internal Representation days.

- Definition of Per Diem for Representation effective July 1, 2017:

The purpose of this payment is to compensate for Board Chair-assigned representation day(s) and related travel for Officers, excluding Board Chair, Chair-Elect and Presidents. Representation is either external to the AMA, or for participation in a group or organization with which the AMA has a key role in creating/partnering/facilitating achievement of the respective organization goals such as the AMA Foundation, PCPI, etc., or for Internal Representation days above eleven (11). The Board Chair may also approve a per diem for special circumstances that cannot be anticipated such as weather-related travel delays.

- Definition of Telephonic Per Diem for Representation effective July 1, 2017:

Officers, excluding the Board Chair, Chair-Elect and Presidents, who are assigned as the AMA representative to outside groups as one of their specific Board assignments or assigned Internal Representation days above eleven (11), receive a per diem rate for teleconference meetings when the total of all teleconference meetings of 30 minutes or longer during a calendar day equal 2 or more hours. Payment for these meetings would require approval of the Chair of the Board.

2. That the Governance Honorarium for all Board members excluding, Board Chair, President, President-elect, and Immediate Past President be increased effective July 1, 2025 to $68,500. (Directive to Take Action)

3. That the Per Diem for Chair-assigned representation for all Board members excluding the Board Chair, and Presidents and related travel be increased effective July 1, 2025 to $1,550 per day. (Directive to Take Action)

4. That the Per Diem for Chair-assigned Telephonic Per Diem for Representation be increased effective July 1, 2025 to $775 as defined. (Directive to Take Action)

Fiscal Note: Estimated annual cost of Recommendations 2, 3 and 4 is $57,000 based on data reported for July 1, 2023 through June 30, 2024.

APPENDIX
Board Leadership Compensation

POSITION	**GOVERNANCE HONORARIUM**
President	$298,865
Immediate Past President	$290,659
President-Elect	$290,659
Chair	$285,886
Chair-Elect	$211,630

REPORT OF THE SPEAKERS

Speakers' Report 1-I-24

Subject: Report of the Election Task Force 2

Presented by: Lisa Bohman Egbert, MD, Speaker; and John H. Armstrong, MD, Vice Speaker

Referred to: Reference Committee F

BACKGROUND

At the 2023 Interim Meeting, Speakers' Report 3-I-23 "Report of the Election Task Force 2" was presented with 29 recommendations. Fourteen of these recommendations were adopted, 14 were referred, and one was not adopted.

Speakers' Report 2-A-24, "Report of the Election Task Force 2," was submitted as an informational report which included suggested additions and deletions to AMA policy as well as a glossary to provide clear definitions related to AMA elections. An open forum seeking input on these items was held on Sunday, June 9, 2024, during the 2024 AMA Annual Meeting. The open forum was well attended, and additional feedback was provided. Subsequently, the Election Task Force 2 (ETF2) met and developed the following report and recommendations.

DISCUSSION

The goal of both Election Task Forces was to ensure that qualified candidates are selected in free and fair elections by reducing obstacles or perceived obstacles that dissuade members from seeking elective office and by enabling and facilitating an informed electorate. On reviewing current policy and the testimony provided, the ETF2 has identified several areas to clarify the rules in order to achieve this goal.

Following adoption of recommendation 29 of the 2023 Interim Meeting, Speakers' Report 3-I-23 "Report of the Election Task Force 2," the election rules previously found in multiple policies were consolidated into AMA Policy G-610.090 AMA Election Rules and Guiding Principles (Appendix A). For ease of further discussion and consideration, each recommendation in this report addresses a single subsection of our consolidated election rules. The first recommendation offers the addition of a glossary which defines terms used within the election policy.

Section II. Guidelines for Nominations for AMA Offices

Amendments to Section II of AMA Policy G-610.090 are recommended to further clarify the policy by using the correct terminology regarding sponsoring versus nominating candidates.

Section III. Candidate Announcement, Nominations and Open Positions

The first suggested amendment to Section III clarifies sponsoring versus endorsing candidates as previously defined by the Election Committee. Per action by the HOD at A-24, the HOD Office was tasked with developing and administering a process by which all candidates are able to

determine from which groups they are eligible to ask for endorsement and monitoring the eligibility for endorsement by listed groups. The HOD Office is only able to verify the group an individual represents in the HOD; thus, that group may sponsor a candidate without the need for HOD Office reporting. Individual membership in all other groups represented in the House cannot be confirmed by the HOD Office. Therefore, groups wishing to publicly support a candidate, other than those candidates that the group is eligible to sponsor, would have to offer an endorsement via the new endorsement process.

Another recommended change in Section III is to remove email addresses from the candidate announcement card to limit any potential unintended interaction with candidates, prior to the active campaigning window, which could be perceived as violating election rules.

Section IV. Communications, Campaign Memorabilia and Literature

Section IV of our Election rules had several areas that needed clarification. The first recommended modification in item 1 succinctly defines the announcement of and timeline for the active campaign window. Previously, the Board of Trustees announced the active campaign window after its Spring meeting. However, in recent practice, the Speaker has made the announcement after the Spring Board of Trustees meeting in conjunction with the distribution of the Official Candidate Notification. The language was changed to reflect this practice. Additionally, the ETF2 heard proposals to move up the window. Testimony was mixed about opening the active campaign window earlier, with no clear consensus heard. Therefore, the task force is not recommending a change to the current timeline.

A new second item in this section provides very clear guidance pertaining to communications about campaigns prior to active campaigning. The task force is aware of the concerns that a rule prohibiting candidates from communicating about their campaigns prior to active campaigning could be interpreted as limiting their ability to form a campaign team or discuss campaign strategy with their team. This clarifies that both are expected and permitted and does not limit the formation of campaign teams nor the discussion of strategy prior to the announcement of the active campaign window.

The ETF2 also seeks to clarify the policy in item 6 as it pertains to communication by candidates to other delegates. Language has been added to specifically prohibit mass outreach by candidates. However, personal communication from candidates is allowed while simultaneously encouraging the reduction in overall volume of communication. Language was added to allow freedom of communication within campaign teams.

To ensure equitable ability for all candidates to share their message with HOD members, the ETF2 believes the route of access should be limited to the official AMA channels: the Election Manual, AMA Candidates' Page and the HOD Office candidate email (which includes campaign materials submitted by candidates). The ETF2 is recommending that candidates may not distribute additional printed or digital campaign materials other than by these AMA channels. The task force further recommends that candidates should neither produce nor link to external websites that contain campaign-related content.

Section VI. Interview Rules

The Election Task Force heard concerns about definitions of timelines, candidacy, and potential election violations that would be incurred by delegations meeting with their own members who happened to be candidates. The proposed language in this section seeks to clarify that there is no

restriction on a group's ability to hold meetings at which all of their members, including announced candidates, may participate.

Recommended amendments in this section better define the interview rules for candidates who announce after the active campaign window opens. Additional proffered language provides clarity that candidates who make presentations to groups in their current formal capacity are not in violation of the interview rules.

CONCLUSION

The work of the Election Task Force 1 and Election Task Force 2 over the last several years have made substantial improvements in AMA policy to address fairness and transparency of AMA Elections. The ETF2 has taken into consideration concerns expressed at I-23 and during the A-24 open forum and makes the following recommendations.

RECOMMENDATIONS

Recommendations adopted from this report will be in effect at the close of Interim 2024. For clarification purposes only, additions within existing policy language are shown in red.

1. That the following "Glossary of Election Terms" be added to our AMA Election Policy (New HOD Policy):

Glossary

Active campaign window – period of time after the Speaker's notice of the opening of active campaigning until the Election Session during the House of Delegates meeting at which elections are being held.

Active campaigning – Outreach by candidates or their surrogate(s), including but not limited to, members of their campaign team, to members of the House of Delegates with the goal of being elected by the AMA House of Delegates.

Announced candidate – person who has indicated their intention to run for elected position; announcement can be made only by sending an electronic announcement card to the Speakers via the HOD office by email to hod@ama-assn.org.

Campaign manager(s) – person(s) identified by the candidate to the HOD Office as the person(s) responsible for running the campaign.

Campaign team – campaign manager(s) and/or staff identified by the candidate to the HOD Office.

Campaign-related – any content that includes reference to an announced candidate in the context of their candidacy for an elected position within the AMA.

Digital – relating to, using, or storing data or information in the form of digital signals; involving or relating to the use of computer technology; this includes, but is not limited to, social media and communication platforms.

Elected position(s) – Council or Officer position within the AMA elected by the House of Delegates of the AMA.

Endorsing group - Any group that wishes to endorse candidates other than the candidates they are eligible to sponsor. See definition of "Sponsoring Group."

Endorse - any public acknowledgement by a candidate or members of a group of the group's support of a candidate, other than from the sponsoring group. Internal discussions of support in a closed session of the group are not considered public for the purpose of this definition.

Featured – identification of a candidate at an event by the host or organizer of the event, including but not limited to, written or verbal announcement of the candidate or their candidacy.

Sponsoring group

- The association, society, AMA section, or other entity for which a prospective candidate serves as an AMA HOD delegate or alternate delegate as certified with the HOD office.
- The Section delegate and alternate delegate are the only individuals who may be sponsored by their respective AMA Section.
- Current trustees seeking re-election as a trustee or election to president-elect may be sponsored by the delegation for which they served as an AMA HOD delegate or alternate delegate immediately prior to their election to the board.
- Individuals may act as their own sponsoring group (self-sponsor)

2. Policy G-610.090 Section II be amended by addition and deletion to read as follows (Modify HOD Policy):

II. Guidelines for Candidacy ~~for Nominations~~ for AMA Offices

1. Every effort should be made to have two or more candidates ~~nominate two or more eligible members~~ for each ~~Council~~ vacancy.
2. The Federation (in ~~nominating or~~ sponsoring candidates for leadership positions), the House of Delegates (in electing Council and Board members), and the Board, the Speakers, and the President (in appointing or nominating physicians for service on AMA Councils or in other leadership positions) should consider the need to enhance and promote diversity.

3. Policy G-610.090 Section III items 1 and 6 be amended by addition and deletion to read as follows (Modify HOD Policy):

III. Candidate Announcement, Nominations and Open Positions

1. Individuals intending to seek election at the next Annual Meeting should make their intentions known to the Speakers by providing the Speaker's office with an electronic announcement "card" that includes any or all of the following elements and no more: the candidate's name, photograph, ~~email address,~~ the office sought, the sponsoring group, if any, and a list of endorsing groups, if any~~societies~~. The Speakers will ensure that the information is posted on our AMA website in a timely fashion, generally on the morning of the last day of a House of Delegates meeting or upon adjournment of the meeting. Announcements that include

additional information (e.g., a brief resume) will not be posted to the website. Printed announcements may not be distributed to members of the House by any method.

6. Our AMA believes that:
   a. specialty society candidates for our AMA House of Delegates elected offices should be listed in the pre-election materials available to the House as the representative of that society and not by the state in which the candidate resides.
   b. elected specialty society members should be identified in that capacity while serving their term of office.
   c. nothing in the above recommendations should preclude ~~formal co-~~endorsement by any state delegation of the national specialty society candidate, if that state delegation should so choose.

4. Policy G-610.090 Section IV items 1, 6, and 7 be amended by addition and deletion to read as follows (Modify HOD Policy):

IV. Communications, Campaign Memorabilia and Literature

1. Active campaigning for ~~our AMA elective office~~ an elected AMA position may not begin until the active campaign window opens as announced by the Speaker following the Spring Board of Trustees meeting immediately preceding the meeting at which the election is scheduled to take place. ~~Board of Trustees, after its April meeting, announces the candidates for council seats. Active campaigning includes mass outreach activities directed to all or a significant portion of the members of the House of Delegates and communicated by or on behalf of the candidate. If in the judgment of the Speaker of the House of Delegates circumstances warrant an earlier date by which campaigns may formally begin, the Speaker shall communicate the earlier date to all known candidates.~~

6. Active campaigning via mass outreach to delegates by candidates or on behalf of a candidate by any method is prohibited. A reduction in the volume of telephone calls and personal electronic communication from candidates and on behalf of candidates is encouraged. No part of this rule shall be interpreted to limit developing or communicating within a campaign team. ~~The Office of House of Delegates Affairs does not provide email addresses for any purpose. The use of E~~electronic messages ~~to contact electors should be minimized, and if used~~ must include a simple mechanism to allow recipients to opt out of receiving future messages.

7. Printed and digital ~~C~~campaign materials may not be distributed to members of the House other than by the HOD office candidate email and on the AMA Candidates' Page. ~~by postal mail or its equivalent. The AMA Office of House of Delegates Affairs will not longer furnish a file containing the names and mailing addresses of members of the AMA HOD. Printed campaign materials may not be distributed in the House of Delegates. Candidates are encouraged to eliminate printed campaign materials.~~

5. Policy G-610.090 Section IV be amended by the addition of a new second and final item with appropriate renumbering to read as follows (New HOD Policy):

2. An announced candidate may discuss their candidacy on an individual basis in private conversations after the announcement of candidacy until the active campaigning period begins. Prior to the active campaigning period, no other individual may discuss the candidacy except in private conversations with the

announced candidate on an individual basis. This rule does not prohibit any candidate from discussions for the purpose of forming a campaign team or from a campaign team discussing a candidate or campaign strategy. This rule also does not prohibit persons not associated with a campaign from discussing candidates in private conversations.

9. Candidates and campaigns may not produce a personal campaign-related website or other digital campaign-related content. Candidates may not direct to personal or professional websites as a method of campaigning other than to the AMA Candidates' Page.

6. Policy G-610.090 Section VI item 4 be amended by addition and deletion to read as follows (Modify HOD Policy):

VI. Interview Rules

Candidates and interviewers must comply with the following rules:

4. Groups conducting interviews with announced candidates for a given office must offer an interview to all ~~individuals that have officially announced their candidacy~~ announced candidates at the time the group's interview schedule is finalized.
    a. A sponsoring group may meet with an announced candidate who is a member of their group during the active campaign window without meeting with ~~interviewing~~ other candidates for the same office.
    b. Interviewing groups may, but are not required to, interview ~~late announcing candidates~~persons who become announced candidates during the active campaign window. Should an interview be offered to such a ~~late~~ candidate, all other announced candidates for the same office (even those previously interviewed) must be afforded the same opportunity and medium.
    c. Any ~~appearance by a candidate before an organized meeting of a caucus or delegation, other than their own, will be considered an interview and fall under the rules for interviews~~campaign-related presentation to an assembly by an announced candidate, with or without being followed by a discussion, question and answer session, or a vote of the assembly regarding the candidate, is an interview and subject to the rules on in-person interviews. No portion of this rule shall be interpreted to mean that a candidate acting in their current formal capacity would be unable to present or discuss matters pertaining to that formal capacity with any group.

Fiscal note: Minimal

Appendix A

AMA Election Rules and Guiding Principles G-610.090

The Speaker and Vice Speaker of the House of Delegates are responsible for overall administration of our AMA elections, although balloting is conducted under the supervision of the chief teller and the Committee on Rules and Credentials. The Speaker and Vice Speaker will advise candidates on allowable activities and when appropriate will ensure that clarification of these rules is provided to all known candidates. The Speaker, in consultation with the Vice Speaker and the Election Committee, is responsible for declaring a violation of the rules.

I. Guiding Principles

The following principles provide guidance on how House elections should be conducted and how the selection of AMA leaders should occur:

1. Our American Medical Association delegates should:
   a. avail themselves of all available background information about candidates for elected positions in our AMA.
   b. determine which candidates are best qualified to help the AMA achieve its mission.
   c. make independent decisions when voting for candidates.
2. Any electioneering practices that distort the democratic processes of House elections, such as vote trading for the purpose of supporting candidates, are unacceptable. This principle applies between as well as within caucuses and delegations.
3. Candidates for elected positions should comply with the requirements and the spirit of House of Delegates policy on campaigning and campaign spending.
4. Candidates and their sponsoring organizations should exercise restraint in campaign spending. Federation organizations should establish clear and detailed guidelines on the appropriate level of resources that should be allocated to the political campaigns of their members for our AMA leadership positions.
5. Incumbency should not assure the re-election of an individual to an AMA leadership position.
6. Service in any AMA leadership position should not assure ascendancy to another leadership position.
7. Delegations and caucuses when evaluating candidates may provide information to their members encouraging open discussion regarding the candidates.
8. Delegations and caucuses should be a source of encouragement and assistance to qualified candidates. Nomination and endorsement should be based upon selecting the most qualified individuals to lead our AMA regardless of the number of positions up for election in a given race. Delegations and caucuses are reminded that all potential candidates may choose to run for office, with or without their endorsement and support.
9. Every state and specialty society delegation is encouraged to participate in a caucus, for the purposes of candidate review activities.

II. Guidelines for Nominations for AMA Offices

1. Every effort should be made to nominate two or more eligible members for each Council vacancy.
2. The Federation (in nominating or sponsoring candidates for leadership positions), the House of Delegates (in electing Council and Board members), and the Board, the Speakers, and the President (in appointing or nominating physicians for service on AMA Councils or in other leadership positions) should consider the need to enhance and promote diversity.

III. Candidate Announcement, Nominations and Open Positions

1. Individuals intending to seek election at the next Annual Meeting should make their intentions known to the Speakers by providing the Speaker's office with an electronic announcement "card" that includes any or all of the following elements and no more: the candidate's name, photograph, email address, the office sought and a list of endorsing societies. The Speakers will ensure that the information is posted on our AMA website in a timely fashion, generally on the morning of the last day of a House of Delegates meeting or upon adjournment of the meeting. Announcements that include additional information (e.g., a brief resume) will not be posted to the website. Printed announcements may not be distributed to members of the House by any method.
2. Announcement cards of all known candidates will be projected on the last day of the Annual and Interim Meetings of our House of Delegates and posted on the AMA website. Following each meeting, an "Official Candidate Notification" will be sent electronically to the House. It will include a list of all announced candidates and all potential newly opened positions which may open as a result of the election of any announced candidate. Additional notices will also be sent out with regular Speaker communications to the HOD and with the Speaker's notice of the opening of active campaigning which generally follows the April Board meeting.
3. Candidates may notify the HOD Office of their intention to run for potential newly opened positions, as well as any scheduled open positions on the elected councils or the Board of Trustees, at any time by submitting an announcement card to the House Office. They will then be included in all subsequent projections of announcements before the House, "Official Candidate Notifications," and in any campaign activity that had not yet been finalized. All previously announced candidates will continue to be included on each Official Candidate Notification. Any candidate may independently announce their candidacy after active campaigning is allowed, but no formal announcement from the HOD office will take place other than on Official Candidate Notifications.
4. The Federation and members of the House of Delegates will be notified of unscheduled potential newly opened positions that may become available as a result of the election of announced candidates. Candidates will be allowed to announce their intention to run for these positions.
5. If a potential newly opened position on the Board or a specified council does not open but there are other open positions for the same council or the Board, an election will proceed for the existing open seats. Candidates will be offered the opportunity to withdraw their nomination prior to the vote. If there are no scheduled open seats on the Board or specified council for which a potential newly opened position is announced and if the potential newly opened position does not open (ie., the individual with the unexpired term is not elected to the office they sought), no election for the position will be held. In the event that a prior election results in a newly opened position without a nominated candidate or more positions are open than nominated candidates, the unfilled positions would remain unfilled until the next annual meeting.
6. Our AMA believes that:

    a. specialty society candidates for our AMA House of Delegates elected offices should be listed in the pre-election materials available to the House as the representative of that society and not by the state in which the candidate resides.

    b. elected specialty society members should be identified in that capacity while serving their term of office.

    c. nothing in the above recommendations should preclude formal co-endorsement by any state delegation of the national specialty society candidate, if that state delegation should so choose.

7. Our AMA requires completion of conflict of interest forms by all candidates for election to our AMA Board of Trustees and councils prior to their election. Conflict of interest forms must be submitted after an individual has announced their candidacy and before the active campaign window begins or, if not previously announced, within 24 hours of the conclusion of the HOD Opening Session. The HOD Office will post such information on the "Members Only" section of our AMA website before election by the House of Delegates, with links to the disclosure statements from relevant electronic documents.
8. Candidates will be provided with a copy of the current election rules and will be required to attest to abiding by them. Candidates are responsible for any and all actions or inaction undertaken on their behalf that is campaign related.

IV. Communications, Campaign Memorabilia and Literature

1. Active campaigning for our AMA elective office may not begin until the Board of Trustees, after its April meeting, announces the candidates for council seats. Active campaigning includes mass outreach activities directed to all or a significant portion of the members of the House of Delegates and communicated by or on behalf of the candidate. If in the judgment of the Speaker of the House of Delegates circumstances warrant an earlier date by which campaigns may formally begin, the Speaker shall communicate the earlier date to all known candidates.
2. An Election Manual containing information on all candidates for election shall continue to be developed annually, with distribution limited to publication on our AMA website, typically on the Web pages associated with the meeting at which elections will occur. The Election Manual will provide a link to the AMA Candidates' Page, but links to personal, professional or campaign related websites will not be allowed. The Election Manual provides an equal opportunity for each candidate to present the material they consider important to bring before the members of the House of Delegates and should relieve the need for the additional expenditures incurred in making non-scheduled telephone calls and duplicative mailings. The Election Manual serves as a mechanism to reduce the number of telephone calls, mailings and other messages members of the House of Delegates receive from or on behalf of candidates.
3. Our AMA Office of House of Delegates Affairs will provide an opportunity for all announced candidates to submit material to the HOD office which will then be sent electronically by the HOD Office in a single communication to all delegates and alternates. Parameters regarding content and deadlines for submission will be established by the Speaker and communicated to all announced candidates.
4. An AMA Candidates' Page will be created on our AMA website or other appropriate website to allow each candidate the opportunity to post campaign materials. Parameters for the site will be established by the Speaker and communicated to candidates.
5. Campaign expenditures and activities should be limited to reasonable levels necessary for adequate candidate exposure to the delegates. Campaign memorabilia and giveaways that include a candidate's name or likeness may not be distributed at any time.
6. A reduction in the volume of telephone calls and electronic communication from candidates and on behalf of candidates is encouraged. The Office of House of Delegates Affairs does not provide email addresses for any purpose. The use of electronic messages to contact electors should be minimized, and if used must include a simple mechanism to allow recipients to opt out of receiving future messages.
7. Campaign materials may not be distributed by postal mail or its equivalent. The AMA Office of House of Delegates Affairs will no longer furnish a file containing the names and mailing addresses of members of the AMA-HOD. Printed campaign materials may not be distributed in the House of Delegates. Candidates are encouraged to eliminate printed campaign materials.

8. Displays of campaign posters, signs, and literature in public areas of the venue at which Annual Meetings are held are prohibited because they detract from the dignity of the position being sought and are unsightly. Campaign posters may be displayed at a single campaign reception at which the candidate is featured. No campaign literature shall be distributed in the House of Delegates and no mass outreach electronic messages shall be transmitted after the opening session of the House of Delegates.
9. Campaign stickers, pins, buttons and similar campaign materials are disallowed. This rule will not apply for pins for AMPAC, the AMA Foundation, specialty societies, state and regional delegations and health related causes that do not include any candidate identifier. These pins should be small, not worn on the badge and distributed only to members of the designated group. General distribution of any pin, button or sticker is disallowed.

V. Group Dinners and Meetings

1. Candidates for our AMA office should not attend meetings of state medical societies unless officially invited and could accept reimbursement of travel expenses by the state society in accordance with the policies of the society.
2. At any AMA meeting convened prior to the time period for active campaigning, campaign-related expenditures and activities shall be discouraged. Large campaign receptions, luncheons, other formal campaign activities and the distribution of campaign literature and gifts are prohibited. It is permissible for candidates seeking election to engage in individual outreach meant to familiarize others with a candidate's opinions and positions on issues.
3. Group dinners, if attended by an announced candidate in a currently contested election, must be "Dutch treat" - each participant pays their own share of the expenses, with the exception that societies and delegations may cover the expense for their own members. This rule would not disallow societies from paying for their own members or delegations gathering together with each individual or delegation paying their own expense. Gatherings of 4 or fewer delegates or alternates are exempt from this rule.

VI. Interview Rules

Candidates and interviewers must comply with the following rules:

1. Groups wishing to conduct interviews must designate their interviewing coordinator and provide the individual's contact information to the Office of House of Delegates Affairs. The Speaker's Office will collect contact information for groups wishing to conduct interviews as well as for candidates and their campaign teams and will provide the information to both groups. Groups must indicate whether they wish to interview in-person or virtually and for which contest by the deadlines designated by the speaker.
2. Any formal questioning of an announced candidate, excluding a written questionnaire, is an interview and subject to the rules for interviews.
3. Interviews may be arranged between the parties once active campaigning is allowed.
4. Groups conducting interviews with candidates for a given office must offer an interview to all individuals that have officially announced their candidacy at the time the group's interview schedule is finalized.

    a. A group may meet with a candidate who is a member of their group without interviewing other candidates for the same office.

    b. Interviewing groups may, but are not required to, interview late announcing candidates. Should an interview be offered to a late candidate, all other announced candidates for the same office (even those previously interviewed) must be afforded the same opportunity and medium.

    c. Any appearance by a candidate before an organized meeting of a caucus or delegation, other than their own, will be considered an interview and fall under the rules for interviews.
5. Groups may elect to conduct interviews virtually or in-person.

6. In-person interviews may be conducted between Friday and Monday of the meeting at which elections will take place.
7. Virtual interviews are subject to the following constraints:
   a. Interviews may be conducted only during a 4–7-day window designated by the Speaker beginning at least two weeks but not more than 4 weeks prior to the scheduled Opening Session of the House of Delegates meeting at which elections will take place.
   b. Interviews conducted on weeknights must be scheduled between 5 pm and 10 pm or on weekends between 8am and 10 pm based on the candidate's local time, unless another mutually acceptable time outside these hours is arranged.
   c. caucuses and delegations scheduling interviews for candidates within the parameters above must offer alternatives to those candidates who have conflicts with the scheduled time.
8. Recording of interviews is allowed only with the knowledge and consent of the candidate.
9. Interviews are recommended to be recorded with consent of all participating individuals and disseminated to the interviewing group members when all are not able to be present for the interview.
10. Recordings of interviews may be shared only among members of the group conducting the interview.
11. A candidate is free to decline any interview request.
12. In consultation with the Election Committee, the Speaker, or where the Speaker is in a contested election, the Vice Speaker, may issue special rules for interviews to address unexpected situations.
13. The Speakers are encouraged to continue recorded virtual interviews of announced candidates in contested races, to be posted on the AMA website.

VII. Campaign Receptions

1. Our AMA will sponsor the AMA Candidate Reception which will be open to all candidates and all meeting attendees. Any candidate may elect to be "featured" at the AMA Candidate Reception. There will not be a receiving line at the AMA Candidate Reception. The rules regarding cash bars only at campaign receptions and limiting each candidate to be featured at a single reception will apply to the AMA Candidate Reception.
2. A state, specialty society, caucus, coalition, etc. may contribute to more than one party. However, a candidate may be featured at only one party, which includes: (a) being present in a receiving line, or (b) appearing by name or in a picture on a poster or notice in or outside of the party venue. At these events, alcohol may be served only on a cash or no-host bar basis.

VIII. Election Process

1. At the Opening Session of the Annual Meeting, officer candidates in a contested election will give a two-minute self-nominating speech, with the order of speeches determined by lot. No speeches for unopposed candidates will be given, except for president-elect. When there is no contest for president-elect, the candidate will ask a delegate to place their name in nomination, and the election will then be by acclamation. When there are two or more candidates for the office of president-elect, a two-minute nomination speech will be given by a delegate. In addition, the Speaker of the House of Delegates will schedule a debate in front of the AMA-HOD to be conducted by rules established by the Speaker or, in the event of a conflict, the Vice Speaker.
2. Nominating speeches for unopposed candidates for office, except for President-elect, will not be heard.
3. AMA elections will be held on Tuesday at each Annual Meeting.
4. Voting for all elected positions including runoffs will be conducted electronically during an Election Session to be arranged by the Speaker.

5. All delegates eligible to vote must be seated within the House at the time appointed to cast their electronic votes.
6. The final vote count of all secret ballots of the House of Delegates shall be made public and part of the official proceedings of the House.
7. The Speaker is encouraged to consider means to reduce the time spent during the HOD meeting on personal points by candidates after election results are announced, including collecting written personal points from candidates to be shared electronically with the House after the meeting or imposing time limits on such comments.

IX. Election Committee

1. In accordance with Bylaw 2.13.7, the Speaker shall appoint an Election Committee of 9 individuals for 1-year terms (maximum tenure of 4 consecutive terms and a lifetime maximum tenure of 8 terms) to report to the Speaker. These individuals would agree not to be directly involved in a campaign during their tenure and would be appointed from various regions, specialties, sections, and interest groups. The primary role of the committee would be to work with the Speakers to adjudicate any election complaint. Additional roles to be determined by the Speaker and could include monitoring election reforms, considering future campaign modifications and responding to requests from the Speaker for input on election issues that arise. The Speaker and Vice Speaker shall be full members of the Election Committee.

X. Campaign Complaint Reporting, Validation and Resolution Process

1. Campaign violation complaints should be directed to the Speaker, the Vice Speaker, or the AMA General Counsel and should include the following details:
   a. The name of the person(s) thought to have violated the rules
   b. The date of the alleged violation and the location if relevant
   c. The specific violation being alleged (i.e., the way the rules were violated)
   d. The materials, if any, that violate the rules; original materials are preferred over copies. Where necessary, arrangements for collection of these materials will be made.
2. Campaign violation complaints will be investigated by the Election Committee or a subcommittee thereof with the option of including the Office of General Counsel or the Director of the House of Delegates.
   a. The Committee will collectively determine whether a campaign violation has occurred. As part of the investigation process the Election Committee or its subcommittee shall inform the candidate of the complaint filed and give the candidate the opportunity to respond to the allegation.
   b. If the complaint implicates a delegation or caucus, the Election Committee or its subcommittee shall inform the chair of the implicated delegation or caucus of the complaint filed and give the implicated delegation or caucus chair(s) the opportunity to answer to the allegation as a part of the investigative process.
   c. For validated complaints, the Committee will determine appropriate penalties, which may include an announcement of the violation by the Speaker to the House.
   d. Committee members with a conflict of interest may participate in discussions but must recuse themselves from decisions regarding the merits of the complaint or penalties.
   e. Deliberations of the Election Committee shall be confidential.
   f. The Speaker shall include a summary of the Election Committee's activities in "Official Candidate Notifications" sent to the House, following each meeting at which an election was held. Details may be provided at the discretion of the Election Committee and must be provided when the penalty includes an announcement about the violator to the House.
3. A record of all complaints and the results of the validation and the resolution processes, including penalties, shall be maintained by our AMA Office of General Counsel and kept confidential.

4. The Election Committee will review the Campaign Complaint Reporting, Validation and Resolution Process as implemented and make further recommendations to the House as necessary.

XI. Endorsements

1. Our American Medical Association requires all groups that endorse candidates turn in information about their endorsement process, the deadline, and a staff contact for applications in a timely and streamlined manner.
2. Our AMA will then post this information on the election website in a timely manner, with the information being easily digestible and accessible.
3. Our AMA will not allow any group that fails to provide this information in a timely manner to offer an endorsement during that election cycle.
4. Our AMA will create a specific period (similar to virtual elections) during which endorsements may be sought.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 601
(I-24)

Introduced by: Texas

Subject: Expanding AMA Meeting Venue Options

Referred to: Reference Committee F

Whereas, our American Medical Association Board of Trustees states in Report 21-A-24, line 19 of page 1, “It is at the discretion of the House of Delegates to change current policy” with regards to Policy G-630.140; and

Whereas, our AMA Board of Trustees states in Report 21-A-24 on line 32, page 1, “This strategic recommendation places a primary emphasis on prioritizing attendee safety, reflecting the values and principles upheld by the AMA;” and

Whereas, since the initial passage of Policy G-630.140 we are not aware of any state legislature citing Policy G-630.140, nor our AMA claiming Policy G-630.140 as being pivotal in rescinding or blocking discriminatory legislation; and

Whereas, during the same period our AMA House of Delegates has witnessed a reduction in the number of acceptable venues in which to meet and a dramatic increase in charges for those venues that will house our AMA HOD meetings, an example being a gallon of coffee or unsweetened iced tea costing delegations $151 per gallon at A-24; and

Whereas, increases such as these have caused associations and delegations to reconsider and actually reduce representation at meetings, with a disproportionate burden borne by decreased funding for medical students and alternate delegates; and

Whereas, our AMA has extraordinary meeting planning staff who, if allowed to look beyond the few currently available locations, could find and work with an event venue to create a meeting experience that is cost-efficient for those involved, allowing for the greatest involvement of all; therefore be it

RESOLVED, that our American Medical Association rescind Policy G-630.140 Item 4. (Rescind HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 9/11/2024

RELEVANT AMA POLICY

G-630.140 Lodging, Meeting Venues, and Social Functions G-630.140
Our American Medical Association's policy on lodging and accommodations includes the following:

1. Our AMA supports choosing hotels for its meetings, conferences, and conventions based on size, service, location, cost, and similar factors.
2. Our AMA shall attempt, when allocating meeting space, to locate the Section Assembly Meetings in the House of Delegates Meeting hotel or in a hotel in close proximity.
3. All meetings and conferences organized and/or primarily sponsored by our AMA will be held in a town, city, county, or state that has enacted comprehensive legislation requiring smoke-free worksites and public places (including restaurants and bars), unless intended or existing contracts or special circumstances justify an exception to this policy, and our AMA encourages state and local medical societies, national medical specialty societies, and other health organizations to adopt a similar policy.
4. It is the policy of our AMA not to hold meetings organized and/or primarily sponsored by our AMA, in cities, counties, or states, or pay member, officer or employee dues in any club, restaurant, or other institution, that has exclusionary policies, including, but not limited to, policies based on, race, color, religion, national origin, ethnic origin, language, creed, sex, sexual orientation, gender, gender identity and gender expression, disability, or age unless intended or existing contracts or special circumstances justify an exception to this policy.
5. Our AMA staff will work with facilities where AMA meetings are held to designate an area for breastfeeding and breast pumping.
6. All future AMA meetings will be structured to provide accommodations for members and invited attendees who are able to physically attend, but who need assistance in order to meaningfully participate.
7. Our AMA will revisit our criteria for selection of hotels and other venues in order to facilitate maximum participation by members and invited attendees with disabilities.

[Res. 2, I-87 Reaffirmed: Sunset Report, I-97 Res. 512, I-98; Consolidated: CLRPD Rep. 3, I-01; Reaffirmation A-04;
Modified: CCB/CLRPD Rep. 3, A-12; Modified: CCB/CLPRD Rep. 2, A-13; Modified: BOT Rep. 17, A-17; Appended: Res. 610, A-22; Modified: BOT Rep.18, A-23; Reaffirmed: BOT Rep. 21, A-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 602
(I-24)

Introduced by: New England

Subject: Delaying the ETF Endorsement Timeline Revision for Section IOP Revisions

Referred to: Reference Committee F

Whereas, the AMA House of Delegates (HOD) Speaker's Letter announced an interpretation of A-24 Resolution 609 such that groups wanting to endorse HOD candidates for Board of Trustees, Councils, etc., must do so over a full year in advance of the House of Delegates election; and

Whereas, A-24 Resolution 609 did not specify a timeline for implementing this change, leaving this up to the discretion of AMA leadership; and

Whereas, internal operating procedures (IOPs) for some of the AMA Sections have historically required Section members planning to run in House of Delegates elections to apply for nomination and/or endorsement by the Interim meeting prior to the HOD election, only six months prior to the election; and

Whereas, the Speaker's planned implementation timeline for endorsements may unintentionally cause inequity for some AMA Sections as, under their current IOPs, a Section's own nominated candidate may not have the endorsement of that same Section due to current nomination timelines; and

Whereas, in Sections where membership is time-limited (by years of practice, training, term-limits, etc.), a requirement to be endorsed a full year prior to the HOD election unduly limits qualified candidates; and

Whereas, the aforementioned Sections are unable to ratify new IOPs until they meet just prior to each national AMA meeting; and

Whereas, any Societies and Sections with conflicting internal rules may not be able to both modify and ratify changes by their voting bodies and by the AMA HOD prior to the October 11th 2024 deadline to become an endorsing body, rendering the membership of these Sections disenfranchised from determining whether and how to participate in the nomination and endorsement process for the 2026 election cycle; therefore be it

RESOLVED, that our American Medical Association House of Delegates candidate endorsement process revisions that were to be implemented for the 2026 election cycle be delayed to allow a thorough evaluation of unintended consequences and for revised State and Society bylaws and Section internal operating procedures to be duly ratified (Directive to Take Action); and be it further

RESOLVED, that our AMA Board of Trustees expedite the approval of amendments to Section internal operating procedures as necessary to allow for their nomination and endorsement

processes to align with impending changes to AMA House of Delegates procedure for nominations and endorsements. (Directive to Take Action)

Fiscal Note: Minimal – less than $1,000

Received: 9/19/2024

REFERENCES

1. Resident & Fellow Section Internal Operating Procedures subsections V.A.1. and V.G.2., and all subsections which refer to these.
2. Young Physician Section Internal Operating Procedures subsections IX.C., IX.D., and X.B., and all subsections which refer to these.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 604
(I-24)

Introduced by: New York

Subject: Opposing Discrimination and Protecting Free Speech Among Member Organizations of Organized Medical Associations

Referred to: Reference Committee F

Whereas, the International Federation of Medical Student Association (IFMSA) is a global organization that fosters collaboration, education, and advocacy among medical students from diverse countries; and

Whereas, the IFMSA has recently suspended the Federation of Israeli Medical Students (FIMS), a member society based on allegations of hostile and threatening comments that are violations of the IFMSA code of conduct; and

Whereas, FIMS denies allegations of hostile and threatening comments while maintaining that the suspension was politically motivated based on actions taken by its host country; and

Whereas, FIMS denies allegations of hostile and threatening comments while maintaining that the suspension was politically motivated based on actions taken by its host country; and

Whereas, the American Medical Association (AMA) upholds principles of individual freedom of speech, equity, inclusion, and the importance of engagement in a diverse global community; and

Whereas, one of the main functions of parliamentary procedures is to assure that the minority voices are heard; and

Whereas, it is essential for international medical organizations to focus on the advancement of medical education and the promotion of human health rather than engaging in politically motivated actions that may undermine the collaborative nature of their mission; and

Whereas, censure of a member society based solely on the political or military policies of its host county, city or state country may unfairly penalize medical professionals who are working toward positive change and who may not have control over the policies, may or may not agree with such policies, and might not be able to speak against such policies; therefore be it

RESOLVED, that our American Medical Association supports that organized medical societies should not discriminate against, suspend, or otherwise punish member societies for the political views or actions of their host city, state, or national governments (New HOD Policy); and be it further

RESOLVED, that our AMA supports that members of organized medical societies should not engage in harassment of other members, threats towards other members, or hate speech (New HOD Policy); and be it further

RESOLVED, that our AMA support these principles on an international level among international medical organizations. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 9/24/2024

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 605
(I-24)

Introduced by: New York

Subject: AMA House of Delegates Expenses

Referred to: Reference Committee F

Whereas, the cost of attending Annual and Interim meetings of the American Medical Association (AMA) is quite high; and

Whereas, cost is often a factor leading many delegations to reduce the number of delegates they bring to such meetings, thereby reducing the diversity of ideas that these delegates would otherwise provide; and

Whereas, our AMA has considerable assets that could be used to defray the expenses incurred by delegates; therefore be it

RESOLVED, that our American Medical Association provide $1000, in 2024 dollars, per designated delegate and alternate delegate that attends the Annual and/or Interim meetings of our AMA (Directive to Take Action); and be it further

RESOLVED, that our AMA give the meeting stipend to the delegate or alternate delegate themselves, rather than to the state or subspecialty society that they represent. (Directive to Take Action)

Fiscal Note: $2.82 million annually based on current delegate count but would increase if the delegate count increases.

Received: 9/24/2024

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 606
(I-24)

Introduced by: New York

Subject: Protecting Free Speech and Encouraging Respectful Discourse Among Member Organizations of Organized Medical Associations

Referred to: Reference Committee F

Whereas, the International Federation of Medical Student Association (IFMSA) is a global organization that fosters collaboration, education, and advocacy among medical students from diverse countries; and

Whereas, the IFMSA has recently suspended the Federation of Israeli Medical Students (FIMS), a member society based on allegations of hostile and threatening comments that are violations of the IFMSA code of conduct; and

Whereas, FIMS denies allegations of hostile and threatening comments while maintaining that the suspension was politically motivated based on actions taken by its host country; and

Whereas, the American Medical Association (AMA) upholds principles of individual freedom of speech, equity, inclusion, and the importance of engagement in a diverse global community; and

Whereas, one of the main functions of parliamentary procedures is to assure that the minority voices are heard; and

Whereas, it is essential for international medical organizations to focus on the advancement of medical education and the promotion of human health rather than engaging in politically motivated actions that may undermine the collaborative nature of their mission; and

Whereas, censure of a member society based solely on the political or military policies of its host country may unfairly penalize medical professionals who are working toward positive change and who may not have control over their country's policies, may or may not agree with such policies, and might not be able to speak against such policies; therefore be it

RESOLVED, that our American Medical Association believes that organized medical societies should not suspend or otherwise punish member societies for the political views or military actions of their host governments (New HOD Policy); and be it further

RESOLVED, that our AMA believes that members of organized medical societies should not engage in harassment of other members, threats towards other members, or hate speech. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 9/24/2024

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 607
(I-24)

Introduced by: New York

Subject: AMA House of Delegates Venues

Referred to: Reference Committee F

Whereas, cost is often a factor leading many delegations to reduce the number of delegates they bring to such meetings, thereby reducing the diversity of ideas that these delegates would otherwise provide; and

Whereas, the cost of American Medical Association (AMA) meetings is often high because of the relatively low number of venues competing to host these meetings; and

Whereas, the cost of the Annual meeting is particularly high because reportedly only one hotel in Chicago that is able to accommodate a meeting of this size, thus eliminating the possibility of exploring less expensive venues; and

Whereas, the ability for the AMA to negotiate better contract terms for the Annual Meeting is hampered by confining the location to only Chicago; and

Whereas, AMA Policy G630.140 Item 4 places undue restrictions on the choice of venues for the Interim meetings; and

Whereas, AMA Board of Trustees Report 21-A-24 stated that “It is at the discretion of the House of Delegates to change current policy" with regard to AMA Policy G630.140; therefore be it

RESOLVED, that our American Medical Association retain the ability to choose any location within the continental United States to hold the Annual Meeting (Directive to Take Action); and be it further

RESOLVED, that our AMA Policy G630.140 Item 4 be rescinded (Rescind HOD Policy); and be it further

RESOLVED, that our AMA Board of Trustees will employ or contract any services that may reduce or alleviate concerns about risk factors related to a particular location venue (Directive to Take Action); and be it further

RESOLVED, that our AMA Board of Trustees re-examine previously used and explore potentially new venues for future Interim meetings. (Directive to Take Action)

Fiscal Note: Minimal – less than $1,000

Received: 9/24/2024

RELEVANT AMA POLICY

Lodging, Meeting Venues, and Social Functions G-630.140

Our American Medical Association's policy on lodging and accommodations includes the following:

1. Our AMA supports choosing hotels for its meetings, conferences, and conventions based on size, service, location, cost, and similar factors.
2. Our AMA shall attempt, when allocating meeting space, to locate the Section Assembly Meetings in the House of Delegates Meeting hotel or in a hotel in close proximity.
3. All meetings and conferences organized and/or primarily sponsored by our AMA will be held in a town, city, county, or state that has enacted comprehensive legislation requiring smoke-free worksites and public places (including restaurants and bars), unless intended or existing contracts or special circumstances justify an exception to this policy, and our AMA encourages state and local medical societies, national medical specialty societies, and other health organizations to adopt a similar policy.
4. It is the policy of our AMA not to hold meetings organized and/or primarily sponsored by our AMA, in cities, counties, or states, or pay member, officer or employee dues in any club, restaurant, or other institution, that has exclusionary policies, including, but not limited to, policies based on, race, color, religion, national origin, ethnic origin, language, creed, sex, sexual orientation, gender, gender identity and gender expression, disability, or age unless intended or existing contracts or special circumstances justify an exception to this policy.
5. Our AMA staff will work with facilities where AMA meetings are held to designate an area for breastfeeding and breast pumping.
6. All future AMA meetings will be structured to provide accommodations for members and invited attendees who are able to physically attend, but who need assistance in order to meaningfully participate.
7. Our AMA will revisit our criteria for selection of hotels and other venues in order to facilitate maximum participation by members and invited attendees with disabilities.

Reference Committee J

Report(s) of the Board of Trustees

05 Protecting the Health of Incarcerated Patients
13 AMA/Specialty Society RVS Update Committee
15 Published Metrics for Hospitals and Hospital Systems

Report(s) of the Council on Medical Service

01 Nonprofit Hospital Charity Care Policies
02 Unified Financing Health Care System
03 Time-Limited Patient Care
04 Biosimilar Coverage Structures

Resolutions

801 Reimbursement for Managing Portal Messages
802 Address Physician Burnout with Inbox Management Resources and Increased Payment
803 Healthcare Savings Account Reform
804 Improving Public Assistance for People with Disabilities
805 Coverage for Care for Sexual Assault Survivors
807 Expanded Pluralism in Medicaid
808 Requirement to Communicate Covered Alternatives for Denied Medications
809 Minimum Requirements for Medication Formularies
810 Immediate Digital Access to Updated Medication Formulary for Patients and Their Physicians
811 AMA Practice Expense Survey Geographic Analysis
812 Advocate for Therapy Cap Exception Process
813 Insurance Coverage for Pediatric Positioning Chairs
814 Legislation for Physician Payment for Prior Authorization
815 Addressing the Crisis of Pediatric Hospital Closures and Impact on Care
817 ACA Subsidies for Undocumented Immigrants
818 Payment for pre-certified/preauthorized procedures
819 Establishing a New Office-Based Facility Setting to Pay Separately from the Medicare Physician Fee Schedule for the Technical Reimbursement of Physician Services Using High-Cost Supplies
820 State Medicaid Coverage of Home Sleep Testing
821 Patient Access to Asthma Medications
822 Resolution on Medicare Coverage for Non-Emergent Dialysis Transport
823 Reigning in Medicare Advantage - Institutional Special Needs Plans
824 Ophthalmologists Required to Be Available for Level I & II Trauma Centers

REPORT OF THE BOARD OF TRUSTEES

B of T Report 05-I-24

Subject:	Protecting the Health of Incarcerated Patients (Resolution 202-I-23)
Presented by:	Michael Suk, MD, JD, MPH, MBA, Chair
Referred to:	Reference Committee J

INTRODUCTION

At the 2023 Interim Meeting, the American Medical Association (AMA) House of Delegates (HOD) referred Resolution 202-I-23 authored by the Medical Student Section for report at the 2024 Interim Meeting. The resolution asked, "That our American Medical Association advocate against the use of for-profit prisons" and "That our AMA advocate for for-profit prisons, public prisons with privatized medical services, and detention centers to be held to the same standards as prisons with public medical services, especially with respect to oversight, reporting of health-related outcomes, and quality of health care."

This report provides background information on private (also referred to as "for-profit") correctional facilities and private companies providing health care services to public correctional facilities. This report further discusses the role of our AMA in ensuring that appropriate, quality health care is provided to inmates in all facilities, regardless of private or public status. Finally, this report recommends reaffirming existing AMA policy.

BACKGROUND

Private Correctional Facilities

In this report, "correctional facility" includes a jail, prison, or other detention facility used to house people who have been arrested, detained, held, or convicted by a criminal justice agency or a court. "Prisons" are facilities under state or federal control where people who have been convicted (usually of felonies) go to serve their sentences. "Jails" are city- or county-run facilities where a majority of incarcerated people are there awaiting trial (in other words, still legally innocent), many because they cannot afford to post bail. However, some people do serve their sentences in local jails, either because their sentences are short or because the jail is renting space to the state prison system.[1]

The U.S. has the highest rate and number of incarcerated individuals in the world, with 1.9 million people in the carceral system.[2] This includes individuals in 1,566 state prisons, 98 federal prisons, 3,116 local jails, 1,323 juvenile correctional facilities, 142 immigration detention facilities, and 80 Indian country jails, as well as in military prisons, civil commitment centers, state psychiatric hospitals, and prisons in the U.S. territories.[3] To complicate matters further, approximately eight percent of all incarcerated persons are in private prisons.[4] Given that the U.S. does not have one criminal legal system, but rather thousands of federal, state, local, and tribal systems, and the

significant amount of churning in and out of facilities that occurs, it is impossible to generalize about conditions in facilities across the nation.

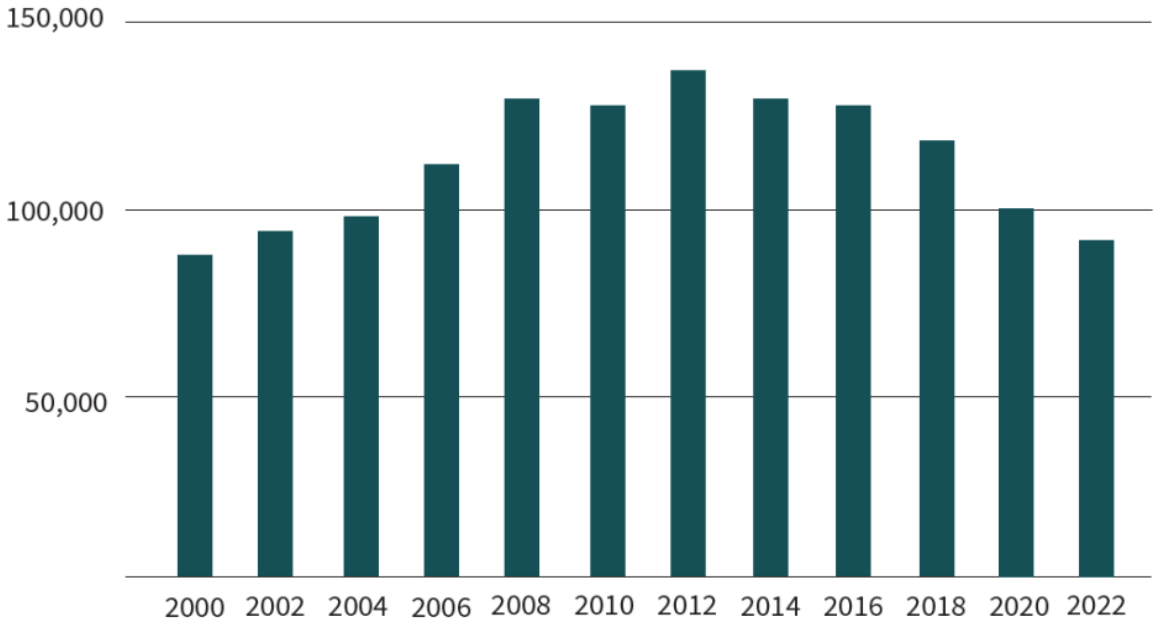
The War on Drugs in the 1970s and harsher sentencing policies, including mandatory minimum sentences, in the 1980s, contributed to a rapid expansion in the nation's incarcerated population. In 1994, former President Bill Clinton signed the Violent Crime Control and Law Enforcement Act into law. The act gave an additional $9.7 billion in funding towards the construction of new prisons. It also created the three-strikes law.[5] The burden on publicly funded prisons led to the rise of for-profit private prisons in many states and at the federal level.[6] Private prisons were seen by many policymakers in state and federal government as an effective solution to the rapid increase of inmates because they arguably could house more of them at a lower cost than state or federal prisons. Congress helped with public funding through the Appropriations Act of 1996, which amended the entire text of Subtitle A of the 1994 Violent Crime Control and Law Enforcement Act and included language specifically authorizing states to use the funding for privatization.[7]

The number of people incarcerated in private prison facilities increased 47 percent while the overall prison population increased only nine percent between 2000 and 2016.[8] At the state level, 27 states used private prison beds, with contracts ranging from 12 in South Carolina to 13,692 in Texas. Six states more than doubled the number of individuals in private prisons between 2000 and 2016, with Arizona having the largest increase, holding 479 percent more people in private facilities during that time period.[9] Privatization in the federal correctional system grew even more than among the states. The number of federal prisoners held in private facilities rose 120 percent from 15,524 in 2000 to 34,159 in 2016, while the number of state prisoners incarcerated privately grew only by 31 percent over the same time period, from 71,845 to 94,164.[10] In 2022, a total of 27 states were utilizing private companies to run some of their correctional facilities.[11]

After a reduction in the overall federal prison population beginning in 2014 and a small decrease in the private prison population, President Obama's Department of Justice (DOJ) decided to phase out federal private for-profit prison contracts.[12] However, the Trump Administration reversed this plan and indicated that the Bureau of Prisons (BOP) would continue to rely on private facilities.[13] This was despite numerous concerns raised by policymakers and advocates about the quality of services and safety in private correctional facilities, which have existed since the growth of the private corrections industry, including a comprehensive report released in August of 2016 by the Office of the Inspector General of the DOJ. This report reviewed the BOP's monitoring of contract prisons and found that contract prisons had more safety and security-related incidents per capita than BOP institutions for most of the indicators that were analyzed, that site visits revealed safety and security concerns and inappropriate housing assignments, and that the BOP's monitoring of contract prisons needed improvement.[14]

Despite the claims of their proponents that private facilities are more cost-efficient at providing services than publicly-run institutions, various studies conducted in the late 1990s and 2000s at both the federal and state levels did not support such assertions.[15] In addition, private prison companies are challenged by reducing costs while at the same time providing adequate services necessary to maintain security and safety, and doing so while also generating a profit for their shareholders.[16] Private prisons have been critiqued by many for prioritizing revenue over rehabilitating incarcerated individuals. Faced with these challenges, the private prison population has been steadily decreasing since 2012, as shown in the chart below.[17]

Number of People in Private Prisons, 2000-2022



In January 2021, as his term began, President Biden signed an executive order which directed the DOJ to phase out the federal criminal system's use of private prisons and eliminate their use. Since this executive order was signed, the BOP has ended its contracts with all for-profit prisons and has transferred the remaining inmates to other Bureau of Prison locations.[18] While this was an important step in limiting the transfer of federal funding to for-profit corporations, it did not cover the federal use of for-profit immigration detention facilities. And, according to an analysis from the American Civil Liberties Union (ACLU) National Prison Project, the U.S. Marshals Service continues to hold nearly a third of its entire detention population in for-profit facilities, totaling 20,000 people. The Marshals Service has obtained waivers from the Biden Administration that allow it to basically ignore the executive order and keep five for-profit facilities open. According to the ACLU, the Marshals Service is also skirting the requirements of the executive order through pass-through agreements, whereby the Service pays a city or county government, which keeps part of the payment and passes along most of the payment to the corporation that runs the facility.[19] An internal government investigation found that these agreements cost the Marshals Service more and provide less control and oversight over operations at its detention facilities.[20]

Privatized Health Care in Correctional Facilities

Privatized health care in federal prisons is a multi-billion-dollar industry led by a handful of companies.[21] Those contracted with these private health care providers pay them a fixed price, regardless of the level of care. Moreover, the company can retain any money that is not spent on health care services. The incentive for these prisons to contract with health care companies is that these privatized health care companies protect prisons from liability through indemnification provisions.[22] These indemnification provisions present themselves as contracts between health care companies and prisons that place the company in a position where they are liable for all liability-related expenses in prison. Critics have stated that this protection enables prisons to prioritize company profits over the wellness of inmates.[23] This includes reports of prison health care services

remaining understaffed or assigning employees to tasks they are not qualified to do to decrease costs intentionally. There are other reports of staff not working enough hours to adequately meet the health care needs of patients.[24] This low standard of care for prisons with health care managed by private companies also has a higher death rate in comparison to prisons that do not utilize privatized health care.[25]

Health of incarcerated populations

It is well documented that justice-involved people have a higher prevalence of acute and chronic health conditions than the general U.S. population.[26] Compared to the general population, individuals with a history of incarceration have worse mental and physical health; they are more likely to have high blood pressure, asthma, cancer, arthritis, and infectious diseases, such as tuberculosis, hepatitis C, and HIV. Several factors contribute to the prevalence of mortality due to illness and disease in this population. The incarcerated population is largely drawn from the most disadvantaged segments of society, with significant health care needs but limited access to regular care. As a result, many incarcerated individuals arrive at correctional facilities in poor health with conditions that were previously undiagnosed.[27] Over half of people in state prisons have a substance use disorder and overdose is a leading cause of death among currently and formerly incarcerated people.[28] [29] Moreover, according to government data last compiled in 2017, close to half of people in jails have a diagnosis of major mental illness.[30] Prisons have been historically ill-equipped to handle the influx of inmates experiencing substance use disorder and mental illness.

Once incarcerated, the conditions of confinement often have a negative impact on health. Stress associated with institutional life, overcrowding, inadequate access to exercise, improper diet, exposure to infectious diseases, and poor sanitation and ventilation can all contribute to mortality. Further, while incarcerated individuals have a constitutional right to health care, the access to and the quality of the care in correctional facilities are variable. As noted above, insufficient resources play a key role, especially limited budgets and regulations that require correctional facilities to prioritize treating certain diseases over others.[31]

National Commission on Correctional Health Care (NCCHC)

Several professional organizations, including the AMA, the American Public Health Association, and later, the National Commission on Correctional Health Care (NCCHC), have established national standards for correctional health care. NCCHC's origins date to the early 1970s, when an AMA study of jails found inadequate, disorganized health services and a lack of national standards. In collaboration with other organizations, the AMA established a program that in 1983 became the NCCHC, an independent, 501(c)(3) nonprofit organization. Forty years later, NCCHC remains the only national organization dedicated solely to improving correctional health care quality. This is done by establishing rigorous standards for health services in correctional facilities, operating a voluntary accreditation program for institutions that meet those standards, offering certification for correctional health professionals, conducting educational conferences and webinars, and producing industry-specific publications and other resources.[32]

EXISTING AMA POLICY AND ADVOCACY

Policy H-430.986, "Health Care While Incarcerated," advocates for adequate payment to health care providers, including primary care and mental health and addiction treatment professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process. This policy also advocates for necessary programs and staff training to address the needs of incarcerated individuals. Moreover, this policy

encourages state Medicaid agencies to accept and process Medicaid applications from individuals who are incarcerated, and to work with correctional facilities to assist individuals to apply and receive a Medicaid eligibility determination.

Policy H-430.997, "Standards of Care for Inmates of Correctional Facilities," states 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.

Policy D-430.997 "Support for Health Care Services to Incarcerated Persons" supports NCCHC standards that improve the quality of health care services, including mental health services, delivered to the nation's correctional facilities; encourages all correctional systems to support NCCHC accreditation; and encourages the NCCHC and its AMA representative to work with departments of corrections and public officials to find cost effective and efficient methods to increase correctional health services funding. This policy also calls on the AMA to work with an accrediting organization, such as NCCHC, in developing a strategy to accredit all correctional, detention and juvenile facilities and to advocate that all correctional, detention and juvenile facilities be accredited by the NCCHC no later than 2025.

AMA Advocacy

The AMA and Manatt Health released a state toolkit to End the Nation's Drug Overdose Epidemic.[41] The toolkit provides recommendations across several domains, including that "States should provide evidence-based medical care to incarcerated populations, including continuing, initiating, and ensuring access to medications for opioid use disorder (MOUD). States should remove criminal and other penalties for pregnant, postpartum, and parenting women for whom MOUD is part of treatment for an opioid use disorder."

The AMA sent a letter of support for H.R. 955 and S. 285, the "Medicaid Reentry Act," which would provide states with the flexibility to allow Medicaid payment for medical services furnished to an incarcerated individual during the 30-day period preceding the individual's release.

DISCUSSION

The Board believes it is important to ensure that proper health care is administered to those in all correctional facilities, whether public or private, and that the same standards should apply to all health care services delivered in all facilities. As a leading organization committed to improving public health and advancing health equity, the AMA has long advocated for quality health care services, humane treatment, and healthy environments for justice-involved populations. The Board notes that, as discussed, our AMA already has existing policy that supports AMA advocacy for appropriate health care in all forms of correctional facilities, including policy stating that correctional and detention facilities should provide medical, including psychiatric and substance use disorder care, that meets prevailing community standards. Additional policy calls on the AMA to work with an accrediting organization, such as the NCCHC, in developing a strategy to accredit all correctional, detention, and juvenile facilities and to advocate that all such facilities be accredited by the NCCHC no later than 2025. The Board believes that the AMA should remain focused on ensuring that appropriate, quality health care is provided to inmates in all facilities, regardless of private or public status. Accordingly, the Board recommends that existing AMA policy be reaffirmed in lieu of Resolution 202.

RECOMMENDATIONS

The Board of Trustees recommends that the following recommendations be adopted in lieu of Resolution 202-I-23, and that the remainder of the report be filed.

> That our American Medical Association reaffirm existing AMA Policies H-430.986, "Health Care While Incarcerated;" H-430.997, "Standards of Care for Inmates of Correctional Facilities;" and D-430.997, "Support for Health Care Services to Incarcerated Persons." (Reaffirm HOD Policy)

Fiscal Note: Less than $500.

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[1] Prison Policy Initiative. Mass Incarceration: The Whole Pie 2023. Available at https://www.prisonpolicy.org/reports/pie2023.html.
[2] Prison Policy Initiative. Mass Incarceration: The Whole Pie 2024. Available at https://www.prisonpolicy.org/reports/pie2024.html.
[3] *Id*.
[4] The Sentencing Project. Private Prisons in the United States. Budd, Kristen M., PhD. February 21, 2024. Available at https://www.sentencingproject.org/reports/private-prisons-in-the-united-states/. Based on U.S. Department of Justice, Bureau of Justice Statistics. Prisoners in 2022 – Statistical Tables, available at https://bjs.ojp.gov/document/p22st.pdf. Note that DOJ numbers do not include individuals housed in immigration detention, since they are not under DOJ jurisdiction.
[5] https://interrogatingjustice.org/ending-mass-incarceration/prison-every-10-days/.
[6] The Sentencing Project. Gotsch, K. Capitalizing on Mass Incarceration: U.S. Growth in Private Prisons. August 2018. Available at https://www.sentencingproject.org/app/uploads/2022/08/Capitalizing-on-Mass-Incarceration.pdf.
[7] Department of Justice Appropriations Act, 1996, PL 104-134, as stated in section 114. Cited in "Inside Private Prisons: An American Dilemma in the Age of Mass Incarceration," Eisen, L-B. Columbia University Press. November 2017.
[8] The Sentencing Project. Gotsch, K. Capitalizing on Mass Incarceration: U.S. Growth in Private Prisons. Available at https://www.sentencingproject.org/app/uploads/2022/08/Capitalizing-on-Mass-Incarceration.pdf.
[9] *Id*.
[10] *Id.*
[11] The Sentencing Project. Private Prisons in the United States. Budd, Kristen M., PhD. February 21, 2024. Available at https://www.sentencingproject.org/reports/private-prisons-in-the-united-states/.
[12] The Sentencing Project. Gotsch, K. Capitalizing on Mass Incarceration: U.S. Growth in Private Prisons. Available at https://www.sentencingproject.org/app/uploads/2022/08/Capitalizing-on-Mass-Incarceration.pdf.
[13] *Id.*
[14] Office of the Inspector General, U.S. Department of Justice. Review of the Federal Bureau of Prisons' Monitoring of Contract Prisons. August 2016.
[15] The Sentencing Project. Gotsch, K. Capitalizing on Mass Incarceration: U.S. Growth in Private Prisons. Available at https://www.sentencingproject.org/app/uploads/2022/08/Capitalizing-on-Mass-Incarceration.pdf.
[16] *Id.*
[17] The Sentencing Project. Private Prisons in the United States. Budd, Kristen M., PhD. February 21, 2024. Available at https://www.sentencingproject.org/reports/private-prisons-in-the-united-states/.
[18] Executive Order on Reforming Our Incarceration System to Eliminate the Use of Privately Operated Criminal Detention Facilities, January 26, 2021, available at https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/26/executive-order-reforming-our-incarceration-system-to-eliminate-the-use-of-privately-operated-criminal-detention-facilities/.
[19] ACLU. President Biden's Order to Ban Private Prisons Faces a Persistent Internal Challenge: The U.S. Marshals Service. March 1, 2024, available at https://www.aclu.org/news/criminal-law-reform/president-bidens-order-to-ban-private-prisons-faces-a-persistent-internal-challenge-the-u-s-marshals-service.

[20] Office of the Inspector General, U.S. Department of Justice. Review of Concerns Raised Related to the United States Marshals Service's Implementation of Executive Order 14006. March 2023. Available at https://oig.justice.gov/sites/default/files/reports/23-055.pdf.
[21] Private Equity Stakeholder Project. Privatized prison healthcare seeks profit at patients' expense, October 17, 2023. Available at https://pestakeholder.org/news/privatized-prison-healthcare-seeks-profit-at-patients-expense/#_ftn10.
[22] *Id.*
[23] *Id.*
[24] https://www.cnn.com/interactive/2019/06/us/jail-health-care-ccs-invs/.
[25] Dying Inside, The Hidden Crisis in America's Jails. October 26, 2020.Available at https://www.reuters.com/investigates/special-report/usa-jails-privatization/.
[26] Conner C, Mitchell C, Jahn J; End Police Violence Collective. Advancing Public Health Interventions to Address the Harms of the Carceral System: A Policy Statement Adopted by the American Public Health Association, October 2021. Med Care. 2022 Sep 1;60(9):645-647. doi: 10.1097/MLR.0000000000001756. Epub 2022 Jul 18. PMID: 35848739.
[27] Study of Best Practices for Acute Care of Patients in the Custody of Law Enforcement or Corrections, https://www.ama-assn.org/system/files/a23-csaph06.pdf.
[28] Public Health and Prisons: Priorities in the Age of Mass Incarceration. Annual Review of Public Health, Dec. 21, 2022. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10128126/.
[29] Nowotny KM, Rogers RG, Boardman JD. Racial disparities in health conditions among prisoners compared with the general population. Popul Health. 2017;3:487–496.
[30] The Marshall Project. "This Company Promised to Improve Health Care in Jails. Dozens of its Patients Have Died. July 30, 2024. Available at https://www.themarshallproject.org/2024/07/30/oklahoma-jail-turn-key-health-deaths.
[31] Study of Best Practices for Acute Care of Patients in the Custody of Law Enforcement or Corrections, https://www.ama-assn.org/system/files/a23-csaph06.pdf.
[32] National Commission on Correctional Health Care. *About us*. Available at https://www.ncchc.org/about-us/.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 13-I-24

Subject:	AMA/Specialty Society RVS Update Committee (Resolution 821-I-23)
Presented by:	Michael Suk, MD, JD, MPH, MBA, Chair
Referred to:	Reference Committee J

At the 2023 Interim Meeting, the House of Delegates (HOD) referred Resolution 821. Introduced by the American College of Physicians, the American Academy of Family Physicians, and the Florida Medical Association, the resolution calls on the American Medical Association (AMA) to:

> Encourage the AMA/Specialty Society Relative Value Scale (RVS) Update Committee (RUC) to modernize the RUC's processes and implement the following principles:
>
> Data-Driven Decision Making: Enhance the data used in making recommendations by shifting from almost exclusive reliance on surveys of physicians and others who perform services to broader use of evidence-based data and metadata (e.g., procedure time from operating logs, hospital length of stay data, and other extant data sources) that permit assessment of resource use and the relative value of physician and other qualified healthcare professional services comprehensively. This can ensure that data is reliable, verifiable, and can be accurately compared to or integrated with other important databases.
>
> Collaboration and Transparency: Seek collaboration with healthcare data experts, stakeholders, and relevant organizations to maintain transparent data collection and analysis methodologies.
>
> Continuous Review and Adaptation: Expand and enhance its system for continuous review and adaptation of relative value determinations beyond its Relativity Assessment Workgroup (RAW) and other current strategies (e.g., New Technology/New Services list) to stay aligned with evolving healthcare practices and technologies.
>
> Equity and Access: Work with the Current Procedural Terminology (CPT®) Editorial Panel and others, as appropriate, to identify the impact that factors related to healthcare equity and access have on the resources used to provide the services of physicians and other qualified healthcare professionals and how to account for those resources in the description and subsequent valuation of those services.
>
> Broader Engagement: Actively engage with other parties to gather input and ensure that relative value determinations align with the broader healthcare community's goals and values.
>
> Education and Training: Invest in the education and training of its members, AMA and specialty society staff, and other participants (e.g., specialty society RUC advisors) to build expertise in evidence-based data analysis and metadata utilization.

Timely Implementation: Invest the necessary resources and establish a clear timeline for the implementation of these modernization efforts, with regular progress self-assessment.

Testimony ranged from those who perceived that datasets of physician time are readily available and should be used to replace national medical specialty society surveys and clinical input to those who did not support the resolution and explained that specialty society information is currently the most available and reliable data. Many delegates supported referral as the RUC process may not be widely understood and a report would provide a greater understanding of its important work.

This report explains the RUC process, its relationship to the AMA, national medical specialty societies and the Centers for Medicare & Medicaid Services (CMS), and the data and methodology utilized to ensure that the Resource-Based Relative Value Scale (RBRVS) remains accurate.

BACKGROUND

In 1992, Medicare significantly changed the way it pays for physician services, based on statutory requirements from the Omnibus Budget Reconciliation Act of 1989. Instead of basing payments on charges, the federal government established a standardized physician payment schedule based on the RBRVS. In the RBRVS system, payments for services are determined by the resource costs needed to provide them. The cost of providing each service is divided into three components: physician work, practice expense, and professional liability insurance. Payments are calculated by multiplying the combined costs of a service by a conversion factor (a monetary amount that is determined by Congress and CMS). Payments are also adjusted for geographical differences.

The physician work component currently accounts for 50.9 percent of the total relative values units (RVUs) in the RBRVS system. The initial physician work relative values were based on the results of a Harvard School of Public Health study. The factors used to determine physician work, defined by statute and regulation, include the time it takes to perform the service; the technical skill and physical effort; the required mental effort and judgment; and stress due to the potential risk to the patient. The physician work relative values are updated each year to account for changes in medical practice described by new CPT codes. Practice expense accounts for 44.8 percent of the total relative values in the RBRVS system and represents the direct costs (e.g., clinical staff, medical supplies, medical equipment) and indirect costs associated with the individual service. Professional liability insurance accounts for 4.3 percent of the total relative values in the RBRVS system.

THE RUC PROCESS

The RUC has served the physician community for more than 30 years, by most importantly ensuring that all physician specialties have an equal opportunity to represent their members and patients in a consistent, standardized, and fair process. Using its First Amendment right to petition the federal government, the RUC submits recommendations to CMS on resources required to provide a physician service. The RUC's data collection, deliberations, and recommendations must reflect the policy requirements of the RBRVS as determined via statute and regulation.

Data Driven Decision Making

The RUC reviews new services in advance of implementation of new and revised CPT codes. National medical specialty societies and other health care professional organizations use a standardized and rigorous survey process, designed to conform to federal requirements, to collect information from a random sample of physicians and others on the time, intensity, and work to perform the service in relationship to other services commonly performed by their members. The median number of survey responses for individual CPT codes is 70 responses. For services with

higher volume, more than 100 responses are expected. The Evaluation and Management (E/M) office visit survey yielded the highest number of responses in the history of the RUC process, with 1,700 physicians completing the survey. The E/M survey was the concerted effort of 51 specialty societies and other health care professional organizations who represent 95 percent of Medicare claims for office visits. The data collected from these surveys provided the underlying basis for CMS implementing substantial payment increases for E/M office visit services in 2021.

Finally, the RUC also convenes a process to identify potentially misvalued services and then reexamines these services. Since 2006, the RUC has identified, reviewed, and submitted recommendations on nearly 2,800 services, resulting in the deletion of CPT codes or decrease in valuation for 58 percent of these services. As a component of participating in the RUC process and having an opportunity to fairly represent their members, national medical specialty societies conduct surveys to update the data for these identified services. In addition, the RUC provides the opportunity for specialty societies to identify national databases that may be utilized to present extant data. The RUC considers these data sets utilizing an approved list of criteria (e.g., ability to track data over time). To date, the RUC has approved the following databases to be utilized in support of the specialty presentations: Society of Thoracic Surgeons (STS) National Database™; American College of Cardiology (ACC) CathPCI Registry®; ACC LAAO Registry™; ACC EP Device Implant Registry™; STS/ACC TVT Registry™; and American Speech Hearing Language Association National Outcomes Measurement System. All participants are invited to submit extant data sources for consideration.

The RUC utilizes Medicare claims data in its processes to determine the typical patient, site-of-service, specialty, diagnosis, and other information to both determine appropriate relative value recommendations and to determine if a service may be potentially misvalued.

Collaboration and Transparency

The RUC is a transparent process. All RUC meeting minutes, votes, and recommendations are available on the AMA website and in a public database. Anyone may attend a RUC meeting. Hundreds of physicians from national specialty societies and other health care professionals attend as RUC participants. CMS sends representatives to each RUC meeting. Other observers include Medicare carrier medical directors, international delegations, MedPAC staff, Congressional staff, and researchers (e.g., Stanford, RAND). Since its inception in 1991, the RUC has sought the advice of AMA economists and other consultants in reviewing methodological or data methods.

Continuous Review and Adaptation

Federal law requires that all relative values be open for public comment and reviewed at least every five years. After initial implementation of the RBRVS in 1992, these reviews occurred for 1997, 2002, and 2007 implementation. In 2006, the RUC created the Relativity Assessment Workgroup (RAW) to ensure that services are identified and reviewed on an annual basis. In addition, CMS provides an annual opportunity, via federal rulemaking, for any individual or organization to identify services for review. The RUC also identifies new technology and maintains a new technology/new services list, reviewed when sufficient claims data become available.

The RAW, and the RUC, have identified and reviewed 2,800 services since the process inception in 2006. Numerous objective screens (e.g., rapid growth in utilization, site-of-service changes) are utilized to identify potentially misvalued services. To date, the RUC has reviewed services that comprise, in total allowed charges, 95 percent of the Medicare Physician Payment Schedule. More than $5 billion of annual spending has been redistributed, resulting from this process. To ensure a fair and consistent process, all participants in the RUC process may propose objective screens to identify such potential misvaluation. In addition, any member of the public may comment to CMS

on individual services they believe to be misvalued. It should be noted that any increases in valuation must be supported by compelling evidence (e.g., that the service or patient population has substantially changed), a hurdle not only for RUC review, but also CMS consideration.

The RUC is further supported by an Administrative Subcommittee, Research Subcommittee, Practice Expense Subcommittee, Professional Liability Insurance Workgroup, and ad hoc workgroups to consider and adapt the RUC process and methodology. The CPT Editorial Panel and RUC often form joint workgroups to consider significant issues such as E/M services. The RUC and RUC process continuously evolve. The RUC's Administrative Subcommittee periodically studies the RUC composition. These reviews over the past two decades resulted in additional seats for neurology, geriatrics, physical medicine and rehabilitation, and primary care. The survey methodology is under constant review, including the Research Subcommittee review of customized surveys, such as for E/M office visits, to capture essential information. At each RUC meeting, RUC members, Advisors and other attendees are welcome to introduce new business items which typically relate to process improvements and are studied by these RUC Subcommittees.

Equity and Access

The RUC has actively worked with the CPT Editorial Panel to identify coding and valuation opportunities to address equity issues. For example, the CPT/RUC Workgroup on E/M was successful in changing the medical decision-making component to recognize that when a diagnosis or treatment is significantly limited by social determinants of health, a higher level of medical decision making for E/M coding may be warranted.

The RUC recently asked the American Urological Association and the American College of Obstetricians and Gynecologists to review services, performed by their members, which may be anatomically analogous but described by different CPT codes, such as hysterectomy vs. prostatectomy, to ensure gender equity in valuation. These specialty societies presented to the RUC that there were no overall inequities in the valuation of the services performed by these two specialties.[1] During that discussion, the RUC identified that the cost of providing a pelvic exam should be recognized to ensure equity in visit payments. The RUC referred the issue to CPT. CMS implemented RUC recommended RVUs for a new code on January 1, 2024.

RUC Composition/Broader Engagement

The RUC is comprised of 32 seats, 29 voting. The RUC requires a two-thirds majority approval to submit a recommendation to CMS. The RUC members do not advocate for their specialty and are strictly prohibited to speak to any code that their nominating specialty society members perform. The RUC must have the required clinical expertise to review the full range of physician services described in CPT and Healthcare Common Procedural Coding System codes. Primary care specialties are the top provider of only 184 of 7,392 CPT codes. The RUC does not review "specialties," but rather individual services described by CPT codes. For example, rather than discuss valuation of primary care, the RUC reviews specific CPT codes describing E/M services. Notably, 25 of the 29 voting members on the RUC are from specialties that receive 40 percent or more of their Medicare payment from E/M services. Therefore, nearly every voting member frequently perform and understand the resource costs required to perform E/M services described by individual CPT codes.

The AMA has one vote on the RUC. Every national medical specialty society in the AMA HOD may also appoint an Advisor, Alternate Advisor, and two staff to participate in the RUC process. In addition, the RUC has an active Health Care Professionals Advisory Committee to represent the non-MD/DOs who report their services based on the Medicare Physician Payment Schedule. RUC meetings are open, and observers are welcome to attend and provide feedback to the RUC.

Education and Training of RUC Participants
The RUC has an orientation process for its members, advisors, staff, and other participants. The RUC process is extremely technical, and it does require investment and time to become proficient in the rules and standards of the RBRVS methodology. The orientation includes participation in 12 webinars and annual in-person training sessions. Most RUC members first serve for years as Advisors before being appointed to the RUC to fully be immersed into the RBRVS system.

Timely Improvements and Resources
The RUC has a continuous mechanism to ensure evolution and improvement in its methodology and processes. The RUC's Administrative Subcommittee, Research Subcommittee, and Practice Expense Subcommittee are all actively engaged in this effort. Collectively, the AMA and national medical specialty societies have devoted significant resources to the RUC process since its inception, spending millions of dollars each year for data collection, meetings, and travel. Hundreds of physician volunteers also spend countless hours preparing for and participating in RUC meetings.

AMA POLICY

The AMA has extensive, long-standing policy that supports the RUC process and the ability of physicians to provide clinical input into the refinement and improvement of the RBRVS (Policies D-400.983, D-400.986, D-400.988, D-400.999, H-70.952, H-70.980, H-400-956, H-400.957, H-400.959, H-400.962, H-400.969, H-400.972, H-400.973, H-400.990, H-400.991). Most relevant to the issues discussed in the report are the following AMA policies supporting the RUC and its ability to implement methodological improvements:

Policy D-400.983 states that the AMA, together with state medical associations and national medical specialty societies, will work to ensure that the resource-based relative value system and work values follow the statutory provisions that require the consideration of time and intensity.

Policy H-400.959 supports the RUC's efforts to improve the validity of the RBRVS through development of methodologies for assessing the relative work of new technologies and for assisting CMS in a more comprehensive review and refinement of the work component of the RBRVS.

Policy 400.969 states that the AMA continue to urge CMS to adopt the recommendations of the RUC for work relative values for new and revised CPT codes, and strongly supports the use of the RUC process as the principal method of refining and maintaining the Medicare RBRVS.

DISCUSSION

This report provides the opportunity to summarize the RUC process and the ongoing activities to offer improvements to the RBRVS. The RUC has successfully advocated on behalf of medicine and other health care professionals since 1991, with CMS often accepting more than 90 percent of the RUC's annual recommendations. The RUC also has engaged in the responsible, yet difficult, endeavor to identify potentially misvalued services. The national medical specialty societies are to be applauded for their ongoing effort to survey members and obtain clinical expertise to ensure that services are accurately and fairly evaluated, even when that review may lead to reduction in valuation for their services and a redistribution to other services.

The RUC has a long history of improving payment for primary care services, including increases to RVUs for preventive medicine, immunization administration, care management and E/M services in 1997, 2007 and 2021. Medical home recommendations were submitted to CMS in 2008.

The RUC has developed numerous standards within its review to ensure consistency and relativity using the national specialty society surveys and clinical expertise. Standards are used for physician pre-time evaluation, positioning and scrub, dress and wait times, and for post-time on the date of surgery. Numerous time standards are used for the tasks performed by clinical staff. These standards were developed with significant input by the national medical specialty societies, reviewed by the RUC, and ultimately published for public comment and review via CMS rulemaking. These standards, along with the national medical specialty society data, and the peer review by the RUC, lead to fair and consistent relative value recommendations to CMS.

The AMA supports the RUC's request for additional claims data from CMS, including updated Medicaid data and Medicare Advantage data. The AMA recently commented to CMS on a request for information on Medicare Advantage data and urged CMS to release these claims data in a manner similar to traditional Medicare claims data. The AMA also continues to investigate available claims data from commercial payers.

In addition, AMA staff have engaged in numerous meetings with staff from Epic and Oracle (which acquired Cerner in 2022) regarding the availability of any data within their electronic health systems that may be beneficial in reviewing physician time of individual services. To date, these systems do not collect meaningful physician time data that may be shared or utilized by the RUC. Ongoing discussions with Oracle on potential length of stay data will continue.

As previously noted, several national medical specialty societies have engaged in creating patient registries and some of these registries include time data. Cardiothoracic Surgery and Cardiology have each shared registry information with the RUC and these sources of extant data are approved for use in the valuation process. Other national medical specialties should be encouraged to share relevant extant databases with the RUC. The AMA, as well as the RUC's Research Subcommittee, will continue to investigate additional valid data sources to supplement specialty surveys, registries and claims databases that can enhance the overall RUC process.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted in lieu of Resolution 821-I-23, and the remainder of the report be filed.

1. That our American Medical Association (AMA) support the continued efforts of the AMA/Specialty Society RVS Update Committee (RUC) to identify extant data to utilize within the ongoing process to improve the Resource Based Relative Value Scale (RBRVS). (New HOD Policy)

2. That our AMA reaffirm Policy D-400.983, which supports the RUC and its ability to implement methodological improvements. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy H-400.959, which supports the RUC's efforts to improve the validity of the RBRVS through development of methodologies for assessing the relative work of new technologies. (Reaffirm HOD Policy)

4. That our AMA reaffirm Policy H-400.969, which calls on the Centers for Medicare & Medicaid Services to adopt the recommendations of the RUC for work relative values for new and revised Current Procedural Terminology (CPT®) codes, and strongly supports the use of the RUC process as the principal method of refining and maintaining the Medicare RBRVS. (Reaffirm HOD Policy)

Fiscal Note: $500

REFERENCES

[1]Hathaway, JK, Schuster MS, Richards KA, Turk TMT. Comparison of Work Relative Value Units Assigned to Urological and Gynecological Surgical Procedures. Urology Practice. 2024 July 1: 11 (4):654-60. Available at: https://www.auajournals.org/doi/10.1097/UPJ.0000000000000612

Board of Trustees Report -I-24
AMA/Specialty Society RVS Update Committee
Policy Appendix

Arbitrary Relative Value Decisions by CMS D-400.983
1. Our AMA, together with state medical associations and national medical specialty societies, will work to ensure that the resource-based relative value system and physician work values follow the statutory provisions that require the consideration of time and intensity. 2. Our AMA, working with state medical associations and national medical specialty societies, strongly advocates that the Centers for Medicare and Medicaid Services restore the Refinement Panel to serve as the appeals process that was appropriately in place from 1993-2010. Res. 107, A-16

The RUC: Recent Activities to Improve the Valuation of Primary Care Services D-400.986
Our AMA continues to advocate for the adoption of AMA/Specialty Society RVS Update Committee (RUC) recommendations, and separate payment for physician services that do not necessarily require face-to-face interaction with a patient. BOT Rep. 14, A-08 Reaffirmed: CMS Rep. 01, A-18

PLI-RVU Component of RBRVS Medicare Fee Schedule D-400.988
Our AMA will: (1) continue its current activities to seek correction of the inadequate professional liability insurance component in the Resource-Based Relative Value Scale Formula; (2) continue its current activities to seek action from the Centers for Medicare & Medicaid Services to update the Professional Liability Insurance Relative Value Units (PLI-RVU) component of the RBRVS to correctly account for the current relative cost of professional liability insurance and its funding; and (3) support federal legislation to provide additional funds for this correction and update of the PLI-RVU component of the RBRVS, rather than simply making adjustments in a budget-neutral fashion. Res. 707, I-03 Reaffirmed: BOT Rep. 18, A-05 Modified: CCB/CLRPD Rep. 2, A-14

Non-Medicare Use of the RBRVS D-400.999
Our AMA will: (1) reaffirm Policy H-400.960 which advocates that annually updated and rigorously validated Resource Based Relative Value Scale (RBRVS) relative values could provide a basis for non-Medicare physician payment schedules, and that the AMA help to ensure that any potential non-Medicare use of an RBRVS reflects the most current and accurate data and implementation methods;.(2) reaffirm Policy H-400.969 which supports the use of the AMA/Specialty Society process as the principal method of refining and maintaining the Medicare relative value scale;(3) continue to identify the extent to which third party payers and other public programs modify, adopt, and implement Medicare RBRVS payment policies;(4) strongly oppose and protests the Centers for Medicare & Medicaid Services Medicare multiple surgery reduction policy which reduces payment for additional surgical procedures after the first procedure by more than 50 percent; and (5) encourage third party payers and other public programs to utilize the most current CPT codes updated by the first quarter of the calendar year, modifiers, and relative values to ensure an accurate implementation of the RBRVS. CMS Rep. 12, A-99 Reaffirmation I-03 Reaffirmation I-07 Modified: BOT Rep. 22, A-17

Medicare Guidelines for Evaluation and Management Codes H-70.952
Our AMA (1) seeks Federal regulatory changes to reduce the burden of documentation for evaluation and management services; (2) will use all available means, including development of new Federal legislation and/or legal measures, if necessary, to ensure appropriate safeguards for physicians, so that insufficient documentation or inadvertent errors in the patient record, that does not meet evaluation and management coding guidelines in and of itself, does not constitute fraud or abuse; (3) urges CMS to adequately fund Medicare Carrier distribution of any documentation

guidelines and provide funding to Carriers to sponsor educational efforts for physicians; (4) will work to ensure that the additional expense and time involved in complying with documentation requirements be appropriately reflected in the Resource Based Relative Value Scale (RBRVS); (5) continues to advise and educate physicians about the guidelines, any revisions, and their implementation by CMS; and (6) AMA policy is that in medical documentation the inclusion of any items unrelated to the care provided (e.g., irrelevant negatives) not be required. Sub. Res. 801, I-97 Reaffirmation I-00 Reaffirmed: CMS Rep. 6, A-10 Modified: CMS Rep. 01, A-20

Bundling CPT Codes H-70.980
1. Our AMA, through its CPT Editorial Panel and Advisory Committee, will continue to work with CMS to provide physician expertise commenting on the medical appropriateness of code bundling initiatives for Medicare payment policies. 2. Our AMA strongly urges the Centers for Medicare & Medicaid Services (CMS) to not treat bundling of existing services into a common code as a new procedure and new code. 3. Our AMA will advocate for a phase-in of new values for codes where the cuts resulting from the identification of misvalued services cause a significant reduction from the value of the existing codes and work with CMS to achieve a smooth transition for such codes. 4. The RUC will take into consideration CMS's willingness or reluctance to transition large payment reductions as it schedules the review of relative values for bundled services or other codes that come before the RUC as a result of the identification of potentially misvalued services. 5. Our AMA strongly supports RUC recommendations and any cuts by CMS beyond the RUC recommendations will be strongly opposed by our AMA. Sub. Res. 801, I-91 Reaffirmed: Res. 814, A-00 Reaffirmed: CMS Rep. 6, A-10 Appended: Res. 118, A-10 Reaffirmation I-13 Reaffirmed: CMS Rep. 01, A-23

RBRVS Development H-400.956
That the AMA strongly advocate CMS adoption and implementation of all the RUC's recommendations for the five-year review; (2) That the AMA closely monitor all phases in the development of resource-based practice expense relative values to ensure that studies are methodologically sound and produce valid data, that practicing physicians and organized medicine have meaningful opportunities to participate, and that any implementation plans are consistent with AMA policies; (3) That the AMA work to ensure that the integrity of the physician work relative values is not compromised by annual budget neutrality or other adjustments that are unrelated to physician work; (4) That the AMA encourage payers using the relative work values of the Medicare RBRVS to also incorporate the key assumptions underlying these values, such as the Medicare global periods; and (5) That the AMA continue to pursue a favorable advisory opinion from the Federal Trade Commission regarding AMA provision of a valid RBRVS as developed by the RUC process to private payers and physicians. BOT Rep. 16, A-95 BOT Rep. 11, A-96 Reaffirmed: CMS Rep. 4, I-02 Reaffirmed: BOT Rep. 14, A-08 Reaffirmed: Sub. Res. 104, A-14 Reaffirmation A-15

Medicare Reimbursement of Office-Based Procedures H-400.957
Our AMA will: (1) encourage CMS to expand the extent and amount of reimbursement for procedures performed in the physician's office, to shift more procedures from the hospital to the office setting, which is more cost effective; (2) seek to have the RBRVS practice expense RVUs reflect the true cost of performing office procedures; and (3) work with CMS to develop consistent regulations to be followed by carriers that include reimbursement for the costs of disposable supplies and surgical tray fees incurred with office-based procedures and surgery. Sub. Res. 103, I-93 Reaffirmed by Rules & Credentials Cmt., A-96 Reaffirmation A-04 Reaffirmation I-04 Reaffirmed: CMS Rep. 1, A-14 Reaffirmed: CMS Rep. 3, A-14 Reaffirmed in lieu of Res. 216,

I-14 Reaffirmed: CMS Rep. 04, I-18 Reaffirmed: BOT Action in response to referred for decision Res. 111, A-19 Reaffirmed: BOT Action in response to referred for decision Res. 132, A-19 Reaffirmation: A-22

Refining and Updating the Physician Work Component of the RBRVS H-400.959
The AMA: (1) supports the efforts of the CPT Editorial Panel and the AMA/Specialty Society RVS Update Committee's (RUC's) work with the American Academy of Pediatrics and other specialty societies to develop pediatric-specific CPT codes and physician work relative value units to incorporate children's services into the RBRVS; (2) supports the RUC's efforts to improve the validity of the RBRVS through development of methodologies for assessing the relative work of new technologies and for assisting CMS in a more comprehensive review and refinement of the work component of the RBRVS; and (3) continues to object to use of the relative values as a mechanism to preserve budget neutrality. BOT Rep. I-93-26 Reaffirmed by BOT Rep. 8-I-94 Res. 806, I-94 Reaffirmed: Sub. Res. 816, I-99 Reaffirmed: CMS Rep. 4, I-02 Reaffirmed: BOT Rep. 14, A-08 Reaffirmed: Sub. Res. 104, A-14 Reaffirmation A-15

The AMA/Specialty Society RVS Update Process H-400.962
Our AMA will strengthen its efforts to secure CMS adoption of the AMA/Specialty Society RVS Update Committee's (RUC) recommendations. BOT Rep. N, A-93 Reaffirmed: Sub. Res. 821, I-99 Reaffirmed: BOT Rep. 14, A-08 Reaffirmed: CMS Rep. 01, A-18

RVS Updating Status Report and Future Plans H-400.969
Status Report and Future Plans: The AMA/Specialty Society RVS Update Committee (RUC) represents an important opportunity for the medical profession to maintain professional control of the clinical practice of medicine. The AMA urges each and every organization represented in its House of Delegates to become an advocate for the RUC process in its interactions with the federal government and with its physician members. The AMA (1) will continue to urge CMS to adopt the recommendations of the AMA/Specialty Society RVS Update Committee for physician work relative values for new and revised CPT codes; (2) supports strongly use of this AMA/Specialty Society process as the principal method of refining and maintaining the Medicare RVS; (3) encourages CMS to rely upon this process as it considers new methodologies for addressing the practice expense components of the Medicare RVS and other RBRVS issues; (4) opposes changes in Relative Value Units that are in excess of those recommended by the AMA/Specialty Society Relative Value Scale Update Committee (RUC); and (5) supports the ongoing effort of members of the federation to analyze the valuation of CPT codes describing similar services by gender to ensure equitable valuation. BOT Rep. O, I-92 Reaffirmed by BOT Rep. 8-I-94 Reaffirmed by BOT Rep. 7, A-98 Reaffirmed: CMS Rep.12, A-99 Reaffirmed: CMS Rep. 4, I-02 Reaffirmed: BOT Rep. 14, A-08 Reaffirmation I-10 Appended: Res. 822, I-12 Reaffirmation I-13 Reaffirmed: Sub. Res. 104, A-14 Reaffirmed in lieu of Res. 216, I-14 Reaffirmation A-15 Appended: Res. 105, A-23

Physician Payment Reform H-400.972
It is the policy of the AMA to (1) take all necessary legal, legislative, and other action to redress the inequities in the implementation of the RBRVS, including, but not limited to, (a) reduction of allowances for new physicians; (b) the non-payment of EKG interpretations; (c) defects in the Geographic Practice Cost Indices and area designations; (d) inappropriate Resource-Based Relative Value Units; (e) the deteriorating economic condition of physicians' practices disproportionately affected by the Medicare payment system; (f) the need for restoration of the RBRVS conversion factor to levels consistent with the statutory requirement for budget neutrality; (g) the inadequacy of payment for services of assistant surgeons; and (h) the loss of surgical-tray benefit for many outpatient procedures (Reaffirmed by Rules & Credentials Cmt., A-96); (2) seek an evaluation of (a) stress factors (i.e., intensity values) as they affect the calculation of the Medicare Payment

Schedule, seeking appropriate, reasonable, and equitable adjustments; and (b) descriptors (i.e., vignettes) and other examples of services used to determine RBRVS values and payment levels and to seek adjustments so that the resulting values and payment levels appropriately pertain to the elderly and often infirm patients; (3) evaluate the use of the RBRVS on the calculation of the work component of the Medicare Payment Schedule and to ascertain that the concept for the work component continues to be an appropriate part of a resource-based relative value system; (4) seek to assure that all modifiers, including global descriptors, are well publicized and include adequate descriptors; (5) seek the establishment of a reasonable and consistent interpretation of global fees, dealing specifically with preoperative office visits, concomitant office procedures, and/or future procedures; (6) seek from CMS and/or Congress an additional comment period beginning in the Fall of 1992; (7) seek the elimination of regulations directing patients to points of service; (8) support further study of refinements in the practice cost component of the RBRVS to ensure better reflection of both absolute and relative costs associated with individual services, physician practices, and medical specialties, considering such issues as data adequacy, equity, and the degree of disruption likely to be associated with any policy change; (9) take steps to assure that relative value units in the Medicare payment schedule, such as nursing home visits, are adjusted to account for increased resources needed to deliver care and comply with federal and state regulatory programs that disproportionately affect these services and that the Medicare conversion factor be adjusted and updated to reflect these increased overall costs; (10) support the concepts of HR 4393 (the Medicare Geographic Data Accuracy Act of 1992), S 2680 (the Medicare Geographic Data Accuracy Act of 1992), and S 2683 (Medicare Geographic Data Accuracy Act) for improving the accuracy of the Medicare geographic practice costs indices (GPCIs) and work with CMS and the Congress to assure that GPCIs are updated in as timely a manner as feasible and reflect actual physician costs, including gross receipt taxes; (11) request that CMS refine relative values for particular services on the basis of valid and reliable data and that CMS rely upon the work of the AMA/Specialty Society RVS Updating Committee (RUC) for assignment of relative work values to new or revised CPT codes and any other tasks for which the RUC can provide credible recommendations; (12) pursue aggressively recognition and CMS adoption for Medicare payment schedule conversion factor updates of an index providing the best assurance of increases in the monetary conversion factor reflective of changes in physician practice costs, and to this end, to consider seriously the development of a “shadow” Medicare Economic Index; (13) continue to implement and refine the Payment Reform Education Project to provide member physicians with accurate and timely information on developments in Medicare physician payment reform; and (14) take steps to assure all relative value units contained in the Medicare Fee Schedule are adjusted as needed to comply with ever-increasing federal and state regulatory requirements. Sub. Res. 109, A-92 Reaffirmed: I-92 Reaffirmed by CMS Rep. 8, A-95 and Sub. Res. 124, A-95 Reaffirmation A-99 and Reaffirmed: Res. 127, A-99 Reaffirmation A-02 Reaffirmation A-06 Reaffirmation I-07 Reaffirmed: BOT Rep. 14, A-08 Reaffirmation A-09 Reaffirmed: CMS Rep. 01, A-19 Reaffirmed: Res. 212, I-21

Limited Licensed Practitioners and RBRVS H-400.973
It is the policy of the AMA to advocate that Medicare expenditure data clearly differentiate between the services of fully licensed physicians and those of limited licensed practitioners and of other Part B services. Sub. Res. 124, I-91 Reaffirmed: BOT Rep. DD, I-92 Modified: CMS Rep. 10, A-03 Modified: CMS Rep. 4, A-13 Reaffirmed: BOT Rep. 09, A-23

Refinement of Medicare Physician Payment System H-400.990
The AMA: (1) reaffirms its support for development and implementation of a Medicare indemnity payment schedule according to the policies established in Policy 400.991; (2) supports reasonable attempts to remedy geographic Medicare physician payment inequities that do not substantially interfere with the AMA’s support for an RBRVS-based indemnity payment system; (3) supports

continued efforts to ensure that implementation of an RBRVS-based Medicare payment schedule occurs upon the expansion, correction, and refinement of the Harvard RBRVS study and data as called for in Board Report AA (I-88), and upon AMA review and approval of the relevant proposed enabling legislation; and (4) continues to oppose any effort to link the acceptance of an RBRVS with any proposal that is counter to AMA policy, such as expenditure targets or mandatory assignment. BOT Rep. BBB, A-89 Reaffirmed: I-92 Reaffirmed and Modified: CMS Rep. 10, A-03 Reaffirmation A-09 Reaffirmed: CMS Rep. 01, A-19 Reaffirmed: Res. 212, I-21

Guidelines for the Resource-Based Relative Value Scale H-400.991
(1) The AMA reaffirms its current policy in support of adoption of a fair and equitable Medicare indemnity payment schedule under which physicians would determine their own fees and Medicare would establish its payments for physician services using: (a) an appropriate RVS based on the resource costs of providing physician services; (b) an appropriate monetary conversion factor; and (c) an appropriate set of conversion factor multipliers. (2) The AMA supports the position that the current Harvard RBRVS study and data, when sufficiently expanded, corrected, and refined, would provide an acceptable basis for a Medicare indemnity payment system. (3) The AMA reaffirms its strong support for physicians' right to decide on a claim-by-claim basis whether or not to accept Medicare assignment and its opposition to elimination of balance billing. (Reaffirmed: Sub. Res. 132, A-94) (4) The AMA reaffirms its opposition to the continuation of the Medicare maximum allowable actual charge (MAAC) limits. (5) The AMA promotes enhanced physician discussion of fees with patients as an explicit objective of a Medicare indemnity payment system. (6) The AMA supports expanding its activities in support of state and county medical society-initiated voluntary assignment programs for low-income Medicare beneficiaries. (7) The AMA reaffirms its current policy that payments under a Medicare indemnity payment system should reflect valid and demonstrable geographic differences in practice costs, including professional liability insurance premiums. In addition, as warranted and feasible, the costs of such premiums should be reflected in the payment system in a manner distinct from the treatment of other practice costs. (8) The AMA believes that payment localities should be determined based on principles of reasonableness, flexibility, and common sense (e.g., localities could consist of a combination of regions, states, and metropolitan and nonmetropolitan areas within states) based on the availability of high-quality data. (9) The AMA believes that, in addition to adjusting indemnity payments based on geographic practice cost differentials, a method of adjusting payments to effectively remedy demonstrable access problems in specific geographic areas should be developed and implemented. (10) Where specialty differentials exist, criteria for specialty designation should avoid sole dependence on rigid criteria, such as board certification or completion of residency training. Instead, a variety of general national criteria should be utilized, with carriers having sufficient flexibility to respond to local conditions. In addition to board certification or completion of a residency, such criteria could include, but not be limited to: (a) partial completion of a residency plus time in practice; (b) local peer recognition; and (c) carrier analysis of practice patterns. A provision should also be implemented to protect the patients of physicians who have practiced as specialists for a number of years. (11) The AMA strongly opposes any attempt to use the initial implementation or subsequent use of any new Medicare payment system to freeze or cut Medicare expenditures for physician services in order to produce federal budget savings. (12) The AMA believes that whatever process is selected to update the RVS and conversion factor, only the AMA has the resources, experience and umbrella structure necessary to represent the collective interests of medicine, and that it seek to do so with appropriate mechanisms for full participation from all of organized medicine, especially taking advantage of the unique contributions of national medical specialty societies. BOT Rep. AA, I-88 Reaffirmed: I-92 Reaffirmed and Modified: CMS Rep. 10, A-03 Reaffirmation A-06 Reaffirmed: CMS Rep. 01, A-16 Reaffirmed: Res 212 I-21

REPORT 15 OF THE BOARD OF TRUSTEES (I-24)
Published Metrics for Hospitals and Hospital Systems
Reference Committee J

EXECUTIVE SUMMARY

At the 2023 Annual Meeting of the House of Delegates (HOD), Resolution 715-A-23, "Published Metrics for Hospitals and Hospital Systems," was referred for report back. The resolution directs our American Medical Association (AMA) to identify transparency metrics, such as physician retention and physician satisfaction, that would apply to hospitals and hospital systems and report back with recommendations for implementing appropriate processes to require the development and public release of such transparency metrics. The following Board of Trustees Report provides this update and will be provided to the HOD for review at the 2024 Interim Meeting.

This report provides detailed information about existing publicly available metrics for hospitals and hospital systems and their potential impact on physicians and patients. Additionally, the report outlines AMA efforts to support health systems in regularly measuring important indicators such as physician burnout and turnover including policies, advocacy, partnerships with professional organizations, development and dissemination of tools, educational resources, and hands-on support for health systems.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 15-I-24

Subject:	Published Metrics for Hospitals and Hospital Systems (Res. 715-A-23)
Presented by:	Michael Suk, MD, JD, MPH, MBA Chair
Referred to:	Reference Committee J

INTRODUCTION

At the 2023 Annual Meeting of the House of Delegates (HOD), the American Association of Neurological Surgeons and Congress of Neurological Surgeons introduced Resolution 715-A-23, "Published Metrics for Hospitals and Hospital Systems". The resolution was referred for report back and directs the American Medical Association to identify transparency metrics (e.g., physician retention and physician satisfaction) applicable to hospitals and hospital systems and report back with recommendations for implementing appropriate processes to require the development and public release of such metrics. The following Board of Trustees Report provides this update and will be provided to the HOD for review at the 2024 Interim Meeting.

BACKGROUND

Nearly 63 percent of physicians in the United States experience at least one symptom of burnout, according to recent research. A dramatic increase in burnout and decrease in job satisfaction occurred among U.S. physicians during the first two years of the COVID-19 pandemic, leading many physicians to consider a reduction in work effort or leaving their organization and the profession altogether.[1] Nearly one-quarter of all physicians noted an intent to leave their job, and a recent study also found that the annual rate of physician turnover in the United States increased between 2010 and 2018.[2,3] A Definitive Healthcare report found that an estimated 117,000 physicians left the workforce in 2021.[4] Similarly, a study using AMA-collected data from 2020-2021 found that clinician burnout and intent to leave gradually increased in the early days of the pandemic and rose sharply in late 2021. Work control, teamwork, and feeling valued were both mitigating and aggravating factors for clinician burnout and retention and could provide mechanisms for worker protection.[5]

Overall, these trends are alarming for the U.S. health care system. Nearly one billion dollars in excess patient costs are tied to physician turnover.[6] Physician burnout and turnover may also have a profound impact on patient access, especially for people living in rural areas and health systems caring for underserved communities. Physician burnout and turnover have myriad consequences for physicians, patients, and the overall health care system. While many hospitals and hospital systems have begun to address the underlying system-level issues that cause burnout and turnover, much work remains to be done to address the work environment of physicians to reduce physician burnout and turnover.

Currently, there are reporting mechanisms by which hospitals and hospital systems are held accountable to for the maintenance of quality and safety standards. These existing transparency metrics are largely focused on patient safety and quality of care. These standards have not traditionally focused on the physician experience (e.g., turnover and job satisfaction) but remain largely in place to provide the public (i.e., patients) with transparent information about the performance and safety of the hospital or hospital system. However, over the last ten years, more hospitals and hospitals systems are beginning to measure and track metrics related to the physician experience, including physician burnout and turnover. They have done so as a foundational strategy to address the underlying causes of these outcomes. While collection and reporting of these measures remains voluntary and are not tied to hospital accreditation, these measures can provide insights to help motivated health system leaders develop data-driven approaches to reduce burnout, improve job satisfaction, and increase retention—and thus, provide an enhanced working environment for their physicians, a better care environment for their patients, and improve overall value and costs. Metrics and reporting mechanisms for the physician experience vary widely by hospital systems. Most do not share these measures publicly, although many do share these measures with their physician staff for increased accountability and shared solution-building.

Physician burnout and turnover have myriad causes and addressing these issues to reduce physician burnout (and lessen physician turnover) is a key pillar of the AMA's "You Are Why We Fight" campaign. Central to these efforts are AMA's collaborations over the past five years with more than 300 hospitals or hospital systems in measuring physician burnout and turnover, and incentivizing health systems to improve the physician experience through the AMA's Joy in Medicine Health System Recognition Program.

In addition to further outlining existing transparency metrics for health systems in the United States, this report provides a more in-depth review of existing AMA resources for hospital systems and its leadership for the adoption of metrics to accurately assess the physician experience.

DISCUSSION

Existing public reporting, accreditation, and grading systems include the Leapfrog group, Joint Commission, and National Integrated Accreditation for Healthcare Organizations (NIAHO) accreditation program. The details of each system are discussed below in addition to the opportunities and risks associated with mandatory reporting of transparency metrics.

Leapfrog Hospital Safety Grades

Overview

The Leapfrog group is an independent, national not-for-profit organization focused on measuring and publicly reporting hospital performance. Hospitals voluntarily participate free of charge.[7] Leapfrog Hospital Safety Grade uses up to 30 national performance measures from the Centers for Medicare & Medicaid Services (CMS) and other supplemental data sources. The goal of the Leapfrog Hospital Safety Grade is to publicly report patient safety and quality information for consumers, purchasers, and physicians to guide their decisions regarding where to seek care and direct patients. Leapfrog Hospital safety grades can be searched by anyone in the public via their website. This public reporting is largely focused on supporting patients in selecting a hospital and advocating for better hospital safety.[8] None of the Leapfrog metrics or related reporting focus on physician or clinician experiences, suggesting an opportunity for Leapfrog to enhance their portfolio of measures.

Some research has been done to assess Leapfrog's grading system. A 2017 analysis found that Leapfrog's measure skews toward positive self-report and bears little association with Medicare outcomes and penalties.[9] A 2023 examination of Leapfrog safety measures and Magnet designation found that Magnet-designated hospitals had higher Leapfrog grades for structural safety measures but not better infection rates.[14] There exists a paucity of literature that provides insights into whether Leapfrog transparency metrics result in behavior or choice modification (e.g., choosing a different hospital) by either patients or physicians. Therefore, the total impact of these measures in their transparent reporting is largely unknown or unattributed.

The Joint Commission

Overview

The Joint Commission is an independent, not-for-profit organization in the United States that accredits and certifies health care organizations and programs. It sets standards for health care quality and safety and conducts regular evaluations to ensure compliance. Hospitals, health care systems, nursing homes, clinics, and other health care facilities voluntarily seek Joint Commission accreditation to demonstrate their commitment to meeting high standards of patient care.

The Joint Commission does not have specific accreditation standards solely focused on physician burnout, turnover, or satisfaction. The Joint Commission touts that their accreditation may help attract and retain qualified personnel who prefer to serve in an accredited organization.[12] The Joint Commission includes reference to several physician well-being resources on its website, but workforce well-being is not explicitly a part of its accreditation standards.[13]

While having Joint Commission accreditation may signal to physicians that their institutions are prioritizing patient safety, quality care, and efficient processes, there has been little to no exploration on whether organizations that have Joint Commission accreditation have lower physician burnout or turnover. In fact, a 2023 study found that while half of Joint Commission-accredited hospitals and Federally Qualified Health Centers are taking steps to improve physician well-being, a small minority of them are measuring well-being and very few are taking a comprehensive approach to advancing well-being as an organizational priority.[14]

Existing Literature

There does not currently appear to be literature that provides insights into whether Joint Commission accreditation and their transparency metrics result in behavior or choice modification (e.g., choosing a different hospital) by either patients or physicians. Therefore, the total impact of these measures in their transparent reporting is largely unknown or unattributed.

DNV Healthcare – NIAHO® Hospital Accreditation

Overview

DNV GL Healthcare offers yet another hospital accreditation—the NIAHO accreditation program. Similar to the Joint Commission, this accreditation program also largely focuses on patient safety, quality of care, facility manager, and adherence to regulatory requirements. Further, this accreditation directly addresses CMS requirements, and standards vary by facility type.[15]

NIAHO measures do include evaluation of leadership and management, clinical excellence, and facility and environmental management. Although this may influence physicians' decisions about joining a hospital, measurements of physician turnover, job satisfaction or burnout are not part of the standard measures.[16]

The Pathway to Excellence Program®

The Pathway to Excellence Program is one accreditation program that can be used as a model for health care organizations interested in utilizing metrics to improve physician well-being. The program is the premier designation for health care organizations and long term care organizations that have achieved healthy practice environments for nurses. To qualify for designation, organizations are required to meet the six Pathway Standards that have been identified as essential for a positive practice environment for nurses. These standards are designed to support nurse satisfaction, high-quality nursing practice, and interprofessional collaboration, and impact an array of factors that in turn influence results such as employee turnover, job satisfaction and engagement, errors and safety events, and patient satisfaction.[17]

Public Reporting of Metrics in Health Care: Benefits and Potential Unintended Consequences

Public and transparent reporting of hospital metrics can have a positive impact but there may also be unintended consequences for physicians, patients, hospitals, and hospital systems that must be weighed against those benefits.

Some benefits of public reporting may include transparency and accountability, informed decision-making, quality improvement initiatives, and benchmarking and learning. Publicly reporting hospital metrics, such as quality of care, patient outcomes, infection rates, and readmission rates creates transparency. Hospitals are held accountable for their performance, encouraging them to strive for better outcomes and quality of care. Patients' and families' access to this information can enable them to make more informed decisions about where to seek care. When patients have access to data on hospital performance, they can choose facilities with better outcomes, which incentivizes hospitals to improve their services to attract patients. Additionally, public reporting can drive hospitals to implement quality improvement initiatives. Knowing that their performance is being publicly evaluated can motivate hospitals to identify areas for improvement and implement changes to enhance care quality and outcomes. Further, public reporting can facilitate hospitals' comparisons of their performance against others, allowing them to identify best practices and areas where improvement is needed. This benchmarking helps hospitals learn from each other and adopt successful strategies to improve care.

Also of importance to recognize is that public reporting of transparency metrics influences, at least to some degree, hospital and health system behavior. For instance, in a 2012 survey of hospital leaders from over 600 U.S. hospitals, participants reported that publicly reported measures impacted planning and improvement initiatives within their organization. Over 70 percent of respondents agreed that public reporting stimulated quality improvement activity at their institution; 89.7 percent reported that their organization's reputation was affected by patient experience measures; 87.1 percent indicated that performance on publicly reported measures was incorporated into their hospital's annual goals; and more than 90 percent reported regularly reviewing the results of publicly reported measures with hospital board of trustees members. However, hospital leadership also expressed concern about the clinical meaningfulness, unintended consequences, and current methods of public reporting.[18] Additionally, in a recent Becker's article, physician executives from four health systems shed light upon their views of national rankings and its use for quality improvement strategies. Many leaders saw greater value in national benchmarking data from private third-party organizations as opposed to rankings from platforms such as Leapfrog, CMS' Overall Hospital Star Ratings, and *U.S. News & World Report's* best hospitals since the latter sources are retrospective in nature.[19]

Importantly, public reporting is not a singular solution and there may be unintended consequences from public and transparent reporting that have implications for patients, physicians, hospitals, and hospitals systems. Much of the concern about publicly reporting hospital and hospital system metrics generally question the validity of these metrics and the potential for misuse. For instance, authors from a 2005 *JAMA* article argue that the value of publicly reporting quality information is largely undemonstrated.[20] Additionally, measures that have been validated for one purpose can be inappropriately used for another purpose. For instance, patient safety indicators from administrative data sources are helpful tools for case identification and tracking rates at a single organization but not useful for comparing rates across hospitals. Research has reported that when rates of postoperative infections were derived from administrative data sources, over 50 percent of the variation in risk-adjusted postoperative infection rate observed across hospitals could be attributed to differences in coding practices rather than actual outcomes. [21]

Another major potential unintended consequence of publicly reporting transparency metrics is reduced access to – and even disparities in – care. For instance, hospitals in neighborhoods with greater social risk often care for patient populations with increased medical complexity and fewer resources than hospitals in other neighborhoods. This has been shown to unfairly and negatively impact hospital ratings, as well as reinforce disincentives to care for patient populations living in neighorhoods with greater social complexity. One study that examined the relationship between neighborhood social risk factors and hospital ratings in Medicare's Hospital Compare Program found that lower hospital summary scores were associated with caring for neighborhoods with higher social risk. This included a reduction in hospital score for every ten percent of residents who reported dual-eligibility for Medicare and Medicaid, lacking a high school diploma, unemployment, Black race, and high commute times to work.[22] Another study found that compared to other hospitals, total reimbursements for patient care at hospitals serving the most Black patients were on average 21.6 percent lower. Mean and median profits per patient day at Black-serving hospitals were also eight dollars and 17 dollars, respectively, while these values were $64 and $126 at other hospitals.[23] Taken together, these studies have implications for the public reporting of hospital metrics such as physician burnout, turnover, and job satisfaction rates and their impact on the care of some of America's most marginalized patient populations. For example, publicly reporting such metrics could potentially exacerbate inequities for patients that receive care at majority Black-serving hospitals, physicians that work at these organizations, and quality rankings appointed to these facilities.

Moreover, publicly reporting physician burnout, turnover, and job satisfaction rates could possibly lead to hospitals becoming risk-averse in their hiring practices to keep these metrics low similar to evidence demonstrating hospitals avoiding high-risk patients when subject to public reporting. For example, a study compared the percentages of white, Black, and Hispanic patients that received coronary artery bypass grafting (CABG), percutaneous transluminal coronary angioplasty, and cardiac catheterization prior to and following the availability of the New York State CABG public report. The study found that there was a greater racial disparity in the percentage of patients who received CABG in the periods after public reporting versus before. Additionally, the disparity was found to be greater in New York as opposed to the twelve comparison states assessed in the study that had not released CABG public reports.[24] This begs the question of whether publicly reporting hospital metrics could potentially lead to hospitals and hospital systems avoiding hiring marginalized and minoritized clinical staff with demonstrated disproportionate rates of burnout such as physicians of color, women physicians, and physicians who are caregivers for children, aging parents or other dependents rather than collaborating with physicians to actually and effectively improve burnout, turnover, and job satisfaction.[25,26]

Lastly, making these metrics publicly available bears the risk of patients and payers misinterpreting this information and incorrectly using it to make decisons about where to seek care and direct patients. Too much data, particularly when devoid of context, can overwhelm the public and fuel misinformation. Patients using this data to guide where to receive care is especially risky because poor performance in one area (e.g., physician burnout) does not mean that performance in another area is also poor (e.g., the percentage of patients that are able to receive a certain procedure).[24]

While transparent reporting of metrics, particularly those related to physician turnover, job satisfaction, or burnout, may increase accountability from hospital system leadership, it could also act as a detractor in establishing physician-organization collaboration and may feel more punitive than solution-seeking. Establishing a strong and collaborative relationship between physicians and their organizations is shown to reduce physician burnout and increase physician engagement.[27] Public and transparent reporting of burnout, satisfaction, and turnover metrics could have the unintended consequence of disrupting the establishment of a strong and collaborative relationship between physicians and their leadership, as hospital leadership could become hyper-focused on specific measures that do not completely capture the nuances and intricacies of the physician experience.

AMA POLICY

The AMA has several policies related to increased transparency of hospital and hospital system metrics that reflect the physician experience.

The AMA will study current tools and develop metrics to measure physician professional satisfaction (Policy D-405.985, "Physician Satisfaction").

The AMA will also foster the creation of quality measures and rating systems that incorporates the satisfaction and perspective of the medical staff regarding individual hospitals (Policy D-215.988, "Capturing Physician Sentiments of Hospital Quality").

Further, the AMA promotes physician-developed guidelines for evaluating patient and physician satisfaction with plans, accreditation standards, utilization, quality and cost policies (Policy H-450.962, "National Committee for Quality Assurance").

Moreover, the AMA supports that the "Triple Aim" be expanded to the Quadruple Aim, adding the goal of improving the work-life balance of physicians and other health care providers.
The AMA will also advocate that addressing physician satisfaction count as a Clinical Practice Improvement Activity under the Merit-Based Incentive Payment System (MIPS) (Policy H-405.955, "Support for the Quadruple Aim").

AMA SUPPORT FOR HEALTH SYSTEMS IN IMPROVING THE PHYSICIAN EXPERIENCE

Overview

The AMA has long supported hospitals and hospital system leadership in measuring the physician experience (i.e., burnout, satisfaction, stress, etc.) and in providing evidence-informed tools and resources to support health systems in comprehensively addressing the physician experience, including physician burnout. Addressing this issue is centered in the AMA's "You Are Why We Fight" campaign and there has been broad investment from the AMA in continuing to support health systems' work to improve the physician experience. The AMA has researched and developed metrics for measuring physician workload, burnout, and experience within their

organizations. Notably, the AMA has worked with hundreds of health systems in providing organizational well-being assessments, evidence-informed resources, a comprehensive roadmap for change, and grants for ongoing research. AMA leaders have been publicly vocal in encouraging health systems to invest in their physician workforce, regularly measure physician burnout, and systemically address issues arising from regular measurement. Outlined below are several programs and initiatives that AMA has continued to undertake in support of health systems improving the physician experience.

The AMA Organizational Biopsy®

The Organizational Biopsy® is an assessment tool and a set of services to support organizations in holistically measuring and taking action to improve the health of their organization. The Organizational Biopsy provides a comprehensive assessment for health systems across four domains: organizational culture (leadership, teamwork, trust, etc.), practice efficiency (team structure, team stability, workflows, etc.), self-care (post-traumatic stress, post-traumatic growth, work-life balance, etc.), and retention (work intentions).[28] The survey is distributed to physicians and other clinicians within the organization and the data is collected by the AMA for analysis.

Following an assessment, organizations receive an executive summary of their key findings and access to the Organizational Biopsy data through an online reporting platform. This platform also includes national comparison data. Following the assessment, the AMA can provide ongoing guidance and communication on interventions, research, and convening opportunities in support of their ongoing improvement efforts. The Organizational Biopsy includes the validated Mini-Z burnout assessment.[29] There is also a separate tool that can be used by residency and fellowship programs to measure and address the trainee experience.[30]

Since 2018, the AMA has collaborated with more than 300 health systems in collecting and sharing organizational well-being assessment results and advising on solutions. A yearly national comparison report is also shared with participating health systems to see how they compare against other institutions. The majority of health systems that the AMA collaborates with complete measurement on an annual basis. The AMA encourages organizations to share their survey results internally with their physicians to allow for greater collaboration, strengthen the physician-organization relationship, support collaborative dialogue about the current state of organization well-being, and identify future solutions and realistic accountability for improvement.

The Joy in Medicine™ Health System Recognition Program

Launched in 2019, the Joy in Medicine Health System Recognition Program (otherwise known as the Recognition Program) incentivizes health systems to improve the physician experience by providing public national recognition for organizations that have met a set of evidence-informed criteria centered on addressing the primary system drivers of physician burnout and organizational well-being.[31]

The Recognition Program provides a comprehensive roadmap to guide organizations through the existing research and interventions to improve organizational well-being—and thus, the physician experience. Measurement of various outcomes and processes are foundational to the program, as AMA asserts that these data can and should be used to understand unique organizational drivers of physician burnout within an organization and to help focus system-specific solutions. Measures included in the Recognition Program criteria include: burnout (using a validated tool), intentions to leave or reduce work effort (via survey), teamwork assessments (via surveys), leadership skills assessments and their impact on direct team members (via surveys), and electronic health record

audit log data to help illuminate the day-to-day experience of physicians and identify workload/workflow improvements. The Recognition Program includes required criteria for health systems to share these data internally with their physicians as well as their executive leadership teams for shared decision making and increased accountability.[32]

Organizational recognition is valid for two years. Since 2019, AMA has recognized more than 100 organizations for their efforts and this body of work continues to gain a national spotlight in the efforts to improve physician well-being.[33] Health system leaders have publicly noted the impact the Recognition Program has had on their efforts to improve conditions for their workforce and in providing them with a critical framework for addressing a complex issue.[34–37]

AMA STEPS Forward®

The program provides free access to a variety of resources to support health systems in implementing interventions. The AMA STEPS Forward program offers a collection of engaging and interactive educational toolkits, playbooks, podcast episodes, and success stories that are practical, actionable guides to transform and improve your practice. They address common practice challenges and offer solutions that aim to save two to three hours a day, reduce physician burnout and improve well-being, optimize team-based workflows, and enhance patient experiences.[38]

Each module provides practical steps to implementation, as well as real-world "success stories", downloadable tools and additional resources.[38] Clinicians, care team members, administrators, and organizational leaders can use these modules to help improve practice efficiency and ultimately enhance patient care, physician satisfaction, and practice sustainability.

Other Activities

The AMA also organizes conferences and provides interactive, hands-on learning opportunities for physicians and members of their care teams including boot camps, coaching, and learning collaboratives.

Alongside the Canadian Medical Association and British Medical Association, the AMA co-sponsors the International Conference on Physician Health™ (ICPH). ICPH is a biennial conference that promotes a healthier culture for physicians through evidence-based solutions, practice skills, and other resources. The theme of this year's conference is "improving well-being through the power of connections".[39] The American Conference on Physician Health (ACPH) is co-sponsored by the AMA, Stanford Medicine, and Mayo Clinic, and is held biennially. ACPH is designed to promote scientific research, discourse about health system infrastructure, and actionable steps that organizations can implement to improve physician well-being.[40]

Another of the offerings provided by the AMA are in-person boot camps wherein the AMA STEPS Forward Innovation Academy convenes attendees over the course of multiple days to equip them with tools and strategies to reform their organization and improve professional satisfaction. Topics discussed in past boot camps include EHR inbox optimization, team-based care practice fundamentals, and reducing barriers to taking paid time off.[41] Additionally, AMA physician faculty provide one to one coaching sessions to health system well-being leaders. These coaching sessions include direct feedback related to establishing strategic well-being initiatives and using data to guide a comprehensive approach to address institutional well-being needs.

Further, the AMA has learning collaboratives planned for this fall designed to transform care delivery. These collaboratives will leverage peer-to-peer learning, group discussions, and the

sharing of results, as well as facilitate connections between health system leaders. Collaborative participants will receive support from physician facilitators and evidence-based resources such as content and education, in addition to benefiting from extra assistance and mentorship during "office hours".

STATEMENTS

AMA President, Dr. Jesse Ehrenfeld released a leadership viewpoint to spotlight the AMA's Joy in Medicine Health System Recognition Program and to encourage health systems and health system leadership to thoroughly examine their support for physician well-being and implement improvements that promote wellness across the entire workforce while strengthening the patient-physician relationship.[42]

Dr. Ehrenfeld also provided remarks at the National Press Club about the physician shortage, where he reaffirmed AMA's commitment to addressing physician burnout and turnover through both advocacy efforts—such as combatting prior authorization—and support for health systems directly through the Joy in Medicine Health System Recognition Program.[43]

CONCLUSION

Although several efforts are currently in place that publicly report hospital performance metrics, these metrics generally do not adequately capture the physician experience. Additionally, insufficient research exists to support that such metrics impact physicians' selection of a particular hospital or hospital system for employment or partnership. The AMA has made substantial efforts to address and improve physician burnout, professional satisfaction, and workforce turnover. Such efforts have included the adoption of a variety of policies, advocacy, partnerships with professional organizations, development and dissemination of tools, educational resources, and hands-on support for health systems to regularly assess the state of their physician workforce. The AMA actively champions and provides resources for the collection of measures related to the physician experience (e.g., burnout, retention, and satisfaction) by health systems to support the development of data-driven solutions. In addition, the Joy in Medicine Health System Recognition Program publicly recognizes organizations taking actionable steps along six domains to improve the work environment for their physicians.

RECOMMENDATIONS

The Board of Trustees recommends that the following recommendation be adopted in lieu of Resolution 715-A-23 and the remainder of the report be filed.

1. That our AMA research useful metrics that hospitals and hospital systems can use to improve physicians' experience, engagement, and work environment.

Fiscal Note: Minimal

REFERENCES

1. Shanafelt TD, West CP, Dyrbye LN, et al. Changes in Burnout and Satisfaction With Work-Life Integration in Physicians During the First 2 Years of the COVID-19 Pandemic. *Mayo Clin Proc*. 2022;97(12):2248-2258. https://www.mayoclinicproceedings.org/article/S0025-6196(22)00515-8/fulltext#%20
2. Rotenstein LS, Brown R, Sinsky C, Linzer M. The Association of Work Overload with Burnout and Intent to Leave the Job Across the Healthcare Workforce During COVID-19. *J Gen Intern Med*. 2023;38(8):1920-1927. https://doi.org/10.1007/s11606-023-08153-z
3. Bond AM, Casalino LP, Tai-Seale M, et al. Physician Turnover in the United States. *Ann Intern Med*. Published online July 11, 2023. Accessed February 1, 2024. https://www.acpjournals.org/doi/10.7326/M22-2504
4. Popowitz E. *Addressing the Healthcare Staffing Shortage: A Definitive Healthcare Report*. Definitive Healthcare; 2022. Accessed August 13, 2024. https://www.definitivehc.com/sites/default/files/resources/pdfs/Addressing-the-healthcare-staffing-shortage.pdf
5. Linzer M, Jin JO, Shah P, et al. Trends in Clinician Burnout With Associated Mitigating and Aggravating Factors During the COVID-19 Pandemic. *JAMA Health Forum*. 2022;3(11):e224163. https://doi.org/10.1001/jamahealthforum.2022.4163
6. Sinsky CA, Shanafelt TD, Dyrbye LN, Sabety AH, Carlasare LE, West CP. Health Care Expenditures Attributable to Primary Care Physician Overall and Burnout-Related Turnover: A Cross-sectional Analysis. *Mayo Clin Proc*. 2022;97(4):693-702. https://linkinghub.elsevier.com/retrieve/pii/S0025619621007096
7. The Leapfrog Group. About The Leapfrog Group. Leapfrog Hospital Safety Grade. 2023. Accessed February 6, 2024. https://www.hospitalsafetygrade.org/about-our-movement/about-the-leapfrog-group
8. The Leapfrog Group. How to Use the Grade. Leapfrog Hospital Safety Grade. 2023. Accessed February 5, 2024. https://www.hospitalsafetygrade.org/your-hospitals-safety-grade/how-to-use-the-grade
9. Smith SN, Reichert HA, Ameling JM, Meddings J. Dissecting Leapfrog: How Well Do Leapfrog Safe Practices Scores Correlate With Hospital Compare Ratings and Penalties, and How Much Do They Matter? *Med Care*. 2017;55(6):606. https://journals.lww.com/lww-medicalcare/Fulltext/2017/06000/Dissecting_Leapfrog__How_Well_Do_Leapfrog_Safe.10.aspx
10. Kernisan LP, Lee SJ, Boscardin WJ, Landefeld CS, Dudley RA. Association Between Hospital-Reported Leapfrog Safe Practices Scores and Inpatient Mortality. *JAMA*. 2009;301(13):1341-1348. https://doi.org/10.1001/jama.2009.422
11. Tai TWC, Mattie A, Miller SM, Yawson RM. An Examination of Leapfrog Safety Measures and Magnet Designation. *J Healthc Risk Manag*. 2023;42(3-4):21-29. https://onlinelibrary.wiley.com/doi/abs/10.1002/jhrm.21533
12. The Joint Commission. Benefits of Joint Commission Accreditation. The Joint Commission. 2024. Accessed February 6, 2024. https://www.jointcommission.org/resources/news-and-multimedia/fact-sheets/facts-about-benefits-of-joint-commission-accreditation/
13. The Joint Commission. Health Care Workforce Safety and Well-Being. The Joint Commission. 2024. Accessed February 6, 2024. https://www.jointcommission.org/resources/patient-safety-topics/healthcare-workforce-safety-and-well-being/
14. Longo BA, Schmaltz SP, Williams SC, Shanafelt TD, Sinsky CA, Baker DW. Clinician Well-Being Assessment and Interventions in Joint Commission–Accredited Hospitals and

Federally Qualified Health Centers. *Jt Comm J Qual Patient Saf*. 2023;49(10):511-520. https://www.jointcommission.org/-/media/tjc/documents/resources/patient-safety-topics/healthcare-workforce-safety-and-well-being/longo-2023-clinician-well-being-assessment-interventions-tjc-accredited-facilities.pdf

15. DNV. National Integrated Accreditation for Healthcare Organizations (NIAHO) Hospital Accreditation. DNV. 2023. Accessed February 6, 2024. https://www.dnv.us/Default
16. DNV. *National Integrated Accreditation for Healthcare Organizations (NIAHO) Accreditation Requirements, Interpretive Guidelines & Surveyor Guidance for Hospitals*. DNV; 2023. Accessed February 6, 2024. https://www.dnv.us/supplychain/healthcare/standards/niaho-ac-dl.html
17. American Nurses Credentialing Center (ANCC). About Pathway. ANCC. October 14, 2017. Accessed August 13, 2024. https://www.nursingworld.org/organizational-programs/pathway/overview/
18. Lindenauer PK, Lagu T, Ross JS, et al. Attitudes of Hospital Leaders Toward Publicly Reported Measures of Health Care Quality. *JAMA Intern Med*. 2014;174(12):1904-1911. https://doi.org/10.1001/jamainternmed.2014.5161
19. Bean M. How Important are National Rankings to Physician Executives? August 7, 2024. Accessed August 13, 2024. https://www.beckershospitalreview.com/quality/how-important-are-national-rankings-to-physician-executives.html
20. Werner RM, Asch DA. The Unintended Consequences of Publicly Reporting Quality Information. *JAMA*. 2005;293(10):1239-1244. https://doi.org/10.1001/jama.293.10.1239
21. Lindenauer P. Getting a Good Report Card: Unintended Consequences of the Public Reporting of Hospital Quality. *Patient Saf Netw*. Published online November 1, 2006. Accessed February 6, 2024. https://psnet.ahrq.gov/web-mm/getting-good-report-card-unintended-consequences-public-reporting-hospital-quality
22. Fahrenbach J, Chin M, Huang E, Springman M, Weber S, Tung E. Neighborhood Disadvantage and Hospital Quality Ratings in the Medicare Hospital Compare Program. *Med Care*. 2020;58(4):376-383. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7171595/
23. Himmelstein G, Ceasar JN, Himmelstein KE. Hospitals That Serve Many Black Patients Have Lower Revenues and Profits: Structural Racism in Hospital Financing. *J Gen Intern Med*. 2023;38(3):586-591. https://doi.org/10.1007/s11606-022-07562-w
24. Totten A, Wagner J, Tiwari A, O'Haire C, Walker M. *5. Public Reporting as a Quality Improvement Strategy*. Agency for Healthcare Research and Quality (AHRQ); 2012. Accessed August 6, 2024. https://effectivehealthcare.ahrq.gov/sites/default/files/pdf/public-reporting-quality-improvement_research.pdf
25. Lemos D, Carlasare L, Okeke N, Qusair Z, De Maio F. *Experiences of Race and Ethnic Minoritized and Marginalized Physicians in the U.S. during the COVID-19 Pandemic*.; 2021. https://www.ama-assn.org/system/files/summary-report-covid-mmps-survey.pdf
26. Yank V, Rennels C, Linos E, Choo EK, Jagsi R, Mangurian C. Behavioral Health and Burnout Among Physician Mothers Who Care for a Person With a Serious Health Problem, Long-term Illness, or Disability. *JAMA Intern Med*. 2019;179(4):571-574. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6450290/
27. Swensen S, Kabcenell A, Shanafelt T. Physician-Organization Collaboration Reduces Physician Burnout and Promotes Engagement: The Mayo Clinic Experience. *J Healthc Manag*. 2016;61(2):105. https://journals.lww.com/jhmonline/abstract/2016/03000/physician_organization_collaboration_reduces.8.aspx
28. American Medical Association. Practice Transformation: Measure. American Medical Association. November 10, 2023. Accessed February 6, 2024. https://www.ama-assn.org/practice-management/sustainability/practice-transformation-measure

29. Linzer M, McLoughlin C, Poplau S, Goelz E, Brown R, Sinsky C. The Mini Z Worklife and Burnout Reduction Instrument: Psychometrics and Clinical Implications. *J Gen Intern Med*. 2022;37(11):2876-2878. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9411313/
30. Linzer M, Shah P, Nankivil N, Cappelucci K, Poplau S, Sinsky C. The Mini Z Resident (Mini ReZ): Psychometric Assessment of a Brief Burnout Reduction Measure. *J Gen Intern Med*. 2023;38(2):545-548. https://pubmed.ncbi.nlm.nih.gov/35882711/
31. American Medical Association. AMA Joy in Medicine™ Health System Recognition Program. American Medical Association. January 23, 2024. Accessed February 6, 2024. https://www.ama-assn.org/practice-management/physician-health/ama-joy-medicine-health-system-recognition-program
32. American Medical Association. *Joy in Medicine Health System Recognition Program: Health System Roadmap*. American Medical Association; 2023. Accessed February 6, 2024. https://www.ama-assn.org/system/files/joy-in-medicine-roadmap.pdf
33. American Medical Association. Joy in Medicine™: Recognized organizations. American Medical Association. November 7, 2023. Accessed February 6, 2024. https://www.ama-assn.org/practice-management/physician-health/joy-medicine-recognized-organizations
34. Berg S. 4 Ways These Star Health Systems Are Tackling Doctor Burnout. American Medical Association. November 30, 2023. Accessed February 6, 2024. https://www.ama-assn.org/practice-management/physician-health/4-ways-these-star-health-systems-are-tackling-doctor-burnout
35. Berg S. How Sanford Health Keeps Pressing on to Prevent Doctor Burnout. American Medical Association. October 17, 2023. Accessed February 6, 2024. https://www.ama-assn.org/practice-management/physician-health/how-sanford-health-keeps-pressing-prevent-doctor-burnout
36. Berg S. Behind Bayhealth's Aggressive Efforts to Improve Physician Well-Being. American Medical Association. September 19, 2023. Accessed February 6, 2024. https://www.ama-assn.org/practice-management/physician-health/behind-bayhealth-s-aggressive-efforts-improve-physician-well
37. American Medical Association. Evidence-Based Strategies to Help Physicians Recapture Joy in Medicine with Aman Sethi, MD. American Medical Association. February 6, 2023. Accessed February 6, 2024. https://www.ama-assn.org/practice-management/physician-health/evidence-based-strategies-help-physicians-recapture-joy
38. AMA Ed Hub™. AMA STEPS Forward Ed Hub Modules. AMA Ed Hub. 2024. Accessed February 6, 2024. http://edhub.ama-assn.org/steps-forward
39. American Medical Association. International Conference on Physician Health™. American Medical Association. 2024. Accessed August 7, 2024. https://www.ama-assn.org/member-benefits/events/international-conference-physician-health
40. American Medical Association. American Conference on Physician Health. American Medical Association. 2024. Accessed August 7, 2024. https://www.ama-assn.org/member-benefits/events/american-conference-physician-health
41. American Medical Association. Saving Time: Practice Innovation Boot Camp. American Medical Association. 2024. Accessed August 7, 2024. https://www.ama-assn.org/member-benefits/events/saving-time-practice-innovation-boot-camp
42. Ehrenfeld J. AMA Joy in Medicine Recognizes Shared Commitment to Wellness. American Medical Association. October 3, 2023. Accessed February 6, 2024. https://www.ama-assn.org/about/leadership/ama-joy-medicine-recognizes-shared-commitment-wellness
43. American Medical Association. Jesse M. Ehrenfeld, MD, MPH: 5-Step Solution to Address Physician Shortage. American Medical Association. October 25, 2023. Accessed February 6, 2024. https://www.ama-assn.org/press-center/speeches/jesse-m-ehrenfeld-md-mph-5-step-solution-address-physician-shortage

REPORT 1 OF THE COUNCIL ON MEDICAL SERVICE (I-24)
Nonprofit Hospital Charity Care Policies
(Resolution 802-I-23)
(Reference Committee J)

EXECUTIVE SUMMARY

At the 2023 Interim Meeting, the House of Delegates referred Resolution 802, which asked the American Medical Association to "advocate for legislation and regulation that requires nonprofit hospitals to notify and screen all patients for financial assistance according to their own eligibility criteria prior to billing, support efforts to establish regulatory standards for nonprofit hospital financial assistance eligibility, and encourage the Centers for Medicare & Medicaid Services to publish the charity-care-to-expense ratio and the charity-care-to-benefit ratio for hospitals listed in Medicare Cost Reports to improve transparency and compliance of charitable care and community benefit activities."

Medical debt is the leading cause of bankruptcy in the United States and can result in those with debt being more likely to skip or delay needed medical care or cut back on basic household expenses. Approximately 100 million individuals have debt related to unpaid medical bills in the United States, totaling between $195-220 billion. Nonprofit hospitals account for 58 percent of community hospitals in the United States. Tax-exempt nonprofit hospitals operate as Section 501(c)(3) organizations, which must be organized and operated exclusively for tax-exempt purposes. As a condition of tax-exempt status, hospitals must administer "charity care" according to broad parameters of federal government regulation, which results in differing terms of eligibility, application procedures, and programs or services. While a patient may be eligible for aid at one hospital, they may not at another hospital across town. In addition, gaps in federal regulation and weak oversight may allow hospitals to provide low levels of charity care.

Hospitals have broad flexibility to establish their own eligibility criteria for charity care, and as a result, criteria vary across hospitals. Aid at some hospitals is limited to patients whose income is below the federal poverty level (FPL), while at others, patients with incomes that are five or six times the FPL can receive assistance. In addition, some nonprofit hospitals may be billing patients with incomes low enough to qualify for charity care. There is also an issue related to the lack of a definition for a community benefit standard and the inability of the Internal Revenue Service to enforce guidelines for nonprofit hospitals to retain their 501(c)(3) status as tax exempt. Charity-care-to-expense ratios may belie the community impact of hospitals because not all spending that hospitals claim as community benefits are meaningful for community health. Beyond this, state regulations vary in terms of eligibility, the minimum level of assistance that must be provided, and the level of transparency required.

The Council on Medical Service recommends new policy for the development of publicly accessible minimum standards for nonprofit hospital financial assistance eligibility programs, required screening of patients for charity care eligibility prior to billing, and standardizing the definition of what is considered a "community benefit" when evaluating community health improvement activities. Additionally, the Council recommends new policy for expansion of governmental oversight of nonprofit hospitals and enforcement of federal and/or state guidelines and standards for community benefit requirements including the ability to enact penalties and/or loss of tax-exempt status.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 1-I-24

Subject: Nonprofit Hospital Charity Care Policies (Resolution 802-I-23)

Presented by: Stephen Epstein, MD, MPP, Chair

Referred to: Reference Committee J

At the 2023 Interim Meeting, the House of Delegates referred Resolution 802. Introduced by the Medical Student Section, the resolution asked the American Medical Association (AMA) to "advocate for legislation and regulation that requires nonprofit hospitals to notify and screen all patients for financial assistance according to their own eligibility criteria prior to billing, support efforts to establish regulatory standards for nonprofit hospital financial assistance eligibility, and encourage the Centers for Medicare & Medicaid Services (CMS) to publish the charity-care-to-expense ratio and the charity-care-to-benefit ratio for hospitals listed in Medicare Cost Reports to improve transparency and compliance of charitable care and community benefit activities."

BACKGROUND

An estimated 100 million people in the United States (41 percent of adults) have debt related to unpaid medical bills, totaling between $195-220 billion.[1] Of this 100 million, approximately 20 million people owe money directly to their hospital, physician, or other non-physician provider.[2] The remaining 80 million people reflect those that have other debts associated with their health care (i.e., credit card debt, loans from family and friends). Medical debt is the leading cause of bankruptcy in the United States and can take many forms, including past due payments owed directly to a hospital or physician, ongoing payment plans, money owed to a bank or collections that has been assigned or sold the debt, credit card debt, and/or money borrowed from family or friends.[3] Those with unaffordable medical bills are more likely to skip or delay needed care, cut back on basic household expenses, take money out of retirement or college savings, or increase credit card debt.[4]

Nonprofit hospitals account for 58 percent of community hospitals in the United States.[5] These hospitals can be exempt from federal, state, and local taxes if they qualify as 501(c)(3) organizations as defined by the Internal Revenue Service (IRS). Seven of the ten most profitable hospitals in the United States are classified as nonprofit.[6]

The IRS defines "charity care" or "financial assistance" as "free or discounted health services provided to persons who meet the organization's eligibility criteria for financial assistance and are unable to pay for all or a portion of these services."[7] Nonprofit hospitals must provide charity care as a condition of their tax-exempt status. The estimated value of tax exemption for nonprofit hospitals has increased from $19 billion in 2011 to $28 billion in 2020.[8] A study by Letchuman, Sunjay, et. al. published in *Health Affairs* (2022) estimated that the exemption from federal, state, and local taxes amounts to roughly $25 billion annually for nonprofit hospitals across the country.[9] Similarly, in 2020, KFF found that the total estimated value of tax exemption for nonprofit hospitals was approximately $28 billion, which divided into $14.4

billion from exempted federal taxes and $13.7 billion from exempted state and local taxes. KFF further found that the $28 billion total estimated value of tax exemption exceeded the total estimated charity costs of $16 billion for these nonprofit hospitals. However, charity care is only a portion of the community benefits reported by nonprofit hospitals.[10]

Within the broad parameters set by government regulation, hospitals establish their own charity care policies, which vary in terms of eligibility criteria, application procedures, and the levels of charity care provided.[11] In 2020, charity care represented 1.4 percent or less of operating expenses at half of all hospitals, although the level of charity care varied significantly across different facilities.[12] One study showed that nonprofit hospitals allocated over 80 percent of their community benefit spending on charity care and payment shortfall from Medicaid, compared to just 12 percent on community health.[13] There could be several reasons for this variation. For example, strengthening the health care safety net by providing charity care is an important community need. It is easier for hospitals to continue investing in clinical programs rather than building infrastructure needed to address social determinants of health, or hospital accounting systems are designed to better track clinical spending, making it difficult to measure the impact of community health initiatives.[14]

According to a recent report by the Lown Institute, approximately 80 percent of nonprofit hospitals give back less to their communities than they receive in tax breaks. For some hospitals, this means that the shortfall was hundreds of millions of dollars a year while they made hundreds of millions of dollars in net income. The 10 hospitals with the largest fair share deficits also reported at least 100 million dollars in net income in 2021, according to the report.[15] The American Hospital Association contested these findings, stating that the Lown Institute's accounting was not done fairly and selectively relies on isolated data to paint a negative picture of nonprofit hospitals and the hospital industry more generally. Specifically, the Lown Institute report does not account for Medicaid shortfall or money spent on medical research. The Lown Institute defended its findings by stating that shortfalls in government reimbursement are different from direct community benefits and hospitals typically receive private or public funds for medical research.[16]

INTERNAL REVENUE SERVICE (IRS) REQUIREMENTS FOR NONPROFIT HOSPITAL CHARITY CARE

Tax-exempt nonprofit hospitals operate as Section 501(c)(3) organizations, which by definition must be organized and operated exclusively for specific tax-exempt purposes and must have the following characteristics: 1) no part of their net earnings is allowed to benefit any private shareholder or individual; 2) no substantial part of their activities can consist of carrying on propaganda or otherwise attempting to influence legislation; and 3) the organization should not participate in or intervene in any political campaign on behalf of (or in opposition to) any candidate for public office.[17]

Additional requirements were added following the passage of the Affordable Care Act (ACA) and are codified in Section 501(r) of the Internal Revenue Code. To retain 501(c)(3) tax-exempt status, nonprofit hospitals must:

- Establish a financial assistance policy (FAP) that describes who is eligible for charity care, the level of assistance provided, and how patients can apply. The FAP must be easily accessible to patients and translated into the languages commonly spoken in the community served by the hospital.
- Cap charges to patients eligible for charity care based on fee-for-service Medicare rates, Medicaid rates, and/or commercial plan payment rates.
- Conduct a community health needs assessment every three years and adopt an implementation strategy to address those needs. Community health needs could include lowering financial barriers to health care or improving social determinants of health.

- Make reasonable efforts to determine if a patient is eligible for charity care before engaging in certain debt collection practices, including selling the patient's debt to third parties, reporting the debt to credit agencies, and taking legal action to control a patient's financial assets.

A hospital has made reasonable efforts under the following conditions:

- The hospital facility notifies the individual about the FAP before initiating any extraordinary collection actions (ECA) to obtain payment for the care and refrains from initiating such ECAs for at least 120 days from the date the hospital facility provides the first post-discharge billing statement for the care.
- In the case of an individual who submits an incomplete FAP application during the 240-day application period, the hospital facility notifies the individual about how to complete the FAP application and gives the individual a reasonable opportunity to do so.
- In the case of an individual who submits a complete FAP application during the 240-day application period, the hospital facility determines whether the individual is FAP-eligible for the care.
- Extension of the application period beyond 240 days to account for a 30-day notification window before initiating one or more ECAs to obtain payment for the care.[18]

Furthermore, to qualify as a 501(c)(3) tax-exempt organization, a nonprofit hospital must demonstrate that it provided benefits to a class of persons that is broad enough to benefit the community and operate to serve a public rather than a private interest. A community benefit for a nonprofit hospital is defined by Revenue Ruling 69-545 as follows: 1) operating an emergency room open to all regardless of ability to pay; 2) maintaining a board of directors drawn from the community; 3) maintaining an open medical staff policy; 4) providing hospital care for all patients able to pay, including those who pay their bills through public programs such as Medicaid and Medicare; 5) using surplus funds to improve facilities, equipment, and patient care; and 6) using surplus funds to advance medical training, education, and research.[19]

Circumstances brought forth by gaps in federal regulation and weak oversight and enforcement may allow hospitals to provide low levels of charity care. Federal regulations do not currently define or set minimum standards for hospitals to determine who is eligible for charity care or the level of assistance that must be provided.[20,21] The IRS requires a tax-exempt hospital to file Schedule H with its Form 990 annually to provide the public with information on its policies and activities and the community benefits that its facilities provide. IRS Schedule H categorizes community benefit spending as charity care, unreimbursed costs for providing services to patients insured by government programs (Medicare and Medicaid), subsidized health service, community health improvement services and community-benefit operations, research, health-professions education, and financial and in-kind contributions to community groups.[22]

According to the Government Accountability Office (GAO), the IRS does not have the authority to define specific types of services and activities that a hospital must undertake to qualify for a tax exemption. Instead, the IRS provides guidance on the types of activities that can demonstrate community benefits. The IRS allows hospitals to report spending on several categories under the community benefit umbrella on Form 990 Schedule H. One category is financial assistance that hospitals provide for eligible patients to help them pay for care. Other categories include programs to improve community health like free clinics in underserved neighborhoods, free screenings or health literacy events, donations to local groups, investments in affordable housing, amongst other things. In addition to these community-based activities, nonprofit hospitals can also report hospital-based activities as community benefits, such as the expense to train health professionals and costs for hospital-based medical research. This can lead to crossover in reporting, which could lead to hospitals receiving credit for these activities in multiple ways. For example, teaching hospitals do not subtract the indirect medical education payments they receive from Medicare from community benefit reporting, thus inflating the amount of community benefit reported. In

addition, hospitals can report the cost of federally funded research as a community benefit even if the hospital did not put any of its own money into the work.[23]

Form 990 Schedule H solicits information inconsistently, resulting in a lack of clarity about the community benefits hospitals provide. As defined on Form 990 Schedule H, the term "community health improvement" is an "activity or program, subsidized by the health care organization, conducted, or supported for the express purpose of improving community health. Such services do not generate inpatient or outpatient revenue, although there may be a nominal patient fee or sliding scale fee for these services." Part II of Schedule H permits hospitals to report expenditures for certain "community building" activities, which encompass physical improvements and housing, economic development, community support, environmental improvements, leadership development and training for community members, coalition building, community health improvement advocacy, workforce development, and other activities.

For some factors, the IRS explicitly directs tax-exempt hospitals to report the extent to which they have addressed them. For the other factors, the IRS provides a space for hospitals to qualitatively describe the community benefits they provide. In the GAO's analysis of hospitals' Form 990 Schedule H filings for tax years 2015 through 2018, it found inconsistencies in what hospitals reported in the narrative description. Therefore, reporting results in inconsistent information on many of the community benefit factors. GAO recommended that the IRS update Form 990 to ensure that the information demonstrating the community benefits a hospital is providing is clear and easily understood by Congress and the public. The IRS made minor adjustments to the form, but still allows hospitals to narratively describe the community benefits they provide which continues to lead to inconsistency among different hospitals and lacks clarity.[24,25]

PATIENT ELIGIBILITY FOR CHARITY CARE

Hospitals have broad flexibility to establish their own eligibility criteria for charity care, and as a result, criteria vary across hospitals. Aid at some hospitals is limited to patients below the federal poverty level (FPL), while at other hospitals, patients with incomes that are five to six times the FPL can receive assistance. One analysis of a large sample of nonprofit hospitals that used FPL to determine eligibility for free care in 2018 found that about 32 percent of the hospitals required patients to have incomes at or below 200 percent FPL or they imposed more restrictive eligibility criteria, while the remaining hospitals (68 percent) relied on higher income caps. For discounted care, about 62 percent of nonprofit hospitals in the study limited eligibility to patients with incomes at or below 400 percent FPL or used lower income levels, with the remaining 38 percent of nonprofit hospitals relying on higher income caps. Hospitals may condition free or discounted care on other criteria in addition to or in lieu of income thresholds based on FPL, such as by requiring that patients have limited assets or reside in the hospital service area or by extending eligibility to patients who are unable to afford large medical bills despite exceeding income or asset thresholds under standard eligibility pathways.[26]

A 2019 *Kaiser Health News* analysis of tax filings found that one half of nonprofit medical systems were billing patients with incomes low enough to qualify for charity care. Eligible patients may not receive charity care because they are unaware that charity care is available, do not know they are eligible, have difficulty finding or completing the application, are improperly denied charity care by the hospital, or choose not to apply. Applying for aid can be complicated for patients, requiring considerable personal financial information and documentation. For example, nonprofit hospitals have estimated that, of the unmanageable debt they reported in 2019, about $2.7 billion came from patients who were eligible for charity care but did not receive it.

COMMUNITY BENEFITS AND CHARITY-CARE-TO-EXPENSE RATIOS

The lack of definition for a community benefit standard and the inability of the IRS to enforce guidelines for nonprofit hospitals to remain 501(c)(3) organizations, and keep their tax-exempt status, complicates this issue further. A 2020 GAO report noted that the IRS had not revoked a hospital's nonprofit status based on providing inadequate community benefits over the prior 10 years. A study by Bai, Ge, et al. published in Health Affairs (2021) found that in aggregate, nonprofit hospitals spent $2.30 of every $100 in total expenses on charity care, which was less than government ($4.10) and for-profit ($3.80) hospitals.[27] For-profit hospitals devote a similar or greater share of operating expenses to charity care than nonprofit. For-profit hospitals may have a greater willingness to provide charity care in some scenarios because they can take a tax deduction for these expenses, and it is possible that some nonprofit hospitals may not expect significant oversight of their charity care practices from government regulators.[28] The discrepancy suggests that many nonprofit hospital charity care provisions are not aligned with their favorable tax treatment. Because IRS guidelines established by the ACA require nonprofit hospitals to provide charity care to eligible patients based on their self-determined criteria, there are no standard qualifications utilized to identify patients eligible for charity care. This lack of standardization is confounded by hospitals' differing definitions of charity. For example, one hospital may include Medicaid shortfall and have a much higher ratio spent on charity care than another hospital, which has a lower ratio but spends more directly on charity care. Due to this inconsistency, charity-care-to-expense ratios may not be reliable forms of comparison between hospitals.

Charity-care-to-expense ratios may also belie the community impact of hospitals, as not all spending that hospitals can claim as community benefits are meaningful for community health. The broad definition of what qualifies as a community benefit allows hospitals to include spending on items that do not directly address community health needs. For example, the largest share of community benefit spending by many nonprofit hospitals is for Medicaid shortfall. Medicaid shortfall is the difference between what Medicaid pays for the care hospitals provide and the actual costs the hospital reports.[29] Some hospitals already make up for the shortfall by charging private insurers higher rates or by receiving disproportionate share hospital (DSH) payments, which are given to hospitals that serve a large population of uninsured or Medicaid patients.[30]

STATE REPORTING REQUIREMENTS AND OUTCOMES

State regulations vary in terms of eligibility criteria and the minimum level of assistance that must be available. State policies aimed at increasing hospital charity care provisions have either used a transparency approach or a minimum requirements approach. The transparency approach mandates hospitals' disclosure or reporting of their charity care policies, implementation plans, or expenses. Examples of states using this approach include California and New York. The minimum requirements approach requires hospitals to provide a minimum charity care amount, such as Illinois and Texas, or provide charity care to patients with incomes below a certain designated threshold, such as Washington and Oregon.[31]

Several states have implemented regulations intended to increase the uptake of charity care among eligible patients and to protect potentially eligible patients from certain debt collection practices. Thirteen states require hospitals to screen patients for eligibility, 16 states require hospitals to notify patients they may be eligible for charity care prior to collecting payment or in every notification about collections, and eight states regulate procedures for patients to appeal denials of charity care.[32]

A recent study by Zare, et al. examined the association between state reporting requirements and community benefit spending by nonprofit hospitals. Nonprofit hospitals in states that required reporting spent a higher percentage of total hospital expenditures on community benefits compared to states without

these requirements. A similar association between the percentage of charity care and total hospital expenditures was found.[33]

Studies have shown that some nonprofit hospitals spend only a small portion of their community benefit spending on services that help the community and a much greater percentage on services that benefit the hospital. A study conducted in 2018 by Singh et al. found that when states adopted multiple community benefit and charity care regulations, hospital community benefit spending increased. Other studies have found a positive association between state regulations on free and discounted care, the amount of charity care, and resource allocation decisions.[34]

Twenty-eight states have passed legislation requiring nonprofit hospitals to report data on community benefits and charity care. Nonprofit hospitals in states with reporting requirements spent on average 9.1 percent of total hospital expenditures on 17 distinct types of community benefits, which was an average of $32.9 million. Hospitals in states without reporting requirements spent approximately 7.7 percent of their total hospital expenditures on community benefits, which was an average of $17.8 million. After excluding Medicaid shortfall, hospital spending reduced to 5.5 percent ($20.7 million) in states with reporting requirements and 4.3 percent ($9.7 million) in states without reporting requirements. Charity care provision averaged 2.3 percent of total hospital expense ($6.7 million) in states with requirements and 1.5 percent ($3.6 million) in states without requirements. The top four community benefits reported across all types of states were Medicaid shortfall, charity care, education, and non-means-tested health services such as qualifying inpatient programs (e.g., neonatal intensive care and inpatient psychiatric units) and outpatient programs (home health programs). Nonprofit hospitals in states with reporting requirements spent 36.6 percent on Medicaid shortfall, 20 percent on charity care, 16.8 percent on education, and 8.9 percent on non-means-tested health services. Nonprofit hospitals in states without community benefit requirements spent a higher percentage on Medicaid shortfall (44.8 percent) and charity care (22.8 percent), and a lower percentage on education (11.8 percent), and non-means-tested health services (9.8 percent).[35]

Most recently, CMS approved a North Carolina plan that will award additional Medicaid funds to the state in exchange for forgiving the medical debt of two million people, potentially alleviating four billion dollars in medical debt.[36] It will cover Medicaid recipients and individuals not enrolled in Medicaid with incomes at or below at least 350 percent of the FPL ($109,200 for a family of four), or for whom total debt exceeds five percent of annual income. Hospitals receiving the extra funds will have to agree to discount medical bills on a sliding scale for patients with incomes at or below 300 percent of the FPL, or $93,600, and automatically enroll people into financial assistance (i.e., charity care). Finally, for individuals whose income is at or below 350 percent of the FPL, hospitals must agree to not sell their medical debt to debt collectors.[37]

AMA POLICY

Policy H-155.958 states that the AMA encourages hospitals to adopt, implement, monitor, and publicize policies on patient discounts, charity care, and fair billing and collection practices, and make access to those programs readily available to eligible patients.

Policy H-160.923 states that the AMA: (1) supports the transitional redistribution of DSH payments for use in subsidizing private health insurance coverage for the uninsured; (2) supports the use of innovative federal- or state-based projects that are not budget neutral for the purpose of supporting physicians that treat large numbers of uninsured patients, as well as EMTALA-directed care; and (3) encourages public and private sector researchers to utilize data collection methodologies that accurately reflect the amount of uncompensated care (including both bad debt and charity care) provided by physicians.

DISCUSSION

Nonprofit hospitals make up most hospitals in the United States and are exempt from federal, state, and local taxes as qualified 501(c)(3) organizations. This determination results in billions of dollars of tax savings annually for these hospitals. As a condition of their tax-exempt status, nonprofit hospitals must provide charity care. Nonprofit hospitals establish their own charity care guidelines within broad parameters of government regulation, resulting in many hospitals having different terms of eligibility, application procedures, and programs or services. A patient may qualify for aid at one hospital, but not at a hospital across town. Often, the application process is not clear and requires patients to complete onerous paperwork and submit personal financial records, discouraging patients from completing financial aid applications. In some cases, patients are not screened by their hospital or physician's office prior to being billed for a service. Therefore, patients who may be eligible for financial assistance may end up getting billed for services they are unable to pay. As a result, patients may accrue medical debt that is sent to collections, beginning a waterfall of associated consequences. In addition, if hospitals were more transparent about their charity care policies, patients would be able to make more informed health care decisions based on charity care coverage.

Some hospitals have routinely engaged in suing their patients over unpaid bills. For instance, the University of Virginia Health System sued more than 36,000 patients over medical debt. It halted the practice after exposure by the media caused public outrage and, in 2021, announced it would cancel all ongoing lawsuits against households with incomes below 400 percent of the FPL.[38] Even amidst the public health crisis related to COVID-19, hospitals continued to sue over debt.[39] A Yale study found that nonprofit hospitals were more likely to sue for medical bills than for-profit hospitals, with the top 10 percent of hospitals filing more than 40 percent of all lawsuits from 2014-2018.[40]

The IRS may not have the authority to define specific types of services a hospital must provide to retain their tax-exempt status, but it could increase enforcement on nonprofit hospitals that provide little to no community benefits. According to the GAO, the IRS has not revoked a hospital's tax-exempt status for failing to provide adequate charity care since 2010. Given that there are no federal regulations defining minimum standards for benefits offered, there is considerable leeway available for nonprofit hospitals and the level of charity care they provide to retain their tax-exempt status. Therefore, increased IRS enforcement would more effectively compel hospitals to abide by charity care regulations by applying more force. In addition, a standardized definition of charity care would aid in providing clear guidelines by which nonprofit hospitals must abide by.

While charity-care-to-expense ratios can be reported based on the amount spent on charity care by nonprofit, for-profit, and government hospitals, those comparisons are limited, as there are many factors that go into determining how much each type of hospital spends on charity care and what qualifies as charity care in the area where the hospital is located. For these measurements to be useful, common definitions and federal regulations would need to be established, which seems unlikely, given the lack of oversight and enforcement by the IRS.

Some states require minimum levels of charity care and other states require nonprofit hospitals to report data on the charity care they provide. Studies have shown that when states adopted regulations to track nonprofit charity care, hospital spending on community benefits increased. More than half of states require all, or a subset of all hospitals, to extend eligibility to certain groups of people. Among those states, 11 broadly extend minimum standards to for-profit, nonprofit, and government hospitals.[41] In addition, 19 states and the District of Columbia fill the gaps in federal law by setting standards for the provision of financial assistance. Some states require hospitals to provide an unspecified amount of financial assistance to people with incomes under a specific threshold (e.g., under 100 percent FPL in Florida; under 400 percent FPL in California), while others require hospitals to provide free care for

people with incomes below certain thresholds (e.g., under 150 percent FPL in Maine; under 250 percent FPL in Vermont).[42] In July 2024, CMS approved a North Carolina plan that will give additional Medicaid funds to hospitals in exchange for forgiving the medical debt of two million people. The plan will alleviate almost four billion dollars in existing medical debt dating back to 2014 and will cover Medicaid enrolled recipients and those not enrolled in Medicaid with incomes at or below at least 350 percent of FPL, or for whom total debt exceeds five percent of total income.[43] A sliding scale has also been agreed upon to discount medical bills for patients at or below 300 percent of FPL.[44]

Certain states have passed laws to institute stricter requirements for screening and to remove barriers related to the application process. Maryland, for example, began requiring hospitals to consider patients already enrolled in financial assistance programs as "presumptively eligible," which means automatic eligibility without applying.[45] Illinois, in addition, has had a similar requirement since 2014 and North Carolina, as part of its 2024 plan, automatically enrolls patients in financial assistance.[46] Beyond this, five states require hospitals to use a state-developed uniform application form to make it easier for community-based organizations to assist patients.[47]

There are several shortcomings with enforcement and regulation of nonprofit community hospitals, including lack of patient screening prior to billing and lack of enforcement and regulation by the IRS. The Council recommends that the AMA support efforts to increase patient screening prior to billing and prior to sending past due bills to collections, in addition to supporting expansion and oversight by the IRS. Additionally, the Council recommends reaffirming Policy H-155.958 which states that the AMA will encourage hospitals to adopt, publicize, and implement policies on charity care and other fair billing and collection processes.

RECOMMENDATIONS

The Council on Medical Service recommends that the following recommendations be adopted in lieu of Resolution 802-I-23, and the remainder of the report be filed:

1) That our American Medical Association (AMA) support that all nonprofit hospitals be required to screen patients for charity care eligibility and other financial assistance program eligibility prior to billing. (New HOD Policy)

2) That our AMA support efforts to encourage debt collectors to ensure a patient has been screened for financial assistance eligibility before pursuing that patient for outstanding debt, provide an appeals process for those patients not screened previously or deemed ineligible, and require the hospital to reassume the debt account if an appeal is successful. (New HOD Policy)

3) That our AMA support development of minimum standards for nonprofit hospital financial assistance eligibility programs which are publicly accessible. (New HOD Policy)

4) That our AMA support a standardized definition of what is considered a "community benefit" when evaluating community health improvement activities. (New HOD Policy)

5) That our AMA support the development of a transparent, publicly available, standardized data set on community benefit including consideration of charity care-to-expense ratios. (New HOD Policy)

6) That our AMA support expansion of governmental oversight of nonprofit hospitals and enforcement of federal and/or state guidelines and standards for community benefit requirements including the ability to enact penalties and/or loss of tax-exempt status. (New HOD Policy)

7) That our AMA reaffirm existing Policy H-155.958, which states that the AMA will encourage hospitals to adopt, implement, monitor, and publicize policies on patient discounts, charity care, and fair billing and collection practices and make access to those programs readily available to eligible patients. (Reaffirm HOD Policy)

Fiscal Note: Less than $500.

REFERENCES

[1] Levey, Noam N. 100 Million People in America Are Saddled with Health Care Debt. Kaiser Health News. June 16, 2022. https://kffhealthnews.org/news/article/diagnosis-debt-investigation-100-million-americans-hidden-medical-debt/.
[2] Rakshit, S. et. al. The burden of medical debt in the United States. Peterson-KFF Health System Tracker. February 12, 2024. https://www.healthsystemtracker.org/brief/the-burden-of-medical-debt-in-the-united-states/#:~:text=This%20analysis%20shows%20that%2020,%24220%20billion%20in%20medical%20debt.
[3] Kona, Maanasa and Vrudhi Raimugia. State Protection Against Medical Debt: A Look at Policies Across the U.S. Commonwealth Fund. September 7, 2023. https://www.commonwealthfund.org/publications/fund-reports/2023/sep/state-protections-medical-debt-policies-across-us.
[4] Rae, Matthew, et. al. The burden of medical debt in the United States. Peterson-KFF Health System Tracker. March 10, 2022.
[5] Godwim, Jamie, et. al., The Estimated Value of Tax Exemption for Nonprofit Hospitals was About $28 Billion in 2020. KFF. March 14, 2023. https://www.kff.org/health-costs/issue-brief/the-estimated-value-of-tax-exemption-for-nonprofit-hospitals-was-about-28-billion-in-2020/.
[6] Chandrashekar, Pooja, et. al., Rethinking Community Benefit Programs – A New Vision for Hospital Investment in Community Health. J Gen Internal Med. January 19, 2022. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8971229/pdf/11606_2021_Article_7324.pdf.
[7] Levinson, Zachary, et. al., Hospital Charity Care: How It Works and Why It Matters. KFF. November 3, 2022. https://www.kff.org/health-costs/issue-brief/hospital-charity-care-how-it-works-and-why-it-matters/.
[8] *Supra*. Note 5.
[9] Letchuman, Sunjay, et. al., Revise the IRS's Nonprofit Hospital Community Benefit Reporting Standard. Health Affairs. April 15, 2022. https://www.healthaffairs.org/content/forefront/revise-irs-s-nonprofit-hospital-community-benefit-reporting-standard.
[10] *Supra*. Note 5.
[11] *Supra*. Note 7.
[12] *Supra*. Note 7.
[13] *Supra*. Note 6.
[14] *Supra*. Note 6.
[15] Lagasse, Jeff. Nonprofit Hospitals Falling Behind Tax Breaks, Report Shows. Healthcare Finance. March 28, 2024. https://www.healthcarefinancenews.com/news/nonprofit-hospitals-charity-care-falling-behind-tax-breaks-report-shows.
[16] American Hospital Association. Statement by President and CEO Rick Pollack. There's Nothing Fair About the Lown Institute's Fair Share Report. March 25, 2024. https://www.aha.org/news/blog/2024-03-25-there-nothing-fair-about-lown-institutes-fair-share-report.
[17] IRS. Charitable Hospitals – General Requirements for Tax-Exempt Under Section 501(c)(3). https://www.irs.gov/charities-non-profits/charitable-organizations/requirements-for-501c3-hospitals-under-the-affordable-care-act-section-501r.
[18] IRS. Billing and Collections – Section 501(r)(6). https://www.irs.gov/charities-non-profits/billing-and-collections-section-501r6.
[19] *Supra*. Note 17.
[20] *Supra*. Note 17.
[21] James, Julia. Nonprofit Hospitals' Community Benefit Requirements. Health Affairs. February 25, 2016. https://www.healthaffairs.org/do/10.1377/hpb20160225.954803/.

[22] Simmons, Kim. Richmond Public Interest Law Review. Nonprofit Hospitals' Community Benefits Should Actually Benefit the Community: How IRS Reforms Can Improve the Provision of Community Benefits. https://scholarship.richmond.edu/pilr/vol22/iss3/7/.
[23] Garber, Judith and Vikas Sani. Are Tax-Exempt Hospitals Giving Back their Fair Share to Communities? It Depends on What You Count. STAT. July 7, 2022. https://www.statnews.com/2022/07/07/nonprofit-hospitals-tax-breaks-focus-true-community-aid/.
[24] Rosenbaum, Sarah, et. al., Modifying Hospital Community Benefit Tax Policy: Easing Regulation, Advancing Population Health. Health Affairs. December 1, 2016. https://www.healthaffairs.org/content/forefront/modifying-hospital-community-benefit-tax-policy-easing-regulation-advancing-population.
[25] GAO. IRS Oversight of Hospitals' Tax Exempt Status. Statement of Jessica Lucas-Judy. Testimony Before Subcommittee on Oversight, Committee on Ways and Means, House of Representatives. April 26, 2023. https://www.gao.gov/assets/gao-23-106777.pdf.
[26] *Supra*. Note 7.
[27] Bai, Ge, et. al., Analysis Suggests Government and Nonprofit Hospitals' Charity Care is not Aligned with Their Favorable Tax Treatment. Health Affairs. April 2021. https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.01627.
[28] *Supra*. Note 7.
[29] *Supra*. Note 22.
[30] *Supra*. Note 22.
[31] *Supra.* Note 26.
[32] *Supra.* Note 7.
[33] Zare, H. et. al., When States Mandate Hospital Community Benefit Reports, Provision Increases. Journal of Healthcare Management. 2023. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9973432/pdf/jhcma-68-083.pdf.
[34] *Ibid*.
[35] *Ibid*.
[36] Adriel Bettelheim, "CMS Approves North Carolina Medical Debt Relief Plan," Axios Health, July 31st, 2024, available at https://www.axios.com/2024/07/31/north-carolina-medical-debt-relief-approved?utm_source=newsletter&utm_medium=email&utm_campaign=newsletter_axiosvitals&stream=top.
[37] *Ibid.*
[38] Jay Hancock and Carmen Heredia Rodriguez, "UVA Suspends Medical Lawsuit In Wake Of KHN Investigation," Kaiser Health News, September 12, 2019, available at https://khn.org/news/uva-suspends-medical-lawsuits-in-wake-of-khn-investigation/; Jay Hancock, "UVA Health will wipe out tens of thousands of lawsuits against patients," *The Washington Post*, April 20, 2021, available at https://www.washingtonpost.com/health/2021/04/20/uva-patient-lawsuits/.
[39] Brian M. Rosenthal, "One Hospital System Sued 2,500 Patients After Pandemic Hit, "*The New York Times,* January 5, 2021, available at https://www.nytimes.com/2021/01/05/nyregion/coronavirus-medical-debt-hospitals.html?smid=tw-share; Bram Sable-Smith, "A Wisconsin hospital promised to stop suing most patients during the pandemic. Then it filed 200 lawsuits.", *TMJ 4,* December 21, 2020, available at https://www.tmj4.com/news/coronavirus/a-wisconsin-hospital-promised-to-stop-suing-most-patients-during-the-pandemic -then-it-filed-200-lawsuits.
[40] Zack Cooper, James Han, and Neale Mahoney, "Hospital Lawsuits Over Unpaid Bills Increased By 37 Percent In Wisconsin From 2001 To 2018," *Health Affairs* 40 (12) (2021): 1830–1835, available at https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.01130.
[41] *Supra*. Note 7.
[42] Kona, Maanasa. State Options for Making Hospital Financial Assistance Programs More Accessible. January 11, 2024. https://www.commonwealthfund.org/blog/2024/state-options-making-hospital-financial-assistance-programs-more-accessible.
[43] *Supra.* Note 38.
[44] *Supra.* Note 38.
[45] *Supra.* Note 44.
[46] *Supra.* Note 38.
[47] *Supra.* Note 44.

Council on Medical Service Report 1-I-24
Nonprofit Hospital Charity Care Policies
Policy Appendix

Appropriate Hospital Charges H-155.958
Our AMA encourages hospitals to adopt, implement, monitor and publicize policies on patient discounts, charity care, and fair billing and collection practices, and make access to those programs readily available to eligible patients.
(CMS Rep. 4, A-09; Reaffirmed in lieu of: Res. 213, I-17)

Offsetting the Costs of Providing Uncompensated Care H-160.923
Our AMA: (1) supports the transitional redistribution of disproportionate share hospital (DSH) payments for use in subsidizing private health insurance coverage for the uninsured;(2) supports the use of innovative federal- or state-based projects that are not budget neutral for the purpose of supporting physicians that treat large numbers of uninsured patients, as well as EMTALA-directed care; and (3) encourages public and private sector researchers to utilize data collection methodologies that accurately reflect the amount of uncompensated care (including both bad debt and charity care) provided by physicians.
(CMS Rep. 8, A-05; Reaffirmation: A-07; Modified: CMS Rep. 01, A-17)

REPORT 2 OF THE COUNCIL ON MEDICAL SERVICE (I-24)
Unified Financing Health Care System
(Resolution 818-I-23, Second Resolve)
(Reference Committee J)

EXECUTIVE SUMMARY

At the 2023 Interim Meeting, the House of Delegates referred the second resolve clause of Resolution 818, which asked the American Medical Association (AMA) to support a national unified financing health care system that meets the principles of choice, freedom and sustainability of practice, and universal access to quality care for patients. Because there has been no serious movement toward unified financing at the federal level in the United States (U.S.), this report describes efforts in California to pursue a unified financing system; outlines the model's potential benefits and challenges; summarizes AMA policy on health system reform policy and the AMA's plan to cover the uninsured; and presents policy recommendations. For the purposes of this report, unified financing is defined as a health care delivery system that pools funding sources to pay for universal coverage of a standard benefits package that is made available to everyone, regardless of age, employment status, and income. A potential role for health plans or other intermediaries distinguishes unified financing from single payer systems, which are a type of unified financing.

Discussions of unified financing at the state level are still in the early stages in this country, with California taking the lead and exploring the pursuit of federal waivers that would permit the state to pool and redistribute federal Medicaid, Medicare, and Affordable Care Act (ACA) funds under a unified financing system. Among its benefits, unified financing has the potential to reduce health system fragmentation, improve health equity, and eliminate insurance churn. However, the Council on Medical Service is strongly concerned that, under this model, patients and physicians would have less choice and physician payments would be reduced. The report cautions that payment cuts under unified financing could negatively impact physician supply and patient access to care, especially given ongoing threats to practice sustainability stemming from Medicare and Medicaid payment inadequacies.

Moreover, many uncertainties about the model's design remain, including how such a system would be funded and what new taxes might be needed; the mechanisms through which and the levels at which physicians and hospitals would be paid; and the role (if any) of private health plans. Without such details and lacking sufficient analyses in the literature on the impact of unified financing on physicians and patients in the U.S., the Council believes it would be premature to comment on the model's advisability. Instead, this report recommends that our AMA continue to monitor federal and state health reform proposals, including the development of state plans and/or waiver applications seeking program approval for unified financing.

Additionally, two policies are recommended for reaffirmation: Policy D-165.942, which advocates that state governments be given the freedom to develop and test different models for covering the uninsured, provided certain standards are met; and Policy H-165.838, which upholds the AMA's commitment to achieving health system reforms that include health insurance for all Americans, expand choice of affordable coverage, assure that health care decisions remain in the hands of patients and their physicians, and are consistent with pluralism, freedom of choice, freedom of practice, and universal access.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 2-I-24

Subject: Unified Financing Health Care System (Resolution 818-I-23, Second Resolve)

Presented by: Stephen Epstein, MD, MPP, Chair

Referred to: Reference Committee J

At the 2023 Interim Meeting, the House of Delegates (HOD) referred the second resolve clause of Resolution 818 and asked the American Medical Association (AMA) to "support a national unified financing health care system that meets the principles of choice, freedom and sustainability of practice, and universal access to quality care for patients." The Board of Trustees assigned this item to the Council on Medical Service for a report back to the HOD at the 2024 Interim Meeting. Relatedly, the HOD voted to not adopt the first resolve clause of Resolution 818-I-23, which would have directed our AMA to remove opposition to single payer health care delivery systems from its policy, and instead evaluate all health care system reform proposals based on our stated principles as in AMA policy.

BACKGROUND

Resolution 818-I-23 defines unified financing as "any system of health care financing that provides uniform and universal access to health care coverage that is high quality and affordable, which can include single payer or multi-payer systems based on managed competition between private insurers and does not necessarily mean government run." Supplemental information provided by the sponsors describes unified financing as a system where all health care financing is managed, to varying levels, through a single integrated mechanism with the aim of streamlining health care funding, reducing fragmentation, enhancing efficiency, and improving access to health services. Analyses of health systems specifically labeled as unified financing models are scant in the health care literature aside from a handful of papers on Brazil's health system and a treatise exploring state-level transformational health reform by the Healthy California for All Commission. This Commission was established by a 2019 state law and charged with developing a plan for achieving a unified financing system in California that could include, among other options, a single payer system. The Commission's deliverable, Key Design Considerations for a Unified Health Care Financing System in California, explains unified financing as a "statewide system to arrange, pay for, and assure health care in which all Californians will be entitled to receive a standard package of health care services; entitlement will not vary by age, employment status, disability status, income, immigration status, or other characteristics; and distinctions among Medicare, Medi-Cal, employer-sponsored insurance, and individual market coverage will be eliminated."[1] A *Health Affairs* paper authored by two California Commission members describes unified financing as a type of single payer system "that pools all sources of financing, public and private, into one source to finance a unified benefit package for everyone."[2] For the purposes of this report, the Council defines unified financing as a health care delivery system that pools funding sources to pay for universal coverage of a standard benefits package that is made available to everyone, regardless of age, employment status, and income. A potential role for health plans or other intermediaries

distinguishes unified financing from single payer systems, which are usually government-run; however, single payer is a type of unified financing. Unified financing also includes multi-payer systems in which a single fund coordinates contributions from various sources while maintaining a standardized approach to benefits and coverage. Interestingly, unified financing can co-exist with supplemental insurance markets or private markets that operate independently, just as substitutive or supplemental private health insurance is available in many countries with unified financing—including single payer—systems. In this country, there has been no serious movement toward unified financing at the federal level and consideration of Medicare-for-All-type proposals has largely stalled; accordingly, this report focuses primarily on California's efforts to implement unified financing reforms.

Because the path towards unified financing in California is still in its early stages, uncertainties about its potential design and implementation remain, including the mechanisms through which or the levels at which physicians, hospitals, and other providers would be paid for their services; the sources of funding that will finance the system; the role (if any) of private health plans; and methods for controlling health care spending, which would be integral to the model's sustainability. According to the Commission, "a threshold issue for California involves securing federal permissions to redirect and consolidate existing federal funding for Medicaid, Medicare, and Affordable Care Act (ACA) advance premium tax credits within a state unified financing system."[3] Furthermore, the reform's sustainability would largely depend on the ability of the state to maintain adequate funding levels and could potentially necessitate new or higher taxes.[4] In October 2023, the California state legislature enacted SB 770, which endorsed the Commission's recommendations for a unified financing system and directed the Secretary of the California Health and Human Services agency to "pursue waiver discussions with the federal government with the objective of a unified health care financing system that incorporates specified features and objectives, including, among others, a comprehensive package of medical, behavioral health, pharmaceutical, dental, and vision benefits, and the absence of cost sharing for essential services and treatments."[5] Updates regarding the need for specific waivers or a timeline for formal waiver applications had not been published at the time this report was written.

At the federal level, unified financing could be implemented through a Medicare-for-All approach, in which eligibility for Medicare is extended to all Americans in a single payer system that replaces employer-sponsored insurance, individual market coverage, and most existing public programs, including Medicaid and Children's Health Insurance Program (CHIP). The Medicare-for-All approach was addressed by the Council in Council Report 2-A-19 and in other reports supporting improvements to the ACA and policies targeting the remaining uninsured. Longstanding AMA policy opposing single-payer systems has been periodically considered by the HOD and was kept in place most recently just a year ago. As the Council has consistently noted, focusing AMA efforts on improving the ACA instead of abandoning it helps promote physician practice viability by maintaining a robust payer mix. Additional concerns about a Medicare-for-All approach include the enormous cost related to implementing such a system and how possible pay-fors would impact patients and physicians.

Some proponents of unified financing also maintain that the model could be implemented by merging employer-sponsored and individual insurance markets and harmonizing their subsidy systems. A Council report presented at the 2024 Annual Meeting addressed this issue and recommended incrementally lowering the ACA affordability firewall so that more workers who have access to employer-sponsored insurance would be eligible to purchase subsidized ACA plans. However, the HOD referred this report back to the Council for further study, in part because of concerns about its potential impact on payer mix and physician practice sustainability. An updated report will be presented by the Council at the 2025 Annual Meeting.

International Unified Financing Models

As noted in Key Design Considerations for a Unified Health Care Financing System in California, a range of unified financing approaches—including single payer systems and mixed models—have been used internationally to achieve universal coverage and access to a standardized set of health services. Under Canada's single payer system, there is no national standardized benefits package; instead, Canadian provinces and territories make most public coverage decisions and administer universal health insurance programs within their jurisdictions. As a result, coverage for services that are not federally mandated (e.g., outpatient prescription drugs and mental health, dental, and vision services) may vary across provinces and territories, most of which provide some level of prescription drug coverage for individuals lacking supplemental private coverage.[6] Two-thirds of Canadians have supplemental private insurance—paid for mostly by employers—that covers vision and dental care, outpatient prescription drugs, private hospital rooms, and other services not covered by the publicly-funded plan.[7]

In addition to Australia's public system, which is funded by general taxation and an income-based tax and covers most hospital and physician services at no cost, patients can purchase private health insurance that facilitates access—at a cost—to private hospitals and specialists and other services not covered by the public system.[8]

Brazil's health system, known as SUS (Sistema Único de Saúde), is decentralized such that the administration and delivery of care is managed at the municipal or state level. Under SUS, which is financed by taxes and contributions from federal, state, and municipal governments, all residents and visitors can access primary, specialty, mental health, and hospital services free of charge and without cost-sharing. Almost a quarter of the population also enrolls in private plans, some of which have their own health facilities, to circumvent delays in accessing care under SUS.[9]

The United Kingdom's (UK) health care system is more centralized; the government-administered National Health Service (NHS), which is funded by general taxation, provides mostly free health care to its residents. NHS owns public hospitals in the UK and pays the salaries of most physicians, nurses, and other care providers and, notably, NHS physicians report high levels of stress and burnout due to staffing shortages and dissatisfaction with pay.[10] As in other countries, more than 10 percent of people in the UK also have private health insurance policies that they either purchase or obtain through an employer. This private coverage provides quicker access to care, greater choice of specialists and hospitals, and amenities for elective hospital procedures but does not include general, emergency, maternity, or mental health care services which are provided by the NHS.[11]

Government plays a lesser role in Germany's universal multi-payer health system, where health insurance is mandatory and provided through either statutory health insurance—administered by competing nonprofit plans known as sickness funds—or substitutive private coverage that individuals can opt into if they make more than €69,300 per year. Health care is financed by mandatory contributions (from employers and workers) imposed as a percentage of wages, which are pooled into a central health fund and reallocated to the sickness funds. Individuals purchasing substitutive private coverage pay risk-adjusted premiums that are determined at the time of enrollment. Although government subsidies are not available to purchase substitutive insurance, these private plans remain attractive, especially to young people, because they may include a broader range of services and lower premiums.[12]

In the Netherlands, all residents must purchase statutory insurance from private health insurers and most people (84 percent) also purchase supplementary insurance that covers dental and vision care and other services not covered by the statutory plan. Statutory insurance is financed through a

combination of a nationally defined income tax, government grants for those under 18 years of age, and community-rated premiums set by each insurer. Such contributions are collected centrally and allocated to insurers according to a risk-based capitation formula. Because supplemental private insurance premiums are not regulated, plans can screen for risks. Interestingly, almost all individuals purchase voluntary supplemental coverage from the same insurer that provides their statutory health insurance.[13]

In its 2017 report on health care financing models around the world, the Council identified both advantages and disadvantages of each of the models studied. In that report, the Council found that the diversity of health care financing models represented different country-to-country priorities, societal beliefs, and acceptable trade-offs related to the level of coverage achieved by the financing model; individual tax burdens; and levels of government regulation, including of health care prices. The Council further found that some financing models were tied to increased government regulation of prices and budgets across the health system, which was perceived as undermining the free market principles long supported by the AMA, and that countries with such systems, including single payer models, tend to have higher rates of taxation and social insurance contributions.

The U.S. is unique among high-income countries in that it lacks a publicly financed system of universal health care. Instead, our pluralistic system incorporates multiple financing models that include a mix of public (e.g., Medicare, financed by federal taxes, a mandatory payroll tax, and individual premiums; and Medicaid and CHIP, jointly financed by federal and state tax revenues) and private (e.g. employment-based insurance, paid for by employers and employees; or plans purchased by individuals, often federally subsidized, on an ACA exchange) options. Although patients enrolled in publicly financed health systems like Medicaid may incur fewer cost-sharing expenses, they may also experience access challenges, lengthier wait times, and/or delayed or lack of access to costly innovative services and therapeutics. The private insurance system in this country reflects free market principles and embraces choice but may be more costly for some patients (and employers), thereby raising equity concerns.[14]

As stated in Council Report 2-A-17, approaches to paying physicians and other providers vary by country and are not wholly dependent on a country's health care financing model. Physicians can be salaried or be paid via fee-for-service or capitation, with fee schedules set by national, regional, or local health authorities, negotiated between national medical societies or trade unions and the government, or negotiated/set by sickness funds or health plans. Hospital financing can vary but generally depends on whether hospitals are public, private, nonprofit, or for-profit. Public hospitals may operate under a global budget determined by the responsible health authority, or receive a majority of their funding from national, regional, or local governments.

While the U.S. surpasses other countries when it comes to health spending, it underperforms on some metrics related to health outcomes. Americans tend to be greater consumers of medical technology and pharmaceuticals and often pay more for care in our market-based system. As noted in Council Report 2-A-17, although many governments across the world finance universal health care, there may be lengthy wait times to see physicians in some countries or an inability to access procedures or innovative therapies that can be obtained in the U.S.

Potential Benefits of Unified Financing

The California Commission's report, Key Design Considerations for a Unified Health Care Financing System in California, outlines many potential benefits of unified financing systems. The report notes that the existing fragmented financing system is administratively burdensome; lacks accountability for quality, costs, and equity; and can lead to coverage gaps for people experiencing job or life changes. According to the report, unified financing would allow the state to achieve notable health goals related to:

- Universality, since unified financing creates universal coverage;
- Improved equity, by eliminating differences in coverage between employer-sponsored insurance, Medicare, Medicaid, nongroup marketplace plans, and the uninsured;
- Affordability, since monthly premiums would no longer be paid, and long-term services and supports and dental services would be covered;
- Access, since uninsurance and underinsurance would be eliminated, and
- Quality, due to the new system being more uniform, which would facilitate quality improvements.[15]

Although it is possible to dispute the report's assertions that unified financing will improve health care quality and access (especially if physician and other provider payments are decreased), unified financing could streamline health care funding and lessen the fragmentation of the existing system, thereby potentially giving rise to a range of benefits, including increased equity and transparency as well as decreased administrative burdens related to the standardization of billing, prior authorization, and other insurance-related expenses, which could produce cost savings for physicians. Additional administrative costs, related to brokers, pharmacy benefit managers, and other middlemen, could also be reduced or eliminated under unified financing.[16] Reduced fragmentation should theoretically result in a system that is less administratively complex for patients to navigate, and if all physicians and hospitals are covered under unified financing, provider networks would be eliminated. Importantly, a unified financing health system would also eliminate insurance churn and reduce gaps in coverage that often occur when individuals, for a variety of reasons, switch coverage types (for example between Medicaid and ESI or ESI and ACA marketplace plans). In principle, universal coverage of standardized benefits should increase access to care, especially among people with lower incomes, and improved access may lead to improved health outcomes.[17]

In terms of design options, the Commission's report analyzed the costs of implementing unified financing under different scenarios that, for example, make direct payments to providers or use a health plan to do so; require zero cost-sharing or income-related cost-sharing; or include long term services and supports (LTSS) as it exists today or expanded LTSS services. According to the report, if federal and state funding streams remain consistent with current levels, and a payroll tax (or combination of other progressive taxes) is used to replace employer-sponsored insurance, a unified financing system would lower health care costs in year one and produce savings over time, primarily because the various scenarios assume significant savings will be incurred from decreases in drug prices as well as provider and payer administrative costs. SB 770 asserts that a unified financing system would save California more than $500 billion over 10 years.

Potential Challenges of Unified Financing

Unifying public and private payers into a single pooled fund would be immensely challenging in this country. Key Design Considerations for a Unified Health Care Financing System in California

recognizes that transitioning to a unified financing system would completely upend health care financing and coverage as it exists today. As such, it is important to consider the feasibility of some of the assumptions delineated above, such as the payroll tax, which—the report states—will produce "winners and losers," since some employers will be required to pay more than others. Additionally, the report assumes that the U.S. Department of Health and Human Services (HHS) will agree to consolidate and redirect current levels of federal Medicaid, ACA, and Medicare funds to the state's new health authority that provides all Californians with the same benefits package, regardless of a person's age, income, or disability. For that to happen, all statutory and regulatory requirements stipulating that certain benefits be provided to particular populations would need to be waived and, moreover, some benefits enshrined in statute may need to be reduced or eliminated. The California Commission acknowledges that a waiver of this magnitude would be unprecedented and controversial, and that it is possible that HHS may not be authorized to approve such a model without new federal authorizing legislation.[18]

Both a direct payment approach, in which providers would be paid directly by the state authority, and an approach that uses health plans or other nonprofits as intermediaries, were discussed in the California Commission's report. If health plans or health systems are used as intermediaries, they would be required to offer the same benefits and cost-sharing structure, which could be perceived as antithetical to choice, which is embraced in AMA policy. Although it is not clear how physicians and other health care providers would be paid under a unified financing system, the report cites the Maryland Total Cost of Care Model, which sets global budgets for hospitals, as a potential design feature. For physicians and other outpatient providers, the Commission's report states that the "unified financing authority would either set or negotiate fee-for-service based payment rates," and that "aggregate payments to physicians would be equal to the weighted average of current Medi-Cal, Medicare, and ESI payments, minus estimated reductions in costs due to reduced billing and administrative costs." The report further states:

> *One implication of [unified financing] UF is that physicians whose patients are currently primarily covered by private insurance will receive less revenue under UF than they do under the status quo, while physicians whose patients are primarily insured by Medicare and Medi-Cal will receive an increase in revenue. The analysis assumes that, because the UF system will be the only source of third-party payment, all California physicians and other health care providers will participate in the UF system.*

Notably, the latter assumption may violate AMA policy on physician choice of practice (Policy H-385.926) and physician freedom to participate in a particular insurance plan or method of payment (Policy H-165.985). Language in SB 770 specifies that unified financing waivers should incorporate "a rate-setting process that uses Medicare rates as the starting point for the development of final rates that avoid disruptions in the health care system and expand the availability of high quality vital services by sustaining a stable, experienced, and equitably compensated workforce."[19] Still, any cuts to physician, hospital, and other provider payments under unified financing in California or any other state, or federally, could have widespread ramifications on the delivery system, physician supply, and patient access to care. As noted in the previous section, fewer administrative burdens under unified financing could lead to reductions in prior authorization and billing costs incurred by physicians producing some cost savings. However, potential payment impacts are especially concerning given that annual Medicare payment reductions and the lack of an inflationary update already threaten the viability of physician practices, add to physician's considerable burdens, and stifle innovation. Medicaid physician payment rates also remain inadequate in many states which negatively impacts patient access to certain care. At the same time, as evidenced by a 3.6 percent projected increase to the MEI in 2025,

the inflationary costs associated with running a practice continue to rise while physician payments under Medicare and Medicaid are failing to keep up.

With regard to pluralism, unified financing assumes a centralization of financing while garnering potential efficiencies, which could potentially cause benefits and payment levels to coalesce into a single or tightly limited range. If this were to occur, patients and physicians would have little recourse should decisions be made to underpay for certain types of medical care or to deny or modify coverage for certain services. In turn, this could affect the adoption of newer technologies and treatments, which some insurers may cover sooner than others or with fewer or more restrictions. Under the current decentralized (pluralistic) system of competing health plans, some patients and physicians can choose not to purchase a particular insurance product, or to not be in network with those payers; however, this may not be feasible in a more centralized unified financing system. These concerns would be mitigated, however, if supplemental private plans offering different benefits become available on top of the standardized unified financing plan.

Although analyses of California's unified financing approach project cost-savings over time, it is important to point out that single payer systems have been estimated to increase federal health spending by more than 50 percent, which may not be politically palatable.[20] Depending on health system design specifications, a unified financing model could necessitate increases in taxation. Additionally, as evidenced by experiences around the world, political and economic shifts can pose serious risks to the stability of unified financing systems which, if not adequately funded, experience capacity and physician shortages as well as bottlenecks that can delay medically necessary care when fiscal austerity measures are put in place. Finally, transitioning residents into a transformed health system could lead to administrative challenges, especially in the early years, similar to those experienced when the ACA was first implemented.

A Potential Feature of Unified Financing: Hospital Global Budgeting

Hospital global budgeting, which has been implemented in other countries (e.g., Canada and the Netherlands) and in U.S. jurisdictions participating in the Centers for Medicare & Medicaid's (CMS) "state total cost of care" demonstrations, was cited by the California Commission as a potential design feature under unified financing that could help control health care costs. In this country, hospitals implementing global budgeting are generally exempt from Medicare's inpatient and outpatient prospective payment systems and are instead paid predetermined, fixed annual budget amounts based on previous years' Medicare and Medicaid payment levels, adjusted for inflation and population changes. Hospitals operating under global budgeting thus experience more payment stability and predictability, since they know what they will be paid from year to year, enabling more proactive planning.[21] Hospitals can also retain some revenues by managing costs below established payment levels, which may incentivize them to provide value-based care and reduce preventable hospitalizations.

To advance hospital global budgeting in more states, CMS launched a new voluntary state total cost of care model called States Advancing All-Payer Health Equity Approaches and Development (AHEAD) in 2023. At the time this report was written, four states had signed on—Maryland, Vermont, Connecticut, and Hawaii.[22] According to CMS, the AHEAD model aims to drive multi-payer alignment across more states through hospital global budgeting coupled with a primary care component. To address improvements in health equity, adjustments for social risk will be incorporated into hospital global budget payments.[23]

Global budgets are not new and could potentially be implemented as part of California's unified financing system. Although about half of the states attempted to regulate hospital prices in the

1970s, Maryland is the only state that has continuously embraced an all-payer approach and has been partnering with CMS to implement global hospital budgeting since 2014.[24] Vermont has administered an all-payer model for accountable care organizations (ACOs) since 2017,[25] the same year that Pennsylvania began implementing a rural health model that pays participating hospitals a fixed amount prospectively, regardless of patient volume.[26] These states have been able to implement such changes by participating in CMS waiver demonstrations and their experiences contributed to the design of the new AHEAD model.

Maryland's global budget is limited to hospitals; physician services provided in hospital settings and care provided outside of hospital campuses are generally excluded. Annual budgets are established by the Health Services Cost Review Commission for each hospital (excluding federal and children's hospitals, and some specialty hospitals) in the state using the previous year's budget as the base coupled with annual updates reflecting inflation and population growth. This independent state agency also sets all-payer pricing for hospital care units of service, which are used to determine a hospital's global budget amount.[27] Through its federal waivers, Maryland has committed to producing $2 billion in Medicare savings between 2019 and 2026 while improving quality and population health in the state. An evaluation of the program found that, in 2022, 41 hospitals were able to retain $1.1 billion in revenue by reducing volume while 11 hospitals surpassed the volume included in their global budgets, resulting in negative $79 million in revenue.[28] From 2014 through 2018, Maryland's all-payer model resulted in $975 million in Medicare savings while reducing inpatient admissions and potentially avoidable hospitalizations.[29]

AMA POLICY ON HEALTH SYSTEM REFORM

The AMA continues to advocate for policies that allow physicians and patients to be able to choose from a range of public and private coverage options with the goal of providing coverage to all Americans. To achieve universal coverage, the AMA has long advocated for the promotion of individually selected and owned health insurance; the maintenance of the safety net that Medicaid and CHIP provide; and the preservation of employer-based coverage to the extent that the market demands it. Notably, the AMA's proposal for health system reform—which is grounded in AMA policies supporting pluralism, freedom of choice, freedom of practice, and universal access for patients—has been extensively debated by the HOD for more than 25 years. Based principally on recommendations developed by the Council, beginning in 1998, AMA policy has advocated for the promotion of individually selected and owned health insurance using refundable and advanceable tax credits that are inversely related to income so that patients with the lowest incomes receive the largest credits (Policies H-165.920 and H-165.865). Our policy also underscores that, in the absence of private sector reforms that would enable people with lower incomes to purchase health insurance, the AMA supports eligibility expansions of public sector programs, such as Medicaid and CHIP, with the goal of improving access to health coverage to groups that would be otherwise uninsured (Policy H-290.974).

The principles and guidelines embedded throughout the AMA's large compendium of health reform policy, which has been refined over the years as the coverage environment has evolved, form the basis by which the AMA continues to thoughtfully evaluate and engage in advocacy around a broad array of approaches to achieve universal health coverage. Since the ACA was enacted, the HOD has adopted a multitude of policies addressing how to cover the remaining uninsured and improve health care affordability, thereby ensuring that our proposal for reform continues to evolve. For example, Policy H-165.823 was amended in 2021 to address uninsured individuals who fall into the "coverage gap" as well as those ineligible for coverage due to immigration status. Policy H-290.955 was adopted in 2022 and subsequently amended in 2023 to address the unwinding of Medicaid's continuous enrollment requirement, which was the most

significant nationwide coverage transition since the ACA and led to improper Medicaid disenrollments of eligible individuals in many states.

This year, the AMA's plan to cover the uninsured focuses on expanding health insurance coverage to five main population targets, which make up the nonelderly uninsured population: 1) individuals eligible for ACA premium tax credits (35 percent of the uninsured); 2) individuals eligible for Medicaid or CHIP (25 percent of the uninsured); 3) people who are ineligible for ACA premium tax credits due to an offer of "affordable" employer-provided insurance (20 percent of the uninsured); 4) individuals ineligible for coverage due to immigration status (15 percent of the uninsured); and 5) people ineligible for Medicaid because they fall into the "coverage gap" in states that have not expanded Medicaid (6 percent of the uninsured).[30] To maximize coverage and improve affordability, the following policies form the basis of the AMA proposal for reform:

- Policy H-165.824 supports improving affordability in health insurance exchanges by expanding eligibility of premium tax credits beyond 400 percent of the federal poverty level (FPL); increasing the generosity of premium tax credits; expanding eligibility for cost-sharing reductions; and increasing the size of cost-sharing reductions.
- Policy H-290.955, which was adopted in response to the Medicaid unwinding, encourages states to facilitate coverage transitions, including automatic transitions to alternate forms of coverage, including for people no longer eligible for Medicaid who are eligible for ACA marketplace plans. This policy also encourages state Medicaid agencies to implement strategies to reduce inappropriate terminations from Medicaid/CHIP for procedural reasons and provide continuity of care protections to patients transitioning to a new health plan that does not include their treating physicians. Finally, this policy supports additional strategies that respond to improper Medicaid disenrollments.
- Policy H-165.828, which is intended to help employees having difficulties affording ESI, supports lowering the threshold used to determine ESI affordability to the level at which premiums are capped for individuals with the highest incomes eligible for subsidized ACA coverage.
- Policy D-290.979 advocates that all states expand Medicaid, as authorized by the ACA.
- Policy H-165.823 advocates 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. This policy establishes standards for supporting a public option and states that it shall be made available to uninsured individuals who fall into the "coverage gap" in states that do not expand Medicaid at no or nominal cost. Policy H-165.823 also directs the AMA to advocate that any federal approach to covering uninsured individuals who fall into the "coverage gap" in non-expansion states makes health insurance coverage available at no or nominal cost, with significant cost-sharing protections. Importantly, this policy supports extending eligibility to purchase ACA marketplace coverage to undocumented immigrants and Deferred Action for Childhood Arrivals recipients. Finally, Policy H-165.823 supports states and/or the federal government pursuing auto-enrollment in health insurance coverage provided it meets certain standards.
- Policies H-165.824, H-290.976, H-290.971, H-290.982 and D-290.982 support investments in outreach and enrollment assistance activities to improve coverage rates of individuals eligible for ACA financial assistance or Medicaid/CHIP.
- Policy D-165.942 advocates that state governments be given the freedom to develop and test different models for covering the uninsured, provided that their proposed alternatives a) meet or exceed the projected percentage of individuals covered under an individual responsibility requirement while maintaining or improving upon established levels of quality of care, b)

ensure and maximize patient choice of physician and private health plan, and c) include reforms that eliminate denials for pre-existing conditions.

A plethora of health reform principles are also delineated throughout the AMA's health reform policy, including Policies H-165.838, H-165.888, H-165.846, and H-165.985. Policy H-165.838 commits the AMA to achieving health reforms that include the following components:

- Health insurance coverage for all Americans;
- Insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions;
- Assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials;
- Investments and incentives for quality improvement and prevention and wellness initiatives;
- Repeal of the Medicare physician payment formula that triggers steep cuts and threaten seniors' access to care;
- Implementation of medical liability reforms to reduce the cost of defensive medicine; and
- Streamline and standardize insurance claims processing requirements to eliminate unnecessary costs and administrative burdens.

Policy H-165.888 directs the AMA to continue its efforts to ensure that health system reform proposals adhere to a range of principles regarding choice and include valid estimates of implementation costs and the identification of sources of funding, including specific types of taxation. Policy H-165.846 supports a series of principles to guide in the evaluation of health insurance coverage options, including that provisions must be made to assist individuals with low-incomes or unusually high medical costs in obtaining health insurance coverage and meeting cost-sharing obligations. Policy H-165.985 reaffirms core AMA health reform principles, including free market competition, freedom of patients to select and change physicians or health plans, freedom of physicians to choose whom they will serve, to establish their fees at a level which they believe fairly reflect the value of their services, and to participate or not participate in a particular plan or method of payment.

The AMA also has policy addressing some of the federal waivers that would be needed for California or another state to move forward with implementing a unified financing model, including:

- Policy H-165.826, which supports the criteria outlined in Section 1332 of the ACA for the approval of State Innovation Waivers, including that the waiver must: a) provide coverage to at least a comparable number of the state's residents as would be provided absent the waiver; b) provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable for the state's residents as would be provided absent the waiver; c) provide coverage that is at least as comprehensive for the state's residents as would be provided absent the waiver; and d) not increase the federal deficit.
- Policy H-290.987, which supports the provision of state Medicaid waivers, provided they promote improving access to quality medical care; are properly funded; have sufficient physician and other provider payment levels to secure adequate access; and do not coerce physicians into participating.
- Policy H-165.829, which encourages the development of state waivers to develop and test different models for transforming employer-provided health insurance coverage, including giving employees a choice between employer-sponsored coverage and individual coverage

offered through health insurance exchanges, and allowing employers to purchase or subsidize coverage for their employees on the individual exchanges.

After thoroughly reviewing the compilation of AMA health reform policies, the Council also notes that, depending on specific design features, unified financing proposals may be inconsistent with the following AMA policies:

- Policy H-165.838, under which the AMA supports health system reform alternatives that are consistent with AMA policies on pluralism, freedom of choice, and freedom of practice. This policy also states that the creation of a new single payer, government-run health care system is not in the best interest of the country and must not be part of national health system reform.
- Policy H-165.920, which affirms AMA support for pluralism of health care delivery systems and financing mechanisms in obtaining universal coverage and access to health care services.
- Policy H-165.888, which states that unfair concentration of market power of payers is detrimental to patients and physicians if patient freedom of choice or physician ability to select mode of practice is limited or denied.
- Policy H-165.985, which opposes socialized or nationalized health care and instead supports: 1) free market competition among all modes of health care delivery and financing, with the growth of any one system determined by the number of people who prefer that mode of delivery, 2) freedom of patients to select and change their physician or medical care plan, 3) freedom of physicians to choose whom they will serve, to establish their fees, and to participate in a particular insurance plan or method of payment, and 4) improved methods for financing long-term care through a combination of private and public resources.
- Policy H-165.844, which reaffirms support of pluralism, freedom of enterprise and strong opposition to a single payer system.
- Policy H-285.998, which is one of the AMA's preeminent policies addressing managed care, states that the needs of patients are best served by free market competition and free choice by physicians and patients between alternative delivery and financing systems.

DISCUSSION

Although the Council last presented a comprehensive report on health care financing models in 2017 (Council Report 2-A-17), several reports since then have enhanced AMA policy on health system reform and covering the uninsured, including:

- Council Report 2-A-18, Improving Affordability in the Health Insurance Exchanges;
- Council Report 3-A-18, Ensuring Marketplace Competition and Health Plan Choice;
- Council Report 2-A-19, Covering the Uninsured Under the AMA Proposal for Reform;
- Council Report 1-Nov-20, Options to Maximize Coverage Under the AMA Proposal for Reform;
- Council Report 3-Nov-21, Covering the Remaining Uninsured;
- Council Report 3-A-22, Preventing Coverage Losses After the Public Health Emergency Ends;
- Council Report 6-A-23, Health Care Marketplace Plan Selection; and
- Council Report 5-I-23, Medicaid Unwinding Update.

Together, these reports have established AMA policy that seeks to guarantee affordable health coverage—and timely access to quality care—for every American while embracing the organization's commitment to universal coverage, and to longstanding principles related to pluralism, choice, freedom and sustainability of practice, and universal access to care. The compilation of health reform policy summarized in this report forms the basis by which the AMA

continues to evaluate and engage in advocacy around health system reform proposals and efforts to improve the health care system for all patients and physicians. As AMA policy evolves, so too does the AMA's plan to cover the uninsured, which is updated biennially to incorporate current metrics on the uninsured and operationalize AMA priorities for improving affordability and covering the remaining uninsured.

At the 2023 Interim Meeting, the HOD voted against removing AMA opposition to single payer systems (e.g., Medicare-for-All-type proposals) from its policy while referring the second resolve of Resolution 818-I-23, which led to the Council's unified financing study and the development of this report. The Council's study of unified financing systems was limited in part by the lack of formal analyses on the impact that such models would have on patients, physicians, hospitals, medical practice, and the costs, quality, and timeliness of care in the U.S. consistent with this limitation, the Council found that discussions of this type of reform are still in the preliminary stages in this country, with California taking the lead as it explores pursuing federal waivers that would be required for the state to pool and redistribute Medicaid, Medicare, ACA, and possibly other federal dollars under a unified financing system. Even in California, the Council believes it is unclear how unified financing would work or how physicians and patients would be impacted. As more details regarding the specific features of California's plan are released, the Council will continue to explore the model's pros and cons and consider critical lessons that will be learned from the state's experience. At this time, while the Council generally finds that unified financing has potential to reduce fragmentation in our health care system, improve health equity, and eliminate insurance churn and coverage gaps, we remain strongly concerned that patients and physicians would have less choice under this model, and that physician and hospital payments may be reduced in order to lower health care costs and fund system redesign. As cautioned in this report, the Council believes that any cuts to physician or hospital payments could have widespread ramifications on the delivery system, physician supply, and patient access to care, especially given ongoing threats to practice sustainability due to longstanding inadequacies of Medicare and Medicaid payment rates.

The Council is intrigued by California's embrace of unified financing and pursuit of transformational health reform; however, we also recognize that the state is likely years away from implementing unified financing and that many uncertainties about its model's design and potential implementation remain, including how such a system would be funded, and what new taxes—payroll or otherwise—might be needed; the mechanisms through which and the levels at which physicians and hospitals would be paid; and the role (if any) of private health plans. Since no state had begun pursuing the necessary waiver applications at the time this report was written, the Council also has lingering questions about the feasibility of unified financing in the U.S., especially since federal waivers, even if approved, can be undone when Administrations change. Furthermore, it is unclear if HHS would even have the statutory authority to consolidate and redirect current levels of federal Medicare, Medicaid, and ACA funds without new federal legislation. As previously noted, there is no significant movement towards unified financing at the federal level and consideration of Medicare-for-All-type proposals has largely stalled.

Although the Council's study included international examples of unified financing systems, we emphasize that models implemented in other countries are not generalizable to the U.S. because of the existing complexities inherent to our current system. Until the aforementioned implementation issues are resolved, we believe it would be premature to recommend new AMA policy on unified financing, such as principles or guardrails that unified financing systems should incorporate (similar to the public option standards delineated in Policy H-165.823). Instead, this report summarizes the potential benefits and challenges of a unified financing model without commenting on its advisability. In order to keep abreast of new unified financing developments in California or

elsewhere, the Council recommends that our AMA continue to monitor federal and state health reform proposals, including the development of state plans and/or waiver applications seeking program approval for unified financing. Consistent with California's exploration of a unified financing model and potential action in other states, the Council also recommends reaffirming Policy D-165.942, which advocates that state governments be given the freedom to develop and test different models for covering the uninsured provided that certain standards are met (e.g., patient choice of physician and private health plan must be ensured).

The Council continues to stand behind the substantial health reform policies summarized herein, which reflect the organization's commitment to achieving universal coverage by improving the current system and expanding its reach to Americans who fall within its coverage gaps. Instead of upending and fully redesigning the health system, which may be unrealistic, AMA policy builds on the foundation already in place—a pluralistic system that embraces competition and freedom of choice—to achieve the right mix of public and private coverage and expanded Medicaid options in every state. The Council has heard the argument that our policy opposing single payer systems precludes the AMA from engaging in discussions of federal and state health reform proposals. However, we maintain that the AMA stands ready to evaluate any mature reform proposal that is introduced, no matter its structure and scope. Furthermore, the Council did not identify any gaps in existing AMA policy that need to be addressed for the AMA to continue advancing its health reform vision with Congress, the Administration, and states. Even if a moderately detailed unified financing proposal was introduced tomorrow, its provisions could be thoroughly vetted for consistency with the existing health reform policies cited in this report, such as Policy H-165.838, which upholds the AMA's commitment to achieving enactment of health system reforms that include health insurance coverage for all Americans, expand choice of affordable coverage, ensure that health care decisions remain in the hands of patients and their physicians, and are consistent with pluralism, freedom of choice, freedom of practice, and universal access.

RECOMMENDATIONS

The Council on Medical Service recommends that the following recommendations be adopted in lieu of the second resolve clause of Resolution 818-I-23, and that the remainder of the report be filed.

1. That our American Medical Association (AMA) continue monitoring federal and state health reform proposals, including the development of state plans and/or waiver applications seeking program approval for unified financing. (Directive to Take Action)

2. That our AMA reaffirm Policy D-165.942, which advocates that state governments be given the freedom to develop and test different models for covering the uninsured, provided that proposed alternatives a) meet or exceed the projected percentage of individuals covered under an individual responsibility requirement while maintaining or improving upon established levels of quality of care, b) ensure and maximize patient choice of physician and private health plan, and c) include reforms that eliminate denials for pre-existing conditions. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy H-165.838, which upholds the AMA's commitment to achieving enactment of health system reforms that include health insurance for all Americans, expand choice of affordable coverage, assure that health care decisions remain in the hands of patients and their physicians, and are consistent with pluralism, freedom of choice, freedom of practice, and universal access. (Reaffirm HOD Policy)

Fiscal Note: Less than $500.

REFERENCES

[1] Healthy California for All Commission. Key Design Considerations for a Unified Health Care Financing System in California. April 2022. Available at: https://www.chhs.ca.gov/wp-content/uploads/2022/04/Key-Design-Considerations_April-2022_Final-Report-for-Distribution.pdf
[2] Hsiao, W and Sheffler R. Unified Financing Of Health Care In California: The Road Ahead. *Health Affairs*, August 11, 2022. Available at: https://www.healthaffairs.org/content/forefront/unified-financing-health-care-california-road-ahead
[3] Healthy California for All Commission, *supra* note 1.
[4] *Ibid*.
[5] Bill Text: California Senate Bill 770 passed October 7, 2023. Available at: https://legiscan.com/CA/text/SB770/id/2789647
[6] The Commonwealth Fund. International Health Care System Profiles: Canada. June 5, 2020. Available at: https://www.commonwealthfund.org/international-health-policy-center/countries/canada
[7] *Ibid*.
[8] Carroll A. Blog: Rethinking Health Care from a Global Perspective: Looking Abroad. The Commonwealth Fund. May 2, 2024. Available at: https://www.commonwealthfund.org/blog/2024/rethinking-health-care-global-perspective-looking-abroad
[9] The Commonwealth Fund. International Health Care System Profiles: Brazil. June 5, 2020. Available at: https://www.commonwealthfund.org/international-health-policy-center/countries/brazil
[10] Coi Giovanna. Why Britain's doctors are striking and stressed—by the numbers. *Politico*. January 4, 2024. Available online at: https://www.politico.eu/article/uk-nhs-england-doctors-are-striking-and-stressed-by-the-numbers/.
[11] The Commonwealth Fund. International Health Care System Profiles: England. June 5, 2020. Available at: https://www.commonwealthfund.org/international-health-policy-center/countries/england
[12] The Commonwealth Fund. International Health Care System Profiles: Germany. June 5, 2020. Available at: https://www.commonwealthfund.org/international-health-policy-center/countries/germany
[13] The Commonwealth Fund. International Health Care System Profiles: Netherlands. June 5, 2020. Available at: https://www.commonwealthfund.org/international-health-policy-center/countries/netherlands
[14] Carroll A. Blog: Rethinking Health Care from a Global Perspective: American Complexity. The Commonwealth Fund. May 16, 2024. Available at: https://www.commonwealthfund.org/blog/2024/rethinking-health-care-global-perspective-american-complexity
[15] Healthy California for All Commission, *supra* note 1.
[16] *Ibid*.
[17] Blumberg L and Holahan J. The Pros and Cons of Single-Payer Health Plans. Urban Institute. March 2019. Available at: https://www.urban.org/sites/default/files/publication/99918/pros_and_cons_of_a_single-payer_plan.pdf
[18] Healthy California for All Commission, *supra* note 1.
[19] Bill Text: California Senate Bill 770 passed October 7, 2023. Available at: https://legiscan.com/CA/text/SB770/id/2789647
[20] Blumberg *supra* note 15.
[21] Centers for Medicare & Medicaid Services Webpage: Total Cost of Care and Hospital Global Budgets. Available at: https://www.cms.gov/priorities/innovation/key-concepts/total-cost-care-and-hospital-global-budgets
[22] Centers for Medicare & Medicaid Services Webpage: States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model. Available at: https://www.cms.gov/priorities/innovation/innovation-models/ahead
[23] *Ibid*.
[24] Centers for Medicare & Medicaid Services Webpage: Maryland Total Cost of Care Model. Available at: https://www.cms.gov/priorities/innovation/innovation-models/md-tccm
[25] Centers for Medicare & Medicaid Services Webpage: Vermont All-Payer ACO Model. Available at: https://www.cms.gov/priorities/innovation/innovation-models/vermont-all-payer-aco-model

[26] Centers for Medicare & Medicaid Services Webpage: Pennsylvania Rural Health Model. Available at: https://www.cms.gov/priorities/innovation/innovation-models/pa-rural-health-model
[27] The Commonwealth Fund. Hospital Global Budgeting: Lessons from Maryland and Selected Nations. June 12, 2024. Available at: https://www.commonwealthfund.org/publications/fund-reports/2024/jun/hospital-global-budgeting-lessons-maryland-selected-nations
[28] Mathematica. Evaluation of the Maryland Total Cost of Care Model: Progress Report. April 2024. Available at: https://www.cms.gov/priorities/innovation/data-and-reports/2024/md-tcoc-1st-progress-rpt
[29] Centers for Medicare & Medicaid Services. Synthesis of Evaluation Results across 21 Medicare Models, 2012-2020. Available at: https://www.cms.gov/priorities/innovation/data-and-reports/2022/wp-eval-synthesis-21models.
[30] KFF. Key Facts about the Uninsured Population. December 18, 2023. Available at: https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 3-I-24

Subject:	Time-Limited Patient Care (Resolution 705-A-24)
Presented by:	Stephen Epstein, MD, MPP, Chair
Referred to:	Reference Committee J

At the June 2024 Annual Meeting, the House of Delegates adopted Resolution 705 (Policy D-450.951), which asks our AMA to "study the impacts of time-limited physician visits on patient care quality, patient satisfaction, and physician satisfaction." Testimony at the 2024 Annual Meeting regarding the resolution was supportive, highlighting a need to study this issue beyond primary care. The Council wishes to note that the core of physician time pressures is not an issue of coding, but rather one of arbitrary time-limits enacted as a result of insurer, administrative, and/or hospital system policies. Therefore, the following report will not focus on coding, but rather on the root causes and possible solutions for this issue. Additionally, this report covers the history of time-limited care and the impact of time limits on patients and physicians, highlights American Medical Association (AMA) advocacy efforts and essential policy, and presents new policy recommendations.

BACKGROUND

While time-limited physician visits are not a national standard or requirement, it is not an uncommon experience for many physicians and patients. The time limits placed on visits, typically 15-20 minutes, have largely been implemented as a result of the need to foster profitability within payment models, especially in large health care systems. When surveyed, only 14 percent of physicians indicated that they felt the time allotted for patient visits was adequate to provide patient care at the desired quality level.[1] For new patient visits, health systems allowed physicians an average of 35 minutes, yet physicians reported needing nearly 46 minutes. Similarly for established patients, physicians indicated that they were allotted an average of 20 minutes but needed close to 24 minutes to satisfactorily meet the patient's needs.[2] Physicians who work in managed care and/or health maintenance organization settings tend to experience these time pressures at an elevated level compared to physicians practicing in other settings. However, pressure to maintain time-limited visits is pervasive throughout the health care system.[2]

Time pressures are thought to be a reflection of the health care system as a whole working to treat acute conditions rather than working preventively, and research has demonstrated that it may be impacting health care disparities. Specifically, patients who are insured through private payers tend to be allotted more time for visits than beneficiaries of public insurance or the uninsured.[3] It has also been shown that Non-Hispanic Black patients had, on average, shorter visits than Non-Hispanic White patients when under the care of the same physician.[3] Additionally, patients dealing with mental health diagnoses, those with disabilities or chronic conditions, and those with limited English proficiency often need more time with their physician(s).[2,3,4] Patients who have more

complex care needs and/or are at higher risk to experience adverse social determinants of health (SDOH) need more time with physicians, and this research demonstrates that they may actually be getting less.[2,3,4]

PHYSICIAN SATISFACTION

Time-limited visits have increased likely as a result of the pressure from payers, hospital systems, and practice administrators to provide short visits, in order to maximize revenue.[2,6] Physicians who report more time pressures, or the inability to complete necessary work in the allotted time, also report decreases in their overall job satisfaction.[1,9] Additionally, strict time pressures on patient visits have been linked to increases in physician stress, burnout, job dissatisfaction, and intent to leave practice.[1,5,9] Interestingly, when physicians consciously choose to ignore the time pressures, associated job satisfaction increases, despite the potential consequences from employers or management.[9] When supported by management or systems to take the necessary time with patients, physicians report better overall personal outcomes, tend to rate their workplace more positively, and are less likely to indicate they are considering leaving practice.[1,5]

With the increase in managed care arrangements, physician pressure to limit visit length seems to be intensifying.[2,3] On average, physicians report being able to spend about 18-20 minutes per visit but are strongly encouraged by administrators to limit visit time to as short as 10 minutes. These pressures have been shown to be more intense for female physicians as opposed to their male counterparts.[5,6] Importantly, this pressure can also stem from low payment rates from insurers and force many physicians to maintain short visit lengths in order to ensure adequate payment.[3,4] Research justifies physician concerns that imposing time limits has negative impacts on patient care and workforce sustainability.

This issue is particularly well studied among primary care physicians (PCPs), as they often face extreme time pressures to maintain the financial viability of a practice or health system. Estimates indicate that PCPs would need to practice for 26.7 hours per day to meet the needs of an average patient panel and maintain financial viability.[7] While much of the research in this area is focused on primary care, there is some research that reveals that physicians across specialties are being pressured by insurers and/or administrators to limit visit length. For example, physicians in the specialties of cardiology, oncology, and urology reported spending as little as nine minutes with patients. Averages from this study indicate that the majority of subspecialists do not spend more than 24 minutes with patients, echoing the trend seen in primary care.[7,8]

PATIENT SATISFACTION & QUALITY OF CARE

Both patients and physicians are in agreement that inappropriately short visits are not just frustrating but can negatively impact patient care and the patient-physician relationship.[1,2,9] When patients feel they have their physician's attention for an adequate amount of time to address concerns, they are more likely to report satisfaction with the specific visit, as well as the physician, practice, or system.[4] This is particularly important as patient satisfaction has been linked to increases in patient willingness to attend appointments and comply with medical advice.[4] In order for physicians to be able to provide effective care, it is essential that patients are comfortable not only attending visits but following advice from their physician.

For patients without complex care needs and/or who are not impacted by SDOH, shorter visits may be appropriate, without any negative impact on quality of care or patient outcomes.[6] However, other research has shown poorer outcomes for all patients when visit time is restricted.[1,10] For example, among patients with chronic noncancer pain (CNCP), time pressures are linked to less

effective pain management, a particular problem as patients with CNCP may be prescribed opioids in lieu of taking the time to explore other pain management options.[11] Similarly, research demonstrates that shorter visits may be linked to less appropriate antibiotic prescribing practices. Due to the time limits, physicians are unable to fully discuss treatment options with patients and may be forced to rely on the "quick fix" of prescribing antibiotics.[3] As previously mentioned, increased time pressures tend to be linked to poorer quality care. This is particularly important as a lack of comprehensive preventive care may lead to higher levels of avoidable downstream health care utilization that burdens an already overwhelmed system.[6]

MANAGEMENT STRATEGIES & OPPORTUNITIES

While the issue of time pressures and its solutions are wrought with complexity, there are some strategies that physicians may utilize to help physicians cope with this stressor. Importantly, none of these strategies are able to fix the core issue of time pressures but may assist physicians in operating in their current systems or employment settings. One of these opportunities is to utilize established management principles and strategies. Research suggests that, among others, strategies like, prioritization, limiting interruptions, and the delegation of responsibilities can assist physicians and yield higher satisfaction and lower stress.[12] Additionally, physician education around cognitive-based principles like cognitive load theory and time-management inventory allowed for physicians to implement changes in their time-management and utilize time more effectively.[13] Finally, established time-management principles, like the Lean Principles,[14] can be helpful for physicians to utilize to manage time pressures. In conjunction with or addition to time-management strategies, physicians may be able to utilize tools which could include virtual scribes, medical or ambient speech recognition, and/or artificial intelligence-based assistants.[15]

In addition to tools and strategies previously mentioned, physicians may be able to utilize collaborative strategies to manage time-pressures. First, physicians could utilize population health management (PHM), a strategy that focuses on improving population health, improving patient experience, and reducing costs. PHM relies on a collaboration between physicians, or other health care providers, social services, and public health departments.[16] Research has begun to show that the utilization of PHM may not only improve patient satisfaction, but also patient outcomes and physician satisfaction.[17,18] Some research has even suggested that PHM may work to reduce health disparities.[19] A second collaboratively-based opportunity that could be utilized by physicians to manage time pressures is medical-legal partnerships (MLPs). In these partnerships, physicians, or other health care providers, work in collaboration with legal professionals to address the legal and social needs that are harming their patient's health.[19] These partnerships can be especially helpful in dealing with time-pressures as physicians caring for patients facing SDOH often report needing more time to address the litany of complex issues their patient is facing.[6] Research has demonstrated that physicians engaged in MLPs not only have partners to rely on in addressing their patient's needs, but also report higher job satisfaction. Additionally, patients treated by physicians in MLPs have shown more positive health outcomes.[20] Not only could MLPs assist in physician time-management through delegation and collaborative teamwork, but they have also been shown to improve outcomes for both patients and physicians.[20] While none of these opportunities are a guaranteed fix, nor do they address the root cause of time pressures, physicians may wish to utilize them in order to operate within the current health care system.

AMA POLICY & ADVOCACY

AMA policy supports physician autonomy, including determination of visit length. Policy H-285.969 outlines AMA efforts to ensure that physicians are able to maintain autonomy in care arrangements or settings. Policy H-70.976 monitors attempts by the third-party payers to institute

time limits on visits and discourages payers from adopting time limit policies. In addition to the policy outlining support for physician autonomy, AMA policy also highlights the importance of ensuring that physicians have the opportunity to be involved with governance structures. Specifically, Policy D-225.977 details support ensuring that employed physicians not only have autonomy, but that opportunities for them to be involved in leadership, self-governance, and partnerships are promoted.

AMA policy also advocates for reducing physician burnout and increasing physician satisfaction. Policy D-310.968 addresses the institutional causes of physician demoralization and burnout, such as the burden of documentation requirements, inefficient workflows, and regulatory oversight. Policy H-405.948 outlines the variety of factors that cause many physicians and medical students to experience burnout. Policy H-405.972 supports an accreditation program for hospitals and systems that facilitate physician well-being. Policy H-405.957 supports the implementation of programs that are aimed to identify and manage stress and burnout in physicians and medical students.

The *AMA Joy in Medicine Health System Recognition Program* utilizes tools to enable health care systems to evaluate themselves in six competency areas toward reducing physician burnout and increasing physician well-being: (1) assessment of burnout and well-being, (2) commitment to improving workforce well-being, (3) efficiency of practice environment, (4) teamwork, (5) supportive leadership, and (6) a supportive environment. Additionally, the AMA *Physician Well-Being Program* aims to raise awareness and advance change to reduce physician burnout and increase physician well-being by better understanding system-level factors associated with physician burnout and its consequences. Similar to the *Joy in Medicine Program*, it offers organizations a tool to assess the supportiveness of their environment as well as resources for improving or maintaining these efforts. Finally, the *AMA Steps Forward* program provides physicians with educational resources and solutions to address a number of topics, including burnout. These resources include playbooks, podcasts, webinars, toolkits, and real-world examples.

DISCUSSION

While a small body of research indicates that for some low-risk patients, time-limited visits may not negatively impact patient care, the majority of available research demonstrates that time-limited visits can be linked to a decrease in quality of care. Therefore, the Council recommends the adoption of new policy to support efforts to ensure that physicians are able to determine the length of patient care visits without undue influence from outside entities like payers, administrators, and health systems. Not only is it important that physicians have autonomy in the length of visits, but it is also important that those caring for patients with more complex issues or dealing with SDOH are able to incorporate these complexities into visit length. Therefore, the Council recommends the adoption of new AMA policy that supports efforts to ensure that patient complexities and SDOHs are factored into the calculations of the appropriate visit length.

In addition to the new policy, it is recommended that Policy H-70.976 be reaffirmed, as it monitors and seeks to prevent attempts by third party payers to institute time limits on visits and stresses the importance of ensuring that physicians maintain their autonomy as it pertains to determining the length of visits. Finally, in order for physicians to be able to have the autonomy and voice in visit length desired, it is essential that they are involved in the governance and leadership of their employers. Therefore, the Council recommends reaffirmation of Policy D-225.977, which supports employed physician autonomy in clinical decision-making and self-governance.

It is clear that physicians who are practicing in settings with more intense time pressures are more likely to experience burnout, dissatisfaction, and stress, along with burgeoning desire to leave

practice. While it is important to ensure that physicians are able to practice in a setting that is conducive to their staying in practice, it is particularly important in the face of a physician shortage. Therefore, the Council recommends reaffirmation of Policy H-405.957, which supports the implementation of programs that are aimed to identify and manage stress and burnout in physicians and medical students.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted, and the remainder of the report be filed:

1. That our American Medical Association (AMA) support efforts to ensure that physicians are able to exercise autonomy in the length of patient care visits free from undue influence from outside entities such as, but not limited to, payers, administrators, and health care systems. (New HOD Policy)

2. That our AMA support efforts to incorporate patient complexities and social determinants of health in calculating appropriate amounts of expected patient care time. (New HOD Policy)

3. That our AMA reaffirm Policy H-70.976 which monitors and seeks to prevent attempts by third-party payers to institute policies that impose time and diagnosis limits. (Reaffirm HOD Policy)

4. That our AMA reaffirm Policy D-225.977 that details support for employed physician involvement in self-governance and leadership. (Reaffirm HOD Policy)

5. That our AMA reaffirm Policy H-405.957 that describes AMA efforts to study, promote, and educate on physician well-being and to prevent physician burnout. (Reaffirm HOD Policy)

6. Rescind Policy D-450.951, as having been completed with this report. (Rescind HOD Policy)

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

REFERENCES

[1] 2016 Survey of America's Physicians: Practice Patterns and Perspectives. 2016. The Physician's Foundation. https://physiciansfoundation.org/wp-content/uploads/2017/12/Biennial_Physician_Survey_2016.pdf
[2] Geraghty E M, et al., 2007. Primary Care Visit Length, Quality, and Satisfaction for Standardized Patients with Depression. J Gen Intern Med 22(12):1641-7. https://doi.org/10.1007/s11606-007-0371-5
[3] Nephrash H T, et al., 2023. Association of Primary Care Visit Length with Potentially Inappropriate Prescribing. JAMA Health Forum 4(3). https://doi.org/10.1001/jamahealthforum.2023.0052
[4] Ulrich M R. 2022. Why Money is Well Spent on Time. AMA J Ethics 24(12). https://doi.org/10.1001/amajethics.2022.1155
[5] Prasad K P, et al., 2019. Time Pressure During Primary Care Office Visits: A Prospective Evaluation of Data from the Healthy Work Place Study. J Gen Intern Med 35(2):465-72. https://doi.org/10.1007/s11606-019-05343-6
[6] Swanson K M, Matulis J C, & McCoy R G. 2022. Association Between Primary Care Appointment Lengths and Subsequent Ambulatory Reassessment, Emergency Department Care, and Hospitalization: A Cohort Study. BMC Primary Care 23(29). https://doi.org/10.1186/s12875-022-01644-8
[7] Porter J, et al., 2022. Revisiting the Time Needed to Provide Adult Primary Care. J Gen Intern Med 38(1):147-55. https://doi.org/10.1007/s11606-022-07707-x
[8] Physician Compensation Report 2017. 2017. Medscape. https://www.medscape.com/slideshow/compensation-2017-overview-6008547
[9] Rabin R C. 2014. 15-Minute Doctor Visits Take a Toll on Patient-Physician Relationships. PBS News. https://www.pbs.org/newshour/health/need-15-minutes-doctors-time
[10] Linzer M, et al. 2015. The End of the 15-20 Minute Primary Care Visit. J Gen Intern Med, 30(11):1584-6. https://doi.org/10.1007/s11606-015-3341-3
[11] Satterwhite S, et al., 2019. Sources and Impact of Time Pressure on Opioid Management in the Safety-Net. J Am Board Fam Med 32:375-82. https://doi.org/10.3122/jabfm.2019.180306
[12] Brunicardi FC, Hobson FL. Time management: a review for physicians. J Natl Med Assoc. 1996;88(9):581-587.
[13] Pitre C, Pettit K, Ladd L, Chisholm C, Welch JL. Physician time management. Med Ed.2018;14:10681. https://doi.org/10.15766/mep_2374-8265.10681
[14] DoD. The Five Principles of Lean. 2017 https://theleanway.net/The-Five-Principles-of-Lean
[15] Technologies for Reducing Documentation Burden. 2024. AAFP. https://www.aafp.org/family-physician/practice-and-career/administrative-simplification/doc-burden/technologies-doc-burden.html
[16] Population Health Management. AMCP. 2019. https://www.amcp.org/concepts-managed-care-pharmacy/population-health-management
[17] Wang J, Leung L, Jackson N, et al. The association between population health management tools and clinician burnout in the United States VA primary care patient-centered medical home. BMC Prim Care. 2024;25(1):164. Published 2024 May 15. doi:10.1186/s12875-024-02410-8
[18] Schmittdiel, J.A., Gopalan, A., Lin, M.W. et al. Population Health Management for Diabetes: Health Care System-Level Approaches for Improving Quality and Addressing Disparities. Curr Diab Rep 17, 31 (2017). https://doi.org/10.1007/s11892-017-0858-3
[19] AMA J Ethics. 2024;26(8):E593-595. https://doi.org/10.1001/amajethics.2024.593
[20] Beeson T, McAllister BA, Regenstein M. Making the Case for Medical-Legal Partnerships: A Review of Evidence. 2013. National Center for Medical-Legal Partnerships, George Washington Health Policy School of Public Health and Health Services. https://www.medical-legalpartnership.org/wp-content/uploads/2014/03/Medical-Legal-Partnership-Literature-Review-February-2013.pdf

Council on Medical Service Report 3-I-24
Time-Limited Patient Care
Policy Appendix

Corporate Investors H-160.891

1. Our American Medical Association (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. (CMS Rep. 11, A-19; Appended: CMS Rep. 2, I-22; Reaffirmed: BOT Rep. 14, A-23)

Limitation of Use of Time Component of Current Procedural Terminology (CPT-4) Coding H-70.976

Our AMA (1) adopts as policy that the time element in the new Evaluation and Management codes in the CPT-4 manual may be used to assist physicians and their staffs in determining appropriate levels of coding;

(2) opposes the use of the time elements to (a) judge how many of any given type of visit may be performed in any one hour; and (b) deny or downgrade services submitted based on a cumulative time;
(3) adopts as policy that there shall be no list of diagnoses used by third party payers to compare against the Evaluation and Management codes in such a fashion as to deny, downgrade, or in any other way seek to limit the submission of any CPT-4 code visit;
(4) will monitor attempts by the third party payers to institute such time limits and diagnosis limits; and
(5) will work with third party payers to prevent them from attempting to adopt and institute policies that would impose such time and diagnosis criteria. (Res. 823, A-92; Reaffirmation I-00; Reaffirmed: CMS Rep. 6, A-1; 0Reaffirmed: CMS Rep. 01, A-20)

Physician Burnout D-405.972

Our AMA will work with: (1) Centers for Medicare and Medicaid Services (CMS), The Joint Commission, and other accrediting bodies and interested stakeholders to add an institutional focus on physician wellbeing as an accreditation standard for hospitals, focusing on system-wide interventions that do not add additional burden to physicians; and (2) hospitals and other stakeholders to determine areas of focus on physician wellbeing, to include the removal of intrusive questions regarding physician physical or mental health or related treatments on initial or renewal hospital credentialing applications. (Res. 723, A-22; Reaffirmation I-22)

Programs on Managing Physician Stress and Burnout H-405.957

1. Our American Medical Association supports existing programs to assist physicians in early identification and management of stress and the programs supported by the AMA to assist physicians in early identification and management of stress will concentrate on the physical, emotional and psychological aspects of responding to and handling stress in physicians' professional and personal lives, and when to seek professional assistance for stress-related difficulties.
2. Our AMA will review relevant modules of the STEPs Forward Program and also identify validated student-focused, high quality resources for professional well-being, and will encourage the Medical Student Section and Academic Physicians Section to promote these resources to medical students. (Res. 15, A-15; Appended: Res. 608, A-16; Reaffirmed: BOT Rep. 15, A-19)

Physician and Medical Student Burnout D-310.968

1. Our AMA recognizes that burnout, defined as emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness, is a problem among residents, fellows, and medical students.
2. Our AMA will work with other interested groups to regularly inform the appropriate designated institutional officials, program directors, resident physicians, and attending faculty about resident, fellow, and medical student burnout (including recognition, treatment, and prevention of burnout) through appropriate media outlets.
3. Our AMA will encourage partnerships and collaborations with accrediting bodies (e.g., the Accreditation Council for Graduate Medical Education and the Liaison Committee on Medical Education) and other major medical organizations to address the recognition, treatment, and prevention of burnout among residents, fellows, and medical students and faculty.
4. Our AMA will encourage further studies and disseminate the results of studies on physician and medical student burnout to the medical education and physician community.
5. Our AMA will continue to monitor this issue and track its progress, including publication of peer-reviewed research and changes in accreditation requirements.

6. Our AMA encourages the utilization of mindfulness education as an effective intervention to address the problem of medical student and physician burnout.
7. Our AMA will encourage medical staffs and/or organizational leadership to anonymously survey physicians to identify local factors that may lead to physician demoralization.
8. Our AMA will continue to offer burnout assessment resources and develop guidance to help organizations and medical staffs implement organizational strategies that will help reduce the sources of physician demoralization and promote overall medical staff well-being.
9. Our AMA will continue to: (a) address the institutional causes of physician demoralization and burnout, such as the burden of documentation requirements, inefficient work flows and regulatory oversight; and (b) develop and promote mechanisms by which physicians in all practices settings can reduce the risk and effects of demoralization and burnout, including implementing targeted practice transformation interventions, validated assessment tools and promoting a culture of well-being. (CME Rep. 8, A-07; Modified: Res. 919, I-11; Modified: BOT Rep. 15, A-19; Reaffirmation: A-22)

Factors Causing Burnout H-405.948
Our American Medical Association recognizes that medical students, resident physicians, and fellows face unique challenges that contribute to burnout during medical school and residency training, such as debt burden, inequitable compensation, discrimination, limited organizational or institutional support, stress, depression, suicide, childcare needs, mistreatment, long work and study hours, among others, and that such factors be included as metrics when measuring physician well-being, particularly for this population of physicians. (Res. 208, I-22)

Physician Independence and Self-Governance D-225.977
Our American Medical Association will continue to assess the needs of employed physicians, ensuring autonomy in clinical decision-making and self-governance.
Our AMA will promote physician collaboration, teamwork, partnership, and leadership in emerging health care organizational structures, including but not limited to hospitals, health care systems, medical groups, insurance company networks and accountable care organizations, in order to assure and be accountable for the delivery of quality health care. (Res. 801, I-11; Modified: BOT Rep. 6, I-12; Reaffirmed: CCB/CLRPD Rep. 1, A-22)

Managed Care Education H-285.969
The AMA will continue to emphasize professionalism, patient and physician autonomy, patient and physician rights, and practical assistance to physicians as key principles to guide AMA advocacy efforts related to managed care. (Sub. Res. 707, A-95; Reaffirmed: CMS Rep. 7, A-05; Reaffirmed: CMS Rep. 1, A-15)

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 4-I-24

Subject: Biosimilar Coverage Structures
(Resolution 207-A-24, Referred Resolve)

Presented by: Stephen Epstein, MD, MPP, Chair

Referred to: Reference Committee J

At the June 2024 Annual Meeting, the House of Delegates (HOD) adopted amended Resolution 207-A-24 which encourages the Federal Trade Commission (FTC) and Department of Justice (DOJ) Antitrust Division to closely scrutinize long-term exclusive contracts signed between biologics originators and pharmacy benefit manages (PBMs) to ensure they do not impede biosimilar development and uptake (Policy H-125.973). The HOD also referred a proposed new resolved clause to Resolution 207-A-24, which was introduced by the Medical Student Section and asked the American Medical Association (AMA) to "support coverage structures that increase use of lower cost biosimilars when clinically appropriate, share savings between patients and payers, and reduce patient costs."

This report provides an overview of biosimilars, the current state of coverage, and related incentives to increase their use. Additionally, this report presents policy recommendations consistent with intent of the referred new resolved clause to Resolution 207-A-24.

BACKGROUND

A biosimilar drug is a type of biologic, or drug that is produced by living organisms, which is very similar in both structure and function to a Food and Drug Administration (FDA) approved branded biologic, or reference medication. Biosimilars may not have the same chemical compound as the reference medication but must have the same efficacy and chemical structure to act on the body (detailed definitions can be found in Appendix A).[1] They are often compared to generic medications; however, they are slightly different. While generic medications are identical to the name brand medication, biosimilars have the same performance as the reference biologic, but there are slight chemical differences in the makeup of the medications.[1] For a more in-depth discussion as to the chemical and molecular makeup of biologic medications, how they differ from the reference medication, and interchangeability please see Council on Science & Public Health Report 5-A-24, *Biosimilar/Interchangeable Terminology*.

While biosimilars have been on the European market since 2006, the first biosimilar was approved by the FDA for use in the United States (U.S.) in 2015.[2] Since then, the U.S. market has seen steady, if rather slow, growth of biosimilars.[3,4,5] Between 2015 and 2020, only nine biosimilar medications entered the U.S. market. However, in recent years there has been significant growth in this market; as of August 2024, there are 59 FDA approved biosimilars in the U.S. market.[6] In 2010, via a portion of the Affordable Care Act (ACA), the Biologics Price Competition and Innovation Act, Congress passed an abbreviated pathway to licensure in order to encourage

increases in biosimilar approval in the U.S..[4,5,7] This abbreviated pathway from the ACA made it possible for biosimilars to be approved in a more efficient manner. Congressional support for biosimilars was primarily based on the potential for financial savings that these medications have for both payers and patients.[3,4,8]

Biosimilars are often thought of as preferable to their equivalent reference medication due to the fact that they are typically less expensive. Cost savings have been seen in both the European Union and the United Kingdom National Health System, which have each saved millions annually by switching to biosimilar medications.[5] Estimates indicate that the use of biosimilar medications could result in a 15-35 percent overall savings in the U.S. market.[5,7,8,9] This is especially important as biologic medications account for just over 40 percent, or about $211 billion, of all annual drug spending in the U.S..[9,10] Some research has indicated that an increase in the use of biosimilars could save the U.S. health care system nearly $54 billion over 10 years.[4,5] While there have been actual savings in the U.S. due to the use of biosimilars, they have only amounted to $12.6 billion, or five percent of a projected $54 billion savings. Additionally, research indicates that savings to patient out-of-pocket cost is, if present at all, only marginal and very dependent on medication type.[7,8]

While it is possible that savings have not been realized due to slow introduction of biosimilars to the U.S. market, it is also possible that payment structures often do not incentivize the switch to biosimilar medications.[7] Recent research finds that there may be several factors affecting the likelihood of biosimilar initiation, including type of insurance coverage and patient age.[11] Medicare Advantage beneficiaries were the most likely to initiate, accounting for 74 percent of all biosimilar initiation. Pediatric patients were the least likely to initiate, likely due to complications of approvals for use in children. Overall, the study found that biosimilar initiation is growing, with 27 percent of patients initiating biosimilars in 2022, up from one percent in 2013.[11]

Despite the initial Congressional support and potential for cost savings, biosimilar use has been limited in the U.S. since their initial approval. A leading factor in the slow uptake of biosimilars is centered around patents. Specifically, manufacturers of the reference medication are able to use strategies, like a minor formula or name change, to ensure that patents last longer in order to delay the entry of biosimilars to the market.[7,8] Additionally, payment structures have historically not incentivized the use of biosimilars over reference medications. A full discussion of the impact of coverage structures can be found in a later section of this report. Furthermore, there has been a significant learning curve for patients and physicians as to the potential advantages of choosing a biosimilar medication over a reference medication.

While federal legislation related to biosimilars has been sluggish,[4] the vast majority of states have laws allowing, or in some cases requiring, the substitution of biosimilars.[12] All but four states, Alabama, Indiana, South Carolina, and Washington, have laws that allow for the automatic substitution of biosimilars for a prescribed reference medication by a pharmacist. In nine states, substitution is only permitted if the cost of the biosimilar is lower than the reference medication. Additionally, nearly all states with these laws require that both the patient and physician be notified regarding this change. Importantly, in every state, physicians and other prescribers are able to prevent automatic substitution by indicating that the prescription be “dispensed as written.”[12] Regardless of law, it is important to note that physicians are generally wary of pharmacist-led drug substitutions, and the AMA has advocated widely on this issue and a discussion of efforts can be found in the policy and advocacy section of this report.

BIOSIMILAR COVERAGE

Historically, public and private payers in the U.S. have not incentivized the use of biosimilar medications and, in some cases, actually incentivized the use of reference biologic medications.[4,7,8,9,13] While rebate information is not publicly disclosed, experts hypothesize that due to the higher list price of biologic reference medications, payers are able to negotiate greater rebates, making the reference medication more financially lucrative for the payer. As a result, payers may not include biosimilar medications on preferred formulary tiers or may deny coverage altogether.[12] Research has indicated that among 17 major private insurance plans, less than half had at least one biosimilar placed on a "preferred" formulary tier and only two plans placed at least half of biosimilar medications on the "preferred" tier.[7] Additionally, research indicates that private payers are either excluding or imposing serious restrictions on biosimilar medication coverage nearly 20 percent of the time. Coverage is most likely to be given in cases of cancer treatment and least likely in pediatric patients.[10] Recently, a few major plans have started to shift to cover biosimilars instead of the reference biologic. Interestingly, plans managed by the three largest PBMs were less likely to impose coverage restrictions on biosimilar medications. It is thought that this is a result of these PBMs leveraging their significant market power to negotiate for more advantageous rebates on biosimilars.[10,14]

In addition to the recent shift towards private payers covering biosimilars, federal legislation has encouraged the usage of biosimilars. The Bipartisan Budget Act of 2018 implemented Medicare formulary changes that provided discounts for biosimilars and led to 23 percent higher coverage of these medications.[5,9] The Inflation Reduction Act of 2022 (IRA) is likely to begin incentivizing biosimilar use in the Medicare program starting in 2025. The IRA has, among other things, a focus on lowering the cost of prescription medication for Medicare beneficiaries and to reduce the federal government's drug spending.[15,16] Historically, Medicare Part D, the portion of Medicare that covers prescription medications, has favored reference biologics over biosimilars. Biosimilars are covered at 80 percent, but only when the patient reaches the "catastrophic coverage" phase, meaning that the patient's out-pf-pocket spending has exceeded $8,000. Prior to patients reaching this phase, plans are formulated in a manner where the reference medication is covered more advantageously.[15]

The IRA has two portions that are expected to significantly alter this and lead to greater coverage of biosimilars before patients reach the "catastrophic coverage" phase. First, the IRA implements federally-mandated discounts for certain branded drugs. This is likely to lessen the power of high list prices yielding more lucrative rebates for payers, thereby removing a major incentive to choose reference biologics over biosimilars. Second, the IRA altered Medicare's catastrophic coverage by eliminating the beneficiary coinsurance requirement. Specifically, the IRA capped out-of-pocket costs at $3,250 and added a hard cap on out-of-pocket spending of $2,000. This is indexed in future years to the rate of increase in per capita Part D costs. It is anticipated that this removal of the catastrophic coverage gap will motivate coverage decisions to favor biosimilars over the reference biologic.[15,16] Additionally, the IRA implemented guidelines to ensure that physicians are not incentivized to prescribe higher cost medications due to greater reimbursement based on the higher sticker price. Specifically, starting in October 2022 the IRA implemented an add-on payment rate for biosimilars if the average sale price of that medication is lower than the reference biologic. This is intended to not only incentivize the use of lower-cost biosimilars but also mitigate issues around physician incentivization based in greater reimbursement for higher-cost biologics.[15]

BIOSIMILAR INCENTIVES

Trends in both public and private payers indicate that biosimilars will not only be covered at a greater rate, but plans may actually be transitioning to incentivizing their use.[14,17] Additionally, across all payer types, biosimilar medications are moving towards self-administration, eliminating the need for a medical professional to administer the medication. This is significant as the administration change may lead to more biologic, both reference and biosimilar, medications to be covered under plans' pharmacy benefits. Coverage under the pharmacy benefit could in turn allow for more efficient switches to biosimilar medications.[14]

In addition to medication administration changes, other incentives are being implemented to ensure greater use of biosimilar medications when clinically appropriate, such as the movement of financial incentives to biosimilars in lieu of reference biologics. Historically, the rebates tied to reference biologics have made them the more financially lucrative choice for payers. However, due in part to a 2022 Executive Order from the Biden Administration to the FDA, the FTC, and the Centers for Medicare & Medicaid Services, financial incentives for payers have started to shift towards biosimilar medications.[10] In turn, some plans are utilizing financial incentives for patients to encourage switching to biosimilars. Plans have provided patients with a monetary reward for switching from a reference biologic to a biosimilar.[14] Additionally, initial research indicates that payers are placing biosimilars on formularies or on more advantageous formulary tiers at a greater rate in recent years.[14]

It remains to be seen if payers' biosimilar financial savings will be passed on to patients in the long-term. However, it does seem that the financial incentives are initially leading to greater coverage of biosimilar medications. If the switch to biosimilar medications is to be successful, it is vital that physicians and patients are adequately educated and in control of the switch. With time, physicians have become increasingly well-educated on biosimilars and their potential advantages, allowing some to become more comfortable; however, others continue to express concern.[18,19] It is important to note that there are still significant legitimate concerns from physicians related to switching to biosimilars. For example, studies have found that as many as 65 percent of physicians indicated concerns with switching a patient from a reference biologic to a biosimilar medication. Physicians listed a wide range of reasons for concern related to the safety, efficacy, and immunogenicity of the biosimilar.[14]

It is also important that patients are adequately educated and supported in the use of biosimilars. Research has demonstrated that patients, like physicians, have a diverse set of opinions on the use of biosimilars.[19] While financial incentives or savings can be a powerful tool to increase interest in a biosimilar medication, some patients cite other advantages of a reference biologic, driving resistance to switching to a biosimilar. Specifically, services from reference biologic medication manufacturers like copay support, on-call support/transport services, and educational or administration materials/devices are often powerful in maintaining patient preference for the reference biologic over the biosimilar.[4,14] Additionally, patients often echo physician concerns related to the safety, efficacy, and immunogenicity of biosimilar medications.[18,19] While some of these concerns can be mitigated by physician/patient education as to the benefits of biosimilars, it is important to ensure that any switch to a biosimilar medication is done in agreement from both the physician and patient.

Finally, two strategies seem to be particularly salient to incentivize the use of biosimilars. First, ensuring that patient cost-sharing or out-of-pocket costs are reduced. In many European countries, patient cost-sharing strategies have been utilized to incentivize the use of biosimilars. Specifically, countries have adopted policies that dictate more expensive medications have a higher co-pay and

cheaper medications have a lower co-pay. In some cases, such as in Germany, the lower cost biosimilar has a copay as low as zero dollars, resulting in significant patient incentive to use that medication. Initial implementation of these plans seems to be resulting in higher uptake of the biosimilars with higher patient cost-sharing.[20] Second, allowing for cost-sharing to be shared between the physician and the patient. Shared savings-type programs have been successfully implemented in international settings and, more recently, in the Medicare program.[20,21] In France and Germany, shared savings programs have been implemented with the intent of increasing biosimilar use. These programs are based on agreements between payers and hospitals/physicians regarding the cost savings of specific biosimilars. Initial research has shown that these programs have been successful in increasing the rate of biosimilar uptake in both countries.[19]

AMA POLICY & ADVOCACY

The AMA has a strong body of policy meant to ensure that prescription medications are affordable and that physicians are educated about and able to prescribe biosimilars. Policy H-110.997 supports physician involvement in prescription medication pricing and ensuring that physicians are able to prescribe the medication that is best for the patient. Policy H-110.987 supports advocacy with federal legislators and regulators to reduce anticompetitive behaviors, like patent manipulation, in drug manufacturing and outlines the importance of physician support in lowering pharmaceutical costs. Policy H-110.990 outlines efforts to ensure that cost-sharing and out-of-pocket costs for prescription drugs are fair and patient-friendly.

In addition to policy designed to ensure that prescription drugs are affordable and accessible to patients and that physicians can prescribe what is most clinically appropriate, the AMA has policy supporting the use of biosimilar medications. Policy D-125.989 supports physician autonomy in determining if a biosimilar or biologic product is dispensed to a patient and ensuring that switches from biologics to biosimilars are not done without notification and authorization of the prescribing physician. Policy H-125.972 outlines AMA efforts to support physician education on biosimilars, their FDA approval process, and surveillance requirements. Policy H-125.973 encourages the FTC and DOJ Antitrust Division to closely scrutinize long-term exclusive contracts signed between biologic originators and PBMs to ensure they do not impede biosimilar development and update.

In addition, the AMA has engaged in extensive state level advocacy regarding substitution of interchangeable biosimilar biologic products since 2012. The AMA has worked with dozens of medical societies to support state amendments to pharmacy practice acts to align with new federal definitions. For example, AMA advocated in support of new laws in Indiana, Washington and Mississippi. Based on the concern many physicians express related to pharmacist-led substitution, these laws support the authority of physicians to limit substitution of biologic products. The AMA has rather extensive policy that both works to maintain the proper scope of pharmacist practice and allow physicians to limit or prevent substitution. Specifically, Policies H-125.995 and D-35.987 outline AMA opposition to pharmacist-led substitution without express permission from the physician. Additionally, Policies H-125.991, H-120.918, and D-120.922 all detail efforts to ensure that physicians have the ability to dictate that a prescription should be dispensed as written.

DISCUSSION

Since their approval in the U.S., the initial uptake of biosimilar medications has been slow, but recent years have demonstrated a quicker uptick in their market availability. Public and private payers are continuing to make changes that will likely incentivize and, in turn, increase the prevalence and use of biosimilar medications in the U.S. IRA-derived revisions to the Medicare Part D benefit will be implemented in 2025, and it is likely that these changes will further

encourage the coverage of biosimilars, initially by public payers and, with time, by private payers as well. Additionally, recent changes by large insurers and PBMs have signaled that these players are moving towards not only covering biosimilars at a greater rate but incentivizing their use via financial rewards. In order to ensure that these financial rewards are passed on to patients so that biosimilar medications are affordable and accessible, the Council recommends the reaffirmation of Policies H-110.987 and H-110.997, which both outline advocacy efforts to ensure that prescription medications are affordable and accessible to patients.

If biosimilars are to be successfully incentivized, it is important that it be done holistically and inclusively for all parties involved, and not just centered around financial incentives to payers, and that no physician is forced to prescribe a biosimilar. In some cases, patients and/or physicians may not be comfortable with prescribing a biosimilar over the reference medication. This could be for a number of reasons, including concerns about the safety, efficacy, and/or immunogenicity of the biosimilar. Therefore, the Council recommends the reaffirmation of Policy H-125.989 which ensures that physicians are able to switch patients to biosimilars if they wish, but no substitutions can be made without the notification and approval of the prescribing physician. To ensure that physicians are comfortable and confident in prescribing and discussing biosimilars, the Council recommends the reaffirmation of Policy H-125.972 which outlines support for physician education on the topic of biosimilars.

Finally, in order to further encourage the use of biosimilars, the Council recommends the adoption of two new policies. First, to lower patient out-of-pocket costs, when deemed appropriate by the physician and amenable to the patient, the Council recommends the adoption of new policy to support the development and implementation of incentivization strategies to increase the use of biosimilar medications, when agreed upon by the patient and physician. Second, to ensure that patients are knowledgeable and comfortable with switching from a reference medication to a biosimilar medication, the Council recommends the adoption of new policy to support patient education on the topic of biosimilars by appropriate organizations.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and the remainder of the report be filed:

1. That our American Medical Association (AMA) support the development and implementation of strategies to incentivize the use of lower cost biosimilars when safe, fiscally prudent for the patient, clinically appropriate, and agreed upon as the best course of treatment by the patient and physician. (New HOD Policy)

2. That our AMA support patient education regarding biosimilars and their safety. (New HOD Policy)

3. That our AMA reaffirm Policy H-110.987, which works to ensure that prescription medications are affordable and accessible to patients. (Reaffirm HOD Policy)

4. That our AMA reaffirm Policy H-110.997 which supports the freedom of physicians in prescribing drugs for their patients and encourages physicians to supplement medical judgments with cost considerations in making these choices. (Reaffirm HOD Policy)

5. That our AMA reaffirm Policy D-125.989, which outlines efforts to ensure that physicians are able to transition patient to biosimilar medications with coverage from payers. (Reaffirm HOD Policy)

6. That our AMA reaffirm Policy H-125.972 which details efforts to encourage physician education related biosimilars. (Reaffirm HOD Policy)

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

APPENDIX A
Definitions of key terms

Biologic drug (or large molecule drugs): a classification of drugs which are produced by living organisms (such as human or animal cells, yeast, or bacteria), rather than by chemical synthesis. As such, this class of drug tends to replicate or mimic common biologic entities. For example, antibody- or protein-based drugs are common examples of biologic drugs.

Small molecule drug: A classification of drugs based on the number of atoms (typically <100) in their structure. Small molecule drugs are generally prepared using chemical synthesis techniques. Small molecule drugs are estimated to represent over 90 percent of all pharmaceuticals used in the clinic today. Typically, small molecule drugs function by binding to a biological entity (protein, receptor, etc.) and altering its function.

Generic drug: A drug produced by a second manufacturer after the patent or other market protections have expired, allowing for manufacturers to be able to produce their own products with the same chemical substance as a branded drug. The term generic drug only applies to small molecule drugs, with few exceptions.

Biosimilar: A biologic drug that has a very similar structure and function to a branded biologic drug after its patent or market protections have expired. Unlike generic drugs, biosimilars are not required to be the same chemical compound, but they are required to have the same chemical structure to act on the body and efficacy.

Interchangeable: An additional designation provided for biosimilar drugs by the FDA. This designation is not required for market approval and indicates that a biosimilar has successfully demonstrated no changes in efficacy or immunogenicity when the biosimilar is substituted for the reference product after a patient has already initiated treatment with the reference product. This designation has implications for reimbursement, and state regulations around pharmacist practice.

Note: these definitions were originally outlined in the Council on Science & Public Health Report 5-A-24, Biosimilar/Interchangeable Terminology. A more in-depth discussion as to the scientific details of these definitions, and biosimilars in general, can be found in the aforementioned CSAPH report.

REFERENCES

[1] U.S. Food and Drug Administration (FDA). Biosimilar and Interchangeable Biologics: More Treatment Choices. 2023. https://www.fda.gov/consumers/consumer-updates/biosimilar-and-interchangeable-biologics-more-treatment-choices

[2] Raedler LA. Zarixo (Pilgrastim-sndz): First Biosimilar Approved in the United States. *Am Health Drug Ben* 2016;9. PMCID: PMC5013845

[3] GaBI. Targets and Incentives to Encourage Use of Biosimilars. *Generics and Biosimilars Initiative.* 2021. https://gabionline.net/reports/Targets-and-incentives-to-encourage-use-of-biosimilars

[4] Holsopple M. Biosimilars: Are they Delivering the Cost Savings Promised? 2024. *Pharmacy Times.* https://www.pharmacytimes.com/view/biosimilars-are-they-delivering-the-cost-savings-promised-

[5] Yang J, et al., Greater Update, an Alternative Reimbursement Methodology Needed to Realize Cost-Saving Potential of Oncology Biosimilars in the United States. *J Manag Care SpecPharm.* 2021;*27*(12): 1642-51. https://doi.org/10.18553/jmcp.2021.21202

[6] U.S. Food and Drug Administration (FDA). Biosimilar Product Information | FDA. 2024. https://www.fda.gov/drugs/biosimilars/biosimilar-product-information

[7] Chambers J D, et al. Coverage for Biosimilars vs Reference Products Among US Commercial Health Plans. *JAMA*. 2020;*323(19):*1972–1973. https://doi.org/doi:10.1001/jama.2020.2229

[8] Feng K, Russo M, Maini L, Kesselheim AS, Rome BN. Patient Out-of-Pocket Costs for Biologic Drugs After Biosimilar Competition. JAMA Health Forum. 2024;5(3):e235429. https://doi.org/doi:10.1001/jamahealthforum.2023.5429

[9] Bertuzzi L & Maini L. Benefit Design and Biosimilar Coverage in Medicare Part D: Evidence and Implications from Recent Reforms. *Health Affairs.* 2024;*43(5):*717-24. https://doi.org/10.1377/hlthaff.2023.01297

[10] USC Schaeffer Center. Biosimilar Drugs Underutilized Due to Commercial Insurance Restrictions. 2023. https://healthpolicy.usc.edu/article/biosimilar-drugs-underutilized-due-to-commercial-insurance-restrictions/

[11] Hong D, Kesselheim AS, Sarpatwari A, Rome BN. Biosimilar Uptake in the US: Patient and Prescriber Factors. *Health Affairs*. 2024; *43(8):*1159-1164. https://doi.org/10.1377/hlthaff.2023.012515

[12] Humphreys S. Understanding Interchangeable Biosimilars at the Federal and State Levels. *Ev-Based Onc.* 2023; 29(7): 545-548. https://doi.org/10.37765/ajmc.2023.89419

[13] Hussaini SMQ, Gupta A, Anderson KE, Ballreich JM, Nicholas LH, Alexander GC. Utilization of Filgrastim and Infliximab Biosimilar Products in Medicare Part D, 2015-2019. JAMA Netw Open. 2022;5(3):e221117. https://doi.org/doi:10.1001/jamanetworkopen.2022.1117

[14] Boutross L, Poblete G, Sangwan S. Pharmacy Benefit is a Whole New Ball game for Biosimilars. ZS Pharmacy and Biotech. 2022. https://www.zs.com/insights/pharmacy-benefit-is-a-whole-new-ball-game-for-biosimilars#:~:text=The%20U.S.%20biosimilar%20landscape%20has,the%20products%20need%20to%20meet.

[15] Baxter A. Biosimilars are Gaining Ground. The IRA Could Push Them Even Further Next Year. *Pharma Voice;*2024. https://www.pharmavoice.com/news/biosimilars-inflation-reduction-act-market-share-payments/715857/

[16] Cubanski J, Neuman T, Freed M. Explaining the Prescription Drug Provisions in the Inflation Reduction Act. *Kaiser Family Foundation;*2023. https://www.kff.org/medicare/issue-brief/explaining-the-prescription-drug-provisions-in-the-inflation-reduction-act/

[17] Murrin S. Medicare Part D and Beneficiaries Could Realize Significant Spendign Reductions with Increased Biosimilar Use. *U.S. Department of Health and Human Services Office of Inspector General;* 2022. https://oig.hhs.gov/reports-and-publications/all-reports-and-publications/medicare-part-d-and-beneficiaries-could-realize-significant-spending-reductions-with-increased-biosimilar-use/

[18] Sarnola K, Merikoski M, Jyrkkä J, et alPhysicians' perceptions of the uptake of biosimilars: a systematic review BMJ Open 2020;10:e034183. https://doi.org/doi:10.1136/bmjopen-2019-034183

[19] Gibofsky A, Evans C. Provider and Patient Knowledge Gaps on Biosimilars: Insights from Surveys. *Am J Manag Care. 2022;28:S227-S233.* https://www.ajmc.com/view/biosimilarssuppl-insightssurveys

[20] Arad N et al. Realizing the Benefits of Biosimilars: What the U.S. Can Learn from Europe. *Duke Margolis Center for Health Policy*. 2021. https://healthpolicy.duke.edu/publications/realizing-benefits-biosimilars-what-us-can-learn-europe

[21] US Department of Health and Human Servies. Medicare Shared Savings Program Saves Medicare More Than $1.8 Billion in 2022 and Continues to Deliver High-Quality Care. 2023. https://www.hhs.gov/about/news/2023/08/24/medicare-shared-savings-program-saves-medicare-more-1-8-billion-2022-continues-deliver-high-quality-care.html

Council on Medical Service Report 4-I-24
Biosimilar Coverage Structures
Policy Appendix

Cost of Prescription Drugs H-110.997
Our American Medical Association (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)

Pharmaceutical Costs H-110.987
1. Our AMA encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives.
2. Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition.
3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry.
4. Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system.

5. Our AMA encourages prescription drugv price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies.
6. Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation.
7. Our AMA supports legislation to shorten the exclusivity period for biologics.
8. Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens.
9. Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients.
10. Our AMA supports:
    a. drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug (generic, brand, or specialty) by 10 percent or more each year or per course of treatment and provide justification for the price increase;
    b. legislation that authorizes the Attorney General and/or the Federal Trade Commission to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients; and
    c. the expedited review of generic drug applications and prioritizing review of such applications when there is a drug shortage, no available comparable generic drug, or a price increase of 10 percent or more each year or per course of treatment.
11. Our AMA advocates for policies that prohibit price gouging on prescription medications when there are no justifiable factors or data to support the price increase.
12. Our AMA will provide assistance upon request to state medical associations in support of state legislative and regulatory efforts addressing drug price and cost transparency.
13. Our AMA supports legislation to shorten the exclusivity period for FDA pharmaceutical products where manufacturers engage in anti-competitive behaviors or unwarranted price escalations.
14. Our AMA supports legislation that limits Medicare annual drug price increases to the rate of inflation. (CMS Rep. 2, I-15; Reaffirmed in lieu of: Res. 817, I-16; Appended: Res. 201, A-17; Reaffirmed in lieu of: Res. 207, A-17; Modified: Speakers Rep. 01, A-17; Appended: Alt. Res. 806, I-17; Reaffirmed: BOT Rep. 14, A-18; Appended: CMS Rep. 07, A-18; Appended: BOT Rep. 14, A-19; Reaffirmed: Res. 105, A-19; Appended: Res. 113, I-21; Reaffirmed in lieu of: Res. 810, I-22; Reaffirmed: Res. 801, I-23; Reaffirmed: Res. 801, I-23)

Cost Sharing Arrangements for Prescription Drugs H-110.990
Our AMA:

1. believes that cost-sharing arrangements for prescription drugs should be designed to encourage the judicious use of health care resources, rather than simply shifting costs to patients;
2. believes that cost-sharing requirements should be based on considerations such as: unit cost of medication; availability of therapeutic alternatives; medical condition being treated; personal income; and other factors known to affect patient compliance and health outcomes;

3. supports the development and use of tools and technology that enable physicians and patients to determine the actual price and patient-specific out-of-pocket costs of individual prescription drugs, taking into account insurance status or payer type, prior to making prescribing decisions, so that physicians and patients can work together to determine the most efficient and effective treatment for the patient's medical condition;
4. supports public and private prescription drug plans in offering patient-friendly tools and technology that allow patients to directly and securely access their individualized prescription benefit and prescription drug cost information; and
5. believes payers should not establish a higher cost-sharing requirement exclusively for prescription drugs approved for coverage under a medical exceptions process. (CMS Rep. 1, I-07; Reaffirmation A-08; Reaffirmed: CMS Rep. 1, I-12; Reaffirmed in lieu of Res. 105, A-13; Reaffirmed in lieu of: Res. 205, A-17; Reaffirmed in lieu of: Res. 207, A-17; Reaffirmed: CMS Rep. 07, A-18; Appended: CMS Rep. 2, I-21; Reaffirmed: Res. 113, A-23Appended: CMS Rep. 01, A-23)

Substitution of Biosimilar Medicines and Related Medical Products D-125.989
Our AMA urges that State Pharmacy Practice Acts and substitution practices for biosimilars in the outpatient arena: (1) preserve physician autonomy to designate which biologic or biosimilar product is dispensed to their patients; (2) allow substitution when physicians expressly authorize substitution of a product; (3) in the absence of express physician authorization to the contrary, allow substitution of the biologic or biosimilar product when (a) the biologic product is highly similar to the reference product, notwithstanding minor differences in clinically inactive components; and (b) there are no data indicating clinically meaningful differences between the biological product and the reference product in terms of the safety, purity, and potency of the product; and (c) the prescribing physician has been adequately notified by the pharmacist. (Res. 918, I-08; Modified: CSAPH Rep. 1, I-11; Modified: CSAPH Rep. 4, A-14; Modified; CSAPH Rep. 5, A-24)

Biosimilar/Interchangeable Terminology H-125.972
1. Our AMA encourages the FDA to continually collect data and critically evaluate biosimilar utilization including the appropriateness of the term "interchangeable" in regulatory activities.
2. Our AMA supports evidence-based physician education on the clinical equivalence of biosimilars, the FDA approval process, and post-market surveillance requirements. (CSAPH Rep. 5, A-24)

Therapeutic and Pharmaceutical Alternatives by Pharmacists H-125.995
The AMA opposes legislative attempts at any level of government that would permit pharmacists, when presented with a prescription for a drug product, to: (1) dispense instead a drug product that is administered by the same route and which contains the same pharmaceutical moiety and strength, but which differs in the salt or dosage form (pharmaceutical alternatives); and (2) dispense a drug product containing a different pharmaceutical moiety but which is of the same therapeutic and/or pharmacological class (therapeutic substitution). Our AMA will work with state medical associations to ensure that state pharmacy laws and medical practice acts are properly enforced so that treating physician's directions cannot be overruled or substituted without prior physician approval. (Res. 89, I-85; Reaffirmed by Sub. Res. 501, A-95; Reaffirmed by CLRPD Rep. 2, I-95; Appended by Res. 501, A-98; Reaffirmed: CSAPH Rep. 2, A-08; Modified: CSAPH Rep. 01, A-18)

Evaluation of the Expanding Scope of Pharmacists' Practice, D-35.987

1. Our AMA will re-evaluate the expanding scope of practice of pharmacists in America and develop additional policy to address the proposed new services provided by pharmacists that may constitute the practice of Medicine.
2. Our AMA will continue to collect and disseminate state specific information in collaboration with state medical societies regarding the current scope of practice for pharmacists in each state; studying if and how each state is addressing these expansions of practice.
3. Our AMA will develop model state legislation to address the expansion of pharmacist scope of practice that is found to be inappropriate or constitutes the practice of medicine, including but not limited to the issue of interpretations or usage of independent practice arrangements without appropriate physician supervision and work with interested states and specialties to advance such legislation.
4. Our AMA opposes federal and state legislation allowing pharmacists to independently prescribe or dispense prescription medication without a valid order by, or under the supervision of, a licensed doctor of medicine, osteopathy, dentistry or podiatry.
5. Our AMA opposes federal and state legislation allowing pharmacists to dispense medication beyond the expiration of the original prescription.
6. Our AMA opposes the inclusion of Doctors of Pharmacy (PharmD) among those health professionals designated as a "Physician" by the Centers for Medicare & Medicaid Services. (Res. 219, A-11; Appended: Res. 218, A-12; Reaffirmed: BOT Rep. 9, A-22)

Drug Formularies and Therapeutic Interchange H-125.991

It is the policy of the AMA:
(1) That the following terms be defined as indicated:
(a) Formulary: a compilation of drugs or drug products in a drug inventory list; open (unrestricted) formularies place no limits on which drugs are included whereas closed (restrictive) formularies allow only certain drugs on the list;
(b) Formulary system: a method whereby the medical staff of an institution, working through the pharmacy and therapeutics committee, evaluates, appraises, and selects from among the numerous available drug entities and drug products those that are considered most useful in patient care;
(c) Pharmacy & Therapeutics (P&T) Committee: an advisory committee of the medical staff that represents the official, organizational line of communication and liaison between the medical staff and the pharmacy department; its recommendations are subject to medical staff approval;
(d) Therapeutic alternates: drug products with different chemical structures but which are of the same pharmacological and/or therapeutic class, and usually can be expected to have similar therapeutic effects and adverse reaction profiles when administered to patients in therapeutically equivalent doses;
(e) Therapeutic interchange: authorized exchange of therapeutic alternates in accordance with previously established and approved written guidelines or protocols within a formulary system; and
(f) Therapeutic substitution: the act of dispensing a therapeutic alternate for the drug product prescribed without prior authorization of the prescriber.
(2) That our AMA reaffirms its opposition to therapeutic substitution (dispensing a therapeutic alternate without prior authorization) in any patient care setting.
(3) That drug formulary systems, including the practice of therapeutic interchange, are acceptable in inpatient hospital and other institutional settings that have an organized medical staff and a functioning Pharmacy and Therapeutics (P&T) Committee, provided they satisfy the following standards:
(a) The formulary system must:

(i) have the concurrence of the organized medical staff;
(ii) openly provide detailed methods and criteria for the selection and objective evaluation of all available pharmaceuticals;
(iii) have policies for the development, maintenance, approval and dissemination of the drug formulary and for continuous and comprehensive review of formulary drugs;
(iv) provide protocols for the procurement, storage, distribution, and safe use of formulary and non-formulary drug products;
(v) provide active surveillance mechanisms to regularly monitor both compliance with these standards and clinical outcomes where substitution has occurred, and to intercede where indicated;
(vi) have enough qualified medical staff, pharmacists, and other professionals to carry out these activities;
(vii)provide a mechanism to inform the prescriber in a timely manner of any substitutions, and that allows the prescriber to override the system when necessary for an individual patient without inappropriate administrative burden;
(viii) provide a mechanism to assure that patients/guardians are informed of any change from an existing outpatient prescription to a formulary substitute while hospitalized, and whether the prior medication or the substitute should be continued upon discharge from the hospital;
(ix) include policies that state that practitioners will not be penalized for prescribing non-formulary drug products that are medically necessary; and
(x) be in compliance with applicable state and federal statutes and/or state medical board requirements.
(b) The P&T Committee must:
(i) objectively evaluate the medical usefulness and cost of all available pharmaceuticals (reliance on practice guidelines developed by physician organizations is encouraged);
(ii) recommend for the formulary those drug products which are the most useful and cost-effective in patient care;
(iii) conduct drug utilization review (DUR) activities;
(iv) provide pharmaceutical information and education to the organization's (e.g., hospital) staff;
(v) analyze adverse results of drug therapy;
(vi) make recommendations to ensure safe drug use and storage; and
(vii) provide protocols for the timely procurement of non-formulary drug products when prescribed by a physician for the individualized care of a specific patient, when that decision is based on sound scientific evidence or expert medical judgment.
(c) The P&T Committee's recommendations must be approved by the medical staff;
(d) Within the drug formulary system, the P & T Committee shall recommend, and the medical staff must approve, all drugs that are subject to therapeutic interchange, as well as all processes or protocols for informing individual prescribing physicians; and
(e) The act of providing a therapeutic alternate that has not been recommended by the P&T Committee and approved by the medical staff is considered unauthorized therapeutic substitution and requires immediate prior consent by the prescriber; i.e., authorization for a new prescription.
(4) That drug formulary systems in any outpatient setting shall operate under a P&T Committee whose recommendations must have the approval of the medical staff or equivalent body, and must meet standards comparable to those listed above. In addition:
(a) That our AMA continues to insist that managed care and other health plans identify participating physicians as their “medical staff” and that they use such staff to oversee and approve plan formularies, as well as to oversee and participate on properly elected P&T Committees that develop and maintain plan formularies;
(b) That our AMA continues to insist that managed care and other health plans have well-defined processes for physicians to prescribe non-formulary drugs when medically indicated, that this

process impose minimal administrative burdens, and that it include access to a formal appeals process for physicians and their patients; and
(c) That our AMA strongly recommends that the switching of therapeutic alternates in patients with chronic diseases who are stabilized on a drug therapy regimen be discouraged.
(5) That our AMA encourages mechanisms, such as incentive-based formularies with tiered co-pays, to allow greater choice and economic responsibility in drug selection, but urges managed care plans and other third party payers to not excessively shift costs to patients so they cannot afford necessary drug therapies. (BOT Rep. 45, I-93; Reaffirmed by Sub. Res. 501, A-95; Appended: BOT Rep. 7, I-99; Modified: Sub. Res. 524 and Reaffirmed: Res. 123, A-00; Reaffirmed: Res. 515, I-00; Reaffirmed: CMS Rep. 8, A-02; Reaffirmed: Res. 533, A-03; Modified: CMS Rep. 6, A-03; Modified: CSA Rep. 2, A-04; Reaffirmation I-04; Reaffirmed in lieu of Res. 535, A-05; Reaffirmed: BOT Action in response to referred for decision Res. 503, A-05; Reaffirmed: CMS Rep. 2, I-05; Reaffirmation A-06; Reaffirmation A-08; Reaffirmed: CMS Rep. 2, A-10; Reaffirmed: CMS Rep. 01, A-20)

Prescription Drug Dispensing Policies H-120.918

1. Our American Medical Association supports the development and implementation of clear guidelines and mechanisms to indicate that the quantity of a prescription should be dispensed only as written using such language as “dispense quantity as written” or “no change in quantity.”
2. Our AMA supports the development, implementation and/or use of electronic or other means of communication to provide cost and coverage information of various prescribing quantities at the point of care allowing physicians to make the best decisions with their patients regarding prescribed medication quantities. (CMS Rep. 05, A-23)

Transparency at the Pharmacy Counter D-120.922

Our American Medical Association advocates for legislation or regulation that mandates that pharmacies, whether physical or mail-order, must inform patients about their prescriptions, to include at a minimum:

1. The dosage and schedule of treatments as written by the prescriber.
2. Any restriction or alteration of the prescriber’s intent due to third party or pharmacy intervention, with the stated justification.
3. Details of other avenues to obtain the original prescription, including out of pocket options, with comparative costs. (Res. 718, A-24)

Biosimilar Use Rates and Prevention of Pharmacy Benefit Manager Abuse, H-125.973

Our American Medical Association will encourage the Federal Trade Commission (FTC) and Department of Justice (DOJ) Antitrust Division to closely scrutinize long-term exclusive contracts signed between biologics originators and PBMs to ensure they do not impede biosimilar development and uptake. (Res. 207, A-24)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 801
(I-24)

Introduced by: Tennessee

Subject: Reimbursement for Managing Portal Messages

Referred to: Reference Committee J

Whereas, CMS has encouraged physicians to be more readily available to their patients through portal access; and

Whereas, answering portal messages can take a significant amount of time for either the physician or the physician's staff; and

Whereas, ever increasing demands on a physician's time are causing significant burnout and moral injury; therefore be it

RESOLVED, that our American Medical Association immediately collaborate with payers to seek adequate reimbursement for professional time spent answering questions on the patient portal not related to a recent visit (Directive to Take Action); and be it further

RESOLVED, that our AMA continue to advocate for physicians to receive adequate compensation or seek relief from overreaching administrative tasks that take physicians' time away from direct patient care during our present climate of ever-increasing unpaid and unfunded mandates on their time. (Directive to Take Action)

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

Received: 9/3/2024

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 802
(I-24)

Introduced by: Texas

Subject: Address Physician Burnout with Inbox Management Resources and Increased Payment

Referred to: Reference Committee J

Whereas, with advances in medicine, the practice of clinical medicine has become more complex, and patients are more engaged in their health care; and

Whereas, this is laudable, yet it fails to consider the extraordinary demands on physician time; and

Whereas, physician payment in the Medicare Physician Fee Schedule is based on relative value units (RVUs) and some institutions apply RVUs in physician performance/productivity determinations, while other create internal metrics for this purpose; and

Whereas, Electronic Health Records (EHRs) have portals giving 24/7 access to patients, while key performance indicator metrics pressure physicians to address them within 24 hours; and

Whereas, physicians do not get credit in institutional metrics or compensation for addressing in-basket messages; and

Whereas, physicians are burning out trying to keep up with this workload; therefore be it

RESOLVED, that our American Medical Association develop additional inbox management resources (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for increasing the relative value unit for inbox management recognizing that it is asynchronous care that provides value and reduces overall health care costs (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for electronic health record tools that calculate physician time spent in the inbox. (Directive to Take Action)

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

Received: 9/11/2024

REFERENCES

1. Texas Medical Association. Electronic Health Records. www.texmed.org/EHR/.
2. Certified Health IT Product List (CHPL). Healthit.gov. 2019. https://chpl.healthit.gov/#/search.
3. Budd J. Burnout related to electronic health record use in primary care. *Journal of Primary Care & Community Health*. 2023 Jan-Dec:14:215013192311669-215013192311669. https://pubmed.ncbi.nlm.nih.gov/37073905/.
4. Sinsky CA, Shanafelt TD, Ripp JA. The electronic health record inbox: recommendations for relief. *Journal of General Internal Medicine*. Aug. 29, 2022 (online). Vol. 37, pp. 4002-4003. https://doi.org/10.1007/s11606-022-07766-0.
5. Centers for Medicare & Medicaid Services. Medicare telemedicine health care provider fact sheet. March 17, 2020. www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet.

6. Diaz N. Hospitals, health systems charging for MyChart in 2023. Becker's Health IT. Sept. 5, 2023. www.beckershospitalreview.com/ehrs/hospitals-health-systems-charging-for-mychart-in-2023.
7. Asmussen D, Gallagher K, Goldsmith A, Lindemann P, Barkley E. Shorter hospital stays associated with patient portal use. Epic Research. https://epicresearch.org/articles/shorter-hospital-stays-associated-with-patient-portal-use.
8. American Medical Association. AMA STEPS Forward Playbook Series. Taming the Electronic Health Record Playbook. www.ama-assn.org/system/files/steps-forward-taming-ehr-playbook.pdf.

RELEVANT AMA POLICY

Physician Burnout D-405.972

1. Our American Medical Association will work with Centers for Medicare and Medicaid Services (CMS), The Joint Commission, and other accrediting bodies and interested stakeholders to add an institutional focus on physician wellbeing as an accreditation standard for hospitals, focusing on system-wide interventions that do not add additional burden to physicians.
2. Our AMA will work with hospitals and other stakeholders to determine areas of focus on physician wellbeing, to include the removal of intrusive questions regarding physician physical or mental health or related treatments on initial or renewal hospital credentialing applications.

Physician and Medical Student Burnout D-310.968

1. Our American Medical Association recognizes that burnout, defined as emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness, is a problem among residents, fellows, and medical students.
2. Our AMA will work with other interested groups to regularly inform the appropriate designated institutional officials, program directors, resident physicians, and attending faculty about resident, fellow, and medical student burnout (including recognition, treatment, and prevention of burnout) through appropriate media outlets.
3. Our AMA will encourage partnerships and collaborations with accrediting bodies (e.g., the Accreditation Council for Graduate Medical Education and the Liaison Committee on Medical Education) and other major medical organizations to address the recognition, treatment, and prevention of burnout among residents, fellows, and medical students and faculty.
4. Our AMA will encourage further studies and disseminate the results of studies on physician and medical student burnout to the medical education and physician community.
5. Our AMA will continue to monitor this issue and track its progress, including publication of peer-reviewed research and changes in accreditation requirements.
6. Our AMA encourages the utilization of mindfulness education as an effective intervention to address the problem of medical student and physician burnout.
7. Our AMA will encourage medical staffs and/or organizational leadership to anonymously survey physicians to identify local factors that may lead to physician demoralization.
8. Our AMA will continue to offer burnout assessment resources and develop guidance to help organizations and medical staffs implement organizational strategies that will help reduce the sources of physician demoralization and promote overall medical staff well-being.
9. Our AMA will continue to:
    a) address the institutional causes of physician demoralization and burnout, such as the burden of documentation requirements, inefficient work flows and regulatory oversight.
    b) develop and promote mechanisms by which physicians in all practices settings can reduce the risk and effects of demoralization and burnout, including implementing targeted practice transformation interventions, validated assessment tools and promoting a culture of well-being.

Fair Reimbursement for Administrative Burdens D-320.978

1. Our American Medical Association will continue its strong state and federal legislative advocacy efforts to promote legislation that streamlines the prior authorization process and reduces the overall volume of prior authorizations for physician practices.
2. Our AMA will continue partnering with patient advocacy groups in prior authorization reform efforts to reduce patient harms, including care delays, treatment abandonment, and negative clinical outcomes.
3. Our AMA will oppose inappropriate payer policies and procedures that deny or delay medically necessary drugs and medical services.

4. Our AMA will advocate for fair reimbursement of established and future CPT codes for administrative burdens related to:
    a. the prior authorization process.
    b. appeals or denials of services (visits, tests, procedures, medications, devices, and claims), whether pre- or post-service denials.

Administrative Simplification in the Physician Practice D-190.974

1. Our American Medical Association strongly encourages vendors to increase the functionality of their practice management systems to allow physicians to send and receive electronic standard transactions directly to payers and completely automate their claims management revenue cycle and will continue to strongly encourage payers and their vendors to work with the AMA and the Federation to streamline the prior authorization process.
2. Our AMA will continue its strong leadership role in automating, standardizing and simplifying all administrative actions required for transactions between payers and providers.
3. Our AMA will continue its strong leadership role in automating, standardizing, and simplifying the claims revenue cycle for physicians in all specialties and modes of practice with all their trading partners, including, but not limited to, public and private payers, vendors, and clearinghouses.
4. Our AMA will prioritize efforts to automate, standardize and simplify the process for physicians to estimate patient and payer financial responsibility before the service is provided, and determine patient and payer financial responsibility at the point of care, especially for patients in high-deductible health plans.
5. Our AMA will continue to use its strong leadership role to support state and specialty society initiatives to simplify administrative functions.
6. Our AMA will continue its efforts to ensure that physicians are aware of the value of automating their claims cycle.

Administrative Costs and Access to Health Care H-155.976

Our American Medical Association supports accurate calculations of the **administrative** costs of government programs (Medicare, Medicaid, TRICARE, etc.) and private health insurance plans. It is the policy of the AMA:

(1) to begin immediately to seek comprehensive reforms to reduce the **administrative** inefficiencies, burdens and expenses involved in paying for health care services and to urge that proposals to increase access to health care also address the need to reduce **administrative** costs and burdens;

(2) that state and county medical societies and national medical specialty societies be urged to utilize the joint Guidelines for Health Benefits Administration in discussions with health care payers directed toward improving the efficiency of utilization management programs and minimizing the **administrative** burdens they impose on physicians and hospitals;

(3) that the AMA strongly encourage further study of the cost-effectiveness of all types of utilization management systems and programs and report further results of such study to the Federation as they become available;

(4) that state medical societies be urged to work for enactment of the AMA model state legislation governing: (a) clarity and readability of contract language and uniform policy provisions; (b) liability of review entities for injury to beneficiaries; (c) physician involvement in the review process; and (d) confidentiality of medical information requested by review entities; and

(5) that this information be conveyed to the American public through appropriate mechanisms.

Refinement of Medicare Physician Payment System H-400.990

1. Our American Medical Association reaffirms its support for development and implementation of a Medicare indemnity **payment** schedule according to the policies established in Policy 400.991.

2. Our AMA supports reasonable attempts to remedy geographic Medicare physician **payment** inequities that do not substantially interfere with the AMA's support for an RBRVS-based indemnity **payment** system.
3. Our AMA supports continued efforts to ensure that implementation of an RBRVS-based Medicare **payment** schedule occurs upon the expansion, correction, and refinement of the Harvard RBRVS study and data as called for in Board Report AA (I-88), and upon AMA review and approval of the relevant proposed enabling legislation.
4. Our AMA continues to oppose any effort to link the acceptance of an RBRVS with any proposal that is counter to AMA policy, such as expenditure targets or mandatory assignment.

Reducing MIPS Reporting Burden D-395.999
Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) to advocate for improvements to Merit-Based Incentive Payment System (MIPS) that have significant input from practicing physicians and reduce regulatory and paperwork burdens on physicians. In the interim, our AMA will work with CMS to shorten the yearly MIPS data reporting period from one-year to a minimum of 90-days (of the physician's choosing) within the calendar year.

Prior Authorization and Utilization Management Reform H-320.939
1. Our American Medical Association will continue its widespread prior authorization (PA) advocacy and outreach, including promotion and/or adoption of the Prior Authorization and Utilization Management Reform Principles, AMA model legislation, Prior Authorization Physician Survey and other PA research, and the AMA Prior Authorization Toolkit, which is aimed at reducing PA administrative burdens and improving patient access to care.
2. Our AMA will oppose health plan determinations on physician appeals based solely on medical coding and advocate for such decisions to be based on the direct review of a physician of the same medical specialty/subspecialty as the prescribing/ordering physician.
3. Our AMA supports efforts to track and quantify the impact of health plans' prior authorization and utilization management processes on patient access to necessary care and patient clinical outcomes, including the extent to which these processes contribute to patient harm.
4. Our AMA will advocate for health plans to minimize the **burden** on patients, physicians, and medical centers when updates must be made to previously approved and/or pending prior authorization requests.

Physician Payment Reform H-390.849
1. Our American Medical Association will advocate for the development and adoption of physician **payment** reforms that adhere to the following principles:
    a. Promote improved patient access to high-quality, cost-effective care.
    b. Be designed with input from the physician community.
    c. Ensure that physicians have an appropriate level of decision-making authority over bonus or shared-savings distributions.
    d. Not require budget neutrality within Medicare Part B.
    e. Be based on **payment** rates that are sufficient to cover the full cost of sustainable medical practice.
    f. Ensure reasonable implementation timeframes, with adequate support available to assist physicians with the implementation process.
    g. Make participation options available for varying practice sizes, patient mixes, specialties, and locales.
    h. Use adequate risk adjustment methodologies.
    i. Incorporate incentives large enough to merit additional investments by physicians.
    j. Provide patients with information and incentives to encourage appropriate utilization of medical care, including the use of preventive services and self-management protocols.
    k. Provide a mechanism to ensure that budget baselines are reevaluated at regular intervals and are reflective of trends in service utilization.
    l. Attribution processes should emphasize voluntary agreements between patients and physicians, minimize the use of algorithms or formulas, provide attribution information to physicians in a timely manner, and include formal mechanisms to allow physicians to verify and correct attribution data as necessary.

m. Include ongoing evaluation processes to monitor the success of the reforms in achieving the goals of improving patient care and increasing the value of health care services.

2. Our AMA opposes bundling of payments in ways that limit medically necessary care, including institutional post-acute care, or otherwise interfere with a physician's ability to provide high quality care to patients.
3. Our AMA supports **payment** methodologies that redistribute Medicare payments among providers based on outcomes (including functional improvements, if appropriate), quality and risk-adjustment measures only if measures are scientifically valid, reliable, and consistent with national medical specialty society- developed clinical guidelines/standards.
4. Our AMA will continue to monitor health care delivery and physician **payment** reform activities and provide resources to help physicians understand and participate in these initiatives.
5. Our AMA supports the development of a public-private partnership for the purpose of validating statistical models used for risk adjustment.

Unfunded Mandates H-270.962
Our AMA vigorously opposes any unfunded mandates on physicians.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 803
(I-24)

Introduced by: New England

Subject: Healthcare Savings Account Reform

Referred to: Reference Committee J

Whereas, individually owned retirements savings plans that grow tax free, e.g. 401k, 403b, and IRAs, have assisted and encouraged financial security in retirement[1]; and

Whereas, individually owned educational savings plans that grow tax free, i.e. 529 plans, have assisted and encouraged people to save for educational expenses[2]; and

Whereas, many people would be able and willing to put money into an account dedicated to healthcare expenses in anticipation of healthcare expenses when they are unable to work; and

Whereas, contributions to healthcare savings accounts (HSAs) could start in childhood with contributions from others; and

Whereas, HSAs could be used as a bridge to cover healthcare expenses when people are between jobs, thereby decreasing limits on job mobility due to gaps in healthcare insurance coverage; and

Whereas, HSAs contributions from direct donations and HSA transfers could be used by a community to assist those most in need, while ensuring that the funds are used exclusively for healthcare needs; and

Whereas, HSAs could be redirected to others in a will or estate plan to ensure that the funds are used only for healthcare needs by the recipient; and

Whereas, allowing people more control over their healthcare dollar could facilitate meaningful healthcare system improvement; therefore be it

RESOLVED, that our American Medical Association advocate for revision of Health Savings Accounts to:

1. Permit contributions from family members, employers, or other designated individuals, not limiting contributions to only those on high deductible health insurance plans;
2. Permit contributions to the accounts of dependents, including children and spouses;
3. Permit contributions from Medicare and Medicaid enrollees;
4. Permit the payment of health, dental, and vision insurance premiums from Health Savings Accounts;
5. Permit the money spent by an employer on health insurance to be directed, in part, into an employee HSA, at the employee's discretion;
6. Prioritize permitting the transfer of funds between HSAs, including between spouses and family members; and
7. Ensure that the expansion of the role and functions of Health Savings Accounts is complementary to, and does not replace, health insurance. (Modify Current HOD Policy)

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

Received: 9/19/2024

REFERENCES

1. Americans' Retirement Savings Show Real Progress | Investment Company Institute https://www.ici.org/viewpoints/24-view-real-progress
2. Use of 529 Plans Rising—Along With Revenue Impact https://www.pewtrusts.org/en/research-and-analysis/articles/2018/10/08/use-of-529-plans-rising-along-with-revenue-impact

RELEVANT AMA POLICY

Update on HSAs, HRAs, and Other Consumer-Driven Health Care Plans D-165.954
Our AMA will:
(1) educate physicians about health insurance plan practices that may impact physician billing and collection of payment from patients with health savings accounts (HSAs), health reimbursement arrangements (HRAs), and other forms of consumer-driven health care; and
(2) monitor and support rigorous research on the impact of HSAs and HRAs on physician practices, and on levels and appropriateness of utilization, including preventive care, costs, and account savings.

Health Savings Accounts for Older Americans D-165.962
Our AMA will monitor pending regulations and take appropriate steps to ensure access to Health Savings Accounts by all Medicare eligible individuals.

Flexible Spending Accounts (FSAs) H-165.863
1. Along with other efforts to liberalize the Health Savings Account rules, our AMA places a top priority on allowing employees to roll-over any unexpended funds in a Flexible Spending Account into a Health Savings Account.
2. Our AMA will advocate for a reasonable increase in Section 125 Flex Spending accounts.

Health Savings Accounts H-165.852
It is the policy of the AMA that:
(1) high-deductible health insurance plans issued to families in conjunction with Health Savings Accounts (HSAs) be allowed to apply lower, per-person deductibles to individual family members with the permitted levels for per-person deductibles being the same as permitted levels for individual deductibles, and with the annual HSA account contribution limit being determined by the full family deductible or the dollar-limit for family policies;
(2) contributions to HSAs should be allowed to continue to be tax deductible until legislation is enacted to replace the present exclusion from employees' taxable income of employer-provided health expense coverage with tax credits for individuals and families;
(3) advocacy of HSAs continues to be incorporated prominently in its campaign for health insurance market reform;
(4) activities to educate patients about the advantages and opportunities of HSAs be enhanced;
(5) efforts by companies to develop, package, and market innovative products built around HSAs continue to be monitored and encouraged;
(6) HSAs continue to be promoted and offered to AMA physicians through its own medical insurance programs; and
(7) legislation promoting the establishment and use of HSAs and allowing the tax-free use of such accounts for health care expenses, including health and long-term care insurance premiums and other costs of long-term care, be strongly supported as an integral component of AMA efforts to achieve universal access and coverage and freedom of choice in health insurance.

Health Savings Accounts in the Medicaid Program H-290.972
It is the policy of our AMA that states offering Medicaid beneficiaries Health Savings Accounts (HSAs) should adhere to the following principles:

A. Make beneficiary participation voluntary;
B. Provide first-dollar coverage of preventive services regardless of whether the beneficiary has met the deductible;
C. Offer positive incentives to reward healthy behavior and offset beneficiary cost-sharing, provided that such incentives do not result in punitive cuts in standard benefits or increased cost-sharing to enrollees who are unable to achieve improvements in personal behavior affecting their health;
D. Set deductibles at 100% of account contributions, but no higher;
E. Allow payments to non-Medicaid providers by beneficiaries to count toward deductibles and out-of-pocket spending limits;
F. Allow the deductible limits for families to be the lower of either the individual or family combined deductible;
G. Ensure that enrollees are protected by standard Medicaid maximum out-of-pocket spending limits;
H. Provide outreach, information, and decision-support that is readily accessible through a variety of formats (e.g., written, telephone, online), and in multiple languages;
I. Encourage HSA enrollees to establish a medical home, in order to assure provision of preventive care services, coordination of care and continuity of care;
J. Prohibit use of HSA funds for non-medical purposes, but consider allowing HSA balances of enrollees who lose Medicaid coverage to be used to purchase private insurance, including the employee share of premium for employer-sponsored coverage;
K. Monitor the impact on utilization and beneficiary financial burden;
L. Test broadening of eligibility to include currently ineligible beneficiary groups; and
M. Ensure that physicians and other providers of health care services have access to up-to-date information verifying beneficiary enrollment and covered benefits, and are paid at point-of-service, or are allowed to use their standard billing procedures to obtain payment from the insurer or account custodian.

Health Insurance Affordability H-165.828
7. Our AMA supports clear labeling of exchange plans that are eligible to be paired with a Health Savings Account (HSA) with information on how to set up an HSA.

Direct Primary Care H-385.912
1. Our AMA supports:
(a) inclusion of Direct Primary Care as a qualified medical expense by the Internal Revenue Service; and
(b) efforts to ensure that patients in Direct Primary Care practices have access to specialty care, including efforts to oppose payer policies that prevent referrals to in-network specialists.
2. AMA policy is that the use of a health savings account (HSA) to access direct primary care providers and/or to receive care from a direct primary care medical home constitutes a bona fide medical expense, and that particular sections of the IRS code related to qualified medical expenses should be amended to recognize the use of HSA funds for direct primary care and direct primary care medical home models as a qualified medical expense.
3. Our AMA will seek federal legislation or regulation, as necessary, to amend appropriate sections of the IRS code to specify that direct primary care access or direct primary care medical homes are not health “plans” and that the use of HSA funds to pay for direct primary care provider services in such settings constitutes a qualified medical expense, enabling patients to use HSAs to help pay for Direct Primary Care and to enter DPC periodic-fee agreements without IRS interference or penalty.

Principles for Structuring a Health Insurance Tax Credit H-165.865
(1) AMA support for replacement of the present exclusion from employees' taxable income of employer-provided health insurance coverage with tax credits will be guided by the following principles:
(a) Tax credits should be contingent on the purchase of health insurance, so that if insurance is not purchased the credit is not provided.
(b) Tax credits should be refundable.
(c) The size of tax credits should be inversely related to income.
(d) The size of tax credits should be large enough to ensure that health insurance is affordable for most people.
(e) The size of tax credits should be capped in any given year.
(f) Tax credits should be fixed-dollar amounts for a given income and family structure.
(g) The size of tax credits should vary with family size to mirror the pricing structure of insurance premiums.

(h) Tax credits for families should be contingent on each member of the family having health insurance.
(i)Tax credits should be applicable only for the purchase of health insurance, including all components of a qualified Health Savings Account, and not for out-of-pocket health expenditures.
(j) Tax credits should be advanceable for low-income persons who could not afford the monthly out-of-pocket premium costs.

Aligning Clinical and Financial Incentives for High-Value Care D-185.979
1. Our American Medical Association supports Value-Based Insurance Design (VBID) plans designed in accordance with the tenets of “clinical nuance,” recognizing that
a. medical services may differ in the amount of health produced.
b. the clinical benefit derived from a specific service depends on the person receiving it, as well as when, where, and by whom the service is provided.
...
7. Our AMA supports legislative and regulatory flexibility to accommodate VBID that
a. preserves health plan coverage without patient cost-sharing for evidence-based preventive services.
b. allows innovations that expand access to affordable care, including changes needed to allow High Deductible Health Plans paired with Health Savings Accounts to provide pre-deductible coverage for preventive and chronic care management services.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 804
(I-24)

Introduced by: New England

Subject: Improving Public Assistance for People with Disabilities

Referred to: Reference Committee J

Whereas, Supplemental Security Income (SSI) helps meet basic needs for 7.5 million low-income people, 85% of whom have severe disabilities[1,2]; and

Whereas, SSI's asset limit has not been updated since 1989 and under current inflation now reflects 20% of its original 1972 value[4-5];

Whereas, SSI's asset limit is $2000 for individuals but $3000 for couples (only 50% more) unfairly creating a "marriage penalty"[4]; and

Whereas, similarly, SSI's monthly pre-tax income cutoff is $1971 for individuals but $2915 for couples (only 47% more), and monthly benefits are $841 for individuals but $1261 for couples (only 50% more), extending the "marriage penalty" across the program[3-7]; and

Whereas, 45% of couples with SSI are in poverty, compared to only 9.8% for individuals[7]; and

Whereas, the SSI Savings Penalty Elimination Act would adjust asset limits for inflation and eliminate the marriage penalty, increasing program costs by only 1% over 10 years[8-10]; and

Whereas, SSI eligibility often automatically makes beneficiaries eligible for Medicaid, even in non-expansion states, improving access to care for patients with disabilities[11]; therefore be it

RESOLVED, that our American Medical Association support appropriate increased asset limits, income cutoffs, and benefits that are indexed to increase at least by inflation for public assistance programs such as Supplemental Security Income (SSI) (New HOD Policy); and be it further

RESOLVED, that our AMA support eliminating the marriage penalty for SSI benefits, such that married couples do not receive fewer benefits or have more restrictive eligibility requirements than they would have as individuals. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 9/19/2024

REFERENCES

1. SSA. SSI monthly statistics, May 2023. Published June, 2023. Accessed March 31, 2024. https://www.ssa.gov/policy/docs/statcomps/ssi_monthly/index.html
2. SSA. Fast facts & figures about Social Security, 2023. Research, Statistics, and Policy Analysis; 2023. https://www.ssa.gov/policy/docs/chartbooks/fast_facts/index.html

3. SSA. Are you eligible for Supplemental Security Income (SSI)? Accessed March 31, 2024. https://www.ssa.gov/pubs/EN-05-11003.pdf
4. SSA. Part A – Determination of Benefits. Compilation of the Social Security Laws. Accessed February 21, 2024. https://www.ssa.gov/OP_Home/ssact/title16b/1611.htm#:~:text=(3)%20Notwithstanding%20anything%20to%20the,an%20eligible%20spouse%2C%20the%20State
5. Romig K, Nunez L, Sherman A. The case for updating SSI asset limits. Center on Budget and Policy Priorities. Published September 20, 2023. Accessed March 31, 2024. https://www.cbpp.org/research/social-security/the-case-for-updating-ssi-asset-limits
6. SSA. Supplemental Security Income program description and legislative history. Published 2022. Accessed March 31, 2024. https://www.ssa.gov/policy/docs/statcomps/supplement/2022/ssi.html#:~:text=The%202022%20SSI%20federal%20benefit,benefit%20rate%20is%20%241%2C261%20monthly.
7. Balkus R, Wilschke S. Research: treatment of married couples in the SSI program. Social Security Administration Research, Statistics, and Policy Analysis. Accessed March 28, 2024.
8. S.2767 – SSI Savings Penalty Elimination Act. Accessed March 31, 2024. https://www.congress.gov/bill/118th-congress/senate-bill/2767
9. H.R.5408 – SSI Savings Penalty Elimination Act. Accessed March 31, 2024. https://www.congress.gov/bill/118th-congress/house-bill/5408
10. SSA Office of the Chief Actuary. Estimated change in federal SSI program cost from enacting S. 2065, the 'Supplemental Security Income Restoration Act of 2021,' introduced on June 16, 2021, by Senators Brown, Warren, Sanders, and others. Accessed March 31, 2024. https://www.ssa.gov/OACT/solvency/SSIRestorationAct_20210716.pdf
11. Rupp K, Riley GF. State Medicaid eligibility and enrollment policies and rates of Medicaid participation among disabled Supplemental Security Income recipients. Social Security Bulletin, 76(3). Accessed March 31, 2024. https://www.ssa.gov/policy/docs/ssb/v76n3/v76n3p17.html

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]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 805
(I-24)

Introduced by: Women Physicians Section

Subject: Coverage for Care for Sexual Assault Survivors

Referred to: Reference Committee J

Whereas, one in five women in the United States report having been raped at some time in their life, yet only 20% of these women will seek medical care, often in emergency departments[1,2]; and

Whereas, the Violence Against Women Act of 1994 prohibits charging patients for the cost of evidence collection as part of a medical forensic exam, yet patients are often charged for treatment of their physical injuries, post-exposure prophylaxis treatment and testing for sexually transmitted disease (STIs), counseling, and emergency contraception[3,4]; and

Whereas, in 2019, almost 18,000 sexual assault survivors who sought care in emergency departments were charged $3,673 on average, and survivors who were abused during pregnancy were charged $4,553 on average[5]; and

Whereas, privately-insured sexual assault survivors pay 14% of emergency department costs, averaging $497 out-of-pocket[5,6]; and

Whereas, medical costs particularly burden low-income women and girls, who are disproportionately sexual assault survivors, and fear of high costs deters survivors from seeking care in emergency departments[7-9]; and

Whereas, many survivors of sexual assault endure short and long term sequelae requiring care and therapeutic services, which are not currently covered by the Violence Against Women Act and may impose significant financial hardship on survivors[10,11]; and

Whereas, survivors of sexual assault and intimate partner violence who seek mental health counseling pay 32-36% of costs out of pocket on average[12]; and

Whereas, under the Illinois law, The Sexual Assault Survivors Emergency Treatment Act (SASETA), sexual assault survivors who are not covered by private insurance or Medicaid may not be billed directly for costs of services or any out-of-pocket expenses, and healthcare providers are reimbursed for services provided to uninsured and underinsured patients[13,14]; and

Whereas, all 50 states have Crime Victim Compensation (CVC) programs that directly reimburse certain eligible sexual assault survivors[15,16]; therefore be it

RESOLVED, that our American Medical Association amend policy H-80.999 “Sexual Assault Survivors” by addition as follows:

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 and prevention, drug 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 (Modify Current HOD Policy); and be it further

RESOLVED, that our AMA advocate for federal and state efforts to reduce financial barriers that limit sexual assault survivors' ability to seek physical and mental health care and social services after sexual assault. (Directive to Take Action)

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

Submitted: 09/19/2024

REFERENCES

1. Smith SG, Zhang X, Basile KC, et al. The National Intimate Partner and Sexual Violence Survey : 2015 data brief – updated release. Accessed August 2, 2024. https://stacks.cdc.gov/view/cdc/60893
2. Tennessee AM, Bradham TS, White BM, Simpson KN. The Monetary Cost of Sexual Assault to Privately Insured US Women in 2013. *Am J Public Health*. 2017;107(6):983-988. doi:10.2105/AJPH.2017.303742
3. A.G. Underwood Announces Settlements With 7 New York Hospitals To Stop Illegal Billing Of Rape Survivors For Forensic Rape Examinations. Published November 29, 2018. Accessed August 2, 2024. https://ag.ny.gov/press-release/2018/ag-underwood-announces-settlements-7-new-york-hospitals-stop-illegal-billing-rape
4. Worthy S, Kulkarni S, Kelly T, Johnson J. #Metoo Meets the Emergency Room: Providing and Paying for Care After a

Sexual Assault. *St Louis Univ J Health Law Policy*. 2020;13(2). https://scholarship.law.slu.edu/jhlp/vol13/iss2/4
5. Dickman SL, Himmelstein G, Himmelstein DU, et al. Uncovered Medical Bills after Sexual Assault. *N Engl J Med*. 2022;387(11):1043-1044. doi:10.1056/NEJMc2207644
6. Ramaswamy A, Frederiksen B, Rae M, Ranji U, Salganicoff A, Published DM. Out-of-Pocket Charges for Rape Kits and Services for Sexual Assault Survivors. KFF. Published March 18, 2022. Accessed August 2, 2024. https://www.kff.org/womens-health-policy/issue-brief/out-of-pocket-charges-for-rape-kits-and-services-for-sexual-assault-survivors/
7. Mosley EA, Prince JR, McKee GB, et al. Racial Disparities in Sexual Assault Characteristics and Mental Health Care After Sexual Assault Medical Forensic Exams. *J Womens Health*. 2021;30(10):1448-1456. doi:10.1089/jwh.2020.8935
8. Loder RT, Robinson TP. The demographics of patients presenting for sexual assault to US emergency departments. *J Forensic Leg Med*. 2020;69:101887. doi:10.1016/j.jflm.2019.101887
9. Bach MH, Beck Hansen N, Ahrens C, Nielsen CR, Walshe C, Hansen M. Underserved survivors of sexual assault: a systematic scoping review. *Eur J Psychotraumatology*. 12(1):1895516. doi:10.1080/20008198.2021.1895516
10. Linden JA. Care of the Adult Patient after Sexual Assault. *N Engl J Med*. 2011;365(9):834-841. doi:10.1056/NEJMcp1102869
11. National Protocol for Sexual Assault Medical Forensic Examinations: Adults/Adolescents, Second Edition | Office of Justice Programs. Accessed August 2, 2024. https://www.ojp.gov/ncjrs/virtual-library/abstracts/national-protocol-sexual-assault-medical-forensic-examinations-0
12. McLean G, Bocinski SG, Bocinski GM and SG. The Economic Cost of Intimate Partner Violence, Sexual Assault, and Stalking - IWPR. Published August 14, 2017. Accessed August 2, 2024. https://iwpr.org/the-economic-cost-of-intimate-partner-violence-sexual-assault-and-stalking/, https://iwpr.org/the-economic-cost-of-intimate-partner-violence-sexual-assault-and-stalking/
13. SASETA Information and Resources. ICASA. Accessed August 2, 2024. https://icasa.org/legal-issues/health-care/saseta-information-and-resources
14. 410 ILCS 70/ Sexual Assault Survivors Emergency Treatment Act. Accessed August 2, 2024. https://www.ilga.gov/legislation/ilcs/ilcs3.asp?actid=1531&chapact=410%C2%A0ilcs%C2%A070/&chapterid=35&chaptername=public+health&actname=sexual+assault+survivors+emergency+treatment+act
15. National Victim Assistance Academy | Office of Justice Programs. Accessed August 2, 2024. https://www.ojp.gov/ncjrs/virtual-library/abstracts/national-victim-assistance-academy
16. Crime Victim Compensation | RAINN. Accessed August 2, 2024. https://rainn.org/articles/crime-victim-compensation

RELEVANT AMA POLICY

Sexual Assault Survivors H-80.999

1. Our AMA supports the preparation and dissemination of information and best practices intended to maintain and improve the skills needed by all practicing physicians involved in providing care to sexual assault survivors.
2. Our AMA advocates for the legal protection of sexual assault survivors' rights and work with state medical societies to ensure that each state implements these rights, which include but are not limited to, the right to: (a) receive a medical forensic examination free of charge, which includes but is not limited to HIV/STD testing and treatment, pregnancy testing, treatment of injuries, and collection of forensic evidence; (b) preservation of a sexual assault evidence collection kit for at least the maximum applicable statute of limitation; (c) notification of any intended disposal of a sexual assault evidence kit with the opportunity to be granted further preservation; (d) be informed of these rights and the policies governing the sexual assault evidence kit; and (e) access to emergency contraception information and treatment for pregnancy prevention.
3. Our AMA will collaborate with relevant stakeholders to develop recommendations for implementing best practices in the treatment of sexual assault survivors, including through engagement with the joint working group established for this purpose under the Survivor's Bill of Rights Act of 2016.
4. Our AMA will advocate for increased post-pubertal patient access to Sexual Assault Nurse Examiners, and other trained and qualified clinicians, in the emergency department for medical forensic examinations.
5. Our AMA will advocate at the state and federal level for (a) the timely processing of all sexual examination kits upon patient consent; (b) timely processing of "backlogged" sexual assault examination kits with patient consent; and (c) additional funding to facilitate the timely testing of sexual assault evidence kits.
6. Our AMA supports the implementation of a national database of Sexual Assault Nurse Examiner and Sexual Assault Forensic Examiner providers.

[Sub. Res. 101, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10; Modified: Res. 202, I-17; Appended: Res. 902, I-18; Appended: Res. 210, A-22; Modified: Res. 211, A-23]

HIV, Sexual Assault, and Violence H-20.900
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. [CSA Rep. 4, A-03; Modified: CSAPH Rep. 1, A-13; Modified: Res. 905, I-18]

Access to Emergency Contraception H-75.985
It is the policy of our AMA: (1) that physicians and other health care professionals should be encouraged to play a more active role in providing education about emergency contraception, including access and informed consent issues, by discussing it as part of routine family planning and contraceptive counseling; (2) to enhance efforts to expand access to emergency contraception, including making emergency contraception pills more readily available through pharmacies, hospitals, clinics, emergency rooms, acute care centers, and physicians' offices; (3) to recognize that information about emergency contraception is part of the comprehensive information to be provided as part of the emergency treatment of sexual assault victims; (4) to support educational programs for physicians and patients regarding treatment options for the emergency treatment of sexual assault victims, including information about emergency contraception; and (5) to encourage writing advance prescriptions for these pills as requested by their patients until the pills are available over-the-counter. [CMS Rep. 1, I-00; Appended: Res. 408, A-02; Modified: Res. 443, A-04; Reaffirmed: CSAPH Rep. 1, A-14; Modified: CSAPH Rep. 01, A-24]

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. [Res. 208, I-15]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 807
(I-24)

Introduced by: Louisiana

Subject: Expanded Pluralism in Medicaid

Referred to: Reference Committee J

Whereas, Medicaid beneficiaries have very limited choice of plan design; and

Whereas, Medicaid beneficiaries have little or no opportunity to directly benefit from utilizing our healthcare system in a more cost-effective way; and

Whereas, the typical Medicaid beneficiary has limited or no ability to create generational wealth; therefore be it

RESOLVED, that our American Medical Association suggest Medicaid reform that introduces more pluralism for Medicaid beneficiaries (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for inclusion of choices of plan that allow Medicaid beneficiaries to directly benefit financially from using our healthcare system in a more cost-effective way (Directive to Take Action); and be it further

RESOLVED, that our AMA investigate whether the Health Savings Account (HSA) model could be adapted as one option in an expanded pluralistic system that would enable Medicaid beneficiaries to directly benefit from utilizing the healthcare system in a more cost-effective manner and, in doing so, offer Medicaid beneficiaries an opportunity to create generational wealth. (Directive to Take Action)

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

Received: 9/23/2024

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 808
(I-24)

Introduced by: Mississippi

Subject: Requirement to Communicate Covered Alternatives for Denied Medications

Referred to: Reference Committee J

Whereas, healthcare is a vital component of wellbeing; and

Whereas, the healthcare system is increasingly complicated, expensive, and difficult for the average adult to navigate in their favor; and

Whereas, health insurance is, for most Americans currently, necessary to access standard of care treatment and prevention for acute and chronic diseases; and

Whereas, health insurance costs and coverage options vary greatly, even within the same company; and

Whereas**,** medication formularies greatly influence which medications can be accessed by patients; and

Whereas**,** medication formularies change at various times of the year for each patient and those changes are unpredictable for the physician or the patient; and

Whereas**,** the harm to patients caused by these changes are not simply or consistently remedied; therefore be it

RESOLVED, that our American Medical Association advocate that Medicare, Medicaid, and all other insurers provide covered alternatives to the patient and the patient's prescribing physician at the time that coverage for a medication is denied. (Directive to Take Action)

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

Received: 9/23/2024

RELEVANT AMA POLICY

Private Health Insurance Formulary Transparency H-125.979

1. Our American Medical Association will work with pharmacy benefit managers, health insurers, and pharmacists to enable physicians to receive accurate, real-time formulary data at the point of prescribing.
2. Our AMA supports legislation or regulation that ensures that private health insurance carriers declare which medications are available on their formularies by October 1 of the preceding year, that formulary information be specific as to generic versus trade name and include copay responsibilities, and that drugs may not be removed from the formulary nor moved to a higher cost tier within the policy term.
3. Our AMA will develop model legislation:
    a. requiring insurance companies to declare which drugs on their formulary will be covered under trade names versus generic.
    b. requiring insurance carriers to make this information available to consumers by October 1 of each year.
    c. forbidding insurance carriers from making formulary deletions within the policy term.
4. Our AMA will promote the following insurer-pharmacy benefits manager - pharmacy (IPBMP) to physician procedural policy: In the event that a specific drug is not or is no longer on the formulary when the prescription is presented, the IPBMP shall provide notice of covered formulary alternatives to the prescriber promptly so that appropriate medication can be provided to the patient within 72 hours.
5. Drugs requiring prior authorization, shall be adjudicated by the IPBMP within 72 hours of receipt of the prescription.
6. Our AMA
    a. promotes the value of online access to up-to-date and accurate prescription drug formulary plans from all insurance providers nationwide.
    b. supports state medical societies in advocating for state legislation to ensure online access to up-to-date and accurate prescription drug formularies for all insurance plans.
7. Our AMA will continue its efforts with the National Association of Insurance Commissioners addressing the development and management of pharmacy benefits.
8. Our AMA will develop model state legislation on the development and management of pharmacy benefits.

Value-Based Management of Drug Formularies H-110.979

Our AMA: (1) will advocate that pharmacy benefit managers (PBMs) and health plans use a transparent process in formulary development and administration, and include practicing network physicians from the appropriate medical specialty when making determinations regarding formulary inclusion or placement for a particular drug class; (2) will advocate that any refunds or rebates received by a health plan or PBM from a pharmaceutical manufacturer under an outcomes-based contract be shared with impacted patients; and (3) opposes indication-based formularies in order to protect the ability of patients to access and afford the prescription drugs they need, and physicians to make the best prescribing decisions for their patients.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 809
(I-24)

Introduced by: Mississippi

Subject: Minimum Requirements for Medication Formularies

Referred to: Reference Committee J

Whereas, healthcare is a vital component of wellbeing; and

Whereas, the healthcare system is increasingly complicated, expensive, and difficult for the average adult to navigate in their favor; and

Whereas, health insurance is assumed by most patients to offer them the lowest price point for a given product or service; and

Whereas, health insurance costs and coverage options vary greatly, even within the same company, and certainly across companies; and

Whereas, many generic medications are inexpensive when paid for with cash or via a non-manufacturer's discount card (like GoodRx); and

Whereas, health insurers commonly request prior authorizations or outright deny coverage for many inexpensive generic medications; and

Whereas, this practice causes harm to patients and physicians by decreasing access to low cost generic medications and increasing administrative burden and physician burnout; and

Whereas, this practice imposes unnecessary costs and burdens to the healthcare system; therefore be it

RESOLVED, that our American Medical Association advocate that Medicare, Medicaid, and all other insurers create, maintain, and enforce a minimum formulary for all beneficiaries, regardless of their specific plan, that includes all commonly prescribed, inexpensive, generic medications unless there are reasonable safety or economic concerns regarding the medication. (Directive to Take Action)

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

Received: 9/23/2024

RELEVANT AMA POLICY

Private Health Insurance Formulary Transparency H-125.979

1. Our American Medical Association will work with pharmacy benefit managers, health insurers, and pharmacists to enable physicians to receive accurate, real-time formulary data at the point of prescribing.
2. Our AMA supports legislation or regulation that ensures that private health insurance carriers declare which medications are available on their formularies by October 1 of the preceding year, that formulary information be specific as to generic versus trade name and include copay responsibilities, and that drugs may not be removed from the formulary nor moved to a higher cost tier within the policy term.
3. Our AMA will develop model legislation:
    a. requiring insurance companies to declare which drugs on their formulary will be covered under trade names versus generic.
    b. requiring insurance carriers to make this information available to consumers by October 1 of each year.
    c. forbidding insurance carriers from making formulary deletions within the policy term.
4. Our AMA will promote the following insurer-pharmacy benefits manager - pharmacy (IPBMP) to physician procedural policy: In the event that a specific drug is not or is no longer on the formulary when the prescription is presented, the IPBMP shall provide notice of covered formulary alternatives to the prescriber promptly so that appropriate medication can be provided to the patient within 72 hours.
5. Drugs requiring prior authorization, shall be adjudicated by the IPBMP within 72 hours of receipt of the prescription.
6. Our AMA
    a. promotes the value of online access to up-to-date and accurate prescription drug formulary plans from all insurance providers nationwide.
    b. supports state medical societies in advocating for state legislation to ensure online access to up-to-date and accurate prescription drug formularies for all insurance plans.
7. Our AMA will continue its efforts with the National Association of Insurance Commissioners addressing the development and management of pharmacy benefits.
8. Our AMA will develop model state legislation on the development and management of pharmacy benefits.

Value-Based Management of Drug Formularies H-110.979

Our AMA: (1) will advocate that pharmacy benefit managers (PBMs) and health plans use a transparent process in formulary development and administration, and include practicing network physicians from the appropriate medical specialty when making determinations regarding formulary inclusion or placement for a particular drug class; (2) will advocate that any refunds or rebates received by a health plan or PBM from a pharmaceutical manufacturer under an outcomes-based contract be shared with impacted patients; and (3) opposes indication-based formularies in order to protect the ability of patients to access and afford the prescription drugs they need, and physicians to make the best prescribing decisions for their patients.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 810
(I-24)

Introduced by: Mississippi

Subject: Immediate Digital Access to Updated Medication Formulary for Patients and Their Physicians

Referred to: Reference Committee J

Whereas, there is wide variation in the compilation of medication formularies among health insurance companies; and

Whereas, medication formularies among health insurance companies change on a regular basis; and

Whereas, there are often multiple appropriate drugs within a medication class from which a physician may choose to prescribe to a patient; and

Whereas, physicians often prescribe one medication to a patient only to find out at a later time that the medication was not taken due to a lack of coverage which contributes to poor outcomes as well as a delay in treatment; and

Whereas, once the lack of medication coverage is discovered, there is often no information easily accessible to inform the physician, the physician's staff, or the patient what medication (if any) has preferred coverage by the insurance company; therefore be it

RESOLVED, that our American Medical Association advocate for the Centers for Medicare & Medicaid Services to provide (or cause their associated carriers to provide) a hyperlink (such as a QR code) to a digital, well-organized, and searchable formulary located on the insured's insurance card to all Medicare patients in such a manner that the patient can easily share and discuss covered medications with their prescribing physician during office appointments or other encounters. (Directive To Take Action)

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

Received: 9/23/2024

RELEVANT AMA POLICY

Private Health Insurance Formulary Transparency H-125.979

1. Our American Medical Association will work with pharmacy benefit managers, health insurers, and pharmacists to enable physicians to receive accurate, real-time formulary data at the point of prescribing.
2. Our AMA supports legislation or regulation that ensures that private health insurance carriers declare which medications are available on their formularies by October 1 of the preceding year, that formulary information be specific as to generic versus trade name and include copay

responsibilities, and that drugs may not be removed from the formulary nor moved to a higher cost tier within the policy term.

3. Our AMA will develop model legislation:
    a. requiring insurance companies to declare which drugs on their formulary will be covered under trade names versus generic.
    b. requiring insurance carriers to make this information available to consumers by October 1 of each year.
    c. forbidding insurance carriers from making formulary deletions within the policy term.
4. Our AMA will promote the following insurer-pharmacy benefits manager - pharmacy (IPBMP) to physician procedural policy: In the event that a specific drug is not or is no longer on the formulary when the prescription is presented, the IPBMP shall provide notice of covered formulary alternatives to the prescriber promptly so that appropriate medication can be provided to the patient within 72 hours.
5. Drugs requiring prior authorization, shall be adjudicated by the IPBMP within 72 hours of receipt of the prescription.
6. Our AMA
    a. promotes the value of online access to up-to-date and accurate prescription drug formulary plans from all insurance providers nationwide.
    b. supports state medical societies in advocating for state legislation to ensure online access to up-to-date and accurate prescription drug formularies for all insurance plans.
7. Our AMA will continue its efforts with the National Association of Insurance Commissioners addressing the development and management of pharmacy benefits.
8. Our AMA will develop model state legislation on the development and management of pharmacy benefits.

Value-Based Management of Drug Formularies H-110.979
Our AMA: (1) will advocate that pharmacy benefit managers (PBMs) and health plans use a transparent process in formulary development and administration, and include practicing network physicians from the appropriate medical specialty when making determinations regarding formulary inclusion or placement for a particular drug class; (2) will advocate that any refunds or rebates received by a health plan or PBM from a pharmaceutical manufacturer under an outcomes-based contract be shared with impacted patients; and (3) opposes indication-based formularies in order to protect the ability of patients to access and afford the prescription drugs they need, and physicians to make the best prescribing decisions for their patients.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 811
(I-24)

Introduced by: Iowa

Subject: AMA Practice Expense Survey Geographic Analysis

Referred to: Reference Committee J

Whereas, the American Medical Association (AMA) has sponsored a new physician practice expense survey to update the Medical Economic Index and Resource Based Relative Value Scale, representing 250,000 physicians (including sites of service), because the last national Physician Practice Information (PPI) survey was in 2006-2007– and the latest PPI survey was reportedly finished in June 2024; and

Whereas, AMA leadership has shown that over the last 23 years, physician practice expenses have grown 54% and with medical inflation increasing, the net result has been a 30% drop in Centers for Medicare and Medicaid Services (CMS) physician payment; and

Whereas, the AMA analyzed the 2006-2007 PPI survey in 2009 and found no differences in non-metro (rural and micropolitan) vs. metro locations, or other geographic differences (except for slightly lower expenses in the North East) in physician practice expenses (published as "Policy Research Perspectives"*); and

Whereas, AMA leadership has emphasized the shortage of physicians in rural America is contributing to significant health inequities in rural America; and

Whereas, rural Americans' health disparities are significant and unacceptable, with mortality rates 23% higher, and preventable hospitalizations 40% higher—across all racial and age groups; and

Whereas, the percent of physicians who practice in rural areas is about 10%, despite 20% of Americans living in rural America; and

Whereas, health care research (Johnston et al**) has shown that the biggest reason for worse rural mortality and preventable hospitalization rates is the shortage in "local-area supply of specialists, which explained 55% of the differences in hospitalization rates and 40% of the difference in mortality rates"; and

Whereas, another research group (Probst et al***) wrote that "rural health disparities are due in part to declining healthcare provider availability and accessibility in rural communities" and "these problems are exacerbated by structural urbanism"... a bias which "systematically shortchanges rural areas"... They also suggested that "current models of health care funding... are innately biased in favor of large populations" and "Until this bias is recognized, the development of viable models of care across the rural-urban continuum cannot move forward"; and

Whereas, rural and many geographic regions have been systematically subjected since 1992 to arbitrary estimates of practice expenses [that used incongruous data from various sources such

as U.S. Department of Housing and Urban Development (HUD) apartment rents, American Community Survey (ACS), Bureau of Labor Statistics (BLS), Occupational Employment and Wage Statistics (OES), Bureau of Labor Statistics Online (BLSO), Occupational Employment and Wage Statistics Online (OEWS), and 1990 or 2000 census data] and therefore have resulted in chronic large downward adjustments in their Medicare payments, called Geographic Practice Cost Indexes (GPCIs); and

Whereas, GPCIs were developed by the Urban Institute in 1992, and these Medicare payment adjustments have never been accurately determined from national practice expense surveys, despite many expense surveys including the 2009 AMA analysis of the PPI survey that showed no difference in rural vs urban or geographic physician practice expenses; and

Whereas, the Medicare GPCI adjustments result in as much as 25-30% lower Evaluation and Management (E&M) and 50-60% lower imaging and lab diagnostic testing fees for service in rural vs. metro areas despite the lack of evidence of a significant difference in physician practice expenses; therefore be it

RESOLVED, that our American Medical Association formally recognize that systemic bias in healthcare financing called “Structural Urbanism”, has been a factor in leading to rural health disparities (New HOD Policy); and be it further

RESOLVED, that our AMA in advocating for health equity for all Americans, point out that Medicare payment policies have played a role in the shortage of rural physicians and the poorer health outcomes in rural America (Directive to Take Action); and be it further

RESOLVED, that our AMA review the results from its 2023-2024 Physician Practice Information Survey to determine whether the data can be used to estimate differences in physician practice expenses across practice geography (e.g., urban vs. rural, or region) (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for the Centers for Medicare and Medicaid Services use evidence rather than bias to determine if Geographic Practice Cost Indexes should continue to adjust physician payment regionally. (Directive to Take Action)

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

Received: 9/23/2024

REFERENCES

1. *Gillis K. Policy Research Perspectives, Physician Practice Expenses by Location. AMA Economic and Health Policy Research, November 2009. Available at https://www.overregulationofmedicalpractice.org/L-Bibliography,%20General%20References/i-Chapter%20IX,%20The%20Cost%20of%20All%20This/Gillis,%20AMA,%20Expenses%20by%20Location,%202009.pdf.
2. **Johnston K, Wen H, Maddox KEJ. Lack of Access to Specialists Associated with Mortality and Preventable Hospitalizations of Rural Medicare Beneficiaries. Health Aff (Millwood) 2019; 38(12): 1993-2002
3. ***Probst J, Eberth JM, Crouch E. Structural Urbanism Contributes to Poorer Health Outcomes for Rural America. Health Aff (Millwood) 2019; 38(12): 1976-1984

RELEVANT AMA POLICY

Transparency, Participation, and Accountability in CMS' Payment Determination Process D-400.984

1. Our American Medical Association will urgently advocate for the Centers for Medicare and Medicaid Services (CMS) to improve its rate-setting processes by first publishing modifications to Medicare physician fees that result from CMS' misvalued codes initiative in the Medicare Physician Fee Schedule proposed rule instead of the final rule to afford adequate time for providers, professional medical societies and other stakeholders to review and comment on such changes before they take effect.
2. Our AMA will demand that CMS be transparent in its processes and methodologies for establishing physician work values and allow adequate opportunity for public comment on its methodologies before changes in physician work values take effect.

Geographic Practice Cost Index D-400.985
Our American Medical Association will provide annual updates on the Centers for Medicare and Medicaid Services efforts to improve the accuracy of Medicare Economic Index weights and geographic adjustments and their impact on the physician payment schedule, and AMA advocacy efforts on these issues.

Update Practice Expense Component of Relative Value Units D-406.992
Our American Medical Association will conduct a pilot study to determine the best mechanism for gathering physician practice expense data, including the feasibility of fielding a new physician practice expense survey, and work with the Centers for Medicare & Medicaid Services (CMS) to update the resource-based relative value practice expense methodology.

Enhancing Rural Physician Practices H-465.981
1. Our American Medical Association supports legislation to extend the 10% Medicare payment bonus to physicians practicing in rural counties and other areas where the poverty rate exceeds a certain threshold, regardless of the areas' Health Professional Shortage Area (HPSA) status.
2. Our AMA encourages federal and state governments to make available low interest loans and other financial assistance to assist physicians with shortage area practices in defraying their costs of compliance with requirements of the Occupational Safety and Health Administration, Americans with Disabilities Act and other national or state regulatory requirements.
3. Our AMA will explore the feasibility of supporting the legislative and/or regulatory changes necessary to establish a waiver process through which shortage area practices can seek exemption from specific elements of regulatory requirements when improved access, without significant detriment to quality, will result.
4. Our AMA supports legislation that would allow shortage area physician practices to qualify as Rural Health Clinics without the need to employ one or more physician extenders.
5. Our AMA will undertake a study of structural urbanism, federal payment polices, and the impact on rural workforce disparities.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 812
(I-24)

Introduced by: Michigan, American Academy of Physical Medicine and Rehabilitation, American Academy of Orthopaedic Surgeons

Subject: Advocate for Therapy Cap Exception Process

Referred to: Reference Committee J

Whereas, the current annual incidence of spinal cord injuries in the United States is estimated to be 54 per million, which translates to 17,800 new injuries per year; and

Whereas, the current annual incidence of stroke in the United States is 795,000; and

Whereas, the current annual incidence of brain injury in the United States is 2.8 million; and

Whereas, outcomes following neurologic and orthopedic injuries improve with appropriate physical rehabilitation; and

Whereas, arbitrary therapy caps restrict access to care regardless of an individual's medical history or complex medical conditions; and

Whereas, patients often ration or forgo care as they near the cap to avoid exhausting their benefits, which often results in the need for higher-cost interventions in the future to remain functional, and

Whereas, AMA policy D-330.941, "Medicare Outpatient Therapy Caps," takes a position against Medicare Outpatient Therapy Caps; and

Whereas, in 2018, Section 50202 of the Bipartisan Budget Act of 2018 repealed application of Medicare's "hard" outpatient therapy caps, and instead retained the cap amounts as annual thresholds with an exception process for patients that require additional visits to reach their full potential; and

Whereas, this process allows for the thresholds to be exceeded when claims are appended with the KX modifier for medically necessary services as justified by appropriate documentation in the medical record; and

Whereas, virtually all commercial health plans continue to impose arbitrary therapy caps without an exception process; therefore be it

RESOLVED, that our American Medical Association actively advocate for all health plans with therapy caps or thresholds to include an exception process. This process should, at a minimum, follow the Medicare standard for therapy cap exceptions, ensuring that patients can access the necessary services to restore functional abilities and enhance quality of life. (Directive to Take Action)

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

Received: 9/23/2024

REFERENCES

1. Jain NB, Ayers GD, Peterson EN, Harris MB, Morse L, O'Connor KC, Garshick E. Traumatic spinal cord injury in the United States, 1993-2012. Jama. 2015 Jun 9;313(22):2236-43.
2. Tsao CW, Aday AW, Almarzooq ZI, et al. Heart disease and stroke statistics—2023 update: a report from the American Heart Association. Circulation. 2023;147:e93–e621
3. G/Michael S, Terefe B, Asfaw MG, Liyew B. Outcomes and associated factors of traumatic brain injury among adult patients treated in Amhara regional state comprehensive specialized hospitals. BMC Emergency Medicine. 2023 Sep 19;23(1):109.
4. Medicare Expired Legislative Provisions Extended and Other Bipartisan Budget Act of 2018 Provisions. Accessed at https://www.cms.gov/Center/Provider-Type/All-Fee-For-Service-Providers/Downloads/Medicare-Expired-Legislative-Provisions-Extended.pdf.
5. Law Would Dismantle Therapy Cap for PT Services for Medicare Beneficiaries, April 15, 2011. Accessed at https://rehabpub.com/conditions/neurological/stroke-neurological/law-would-dismantle-therapy-cap-for-pt-services-for-medicare-beneficiaries/.

RELEVANT AMA POLICY

Medicare Outpatient Therapy Caps D-330.941
Our American Medical Association will not support medicare outpatient rehabilitation therapy caps.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 813
(I-24)

Introduced by: American Academy of Physical Medicine & Rehabilitation, American Association of Neuromuscular & Electrodiagnostic Medicine, Association of Academic Physiatrists

Subject: Insurance Coverage for Pediatric Positioning Chairs

Referred to: Reference Committee J

Whereas, children with cerebral palsy, traumatic brain injury (TBI) and other neuromuscular conditions that affect sitting balance and ambulation, require the support of a custom wheelchair for sitting upright due to weakness of the trunk muscles, spasticity, and poor balance; and

Whereas, adaptive seating systems may be associated with gains in body function including oro-motor skills, vocalization, improvement in seating posture, activity and participation; and

Whereas, many payors refuse to pay for children to have both a custom wheelchair for use for mobility outside of the home and a positioning chair for use inside the home; and

Whereas, due to lack of funding, children who need support sitting for daily activities including feeding and play, have only a wheelchair to use in the home; and

Whereas, without a positioning chair, the same wheelchair that is used in the home and in the community, is the only option that can be used in the home for any upright positioning and for feeding; and

Whereas, depending on the home environment, for some families there is an extra burden of care moving the wheelchair in/out of a small home or apartment or upstairs for a second or third floor apartment; and

Whereas, the wheelchair is a relatively large footprint item that has to "fit" in the home setting, which is challenging in small areas; and

Whereas, the size of the wheelchair is also not conducive to inclusion of the child at the family table or in family activities in the home; and

Whereas, many families find the burden of care such that they forego using the wheelchair in the home and therefore prop the child poorly on a couch and forego all the advantages that proper trunk and body support offers; and

Whereas, thankfully, most people don't have to be relegated to a singular seat/chair all day; therefore be it

RESOLVED, that our American Medical Association advocate that private and public insurance companies pay for a physician prescribed positioning chair for children who need support for sitting for daily activities in the home, in addition to the wheelchair that the patient uses for all mobility in the home and community. (Directive to Take Action)

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

Received: 9/23/2024

REFERENCES:
1. Ward, Marcie, et al. “Orthotics & Assistive Devices.” *Pediatric Rehabilitation: Principles and Practice*, 6th ed., demos Medical, New York, NY, 2020, pp. 196–229.
2. Child and Adolescent Health Measurement Initiative. 2022 National Survey of Children’s Health (NSCH) data query. Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved [04/13/24] from [www.childhealthdata.org].
3. Digiovine, Carmen P, et al. “Wheelchairs and Seating Systems.” *Bradom’s Physical Medicine and Rehabilitation*, 6th ed., Elsevier, 2021, pp. 261–290. *Clinical Key*, https://www-clinicalkey-com. ezproxy.shsu.edu/#!/content/book/3-s2.0-B978032362539500014X. Accessed 14 Apr. 2024.
4. Lisa I. Iezzoni, M. (2022, July 21). *Millions rely on wheelchairs for mobility, but repair delays are hurting users*. Harvard Health. https://www.health.harvard.edu/blog/millions-rely-on-wheelchairs-formobility-but-repair-delays-are-hurting-users-202207212785
5. Roberts, A. J. published (2021, October 13). *Wheelchair and power mobility for adults*. PM&R Knowledge Now. https://now.aapmr.org/wheelchair-and-power-mobility/# gaps-in-knowledge/evidence-base
6. Rinaldi, R. J., & Srinivasan, R. (2022). *Handbook of Pediatric Rehabilitation Medicine*. Springer Publishing Company. https://doi.org/10.1891/9780826184498
7. Inthachom R, Prasertsukdee S, Ryan SE, Kaewkungwal J, Limpaninlachat S. Evaluation of the multidimensional effects of adaptive seating interventions for young children with non-ambulatory cerebral palsy. *Disabil Rehabil Assist Technol*. 2021;16(7):780-788. doi:10.1080/17483107.2020.1731613
8. Harris SR, Roxborough L. Efficacy and effectiveness of physical therapy in enhancing postural control in children with cerebral palsy. *Neural Plast*. 2005;12(2-3):229-272. doi:10.1155/NP.2005.229
9. Angsupaisal M, Maathuis CG, Hadders-Algra M. Adaptive seating systems in children with severe cerebral palsy across International Classification of Functioning, Disability and Health for Children and Youth version domains: a systematic review. *Dev Med Child Neurol*. 2015;57(10):919-930. doi:10.1111/dmcn.12762

RELEVANT AMA POLICY

D-330.907 Our AMA strongly encourages the Centers for Medicare and Medicaid Services (CMS) to refrain from implementing policies on January 1, 2016 that would curtail access to complex rehabilitation technology (CRT) wheelchairs and accessories by applying competitively bid prices to these specialized devices. In the event that CMS does not refrain from implementing policies limiting access to CRT wheelchairs, our AMA will encourage Congress to support legislation (e.g. H.R. 3229) that would provide a technical correction to federal law to clarify that CMS cannot apply Medicare competitive bidding pricing to CRT wheelchairs.

H-185.91 Our American Medical Association supports health insurance coverage to eliminate barriers for patients to obtain wheelchair repair; ensure that repairs and services are safe, affordable, timely, and support mobility and independence for those who utilize power and manual wheelchairs; eliminate unnecessary paperwork and prior authorization requirements for basic repairs, including proof of continuous need; cover temporary rental of a substitute wheelchair when repairs require the primary wheelchair to be taken out of the home; and would include preventive maintenance and transporting the wheelchair between the patient’s home and the repair facility.

Our AMA will identify procedures for obtaining changes to Medicare and other payers’ current policies on repairing wheelchairs.

Our AMA supports suppliers of power and manual wheelchairs providing preventive maintenance and repair services for wheelchairs they supply to patients and permits consumers to perform self-repairs as permitted by the manufacturer and when it does not void the warranty.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 814
(I-24)

Introduced by: American Association of Clinical Urologists

Subject: Legislation for Physician Payment for Prior Authorization

Referred to: Reference Committee J

Whereas, policy H-385.951 Remuneration for Physician Services supports that insurers pay physicians fair compensation for work associated with prior authorizations, including pre-certifications and prior notifications, that reflects the actual time expended by physicians to comply with insurer requirements and that compensates physicians fully for the legal risks inherent in such work; and

Whereas, nearly 15 percent of all claims submitted to private payers for reimbursement are initially denied, including many that were pre-approved to move forward through the prior authorization process; and

Whereas, over half (54.3%) of denials by private payers were ultimately overturned and the claims paid, but only after multiple, costly rounds of provider appeals; and

Whereas, the average cost incurred by providers fighting denials is $43.84 per claim – meaning that providers spend $19.7 billion a year just to adjudicate with payers; therefore be it

RESOLVED, that our American Medical Association initiates prior authorization legislation aimed at Medicare Advantage plans, state Medicaid programs as well as commercial payers, via model legislation, that allows for fair reimbursement for physician's time and that of their office staff when dealing with prior authorization. (Directive to Take Action)

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

Received: 9/24/2024

REFERENCES

1. Trend Alert: Private Payers Retain Profits by Refusing or Delaying Legitimate Medical Claims, Premier, March 21, 2024 Premier Inc.

RELEVANT AMA POLICY

H-385.951 Remuneration for Physician Services

1. Our American Medical Association actively supports payment to physicians by contractors and third party payers for physician time and efforts in providing case management and supervisory services, including but not limited to coordination of care and office staff time spent to comply with third party payer protocols.

2. It is our AMA policy that insurers pay physicians fair compensation for work associated with prior authorizations, including pre-certifications and prior notifications, that reflects the actual time expended by physicians to comply with insurer requirements and that compensates physicians fully for the legal risks inherent in such work.
3. Our AMA urges insurers to adhere to the AMA's Health Insurer Code of Conduct Principles including specifically that requirements imposed on physicians to obtain prior authorizations, including pre-certifications and prior notifications, must be minimized and streamlined and health insurers must maintain sufficient staff to respond promptly.
[Sub. Res. 814, A-96; Reaffirmation A-02; Reaffirmation I-08; Reaffirmation I-09 Appended: Sub. Res. 126, A-10; Reaffirmed in lieu of Res. 719, A-11; Reaffirmed in lieu of Res. 721, A-11; Reaffirmation A-11; Reaffirmed in lieu of Res. 822, I-11; Reaffirmed in lieu of Res. 711, A-14; Reaffirmed: Res. 811, I-19; Reaffirmation: A-22; Reaffirmed: BOT Rep. 30, A-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 815
(I-24)

Introduced by: Society of Critical Care Medicine, American Academy of Pediatrics

Subject: Addressing the Crisis of Pediatric Hospital Closures and Impact on Care

Referred to: Reference Committee J

Whereas, there has been a concerning trend of pediatric hospital and unit closures across the United States, with inpatient pediatric units decreasing by 19.1% from 2008 to 2018, leading to reduced access to pediatric care, especially in rural areas[1,2]; and

Whereas, financial pressures, including low Medicaid reimbursement rates that vary by state, are putting many pediatric hospitals and units in financial distress, leading to consolidation and closures[3,4]; and

Whereas, the closure of pediatric units and hospitals has resulted in increased distances to care for nearly a quarter of U.S. children, potentially delaying critical care and worsening health outcomes[5]; and

Whereas, the consolidation of pediatric care into fewer, larger centers may improve care for some specialized conditions but can also create access barriers, increase costs, and disrupt established patient-provider relationships[6]; and

Whereas, the COVID-19 pandemic has exacerbated financial pressures on hospitals and highlighted the need for maintained pediatric inpatient and critical care capacity[7]; and

Whereas, the American Hospital Association has not taken a strong public stance on this critical issue affecting children's health care access; therefore be it

RESOLVED, that our American Medical Association recognize the closure of pediatric hospitals and units as a critical threat to children's health care access and quality (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for federal and state policies to support the financial viability and access to pediatric care delivery organizations, particularly inpatient care units (Directive to Take Action); and be it further

RESOLVED, that our AMA work with relevant organizations, for example the American Academy of Pediatrics, American Hospital Association, Children’s Hospital Association, and National Rural Health Association, to study the current and future projected impact of pediatric hospital and unit closures on health outcomes, access to care, and health disparities (Directive to Take Action); and be it further

RESOLVED, that our AMA build a national coalition with the American Hospital Association and other like-minded organizations to increase awareness on the issue of pediatric hospital closures and to develop strategies to preserve access to high-quality pediatric inpatient and critical care. (Directive to Take Action)

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

Received: 9/24/2024

REFERENCES

1. Baumgaertner E. As Hospitals Close Children's Units, Where Does That Leave Lachlan? The New York Times. https://www.nytimes.com/2022/10/11/health/pediatric-closures-hospitals.html. Published October 11, 2022.
2. Cushing AM, Bucholz EM, Chien AT, Rauch DA, Michelson KA. Availability of pediatric inpatient services in the united states. *Pediatrics*. 2021;148(1):e2020041723.
3. Miller B. Pediatrics and profits: Why children's hospital units are closing. Lown Institute. https://lowninstitute.org/pediatrics-and-profits-why-childrens-hospital-units-are-closing/. Published December 5, 2022.
4. Carbajal E. Hospitals cut pediatrics to make room for more lucrative adult patients. https://www.beckershospitalreview.com/care-coordination/hospitals-cut-pediatrics-to-make-room-for-more-lucrative-adult-patients.html. Beckers Hospital Review. Published October 11, 2022.
5. França UL, McManus ML. Trends in Regionalization of Hospital Care for Common Pediatric Conditions. Pediatrics. 2018;141(1):e20171940.
6. Miller E. The Cost of Yet Another Pediatric Hospital Closure. MedPage Today. https://www.medpagetoday.com/opinion/second-opinions/103419. March 7, 2023.
7. Mooz EL. End of an Era: The Closing of Tufts Children's Hospital, Putting Inpatient Pediatric Care in Context. Tufts CHSP. https://sites.tufts.edu/chsp/2022/04/08/end-of-an-era-the-closing-of-tufts-childrens-hospital-putting-inpatient-pediatric-care-in-context/. April 8, 2022.

RELEVANT AMA POLICY

Expanding AMA Payment Reform Work and Advocacy to Medicaid and Other Non-Medicare Payment Models for Pediatric Health Care and Specialty Populations (H-385.901)

1. Our American Medical Association supports appropriate demonstration projects, carve outs, and adjustments for pediatric patients and services provided to pediatric patients within the payment reform arena.
2. Our AMA will extend ongoing payment reform research, education, and advocacy to address the needs of specialties and patient populations not served by current CMMI models or other Medicare-focused payment reform efforts.
3. Our AMA will support and work with national medical specialty societies that are developing alternative payment models for specific conditions or episodes, target patient populations including pediatric populations, and medical and surgical specialties and continue to advocate that the Centers for Medicare and Medicaid Services, including the Center for Medicare and Medicaid Innovation; state Medicaid agencies; and other payers implement physician-developed payment models.
4. Our AMA will consider improved Medicaid payment rates to be a priority given the critical impact these payment rates have on patient care and patient access to care.
5. Our AMA will support and collaborate with state and national medical specialty societies and other interested parties on the development and adoption of physician-developed alternative payment models for pediatric health care that address the distinct prevention and health needs of children and take long-term, life-course impact into account. *Policy Timeline | Res. 817, I-23*

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 817
(I-24)

Introduced by: Minority Affairs Section

Subject: ACA Subsidies for Undocumented Immigrants

Referred to: Reference Committee J

Whereas, the uninsurance rate among undocumented immigrants is approximately 50% compared to 7.7% for U.S. residents, meaning that approximately 5 million undocumented immigrants are uninsured, which can lead to decreased access to care and poorer health outcomes[1-5]; and

Whereas, expanding health insurance coverage to undocumented immigrants improves access to care and health outcomes[6,7]; and

Whereas, undocumented immigrants may file federal taxes through the use of an Individual Taxpayer Identification Number (ITIN), but are not eligible for a Social Security Number, meaning that undocumented immigrants collectively pay billions into the tax system[8,9]; and

Whereas, the reporting of income to the federal government through ITINs may render undocumented immigrants ineligible for means-tested insurance programs like Medicaid based on their income, even if their state permits undocumented immigrants to enroll in Medicaid[1,10,11]; and

Whereas, undocumented immigrants are currently prohibited from purchasing insurance through the Affordable Care Act (ACA) marketplaces and are ineligible for premium tax credit and cost-sharing reduction subsidies[12-15]; and

Whereas, in order to fully realize the benefits of extending eligibility to purchase plans on the ACA marketplaces, undocumented immigrants would also need to be made eligible to receive premium tax credits and cost-sharing reductions, but are currently prohibited from receiving these subsidies[12]; and

Whereas, states including Colorado and Washington have implemented programs to provide state subsidies for undocumented immigrants to purchase health insurance on state exchanges, leading to 11,000 immigrants enrolling in subsidized coverage in Colorado in 2024[16]; and

Whereas, pending state and federal legislation would expand ACA premium tax credit and cost sharing reduction eligibility to undocumented immigrants, in addition to allowing them to purchase coverage through ACA marketplaces[17, 18]; and

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

RESOLVED, that our American Medical Association support federal and state efforts to provide subsidies for undocumented immigrants to purchase health insurance, including by extending

eligibility for premium tax credits and cost-sharing reductions to purchase Affordable Care Act (ACA) plans. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 9/24/2024

REFERENCES

1. Key facts on health coverage of immigrants. Kaiser Family Foundation. September 17, 2023.
2. New HHS report shows national uninsured rate reached all-time low in 2023 after record-breaking ACA enrollment period. HHS.gov. August 8, 2023. Accessed March 30, 2024. https://www.hhs.gov/about/news/2023/08/03/new-hhs-report-shows-national-uninsured-rate-reached-all-time-low-2023-after-record-breaking-aca-enrollment-period.html.
3. Chang CD. Social Determinants of Health and Health Disparities Among Immigrants and their Children. Current Problems in Pediatric and Adolescent Health Care. January 2019. https://www.sciencedirect.com/science/article/abs/pii/S1538544218301755?casa_token=GMzR54E9sNwAAAAA%3Aru3Dur4bcNMprf_PqYTHi-Q8K2D3PzKHjuQZqjcUkmVWaEEfdDsjG-IqMQhfJaa52BQUbXUx_w.
4. Douthit NT, Old C. Renal Replacement Therapy for Undocumented Immigrants: Current Models with Medical, Financial, and Physician Perspectives—a Narrative Review. August 6, 2019. https://link.springer.com/article/10.1007/s11606-019-05237-7.
5. Gostin LO. Is Affording Undocumented Immigrants Health Coverage a Radical Proposal? JAMA. October 15, 2019. https://jamanetwork.com/journals/jama/article-abstract/2752913.
6. Pintor JK, Call KT. State-Level Immigrant Prenatal Health Care Policy and Inequities in Health Insurance Among Children in Mixed-Status Families. Global Pediatric Health.
7. Cervantes L, Rizzolo K, Tummalapalli SL, Powe NR. Economic Impact of a Change in Medicaid Coverage Policy for Dialysis Care of Undocumented Immigrants. Journal of the American Society of Nephrology. July 2023. https://journals.lww.com/jasn/Fulltext/2023/07000/Economic_Impact_of_a_Change_in_Medicaid_Coverage.4.aspx.
8. Adding Up the Billions in Tax Dollars Paid by Undocumented Immigrants. American Immigration Council. April 4, 2016. https://www.americanimmigrationcouncil.org/research/adding-billions-tax-dollars-paid-undocumented-immigrants.
9. Individual Taxpayer Identification Number. Internal Revenue Service. January 4, 2024. Accessed March 1, 2024. https://www.irs.gov/individuals/individual-taxpayer-identification-number.
10. Bluth R. Bill to Expand Coverage to Migrants May Test Newsom's Pledge on Universal Health Care. California Healthline. February 27, 2023. https://californiahealthline.org/news/article/covered-california-bill-undocumented-immigrant-health-insurance/.
11. Dietz M, Lucia L, Kadiyala S, et al. California's uninsured in 2024: Medi-Cal expands to all low-income adults, but half a million undocumented Californians lack affordable coverage options. UC Berkeley Labor Center. May 30, 2023. Accessed March 30, 2024. https://laborcenter.berkeley.edu/californias-uninsured-in-2024/.
12. Health coverage for immigrants. HealthCare.gov. Accessed March 1, 2024. https://www.healthcare.gov/immigrants/.
13. Explaining Health Care Reform: Questions About Health Insurance Subsidies. KFF. October 30, 2023. https://www.kff.org/affordable-care-act/issue-brief/explaining-health-care-reform-questions-about-health-insurance-subsidies/.
14. Key Facts: Premium Tax Credit. Beyond the Basics. August 2023. https://www.healthreformbeyondthebasics.org/premium-tax-credits-answers-to-frequently-asked-questions/.
15. Cox C, McDermott D, Amin K. Impact of Key Provisions of the American Rescue Plan Act of 2021 COVID-19 Relief on Marketplace Premiums. KFF. March 15, 2021. https://www.kff.org/affordable-care-act/issue-brief/impact-of-key-provisions-of-the-american-rescue-plan-act-of-2021-covid-19-relief-on-marketplace-premiums/.
16. Scott D. The US doesn't have universal health care - but these states (almost) do. Vox. November 26, 2023. https://www.vox.com/policy/23972827/us-aca-enrollment-universal-health-insurance.
17. Giovannelli J, Schwab R. States Expand Access to Affordable Private Coverage for Immigrant Populations. Commonwealth Fund. February 8, 2024. https://www.commonwealthfund.org/blog/2024/states-expand-access-affordable-private-coverage-immigrant-populations.
18. S.2646 - HEAL for Immigrant Families Act of 2023. Congress.Gov. July 27, 2023. https://www.congress.gov/bill/118th-congress/senate-bill/2226.

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 HOUSE OF DELEGATES

Resolution: 818
(I-24)

Introduced by: New York

Subject: Payment for pre-certified/preauthorized procedures

Referred to: Reference Committee J

Whereas, many insurers require pre-certification/preauthorization for diagnostic and surgical procedures; and

Whereas, many insurers require extensive pre-approval/preauthorization documentation submission and approval process, and have ample opportunities to consider and request additional documentation to decide on approval or denial of the pre-certification request; and

Whereas, Current Procedural Terminology (CPT) codes defining the procedures/testing to be performed are routinely required under pre-certification/preauthorization process; and

Whereas, pre-certification/preauthorization process is both time and labor intensive; and

Whereas, certain Gold Card program waiving pre-certification/preauthorization requirement is under consideration by the NY State legislature; and

Whereas, insurers not infrequently deny payments for such pre-certified/preauthorized procedures; and

Whereas, such pre-certification/preauthorization process and post-procedure claim denial cause significant administrative burden on physician practice; therefore be it

RESOLVED, that our American Medical Association support the position that the practice of retrospective denial of payment for care which has been pre-certified by an insurer should be banned, except when false or fraudulent information has knowingly been given to the insurer by the physician, hospital or ancillary service provider to obtain pre-certification (New HOD Policy); and be it further

RESOLVED, that our AMA continue to advocate for legislation, regulation, or other appropriate means to ensure that all health plans including those regulated by ERISA, pay for services that are pre-authorized, or pre-certified by such health plan, including services that are deemed pre-authorized or pre-certified because the physician participates in a “Gold Card” program operated by that health plan. (Directive to Take Action)

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

Received: 9/24/2024

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 819
(I-24)

Introduced by: Society for Cardiovascular Angiography and Interventions; Outpatient Endovascular and Interventional Society; the American College of Radiation Oncology

Subject: Establishing a New Office-Based Facility Setting to Pay Separately from the Medicare Physician Fee Schedule for the Technical Reimbursement of Physician Services Using High-Cost Supplies.

Referred to: Reference Committee J

Whereas, Medicare Physician Fee Schedule (MPFS) reimbursement cuts have become so severe for certain non-facility services that, in 2024, 195 non-facility services are paid at rates less than the direct costs associated with those procedures, according to data from the Centers for Medicare and Medicaid Services (CMS)[1]; and

Whereas, in the 2025 PFS Proposed Rule, the number of non-facility services paid less than direct costs will grow to 300, a 50% increase[2]; and

Whereas, because these data do not account for other costs, including indirect costs and physician work, the number of services under the MPFS for which reimbursement does not even cover cost likely is much higher than 300 services; and

Whereas, non-facility services are increasingly unsustainable under the MPFS, which is a catalyst for (1) private practice closure[3], (2) site-of-service reimbursement disparities[4], (3) higher Medicare spending and beneficiary coinsurance as services migrate to high-cost sites of service[5], (4) reduced rural access to important specialty care services[6]; and

Whereas, non-facility services are critical to the MPFS (1) as a lowest cost option to Medicare beneficiaries[7], (2) for rural access where ambulatory surgical centers are not typically present[8], and (3) as an option during pandemics so hospitals can focus on the most vulnerable patients; and

Whereas, the migration of non-facility care to higher cost settings results in higher Medicare spending, higher Medicare beneficiary coinsurance, and reduced access to care[9]; and

Whereas, in many states, certificate of need laws and cost considerations are a barrier to ambulatory surgical centers, thus making hospitals the only site-of-service option outside of a non-facility setting[10]; and

Whereas, office-based services under the MPFS for which reimbursement does not cover cost predominantly utilize high-cost supplies and equipment; and

Whereas, the decades-long migration of high-cost supplies and equipment from the Hospital Outpatient Prospective Payment System to the PFS has not been accompanied by corresponding funding allocations and has contributed to the dilution of the MPFS; and

Whereas, in 2010, CMS removed high-cost Part B drugs from the PFS in 2010 due to similar concerns relating to the impact on the MPFS[11]; and

Whereas, the AMA RUC has recommended for many years that CMS separately identify and pay for high-cost disposable supplies priced more than $500[12]; and

Whereas, removing high-cost supplies from the PFS would (1) help to address the ongoing closures of non-facility centers, (2) bolster resources available for the PFS, and (3) meaningfully addresses site-of-service reimbursement differences; therefore be it

RESOLVED, that our American Medical Association study options to reform the Medicare Physician Fee Schedule by (1) removing high-cost supplies from the Medicare Physician Fee Schedule by establishing a new office-based facility setting to pay separately for the technical reimbursement of physician services using high-cost supplies (2) removing high-cost radiation therapy equipment from the Medicare Physician Fee Schedule by establishing a new case rate model for radiation oncology. (Directive to Take Action)

Fiscal Note: (Moderate – between $5,000 - $10,000

Received: 9/24/2024

REFERENCES

1. Data is based on 2024 Physician Fee Schedule Final Rule Total Non-Facility Reimbursement and Total Direct Costs
2. Data is based on 2025 Physician Fee Schedule Proposed Rule Total Non-Facility Reimbursement and Total Direct Costs
3. American Medical Association, Carol Kane, PhD, Recent Changes in Physicain Practice Arrangements: Shifts Away from Private Practice and Towards Larger Practice Size Continue Through 2022
4. Medicare Payment Advisory Commission, June 2024 Report to the Congress: Medicare and the Health Care Delivery System, 13 June 2024 Report
5. Ibid
6. Medicare Payment Advisory Commission, Ambulatory surgical center services: Status report, 11 January 2024
7. Medicare Payment Advisory Commission, June 2024 Report to the Congress: Medicare and the Health Care Delivery System, 13 June 2024 Report
8. Medicare Payment Advisory Commission, Ambulatory surgical center services: Status report, 11 January 2024
9. Medicare Payment Advisory Commission, March 2020 Report to the Congress: Medicare Payment Policy, 13 March 2020
10. National Conference of State Legislatures, Certificate of Need State Laws, 26 February 2024
11. CY 2010 PFS Proposed and Final Rules. 74 FR 33650 and 74 FR 61965
12. American Medical Association, February 2024 Recommendations

RELEVANT AMA POLICY

H-330.925 Appropriate Payment Level Differences by Place and Type of Service
Our AMA (1) encourages CMS to adopt policy and establish mechanisms to fairly reimburse physicians for office-based procedures; (2) encourages CMS to adopt a site neutral payment policy for hospital outpatient departments and ambulatory surgical centers; (3) advocates for the use of valid and reliable data in the development of any payment methodology for the provision of ambulatory services; (4) advocates that in place of the Consumer Price Index for all Urban Consumers (CPI-U), CMS use the hospital market basket index to annually update ambulatory surgical center payment rates; (5) encourages the use of CPT codes across all sites-of-service as the only acceptable approach to payment methodology; and (6) will join other interested organizations and lobby for any needed changes in existing and proposed regulations affecting payment for ambulatory surgical centers to assure a fair rate of reimbursement for ambulatory surgery. [Sub. Res. 104, A-98Reaffirmation I-98Appended: CMS Rep. 7, A-99Reaffirmation A-00Reaffirmation I-03Reaffirmation A-11Reaffirmed: CMS Rep. 3, A-13Reaffirmed: Sub. Res. 104, A-14Reaffirmed: Res. 116, A-14Modified: CMS Rep. 3, A-14Reaffirmation A-14 Reaffirmation A-15Reaffirmation: I-17]

D-330.902 The Site-of-Service Differential

1. Our American Medical Association supports Medicare payment policies for outpatient services that are site-neutral without lowering total Medicare payments.

2. Our AMA supports Medicare payments for the same service routinely and safely provided in multiple outpatient settings (eg, physician offices, HOPDs, and ASCs) that are based on sufficient and accurate data regarding the actual costs of providing the service in each setting.

3. Our AMA will urge CMS to update the data used to calculate the practice expense component of the Medicare physician fee schedule by administering a physician practice survey (similar to the Physician Practice Information Survey administered in 2007-2008) every five years, and that this survey collect data to ensure that all physician practice costs are captured.

4. Our AMA encourages CMS to both:
a. Base disproportionate share hospital payments and uncompensated care payments to hospitals on actual uncompensated care data.
b. Study the costs to independent physician practices of providing uncompensated care.

5. Our AMA will collect data and conduct research both:
a. to document the role that physicians have played in reducing Medicare spending.
b. to facilitate adjustments to the portion of the Medicare budget allocated to physician services that more accurately reflects practice costs and changes in health care delivery.

6. Our AMA will produce a graphic report illustrating the fiscal losses and inequities that practices without facility fees have endured for decades as a result of the site of service differential factoring in inflation.

7. Our AMA will consider disseminating the resulting educational materials and graphics.
[CMS Rep. 04, I-18Reaffirmed: BOT Action in response to referred for decision Res. 111, A-19Reaffirmed: BOT Action in response to referred for decision Res. 132, A-19Appended: Res. 826, I-22]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 820
(I-24)

Introduced by: American Thoracic Society

Subject: State Medicaid Coverage of Home Sleep Testing

Referred to: Reference Committee J

Whereas, sleep disordered breathing, most commonly obstructive sleep apnea, is a chronic health concern for millions of Americans; and

Whereas, there are effective interventions to treat patients with sleep disordered breathing that reduces risk of death and cardiopulmonary disease while improving overall well-being, alertness and reductions in daytime fatigue; and

Whereas, home-based sleep testing is an effective and inexpensive way to detect sleep disordered breathing in patients suspected of sleep disordered breathing; and

Whereas, prior to the development of home testing, patients were required to undergo facility-based polysomnography to confirm the diagnosis of sleep disordered breathing; and

Whereas, facility base polysomnography is effective, it added costs and inconvenience for patients seeking to confirm a diagnosis of sleep disordered breathing; and

Whereas. Medicare has covered home sleep apnea testing for several years; and

Whereas, very few state Medicaid programs have allowed home sleep testing for sleep apnea and instead require facility-based polysomnography to confirm the diagnosis of sleep disordered breathing; and

Whereas, the requirement of facility-based polysomnography is a barrier to care for many Medicaid beneficiaries, leading to undertreatment of sleep disordered breathing in the Medicare population; therefore be it

RESOLVED, that our American Medical Association support efforts to expand access to and insurance coverage of home sleep testing, including for Medicaid beneficiaries, for the purpose of identifying sleep apnea and related sleep conditions. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 9/24/2024

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Late Resolution: 821
(I-24)

Introduced by: American Thoracic Society
American Academy of Allergy Asthma and Immunology

Subject: Patient Access to Asthma Medications

Referred to: Reference Committee J

Whereas, for children with asthma, inhaled corticosteroids (ICS) are an essential intervention to help patients control their asthma

Whereas, for young children, inhaled corticosteroids in metered dose inhaler (MDI) format, with a spacer and mask, are the most effective way to deliver inhaled asthma medications; and

Whereas, in the US there are a limited number of FDA approved inhaled corticosteroids in MDI formulation on the market; and

Whereas, fluticasone HFA is currently the most widely used ICS to treat pediatric asthma; and

Whereas, the transition of fluticasone HFA from a branded product to a generic product has caused significant disruption in Medicaid coverage for fluticasone HFA with some states having no ICS in MDI formulation on the preferred drug list while other states only cover ICS in MDI formulation with prior authorization; and

Whereas, the disruption in Medicare beneficiary access to appropriate asthma medication has led to anecdotal reports of avoidable asthma exacerbations and significant frustration for patients and physicians; and

Whereas, pulmonary and allergy medical professional societies have contacted state Medicaid programs to urge changes in Medicaid coverage policy to ensure appropriate access to a least one ICS in MDI formulation for young patients with asthma; therefore be it

RESOLVED, that our American Medical Association supports efforts to ensure access to and insurance coverage, including Medicaid coverage, for metered-dose inhaler formulations for children and others who require it for optimal medication administration. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 9/24/2024

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 822
(I-24)

Introduced by: Renal Physicians Association

Subject: Resolution on Medicare Coverage for Non-Emergent Dialysis Transport

Referred to: Reference Committee J

Whereas, access to dialysis is critical for patients with end-stage renal disease (ESRD), ensuring they receive life-saving treatments multiple times a week[11]; and

Whereas, studies have shown that barriers to transportation are a determinant of healthcare access and patient outcomes[10]; and

Whereas, non-emergent medical transportation (NEMT) is essential for many dialysis patients who are unable to transport themselves due to medical or financial constraints[8]; and

Whereas, according to the United States Department of Transportation, 66% of rural Americans live in an area where there is no access to public transportation, or public transportation is negligible[4]; and

Whereas, many dialysis patients are elderly or have comorbid conditions that limit their ability to use public or personal transportation[6]; and

Whereas, at least 22% of missed dialysis appointments can be attributed to lack of transportation[9]; and

Whereas, 84% of nephrology social workers state that patients' dialysis treatments are not completed due to public transportation, and 72% of nephrology social workers state that patients miss dialysis completely due to unreliability of public transportation[4]; and

Whereas, when dialysis access was compared across countries, shortened or missed dialysis treatments as a result of transportation disproportionately impacted patients in the United States4; and

Whereas, shortened or missed dialysis appointments as a result of transportation disproportionately impacted minority populations in the United States[4]; and

Whereas, reliable transportation to dialysis treatments is crucial for maintaining patients' health and preventing complications associated with missed dialysis sessions[4]; and

Whereas, emergency dialysis services cost the health system nearly $72,000 more per person annually than scheduled dialysis appointments[5]; and

Whereas, non-emergent dialysis transport can reduce the burden on emergency medical services and emergency departments by preventing avoidable crisis[1]; and

Whereas, the Centers for Medicare & Medicaid Services (CMS) currently does not cover non-emergent dialysis transport under Medicare[3]; and

Whereas, over 80% of Americans living with ESRD are enrolled in Medicare[6]; and

Whereas, Providing Medicare coverage for non-emergent dialysis transport can reduce healthcare costs by preventing missed dialysis sessions and subsequent hospitalizations, and alleviate the burden on primary care providers by eliminating unnecessary paperwork for ambulance transfers[1,7]; and

Whereas, ensuring access to regular dialysis treatments through adequate transportation can improve the quality of life and support better long-term health outcomes for ESRD patients[2]; and

Whereas, non-emergent dialysis transport coverage could align with broader efforts promote health equity[4]; therefore be it

RESOLVED, that our American Medical Association advocate for Medicare coverage of non-emergent medical transportation specifically for patients requiring dialysis treatment (Directive to Take Action); and be it further

RESOLVED, that our AMA partner with Center for Medicare and Medicaid Services (CMS) to develop policies to ensure financial assistance for non-emergent medical transportation for dialysis treatments and to transplant centers for kidney transplant evaluation and related care for Medicare beneficiaries. (Directive to Take Action)

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

Received: 9/24/2024

References:

1. Bartolacci J, Goldstein J, Kiberd B, Swain J, Vinson A, Clark D. *Burden of Emergency Medical Services Usage by Dialysis Patients*. Prehospital Emergency Care. Published online 2018. doi:https://doi.org/10.1080//10903127.2018.1454558

2. Chan KE, Thadhani RI, Maddux FW. Adherence Barriers to Chronic Dialysis in the United States. *Journal of the American Society of Nephrology*. 2014;25(11):2642-2648. doi:https://doi.org/10.1681/asn.2013111160

3. Dialysis services & supplies. Medicare. Published 2024. Accessed September 20, 2024. https://www.medicare.gov/coverage/dialysis-services-supplies#:~:text=What%20will%20I%20pay%20for,will%20pay%20the%20remaining%2080%25

4. Ellis E, Knapp S, Quan J, Sutton W, Regenstein M, Shafi T. *Dialysis Transportation: The Intersection of Transportation and Healthcare*. Published online August 14, 2019. doi:https://doi.org/10.17226/25385

5. Lavingia R, Raghavan R, Morain SR. Emergency-Only Hemodialysis Policies: Ethical Critique and Avenues for Reform. *The Journal of Law, Medicine & Ethics*. 2020;48(3):527-534. doi:https://doi.org/10.1177/1073110520958877

6. Lin D, Cui J. T*ransport and Mobility Needs for an Ageing Society from a Policy Perspective: Review and Implications*. International Journal of Environmental Research and Public Health. 2021;18(22):11802-11802. doi:https://doi.org/10.3390/ijerph182211802

7. Medicare. National Kidney Foundation. Published August 13, 2024. Accessed September 20, 2024. https://www.kidney.org/kidney-topics/medicare#:~:text=Medicare%20is%20not%20just%20for,not%20related%20to%20kidney%20disease

8. Park S, Kear TM. *Current State-of-Practice: Transportation for Patients with End Stage Renal Disease*. Nephrology Nursing Journal. 2017;44(4):309-315.

9. Transportation Issues and Their Impact upon In-Center Hemodialysis. National Kidney Foundation. https://www.kidney.org/sites/default/files/v23_a6.pdf

10. Wolfe MK, McDonald NC, Holmes GM. *Transportation Barriers to Health Care in the United States: Findings From the National Health Interview Survey, 1997-2017*. American Journal of Public Health. 2020;110(6):815-822. doi:10.2105/AJPH.2020.305579

11. Wouk N. *End-Stage Renal Disease: Medical Management*. American Family Physician. 2021;104(5):493-499

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 823
(I-24)

Introduced by: Louisiana

Subject: Reigning in Medicare Advantage - Institutional Special Needs Plans

Referred to: Reference Committee J

Whereas, addressing the many issues plaguing Medicare Advantage plans is one of the top advocacy priorities for the AMA; and

Whereas, to date these advocacy efforts have been contained, for the most part, to traditional Medicare Advantage plans; and

Whereas, Institutional Special Needs Plans or I-SNPs were designed as a subset of traditional Medicare Advantage plans to serve the ever-growing frail, disabled, and chronically ill population within a nursing facility; and

Whereas, federal regulations within the Centers for Medicare and Medicaid (CMS) provide little to no oversight over I-SNPs, allowing nursing facilities to own and operate their own I-SNPs; and

Whereas, when an I-SNP is owned by the nursing facility, there is an inherent conflict of interest because the plan, acting as an insurer, can deny coverage for care, even care within its own skilled nursing facility; and

Whereas, these I-SNPs typically utilize nurse practitioners to manage their patient populations, even when the patients already have a primary care physician who has no relationship with the ISNP nor a collaborative practice agreement with the ISNP nurse practitioner; and

Whereas, these conflicts of interest, and lack of physician participation or supervision, place our most vulnerable elderly patients at risk based on health care decisions being made for profits over outcomes, and/or without physician involvement; therefore be it

RESOLVED, that our American Medical Association add I-SNPs to its advocacy efforts related to Medicare Advantage plans (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for increased policies, rules, and general oversight over I-SNPs (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for an overall ban on facility-owned I-SNPs. (Directive to Take Action)

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

Received: 9/23/2024

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 824
(I-24)

Introduced by: American Academy of Ophthalmology

Subject: Ophthalmologists Required to Be Available for Level I & II Trauma Centers

Referred to: Reference Committee J

Whereas, the Level of Hospital Trauma Centers (I – V) are designated at the State and Local Levels but are verified by the American College; and

Whereas, Level I & II require coverage by medical and surgical specialists where Ophthalmology is not specifically listed; and

Whereas, the Level of Hospital Trauma Centers (I -V) are designated at the State and Local Levels but are verified by the American College of Surgeons; and

Whereas, Level I & II require coverage by medical and surgical specialists where Ophthalmology is not specifically listed; and

Whereas, the second largest University Hospital in New Jersey which is a Level I Trauma Center is permitting optometrists to take first call in the ER; and

Whereas, optometrists do not have the education or training to care for severe ocular or periocular trauma; and

Whereas, designation of a Level Trauma Center identifies that Hospital as the place that treats severe trauma including eye trauma; and

Whereas, having optometrists providing first call in a designated Trauma Center creates a huge advocacy problem for our Scope of Practice Partnership, preventing optometric surgery; therefore be it

RESOLVED, that our American Medical Association work with the American College of Surgeons and the American Trauma Society to specifically name Ophthalmology as a requirement for Level I & II Trauma Centers (Directive to Take Action); and be it further

RESOLVED, that our AMA work with the American College of Surgeons and the American Trauma Society to ensure that during the verification process it has to be insisted that there is availability of Ophthalmology Trauma coverage. (Directive to Take Action)

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

Received: 9/24/2024

Reference Committee K

Report(s) of the Board of Trustees

07 Reevaluation of Scoring Criteria for Rural Communities in the National Health Service Corps Loan Repayment Program
11 Carbon Pricing to Address Climate Change

Report(s) of the Council on Science and Public Health

01 Cannabis Therapeutic Claims in Marketing and Advertising
02 Drug Shortages: 2024 Update
03 HPV-Associated Cancer Prevention
04 Reducing Sodium Intake to Improve Public Health
05 Teens and Social Media

Resolutions

901 Heat Alerts and Response Plans
902 Advancing Menopause Research and Care
903 Improving the Identification of Intimate Partner Violence (IPV) in People with Disabilities
904 Regulation of Ionized Radiation Exposure for Healthcare Workers
905 Regulation and Transparency of Contaminants in Menstrual Hygiene Products
907 Call for Study: The Need for Hospital Interior Temperatures to be Thermally Neutral to Humans within Those Hospitals
909 Support of Universal School Meals for School Age Children
910 Food Insecurity Among Patients with Celiac Disease, Food Allergies, and Food Intolerance
911 Adequate Masking and HPV Education for Health Care Workers (including those over age 45)
912 Assuring Representation of Older Age Adults in Clinical Trials
913 Sexually Transmitted Infections are on the Rise in the Senior Population
915 Reducing Barriers in Sports Participation for LGBTQIA+ People
916 Access to Healthcare for Transgender and Gender Diverse People in the Carceral System
917 Mpox Global Health Emergency Recognition and Response
918 Healthcare in Tribal Jails
919 Improving Rural Access to Comprehensive Cancer Care Service
920 Revise FAA Regulations to Include Naloxone (Narcan) in the On-Board Medical Kit for Commercial Airlines flying within the Continental United States
922 Advocating for the Regulation of Pink Peppercorn as a Tree Nut
923 Updated Recommendations for Child Safety Seats
926 Development of Climate Health Education Tools for Physicians
928 Public Safety Agencies Data Collection Enhancement
929 Safety Concerns Regarding Inadequate Labeling of Food Products Upon Ingredient Changes with Known Major Food Allergens
930 Economic Factors to Promote Reliability of Pharmaceutical Supply

REPORT OF THE BOARD OF TRUSTEES

B of T Report 07-I-24

Subject:	Re-evaluation of Scoring Criteria for Rural Communities in the National Health Service Corps Loan Repayment Program (Resolution 307-I-23)
Presented by:	Michael Suk, MD, JD, MPH, MBA, Chair
Referred to:	Reference Committee K

INTRODUCTION

Resolution 307-I-23, submitted by the Idaho Delegation, asked that the AMA "advocate, in partnership with other major medical associations at the federal level, for a comprehensive reevaluation and assessment of the effectiveness and equity of the Health Professional Shortage Area scoring criteria employed by the National Health Service Corps Loan Repayment Program with appropriate revisions to meet the physician workforce needs for the neediest rural communities and underserved areas." (Directive to Take Action)

Testimony was supportive of this item and cited concerns about bias in scoring as well as the need for a comprehensive reevaluation and assessment of the effectiveness and equity of the Health Professional Shortage Area (HPSA) scoring criteria. Testimony noted there is a Shortage Designation Modernization Project underway by the federal government. The resolution was referred.

BACKGROUND

The National Health Service Corps (NHSC) is a "federal government program administered by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Bureau of Health Workforce, and created to address a growing primary care workforce shortage. Since 1972, the National Health Service Corps has been building healthy communities, ensuring access to health care, preventing disease and illness, and caring for the most vulnerable populations who may otherwise go without care. National Health Service Corps programs provide scholarships and student loan repayment to health care professionals in exchange for a service commitment to practice in designated HPSAs."[1] NHSC has granted scholarships and operated loan repayment programs for over 50 years to support about 75,000 primary care physicians, dentists, and behavioral health providers who supply health care services, regardless of a patient's ability to pay, in communities with significant health professional shortages.[2]

Loan Repayment Program

For physicians, the NHSC Loan Repayment Program has traditionally provided primary care specialists (as well as dentists and mental and behavioral health care clinicians) with up to $50,000 toward student loans in exchange for their service in an underserved community.[3] In 2024, NHSC "increased the award amount for physicians, nurse practitioners, certified nurse midwives, and physician assistants who provide primary care services in high-need communities (located in a

primary care HPSA) to address the critical shortages of these practitioners" such that primary care awardees can receive up to $75,000 for a full-time, two-year commitment or up to $37,500 for a half-time, two-year commitment. Further, they will provide a one-time enhancement award of $5,000 for those awardees with Spanish-language proficiency (for a total of up to $80,000/ $42,500) if they can pass a Spanish-language competency assessment. Non-primary care participants are also eligible but at a lower amount of up to $55,000/$30,000.

To determine eligibility for the loan repayment program, an individual must be:

- "A United States citizen (U.S. born or naturalized) or a United States national.
- A provider (or eligible to participate as a provider) in the Medicare, Medicaid, and the State Children's Health Insurance Program, as appropriate.
- Fully trained and licensed to practice in the NHSC-eligible discipline and state in which you are applying to serve. [The HRSA website] lists eligible disciplines and specialties for primary care, dental care, mental/behavioral health care, and maternity care.
- A health professional in an eligible discipline with qualified student loan debt for education that led to your degree.
- Working at an NHSC-approved site."[4]

To apply to the loan repayment program, an MD or DO must be board certified in family medicine, general internal medicine, general pediatrics, obstetrics/gynecology, psychiatry, or geriatrics and willing to serve at least two years at an NHSC-approved site in a HPSA.[5] The NHSC website provides additional information regarding the sections of the online application, required supporting documentation, and additional supplemental documentation if applicable. Applicants can access the Bureau of Health Workforce Customer Service Portal to view their application status. The NHSC loan repayment program Fiscal Year 2024 Application and Program Guidance document provides detailed information to applicants. Also, the NHSC provides several links to resources for applicants on their website https://nhsc.hrsa.gov/loan-repayment/selection-factors.

Health Professional Shortage Areas

Definition and Governance

A HPSA is defined in the Public Health Service Act as being "any of the following which the Secretary determines has a shortage of health professional(s):

1. An urban or rural area (which need not conform to the geographic boundaries of a political subdivision and which is a rational area for the delivery of health services);
2. a population group; or
3. a public or nonprofit private medical facility."[6]

The statue that governs this program is 42 U.S. Code 254e "Health Professional Shortage Areas."[11] [7] Additional information about HPSAs can be found at https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation. HRSA provides a search tool of current HPSA sites and related data at https://data.hrsa.gov/tools/shortage-area/hpsa-find.

Scoring Criteria

Applications for shortage designations are received from state primary care offices. Once an area is designated, NHSC calculates a score using the Shortage Designation Management System (SDMS), which contains standard national data sets. Supplemental data is provided by state primary care offices and facilities. HPSA scores are calculated based on methodology that includes three disciplines: primary care, dental health, and mental health. Common across all HPSA disciplines are three scoring criteria: population-to-provider ratio, percent of the population with

incomes below 100% of the Federal Poverty Level (FPL), and travel time to the nearest source of care (NSC) outside the HPSA designation area. The scoring details for each element are listed in Appendix A. According to HRSA, the scores range from 0 to 25 "where the higher the score, the greater the priority."[8] In sum, the scoring calculation reads as follows:

(Image reprinted with permission from the Shortage Designation Branch, HRSA.)

According to the notice "Criteria for Determining Priorities Among Health Professional Shortage Areas" in the Federal Register, "a scale is developed for scoring each factor. The scale generally includes five scoring levels, and reflects different patient utilization patterns for primary care, dental, and mental health services. Relative weights for the various factors are established, based on the significance of the factors in determining a shortage. Each HPSA is scored on each factor. The factor scores are weighted and summed for each HPSA. The total scores for each HPSA are ranked from highest to lowest for each HPSA category. A level is selected annually to identify the boundary between the HPSAs of greatest shortage and all other HPSAs. Those HPSAs with total scores equal to or greater than the selected boundary level within each category are identified as the HPSAs of greatest shortage."[9] HRSA publishes, before July 1 of each year, the minimum HPSA score for NHSC scholars who are in their final year of training. NHSC approved sites must meet this score by class year (CY). For primary care, the scores are as follows: CY 2021= 20; CY 2022 = 20; CY 2023 = 18; CY 2024 = 19; and CY 2025 = 19.[10] Additional information about the HPSA score and NHSC Scholar requirements can be found at https://nhsc.hrsa.gov/scholarships/requirements-compliance/jobs-and-site-search.

HRSA Shortage Designation Modernization Project

HRSA first launched the Shortage Designation Modernization Project in 2013 with the goal of creating efficiencies. In Phase I, the SDMS was established. This tool allowed state primary care offices to manage their health workforce data, apply for HPSA and Medically Underserved Areas/Populations designation, and request automatic (auto-)HPSA rescores. The SDMS was also used to review shortage designation applications, communicate with state primary care offices, and review auto-HPSA rescore requests. Phase II in 2017 saw the completion of the first National Shortage Designation Update of geographic, population, and facility HPSA designations (not including those automatically-designated). In Phase III in 2019, HRSA completed the first National Shortage Designation Update of auto-HPSAs.

During Phase IV, HRSA hosted a webinar in March 2021 entitled "National Shortage Designation 2.0" to provide updated information. Also, HRSA gathered public comment regarding the HPSA scoring criteria and Maternity Care Target Areas, and the SDMS was updated. Also, the due date for Statewide Rational Service Areas plans was moved to March 31, 2024, while addressing how these plans will be submitted and reviewed in the SDMS. The responses to the public comment were reviewed and the Shortage Designation Branch of HRSA is determining the optimal way to share the results, which will inform HRSA's options and next steps in modernizing the current HPSA scoring methodology. The AMA contacted HRSA in June 2024 and was told Phase IV is ongoing.

NHSC Sites

To become an NHSC-approved site, NHSC provides a Site Reference Guide and makes available their eligibility requirements. NHSC-approved sites provide outpatient, comprehensive primary health care services to people in HPSAs. "Eligible sites providing comprehensive primary care must become NHSC-approved BEFORE recruiting participants or supporting loan repayment applications from their existing clinician staff."[1] Once approved, sites may be able to recruit individuals into not only the scholarship program and loan repayment program discussed previously, but also the NHSC Students to Service Loan Repayment Program, Substance Use Disorder Workforce Loan Repayment Program, and Rural Community Loan Repayment Program.

Where Physicians Serve

HRSA provides data on those who serve in their programs. Their Field Strength Dashboard allows users to search and filter by specific subsets of data such as year, program, region, state, site type, rural status, provider type, site HPSA score, clinical discipline, ethnicity, race, and gender. Data is presented as of September 30 of a given fiscal year. For example, when filtering by "2023," "rural," "primary care," and "physician," results show a total of 680 participants across the country in such programs. The top five states with the most participating primary care physicians were Missouri (60), Michigan (50), Alaska (36), New York (31), and Arizona (30). Comparatively, the five states and U.S. territories with the lowest numbers were North Dakota (4), Pennsylvania (3), South Dakota (3), Delaware (1), and Guam (1).[11]

To aid interested and involved physicians and non-physician providers, HRSA provides the Health Workforce Connector database to identify NHSC sites as well as employment and training opportunities. Also, the NHSC Empowerment Initiative provides a curriculum intended to "equip NHSC participants with the information they need to succeed as they enter the workforce and begin caring for patients with complex medical needs and barriers to care and guide NHSC-approved sites in their efforts to support clinician well-being and develop organizational resilience."[10]

DISCUSSION

Resolution Author Concern

The original author of Resolution 307-I-23 cited concerns about the lack of NHSC approved HPSAs in Idaho, particularly as it relates to rural health and an applicant's ability to serve in Idaho pending the HPSA scores. According to the dashboard cited above, Idaho had only 12 primary care physicians serving in rural sites in 2023.[11] A search of all counties in Idaho on the HPSA Find tool indicated the following (most of which were listed as having "rural" or "partially rural" status):

- 12 geographic HPSAs (with one labeled as "high need")
- 2 low-income migrant farmworker population HPSAs
- 30 low-income population HPSAs
- 15 federally qualified health centers (FQHCs)
- 7 Indian Health Service, Tribal Health, and Urban Indian Health Organizations
- 31 rural health clinics
- 4 correctional facilities.[8]

Among these 101 HPSAs, only 26% of them scored 16 or higher. The HRSA website indicates that a level is selected annually to identify the boundary between the HPSAs of greatest shortage and all

other HPSAs but does not provide the annual determination. Therefore, the cut-off score is unclear from year to year. This lack of transparency may further fuel frustrations.

Concerns From Others

Entities have raised concerns about the HPSA scoring criteria. For example, the National Organization of State Offices of Rural Health (NOSORH) conducted an analysis in 2020 of HPSA scoring for Primary Medical Care HPSAs to provide comments on the HRSA/Bureau of Health Workforce request for information on the HPSA scoring criteria. The analysis "focused on the number and percentage of Primary Medical Care HPSAs which received a score of 16 or higher – the effective cutoff point for potential assignment of NHSC personnel."[12] It found that:

- few geographic Primary Medical Care HPSAs scored above 16;
- fewer than half of rural Primary Medical Care Population HPSAs and Rural Health Clinic HSPAs received NHSC-qualifying scores; and
- there is a low percentage of NHSC-qualifying rural Primary Medical Care FQHC HPSAs (compared to non-rural).[12]

Related listening sessions with member SORHs noted:

- Difficulties for geographic and low-income population HPSAs in rural areas to achieve NHSC-qualifying scores,
- Rural Health Clinic HPSAs and Indian Health Service/Tribal facility HPSAs as well as small rural population, remote rural, and frontier HPSAs do not receive scores which accurately reflect their needs.
- Current health indicators used in HPSA-scoring do not adequately measure HPSA health status,
- SDMS data are insufficient in many areas, and
- States have differential abilities to correct and supplement the SDMS dataset.[12]

As a result, NOSORH recommended that HRSA modify their scoring mechanism to more accurately reflect the severity of need within rural and frontier areas (for primary medical care, mental health, and dental health HPSAs as well as geographic, population and auto-scored facility HPSAs). NOSORH recommended further changes such as:

- Scoring measures
    - Add a factor to the scoring process that reflects the rurality of a HPSA's location.
    - Revise the factors used to measure population health status and health disparities and that a planning group be convened to identify and select such factors.
    - Revise the factors used in the measurement of distance/travel time, led by a planning group charged with identifying and selecting an appropriate redefinition.
    - Revise the factors used in the measurement of low-income population such that it be adjusted to include the low-income population with incomes below 200% of the Federal Poverty Level, as well as consideration for the uninsured population.
    - Revise the formula used to calculate facility HPSA scores for FQHCs, RHCs, and Indian Health Service-Tribal Facilities and use standardized approaches to service area definition, service population calculation, and calculation of low-income population.
- Scoring scales and factor weighting
    - Revise scoring scales to rule out bias against small rural and frontier HPSAs.
    - Revise the weighting of scoring so that the weights given to measure components are standardized, led by a planning group charged with creating revised scoring formulae for all HPSA disciplines.
- Scoring process

    - Establish a distinct scoring process just for small rural and frontier HPSAs.
    - Allow service areas to be designated as both geographic and population HPSAs.
    - Develop a more accurate national dataset for designation, recognizing the limits of the SDMS national provider dataset.
    - Increase investment in state capacity to assess HPSAs.[12]

Details related to these recommended changes can be found on the NOSORH website.

AMA EFFORTS

The Council on Medical Education issued a report on Rural Health Physician Workforce Disparities that was adopted at the Special November 2021 meeting. In March 2023, the AMA sent a letter to Senators Bernie Sanders and Bill Cassidy of the Committee on Health, Education, Labor and Pensions. Specific to this topic, the letter asked that:

- additional funding be provided to bolster the scholarship aspect of the NHSC program,
- NHSC program provide intensive and frequent counseling to NHSC scholars as they enter and then proceed through the NHSC program, and
- NHSC be expanded to include more scholarships, greater loan forgiveness, and the inclusion of all medical specialties in need.

RELEVANT AMA POLICIES

The AMA has policy in support of the National Health Service Corps (NHSC) and their Loan Repayment Program as well as physician workforce related to the needs of rural communities and underserved areas. While policy does address Health Professional Shortage Areas, it does not specifically denote scoring criteria. Full policies are listed in Appendix B and in the Policy Finder.

- Effectiveness of Strategies to Promote Physician Practice in Underserved Areas D-200.980
- Principles of and Actions to Address Medical Education Costs and Student Debt H-305.925
- Educational Strategies for Meeting Rural Health Physician Shortage H-465.988
- Difficulties in the Fulfillment of National Health Service Corps Contractual Obligations H-200.991
- Access to and Quality of Rural Health Care H-465.997
- Primary Care Physicians in Underserved Areas H-200.972

Additional policies include:

- Access to Physician Services in Rural Health Clinics H-465.984
- Rural Health Physician Workforce Disparities D-465.997
- Improving Rural Health H-465.994
- Diversity in the Physician Workforce and Access to Care D-200.982
- Enhancing Rural Physician Practices H-465.981
- Teleconsultations And Medicare Reimbursement D-480.997

SUMMARY AND RECOMMENDATIONS

HPSAs serve a critical function in determining areas of greatest need. Such determinations impact the resources and NHSC scholars deployed to said areas. The HRSA Shortage Designation Modernization Project has been underway for over a decade, but next steps have not yet been made clear. Reevaluation of the scoring criteria as well as greater clarity and transparency are recommended to better inform all interested parties.

The analysis by NOSORH illuminated inequities in the process, whereby many HPSAs do not seem to receive scores that reflect their actual need and health indicators do not adequately measure health status. These problems can lead to significant negative impacts on underserved populations. The actionable changes, such as those recommendations by NOSORH, can lead the way to better outcomes.

Therefore, the Board of Trustees recommends that the following recommendations be adopted and the remainder of the report be filed:

1. Our AMA supports the efforts of the Health Resources and Services Administration (HRSA) to conduct a comprehensive reevaluation and assessment of the effectiveness and equity of the Health Professional Shortage Area scoring criteria in order to meet the physician workforce needs of rural communities and underserved areas. (New HOD Policy)

2. Our AMA urges increased federal and state resources to improve the accuracy of the Shortage Designation Management System (SDMS) data used to determine Health Professional Shortage Area (HPSA) scoring.

3. AMA policies D-200.980, H-305.925, H-465.988, and H-200.991, which support funding for NHSC and loan repayment programs, be reaffirmed.

4. AMA policy H-465.997, which supports efforts to place NHSC physicians in underserved areas, be reaffirmed.

5. AMA policy H-200.972, which supports efforts to increase recruitment and retention of physicians to practice in HPSAs, be reaffirmed.

Fiscal note: $1,000

APPENDIX A – HPSA scoring criteria:

Score for population-to-full-time-equivalent primary care physician (PCP) ratio:

- Ratio > 10,000:1, or no PCPs and population greater than or equal to (GE) 2500 = 5 points
- 10,000:1 > Ratio GE 5,000:1, or no PCPs and population GE 2000 = 4 points;
- 5,000:1 > Ratio GE 4,000:1, or no PCPs and population GE 1500 = 3 points;
- 4,000:1 > Ratio GE 3,500:1, or no PCPs and population GE 1000 = 2 points;
- 3,500:1 > Ratio GE > 3,000:1, or no PCPs and population GE 500 = 1 point.[9]

Score for percent of population with incomes below poverty level (P):

- P GE 50% = 5 points;
- 50% > P GE 40% = 4 points;
- 40% > P GE 30% = 3 points;
- 30% > P GE 20% = 2 points;
- 20% > P GE 15% = 1 point;
- P GE < 15% = 0 points.[9]

Score for travel distance/time to nearest source of accessible care outside the HPSA:
Nearest source of care is defined as the closest location where the residents of the area or population can access comprehensive primary care services.

- Time GE 60 minutes or distance GE 50 miles = 5 points;
- 60 min > time GE 50 min or 50 mi > distance GE 40 mi = 4 points;
- 50 min > time GE 40 min or 40 mi > distance GE 30 mi = 3 points;
- 40 min > time GE 30 min or 30 mi > distance GE 20 mi = 2 points;
- 30 min > time GE 20 min or 20 mi > distance GE 10 mi = 1 point;
- Time < 20 min or distance < 10 mi = 0 points.[9]

For primary care, the scoring also includes the Infant Health Index, which evaluates both the infant mortality rate (IMR) and low birth weight (LBW) rate and awards points based on the one with the higher score.

- IMR GE 20 or LBW GE 13 = 5 points;
- 20>IMR>18 OR 13>LBW>11 = 4 points;
- 18>IMR>15 or 11>LBW>10 = 3 points;
- 15>IMR>12 or 10>LBW>9 = 2 points;
- 12>IMR>10 or 9>LBW>7 = 1 point;
- IMR<10 or LBW<7 = 0 points.[9]

Source: https://www.federalregister.gov/documents/2003/05/30/03-13478/criteria-for-determining-priorities-among-health-professional-shortage-areas

APPENDIX B – RELEVANT AMA POLICIES:

Effectiveness of Strategies to Promote Physician Practice in Underserved Areas D-200.980

1. Our American Medical Association, in collaboration with relevant medical specialty societies, will continue to advocate for the following:
   a. Continued federal and state support for scholarship and loan repayment programs, including the National Health Service Corps, designed to encourage physician practice in underserved areas and with underserved populations.
   b. Permanent reauthorization and expansion of the Conrad State 30 J-1 visa waiver program.
   c. Adequate funding (up to at least FY 2005 levels) for programs under Title VII of the Health Professions Education Assistance Act that support educational experiences for medical students and resident physicians in underserved areas.
2. Our AMA encourages medical schools and their associated teaching hospitals, as well as state medical societies and other private sector groups, to develop or enhance loan repayment or scholarship programs for medical students or physicians who agree to practice in underserved areas or with underserved populations.
3. Our AMA will advocate to states in support of the introduction or expansion of tax credits and other practice-related financial incentive programs aimed at encouraging physician practice in underserved areas.
4. Our AMA will advocate for the creation of a national repository of innovations and experiments, both successful and unsuccessful, in improving access to and distribution of physician services to government-insured patients (National Access Toolbox).
5. Our AMA supports elimination of the tax liability when employers provide the funds to repay student loans for physicians who agree to work in an underserved area.

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. Our 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.
    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.

Educational Strategies for Meeting Rural Health Physician Shortage H-465.988

1. In light of the data available from the current literature as well as ongoing studies being conducted by staff, our American Medical Association recommends that:
    a. Our AMA encourage medical schools and residency programs to develop educationally sound rural clinical preceptorships and rotations consistent with educational and training requirements, and to provide early and continuing exposure to those programs for medical students and residents.
    b. Our AMA encourage medical schools to develop educationally sound primary care residencies in smaller communities with the goal of educating and recruiting more rural physicians.
    c. Our AMA encourage state and county medical societies to support state legislative efforts toward developing scholarship and loan programs for future rural physicians.
    d. Our AMA encourage state and county medical societies and local medical schools to develop outreach and recruitment programs in rural counties to attract promising high school and college students to medicine and the other health professions.
    e. Our AMA urge continued federal and state legislative support for funding of Area Health Education Centers (AHECs) for rural and other underserved areas.
    f. Our AMA continue to support full appropriation for the National Health Service Corps Scholarship Program, with the proviso that medical schools serving states with large rural underserved populations have a priority and significant voice in the selection of recipients for those scholarships.
    g. Our AMA support full funding of the new federal National Health Service Corps loan repayment program.
    h. Our AMA encourage continued legislative support of the research studies being conducted by the Rural Health Research Centers funded by the National Office of Rural Health in the Department of Health and Human Services.
    i. Our AMA continue its research investigation into the impact of educational programs on the supply of rural physicians.
    j. Our AMA continue to conduct research and monitor other progress in development of educational strategies for alleviating rural physician shortages.
    k. Our AMA reaffirm its support for legislation making interest payments on student debt tax deductible.
    l. Our AMA encourage state and county medical societies to develop programs to enhance work opportunities and social support systems for spouses of rural practitioners.
2. Our AMA will work with state and specialty societies, medical schools, teaching hospitals, the Accreditation Council for Graduate Medical Education (ACGME), the Centers for Medicare and Medicaid Services (CMS) and other interested stakeholders to identify, encourage and incentivize qualified rural physicians to serve as preceptors and volunteer faculty for rural rotations in residency.

3. Our AMA will:
    a. work with interested stakeholders to identify strategies to increase residency training opportunities in rural areas with a report back to the House of Delegates; and
    b. work with interested stakeholders to formulate an actionable plan of advocacy with the goal of increasing residency training in rural areas.
    4. Our AMA will encourage ACGME review committees to consider adding exposure to rural medicine as appropriate, to encourage the development of rural program tracks in training programs and increase physician awareness of the conditions that pose challenges and lack of resources in rural areas.
    5. Our AMA will encourage adding educational webinars, workshops and other didactics via remote learning formats to enhance the educational needs of smaller training programs.

Difficulties in the Fulfillment of National Health Service Corps Contractual Obligations H-200.991
1. The AMA strongly urges the NHSC to provide intensive and frequent counseling to NHSC scholars as they enter and then proceed through the NHSC program. Through such briefings, as well as frequent written communications, the NHSC Administration should emphasize: (a) the dynamic nature of the HMSA Placement Opportunity List and the possibility of changes in placement options at any time; (b) the extent of any financial commitments that a scholar may have to incur to develop a Private Practice Option opportunity; and (c) the future possibilities of obtaining a Private Practice Option and/or a federal placement.
2. The AMA urges the NHSC to make particular effort to minimize, to the degree possible, the imposition of changes in assignment options during the last year of the obligee's education, so as to avoid disruption of personal and family plans.

Access to and Quality of Rural Health Care H-465.997
(1) 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.

Primary Care Physicians in Underserved Areas H-200.972
1. Our American Medical Association should pursue the following plan to improve the recruitment and retention of physicians in underserved areas:
    a. encourage the creation and pilot-testing of school-based, faith-based, and community-based urban/rural family health clinics, with an emphasis on health education, prevention, primary care, and prenatal care;
    b. encourage the affiliation of these family health clinics with local medical schools and teaching hospitals;
    c. advocate for the implementation of AMA policy that supports extension of the rural health clinic concept to urban areas with appropriate federal agencies;
    d. encourage the AMA Senior Physicians Section to consider the involvement of retired physicians in underserved settings, with appropriate mechanisms to ensure their competence;
    e. urge hospitals and medical societies to develop opportunities for physicians to work part-time to staff health clinics that help meet the needs of underserved patient populations;
    f. encourage the AMA and state medical associations to incorporate into state and federal health system reform legislative relief or immunity from professional liability for senior, part-time, or other physicians who help meet the needs of underserved patient populations and
    g. urge hospitals and medical centers to seek out the use of available military health care resources and personnel, which can be used to help meet the needs of underserved patient populations.
2. Our AMA supports efforts to:
    a. expand opportunities to retain international medical graduates after the expiration of allocated periods under current law; and
    b. increase the recruitment and retention of physicians practicing in federally designated health professional shortage areas.

REFERENCES:

1. U.S. Department of Health & Human Services. Health Resources & Services Administration. National Health Service Corps. Site Reference Guide. May 2024. Accessed June 18, 2024. https://nhsc.hrsa.gov/sites/default/files/nhsc/nhsc-sites/nhsc-site-reference-guide.pdf.

2. U.S. Department of Health & Human Services. Health Resources & Services Administration. National Health Service Corps. Accessed June 17, 2024. https://nhsc.hrsa.gov/.

3. U.S. Department of Health & Human Services. Health Resources & Services Administration. National Health Service Corps. Loan Repayment Program. Accessed June 17, 2024. https://nhsc.hrsa.gov/sites/default/files/nhsc/loan-repayment/nhsc-lrp-fact-sheet.pdf.

4. U.S. Department of Health & Human Services. Health Resources & Services Administration. National Health Service Corps. NHSC Loan Repayment Program. Accessed June 18, 2024. https://nhsc.hrsa.gov/loan-repayment/nhsc-loan-repayment-program

5. U.S. Department of Health & Human Services. Health Resources & Services Administration. HRSA Health Workforce. Apply for Loan Repayment. Accessed June 17, 2024. https://bhw.hrsa.gov/funding/apply-loan-repayment#nhsclrp.

6. National Archives. Code of Federal Regulations. Part 5—Designation Of Health Professional(S) Shortage Areas. November 17, 1980. Accessed June 19, 2024. https://www.ecfr.gov/current/title-42/chapter-I/subchapter-A/part-5.

7. Cornell Law School. Legal Information Institute. 42 U.S. Code § 254e - Health professional shortage areas. Accessed June 19, 2024. https://www.law.cornell.edu/uscode/text/42/254e.

8. U.S. Department of Health & Human Services. Health Resources & Services Administration. HPSA Find. Accessed June 19, 2024. https://data.hrsa.gov/tools/shortage-area/hpsa-find.

9. National Archives. Federal Register. Criteria for Determining Priorities Among Health Professional Shortage Areas. May 30, 2003. Accessed June 18, 2024. https://www.federalregister.gov/documents/2003/05/30/03-13478/criteria-for-determining-priorities-among-health-professional-shortage-areas

10. Association of Clinicians for the Underserved. National Health Service Corps (NHSC) Empowerment Initiative: Advancing Clinician Wellness & Health Equity. Accessed July 23, 2024. https://clinicians.org/corps-about/.

11. U.S. Department of Health & Human Services. Health Resources & Services Administration. Bureau of Health Workforce Field Strength and Students and Trainees Dashboards. Accessed July 24, 2024. https://data.hrsa.gov/topics/health-workforce/field-strength.

12. National Organization of State Offices of Rural Health. Comments on HRSA/Bureau of Health Workforce Request for Information – Health Professional Shortage Area Scoring Criteria. 2020. Accessed June 19, 2024. https://nosorh.org/wp-content/uploads/2020/10/Health-Professional-Shortage-Areas-criteria-RFI_NOSORH-Comments-1.pdf.

REPORT 11 OF THE BOARD OF TRUSTEES (I-24)
Carbon Pricing to Address Climate Change

EXECUTIVE SUMMARY

BACKGROUND. Resolution 601-I-23, introduced by the Medical Student Section, proposed modifying current House of Delegate policy D-135.966, "Declaring Climate Change a Public Health Crisis," to include language calling for the American Medical Association (AMA) to advocate for federal and state carbon pricing systems, for U.S. support of international carbon pricing, and for the AMA to work with the World Medical Association and interested countries' medical associations on international carbon pricing and other ways to address climate change. The resolution was referred for study, to better understand the benefits and pitfalls of carbon pricing, including the possible consequences of our AMA endorsing a specific climate-saving alternative.

METHODS. English-language reports were selected from a PubMed and Google Scholar search of the literature using the search terms "carbon pricing" or "carbon tax" or "carbon pricing policy" in combination with "evaluation," "benefits," "challenges," and "health impacts." Additionally, the websites of relevant organizations and agencies, such as the Environmental Protection Agency, the United Nations, the Intergovernmental Panel on Climate Change, the World Bank, and the Center for Climate and Energy Solutions were reviewed for applicable resources and information.

DISCUSSION. Climate change is a growing concern as global surface temperatures have significantly increased over the past 150 years.[1] Human contributions to climate change are primarily caused by increases in global greenhouse gas (GHG) emissions released as a result of the burning of fossil fuels.[1,2] One policy solution to reduce GHG emissions that has gained popularity is carbon pricing. Carbon pricing places a specific price on emitting carbon dioxide and passes the cost of emitting carbon emissions to the emitters.[3] The two primary mechanisms employed are through a tax on carbon, in which a fee is charged for the amount of carbon emitted wherever fossil fuels enter the economy, or through an emission trading scheme (ETS).[4,5] As of 2024, more than 70 carbon pricing schemes have been implemented globally and they vary widely.[5,6] The U.S. and Australia are currently the only countries with developed economies who do not have a nationwide carbon pricing system.[4] A recent systematic review and meta-analysis found consistent evidence that across the globe, carbon pricing policies (including both cap-and-trade and carbon tax policies) were effective at reducing GHG emissions between 5 to 21 percent.[6]

While there are many challenges with implementing carbon pricing policies, including carbon leakage, fairness and equity, economic competitiveness, market manipulation, public acceptability, and administrative burden, there are also many potential health benefits.[5,7,8] One of the most direct ways that carbon pricing can improve health is through improvements in air quality through lower air pollution, resulting in improved respiratory health outcomes and health care savings.[9] Funding from carbon pricing programs could also support active transportations options, such as walking, bicycling and public transportation which are associated with more physical activity.[7,10] Improved public health outcomes are also most likely to impact communities that have been historically marginalized and therefore improve overall health inequities.[11,12]

CONCLUSION. The threat of catastrophic climate change is becoming increasingly likely if aggressive measures to reduce GHG emissions are not taken. Despite challenges and concerns with carbon pricing, existing programs have been found to be effective at reducing GHG emissions and generating funding for clean energy programs, energy efficiency projects, subsidizing energy costs for low-income households, and improving public health outcomes.

REPORT OF THE BOARED OF TRUSTEES

B of T Report 11-I-24

Subject: Carbon Pricing to Address Climate Change (Resolution 601-I-23)

Presented by: Michael Suk, MD, JD, MPH, MBA, Chair

INTRODUCTION

Resolution 601-I-23, introduced by the Medical Student Section, proposed modifying current HOD policy D-135.966, "Declaring Climate Change a Public Health Crisis," to include the following language:

> 6. Our AMA will advocate for federal and state carbon pricing systems and for US support of international carbon pricing.
>
> 7. 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.

The resolution was referred for study to gain a better understanding of the benefits and pitfalls of carbon pricing, including the possible consequences of our AMA endorsing a specific climate-saving alternative.

BACKGROUND

According to the Intergovernmental Panel on Climate Change (IPCC), global surface temperatures from 2011-2020 are approximately 1.1 degrees Celsius higher on average than in the period between 1850-1900.[1] Further, the U.S. Fifth National Climate Assessment states, "the evidence for warming across multiple aspects of the Earth system is incontrovertible, and the science is unequivocal that increases in atmospheric greenhouse gases (GHG) are driving many observed trends and changes."[13] Anthropogenic (i.e., human caused) increases in global GHG emissions are primarily a result of the burning of fossil fuels for electricity generation and transportation, deforestation, and unsustainable agricultural practices.[1,2,13] Recent research has demonstrated that human activities are responsible for 92 percent of observed warming.[14] Atmospheric concentrations of several GHG are at historically high levels within human history; with carbon dioxide (CO2) concentrations at 419 parts per million, higher than at any time in at least two million years.[14] Additionally, concentrations of methane are at 1,923 parts per billion, and nitrous oxide are at 337 parts per billion, higher than at any time in at least 800,000 years.[1,14] The year 2023 was the planet's hottest calendar year on record, surpassing the 1.5 degree Celsius threshold set by the Paris Agreement and 2024 is on track to be as hot or hotter than 2023, with 1,400 heat records broken by June 2024.[15,16]

As concern over anthropogenic climate change has increased over the past few decades, several international agreements have been established to address the issue. The United Nations (UN) Framework Convention of Climate Change, adopted in 1992, was the first international treaty to explicitly address climate change and was ratified by 197 countries, including the U.S.[17] A key component of this framework was the establishment of an annual forum known as the Conference

of the Parties, or COP, aimed at facilitating international discussions on establishing the concentration of GHG in the atmosphere.
Five years later, the Kyoto Protocol was adopted, establishing the first legally binding climate treaty aimed at reducing signatory country emissions by an average of five percent below 1990 levels as well as a system to monitor process.[17] While adopted in 1997, the treaty went into effect in 2005. While the U.S. signed the agreement, it was never ratified, and the U.S. later withdrew its signature. In 2015, the Paris Accord agreement was adopted, requiring all signatory countries to set emission-reduction pledges with the goal of preventing global average temperatures from rising two degrees Celsius above preindustrial levels but with the real aim of keeping temperature increases below 1.5 degrees Celsius.[17] The U.S. withdrew from the accord under former President Donald Trump although President Biden reentered the U.S. into agreement upon entering office. As part of the Paris Agreement, National Determined Contributions (NDCs) are supposed to be submitted. NDCs form the basis for how countries are supposed to achieve the objectives of the Paris agreement and include information on targets, mitigation policies, and measures for reducing emissions.[18] "Mitigation" refers to efforts that aim to reduce emissions directly or reduce the current concentration of GHG in the atmosphere by enhancing carbon dioxide sinks (e.g. increasing the area of forests, which absorb carbon dioxide).[19] The U.S. NDC target is an economy-wide reduction of GHG emissions by 50-52 percent below 2005 levels by 2030.[20]

At the COP 2023 UN Climate Summit in Dubai, it was concluded that governments are not doing enough to prevent the global average temperature from rising by 1.5 degrees Celsius.[21] The significance of this global temperature target is that scientists warn that with consistent warming above 1.5 degrees Celsius, the Earth will experience catastrophic environmental consequences with dire impacts for human health and settlements as well as mass animal and plant species loss. While a recent analysis found U.S. GHG emission reductions have accelerated in the past few years, primarily due to the passage of the Inflation Reduction Act and Infrastructure Investment and Jobs Act, the adoption of a suite of federal regulations aimed at driving down emissions, and ambitious state action, it is still not enough to achieve the Paris Agreement climate commitment of a 50-52 percent reduction by 2030.[22]

There are many potential mitigation policies countries can adopt to address GHG emissions from multiple sectors. One policy solution that has gained popularity is carbon pricing. The following report describes what carbon pricing is, examines the economic logic behind it and summarizes available evidence of how effective existing programs are in terms of reducing GHG emissions. Lastly, the report reviews the challenges and benefits of carbon pricing, with a specific focus on potential health benefits, and outlines alternative policies for reducing GHG emissions.

METHODS

English-language reports were selected from a PubMed and Google Scholar search of the literature using the search terms "carbon pricing" or "carbon tax" or "carbon pricing policy" in combination with "evaluation," "benefits," "challenges," and "health impacts." Additionally, the websites of relevant organizations and agencies, such as the Environmental Protection Agency, the United Nations, the Intergovernmental Panel on Climate Change, the World Bank, and the Center for Climate and Energy Solutions were reviewed for applicable resources and information.

DISCUSSION

What is carbon pricing?

In the broadest sense, carbon pricing places a specific price on emitting carbon dioxide and passes the cost of emitting carbon emissions to the emitters.[3] The two primary mechanisms employed are through a tax on carbon, in which a fee is charged for the amount of carbon emitted wherever fossil fuels enter the economy, or through an emission trading scheme (ETS).[4,5] Within ETS, a limit is set for total emissions allowed and companies can buy or sell carbon emission allotments. For example, companies that produce less carbon emissions can sell shares of their carbon allotment to other companies that are higher carbon emitters.[5] ETS – also known as cap and trade - limits the total GHG permitted within a specific region and can help facilitate gradual emission decreases and keep total emissions within a designated amount.[5,23] As gains are made in terms of improved energy efficiency and technologies, the cap can continue to be lowered over time.

Carbon taxes, however, do not predetermine the total amount of allowable emissions, but rather, are focused on establishing a set price for carbon. In either form of carbon pricing, the policy follows a basic economic argument and logic – "faced with a price on carbon, economic agents will avail themselves to opportunities to abate emissions that are cheaper than paying the price."[7] Less well-known carbon pricing instruments include crediting mechanisms, a results-based climate finance framework, and internal carbon pricing schemes.[3] (See Table 1) There are also several indirect methods of pricing carbon, including fuel taxes, the removal of fossil fuel subsidies, and regulations that incorporate a social cost of carbon, which is intended to reflect the cost of effects created by generating one or more ton of emissions at any given period.[5,24]

As a policy solution, carbon pricing is not without historical precedent. For example, the sulfur dioxide cap and trade program for power plants in the U.S. was established under Title IV of the 1990 Clean Air Act Amendments; the world's first large-scale pollutant cap-and-trade system, in response to widespread environmental concern over acid rain.[25] Despite industry opposition to the policy, this program was immensely successful at lowering sulfur dioxide levels and it led to such rapid technological advancements in controlling sulfur dioxide emissions that the marginal abatement costs fell to less than half of what had been predicted.[7] To be effective, many proponents believe carbon pricing should be implemented at a global scale and while this may seem unrealistic, successful international agreements on environmental action have been implemented and achieved their goals. For example, the Montreal Protocol, adopted in 1987, is an example of a successful international environmental agreement brought about by concern over the growing hole in our planet's ozone layer, which led to the phasing out of chlorofluorocarbons from industrial and pharmaceutical uses, and the ozone layer has since recovered.[26,27]

One of the most compelling reasons for carbon pricing, particularly a cap-and-trade model, is to guarantee emission targets are met.[7] Additionally, cap-and-trade programs provide economic incentives for reducing GHG emissions through the reinvestment of profits made through the program into renewable energy sources, changing consumption patterns, and improving energy efficiency.[7,23] Other considerations for a carbon tax versus a cap-and-trade model is the price elasticity of electricity generation.[7] Price elasticity is a term used to describe how responsive consumer demand is for a product based on its price. When something is price elastic, consumer demand is very sensitive to fluctuations in price (these tend to be pure commodities), versus price inelastic, meaning consumers will not change their usage much as price changes.[28] Energy and fuel consumption is generally a necessity versus a luxury, lending itself to being price inelastic. For many people, they will still power their homes, keep it at comfortable temperature, or drive their car no matter what the price of electricity or fuel, particularly those who do not have alternative methods of transportation. A main argument against a carbon tax is that it is regressive and will be passed down to consumers, with lower-income households being disproportionately impacted.[7,28] Proponents of ETS based carbon pricing policies argue that these systems are less likely to be subject to political intervention and pressure during periods of economic stress and are better able

to respond to fluctuations in the economy overall.[23] Solutions to address these concerns are described further below.

Proponents of a carbon price argue the cap-and-trade approach requires additional bureaucracy to implement it and provides polluters with loopholes and options to buy their way out of penalties or regulation, versus implementing real change to reduce pollution.[4] A carbon tax is considered the most upstream approach to pricing carbon by defining a set price (versus a total limit) that is spread across all sectors of the economy that emit fossil fuels.[7,24] In essence, a carbon tax treats all fossil carbon equally, regardless of where it enters the system.[7] This approach greatly minimizes administrative burden and costs associated with a cap-and-trade model for carbon pricing.

Examples of carbon pricing programs and evidence of effectiveness

As of 2024, more than 70 carbon pricing schemes have been implemented globally and they vary widely.[5,6] The U.S. and Australia are currently the only countries with developed economies who do not have a nationwide carbon pricing system.[4] A recent systematic review and meta-analysis found consistent evidence that across the globe, carbon pricing policies (including both cap-and-trade and carbon tax policies) were effective at reducing GHG emissions between 5 to 21 percent.[6] As carbon ETS systems have been in effect for nearly twenty years and examples of their implementation exist in the U.S., a few of these programs are described in further detail below.

The European Union (EU) was the first to establish a cap-and-trade emissions system in 2005, and it remains the largest carbon market in the world.[29] The EU Emissions Trading System (EU ETS) primarily covers emissions created by the energy sector, manufacturing industry, as well as aircraft operators within the EU, which represents around 40 percent of the EU's emissions.[30] Based on a 2023 report by the European Commission, the EU ETS has thus far helped lower GHG emissions from the power and energy sectors by about 37 percent below 2005 levels.[31] Additionally, since the adoption of the EU ETS, there has been an increase in patent activity in low-carbon technologies.[7] In 2023, the EU developed a new separate emissions trading system (ETS2), which addresses the carbon dioxide emissions from fuel combustion in buildings, road transport and additional sectors (mainly small industry not covered by the existing ETS).[32] As this new trading scheme was recently established, there is no available data on its implementation and effectiveness.

While there is no nationwide carbon pricing policy, within the U.S., there are three active carbon ETS initiatives: (1) the Regional Greenhouse Gas Initiative (RGGI), which includes eleven participating states in the Northeast region of the U.S., (2) California, and (3) Washington. The RGGI was the first mandatory cap-and-trade program in the U.S. aimed at reducing carbon dioxide emissions from power plants within each participating state. Similar to the EU program, RGGI was established in 2005 and administered its first auction of carbon dioxide emissions allowances in 2008.[33] As a result of this program, annual average carbon dioxide emissions from electric generation sources decreased by 48 percent within a ten-year period (from 2006-2008 to 2016-2018).[33] Between 2009-2018, participating RGGI states have seen a net economic benefit of $4.7 billion, which has been reinvested by states back into their participating communities and has included funding for clean energy programs, energy efficiency, and energy bill assistance programs to local business and communities.[33,34] Additional analyses of the program have found the RGGI has added 48,000 job-years (equivalent of one full-time job for the duration of one year) and contributed to positive health impacts in the form of avoided adverse child health outcomes from lower pollution levels.[9,35]

California's Cap-and-Trade program was initiated by the California legislature's approval of Assembly Bill 32 (AB 32) in 2006, which established the State's 2020 GHG reduction target and authorized the California Air Resources Board (CARB) to include a cap-and-trade program as one

tool to help achieve the target.[36] After attempts to delay the implementation of the program, the defeat of a 2010 ballot initiative paved the way for the program to move forward and it began in 2013. A 2023 inventory report by the CARB indicates GHG emissions within the state have demonstrated a consistent decline between the years 2000 and 2021.[37]

Within the past five years, both Washington and Oregon passed legislation enabling the creation of carbon pricing initiatives. However, the Oregon Climate Protection Program was invalidated by the Oregon Court of Appeals in 2023 and a new regulatory process is underway to reestablish the program.[38–40] Washington state's cap-and-invest program was passed by the state legislature in 2021 under the Climate Commitment Act and the program officially started in January 2023.[41] The goal of this program, in addition to other clean energy initiatives in the state, is to reduce GHG emissions to 45 percent below 1990 levels by 2030, 70 percent below 1990 levels by 2040, and 95 percent below 1990 levels by 2050.[38] As Washington's program just started last year, there is no available data on its implementation and effectiveness.

As noted, there is no national carbon pricing scheme in place in the U.S. However, in 2023, legislation was introduced in the House of Representatives, H.R.5744 - Energy Innovation and Carbon Dividend Act of 2023, which would impose a fee on the carbon content of fuels, including crude oil, natural gas, coal, or any other product derived from those fuels and the revenue from those fees would be deposited into a Carbon Dividend Trust Fund and used for administrative expenses and dividend payments to U.S. citizens or lawful residents.[42] This proposed legislation is not likely to move forward this legislative session.

Implementation Challenges

There are several challenges with implementing carbon pricing schemes, which include carbon leakage (defined below), fairness and equity, public acceptance, competitiveness, market manipulation, and administrative burden. A well-designed carbon pricing mechanism should address carbon leakage - the phenomenon by which carbon-intensive industries or firms shift operations to lower-cost jurisdictions - resulting from geographically inconsistent policies and regulations. The lack of international agreement (or even national agreement within the U.S.) and/or implementation on carbon pricing has resulted in nonuniform pricing across the world resulting in the issue of carbon leakage. As one author noted, a uniform carbon pricing scheme across all global countries would be most ideal, to prevent certain "bad actors" simply moving their operations to an area of the world with less stringent environmental standards.[5] The Carbon Pricing Leadership Coalition – a group of leaders from government, private sector, academia, and civil society who aim to expand the use of carbon pricing policies – recommends that carbon pricing mechanisms be expanded and coordinated across countries to cover a higher proportion of global emissions.[3]

Another challenge for carbon pricing schemes is figuring out how generated revenue will be used and distributed. Critics of carbon pricing policies have argued that increased costs of fossil fuels will disproportionately impact low-income populations as well as fragile industries, who are more susceptible to energy price increases.[5,11] Customizing programs to be responsive to vulnerable populations who are most susceptible to energy price increases is crucial.[46] Strategies to reduce negative impacts on disadvantaged communities as well as address fairness and competitiveness concerns include targeting funds from carbon pricing to energy efficiency projects, supporting cleaner energy production technologies, carbon dividends, funding public transportation systems, and protecting or subsidizing energy costs for lower-income households.[5,8]

Carbon dividends, otherwise known as carbon cashback, is one potential strategy for reducing the economic burden of carbon pricing on households with low incomes that has gained popularity.[4,7,47] Carbon dividends is when a proportion of revenues from a carbon tax are returned to households impacted by the policy, as opposed to transferring this money to firms (as in a cap-and-trade system with free permits) or to the government (as would happen if permit auction or carbon tax revenue goes to the treasury).[7,47] Multiple studies have projected that a carbon tax program implemented with a cashback option for U.S. citizens would provide an economic boost for many low-income households.[47] How revenues from carbon pricing are used also impact public acceptability and support for the policy, which has been a challenge. Carbon pricing policy has met considerable resistance in terms of general public acceptance, exemplified by the cancellation of a carbon pricing scheme in Australia after only two years and rejection of various ballot initiatives in the U.S.[7,48] A study on perceived fairness and public acceptability of carbon pricing found that the general population demonstrated little trust in the ability of governments to put the funds to good use but there were clear preferences for using funds to ensure fair outcomes and for environmental projects of various kinds.[48]

Another major challenge in developing and implementing carbon pricing policy is opposition from influential stakeholders whom the policy may negatively impact, such as fossil fuel companies and the energy sector more broadly.[5,36] Industry stakeholders have pushed back on carbon pricing policies citing potential impacts to competitiveness and predicting that it would hinder economic growth and job creation.[49] However, as cited above, the RGGI and EU ETS have generated net economic benefit of billions of dollars, have spurred job creation in the green energy sector, and prompted research and development funding into new green technologies leading to an increase in new patents in this area, calling into question the economic logic behind industry fears.[5,35]

Other challenges with cap-and-trade programs have been market manipulation and speculation, lack of transparency, and the possibility of being overly bureaucratic and administratively burdensome. Similar to other trading systems and capital markets, the ability to manipulate the market in your favor is a risk.[50] A way to avoid this issue is by creating a transparent, secure registry to track transactions and prevent manipulative tactics.[51] The issue of "greenwashing," the process of conveying false or misleading impression intended to deceive consumers into believing that a product or service is environmentally friendly or preferable to alternatives, has been raised as a concern with California's cap-and-trade program.[52] In response, California recently passed AB 1305, which went into effect in January 2024, requiring businesses marketing or selling voluntary carbon offsets (VCOs) or marketing products as having significantly reduced emissions within California to disclose on their website certain information concerning the projects that generated the VCOs and emission reductions.[53] This law represents California's attempt to hold businesses accountable for claims concerning GHG emission reductions and intensify transparency within the VCOs market.

Other potential solutions to minimize issues of market manipulation and lack of transparency include using technology to monitor and report emissions efficiently, establishing clear and transparent guidelines, and involving impacted stakeholders and citizen groups early in the formation process.[5] A 2018 review of existing ETS carbon pricing systems also found that more recently implemented programs demonstrated significant institutional learning from previous systems (like the EU ETS), thus making the administrative and regulatory structures easier to establish as the new programs are implemented.[54] Therefore, administrative hurdles may become less of a challenge as more programs are established. Lastly, these challenges are primarily of concern with a cap-and-trade mechanism of carbon pricing, thus could be reduced with the use of a broader carbon tax mechanism.

Another key consideration of any carbon pricing policy is how to define a reasonable and effective price for carbon. The Carbon Pricing Leadership Coalition noted in their most recent report that "Carbon prices must … be high enough to provide effective signals to society, which will drive the level of investment and technological changes necessary to reach net-zero and be taken in conjunction with complementary policy actions to make carbon pricing relevant across company value chains."[55] One strategy to define a reasonable and effective price for carbon is to calculate the social cost of carbon (SCC).[5] The SCC is an "economic metric intended to provide a comprehensive estimate of the net damages - that is, the monetized value of the net impacts, both negative and positive - from the global climate change that results from a small (1-metric ton) increase in carbon-dioxide emissions."[56] In the U.S., existing Executive Orders requiring the use of the SCC to determine regulatory impact have been in place since 2008.[56] Methods for estimating the SCC using integrated assessment models have been developed by an Interagency Working Group on the Social Cost of Carbon, set up in 2010, and continues to be refined as new data becomes available and models are updated.[56] However, there are still many challenges in calculating total risk and associated costs from carbon and SCC estimates have varied depending on political leadership at the federal level, ranging from $3-5 to $190 as determined by the U.S. Environmental Protection Agency in 2022.[5,7]

Potential Benefits

Despite the challenges, there are many benefits to carbon pricing policies, particularly health benefits. Overall, fossil fuel extraction and consumption have many negative environmental consequences that also lead to poor health outcomes, including contamination of drinking and recreational water sources, pipeline leaks or spills, gas leaks leading to explosions, and air pollution.[11,57,58] These health impacts do not include those that are directly or indirectly related to climate change. Direct health impacts from climate change include heatwaves and other extreme weather events such as hurricanes, forest fires, floods, or droughts. Indirect impacts are those mediated through the effects of climate change on ecosystems, such as agricultural losses and changing patterns of disease, economies, and social structures (such as displacement and conflict).[59] Additionally, climate change also poses risks to health care infrastructure, which threatens community health and the financial viability of health care organizations.[60] Climate change impacts are also already causing billions of dollars in economic losses.[61] To provide one example, economic losses from extreme weather events increased by 23 percent from 2010-14 to 2018-22, equaling $254 billion in 2022 alone.[62] For more detailed information on climate change and its health impacts, see AMA's Council on Science and Public Health report on climate change and health, written and adopted in 2022.[63] In short, the adverse health impacts and health care costs from climate change are already staggering and are only predicted to get worse.[62]

One of the most direct ways that carbon pricing can improve health is through improvements in air quality through lower air pollution. For example, based on evaluations of the RGGI, the program is estimated to have avoided several adverse child health outcomes, including 537 asthma cases, 112 preterm births, 98 cases of autism spectrum disorder, and 56 cases of term low birth weight.[9] These avoided adverse health outcomes are associated with an avoided cost estimated at $191 to $350 million. A study on a proposed carbon fee in Massachusetts estimated the program would yield nearly $3 billion in health benefits.[11,64] A report by CalEPA's Office of Environmental Health Hazard Assessment notes that reductions in co-pollutant emissions from California's carbon cap-and-trade program has resulted in major health benefits, including a reduction in premature pollution-related deaths, particularly in communities of color and disadvantaged communities.[12] Additionally, a 2021 study of potential impacts based on different mitigation scenarios in the U.S. found that nationwide health benefits from cleaner air-quality could be realized very rapidly from

emission reductions and the cost savings from these benefits would exceed the costs of implementation within the first decade after going into effect.[65]

Higher fuel prices and funding from carbon pricing programs could also encourage and support alternative, active transportations options, such as walking, bicycling and public transportation. The use of active transportation modes, versus automobiles, is associated with greater levels of daily physical activity and lower air pollution.[59,66] Increased daily physical activity is associated with many health benefits, including reduced high blood pressure and risk of heart disease and stroke, reduced risk of type 2 diabetes, reduced risk of osteoporosis and falls, reduced symptoms of depression and anxiety, and improved sleep quality.[10]

Another potential impact from carbon pricing is the price of food, with carbon pricing most likely making the cost of some foods more expensive, namely red meat. Livestock production, and particularly cattle, is a major contributor to methane gas emissions, contributing almost 80 percent of agricultural GHG emissions.[67] It has been estimated that animal products with even the lowest environmental impacts generally exceed the environmental impacts related to all vegetable substitutes.[68] In general, plant-based diets (for example, Mediterranean, pescatarian, vegetarian, vegan) are associated with reduced disease risk compared with conventional Western diets and the widespread adoption of a healthy diet that emphasizes plants foods over red meat and dairy has been projected to prevent globally an estimated 10.8 million to 11.6 million deaths annually.[69,70] Carbon pricing could incentivize a transition to more plant-based diets, which would help reduce agricultural emissions, promote health, and generate financial savings.[69,71] One study in Australia estimated changes to food consumption habits and potential resulting health outcomes resulting from a carbon pricing scheme. The study estimated lower consumption of red and processed meats, with an increase in fruit consumption, resulting in lower body weight and decreased overweight and obesity prevalence.[71] The study concluded that carbon pricing on food commodities in Australia could have overall public health benefits.

Lastly, carbon pricing has the potential to improve health equity in several ways.[11] First, climate change impacts on health are disproportionately experienced by the most vulnerable and disadvantaged communities, including ethnic and racial minorities, communities of low-income, children, women, migrants and displaced communities, people with disabilities and existing health conditions, and indigenous populations.[61,72] Therefore, mitigating the future harmful impacts of climate change will most benefit these vulnerable communities. Additionally, the public health benefits of reduced air pollution that could be achieved by the phasing out of fossil fuels would be greatest for low-income communities of color that experience disproportionately high exposure to air pollution.[73,74] While there have been concerns raised that the California cap-and-trade program has worsened local air quality within environmental justice communities, several studies have found the opposite to be true. In communities of color, there have been improvements in local air pollution and a reduction in exposure to toxic air pollutants from facilities covered by the cap-and-trade program.[12,36]

Alternatives

There are several other available strategies to meaningfully reduce GHG emissions outside of carbon pricing policies. Stricter regulations on CO2 and other greenhouse gases from electricity generation facilities as well as higher fuel efficiency standards for cars and trucks are policy options which push industry to make meaningful emission reductions.[7,11] Within the past few years, the AMA has joined with organizational partners urging federal agencies to pass such policies.[75,76] Another strategy is to invest and promote more renewable and sustainable energy sources.[11] The Inflation Reduction Act, enacted in 2022, has done just that, leading to $110 billion in new clean

energy manufacturing investments within just 12 months of the bill being signed into law.[77] Investing in public transportation infrastructure, as well as sidewalks and bike lanes, and promoting their use over automobiles is another critical strategy to shift a general overreliance on personal vehicles for everyday trips.[7] Ultimately, in order to achieve current GHG emission reduction targets, all of these policies should be pursued as part of a holistic approach to reducing carbon emissions.

EXISTING AMA POLICY

The AMA has several existing policies on climate change and health (D-135.966 and H-135.938). D-135.966 is most relevant in regard to carbon pricing in that it calls on AMA to advocate 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."[78] At the 2024 Annual Meeting, the Board of Trustee's Report 25 Environmental Sustainability of AMA National Meetings was adopted with the recommendations that AMA is committed to make progress towards net zero emissions for its business operations by 2030 and to work with appropriate entities to encourage the U.S. health care system to decrease emissions to half of 2010 levels by 2030, achieve net zero by 2050, and remain net zero or negative.[79]

POSITION OF OTHER HEALTH CARE ORGANIZATIONS

Carbon pricing has been supported by other organizations within the health care sector. In October 2021, 100 leaders from the National Academy of Medicine signed a petition stating their strong support for a carbon pollution fee.[80] Additionally, the 2015 Lancet Commission on Health and Climate Change recommended that governments establish a framework for an international carbon pricing mechanism as a key policy strategy to protect public health.[59]

CONCLUSIONS

The threat of catastrophic climate change is becoming increasingly likely if the global community does not enact aggressive measures to reduce GHG emissions. As stated by a recent article, "Human-induced warming has been increasing at a rate that is unprecedented in the instrumental record, reaching 0.26 [0.2–0.4] °C per decade over 2014–2023."[14] This increasing rate of warming is directly tied to persistently high global GHG emissions. Despite existing challenges and concerns with carbon pricing, it is imperative that all GHG reduction strategies be on the table to meet reduction targets established by the Paris Agreement. While carbon pricing initiatives can be challenging to implement and must be thoughtfully designed, existing programs have been found to be effective at reducing GHG emissions and generating money to fund clean energy programs, energy efficiency projects, and subsidizing energy costs for low-income households. Despite challenges, there are many potential health benefits of carbon pricing initiatives that could result from a decrease in the extraction, processing, and use of fossil fuels, which could also result in health care cost savings.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted and the remainder of the report be filed.

1. Amend current HOD policy, D-135.966: Declaring Climate Change a Public Health Crisis, by addition to read as follows:

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 and ~~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.

6. Our AMA supports the use of international, federal, regional, and state carbon pricing systems as an important tool to reduce global greenhouse gas emissions and achieve net-zero targets. Our AMA recommends that carbon dividends or energy subsidies for low-income households be a key component of any established carbon pricing system, to reduce the potential economic burden on households with lower incomes.

Fiscal Note: Less than $1,000

TABLES AND FIGURES

Table 1: Different Carbon Pricing instruments[3]

Carbon tax	Creates a direct price on GHG emissions and requires economic actors to pay for every ton of carbon pollution emitted.
Emission Trading System (ETS)	Also known as a cap-and-trade system, this instrument sets a limit on total direct GHG emissions from specific sectors and sets up a market where the rights to emit (in the form of carbon permits or allowances) are traded.
Crediting Mechanism	Emissions reductions that occur from a project, either by a business, government, or policy, are assigned credits, which can then be bought or sold. Entities seeking to lower their emissions can buy the credits as a way to offset their actual emissions.
Results-based climate finance framework	Entities, such as businesses, receive funds when they meet pre-defined climate-related goals, such as emissions reductions.
Internal carbon pricing	Governments, firms, and other entities assign their own internal price to carbon use and factor this into their investment decisions. These internal prices generally take two forms: a shadow price or an internal carbon fee.

REFERENCES

1. Intergovernmental Panel on Climate Change. *Climate Change 2023: Synthesis Report. Summary for Policymakers*.; 2023. Accessed July 29, 2024. https://www.ipcc.ch/report/ar6/syr/downloads/report/IPCC_AR6_SYR_SPM.pdf

2. Lancet Policy Brief for the United States of America. LANCET COUNTDOWN: Accessed February 1, 2024. https://www.lancetcountdownus.org/2022-lancet-countdown-u-s-brief/

3. Carbon Pricing Leadership Coalition. Understanding carbon pricing. Carbon Pricing Leadership Coalition. Accessed June 27, 2024. https://www.carbonpricingleadership.org/what

4. Citizens Climate Lobby. Pricing Carbon 101. Citizens' Climate Lobby. Published 2024. Accessed July 18, 2024. https://citizensclimatelobby.org/price-on-carbon/

5. Ali J. Road map for sustainable and effective carbon pricing: bridging the gap of realities and ambitions. *Environ Sci Pollut Res*. 2023;30(41):94070-94080. doi:10.1007/s11356-023-29034-2

6. Döbbeling-Hildebrandt N, Miersch K, Khanna TM, et al. Systematic review and meta-analysis of ex-post evaluations on the effectiveness of carbon pricing. *Nat Commun*. 2024;15(1):4147. doi:10.1038/s41467-024-48512-w

7. Boyce JK. Carbon Pricing: Effectiveness and Equity. *Ecol Econ*. 2018;150:52-61. doi:10.1016/j.ecolecon.2018.03.030

8. Carbon Pricing Leadership Coalition. *What Are the Options for Using Carbon Pricing Revenues?*; 2016. https://pubdocs.worldbank.org/en/668851474296920877/CPLC-Use-of-Revenues-Executive-Brief-09-2016.pdf

9. Perera F, Cooley D, Berberian A, Mills D, Kinney P. Co-Benefits to Children's Health of the U.S. Regional Greenhouse Gas Initiative. *Environ Health Perspect*. 2020;128(7):077006. doi:10.1289/EHP6706

10. CDC. Benefits of Physical Activity. Centers for Disease Control and Prevention. Published August 1, 2023. Accessed January 4, 2024. https://www.cdc.gov/physicalactivity/basics/pa-health/index.htm

11. Ambasta A, Buonocore JJ. Carbon pricing: a win-win environmental and public health policy. *Can J Public Health Rev Can Santé Publique*. 2018;109(5-6):779-781. doi:10.17269/s41997-018-0099-5

12. Plummer L, Budahn A, Chen AI, Wu L, Alvarado Á. *Impacts of Greenhouse Gas Emission Limits within Disadvantaged Communities: Progress toward Reducing Inequities*. CalEPA Office of Environmental Health Hazard Assessment; 2022. https://oehha.ca.gov/media/downloads/environmental-justice/impactsofghgpoliciesreport020322.pdf

13. U.S. Global Climate Research Program. *Fifth National Climate Assessment: Chapter 2 - Climate Trends.*; 2023. https://nca2023.globalchange.gov/chapter/2/

14. Forster PM, Smith C, Walsh T, et al. Indicators of Global Climate Change 2023: annual update of key indicators of the state of the climate system and human influence. *Earth Syst Sci Data*. 2024;16(6):2625-2658. doi:10.5194/essd-16-2625-2024

15. Dance S. A year of record global heat has pushed Earth closer to dangerous threshold. *Washington Post*. https://www.washingtonpost.com/weather/2024/06/05/global-temperatures-1-5-celsius-record-year/. Published June 5, 2024. Accessed July 29, 2024.

16. Kaplan S, Dance S. Billions of people just felt the deadly intensity of climate-fueled heat waves. *Washington Post*. https://www.washingtonpost.com/climate-environment/2024/06/22/deadly-heat-wave-climate-change/. Published June 22, 2024. Accessed July 29, 2024.

17. Maizland L. Global Climate Agreements: Successes and Failures. Council on Foreign Relations. Published December 5, 2023. Accessed April 1, 2024. https://www.cfr.org/backgrounder/paris-global-climate-change-agreements

18. United Nations Climate Change. NDC Synthesis Report. Accessed July 29, 2024. https://unfccc.int/process-and-meetings/the-paris-agreement/nationally-determined-contributions-ndcs/ndc-synthesis-report/ndc-synthesis-report

19. United Nations Climate Change. Introduction to Mitigation. Accessed May 20, 2024. https://unfccc.int/topics/introduction-to-mitigation

20. *The United States of America Nationally Determined Contribution; Reducing Greenhouse Gases in the United States: A 2030 Emissions Target*.; 2021. https://unfccc.int/sites/default/files/NDC/2022-06/United%20States%20NDC%20April%2021%202021%20Final.pdf

21. The world isn't on track to meet Paris Agreement goals, says UN climate review. POLITICO. Published September 8, 2023. Accessed July 29, 2024. https://www.politico.eu/article/paris-agreement-goals-failed-climate-change-global-warming-united-nations-climate-review/

22. King B, Kolus H, van Brummen A, Gaffney M, Dasari N, Larsen J. *Taking Stock 2024: US Energy and Emissions Outlook*. Rhodium Group; 2024. Accessed July 23, 2024. https://rhg.com/research/taking-stock-2024/

23. Natural Resource Defense Council. *Why Cap and Invest Is Better than a Carbon Tax*. Natural Resource Defense Council; 2009. Accessed July 29, 2024. https://www.nrdc.org/sites/default/files/why.pdf

24. World Bank. What is Carbon Pricing? World Bank. Published 2024. Accessed July 23, 2024. https://www.worldbank.org/en/programs/pricing-carbon

25. Stavins R. The U.S. Sulphur Dioxide Cap and Trade Programme and Lessons for Climate Policy. *Vox*. Published online August 12, 2012. Accessed July 23, 2024. https://www.hks.harvard.edu/publications/us-sulphur-dioxide-cap-and-trade-programme-and-lessons-climate-policy

26. Woodcock A. Hydrofluorocarbons, Climate, and Health — Moving the Montreal Protocol beyond Ozone-Layer Recovery. *N Engl J Med*. 2023;388(26):2404-2406. doi:10.1056/NEJMp2302197

27. U. N. Environment Program. About Montreal Protocol. Ozonaction. Published October 29, 2018. Accessed July 29, 2024. http://www.unep.org/ozonaction/who-we-are/about-montreal-protocol

28. Gallo A. A Refresher on Price Elasticity. *Harv Bus Rev*. Published online August 21, 2015. Accessed July 10, 2024. https://hbr.org/2015/08/a-refresher-on-price-elasticity

29. European Commission. EU Emissions Trading System (EU ETS). Accessed June 26, 2024. https://climate.ec.europa.eu/eu-action/eu-emissions-trading-system-eu-ets_en

30. What is the EU ETS? - European Commission. Accessed June 26, 2024. https://climate.ec.europa.eu/eu-action/eu-emissions-trading-system-eu-ets/what-eu-ets_en

31. European Commission. EU carbon market continues to deliver emission reductions. Published October 31, 2023. Accessed June 27, 2024. https://climate.ec.europa.eu/news-your-voice/news/eu-carbon-market-continues-deliver-emission-reductions-2023-10-31_en

32. European Commission. ETS2: buildings, road transport and additional sectors. Accessed July 31, 2024. https://climate.ec.europa.eu/eu-action/eu-emissions-trading-system-eu-ets/ets2-buildings-road-transport-and-additional-sectors_en

33. Center for Climate and Energy Solutions. Regional Greenhouse Gas Initiative (RGGI). Accessed July 29, 2024. https://www.c2es.org/content/regional-greenhouse-gas-initiative-rggi/

34. RGGI, Inc. *About the Regional Greenhouse Gas Initiative*.; 2024. https://www.rggi.org/sites/default/files/Uploads/Fact%20Sheets/RGGI_101_Factsheet.pdf

35. Stuart D, Hibbard P. *The Economic Impacts of the Regional Greenhouse Gas Initiative on Ten Northeast and Mid-Atlantic States*. Analysis Group; 2023. Accessed July 29, 2024. https://www.analysisgroup.com/Insights/publishing/the-economic-impacts-of-the-regional-greenhouse-gas-initiative-on-ten-northeast-and-mid-atlantic-states2/

36. California Air Resources Board. FAQ Cap-and-Trade Program. Published September 2022. https://ww2.arb.ca.gov/resources/documents/faq-cap-and-trade-program

37. California Air Resources Board. *California Greenhouse Gas Emissions from 2000 to 2021: Trends of Emissions and Other Indicators*.; 2023. https://ww2.arb.ca.gov/sites/default/files/2023-12/2000_2021_ghg_inventory_trends.pdf

38. Washington State Department of Ecology. Washington's Cap-and-invest Program. Accessed July 1, 2024. https://ecology.wa.gov/air-climate/climate-commitment-act/cap-and-invest

39. State of Oregon Department of Environmental Quality. Climate Protection Program. Accessed July 29, 2024. https://www.oregon.gov/deq/ghgp/cpp/pages/default.aspx

40. State of Oregon Department of Environmental Quality. Climate Protection Program 2024. Accessed July 1, 2024. https://www.oregon.gov/deq/rulemaking/Pages/CPP2024.aspx

41. Washington State Legislature. Chapter 70A.65 RCW: GREENHOUSE GAS EMISSIONS—CAP AND INVEST PROGRAM. Accessed July 1, 2024. https://app.leg.wa.gov/RCW/default.aspx?cite=70A.65

42. Rep. Carbajal SO [D C 24. H.R.5744 - 118th Congress (2023-2024): Energy Innovation and Carbon Dividend Act of 2023. Published September 29, 2023. Accessed July 29, 2024. https://www.congress.gov/bill/118th-congress/house-bill/5744

43. Gleason P. Kamala Harris Backs Carbon Tax, As Josh Shapiro Sues For Cap-And-Trade. *Forbes*. https://www.forbes.com/sites/patrickgleason/2024/07/24/kamala-harris-backs-carbon-tax-as-josh-shapiro-sues-for-cap-and-trade/. Published July 24, 2024. Accessed July 29, 2024.

44. Davenport C, Gabriel T. Climate Town Hall: Several Democratic Candidates Embrace a Carbon Tax. *The New York Times*. https://www.nytimes.com/2019/09/04/us/politics/democrats-climate-change-plans.html. Published September 4, 2019. Accessed July 29, 2024.

45. US Republican idea for tax on carbon makes climate sense. *Nature*. 2017;542(7641):271-272. doi:10.1038/542271b

46. Klenert D, Mattauch L, Combet E, et al. Making carbon pricing work for citizens. *Nat Clim Change*. 2018;8(8):669-677. doi:10.1038/s41558-018-0201-2

47. Novoselov A, Cerceo E. Enacting A Price On Carbon Pollution Is Key To Mitigating Health Care's Climate Impacts. doi:10.1377/forefront.20240722.872630

48. Maestre-Andrés S, Drews S, van den Bergh J. Perceived fairness and public acceptability of carbon pricing: a review of the literature. *Clim Policy*. 2019;19(9):1186-1204. doi:10.1080/14693062.2019.1639490

49. Omolere MP. Carbon Tax: Definition, Pros and Cons, and Implementation. Earth.Org. Published January 9, 2024. Accessed July 29, 2024. https://earth.org/explainer-what-is-a-carbon-tax-pros-and-cons-and-implementation-around-the-world/

50. Gorin D. Types of Illegal Stock Market Manipulation. Published March 19, 2024. Accessed July 31, 2024. https://www.thefederalcriminalattorneys.com/stock-market-manipulation

51. Center for Climate and Energy Solutions. Cap and Trade Basics. Accessed July 31, 2024. https://www.c2es.org/content/cap-and-trade-basics/

52. Gordon D, Zuegge KL. Greenwashing in Health Care Marketing. *ASA Monit*. 2020;84(4):18-21.

53. California Legislature. *AB-1305 Voluntary Carbon Market Disclosures*.; 2023. Accessed July 31, 2024. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB1305

54. Narassimhan E, Gallagher KS, Koester S, Alejo JR. Carbon pricing in practice: a review of existing emissions trading systems. *Clim Policy*. 2018;18(8):967-991. doi:10.1080/14693062.2018.1467827

55. Carbon Pricing Leadership Coalition. *Report of the Task Force on Net Zero Goals & Carbon Pricing*. The World Bank Group; 2021. https://static1.squarespace.com/static/54ff9c5ce4b0a53decccfb4c/t/614b3a242b48a65e02ccc978/1632320041214/CPLC+_NetZero_Report.pdf

56. National Academies of Science, Engineering, and Medicine. *Valuing Climate Damages: Updating Estimation of the Social Cost of Carbon Dioxide*. National Academies of Science, Engineering, and Medicine; 2017. https://nap.nationalacademies.org/catalog/24651/valuing-climate-damages-updating-estimation-of-the-social-cost-of

57. Perera F, Nadeau K. Climate Change, Fossil-Fuel Pollution, and Children's Health. *N Engl J Med*. 2022;386(24):2303-2314. doi:10.1056/NEJMra2117706

58. Fossil Free for Health. *Fossil Free for Health Policy Brief: Call for Action, Background, and Detailed Policy Action Agenda*.; 2024. https://www.fossilfree4health.org/_files/ugd/fb71df_8274181b0ef2447ab328af51b8b39ab3.pdf

59. Watts N, Adger WN, Agnolucci P, et al. Health and climate change: policy responses to protect public health. *The Lancet*. 2015;386(10006):1861-1914. doi:10.1016/S0140-6736(15)60854-6

60. Johns M, Rosenthal J. *Climate-Resilient Health Care Promotes Public Health, Equity, and Climate Justice*. Center for American Progress; 2024. Accessed July 31, 2024. https://www.americanprogress.org/article/climate-resilient-health-care-promotes-public-health-equity-and-climate-justice/

61. World Health Organization. Climate change. Published October 12, 2023. Accessed July 31, 2024. https://www.who.int/news-room/fact-sheets/detail/climate-change-and-health

62. Romanello M, Napoli C di, Green C, et al. The 2023 report of the Lancet Countdown on health and climate change: the imperative for a health-centred response in a world facing irreversible harms. *The Lancet*. 2023;402(10419):2346-2394. doi:10.1016/S0140-6736(23)01859-7

63. AMA Council on Science and Public Health. *Climate Change and Human Health*. American Medical Association; 2022. https://www.ama-assn.org/system/files/i22-csaph-report-02.pdf

64. Buonocore JJ, Levy JI, Guinto RR, Bernstein AS. Climate, air quality, and health benefits of a carbon fee-and-rebate bill in Massachusetts, USA. *Environ Res Lett*. 2018;13(11):114014. doi:10.1088/1748-9326/aae62c

65. Shindell D, Ru M, Zhang Y, et al. Temporal and spatial distribution of health, labor, and crop benefits of climate change mitigation in the United States. *Proc Natl Acad Sci*. 2021;118(46):e2104061118. doi:10.1073/pnas.2104061118

66. Glazener A, Khreis H. Transforming Our Cities: Best Practices Towards Clean Air and Active Transportation. *Curr Environ Health Rep*. 2019;6(1):22-37. doi:10.1007/s40572-019-0228-1

67. Bonnet C, Coinon M. Environmental co-benefits of health policies to reduce meat consumption: A narrative review. *Health Policy Amst Neth*. 2024;143:105017. doi:10.1016/j.healthpol.2024.105017

68. Poore J, Nemecek T. Reducing food's environmental impacts through producers and consumers. *Science*. 2018;360(6392):987-992. doi:10.1126/science.aaq0216

69. Patz JA, Stull VJ, Limaye VS. A Low-Carbon Future Could Improve Global Health and Achieve Economic Benefits. *JAMA*. 2020;323(13):1247-1248. doi:10.1001/jama.2020.1313

70. Willett W, Rockström J, Loken B, et al. Food in the Anthropocene: the EAT–Lancet Commission on healthy diets from sustainable food systems. *The Lancet*. 2019;393(10170):447-492. doi:10.1016/S0140-6736(18)31788-4

71. Springmann M, Sacks G, Ananthapavan J, Scarborough P. Carbon pricing of food in Australia: an analysis of the health, environmental and public finance impacts. *Aust N Z J Public Health*. 2018;42(6):523-529. doi:10.1111/1753-6405.12830

72. U.S. Global Climate Research Program. *Fifth National Climate Assessment: Chapter 15 - Human Health.*; 2023. https://nca2023.globalchange.gov/chapter/15/

73. US EPA O. Outdoor Air Quality. Published November 2, 2017. Accessed February 1, 2024. https://www.epa.gov/report-environment/outdoor-air-quality

74. American Lung Association. Disparities in the Impact of Air Pollution. Accessed February 1, 2024. https://www.lung.org/clean-air/outdoors/who-is-at-risk/disparities

75. American Lung Association. Comments on Docket #EPA-HQ-OAR-2023-0072. Published online August 8, 2023. https://www.lung.org/getmedia/c44f6163-5c61-4e3c-840d-63adbcdc0a43/Comments-from-Health-Orgs-on-Carbon-Pollution-from-Power-Plants-Rules.pdf

76. American Lung Association. Comments on Docket # EPA-HQ-OAR-2022-0829. Published online July 5, 2023. https://www.lung.org/getmedia/c3e49194-f972-4302-a97b-06a09be6b911/EPA-LDV-Comments-for-Health-Orgs-2023.pdf

77. The White House. FACT SHEET: One Year In, President Biden's Inflation Reduction Act is Driving Historic Climate Action and Investing in America to Create Good Paying Jobs and Reduce Costs. The White House. Published August 16, 2023. Accessed July 29, 2024. https://www.whitehouse.gov/briefing-room/statements-releases/2023/08/16/fact-sheet-one-year-in-president-bidens-inflation-reduction-act-is-driving-historic-climate-action-and-investing-in-america-to-create-good-paying-jobs-and-reduce-costs/

78. D-135.966 Declaring Climate Change a Public Health Crisis | AMA. Accessed February 26, 2024. https://policysearch.ama-assn.org/policyfinder/detail/climate%20change?uri=%2FAMADoc%2Fdirectives.xml-D-135.966.xml

79. American Medical Association House of Delegates. *Report of Reference Committee F*. American Medical Association; 2024:14-15. https://www.ama-assn.org/system/files/a24-refcomm-f-annotated.pdf

80. National Academy of Medicine. Climate Crisis and Health Petition 2021. Published online October 25, 2021. https://drive.google.com/file/d/1hlkOchcC3QOuGJKiNr8QQk5rd5n9vxZG/view

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

Subject: Cannabis Therapeutic Claims in Marketing and Advertising

Presented by: John T. Carlo, MD, Chair

Referred to: Reference Committee K

At the 2023 American Medical Association (AMA) Interim Meeting, the House of Delegates (HOD) referred recommendation 6 of the Council on Science and Public Health (CSAPH) Report 6-I-23, "Marketing Guardrails for the 'Over-Medicalization' of Cannabis Use." Recommendation 6 asked that "[o]ur AMA support and encourage state regulation of therapeutic claims in cannabis advertising." This report represents the Council's findings and recommendations.

CSAPH has issued seven previous reports that include research on cannabis including synthetic cannabinoids:

1. CSAPH Report 6-A-01, "Medical Marijuana"
2. CSAPH Report 3-I-09, "Use of Cannabis for Medical Purposes"
3. CSAPH Report 2-A-17, "Emerging Drugs of Abuse Are a Public Health Threat"
4. CSAPH Report 5-I-17, "Clinical Implications and Policy Considerations of Cannabis Use"
5. CSAPH Report 3-I-19, "Patient Use of Non-FDA Approved Cannabis and Cannabinoid Products in Hospitals"
6. CSAPH Report 5-I-20, "Public Health Impacts of Cannabis Legalization"
7. CSAPH Report 6-I-23, "Marketing Guardrails for the 'Over-Medicalization' of Cannabis Use"

In CSAPH Report 6-I-23, the Council studied the marketing practices of cannabis companies. The policies that stemmed from the report state that our AMA will request more direct oversight from the Food and Drug Administration (FDA) and the Federal Trade Commission (FTC) on the marketing of cannabis, generate a letter for use by state medical societies requesting more oversight by state governments, and support research on the effects of cannabis marketing to identify best practices (D-95.958). The report also explained the categories of cannabis marketing regulations, including medium restrictions (e.g., radio, television, print media, internet) and physical restrictions (e.g., proximity to schools, signs visible to the public, signs on public transportation).

Generally, cannabis content restrictions can be divided into six categories: (1) therapeutic claims, (2) safety claims, (3) content targeting children, (4) validity of statements, (5) gifts, and (6) product warnings.[4] This report will focus on health claim content restrictions, with an emphasis on therapeutic and curative claims, addressing the specifications and limitations placed on content within cannabis advertisements. While the Council is aware of additional cannabis content restrictions such as product warnings and prohibitions on content targeting children, these are outside the scope of this report and already included in AMA policy.

METHODS

English-language reports, peer-reviewed articles, white papers, government publications, and grey literature was selected from PubMed and an Internet search, using the text terms "cannabis," "marijuana," "claims," "advertising," and "marketing." Additional information was obtained from

state government websites and organizations that specialize in public health law or cannabis regulation to identify current cannabis marketing and advertising laws.

BACKGROUND

Marketing is categorized as "any commercial communication or other activity, including advertising, promotion, and sponsorship, that is designed to increase the recognition, appeal and/or consumption" of the product being marketed.[1] States have varying approaches to the marketing of cannabis and tetrahydrocannabinol (THC) containing products. While federal regulatory agencies oversee the marketing and advertising of hemp (including cannabidiol or CBD), the regulation of cannabis and cannabis-derived products varies by state. The challenges of cannabis products are accentuated by the lack of research and guidance on dosing and adverse effects, leading consumers to rely on potentially inaccurate marketing sources like dispensary staff or online sites, emphasizing the need to ensure accurate and consistent information in marketing.

In most states where the adult-use or medical use of cannabis is legal, states have established regulatory bodies, officers, and/or departments that provide licensing and industry oversight to ensure compliance with existing cannabis laws, the development of marketing and advertising guidelines, and the enforcement of violation penalties. However, there are no federal standardized regulations, guidelines, or laws for non-FDA-approved cannabis or cannabis-based products. The marketing and advertising landscape has changed over time as states have implemented legislation granting state-based regulatory bodies the authority to enforce cannabis marketing guardrails.

Marketing can lead to changes in patient or consumer attitudes, beliefs, and behavior. In some cases a "positive halo effect" can be seen when medical benefits are highlighted, leading consumers to perceive all cannabis products as beneficial, safe, and health-promoting, even in adult use contexts.[2] Conversely, a "negative halo effect" may occur following negative press or reports on cannabis-related incidents, causing consumers to view all cannabis products or uses as harmful or risky, regardless of the specific circumstances or evidence.[3] This psychological phenomenon is one of many broader public health and regulatory concerns.

DISCUSSION

According to the FDA, a claim says something about the advertised drug or what it does.[5] Claims usually relate to benefits and are made directly by stating, for example, "Brand X treats heartburn." Claims also can be made indirectly by the use of pictures or other graphics."[5] Additionally, "the truthfulness of claims must be supported by 'substantial evidence' or substantial clinical experience."[5] However, because cannabis companies are not regulated by the FDA, they may make claims that are not supported by rigorous research (as required by the FDA). Therapeutic claims are usually made in relation to the products usefulness, are supported by expert medical opinion or controlled clinical studies, and encompass phrases such as "for," "in the treatment of," and "indicated."[6] FDA's drug approval process includes an analysis of the benefits and risks from clinical data, and strategies for managing risks.[7] AMA policy details our support of the FDA evaluation and approval process based on sound scientific and medical evidence derived from controlled trials (H-100.992, "FDA").

In early 2017, the National Academies of Sciences, Engineering, and Medicine released a report based on over 10,000 scientific abstracts from cannabis health research.[8] In an evaluation of the therapeutic effects of cannabis and cannabinoids, they conclude there is evidence to support the therapeutic effect of cannabis and cannabinoids in several conditions (See Table 1), but this evidence relates to the FDA approved cannabinoid products (dronabinol, nabilone, and

nabiximols).[8] There is limited evidence to support claims for non-FDA approved cannabis products.[8–10] Uncertainty about the appropriate use, risks, and benefits of cannabis necessitates ongoing research to support claims and inform clinical practice. As varying cannabis products and consumption methods remain under-studied, making evidence-based recommendations on cannabis is challenging.

Cannabis Therapeutic Claims Research

While cannabis claims are regulated on a state-by-state basis, the FDA has noted common drug promotion issues that could potentially relate to marketing and advertising of cannabis therapeutic claims. Common drug promotion issues include, exaggerating the drug's benefit, missing or de-emphasizing risk, failing to offer a "fair balance: of risk and benefit information, misrepresenting data from the studies, creating claims that are not appropriately backed, omitting material facts about the drug, misbranding and investigational medication, and making misleading medication comparisons."[11] Current research on cannabis therapeutic claims, including industry practices, state regulations, and enforcement, is limited in both scope and content.

A 2015-2016 cross-sectional study examined recreational dispensary compliance with advertising regulations in Washington state (i.e., Washington Administrative Code (WAC) § 314-55-155).[12] The law states advertising must not contain any statement or illustration that is false or misleading, promotes overconsumption, represents the use of cannabis as having curative or therapeutic effects, or depicts a person under legal age consuming cannabis.[13] The study analyzed 1,027 posts from 12 cannabis business pages on Facebook and Twitter, representing six companies equally across rural and urban areas.[12] Out of the 1,027 posts, 137 (13.3 percent) highlighted curative or therapeutic benefits, with 121 (11.8 percent) focusing on stress relief and 16 (1.6 percent) promoting treatment for medical conditions.[12] Examples included posts like "#Cannabis Used To Ease PTSD." Notably, a majority (69 percent) came from one company.[12]

A separate state-based analysis compared 94 cannabis medical and adult-use dispensary websites across Nevada, Oregon, Arizona, California, Colorado, Illinois, Michigan, Montana, New Mexico, and Washington.[14] Of the 94 dispensaries, 63 (67 percent) included health claims related to medical conditions treatable by cannabis products on their menus.[14] Over half of the 94 dispensaries claimed their products could address issues such as pain, stress/relaxation, appetite, anxiety/panic attacks, insomnia/sleep problems, depression, nausea/stomach ailments, and muscle spasms (See Table 2).[14] Additionally, 35 dispensaries (37 percent) made health claims on other than the menu page.[14] Claims made by at least 20 percent of dispensaries on these pages included treatment for pain, appetite, anxiety/panic attacks, insomnia/sleep problems, depression, nausea, muscle spasms, and epilepsy/seizures.[14] Less common health claims included treatments for autism, Hepatitis C, Alzheimer's disease, AIDS, and autoimmune disorders.[14] The prevalence of health claims did not significantly differ based on whether the dispensary was medical only or adult-use and medical (54/70, 77 percent vs. 19/23, 83 percent; p=0.772).[14] A small percentage of dispensaries (8/94, 9 percent) included specific comparisons of cannabis to other prescription or over-the-counter drugs, such as prescription painkillers.[14]

In a similar study researchers found that 23 out of 94 (24 percent) of dispensaries provided citations from scientific journals, links to medical literature (18 dispensaries), and/or endorsements from medical professionals (eight dispensaries) to support their health claims.[14] This practice was more common among medical dispensaries compared to those offering both medical and adult-use cannabis (23/70, 33 percent vs. 0/23, 0 percent; p=0.001).[14] The authors concluded that most dispensaries made health claims pertaining to medical conditions that could be treated by their cannabis products.[8,14] However, claims regarding the treatment of symptoms related to epilepsy,

anorexia, Parkinson's Disease, and ALS have limited or insufficient scientific evidence.[8,14] While these health claims may align with state-approved conditions for cannabis use for medical purposes, it is important for dispensaries to distinguish between scientifically validated treatments and those not yet supported by empirical evidence to avoid misleading patients.[14]

From 2022-2023, researchers examined the online practices of 175 non-medical cannabis retailers in five cities (Denver, Colorado; Seattle, Washington; Portland, Oregon; Las Vegas, Nevada; Los Angeles, California).[15] They found that content claiming any health benefits of cannabis use declined from 105 (60 percent) in 2022 to 93 (47.4 percent) in 2023.[15] Of the total online cannabis retailers reviewed, 93 retailers (52.6 percent) had no health claims. Conversely, 83 retailers (47.4 percent) included health claims; among these seven retailers (4 percent) specified only medical claims, 14 retailers (eight percent) specified only mental health claims, and 62 retailers (35.4 percent) contained both medical and mental health claims (See Table 3).[15] In 2022, a similar study came to the same conclusions finding that among 195 cannabis retailers, 59.0 percent posted some unsubstantiated health claims, and 44.6 percent indicated physical and mental health benefits.[16] Although Colorado, Washington, and Oregon prohibit health claims, 51.2–53.8 percent of retailers posted them in these states.[16]

Overall, online cannabis retail presents health risks by emphasizing health benefit claims that lack sufficient evidence. In a 2022 mystery shopper study of 140 cannabis retailers in Denver, Seattle, Portland, Las Vegas, and Los Angeles researchers found despite health claim prohibitions in Colorado, Washington, and Oregon, over 90 percent of retailers in these states endorsed cannabis for anxiety, insomnia, and pain. Additionally, 54.3 percent endorsed its use for pregnancy-related nausea (ranging from 23.3 percent in Denver to 76.7 percent in Seattle), while 26.4 percent warned against use during pregnancy (most often in Denver at 46.7 percent, and least often in Seattle and Portland at 13.3 percent).[17] Likewise, a study conducting point-of-sale audits found that among 150 cannabis retailers in the same cities 28.7 percent posted health claims, 72 percent posted pregnancy/breastfeeding warnings, and 38 percent posted health risks.[18] Findings emerging from cannabis research show associations between exposure to marketing and use.[14,17,19,20] As the cannabis retail market expands in the U.S., surveillance of retail practices is crucial to inform regulations and protect consumers..

Cannabis Therapeutic Claims in Marketing and Advertising: Regulatory Landscape

It is important to understand how jurisdictions utilize laws to regulate cannabis therapeutic claims in both adult-use and medical use programs. Thirty-three states and territories have some law either on claim restrictions or untrue statements in cannabis marketing and advertising; however, there are 11 states and one territory that have no laws prohibiting false claims or statements. Further, nine states have claim restrictions where the evidence standard is stated in the law. State's cannabis regulatory authority can be found in Table 4.

Cannabis therapeutic claim laws can be split broadly into five categories (See Table 5). The description below gives an overview of the varying laws across U.S states and territories:

<u>No Claim Restrictions</u>. Eleven states do not have a law on cannabis advertising/marketing claim restrictions. *State Examples:* Arizona, Vermont, and Montana have laws on cannabis advertising; however, the laws do not mention claims. Neither Arizona nor Montana laws detail claim restrictions, false or untrue statements, or any evidence standard. Vermont's law states that advertisements must be submitted to the state Cannabis Control Board prior to dissemination of the advertisement. The Board then determines if the advertisement requires a specific disclosure based

on if the advertisement would be "false or misleading without such a disclosure," or they may require changes that are "necessary to protect the public health, safety, and welfare."

Claim Restrictions. Sixteen states have cannabis advertising/marketing claim restrictions or false/unsubstantiated statement prohibitions, but do not detail any evidence standard. *State Examples*: New York law notes "explicit rules prohibiting advertising that makes medical claims or promotes adult-use cannabis for a medical or wellness purpose." Washington, D.C. (D.C.) law prohibits false or misleading health benefit statements. California law specifically prohibits false or misleading therapeutic claims.

Claims are Restricted and Substantiated**.** Nine states have cannabis advertising/marketing claim restrictions with additional details to substantiate the claim restriction such as scientific evidence. *State Examples:* New Mexico law requires claims to be supported by evidence and data. Oregon law requires any claim to be supported by "the totality of publicly available scientific evidence." On the other hand, New Jersey law states that claims must be demonstrated by substantial scientific or clinical evidence consisting of two or more studies; there is no specification regarding which type of study counts towards this requirement.

Claim Restrictions Refer to Federal Law or Agency. Four states have cannabis laws that refer to federal agency standards or federal law on drugs. *State Examples:* Utah law states no statement, claim, or information that would violate the Food, Drug, and Cosmetic Act, while Missouri law states that unverified claims cannot be made unless the statement has been evaluated and approved by the FDA.

Not Applicable (N/A). Eleven states have no law on cannabis advertising/marketing because medical and adult-use cannabis are illegal.

Furthermore, forty-six states/territories have a regulatory body to oversee state cannabis policies. Generally, state law either dictates who should be appointed to the regulatory body or leaves the appointment rules to the regulatory body; however, not every state requires a physician to be on the board. In 13 states, the Department of Health (DOH) or a body within the DOH is designated as the cannabis regulatory body. In 17 states and three territories there is a cannabis commission, board, or administration that typically encompass individuals with varied expertise in health, policy, and medicine. Four states and D.C. have a duo alcohol and cannabis regulatory body, and seven states have relegated control to agencies outside the state DOH. For example, in New Mexico, the regulatory body designated is the Regulation and Licensing Department and in Utah the regulatory body is the Department of Government Operations (Table 6). Overall, every state with medical or adult-use cannabis has a regulatory body that may oversee therapeutic claims in marketing and advertising.

EXISTING AMA POLICY

Our AMA has significant policy on cannabis, including encouraging state regulatory bodies to enforce cannabis marketing laws, social media platforms to set a threshold age of 21 for exposure to advertising and support physician education on the health risks of cannabis (D-95.958, "Marketing Guardrails for the 'Over-Medicalization' of Cannabis Use"). AMA policy supports the traditional federal drug approval process for assessing the safety and efficacy of cannabis-based products for medical use and notes that cannabis products that have not been approved by the FDA, but are marketed for human ingestion in many states, should carry a warning label that this product has not been approved by the FDA for preventing or treating any disease process (D-95.969, "Cannabis Legalization for Medicinal Use").

Our AMA also has policy on cannabis addressing marketing and advertising, public health and safety messaging, prevention, harm reduction, education, treatment, research, regulation, and claims related to FDA-approved drugs. In 2022, AMA submitted a letter to the FDA and FTC relaying concern of the lack of federal regulation of cannabis and encouraging additional action to protect consumers by combating marketing of unapproved medical claims.[23] The AMA is currently working on a letter to request more oversight by state regulators. On May 16, 2024, the Drug Enforcement Administration (DEA) submitted a notice of proposed rulemaking to consider rescheduling cannabis from Schedule I to Schedule III under the Controlled Substances Act. In response, our AMA submitted a letter to the DEA highlighting several key considerations including the need to ensure public health and safety, additional research and data, consistent regulatory oversight, and protective measures for historically vulnerable populations.[24] Emphasis is placed on the clear need for more effective regulatory boundaries and guidelines concerning cannabis marketing and promotion.

CONCLUSION

There is a vast range of how states address health or medical claims for cannabis, including therapeutic claims, misleading statements, and substantial evidence. In some cases, the therapeutic claims for certain state-legalized cannabis products are unsupported, misleading, or false. In other cases, therapeutic claims are marketed by cannabis companies with sparse evidence and without medical consensus. These practices extend to both states with medical use only and both medical and adult use cannabis.

False and inaccurate claims can confuse consumers about the safety and effectiveness of cannabis products, misleading many that cannabis products (whether purchased from medical or non-medical legal markets or from illicit sellers) are less risky and more beneficial than they actually are.[21] Cannabis companies that promote the medical benefits of cannabis through these claims can create this "health halo effect," which leads to positive perceptions of adult use.[2] Such misinterpretations could increase medical and adult-use of cannabis, and prompt patients to use cannabis products to treat certain medical conditions when there is either no evidence of benefit, clear evidence that they will do more harm than good, or when conventional medicines or treatments would be safer or more effective.[8,21,22] Lastly, the lack of consistent marketing guidelines could expose youth and populations made vulnerable to false and misleading cannabis advertisements.

RECOMMENDATIONS

The Council on Science and Public Health recommends that the following be adopted, and the remainder of the report be filed.

1. That our AMA:
    a. Oppose cannabis and cannabis-based product advertising that includes claims or statements that are not supported by scientific evidence.
    b. Will continue to monitor regulatory approaches to cannabis marketing. (New HOD Policy)

Fiscal Note: less than $1,000

REFERENCES

1. Whitehill JM, Trangenstein PJ, Jenkins MC, Jernigan DH, Moreno MA. Exposure to Cannabis Marketing in Social and Traditional Media and Past-Year Use Among Adolescents in States With Legal Retail Cannabis. *Journal of Adolescent Health*. 2020;66(2):247-254. doi:10.1016/j.jadohealth.2019.08.024

2. Kees J, Fitzgerald P, Dorsey JD, Hill RP. Evidence-Based Cannabis Policy: A Framework to Guide Marketing and Public Policy Research. *Journal of Public Policy & Marketing*. 2020;39(1):76-92. doi:10.1177/0743915619848422

3. Kerger BD, Bernal A, Paustenbach DJ, Huntley-Fenner G. Halo and spillover effect illustrations for selected beneficial medical devices and drugs. *BMC Public Health*. 2016;16:979. doi:10.1186/s12889-016-3595-7

4. The Network for Public Health Law. *State Regulation of Adult-Use Cannabis Advertising*.; 2022. Accessed July 18, 2023. https://www.networkforphl.org/wp-content/uploads/2022/11/State-Regulation-of-Adult-Use-Cannabis-Advertising.pdf

5. Center for Drug Evaluation and Research. Drug Advertising: A Glossary of Terms. Food and Drug Administration. Published January 19, 2020. Accessed July 1, 2024. https://www.fda.gov/drugs/prescription-drug-advertising/drug-advertising-glossary-terms

6. Stewart ML. Therapeutic Claims Under the Federal Food, Drug, and Cosmetic Act. *Food, Drug, Cosmetic Law Quarterly*. 1949;4(4):536-551.

7. U.S Food and Drug Administration. Development & Approval Process. FDA. Published August 8, 2022. Accessed July 10, 2024. https://www.fda.gov/drugs/development-approval-process-drugs

8. *The Health Effects of Cannabis and Cannabinoids: The Current State of Evidence and Recommendations for Research*. National Academies Press; 2017. doi:10.17226/24625

9. Abrams DI. The therapeutic effects of *Cannabis* and cannabinoids: An update from the National Academies of Sciences, Engineering and Medicine report. *European Journal of Internal Medicine*. 2018;49:7-11. doi:10.1016/j.ejim.2018.01.003

10. Goodin AJ, Tran PT, McKee S, et al. Proceedings of the 2023 Cannabis Clinical Outcomes Research Conference. *Med Cannabis Cannabinoids*. 2023;6(1):97-101. doi:10.1159/000533943

11. So BK, Kim PY. Understanding Prescription Drug Advertising. In: *StatPearls*. StatPearls Publishing; 2024. Accessed July 1, 2024. http://www.ncbi.nlm.nih.gov/books/NBK574520/

12. Moreno MA, Gower AD, Jenkins MC, et al. Social Media Posts by Recreational Marijuana Companies and Administrative Code Regulations in Washington State. *JAMA Network Open*. 2018;1(7):e182242. doi:10.1001/jamanetworkopen.2018.2242

13. Legal Information Institute. Wash. Admin. Code § 314-55-155 - Advertising requirements and promotional items-Coupons, giveaways, etc. Cornell Law School Legal Information Institute. Published 2016. Accessed July 3, 2024. https://www.law.cornell.edu/regulations/washington/WAC-314-55-155

14. Cavazos-Rehg PA, Krauss MJ, Cahn E, et al. Marijuana Promotion Online: an Investigation of Dispensary Practices. *Prev Sci*. 2019;20(2):280-290. doi:10.1007/s11121-018-0889-2

15. Cui Y, Duan Z, LoParco CR, et al. Changes in online marketing and sales practices among non-medical cannabis retailers in 5 US cities, 2022 to 2023. *Preventive Medicine Reports*. 2024;42:102755. doi:10.1016/j.pmedr.2024.102755

16. Duan Z, Kasson E, Ruchelli S, et al. Assessment of Online Marketing and Sales Practices Among Recreational Cannabis Retailers in Five U.S. Cities. *Cannabis Cannabinoid Res*. Published online September 12, 2023. doi:10.1089/can.2022.0334

17. Romm KF, Cavazos-Rehg PA, Williams R, et al. Cannabis Retailer Communication About Cannabis Products, Health Benefits, and Risks: A Mystery Shopper Study of Licensed Retailers in Five U.S. Cities. *J Stud Alcohol Drugs*. 2024;85(1):100-108. doi:10.15288/jsad.23-00034

18. Berg CJ, Romm KF, Pannell A, et al. Cannabis retailer marketing strategies and regulatory compliance: A surveillance study of retailers in 5 US cities. *Addictive Behaviors*. 2023;143:107696. doi:10.1016/j.addbeh.2023.107696

19. Cabrera-Nguyen EP, Cavazos-Rehg P, Krauss M, Bierut LJ, Moreno MA. Young Adults' Exposure to Alcohol- and Marijuana-Related Content on Twitter. *J Stud Alcohol Drugs*. 2016;77(2):349-353. doi:10.15288/jsad.2016.77.349

20. Lau N, Gerson M, Korenstein D, Keyhani S. Internet Claims on the Health Benefits of Cannabis Use. *J Gen Intern Med*. 2021;36(11):3611-3614. doi:10.1007/s11606-020-06421-w

21. Lindblom EN. How FDA Could Use Its Existing Authorities to Make State Legalization of Cannabis More Safe and Effective. *Food and Drug Law Journal*. 2019;74(2):191-211.

22. Ghosh TS, Van Dyke M, Maffey A, Whitley E, Erpelding D, Wolk L. Medical Marijuana's Public Health Lessons — Implications for Retail Marijuana in Colorado. *N Engl J Med*. 2015;372(11):991-993. doi:10.1056/NEJMp1500043

23. American Medical Association. RE: Marketing of Cannabis. Published online October 20, 2022. Accessed July 24, 2024. https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Fltrfdr.zip%2F2022-10-20-Letter-to-Califf-and-Kahn-re-Marketing-of-Medical-Cannibis-v2.pdf

24. American Medical Association. RE: Docket No. DEA-1362; A.G. Order No. 5931-2024 Schedules of Controlled Substances: Rescheduling of Marijuana; Notice of Proposed Rulemaking. Published online July 22, 2024. Accessed July 24, 2024. https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Flfus.zip%2F2024-7-22-Letter-to-Milgram-re-Rescheduling-of-Marijuana-NPRM-Comments-v2.pdf

TABLE 1. NATIONAL ACADEMIES OF SCIENCES, ENGINEERING, AND MEDICINE REPORT BOX 4-1 SUMMARY OF CHAPTER CONCLUSIONS

National Academies of Sciences, Engineering, and Medicine. 2017. *The Health Effects of Cannabis and Cannabinoids: The Current State of Evidence and Recommendations for Research*. Washington, D.C.: The National Academies Press. https://doi.org/10.17226/24625.

BOX 4-1
Summary of Chapter Conclusions*

There is conclusive or substantial evidence that cannabis or cannabinoids are effective:

- For the treatment of chronic pain in adults (cannabis) (4-1)
- As antiemetics in the treatment of chemotherapy-induced nausea and vomiting (oral cannabinoids) (4-3)
- For improving patient-reported multiple sclerosis spasticity symptoms (oral cannabinoids) (4-7a)

There is moderate evidence that cannabis or cannabinoids are effective for:

- Improving short-term sleep outcomes in individuals with sleep disturbance associated with obstructive sleep apnea syndrome, fibromyalgia, chronic pain, and multiple sclerosis (cannabinoids, primarily nabiximols) (4-19)

There is limited evidence that cannabis or cannabinoids are effective for:

- Increasing appetite and decreasing weight loss associated with HIV/AIDS (cannabis and oral cannabinoids) (4-4a)
- Improving clinician-measured multiple sclerosis spasticity symptoms (oral cannabinoids) (4-7a)
- Improving symptoms of Tourette syndrome (THC capsules) (4-8)
- Improving anxiety symptoms, as assessed by a public speaking test, in individuals with social anxiety disorders (cannabidiol) (4-17)
- Improving symptoms of posttraumatic stress disorder (nabilone; a single, small fair-quality trial) (4-20)

There is limited evidence of a statistical association between cannabinoids and:

- Better outcomes (i.e., mortality, disability) after a traumatic brain injury or intracranial hemorrhage (4-15)

There is limited evidence that cannabis or cannabinoids are *ineffective* for:

- Improving symptoms associated with dementia (cannabinoids) (4-13)
- Improving intraocular pressure associated with glaucoma (cannabinoids) (4-14)
- Reducing depressive symptoms in individuals with chronic pain or multiple sclerosis (nabiximols, dronabinol, and nabilone) (4-18)

There is no or insufficient evidence to support or refute the conclusion that cannabis or cannabinoids are an effective treatment for:

- Cancers, including glioma (cannabinoids) (4-2)
- Cancer-associated anorexia cachexia syndrome and anorexia nervosa (cannabinoids) (4-4b)
- Symptoms of irritable bowel syndrome (dronabinol) (4-5)
- Epilepsy (cannabinoids) (4-6)
- Spasticity in patients with paralysis due to spinal cord injury (cannabinoids) (4-7b)
- Symptoms associated with amyotrophic lateral sclerosis (cannabinoids) (4-9)
- Chorea and certain neuropsychiatric symptoms associated with Huntington's disease (oral cannabinoids) (4-10)
- Motor system symptoms associated with Parkinson's disease or the levodopa-induced dyskinesia (cannabinoids) (4-11)
- Dystonia (nabilone and dronabinol) (4-12)
- Achieving abstinence in the use of addictive substances (cannabinoids) (4-16)
- Mental health outcomes in individuals with schizophrenia or schizophreniform psychosis (cannabidiol) (4-21)

* Numbers in parentheses correspond to chapter conclusion numbers.

TABLE 2. HEALTH CLAIMS MADE ABOUT CANNABIS WHEN DESCRIBING THE EFFECTS OF THEIR PRODUCTS

Cavazos-Rehg PA, Krauss MJ, Cahn E, et al. Marijuana Promotion Online: An Investigation of Dispensary Practices. Prev Sci. 2019;20(2):280-290. doi:10.1007/s11121-018-0889-2

Table 2 Health claims made about marijuana when describing the effects of their products ($N = 94$)

Health claims made within menu

≥ 50% of dispensaries	11–49% of dispensaries		≤ 10% of dispensaries	
Anxiety/Panic attacks	ADHD	Glaucoma	Alzheimer's disease	Fibromyalgia
Appetite[b]	Arthritis	Inflammation	AIDS	Hepatitis C
Depression	Cancer	Mental illness	Anorexia nervosa	Menstrual problems
Insomnia	Epilepsy	Migraine/Headaches	Asthma	Neuropathy
Muscle spasms[a]	Fatigue	***Multiple sclerosis***	Autism	Parkinson's disease
Nausea	Gastrointestinal disorders	PTSD	Autoimmune disorders	Sjögren's syndrome
Pain			Colitis	Trauma
Stress/Relaxation			Crohn's disease	Urinary systems condition

Health claims observed within the website, but outside of their menu

≥ 20% of dispensaries	11–19% of dispensaries		≤ 10% of dispensaries	
Anxiety/Panic Attacks	ADHD	Glaucoma	ALS	High blood pressure
Appetite[b]	*AIDS*	Inflammation	Alzheimer's disease	Hydrocephalus
Depression	Anorexia nervosa	Mental illness	Asthma	Menstrual problems
Epilepsy	Arthritis	Migraine/Headaches	Autism	Neuropathy
Insomnia	Cancer	Multiple sclerosis	Autoimmune disorders	Opioid dependence
Muscle Spasms[a]	Fatigue	Stress/Relaxation	Colitis	Parkinson's disease
Nausea	Gastrointestinal disorders		Crohn's disease	*PTSD*
Pain			Diabetes	*Tourette syndrome*
			Fibromyalgia	Trauma
			Hepatitis C	Urinary systems condition

Italics and bold represent conditions that have conclusive/substantial evidence or moderate evidence. *Italics* represent conditions that have limited evidence associated with marijuana therapies. Non-italics represent conditions that have little or no evidence associated with marijuana therapies (National Academies of Sciences, Engineering, and Medicine 2017)

ADHD attention-deficit/hyperactivity disorder, *PTSD* post-traumatic stress disorder, *AIDS* acquired immunodeficiency syndrome, *ALS* amyotrophic lateral sclerosis, Lou Gehrig's disease

[a] Evidence for muscle spasms as a symptom of Multiple Sclerosis

[b] Evidence for increasing appetite in individuals with HIV/AIDS

TABLE 3: SUPPLEMENTAL TABLE 5 MARKETING STRATEGIES AMONG CANNABIS RETAILER WEBSITES IN 5 US CITIES

Cui Y, Duan Z, LoParco CR, et al. Changes in online marketing and sales practices among non-medical cannabis retailers in 5 US cities, 2022 to 2023. *Preventive Medicine Reports*. 2024;42:102755. doi:10.1016/j.pmedr.2024.102755

Supplementary Table 5. Marketing strategies among cannabis retail websites in 5 US cities in 2023, N=175

	Total N=175 (100%)	**Denver N=31 17.7%)**	**Seattle N=37 (21.1%)**	**Portland N=36 (20.6%)**	**Las Vegas N=34 (19.4%)**	**LA N=37 (21.1%)**	
Variable	**n (%)**	**n (%)**	**n (%)**	**n (%)**	**n (%)**	**n (%)**	**p-value**
Content claiming health benefits of cannabis use							
Not indicated	92 (52.6)	9 (29.0)	27 (73.0)	21 (58.3)	10 (29.4)	25 (67.6)	**<.001**
Any benefits indicated	83 (47.4)	22 (71.0)	10 (27.0)	15 (41.7)	24 (70.6)	12 (32.4)	
Medical benefits only	7 (4.0)	1 (3.2)	3 (8.1)	0 (0.0)	2 (5.9)	1 (2.7)	
Mental health benefits only	14 (8.0)	1 (3.2)	1 (2.7)	7 (19.4)	5 (14.7)	0 (0.0)	
Both medical and mental health benefits	62 (35.4)	20 (64.5)	6 (16.2)	8 (22.2)	17 (50.0)	11 (29.7)	
Content targeting/representing specific populations							
Youth or young adults	53 (30.3)	23 (74.2)	4 (10.8)	6 (16.7)	17 (50.0)	3 (8.1)	**<.001**
Veterans	39 (22.3)	11 (35.5)	4 (10.8)	3 (8.3)	15 (44.1)	6 (16.2)	**.001**
LGBTQ+	10 (5.7)	7 (22.6)	0 (0.0)	1 (2.8)	1 (2.9)	1 (2.7)	**.001**
Racial/ethnic minorities	37 (21.1)	9 (29.0)	2 (5.4)	4 (11.1)	16 (47.1)	6 (16.2)	**<.001**
Content themes							
Party/cool/popularity imagery	62 (35.4)	23 (74.2)	6 (16.2)	7 (19.4)	22 (64.7)	4 (10.8)	**<.001**
Celebrity/influencer endorsement	36 (20.6)	11 (35.5)	4 (10.8)	0 (0.0)	14 (41.2)	7 (18.9)	**<.001**
Exclusivity/luxury imagery	66 (37.7)	25 (80.6)	2 (5.4)	10 (27.8)	18 (52.9)	11 (29.7)	**<.001**

TABLE 4. STATE LAW GOVERNING CANNABIS CLAIM RESTRICTIONS EXCEL SHEET

State	Medical	Adult-Use	Claim Restrictions	State Regulator	Marketing/Advertising Law
Alabama	Yes	No	Restricted unless supported by substantial clinical data	Alabama Medical Cannabis Commission	Ala. Admin. Code r. 538-X-4-.17
Alaska	Yes	Yes	Restricted	The director, an enforcement agent, an employee of the board, or a peace officer acting in an official capacity	Alaska Admin. Code tit. 3, § 306.770
American Samoa	No	No	N/A	N/A	N/A
Arizona	Yes	Yes	No Restriction	Arizona Department of Health Services	Ariz. Rev. Stat. § 36-2859
Arkansas	Yes	No	Restriction on false statements	Arkansas Alcoholic Beverage Control Board	Arkansas Medical Marijuana Amendment of 2016
California	Yes	Yes	Prohibits false or misleading therapeutic claims	Department of Cannabis Control	Cal. Bus. & Prof. Code § 26150
Colorado	Yes	Yes	Restricted	Colorado Marijuana Enforcement Division	1 Colo. Code Regs. § 212-3
Connecticut	Yes	Yes	Restricted unless substantiated or conveyed by medical professional	The Department of Consumer Protection	Conn. Gen. Stat. § 21a-421bb
Delaware	Yes	Yes	No Restriction	The Marijuana Commissioner	Delaware Marijuana Control Act
District of Columbia	Yes	Yes	Prohibits false or misleading health benefit statements	Alcoholic Beverage and Cannabis Administration	D.C Municipal Regulations Title 22-C 5801.2
Florida	Yes	No	No Restriction	Florida Department of Health	381.986. Medical Use of Marijuana
Georgia	Yes*	No	No Restriction	Georgia Access to Medical Cannabis Commission	Ga. Comp. R. & Regs. 351-6-.07
Guam	Yes	No	Cannot represent a curative or therapeutic effect	Guam Cannabis Control Board	11 Guam Code §§ 8101 - 8120
Hawaii	Yes	No	No unsubstantiated, false, or misleading claims	Director of the Hawaii Department of Health	Haw. Code R. § 11-850-145
Idaho	No	No	N/A	N/A	N/A

State	Medical	Adult-Use	Claim Restrictions	State Regulator	Marketing/Advertising Law
Illinois	Yes	Yes	Restricted	Illinois Department of Public Health	410 Ill. Comp. Stat. Ann. 705/55-20
Indiana	No*	No	N/A	N/A	N/A
Iowa	Yes*	No	Prohibits unsubstantiated medical claims and business website false, misleading, or unsubstantiated statements.	Iowa Department of Public Health	Iowa Admin. Code R.641-154.44
Kansas	No	No	N/A	N/A	N/A
Kentucky	No*	No	N/A	N/A	N/A
Louisiana	Yes	No	No Restriction	Louisiana Department of Health	Louisiana HB 524
Maine	Yes	Yes	Restricted	Maine Department of Administrative and Financial Services - Office of Cannabis Policy	CMR 18-691-001
Maryland	Yes	Yes	Claims must be supported by competent and reliable scientific evidence	Maryland Cannabis Administration	2023 Md. ALS 254, 2023 Md. Laws 254, 2023 Md. Chap. 254, 2023 Md. HB 556
Massachusetts	Yes	Yes	Claims must be supported by substantial evidence or substantial clinical data with reasonable scientific rigor	Massachusetts Cannabis Control Commission	935 CMR 500.105
Michigan	Yes	Yes	Restricted unless complies with FDA Letter of Enforcement Discretion or other FDA approval	The Marijuana Regulatory Agency	Mich. Admin. Code r. 420.507
Minnesota	Yes	Yes	Cannot make unverified claims	The Office of Cannabis Management	Chapter 121, Article 2, Section 131
Mississippi	Yes	No	Restricted	Mississippi State Department of Health	15 Miss. Code R. § 22-6.1
Missouri	Yes	Yes	Cannot make unverified claims unless such statement has been evaluated and approved by the FDA	Missouri Department of Health and Senior Services	19 CSR 100-1.010
Montana	Yes	Yes	No Restriction	Montana Cannabis Control Division	Mont. Admin. R. 42.39.123
Nebraska	No	No	N/A	N/A	N/A
Nevada	Yes	Yes	No Restriction	NV Cannabis Compliance Board	Nev. Rev. Stat. Ann. § 678B.520

State	Medical	Adult-Use	Claim Restrictions	State Regulator	Marketing/Advertising Law
New Hampshire	Yes	No	Prohibition on Misrepresentation	NH Department of Health and Human Services	Section 126-X:6
New Jersey	Yes	Yes	Claim must be demonstrated by substantial scientific or clinical evidence consisting of two or more studies.	New Jersey Cannabis Regulatory Commission	N.J. Admin. Code § 17:30-17.2
New Mexico	Yes	Yes	Cannot make unproven claims. Claims must be supported by substantial evidence or substantial clinical data	New Mexico Regulation and Licensing Department, Cannabis Control Division	N.M. Code R. § 16.8.3.8
New York	Yes	Yes	Restricted	NY Cannabis Control Board	N.Y. Can. 86
North Carolina	No	No	N/A	N/A	N/A
North Dakota	Yes	No	No Restriction	ND Department of Health	N.D. Admin. Code 33-44-01-23
Northern Mariana Islands	Yes	Yes	No false or misleading statements	Commonwealth of the Northern Mariana Islands Cannabis Commission	§ 180-10.1-1110
Ohio	Yes	No	Under medical marijuana laws, cannot make therapeutic claims about recreational marijuana	Ohio Department of Commerce	Ohio Admin. Code Rule 3796:5-7-01
Oklahoma	Yes	No	No statements that are statements that are deceptive, false, or misleading, or "represents that the use of marijuana has curative or therapeutic effects"	Oklahoma Medical Marijuana Authority	Okla. Admin. Code § 442:10-7-3
Oregon	Yes	Yes	Claim must be supported by the totality of publicly available scientific evidence.	The Oregon Liquor and Cannabis Commission	OAR 845-025-8040

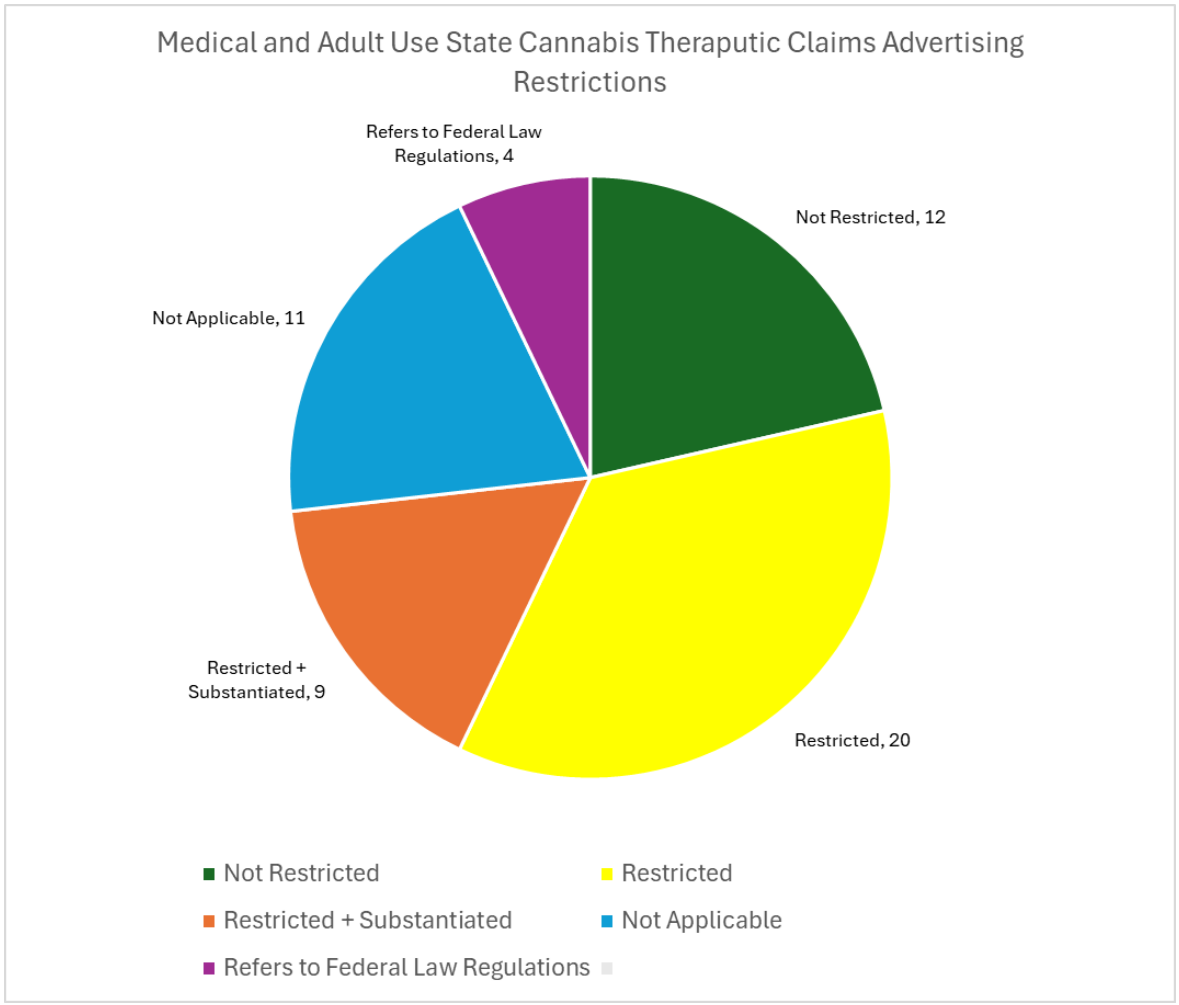
State	Medical	Adult-Use	Claim Restrictions	State Regulator	Marketing/Advertising Law
Pennsylvania	Yes	No	Advertising and Marketing must be consistent with federal regulations governing prescription drug advertising and marketing in 21 CFR 202.1 (relating to prescription-drug advertisements)	Pennsylvania Department of Health	28 Pa. Code § 1141a.50
Puerto Rico	Yes	No	No Restriction	The Medicinal Cannabis Regulatory Board within Puerto Rico's Department of Health	§ 2625 Regulations
Rhode Island	Yes	Yes	No Restriction	An Independent Three Member Commission	R.I. Gen. Laws Section 21-28.11-5
South Carolina	No	No	N/A	N/A	N/A
South Dakota	Yes	No	Prohibits deceptive false or misleading statements. Prohibits curative or therapeutic effect claims. Cannot claim any health or physical benefits	South Dakota Department of Health	Admin. Code R. ARSD 44:90:10:17-19
Tennessee	No*	No	N/A	N/A	N/A
Texas	Yes*	No	No Restriction	Texas Department of Public Safety	37 Tex. Admin. Code 1, Chap.12
Utah	Yes	No	No statement, claim, or information that would violate the federal Food, Drug, and Cosmetic Act, 21 U.S.C. Sec. 301	Department of Government Operations	4-41a-403
Vermont	Yes	Yes	No Restriction	Cannabis Control Board	Vt. Stat. Ann. tit. 7, § 864
Virgin Islands	Yes	Yes	No false or misleading statements	Office of Cannabis Regulation	2024 VICUA
Virginia	Yes	Yes	No advertisements that are "misleading, deceptive, or false"	Virginia Cannabis Control	Virginia § 4.1-1401

State	Medical	Adult-Use	Claim Restrictions	State Regulator Authority	Marketing/Advertising Law
Washington	Yes	Yes	Restricted	Washington State Liquor and Cannabis Board	Wash. Admin. Code § 314-55-155
West Virginia	Yes	No	No statements that are statements that are deceptive, false, or misleading	West Virginia Bureau for Public Health within the WV Department of Health and Human Resources	W. Va. Code R. § 64-109-23
Wisconsin	No	No	N/A	N/A	N/A
Wyoming	No	No	N/A	N/A	N/A

* As of July 3, 2024, CBD Oil with THC has an ingredient is illegal, but subject to state limits e.g., CBD oil may be legal to 0.5% THC.

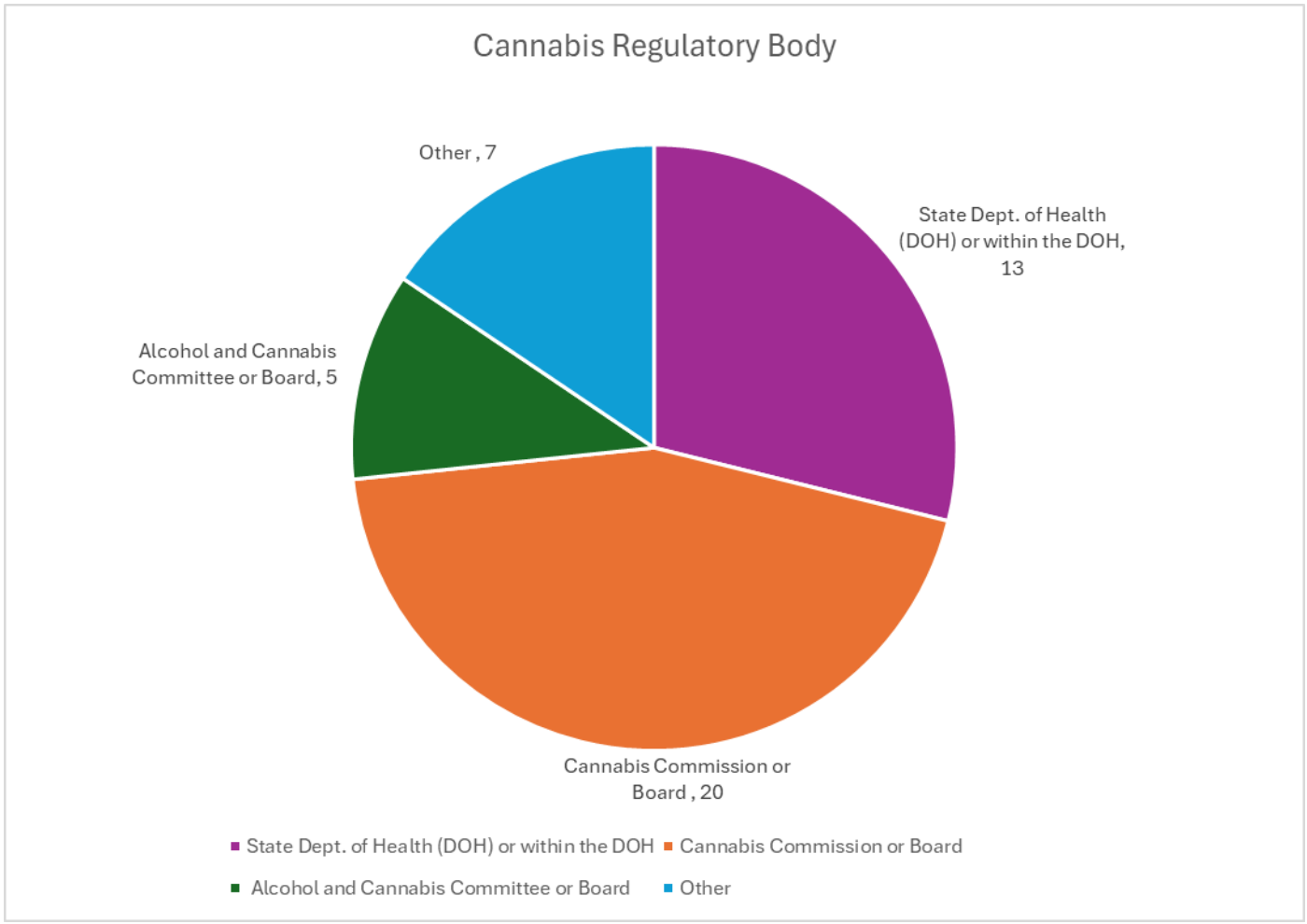
** Medical Cannabis Legal in 2025

TABLE 5. STATE CLAIM RESTRICTION DATA CHART



Not Restricted	Restricted	Restricted + Substantiated	Not Applicable	Refers to Federal Law Regulations
Arizona	Alaska	Alabama	American Samoa	Michigan
Delaware	Colorado	Connecticut	Idaho	Missouri
Florida	Guam	Iowa	Indiana	Pennsylvania
Georgia	Illinois	Maryland	Kansas	Utah
Louisiana	Maine	Massachusetts	Kentucky	
Montana	Mississippi	Minnesota	Nebraska	
Nevada	New York	New Jersey	North Carolina	
North Dakota	Ohio	New Mexico	South Carolina	
Puerto Rico	Oklahoma	Oregon	Tennessee	
Rhode Island	Washington		Wisconsin	
Vermont	Arkansas		Wyoming	
Texas	California			
	District of Columbia			
	Hawaii			
	New Hampshire			
	Northern Mariana Islands			
	South Dakota			
	US Virgin Islands			
	Virginia			
	West Virginia			

TABLE 6. STATE CANNABIS REGULATORY BODY DATA CHART



State Dept. of Health (w/i) Department of Health	Cannabis Commission or Board	Alcohol and Cannabis Committee or Board	Other
Arizona	Alabama	Alaska	Connecticut
Florida	California	Arkansas	Maine
Hawaii	Colorado	District of Columbia	New Mexico*
Illinois	Delaware	Oregon	Ohio
Iowa	Georgia	Washington	Rhode Island**
Louisiana	Guam		Utah
Mississippi	Maryland		Texas*****
Missouri	Massachusetts		
New Hampshire	Michigan		
North Dakota	Minnesota		
Pennsylvania	Montana		
South Dakota	Nevada		
West Virginia***	New Jersey		
	New York		
	Northern Mariana Islands		
	Oklahoma		
	Puerto Rico****		
	Vermont		
	US Virgin Islands		
	Virginia		

*New Mexico Regulation and Licensing Department, Cannabis Control Division
**R.I. Gen. Laws § 21-28.11-2
***West Virginia Bureau for Public Health within the WV Department of Health and Human Resources
**** The Medicinal Cannabis Regulatory Board within Puerto Rico's Department of Health
***** Texas Department of Public Safety

REPORT 2 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (I-24)
Drug Shortages: 2024 Update
(Reference Committee K)

EXECUTIVE SUMMARY

BACKGROUND. American Medical Association (AMA) Policy H-100.956, "National Drug Shortages," directs the Council on Science and Public Health (CSAPH) to evaluate the drug shortage issue and report back at least annually to the House of Delegates (HOD) on progress made in addressing drug shortages in the United States (U.S.). Drug shortages are defined by the Food and Drug Administration (FDA) as "a period of time when the demand or projected demand for the drug within the United States exceeds the supply of the drug." This report provides an update on continuing trends in national drug shortages and ongoing efforts to further evaluate and address this critical public health issue. Additionally, Resolution 922-I-23, "Prescription Drug Shortages and Pharmacy Inventories" was referred for study. Due to the similarity of their subject matter, these two reports have been combined.

METHODS. English-language reports were selected from a PubMed and Google Scholar search from September 2021 to June 2024, using the text terms "drug shortages" and "prescription transfers". Additional articles were identified by manual review of the references cited in these publications. Further information was obtained from the Internet sites of the FDA, National Academies of Sciences, Engineering, and Medicine, U.S. Department of Health and Human Services, American Society of Health-System Pharmacists, and Duke Margolis Center for Health Policy, and contemporary media reporting.

DISCUSSION. Drug shortages remain an ongoing and complex public health concern in the United States and the AMA continues to monitor the situation and act when appropriate. Overall, drug shortages are the highest they have been in a decade, including many instances of high-profile drug shortages with visibility in the public sphere, including amphetamine/dextroamphetamine salts (trade name Adderall or Mydayis) and semaglutide (trade name Ozempic, Wegovy, or Rybelsus). This report examines three categories of drugs in shortage, controlled substances, generic drugs, and on-patent drugs as well as proposed government actions to address them.

CONCLUSION. Drug shortages continue to be a complicated, multi-factorial issue which directly impacts patient care in the U.S. The AMA's policy regarding drug shortages is timely and comprehensive, and updates are proposed to align with the topics discussed. New policy is also recommended for regulations or market practices which limit access to drugs even if there is adequate supply, functioning as an artificial shortage.

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 2-I-24

Subject: Drug Shortages: 2024 Update
(H-100.956 and Resolution 922-I-23)

Presented by: John T. Carlo, MD, Chair

Referred to: Reference Committee K

American Medical Association (AMA) Policy H-100.956, "National Drug Shortages," directs the Council on Science and Public Health (CSAPH) to evaluate the drug shortage issue and report back at least annually to the House of Delegates (HOD) on progress made in addressing drug shortages in the United States. Drug shortages are defined by the Food and Drug Administration (FDA) as "a period of time when the demand or projected demand for the drug within the United States (U.S.) exceeds the supply of the drug." This report provides an update on continuing trends in national drug shortages and ongoing efforts to further evaluate and address this critical public health issue.

Additionally, Resolution 922-I-23, "Prescription Drug Shortages and Pharmacy Inventories" was referred for study. Resolution 922-I-23 asked that our AMA:

> work with the pharmacy industry to develop and implement a mechanism to transfer prescriptions without requiring a new prescription [and] advocate for legislation and/or regulations permitting pharmacies to transfer prescriptions to other pharmacies when prescription medications are unavailable at the original pharmacy or the patient requests the prescription be transferred.

Due to the similarity of their subject matter, these two reports have been combined.

CSAPH has issued 14 reports on drug shortages, with the most recent being at the 2023 Interim Meeting of the HOD. As such, this report will focus on developments that have occurred primarily in the last year and the near horizon.

METHODS

English-language reports were selected from a PubMed and Google Scholar search from September 2021 to June 2024, using the text terms "drug shortages" and "prescription transfers". Additional articles were identified by manual review of the references cited in these publications. Further information was obtained from the Internet sites of the U.S. Food and Drug Administration (FDA), National Academies of Sciences, Engineering, and Medicine, U.S. Department of Health and Human Services (HHS), American Society of Health-System Pharmacists (ASHP), and Duke Margolis Center for Health Policy, and contemporary media reporting.

DISCUSSION

Current Trends in Drug Shortages

The year 2024 marked the worst year on record for drug shortages, with 323 individual drug shortages reported in Q1, more than any year with data collected.[1] Several drugs in shortage received significant media attention, such as mixed amphetamine salts (MAS) for the treatment of attention-deficit hyperactivity disorders, where only approximately 42 percent of prescriptions were filled in 2023.[2] While there appears to be some positive movement on this front, such as reports that brand-name MAS products are in-stock, problems sourcing lower cost generic medications still persist.[3] Similarly, a National Comprehensive Cancer Network study found that platinum-based chemotherapy shortages were easing, with only seven percent of surveyed centers reporting a shortage of cisplatin, down from 70 percent in 2023.[4] However, that same report found that 89 percent of cancer centers reported a shortage of at least one critical anti-cancer agent, demonstrating that while progress can be made on individual drug shortages, systemic issues in drug procurement remain.[4]

According to ASHP statistics (see Appendix 1), trends in drug shortages have gotten worse in the last year.[5] Continuing the trend from 2023, new drug shortages are continuing to rise, and existing drug shortages take longer to resolve. When combined, these two factors have resulted in the worst year of drug shortages recorded. For the first quarter of 2024, there have been 48 new drugs in shortage. If that trend were to continue for the remainder of the calendar year, 2024 would have the most new drug shortages since 2012. So far in 2024, the five classes of drugs facing the largest number of shortages are: central nervous system therapies (66), antimicrobials (43), hormones (34), chemotherapies (32), and fluids/electrolytes (25), placing significant burden on physicians and patients across all health care settings, including urban, rural, and outpatient and inpatient.

More optimistically, the number of high-profile drugs, such as chemotherapy agents, and overall severity of current shortages has resulted in a marked increase in activity from lawmakers, regulators, and stakeholder groups, including the AMA, in addressing and alleviating drug shortages. Drug shortage developments in the past year can broadly be divided into three categories described in this report: controlled substances, generic drugs, and on-patent drugs.

Controlled Substances and Artificial Shortages

Controlled substances, such as MAS and opioids, have been a topic of interest in several of the past drug shortages reports, and persist as a class of interest. In previous reports, the Council has described how manufacturing quotas from the Drug Enforcement Administration (DEA) have unnecessarily created drug shortages for some controlled substances, including MAS. The AMA continues to monitor this issue and act where appropriate, as described later in this report.

The national opioid litigation settlement agreements have created issues for accessing controlled substances. In 2021, nationwide settlements were reached between state attorneys general and a series of opioid manufacturers and distributors. In 2022, additional settlements were reached with several pharmacy chains. These settlements represented significant negotiations and included billions of dollars in payments and substantial changes to policies regarding the production, distribution, and marketing of opioids and other controlled substances. While most of the topics covered by the settlements are outside the scope of this report, there have been changes to distributors' risk mitigation and suspicious order surveillance and reporting which may have artificially created or otherwise exacerbated drug shortages.

Under the distributors settlement agreement, Exhibit P requires, among other things, that distributors and pharmacies abide by a series of new "red flag" regulations regarding the fulfillment, ordering, and dispensing of controlled substances.[6] These red flag policies include requirements to monitor and identify pharmacies and prescribers' "ordering ratio" of controlled

substances to non-controlled substances, "excessive" ordering of controlled substances, orders to fill prescriptions of patients traveling more than 50 miles from the pharmacy, and multiple different metrics for "top prescribers" of controlled substances. Any one of these metrics (or others) are further influenced by—and most relevant to this report—extensive requirements for distributors to set "thresholds" on the amount and type of medication it will supply to a pharmacy. In the event a pharmacy exceeds its threshold limit for the procurement of controlled substances, its orders of controlled substances may be canceled, held for further inquiry or reported to the DEA as a suspicious order report. Unlike production quotas which are calculated by the DEA and made public, distributors and pharmacies implementing the red flag and threshold policies are not subject to any measure of transparency or review of implications on patients' access to care. Further, these thresholds may vary widely between distributors, impacting some pharmacies more than others, which is of particular concern when patients may have limited choice for pharmacies they can utilize.

In May 2024, the AMA joined the American Pharmacists Association (APhA), the American Society of Addiction Medicine, and ASHP in writing to the DEA and other federal stakeholders with concerns about this approach.[7] The letter described reports of pharmacies choosing not to keep adequate stock of controlled substance medications out of fear that suspicious order reports will be filed against them, or that they will be cut off from purchasing other critical controlled substance medications. As such, individual pharmacies are unable to fill prescriptions not due to a lack of supply or demand, but rather an artificial barrier that acts like a shortage for patients and physicians. Through its work with these and other physician and pharmacy organizations, the AMA has learned of physicians and/or pharmacies being cut off from ordering medication or being able to prescribe medication, including opioids, stimulants, and medications for opioid use disorder, in multiple states.

These pharmacy-specific shortages are further amplified by the electronic prescription regulatory landscape. Historically, when prescriptions were handwritten, the transference of a prescription from one pharmacy to another was a simple affair – if there was a lack of stock at one pharmacy, the patient could simply bring their written prescription to a new pharmacy. With the ubiquity of electronic prescriptions, however, concerns over multiple fillings (either accidental or intentional) of a single prescription by different locations has hampered this process. For example, if an electronic prescription has been received and begun to be processed by a pharmacy after it has closed for the day, it cannot be transferred to another, open pharmacy and the patient would be required to go back to their original prescriber to cancel the current prescription and then file a new one. Additionally, some pharmacies maintain policies where they do not disclose to patients if they have controlled substances in stock, meaning that the prescribing physician can often be further tasked with calling the pharmacy directly to inquire if a prescription can be filled.

Prior to August 28th, 2023, it was also illegal to transfer any prescription from one pharmacy to another for a Schedule II through V controlled substance. This rule was only recently modified to allow a single, one-time-only transfer for the initial filling for these drugs. The entire prescription, including any authorized refills, must all be filled at the same pharmacy, and must otherwise comply with state laws. It should be noted that some states may have stricter laws around pharmacy transfers than those proposed by the DEA, and as such would not benefit from this rule-change. Additionally, prescriptions may be required to be transferred by other entities, such as payers who have changed their in-network requirements for coverage. In those instances, a patient may have a prescription already filled at one pharmacy, but are unable to pay for it, meaning it may be impossible to re-prescribe, and then have payers cover a new prescription.

Currently, our AMA maintains two policies on prescription transfers: H-120.923, "Legalization of Interpharmacy Transfer of Electronic Controlled Substance Prescriptions" and H-120.920, "Access to Medications" (full text available at the end of this report). Briefly, they outline our AMA's support for legislative and regulatory changes which increase the ease of transferring prescriptions, particularly when prescriptions are for controlled substances. When combined with policy changes from the opioid settlement, these restrictions on prescription transfers can result in wholly artificial, localized drug shortages that prevent patients from accessing critical medications, even if the manufacturers have adequate supply.

Pharmacy Benefit Managers

Artificial drug shortages are further exacerbated by the increasing consolidation of power in intermediaries, such as pharmacy benefit managers (PBMs), who use their purchasing power to dictate the drugs patients can access. In last year's report, the practice of PBMs only including drugs in shortage on their formularies, while excluding available alternatives, was discussed. AMA policy opposes this practice. In July of this year, the Federal Trade Commission (FTC) released an interim report into their investigation into PBM practices.[8]

While much of the focus was on PBMs increasing prices for costly, branded medications, several alarming trends emerged regarding PBM practices creating artificial drug shortages. For example, CVS Caremark, the largest PBM in the country, processed 34 percent of U.S. prescriptions in 2023, and owns its own chain of retail pharmacies. In their report, the FTC found that CVS Caremark forced patients to use CVS pharmacies, which causes smaller pharmacies to become financially unviable. This lack of choice further ingrains artificial drug shortages, particularly when an individual pharmacy may be choosing to not stock a certain drug, or prescription transfers are blocked. While CVS Caremark was the only PBM with a retail pharmacy chain, all major PBMs analyzed utilized their own pharmacies for mail-order and specialty products.

Of particular relevance to this report is the experience described by a patient's public comment received by the FTC, which describes their experience being required to utilize a PBM-owned pharmacy:

> *I generally have to place around 20 phone calls, often spending upwards of 10 hours on the phone with Accredo, before my medication finally gets shipped. In total I am waiting 3+ weeks to receive my medication [...] I have explained to my insurance company that the requirement to use Accredo results in delays receiving my medication, but they refuse to authorize me to use an alternative pharmacy […] in my community that could provide me my medication the same day.*[9]

Similarly, manufacturer GSK halted production of its asthma medication Flovent (fluticasone propionate) in January 2024.[10] The company claimed that due to restrictions on sudden price increases, the product was no longer financially viable, but they only left the market once a generic version was available. However, reporting suggests that these generic products are not available on formularies, in part due to the inability for generic manufacturers to provide rebates to PBMs, effectively removing access to these critical medications.[11]

These changes coincided with the removal of the cap on Medicaid rebates in the American Rescue Plan Act of 2021. Previously, Medicaid drug rebates were calculated based on a percentage of the historic average price. For example, Flovent (fluticasone) HFA and Diskus, which had recently

been increasing prices at a much higher rate than inflation, were thus faced with significantly higher rebates owed.[12] By authorizing a new generic product that did not have the same pricing history as the original branded product, GSK was able to escape paying these higher Medicaid rebates. As a result, PBMs may choose to not add the generic to their formulary despite its lower list price due to its net price (list price minus rebate) being higher than the previously available branded product.

In response to the FTC's report, members of Congress have indicated support for PBM regulations to address vertical consolidation and several of the practices which lead to artificial drug shortages, such as the skirting of Medicaid rebates.[13,14]

GENERIC DRUGS, COST CONTROL, AND STOCKPILES

Congressional Proposals

As described in detail in previous drug shortage reports, one of the persistent sources of drug shortages are poor manufacturer incentives to produce low-cost generic drugs. One of the leading risk factors for a drug being under shortage is the age of the drug.[15] This may seem counterintuitive – the longer a drug has been on the market, the better understanding we should have of expected demand, and have had more time to improve manufacturing yields. However, age has a significant impact on profit margins and thus market supply. Since cisplatin and carboplatin are available as generic medications, the profit incentives for their manufacturing dramatically decreases. The unit price of cisplatin and carboplatin are estimated to be $15 and $23 USD, respectively.[16] For several generic drugs, there may only be one or two manufacturers that have been able to produce the drug with a razor-thin profit margin, and any disruption, such as an FDA quality inspection, a natural disaster, or a change in ingredient prices, may cause manufacturers to halt manufacturing entirely rather than invest further.

One of the proposed legislative solutions is to require hospitals or other procurers to pay more for generic drugs. For example, the currently proposed version of the Drug Shortage Prevention and Mitigation Act contains provisions which would exclude generic drugs in shortage from the 340B Drug Pricing Program, and/or waive inflation rebates under the Medicaid Drug Rebate Program if it were to pass.[17] Under the proposed law, generic drugs in shortage would see their purchasing prices increase, with the intention of incentivizing more manufacturers to begin producing the generic drug in question at increased profit.

However, by increasing profit margins only on drugs in shortage, it creates a financial incentive for manufacturers to allow for their drugs to slip into dangerously short supply rather than invest in more efficient manufacturing practices. If the drug supply is then stabilized and the financial incentive goes away, there is no guarantee that the same manufacturers will simply again choose to opt-out of manufacturing a low-profit drug, creating the shortage all over again. The AMA has sent comment on record to the Senate Finance Committee expressing concerns over the bill and a willingness to work towards actionable legislation addressing drug shortages.[18]

To incentivize manufacturers to invest in efficient manufacturing, the FDA maintains an Advanced Manufacturing Technologies (AMT) Designation program.[19] In the AMT program, manufacturers can obtain this initial designation by demonstrating to the FDA that their drug manufacturing uses new technologies, or utilizes older technologies in innovative ways to increase quality and/or quantity of drugs produced. Beyond improvements in yield, the FDA details that manufacturers will gain other benefits, such as increased priority for communications, although these benefits are more targeted to New Drug Applications, with lesser benefit to those seeking to upgrade ongoing

processes or generic drug manufacturing. As such, a financial incentive, either through direct grant or adjustment of user fees, may be necessary for those manufacturing generic medications to increase uptake of AMT. The initial guidance for the AMT Designation program is anticipated to be finalized in late 2024 or early 2025 and will be continued to be monitored for its impact on mitigating drug shortages.

Health and Human Services Proposal

A separate approach to stabilizing the generic medication supply chain has gained traction over the last few years, as described in a white paper released from the HHS, "Policy Considerations to Prevent Drug Shortages and Mitigate Supply Chain Vulnerabilities in the United States".[20] The HHS white paper outlines two major policy proposals: (1) the Manufacturer Resiliency Assessment Program (MRAP), and (2) the Hospital Resilient Supply Program (HRSP).

Under MRAP, HHS would contract with a private entity to evaluate manufacturers based on their expected resilience against shortages and provide a publicly available "scorecard." The criteria manufacturers will be judged upon has not been decided but could include the ability to acquire ingredients from multiple sources, regional geopolitical stability, level of investment in innovation, and frequency of communication with U.S. regulators. It is believed that by having the scorecard available, hospitals and group purchasing organizations would be able to evaluate multiple manufacturers and may be willing to pay a premium for drugs that come from facilities with a lower risk of supply disruption. This approach is aligned with current AMA policy H-100.956, "National Drug Shortages," regarding manufacturer quality.

HRSP, however, would focus on rewarding and penalizing hospitals for their purchasing behaviors. Briefly, health systems, hospitals or even individual practices, would be incentivized to enter into longer-term, fixed volume purchasing agreements, and thus maintain an individual stockpile of drugs that are at high risk for having a shortage. Theoretically, these stockpiles would minimize disruptions to care during an active shortage, while also giving manufacturers a steadier, more reliable stream of income by entering into longer-term contracts with easily anticipated demand. In its current proposal, HHS seeks to emulate the Promoting Interoperability program they leveraged for electronic health record uptake.[21] Briefly, the Promoting Interoperability program scores participants on a number of criteria regarding their use of electronic medical records, such as electronic prescriptions, provider-to-patient information communication, and information exchange with public health and other clinical entities. To encourage initial uptake, eligible participants received incentive payments for achieving a certain score, but those incentives have since been phased out and instead replaced with a penalty in Medicare payment for non-participation. Under HRSP, hospitals would have Medicare payments and penalties linked to activities intended to promote a healthier generic drug manufacturing ecosystem. For example, hospitals would be rewarded for (or punished for not) maintaining their own stockpiles of essential medicines, entering in longer-term contracts, having minimum volume purchasing requirements, or purchasing from entities with higher MRAP-administered scores.

Under the current proposal, HRSP would only apply to inpatient hospitals. Incentives and penalties would apply for the first five years of the program and would aim to move to a penalty-only model after year six. While there is no current AMA policy describing an approach such as that described in HSRP, when a similar punitive approach was taken towards EHR interoperability, the AMA opposed it in part due to the physician's inability to control the EHR products on the market.[22] Similarly, physicians may have limited influence on the contracts which drug manufacturers are willing to enter into, particularly for smaller practices with limited purchasing power.

Beyond the punitive approach the proposed HSRP would have on physicians and hospitals, it is also not necessarily a proven strategy for addressing many common causes of drug shortages. For example, penicillin is currently experiencing a shortage in part due to a surge of syphilis cases.[23] While stockpiles may help initially with lapses in supply, they do little to buffer against surges in demand. HRSP is currently very narrowly targeted at generic sterile injectables, in part to address this. Additionally, buffer supplies may place a significant administrative burden on hospitals for managing a drug stockpile, promote waste, and could exacerbate the stark divide between well-funded academic centers and rural hospitals competing for essential medicines.

ON-PATENT DRUGS AND QUESTIONABLE MARKET PRACTICES

By contrast, drugs which are on-patent and highly profitable but otherwise experiencing a shortage have the inverse problem to generic drugs: it is so enticing for market actors to source these drugs that they may skirt regulations or best practices.

For example, in previous versions of this report, the advertising practices of semaglutide and other glucagon-like peptide-1 (GLP-1) agonists were discussed. Unlike many other drugs under shortage, semaglutide's increase in popularity can largely be attributed to a massive advertising presence, particularly through social media. For example, one report suggests that by November 2022, one hashtag (#Ozempic) was viewed over 273 million times on the social media platform TikTok.[24] Since then, the semaglutide shortage has persisted, with demand expected to continue to grow as more uses for GLP-1 agonists emerge. Prolonged shortages combined with ultra-high demand have attracted several bad actors, including significant concerns over counterfeit products being sold to pharmacies struggling to keep up with patient needs.[25]

Due to the highly profitable nature of semaglutide sales, several online companies, such as Hims & Hers Health, have begun to utilize a rule in the Food, Drug & Cosmetics Act which allows for compounding pharmacies to prepare compounded forms of drugs experiencing a shortage, even if they are not the patent holder.[26] This rule was intended for instances where the precursors or active ingredients for these drugs are readily available on the market, but the manufacturers are experiencing difficulty with final-stage processes, commonly known as fill-finish. In those instances, compounding pharmacies could serve as a valuable, temporary stop-gap solution to getting patients a useable form of the drug.

However, the FDA has reported that compounders may be using non-approved forms of semaglutide, such as its salts, which are a different active ingredient, have a different safety profile, and have not been evaluated for safety and efficacy by the FDA.[27] In July 2024, the FDA released a warning around compounded semaglutide and an increased risk for overdose.[28] Additionally, marketing these products designed for continuous, chronic use, to new patients amidst a shortage may be irresponsible. In its report to investors, Hims & Hers Health disclosed that in the quarter after they started offering compounded semaglutide, they saw a 45 percent increase in online revenue, a record 172,000 new subscribers to their platform, and expect their weight loss offerings to result in over $100 million in sales.[29]

When utilized appropriately, rules that allow for compounders to bolster the supply of drugs in shortage are a useful tool for ensuring that patients have continuous access to the medications they need. However, when they are utilized as an attempt to accrue market share for popular drugs that still retain patent protections, patient safety and unfair market practices should be investigated.

Telemedicine prescribing, particularly for controlled substances, has been an area of increased scrutiny from federal regulators in the past years. Since COVID-19 flexibilities allowed for

expanded access and comfort with telemedicine, there have been increases in demand for some medications, particularly for those which may carry stigma such as MAS. In some instances, telemedicine companies have abused these new flexibilities for profit rather than for patient wellbeing. In June 2024, a telehealth company CEO was indicted by the Department of Justice for fraudulent reimbursement claims for prescriptions of MAS.[30] In the indictment, the company was accused of using deceptive marketing practices to drive individuals to their service, where they would prescribe MAS even when not medically necessary, resulting in an estimated $100 million in profit and flooding the market with unnecessary demand, exacerbating shortages. The resulting surge in demand resulted in the Centers for Disease Control and Prevention issuing a Health Advisory Notice for potential treatment disruptions.[31]

Newly utilized and expanded flexibilities on telemedicine and prescribing have been an ongoing tension between access and drug shortages. Bad actors have utilized deceptive marketing practices to drive profits over patient wellbeing and made it challenging for patients with valid prescriptions to source the medications they need. The AMA has been in regular communication with the DEA and other regulators overseeing telemedicine prescribing flexibilities, including a 2023 letter on prescriptions for patients that have not had an in-person examination with their physician.[32] Amongst its other recommendations, the AMA recommended that the DEA focus its enforcement efforts on outlier practices, such as companies using deceptive advertising, rather than placing additional barriers to care on legitimate telemedicine encounters.

ADDITIONAL AMA ACTIVITIES

The AMA has been active in combatting drug shortages. Advocacy efforts have been targeted at both legislators and regulators to create impactful policies that could help alleviate drug shortages. The AMA also served as a subject matter expert for the Government Accountability Office's ongoing review of the federal government's response to drug shortages.

Beyond advocacy, the AMA is a founding member of the Task Force on Preventing and Mitigating Drug Shortages, a national group including the US Pharmacopeia, the Association for Clinical Oncology, APhA, ASHP, the American Cancer Society Action Network, the National Consumers League, the Susan G. Komen Foundation, and more. For drug-specific shortages, such as those observed with buprenorphine, other AMA groups such as the Substance Use and Pain Care Taskforce, which includes many members from the Federation of Medicine, have also convened to discuss challenges and engaged in advocacy outreach. The AMA continues to build upon its profile as a thought leader and advocate in this space, including initiating new research projects on the impacts of drug shortages on physician practices, and speaking at academic conferences on the subject.

As drug shortages will continue to be studied and reported on with an annual cadence, some topics relevant to drug shortages are currently being monitored but may be included in a future report, such as Section 804 importation programs, wherein individual states may directly contract with Canadian manufacturers for drug importation, a recently announced study by the Department of Commerce on the health of the precursor supply chain, and the roll-out of compulsory licensing and march-in rights for drugs developed with significant public investment.[33-35]

CONCLUSIONS

Drug shortages continue to be a persistent problem for patient safety and the quality of health care patients receive. Due to the increase in highly visible drugs experiencing a shortage, along with advocacy from groups such as the AMA, there has been an increase in both urgency and action

from legislators and regulators. In the past year, new proposals have included a report-card system for drug manufacturers, an emphasis on buffer supplies, and multiple strategies for stabilizing the generic drug supply chain. However, given the significant implications of some of the proposed programs, a more nuanced approach may be required to achieve the desired outcomes. To that end, updates have been recommended to the AMA's existing drug shortage policy to reflect the current landscape. Additionally, artificial barriers to drug access, procurement thresholds and restrictions on pharmacy choice, were examined. Given the subtle distinction between these practices and a traditional drug shortage, in which supply does not meet demand, a new standalone policy is recommended. Finally, existing AMA policy regarding inter-pharmacy prescription transfers and pharmacy benefit managers was reviewed and found to be supportive and synergistic with current drug shortage policy and is thus recommended for reaffirmation.

RECOMMENDATIONS

The Council on Science and Public Health recommends that the following be adopted in lieu of Resolution 922-I-23, and that the remainder of the report be filed:

1. That Policy H-100.956, "National Drug Shortages," be amended by addition and deletion to read as follows:

1. Our American Medical Association considers drug shortages to be an urgent public health crisis, and recent shortages have had a dramatic and negative impact on the delivery and safety of appropriate health care to patients.
2. Our AMA supports recommendations that have been developed by multiple stakeholders to improve manufacturing quality systems, identify efficiencies in regulatory review that can mitigate drug shortages, and explore measures designed to drive greater investment in production capacity for products that are in short supply, and will work in a collaborative fashion with these and other stakeholders to implement these recommendations in an urgent fashion.
3. Our AMA supports authorizing the Secretary of the U.S. Department of Health and Human Services (DHHS) to expedite facility inspections and the review of manufacturing changes, drug applications and supplements that would help mitigate or prevent a drug shortage.
4. Our AMA will advocate that the U.S. 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.
5. The Council on Science and Public Health shall continue to evaluate the drug shortage issue, including the impact of group purchasing organizations and pharmacy benefit managers on drug shortages, and report back at least annually to the House of Delegates on progress made in addressing drug shortages.
6. Our AMA urges continued analysis of the root causes of drug shortages that includes consideration of federal actions, evaluation of manufacturer, Group Purchasing Organization (GPO), pharmacy benefit managers, and distributor practices, contracting practices by market participants on competition, access to drugs, pricing, and analysis of economic drivers, and supports efforts by the Federal Trade Commission (FTC) to oversee and regulate such forces.
7. Our AMA urges regulatory relief designed to improve the availability of prescription drugs by ensuring that such products are not removed from the market or caused to stop

production due to compliance issues unless such removal is clearly required for significant and obvious safety reasons.

8. Our AMA supports the view that wholesalers should routinely institute an allocation system that attempts to fairly distribute drugs in short supply based on remaining inventory and considering the customer's purchase history.
9. Our AMA will collaborate with medical specialty society partners and other stakeholders in identifying and supporting legislative remedies to allow for more reasonable and sustainable payment rates for prescription drugs.
10. Our AMA urges that during the evaluation of potential mergers and acquisitions involving pharmaceutical manufacturers, the FTC consult with the FDA to determine whether such an activity has the potential to worsen drug shortages.
11. Our AMA urges the FDA to require manufacturers and distributors to provide greater transparency regarding the pharmaceutical product supply chain, including production locations of drugs, any unpredicted changes in product demand, and provide more detailed information regarding the causes and anticipated duration of drug shortages.
12. Our AMA supports the collection and standardization of pharmaceutical supply chain data in order to determine the data indicators to identify potential supply chain issues, such as drug shortages.
13. Our AMA encourages global implementation of guidelines related to pharmaceutical product supply chains, quality systems, and management of product lifecycles, as well as expansion of global reporting requirements for indicators of drug shortages.
14. Our AMA urges drug manufacturers to accelerate the adoption of advanced manufacturing technologies such as continuous pharmaceutical manufacturing~~.~~, and supports the use of incentives such as prioritized regulatory review, reduction of user fees, and direct grant opportunities for manufacturers seeking to invest in manufacturing processes.
15. Our AMA supports the concept of creating a rating system to provide information about the quality management maturity, resiliency and redundancy, and shortage mitigation plans, of pharmaceutical manufacturing facilities to increase visibility and transparency and provide incentive to manufacturers. Additionally, our AMA encourages GPOs and purchasers to contractually require manufacturers to disclose their quality rating, when available, on product labeling.
16. Our AMA encourages electronic health records vendors to make changes to their systems to ease the burden of making drug product changes.
17. Our AMA urges the FDA to evaluate and provide current information regarding the quality of outsourcer compounding facilities.
18. Our AMA urges DHHS and the U.S. Department of Homeland Security to examine and consider drug shortages as a national security initiative and include vital drug production sites in the critical infrastructure plan.
19. Our AMA urges the Drug Enforcement Agency and other federal agencies to regularly communicate and consult with the FDA regarding regulatory actions which may impact the manufacturing, sourcing, and distribution of drugs and their ingredients.
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.
21. Our AMA supports the public availability of FDA facility inspection reports to allow purchasers to better assess supply chain risk.
22. Our AMA opposes the practice of preferring drugs experiencing a shortage on approved pharmacy formularies when other, similarly effective drugs are available in adequate supply but otherwise excluded from formularies or coverage plans.

23. Our AMA shall continue to monitor proposed methodologies for and the implications of a buffer supply model for the purposes of reducing drug shortages and will report its findings as necessary.
24. Our AMA opposes increasing drug prices or waiving fee exemptions in a manner that incentivizes a drug manufacturer to have its drug be declared in shortage.
25. Our AMA opposes the use of punitive fees on physician practices that do not maintain buffer supplies of drugs.
26. Our AMA encourages the FDA, the FTC, or other relevant oversight entities, to examine the practice of compounding pharmacies advertising drugs actively in shortage, particularly when targeted to new patients. (Modify Current Policy)

2. That the following new HOD policy be adopted:

Artificial Drug Shortages Limiting Access to Medications

Our AMA will:
1. Oppose laws, regulations, or business practices which create artificial scarcity of drugs, such as limitations on pharmacy procurement or restrictions on which pharmacies a patient can use, which prevent the filling of an otherwise valid prescription from their physician;
2. Advocate for pharmacies and distributors subject to the national opioid litigation settlement to make public the specific metrics, formulas, data sources, algorithms, thresholds and other policies and analyses that are used to delay or deny orders to pharmacies, restrict physicians' prescribing privileges and other actions that impede patients' access to medication; and
3. Advocate for pharmacies and distributors to provide physicians with all due process rights and opportunities to contest any decision to restrict a physician's prescribing privileges based on a pharmacy or distributor metric, formula, algorithm or other policy before such restriction is put into effect. (New HOD Policy)

3. That policies H-120.923, "Legalization of Interpharmacy Transfer of Electronic Controlled Substance Prescriptions", H-120.920, "Access to Medications", and D-110.987, "The Impact of Pharmacy Benefit Managers on Patients and Physicians" be reaffirmed. (Reaffirm HOD Policy)

Fiscal Note: less than $1,000

CITED POLICIES

Legalization of Interpharmacy Transfer of Electronic Controlled Substance Prescriptions H-120.923
Our AMA will advocate for the removal of state, federal and other barriers that impede interpharmacy transfers of valid electronic prescriptions for Schedule II-V medications.

Access to Medication H-120.920
Our AMA will advocate against pharmacy practices that interfere with patient access to medications by refusing or discouraging legitimate requests to transfer prescriptions to a new pharmacy, to include transfer of prescriptions from mail-order to local retail pharmacies.

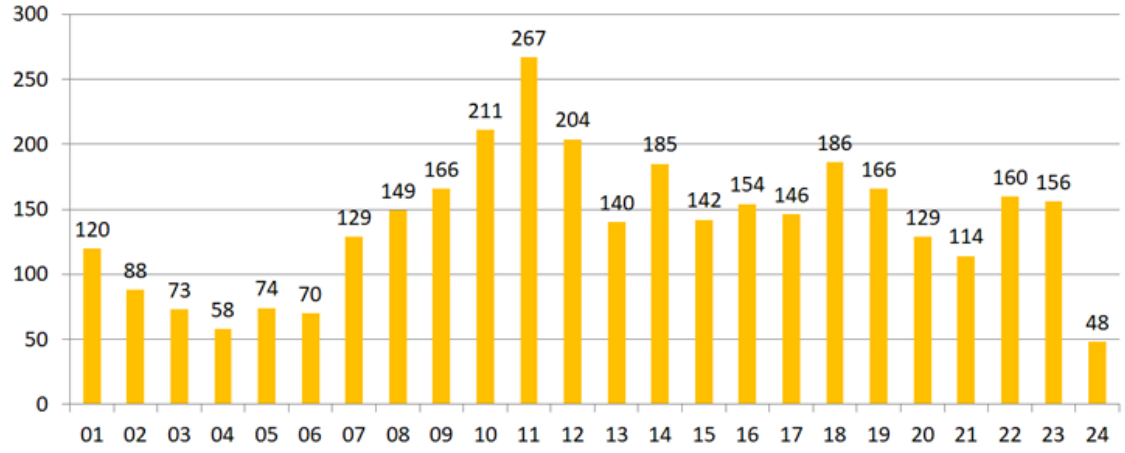
The Impact of Pharmacy Benefit Managers on Patients and Physicians D-110.987
1. Our AMA supports the active regulation of pharmacy benefit managers (PBMs) under state departments of insurance.
2. Our AMA will develop model state legislation addressing the state regulation of PBMs, which shall include provisions to maximize the number of PBMs under state regulatory oversight.
3. Our AMA supports requiring the application of manufacturer rebates and pharmacy price concessions, including direct and indirect remuneration (DIR) fees, to drug prices at the point-of-sale.
4. Our AMA supports efforts to ensure that PBMs are subject to state and federal laws that prevent discrimination against patients, including those related to discriminatory benefit design and mental health and substance use disorder parity.
5. Our AMA supports improved transparency of PBM operations, including disclosing:
- Utilization information;
- Rebate and discount information;
- Financial incentive information;
- Pharmacy and therapeutics (P&T) committee information, including records describing why a medication is chosen for or removed in the P&T committee's formulary, whether P&T committee members have a financial or other conflict of interest, and decisions related to tiering, prior authorization and step therapy;
- Formulary information, specifically information as to whether certain drugs are preferred over others and patient cost-sharing responsibilities, made available to patients and to prescribers at the point-of-care in electronic health records;
- Methodology and sources utilized to determine drug classification and multiple source generic pricing; and
- Percentage of sole source contracts awarded annually.
6. Our AMA encourages increased transparency in how DIR fees are determined and calculated.

Box 1. Resources available to assist in mitigation of drug shortages.

1. ASHP Resource Center
2. ASHP list of current shortages
3. FDA Drug Shortages Page (includes current shortages list, extended use dates, mobile app, and additional information)

APPENDIX 1

Figure 1. National Drug Shortages: New Shortages by Year: January 2001 to March 31, 2024

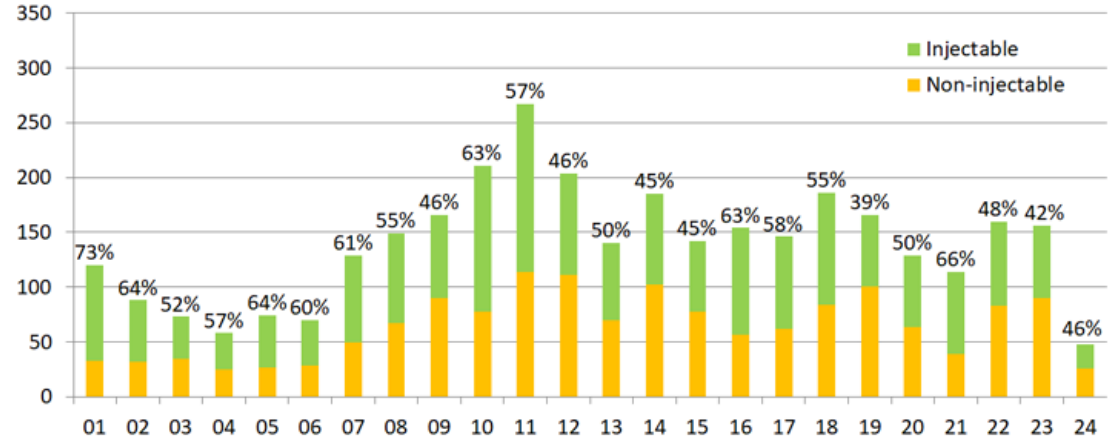


Note: Each column represents the number of new shortages identified during that year.

University of Utah Drug Information Service

Contact: Erin.Fox@hsc.utah.edu, @foxerinr for more information.

Figure 2. National Drug Shortages: New Shortages by Year
Percent Injectable: January 2001 to March 31, 2024, % Injectable



Note: Each column represents the number of new shortages identified during that year.

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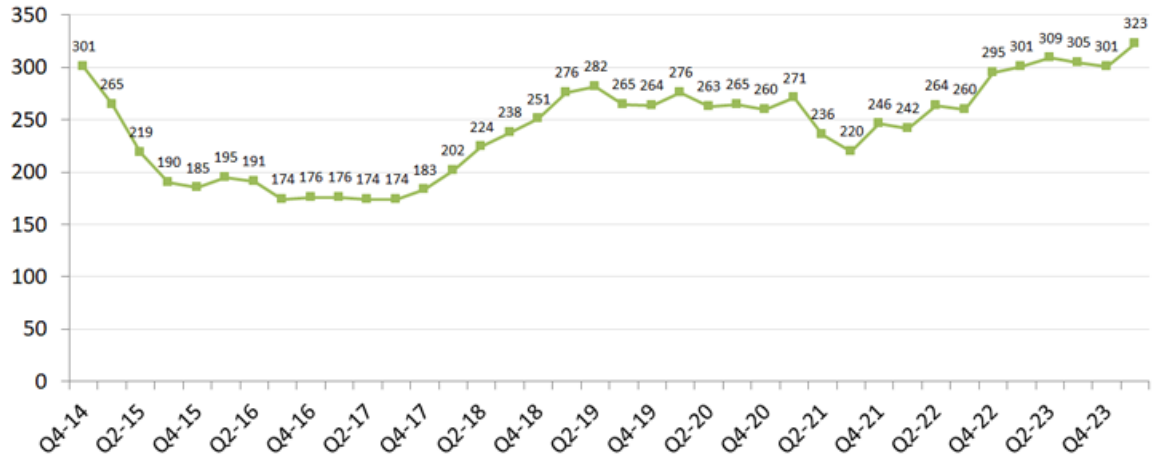
Figure 3. National Drug Shortages: Active Shortages by Quarter: 5 Year Trend



Note: Each point represents the number of active shortages at the end of each quarter.

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Figure 4. National Drug Shortages: Active Shortages Top 5 Drug Classes

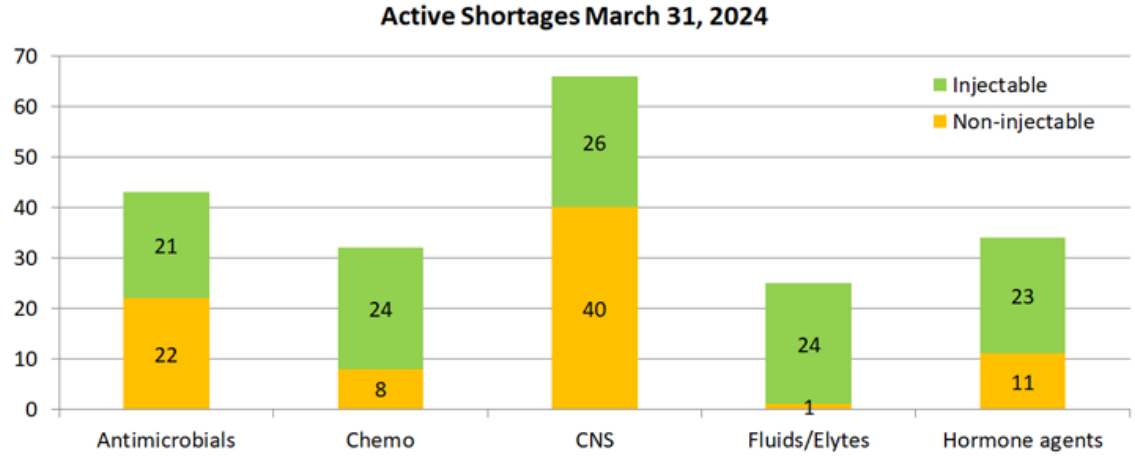

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Figure 5. National Drug Shortages: Common Drug Classes in Short Supply: 5 Year Trend

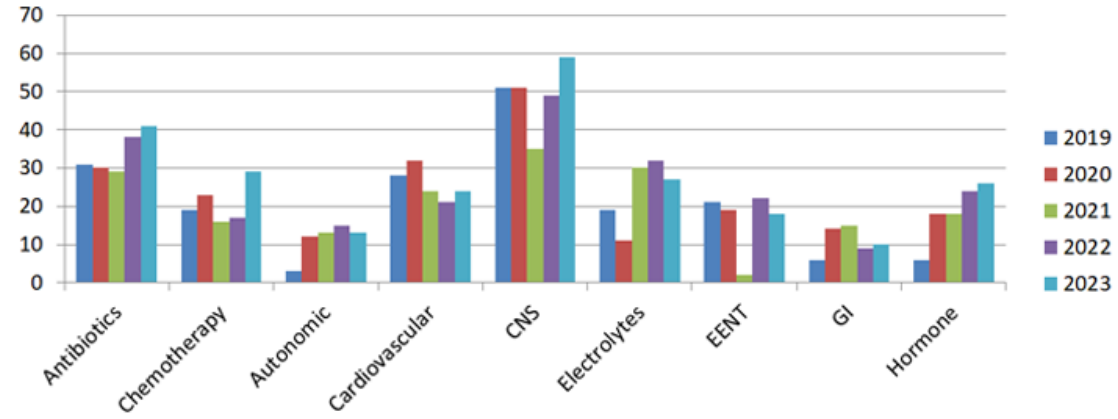

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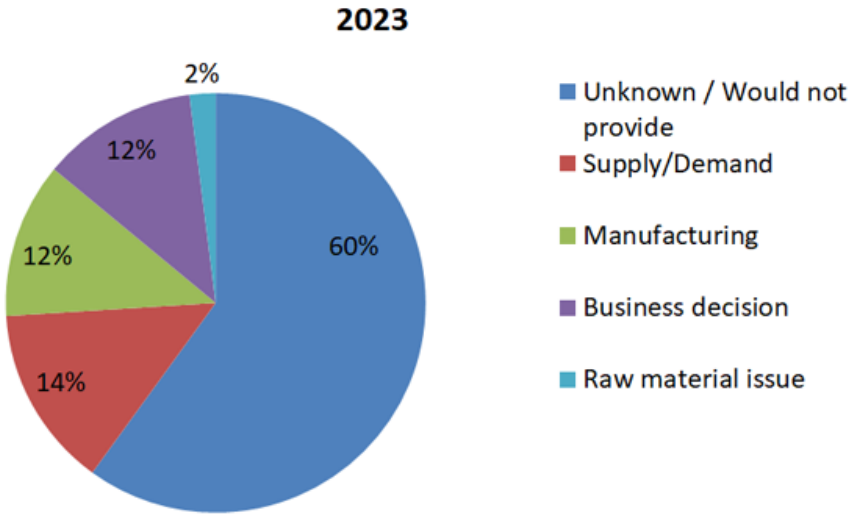
Figure 6. National Drug Shortages: Reasons for Shortages as Reported by Manufacturers During UUDIS Investigation — 2023



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REFERENCES

1. McPhillips D. Drug shortages reach record high in US. *CNN.* April 12, 2024.
2. Reed T. More Americans forgoing ADHD meds as shortages drag on. *Axios.* April 3, 2024.
3. Becker Z. Teva's Adderall makes it off the FDA shortage list while generic ADHD med supply squeeze persists. *Fierce Pharma.* May 22, 2024.
4. National Comprehensive Cancer Network. NCCN Findings on Cancer Drug Shortages. https://www.nccn.org/business-policy/policy-and-advocacy-program/nccn-findings-on-cancer-drug-shortages. Published 2024.
5. American Society of Health-System Pharmacists. Drug Shortage Statistics. https://www.ashp.org/drug-shortages/shortage-resources/drug-shortages-statistics. Published 2024.
6. National Opioids Settlement. Distributor Settlement Agreement. https://nationalopioidsettlement.com/wp-content/uploads/2022/03/Final_Distributor_Settlement_Agreement_3.25.22_Final.pdf. Published 2022.
7. American Medical Association. Suspicious Order Reporting Requirements for Buprenorphine Products Approved for Opioid Use Disorder. https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Ffinder.zip%2Ffinder%2F2024-5-10-AMA-Sign-On-Letter-to-DEA-ASH-SAMHSA-ONDCP.pdf. Published 2024.
8. Federal Trade Commission. Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs and Squeezing Main Street Pharmacies. https://www.ftc.gov/reports/pharmacy-benefit-managers-report. Published 2024.
9. Federal Trade Commission. Comment Submitted by Rachel Marren. https://www.regulations.gov/comment/FTC-2022-0015-0075. Published 2022.
10. Merelli A. GSK is replacing its popular Flovent inhaler with authorized generics, raising cost concerns for asthma patients. *STAT News.* January 5, 2024.
11. Yu A. A discontinued asthma medication has patients scrambling, some to the ER. *NPR.* July 22, 2024.
12. Cohen J. New Medicaid Rebate Rule Causes Problems For Asthma Patients On Flovent. *Forbes.* January 3, 2024.
13. United States Senate Committee on Finance. Wyden Renews Call for PBM Reforms Needed to Lower Drug Prices and Increase Access Following New FTC Report. https://www.finance.senate.gov/chairmans-news/wyden-renews-call-for-pbm-reforms-needed-to-lower-drug-prices-and-increase-access-following-new-ftc-report. Published 2024.
14. Senator Maggie Hassan. Letter to Emma Walmsley, Chief Executive Officer of GlaxoSmithKline https://www.hassan.senate.gov/imo/media/doc/flovent_letter.pdf. Published 2024.
15. Parsons HM, Schmidt S, Karnad AB, et al. ReCAP: Association Between the Number of Suppliers for Critical Antineoplastics and Drug Shortages: Implications for Future Drug Shortages and Treatment. *Journal of Oncology Practice.* 2016;12(3):249-250.
16. Reed T, Dreher A. Cancer drug shortages highlight supply chain vulnerabilities. *Axios.* June 14, 2023.
17. United States Senate Committee on Finance. Wyden and Crapo Release Draft Legislation to Combat Prescription Drug Shortages. https://www.finance.senate.gov/chairmans-news/wyden-and-crapo-release-draft-legislation-to-combat-prescription-drug-shortages. Published 2024.
18. American Medical Association. Letter to Chairman Wyden and Ranking Member Crapo. https://searchlf.ama-

assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Flfcmts.zip%2F2024-6-6-Letter-to-Wyden-and-Crapo-re-Drug-Shortages-v2.pdf. Published 2024.

19. U.S. Food and Drug Administration. Advanced Manufacturing Technologies Designation Program. https://www.fda.gov/regulatory-information/search-fda-guidance-documents/advanced-manufacturing-technologies-designation-program. Published 2024.
20. U..S Department of Health and Human Services. Policy Considerations to Prevent Drug Shortages and Mitigate Supply Chain Vulnerabilities in the United States. https://aspe.hhs.gov/sites/default/files/documents/3a9df8acf50e7fda2e443f025d51d038/HHS-White-Paper-Preventing-Shortages-Supply-Chain-Vulnerabilities.pdf. Published 2024.
21. Centers for Medicare & Medicaid Services. Promoting Interoperability Programs. https://www.cms.gov/medicare/regulations-guidance/promoting-interoperability-programs. Published 2024.
22. American Medical Association. Letter to U.S. Department of Health and Human Services. https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Fonc-interoperability-roadmap-letter-03april2015.pdf. Published 2015.
23. Sweeney C. Surge in Syphilis Cases Leads Some Providers to Ration Penicillin. *KFF Health News.* February 1, 2024.
24. Blum D. What Is Ozempic and Why Is It Getting So Much Attention? *The New York Times.* November 22, 2022.
25. Ruder K. WHO Warns of Counterfeit Ozempic in the Global Supply Chain—Here's What to Know. *JAMA.* 2024.
26. Landi H. Hims & Hers expands weight loss program to include access to compounded GLP-1 medications. May 20, 2024.
27. U.S. Food and Drug Administration. Medications Containing Semaglutide Marketed for Type 2 Diabetes or Weight Loss. https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/medications-containing-semaglutide-marketed-type-2-diabetes-or-weight-loss. Published 2024.
28. U.S. Food and Drug Administration. FDA alerts health care providers, compounders and patients of dosing errors associated with compounded injectable semaglutide products. https://www.fda.gov/drugs/human-drug-compounding/fda-alerts-health-care-providers-compounders-and-patients-dosing-errors-associated-compounded. Published 2024.
29. Hims & Hers Health. Q1 2024 - Shareholder Letter. https://s27.q4cdn.com/787306631/files/doc_financials/2024/FINAL-Q1-2024-Shareholder-Letter-3.pdf. Published 2024.
30. Founder/CEO and Clinical President of Digital Health Company Arrested for $100M Adderall Distribution and Health Care Fraud Scheme. https://www.justice.gov/opa/pr/founderceo-and-clinical-president-digital-health-company-arrested-100m-adderall-distribution. Published 2024.
31. Center for Disease Control and Prevention. Disrupted Access to Prescription Stimulant Medications Could Increase Risk of Injury and Overdose. https://emergency.cdc.gov/han/2024/han00510.asp. Published 2024.
32. American Medical Association. Docket No. DEA-407, Telemedicine Prescribing of Controlled Substances When the Practitioner and the Patient Have Not Had a Prior In-Person Medical Evaluation. https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Flfrd.zip%2F2023-3-31-Letter-to-Milgram-re-Telemedicine-Prescribing-of-Controlled-Substances-v4.pdf. Published 2023.
33. Luhby T. FDA approves first state request to import drugs from Canada. *CNN.* January 5, 2024.

34. Fortnam B. BIS Launches Assessment Of Pharmaceutical Supply Chain. *InsideHealthPolicy*. July 10, 2024.
35. The White House Press Office. FACT SHEET: Biden-Harris Administration Announces New Actions to Lower Health Care and Prescription Drug Costs by Promoting Competition. https://www.whitehouse.gov/briefing-room/statements-releases/2023/12/07/fact-sheet-biden-harris-administration-announces-new-actions-to-lower-health-care-and-prescription-drug-costs-by-promoting-competition/. Published 2023.

REPORT 3 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (I-24)
HPV-Associated Cancer Prevention
(Reference Committee K)

EXECUTIVE SUMMARY

BACKGROUND. American Medical Association (AMA) Policy H-440.872 "HPV-Associated Cancer Prevention," asked that our AMA study requiring human papillomavirus (HPV) vaccination for school attendance and report its findings to the AMA House of Delegates by the 2023 Interim Meeting. CSAPH Report 3-I-23, which reported the findings and recommendations of that study, was referred for further study.

METHODS. English language articles were selected from searches of PubMed and Google Scholar using the search terms "HPV vaccination", "HPV vaccine mandates," "HPV vaccine requirement," "mandated vaccines AND schools" and "school attendance AND HPV vaccine mandate". Additional articles were identified by manual review of the reference lists of pertinent publications. Web sites managed by government agencies; applicable organizations were also reviewed for relevant information.

DISCUSSION. HPV vaccination remains the best method for preventing cancer-causing infections and precancers. HPV infections and cervical precancers have dropped since 2006, when HPV vaccines were first used in the United States. Among teen girls, infections with HPV types that cause most HPV cancers and genital warts have dropped 88 percent and among young adult women, they have dropped 81 percent. Among vaccinated women, the percentage of cervical precancers caused by the HPV types most often linked to cervical cancer have dropped by 40 percent. HPV vaccination is recommended for male and female adolescents and young adults by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices.

Few states require the HPV vaccine for school attendance in part because HPV is a sexually transmitted infection, and it is not likely to be transmitted in schools. Adding vaccines to the list required for attendance is viewed by some as putting up unnecessary roadblocks for school attendance. Opponents have also expressed moral objections related to a vaccination requirement for a STI. However, proponents of HPV vaccine requirements for school entry argue that it is important to promote immunization when the vaccine is most effective – before the initiation of sexual activity and exposure to HPV. Those already infected with HPV can also benefit from the vaccine because it can prevent infection against HPV strains that they may not have contracted. Additionally, the vaccine elicits a higher immune response in adolescents ages 11 to 12 than in older teens.

CONCLUSION. Currently available evidence shows that the efficacy of HPV vaccine requirements is state-specific. School-entry HPV vaccine requirements, on their own, are limited in their ability to encourage HPV vaccine initiation and series completion. Without widespread public support, monitoring, funding, enforcement for noncompliance, and changes to strengthen lenient opt-out policies, HPV vaccine requirements have not improved vaccine completion rates. Other efficacious practices to improve vaccination rates include in-depth discussions with vaccine hesitant parents or caregivers and establishing vaccination as the default health care practice. This report is focused on the history of vaccine requirements for school entry, the legality of vaccine requirements, public health ethical considerations, assessment on the effectiveness of HPV vaccine requirements on HPV vaccination rates, and other interventions to increase HPV vaccination rates.

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 3-I-24

Subject: HPV-Associated Cancer Prevention

Presented by: John T. Carlo, MD, Chair

Referred to: Reference Committee K

INTRODUCTION

American Medical Association (AMA) Policy H-440.872 "HPV-Associated Cancer Prevention," asked that our AMA study requiring HPV vaccination for school attendance and report its findings to the AMA House of Delegates by the 2023 Interim Meeting. CSAPH Report 3-I-23, which reported the findings and recommendations of that study, was referred for further study.

BACKGROUND

Human papillomavirus (HPV) is a group of more than 200 related viruses, some of which are spread through vaginal, anal, or oral sex.[1] The majority of HPV infections are self-limited and are asymptomatic. Sexually transmitted HPV types fall into two groups, low and high risk.[6] Low-risk HPVs generally cause no disease.[6] However, a few low-risk HPV types can cause warts on or around the genitals, anus, mouth, or throat. High-risk HPVs can cause several types of cancer.[6] There are about 14 high-risk HPV types including HPV16 and HPV18, which are responsible for most HPV-related cancers.[6] Nearly all people are infected with HPV, with low malignant potential, within months to a few years after becoming sexually active. Around half of these infections are with a high-risk HPV type.[6] HPV can infect anyone regardless of their sex, gender identity, or sexual orientation. HPV vaccination is the best method to prevent infection with disease-causing HPV types, preventing many HPV-related cancers and cases of genital warts. Before HPV vaccines were introduced, approximately 355,000 new cases of ano-genital warts occurred every year.[2]

Prevalence of HPV-associated cancers

Long-lasting infections with high-risk HPVs can cause cancer in parts of the body where HPV infects cells, such as in the cervix, oropharynx, anus, penis, vagina, and vulva.[6] HPV infects the squamous cells that line the inner surfaces of these organs. For this reason, most HPV-related cancers are squamous cell carcinomas. Some cervical cancers come from HPV infection of gland cells in the cervix and are adenocarcinomas.[6] Each year, there are about 45,000 new cases of cancers in parts of the body where HPV is often found, and HPV is estimated to cause about 36,000 of these.[6]

Background on HPV Vaccines and Recommendations for Vaccination

The Food and Drug Administration (FDA) approved first-generation Gardasil®, produced by Merck, in 2006, which prevented infection of four strains of HPV – 6, 11, 16, and 18.[3] In December 2014, Gardasil®9 was approved by the FDA.[8] This vaccine protects against nine strains of HPV: the four strains approved in the previous Gardasil vaccine, as well as 31, 33, 45, 52, and

58.[8] These strains are associated with the majority of cervical cancer, anal cancer, and throat cancer cases as well as most genital warts cases and some other HPV-associated ano-genital diseases.[4] The vaccine was initially approved for cervical cancer prevention, but in 2020 the FDA broadened its approval to include the prevention of oropharyngeal cancer and other head and neck cancers.[5]

HPV vaccination is recommended at age 11 or 12 years but can be started at nine years of age. The Centers for Disease Control and Prevention (CDC) also recommends vaccination for everyone through age 26 years if not adequately vaccinated when younger.[15] For adults ages 27 through 45 years, health care professionals, using shared clinical decision-making, can consider discussing HPV vaccination with people who are most likely to benefit.[15] HPV vaccination is given as a series of either two or three doses, depending on age at initial vaccination.[15] HPV vaccines are currently not recommended for use in pregnant persons.[15] HPV vaccines can be administered regardless of history of ano-genital warts, abnormal Pap test or HPV test, or ano-genital precancer.[15]

With over 120 million doses of HPV vaccines distributed in the United States (U.S.), robust data demonstrate that HPV vaccines are safe.[6] There have been relatively few adverse events reported after HPV vaccination. Commonly reported symptoms include injection-site reactions such as pain, redness and swelling, as well as dizziness, fainting, nausea, and headache.[7] Current research suggests the vaccine protection is long-lasting: more than 10 years of follow-up data indicate the vaccines are still effective and there is no evidence of waning protection, although it is still unknown if recipients will need a booster.[8] Further, HPV vaccination has not been associated with decreased age in the initiation of sexual activity or sexual risk behaviors.[9]

HPV vaccination remains the best method for preventing cancer-causing infections and precancerous lesions. HPV infections and cervical precancers have dropped since 2006, when HPV vaccines were first used in the U.S. For example, among teen girls, infections with HPV types that cause most HPV cancers and genital warts have dropped 88 percent and among young adult women they dropped 81 percent.[10] Despite the benefits of vaccination, a 2022 analysis of data from the National Immunization Survey–Teen showed that for the first time since 2013, HPV vaccination initiation did not increase among adolescents aged 13–17 years.[11] Among all adolescents aged 13–17 years, 2022 HPV vaccination coverage levels did not differ from 2021 levels; however, initiation of the HPV vaccination series decreased among those who were insured by Medicaid.[35] In 2022, 89.9 percent of adolescents aged 13–17 years had received ≥1 HPV vaccine dose, and 62.6 percent were up to date with HPV vaccination (HPV UTD).[35] During 2015–2021, among adolescents aged 13–17 years, coverage with ≥1 HPV vaccine dose was higher among those insured by Medicaid than among those with private insurance; however, in 2022, coverage with ≥1 HPV vaccine dose among Medicaid beneficiaries declined by 3.3 percentage points compared with coverage in 2021, whereas ≥1-dose HPV coverage among those with private insurance was stable, resulting in similar coverage between the two groups in 2022.[35] Coverage with ≥1 HPV vaccine dose remains lowest among uninsured adolescents.[35]

HPV vaccination initiation fell among adolescents insured by Medicaid and remained lowest among the uninsured (two of the four groups that constitute the Vaccines for Children [VFC]–eligible population), highlighting the continued need for outreach among adolescents eligible for VFC.[35] VFC vaccine ordering data provide additional evidence that HPV vaccination coverage might be declining in VFC-eligible populations.[35] VFC provider orders for HPV vaccines decreased 24 percent during 2020, nine percent during 2021, and 12 percent during 2022 compared with 2019, while provider orders for non-HPV vaccines have rebounded to pre-pandemic levels.[35] The VFC program is vital to reach and administer vaccines to eligible adolescents to maintain vaccination coverage in underserved communities.[35] Children living in large central metropolitan areas (39.4 percent), large fringe metropolitan areas (41.1 percent), and medium and small

metropolitan areas (39.4 percent) were more likely to have received one or more HPV vaccine doses, compared with children living in nonmetropolitan areas (30.0 percent).[12] Hispanic children (34.4 percent) were less likely than White non-Hispanic children (39.9 percent) to have received one or more HPV vaccine doses.[36] All other observed differences between Asian non-Hispanic, Black non-Hispanic, White, and Hispanic children were not significant.[36]

CDC vaccine recommendations, as informed by the Advisory Committee on Immunization Practices (ACIP), provide clinical guidance on how to use vaccines to control diseases in the U.S. School vaccination requirements are generally determined by state legislatures or state health departments. Few states require the HPV vaccine for school attendance in part because HPV is considered a sexually transmitted infection (STI), and it is not likely to be transmitted in schools.[13] Adding vaccines to the list required for school entry is viewed by some as putting up unnecessary roadblocks for school attendance. For the HPV vaccine, some have expressed moral objections related to a vaccination requirement for a STI.[14] This report is specifically focused on the history of vaccine requirements for school entry, the legality of vaccine requirements, assessment on the effectiveness of HPV vaccine requirements on HPV vaccination rates, and other interventions to increase HPV vaccination rates.

METHODS

English language articles were selected from searches of PubMed and Google Scholar using the search terms “HPV vaccination”, “HPV vaccine mandates,” “HPV vaccine requirement,” “mandated vaccines AND schools” and “school attendance AND HPV vaccine mandate”. Additional articles were identified by manual review of the reference lists of pertinent publications. Web sites managed by government agencies and applicable organizations were also reviewed for relevant information.

VACCINE REQUIREMENTS

Legality of Vaccination Requirements

In the early 19th century, smallpox was one of the largest threats to public health. Amid frequent smallpox outbreaks, Massachusetts passed the nation’s first vaccine mandate in 1810. The Massachusetts law gave local health boards the authority to require vaccination when outbreaks occurred, imposing fines or quarantine for non-compliance.[15] In 1827, Boston enacted the first school vaccine requirement for smallpox; other cities and states soon followed.[16] Today, four common childhood vaccinations – DtaP, MMR, polio, and varicella – are required for children to enroll in kindergarten in every state,[1] with 44 states also requiring a hepatitis B vaccination before kindergarten and 30 states requiring a meningitis vaccination before entering later grades.[17] Until the COVID-19 pandemic, vaccine requirements in the U.S. had mostly been enacted by state and local governments in relation to public venues, schools, and health care facilities, with the military also requiring certain vaccines.[18] Vaccine mandates require that individuals be vaccinated against certain illnesses, usually as a condition of entry to or participation in certain activities. The most common vaccine requirements are applied to enrollment in schools. However, vaccine requirements are not absolute. School vaccine requirements in every state allow for exemptions.

The legal basis for vaccine requirements typically lies within the police powers of a state. Police powers encompass the broad power of a state to regulate matters affecting the health, safety, and general welfare of the public, housed within the Tenth Amendment of the Constitution.[2,19] While

[1] With the exception of Iowa, which does not require a mumps vaccine.

school vaccination requirements are framed as conditional, courts often view them as compulsory; however, these compulsory requirements have been widely accepted and judicially sanctioned.[16] The legitimacy of compulsory vaccination programs depends on both scientific factors and constitutional limits. Scientific factors include the prevalence, incidence, and severity of the contagious disease; the mode of transmission; the safety and effectiveness of any vaccine in preventing transmission; and the nature of any available treatment. Constitutional limits include protection against unjustified bodily intrusions, such as forcible vaccination of individuals at risk for adverse reactions, and physical restraints and unreasonable penalties for refusal.[20] Vaccination programs have been legally challenged as inconsistent with federal constitutional principles of individual liberty and due process, an unwarranted governmental interference with individual autonomy, and an infringement of personal religious beliefs under First Amendment principles.[2]

The U.S. Supreme Court has addressed vaccine requirements in two cases. In 1905, the Court upheld the constitutionality of vaccine requirements in the seminal case *Jacobson v. Massachusetts*.[21] Jacobson challenged the Massachusetts law mentioned earlier that gave local health boards the authority to require vaccination when outbreaks occurred. The Court held that a vaccine requirement was valid so long as there was a danger to public health and safety and the requirement had a real or substantial relation to the goal of protecting public health. In 1922, the Court upheld vaccine requirements as a condition of school attendance in *Zucht v. King*.[22] In its brief, three paragraph opinion, the Court reaffirmed the broad discretion of the states to employ police powers and states' authority to delegate those powers to municipalities to determine under which conditions health regulations become operative.

The most frequent arguments against compulsory vaccination are the religious clauses in the First Amendment. Supreme Court jurisprudence outside the realm of vaccination has clarified that the right of free exercise of religion does not relieve an individual of the obligation to comply with a valid and neutral law of general applicability.[2] The majority of states grant religious exemptions to school vaccine requirements, but even laws that do not provide for religious exemptions have been deemed constitutional.[23] Arguments have also been made under the Equal Protection Clause of the Fourteenth Amendment, but courts have rejected arguments that school vaccine requirements discriminate against school children to the exclusion of other groups because school children are not a constitutionally protected class.[2]

Other constitutional arguments have had less success. Constitutional rights are generally framed as the right to be free of some form of government intrusion or restriction. As such, courts have found that the Constitution does not guarantee "positive" rights, (e.g., any requirement that the government provide anything). This includes education, thus there is no limit on the sort of reasonable regulations that a state may choose to impose on the privilege of a public education.[2] Arguments that vaccine requirements are arbitrary, capricious, or unreasonable have also failed, as well as arguments that school vaccination laws constitute illegal searches and seizures that violate the Fourth Amendment.[2]

Vaccine Exemptions

Vaccine exemption laws vary by jurisdiction. All 50 states and Washington D.C. (D.C) allow for vaccine exemptions for medical reasons. There are 45 states and D.C. that grant religious exemptions.[24] Currently, 15 states allow philosophical exemptions for children whose parents object to immunizations because of personal, moral or other beliefs. How exemptions are enforced also varies among states. Examples of how states have addressed enforcement include: parental notarization or affidavit in the exemption process, and education about the benefits of vaccination and risk of being unvaccinated.[25] To reduce non-medical exemptions, the CDC recommends that

states strengthen the rigor of the application process, frequency of submission, and enforcement as strategies to improve vaccination rates.[25]

There is a growing body of evidence regarding the impact of state vaccination requirements for school age children on vaccination coverage and the association of non-medical exemption rates with increased disease incidence. The use of philosophical exemptions and under immunization tends to cluster geographically, putting some communities at greater risk for outbreaks. This geographic clustering of exemptions is associated with increased local risk of vaccine-preventable diseases, such as pertussis and measles.[25]

Many of the vaccine-related bills introduced in state legislatures in 2023 reflect similarities to legislation enacted in 2021 and 2022, such as limitations on COVID-19 requirements for public and private sector employees and in schools, as well as requirements for vaccine exemptions based on medical, religious, and philosophical reasons.[26] However, the vaccine-related bills enacted during the 2023 state legislative sessions have shifted in focus beyond COVID-19 to address routine immunizations and limitations on private entities.[28]

Possibility of HPV Vaccine Requirements

When discussion surrounding an HPV vaccine requirement first began, it was riddled with controversy. Being initially recommended only for females aged 11-12 years,[27] parents were uncomfortable with the idea of giving a vaccine for a STI to young girls, especially as the manufacturer mounted an expensive lobbying campaign to establish vaccine requirements.[28] The target age for vaccination was selected to capture youth prior to initiation of any sexual activity so that all children are protected.[29] However, a common misperception by parents is that the act of vaccination somehow conveys a message that sexual activity is permissible at that age.[30,31]

The traditional rationale of tying vaccination to school attendance, is to prevent the spread of a disease outbreak that would prevent large numbers of children from attending school. The traditional justification for tying vaccination to school entry not only fails to comprehensively weigh the risks and benefits of HPV vaccination, it also does not reflect the realities of vaccine requirements today. In *Boone v. Boozman*, an Arkansas court explained in the context of hepatitis B vaccines that the method of transmission is not the only factor by which a disease can be judged dangerous and thus require vaccination.[32] The caveat to *Boone* is that the court noted that the longevity of the virus on fomites added to the danger warranting a vaccination requirement for the high-traffic environment of a school setting, which may not be said of HPV. There is limited data assessing the role of fomites in the transmission of HPV, however HPV-DNA positivity has been reported in health care settings such as on transvaginal ultrasound probes and colposcopes after routine disinfection.[33]

LESSONS FROM JURISDICTIONS WITH HPV VACCINE REQUIREMENTS

Since 2006, 46 states, D.C. and Puerto Rico (P.R.) have proposed legislation to require the HPV vaccine for school entry, fund HPV vaccine administration programs, or educate the public or school children about the benefits of HPV vaccination.[34,35] However, only Virginia, D.C., and P.R. have enacted such legislation into law, with Rhode Island and Hawaii adopting the policy through an administrative ruling from their health departments.[38] In these five jurisdictions, the capacity to opt-out of HPV vaccination, and procedures to obtain an exemption vary by jurisdiction.[37,36,37] A limited number of studies have explored whether the enactment of school-entry requirement for HPV vaccine has impacted population-level vaccination rates, and these studies highlight the state-specific efforts that led to success or failures.[37] The findings suggest that sex-neutral, restrictive

HPV vaccination requirements for school entry are associated with increased vaccination initiation among adolescents aged 13 to 17 years, however it should be noted that initiation does not mean completion of the HPV vaccine series.[38,39,40,41] It should also be observed that most of the data collected from these studies do not assess the impact of the COVID-19 pandemic on HPV vaccination rates. Further, studies have cited that the socio-political differences, barriers and facilitators, including resources and political will, to adopt, implement, and enforce vaccine requirements may vary state by state.[42]

Rhode Island

Rhode Island continues to be a national leader in adolescent immunizations. In Rhode Island, teens are at or above the national averages for every vaccine type, due in large part to its unique infrastructure and vaccination funding.[43] Rhode Island is the smallest state and does not have individual county health departments. Instead, the Rhode Island Department of Health (RIDOH) coordinates health care directly within the state and works with Rhode Island Vaccine Advisory Committee (RIVAC) regarding vaccination.[44] Therefore, the RIDOH has the authority to set vaccination regulations without legislative action or approval. It should be noted that the recommendations made by RIVAC are subject to community review through a public hearing.[47] From start to finish, the process to include HPV vaccination in school requirements took about three years for the health department to implement, which is a little longer than normal due to the controversy surrounding the vaccine.[47] Even though Rhode Island was among the states with the highest levels of HPV vaccine coverage prior to enacting requirements, they still faced opposition.[45,46,47] It should be noted that it is unclear whether states with lower uptake than Rhode Island would have the same outcome.[48,50]

Further, Rhode Island is one of the universal purchase vaccine states, meaning federal and other funding sources are used to provide vaccines to all children regardless of insurance status. All childhood and adolescent vaccines, and most adult vaccines, recommended by the ACIP are purchased by RIDOH from the CDC federal contract at a reduced price and distributed to immunization providers at no cost to the providers.[47,48] Federal and private insurer funding covers the cost of vaccine purchased. This eliminates the financial burdens of providers purchasing their own vaccine supply, reduces barriers, and improves equal access to all vaccines.[47] Through this program, HPV vaccines have been provided for girls since 2006 and boys since 2011.[47] During early implementation, the state promoted vaccine education by employing a physician consultant who advised pediatricians and expanded the in-school vaccination program to include middle schools.[47] Through these educational efforts, the discounted vaccine cost, and the use of programs such as “Vaccinate Before You Graduate”, the state enjoyed the highest vaccination rates in the country in 2014.[47,49]

In October 2013, the RIVAC voted to recommend HPV vaccination as a school requirement over three years with a graduated approach beginning in 2015.[37] The graduated integration was intended to ensure progress in vaccination, while also slowly increasing the logistical and administrative burdens for parents, students, and clinicians. After the measure was approved, RIDOH implemented a combined media and educational approach to provide factual information and raise awareness.[37] Rhode Island was the first state to enact a school-entry requirement for HPV vaccination that did not allow special exemptions and that applies to both males and females.[37] Rhode Island was well positioned for this challenge as they were leading the nation in HPV vaccination rates: 77 percent initiation for girls and 69 percent for boys in 2013.[50,51] By including a HPV vaccine requirement after achieving high vaccination rates and broad public support, including having both males and females in the requirements, and not allowing opt-out provisions that do not apply to other vaccines, the Rhode Island HPV vaccine requirement succeeded. As a

result in 2015, it resulted in 68 percent of girls and 58 percent of boys aged 13 to 17 in Rhode Island having completed all three doses, up from 56.5 percent and 43.2 percent from 2013.[49,52] However, an analysis examining initiation rates identified an 11 percent increase in HPV vaccine initiation among boys in Rhode Island after the school-entry requirement was enacted, whereas no significant change was observed for girls.[53] This set of findings indicates that school-entry requirements may reduce gender disparities and close the gap in HPV vaccine uptake.[57] It was noted that significant differences in HPV vaccine initiation among girls might not have been seen because of their already high HPV vaccination initiation rate (87.9 percent) in 2015.[49]

Washington D.C.

HPV vaccination requirements for school entry were successfully implemented in D.C. in 2009, which included liberal opt-out language and resulted in less public backlash.[53] In the case of the HPV vaccine requirements in D.C., legislation moved rapidly through the Council of the District of Columbia.[53] In the absence of public consensus about the vaccine's benefits, there were widely publicized debates about concerns that HPV vaccines were too new to be considered safe and effective, that pharmaceutical companies were untrustworthy, that the media had exaggerated the worries that the HPV vaccine would promote promiscuity, and that requirements were impinging on parental rights to make decisions for their children and forcing them to have conversations about sexuality before they believed their children were ready.[53,54,55,56] The requirement called for sixth grade girls in D.C. to: (1) receive the HPV vaccine or (2) submit a one-time opt-out form.[57] According to an analysis of the 2009-2013 CDC National Immunization Survey (NIS)-Teen Vaccine Dataset, D.C.'s HPV vaccination school-entry policy was not associated with higher levels of HPV vaccination compared with non-policy jurisdictions.[58] However, in 2014, the requirement was expanded to 6th grade boys and all students up through 12th grade.[60] Additionally, all those not vaccinated were required to opt-out annually. As such, the implications for teen girls was not a move from "no requirement" to an "HPV vaccine requirement," but rather a change from a one-time opt-out in 6th grade to an annual opt-out requirement through 12th grade.[60]

The sex- and age-inclusive policy was associated with increased rates of HPV vaccination.[61] In 2017, the level of HPV vaccination was higher in D.C. compared with that in non-policy states.[61] In addition, D.C. had higher levels of HPV vaccination compared with Virginia (another state with broad opt-out provisions), suggesting that the former's more inclusive and stricter policy (i.e., annual exemption filing requirements) was associated with greater increases in vaccination initiation than the latter.[61] Furthermore, the jurisdiction's school-entry policy appeared to increase post-policy HPV vaccination initiation among boys and younger girls.[61]

The D.C. policy change offers broader insights into the importance of how vaccine requirements are implemented. While respondents view vaccine school requirements more favorably if they contain broad opt-out provisions, these provisions likely reduce the requirement's efficacy.[59]

Virginia

In April 2007, Virginia became the first state to enact a law requiring HPV vaccination of girls before entry into the sixth grade.[60] The requirement became effective in October 2008; however, given the timing of when the requirement went into effect, it did not change school admission requirements until the 2009 school year.[63] Virginia allows for both medical and religious exemptions for all vaccines recommended as part of the Advisory Committee on Immunization Practices recommended series. However, when the HPV requirement was added to the Code of Virginia, it allowed for an HPV-specific philosophic exemption.[63] The rationale for the exemption reads: "Because the human papillomavirus is not communicable in a school setting, a parent or

guardian, at the parent or guardian's sole discretion, may elect for their child not to receive the human papillomavirus vaccine, after having reviewed materials describing the link between the human papillomavirus and cervical cancer approved for such use by the Board." [63,61]

The HPV vaccine requirement in Virginia (similar to the pre-2014 requirement in D.C.) moved rapidly through the legislature without input from key stakeholders.[53] Interviews with Virginia parents indicated that many parents did "opt-out" of vaccinating their daughters, and the data in other studies corroborate low-levels of compliance with requirements.[53,62] Studies found there was no effect on the rate of HPV vaccination in the five years since its enactment in Virginia.[63,63] Among a cohort of girls who sought well-child care, HPV vaccine uptake was noted to be higher among minorities and those with public insurance than White girls or those who were privately insured.[63,64] These findings are concordant with the pre-requirement vaccination data and with the rates of HPV vaccine uptake, which was defined as ≥1 dose, within the NIS Teen Vaccine Dataset.[63,66] Understanding the implications of these findings requires a consideration of Virginia law against a broader context of compulsory vaccination in the U.S.[63] The philosophic exemption for HPV vaccination in Virginia is broad, easy to cite verbally, and is largely unenforced.[63] As a result, philosophic exemption was noted as likely a large contributor to the findings of these studies.[63] It was also noted that these findings are not explained entirely by the presence of a lax exemption.[63] Parental education and perceived susceptibility to HPV, physician recommendation, and the cost of vaccination are all factors involved in the parental decision to accept or opt-out of vaccination.[63]

Puerto Rico

In part due to P.R. having high HPV vaccination rates in adolescents ages 13-17, in June 2017, P.R.'s Department of Health (DOH) announced that the HPV vaccine would be added to the list of school-entry required vaccines for fall 2018.[45,65,66] Subsequently, in May 2018, the DOH formally announced that the HPV vaccine would be required for 11 to 12-year-old children starting during the 2018–2019 academic year.[45,68,69] As established by P.R.'s Immunization Law of 1983, only medical or religious exemptions are permitted. Similar to other vaccine school-entry requirements, not having the required vaccines would ultimately result in children not being permitted to attend school.[45,67] For the 2019–2020 academic year, the requirement was expanded to include adolescents up to 14 years old.[45,68] The adoption of this policy was influenced by stakeholders from medical professional organizations, academia, government staff, non-profit organizations, and the members of the private sector.[45,68] Adopting this policy took many years and much groundwork (i.e., legislation, education).[45] The epidemiologic impact of the disease was considered before the policy's adoption, as was the jurisdictions already high HPV vaccine initiation rates.[45] In 2016, before the implementation of the requirement, vaccination rates were 80.8 percent in girls and 71.1 percent in boys with one or more HPV vaccine doses.[68] Another consideration was the initial cohort chosen (i.e., children aged 11 to 12 years), which requires only two doses of the vaccine, resulting in a more cost-efficient approach.[69]

Previous studies have documented that parents, primarily Latino or Spanish-speaking parents, perceive that the age of 11 is too early for HPV vaccination and also express concern that this could promote sexual activity.[68,70] Hence, prior to implementation, most of those who initiated vaccination were between 13 to 17 years old.[68,73] Post-implementation studies found significant evidence of improvement in vaccination rates associated with the HPV school-entry vaccination requirement.[71] One year after implementation of the requirement, adolescents from 11 to 12 years old, , began to lead initiation rates (89.8 percent) compared to adolescents 13 to 17 years (82.6 percent).[74] Although adolescents aged 13 to 17 years lead HPV UTD vaccine coverage rates, the UTD vaccine coverage rates for adolescents between 11 and 12 years improved after policy

implementation.[74] These findings support the notion that the way the school-entry vaccine requirement policy is designed and implemented impacts HPV vaccination uptake.

In P.R., the adoption of the HPV vaccine school-entry requirement can be evaluated, in part, through a bottom-up approach to policy making (i.e., driven by diverse sectors of society, not necessarily starting with the top level of policy makers/politicians).[45,72] Using the bottom-up approach allowed a more thorough understanding of policy creation and implementation by evaluating the 'network of actors' that participated in the process and focusing on local factors.[45,75] Empowered with local data, stakeholders created multisectoral collaborations to combine limited resources. Moreover, educational efforts and the publicized case of Rhaiza (a mother of three who died from cervical cancer) facilitated the adoption process. Rhaiza's case was a catalyst for increasing HPV-related and cervical cancer knowledge among the public.[45] It served to create a public face and champion that was relatable, as a mother, spouse, and daughter. Champions, usually studied at the organizational level, have been highlighted as a need for effective implementation.[45,73] Moreover, humanizing the impacts of disease proved useful among certain segments of the population who might have otherwise been hesitant to be vaccinated.

Vaccine policy adoption and implementation in P.R. benefited from the assessment and consideration of context-specific factors to help build trust and confidence among communities.[45,74] For instance, Hispanics show higher odds of support for HPV vaccine school-entry requirements compared to non-Hispanic Whites in the U.S.[45,75] In the case of P.R., perspectives on the implementation of the HPV vaccine school-entry requirement from parents of unvaccinated children were reported as mixed.[45,72] Half of the parents supported the policy, while those who were uncertain mentioned concerns related to the early age of vaccine administration, vaccine safety, and parental autonomy.[45,72] Therefore, it was important for individuals and organizations involved in vaccination efforts, such as local health departments, to adapt and tailor to context, including the politico-cultural context, when considering vaccine policies and educational interventions.[45,76] In P.R., a broad coalition of individuals and organizations from multiple facets of society (i.e., physicians, non-profit organizations) convened to rally for support of the requirement.[45,72] Further, diverse perspectives were included when thinking about and implementing vaccine requirements that affect historically marginalized populations (e.g., groups with limited access to providers who can offer the required vaccine).[45] The HPV vaccine was also covered for eligible students, via the federal program Vaccines for Children, the government-funded insurance, or private insurance.[45,72]

BEST PRACTICES FOR IMPLEMENTING VACCINE REQUIREMENTS

Studies that examined school-entry requirements noted that they should be considered alongside other initiatives and policies for promoting HPV vaccine uptake.[56] In fact, it was found that a combination of policies, such as Medicaid expansion, policies allowing pharmacists to administer HPV vaccines, school-entry requirements, and sexual education requirements are associated with higher HPV vaccine uptake.[56,77] As seen through the successes in Rhode Island, P.R., and D.C., a multi-pronged approach that is state specific is necessary to ensure success.[45,47,61] This includes limiting broad opt-out provisions, collaborations with public health entities, schools, and the public, providing the HPV vaccine at no cost, understanding the socio-political differences, barriers and facilitators to adopt and implement vaccine requirements, educational efforts to address concerns about HPV vaccine safety and efficacy, and building confidence and trust with the public.[78]

In establishing a vaccine requirement, it is important to consider implementation with care and with regard to the context.[79] Overly strict vaccine requirements can result in parents finding ways to

avoid the vaccine, and selective requirements might damage the broader vaccination program.[82] Removing the choice of opting out entirely might simply induce parents to seek loopholes, and, worse, fuel negative attitudes towards vaccination.[82] For example, in 2015, California became the third U.S. state to eliminate all non-medical exemptions.[82] This change in the law was preceded by a 2014 administrative initiative to reduce the misuse of a school admission process involving 'conditional entrants' — children who have started the required vaccination schedule but have not completed it.[82,80] Following the elimination of non-medical exemptions, many parents with strong objections to vaccination simply acquired medical exemptions instead, educated their children at home, enrolled them in independent study programs that do not require classroom-based instruction, or found other loopholes.[82,83] Medical exemptions rose from 0.2 percent to 0.7 percent in the year following the bill.[81]

A requirement to vaccinate when the vaccine or primary-care service is difficult or impossible for many people to access creates further inequities.[81,82] Therefore, before even considering requirements, states must ensure that people from all sectors of society can get vaccines easily and safely. This includes ensuring a stable supply of vaccines. The following steps are considered essential best practices (also summarized in Appendix I Figure 1) before states assess if requirements are considered politically appropriate: (1) ensure access to the required vaccine which includes ensuring a stable supply of the vaccine at various locations of access; and (2) use multiple interventions to improve uptake which includes understanding the reasons for under-vaccination, using reminders, and providing vaccinations in communities.[81]

CURRENT BARRIERS TO IMPLEMENTING VACCINE REQUIREMENTS

The COVID-19 pandemic highlighted several barriers to vaccine requirements overall. There was speculation that rampant misinformation related to the COVID-19 vaccine would lead to a spillover of distrust into vaccination in general, potentially leading to a reduction in childhood vaccination rates.[35] Attitudes regarding school requirements for routine vaccinations became more negative, suggesting a spillover of anti-requirement sentiments more broadly.[83] During the 2020–21 school year, national coverage with state-required vaccines among kindergarten students declined from 95 percent to approximately 94 percent.[84] Despite widespread return to in-person learning, COVID-19–related disruptions continue to affect vaccination coverage, preventing a return to pre-pandemic coverage levels among kindergarten students and adolescents. Compounding matters, a recent study evaluated the prevalence of vaccine hesitancy among parents about specific vaccines, including HPV. That study found that 55.9 percent of children had a parent hesitant about COVID-19 vaccine, 30.9 percent hesitant about influenza vaccine, 30.1 percent hesitant about HPV vaccine, and 12.2 percent had a parent hesitant about other vaccines such as measles, polio, and tetanus.[85] Public support for school requirements for routine childhood vaccination dropped by 10 to 12 percentage points between 2019 and 2023 (down to only 70-74 percent support three years into the pandemic).[37] This left about one-quarter of U.S. adults (25-28 percent) opposed to vaccine requirements in 2023, which is the highest level of opposition to routine childhood vaccination requirements in recent history.[37] Notable drops in support during this time occurred among specific political parties, as well as among adults who are not vaccinated against COVID-19.[83]

The vaccine requirement tension can be highlighted by recent attempts to add required vaccines for school kids in Wisconsin and California.[86] AB 659 introduced during the California 2023-2024 legislative session originally required pupils to be fully immunized against HPV before admission or advancement to the 8th grade level of any private or public elementary or secondary school.[87] The bill passed after being amended by removal of the requirement for middle schoolers.[87,88] Lawmakers stripped out that provision without any debate, reflecting the contentious nature of school vaccine requirements even in a state with some of the nation's strictest immunization

laws.[87,88] Wisconsin is one of the only other states that attempted to enact any kind of vaccine requirement in 2023, through its health department.[87] What should have been a simple update — to put the state in line with federal recommendations requiring that 7th-graders be vaccinated against meningitis and 12th-graders be boosted for it — became a supercharged political issue as lawmakers blocked it from passing.[87]

INTERVENTIONS FOR INCREASING HPV VACCINATION RATES

One of the most effective interventions to increase vaccine uptake in individuals is strong recommendation for vaccination by their health care professional.[39,88] Research documenting HPV vaccination inequities suggests low-income and Black (vs. White) girls are less likely to receive a strong health care professional recommendation for vaccination and the racial gap in recommendations has waned, but not disappeared, over time.[89,90] Reminder-based interventions for health care professionals such as standing orders and social media campaigns have improved vaccination coverage.[91] In addition to campaigns and interventions to improve health care professional recommendations for the HPV vaccine, statewide policies can lead to downstream impact on HPV vaccination.[56,80] A recent analysis of Medicaid expansion and HPV vaccine uptake supports improvements in vaccination in states that expanded Medicaid.[56,92] Taking a comprehensive systems approach to HPV vaccination is needed. Further, a review of studies evaluating school entry requirements for other adolescent vaccines observed positive spillover effects for HPV vaccination. Federally funded programs related to VFC and Medicaid were consistently associated with higher HPV vaccination coverage.[93] Finally, studies have found that environmental interventions, particularly school-based and childcare center-based vaccination programs were most effective in increasing vaccination coverage.[94]

The Community Preventive Services Task Force has also released the following findings on what works in public health to improve vaccination rates based on available evidence. The following interventions could be applied to increasing HPV vaccination rates:

- Home visits to increase vaccination rates.[95]
- Vaccination programs in schools and organized child-care centers.[96]
- Vaccination programs in (Women, Infants, Children) WIC settings.[97]
- Immunization information systems set up to create or support effective interventions, such as client reminder and recall systems, provider assessment and feedback, and clinician reminders for vaccination or missed vaccination opportunities.[98]

EXISTING AMA POLICY

AMA policy H-440.872 “HPV-Associated Cancer Prevention” urges physicians to educate themselves and their patients about HPV and associated diseases, HPV vaccination, as well as routine HPV related cancer screening. This policy also states that the AMA will intensify efforts to improve awareness and understanding about HPV and associated diseases in all individuals, regardless of sex, such as, but not limited to, cervical cancer, head and neck cancer, anal cancer, and genital cancer, the availability and efficacy of HPV vaccinations, and the need for routine HPV related cancer screening in the general public. Further, it recommends HPV vaccination for all groups for whom the federal Advisory Committee on Immunization Practices recommends HPV vaccination and encourages interested parties to investigate means to increase HPV vaccination rates by facilitating administration of HPV vaccinations in community-based settings including school settings.

AMA policy H-440.970, “Nonmedical Exemptions from Immunizations” states that the AMA believes that nonmedical (religious, philosophic, or personal belief) exemptions from

immunizations endanger the health of the unvaccinated individual and the health of those in the community at large. It also supports the immunization recommendations of ACIP for all individuals without medical contraindications. It is of particular importance to note is that this policy recommends that states have in place an established mechanism, which includes the involvement of qualified public health physicians, of determining which vaccines will be mandatory for admission to school and other identified public venues based upon the recommendations of the ACIP and policies that permit immunization exemptions for medical reasons only.

The AMA has not singled out specific vaccines for school entry requirements, beyond outlining conditions that should be met before decisions to mandate COVID-19 vaccination for school attendance for children and college/university students. Those considerations included:

a. After a vaccine has received full approval from the U.S. Food and Drug Administration through a Biological Licenses Application.
b. In keeping with recommendations of the Advisory Committee on Immunization Practices for use in the population subject to the mandate as approved by the Director of the Centers for Disease Control and Prevention.
c. When individuals subject to the mandate have been given meaningful opportunity to voluntarily accept vaccination.
d. Implementation of the mandate minimizes the potential to exacerbate inequities or adversely affect already marginalized or minoritized populations.

The AMA also continues to develop material and publish new stories on how doctors can effectively communicate with patients to help build vaccine confidence.[99,100]

CONCLUSION

HPV is a common virus, some types of which spread through sexual contact.[101] Some sexually transmitted HPVs can cause genital warts, whereas others, called high-risk or oncogenic HPVs, can cause cancer.[102] High-risk HPVs cause virtually all cervical cancers, most anal cancers, and some vaginal, vulvar, penile, and oropharyngeal cancers.[6] Research has demonstrated that the HPV vaccine is a safe and effective way to decrease HPV-related cancers. However, the vaccination rate in the U.S. is suboptimal.

When first proposed, HPV school vaccine requirements were controversial. Some parents were uncomfortable with the idea of giving a vaccine for a STI to young girls age 11-12.[25] The U.S. has a long history of using school requirements to increase vaccination rates; these requirements have been consistently upheld by U.S. courts against claims that they violate individual rights.[102] Currently, Hawaii, Rhode Island, Virginia, P.R, and D.C. have laws that require HPV vaccination for school entry. The requirement and opt-out provisions vary by state/territory as well as the success of the school entry requirement on HPV vaccine series initiation and completion. Findings suggest that sex-neutral, restrictive HPV vaccination requirements for school entry are associated with increased vaccination initiation among adolescents aged 13 to 17 years.[41-44] However, it should be noted that initiation does not mean completion of the HPV vaccine series.

Data studying jurisdictions with HPV vaccine requirements have shown that broad opt-out provisions, low enforcement of—and adherence to—HPV vaccine requirements, and no mechanism to ensure completion of the HPV vaccine series have limited the success of requirements.[91] Moreover, without widespread public support, monitoring, sanctions for noncompliance, or changes to the method of vaccine administration, school-entry HPV vaccine requirements are limited in encouraging HPV vaccine initiation and completion alone.[39] Therefore

successful efforts have been attributed to limited opt-out provisions, funding efforts to provide HPV vaccines for free, educational campaigns, the route of enacting the HPV requirement, and involvement of a diverse group of interested parties prior to implementation of vaccine requirements.[45,47,61,81] Failed efforts have been attributed to broad opt-out provisions, lack of educational campaigns, and sex-specific requirements.[45,47,61,81] Further, studies have noted that the socio-political differences, barriers and facilitators, including resources and political will, to adopt and implement vaccine requirements are important to consider when evaluating the success of HPV vaccine requirements.[45,47,61,81]

Finally, strong recommendations from health care professionals, parent education, and school and childcare center-based vaccination programs are also effective ways to increase initiation of HPV vaccination and ensure completion of the HPV vaccine series.[103] Stronger health care practices such as more in-depth discussions with hesitant parents and establishing vaccination as the default are strategies that could also help improve vaccination coverage rates.[49]

Current AMA policy supports ACIP recommended vaccines and does not single out specific vaccines that should be required for school entry. Rather, AMA policy supports states to have in place an established mechanism, which includes the involvement of qualified public health physicians, of determining which vaccines will be mandatory for admission to school and other identified public venues based upon the recommendations of the ACIP and policies that permit immunization exemptions for medical reasons only.

RECOMMENDATIONS

The Council on Science and Public Health recommends that the following be adopted, and the remainder of the report be filed.

1. That our AMA amend policy H-440.872, "HPV-Associated Cancer Prevention" by addition and deletion to read as follows:

> HPV-Associated Cancer Prevention, H-440.872
> 1. Our AMA (a) strongly urges physicians and other health care professionals to educate themselves, appropriate patients, and patients' parents or caregivers when applicable, about HPV and associated diseases, the importance of initiating and completing HPV vaccination, as well as routine HPV related cancer screening; and (b) encourages the development and funding of programs targeted at HPV vaccine introduction and HPV related cancer screening in countries without organized HPV related cancer screening programs.
> 2. Our AMA will work with interested parties to intensify efforts to improve awareness and understanding about HPV and associated diseases in all individuals, regardless of sex, such as, but not limited to, cervical cancer, head and neck cancer, anal cancer, and genital cancer, the availability and efficacy of HPV vaccinations, and the need for routine HPV related cancer screening in the general public.
> 3. Our AMA supports legislation and funding for research aimed towards discovering screening methodology and early detection methods for other non-cervical HPV associated cancers.
> 4. Our AMA:
> (a) encourages the integration of HPV vaccination and ~~routine cervical~~ appropriate HPV-related cancer screening into all appropriate health care settings and visits,

(b) supports the availability of the HPV vaccine and routine cervical cancer screening to appropriate patient groups ~~that benefit most from preventive measures~~, including but not limited to low-income and pre-sexually active populations,
(c) recommends HPV vaccination for all groups for whom the federal Advisory Committee on Immunization Practices recommends HPV vaccination.
5. Our AMA supports ~~will encourage~~ efforts by states ~~appropriate stakeholders to investigate means~~ to increase HPV vaccine availability and accessibility, and HPV vaccination rates through a combination of policies such as ~~by~~ facilitating administration of HPV vaccinations in community-based settings ~~including school settings~~ including local health departments and schools, reminder-based interventions, school-entry requirements, and requirements for comprehensive and evidence-based sexual education.
~~6. Our AMA will study requiring HPV vaccination for school attendance.~~
6~~7~~. Our AMA encourages collaboration with interested parties to make available human papillomavirus vaccination, according to ACIP recommendations, to people who are incarcerated for the prevention of HPV-associated cancers.
7. Our AMA advocate that racial, ethnic, socioeconomic, and geographic differences in high-risk HPV subtype prevalence be taken into account during the development, clinical testing, and strategic distribution of next-generation HPV vaccines
8. Our AMA will encourage continued research into (a) interventions that equitably increase initiation of HPV vaccination and completion of the HPV vaccine series; (b) the impact of broad opt-out provisions on HPV vaccine uptake; and (c) the impact of the COVID-19 pandemic and vaccine misinformation on HPV vaccine uptake. (Modify Current HOD Policy)

2. That our AMA adopt the following new HOD policy.

IMMUNIZATON REQUIREMENTS

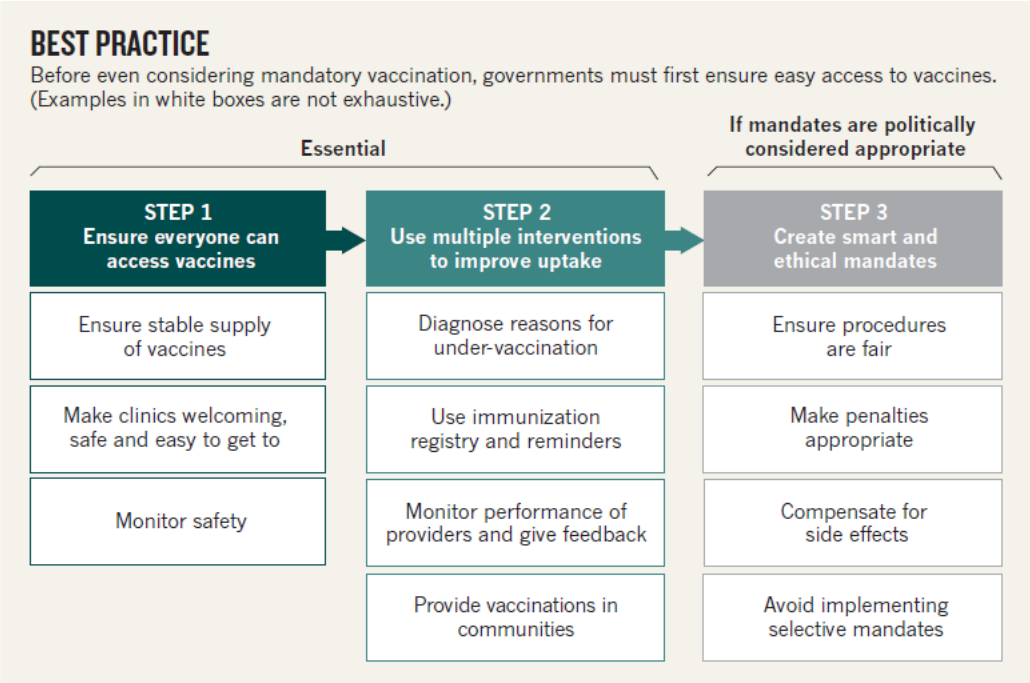
Our AMA recognizes that immunization requirements, including those for school attendance, serve as a strong motivator for parents and families to immunize their children according to the schedule recommended by the Centers for Disease Control and Prevention. (New HOD Policy)

3. That our AMA reaffirm Policy H-440.970, “Nonmedical Exemptions from Immunizations. (Reaffirm HOD Policy)

Fiscal Note: $5,000 - $10,000

APPENDIX I

Figure 1. Best Practices to Consider for Mandatory Vaccination



Source: Omer SB, Betsch C, Leask J. Mandate vaccination with care. Nature. 2019;571(7766):469-472. doi:10.1038/d41586-019-02232-0

REFERENCES

[1] National Cancer Institute. *HPV and Cancer*. Accessed August 1, 2023. Available at https://www.cancer.gov/about-cancer/causes-prevention/risk/infectious-agents/hpv-and-cancer.
[2] CDC. *Human Papillomavirus (HPV) Infection*. Accessed August 1, 2023. Available at https://www.cdc.gov/std/treatment-guidelines/hpv.htm.
[3] CDC. *HPV Vaccine Information for Clinicians*. Accessed August 1, 2023. Available at https://www.cdc.gov/hpv/hcp/need-to-know.pdf.
[4] Joura E, et al. (2007). *Efficacy of a Quadrivalent Prophylactic Human Papillomavirus (types 6, 11, 16, and 18) L1 virus-like-particle vaccine against high-grade vulval and vaginal lesions: A combined analysis of three randomized clinical trials.* The Lancet, 369(9574); Garland, S., et al. (2007). Quadrivalent vaccine against Human Papillomavirus to prevent anogenital diseases. NEJM, 356(19).
[5] Kaiser Family Foundation. *The HPV Vaccine: Access and Use in the U.S.* Accessed August 1, 2023. Available at https://files.kff.org/attachment/fact-sheet-the-hpv-vaccine-access-and-use-in-the-u-s.

[6] CDC. *Vaccine Safety.* Accessed August 1, 2023. Available at https://www.cdc.gov/vaccinesafety
[7] CDC. *Human Papillomavirus (HPV) Vaccine*. Accessed August 1, 2023. Available at https://www.cdc.gov/vaccinesafety/vaccines/hpv-vaccine.html.
[8] Goldstone SE. *Human papillomavirus (HPV) vaccines in adults: Learnings from long-term follow-up of quadrivalent HPV vaccine clinical trials.* Hum Vaccin Immunother. 2023 Dec 31;19(1):2184760. doi: 10.1080/21645515.2023.2184760. Epub 2023 Mar 13. PMID: 36916016; PMCID: PMC10038021.
[9] Mayhew A, Mullins TL, Ding L, et al. *Risk perceptions and subsequent sexual behaviors after HPV vaccination in adolescents.* Pediatrics 2014;133:404–11. PMID:24488747 https://doi.org/10.1542/peds.2013-2822.
[10] Center for Disease Control. *HPV Vaccine*. Accessed August 1, 2023. Available at https://www.cdc.gov/hpv/parents/vaccine-for-hpv.html.
[11] Pingali C, Yankey D, Elam-Evans LD, et al. Vaccination Coverage Among Adolescents Aged 13–17 Years — National Immunization Survey–Teen, United States, 2022. MMWR Morb Mortal Wkly Rep 2023;72:912–919. DOI: http://dx.doi.org/10.15585/mmwr.mm7234a3.
[12] Villarroel MA, Galinsky AM, Lu PJ, Pingali C. Human papillomavirus vaccination coverage in children ages 9–17 years: United States, 2022. NCHS Data Brief, no 495. Hyattsville, MD: National Center for Health Statistics. 2024. DOI: https://dx.doi.org/10.15620/cdc:145593.
[13] National Academy for State Health Policy. *States Address School Vaccine Mandates*. Accessed August 1, 2023. Available at https://nashp.org/states-address-school-vaccine-mandates-and-mask-mandates/.
[14] Shelton RC, Snavely AC, De Jesus M, Othus MD, Allen JD. *HPV vaccine decision-making and acceptance: does religion play a role?* J Relig Health. 2013 Dec;52(4):1120-30. doi: 10.1007/s10943-011-9553-x. PMID: 22076049; PMCID: PMC4616263.
[15] Jess McHugh, *First U.S. vaccine mandate in 1810 launched 200 years of court battles* (The Washington Post; Dec. 12, 2021). https://www.washingtonpost.com/history/2021/12/12/first-vaccine-mandate-massachusetts-waterhouse/?utm_source=pocket_saves
[16] James G. Hodge Jr. & Lawrence O. Gostin, *School Vaccination Requirements: Historical, Social, and Legal Perspectives*, Kentucky Law Journal: Vol. 90, Iss. 4, Art. 7 (2002). https://uknowledge.uky.edu/cgi/viewcontent.cgi?article=1480&context=klj
[17] CDC, *State School Immunization Requirements and Vaccine Exemption Laws* (Feb. 2022). https://www.cdc.gov/phlp/docs/school-vaccinations.pdf
[18] Minami Funakoshi, *U.S. Vaccine Mandates in Schools*, Reuters (Sept. 15, 2021). https://www.reuters.com/graphics/HEALTH-CORONAVIRUS/BIDEN/zgpombrajpd/
[19] Library of Congress, *State Police Power and Tenth Amendment Jursiprudence*. https://constitution.congress.gov/browse/essay/amdt10-3-2/ALDE_00013622/
[20] Wendy K. Mariner, George J. Annas, & Leonard H. Glantz, Jacobson v Massachusetts*: It's Not Your Great-Great-Grandfather's Public Health Law*, American Journal of Public Health 95, no. 4 (Apr. 1, 2005): pp. 581-590. https://doi.org/10.2105/AJPH.2004.055160
[21] *Jacobson v. Massachusetts*, 197 U.S. 11 (1905).
[22] *Zucht v. King*, 260 U.S. 174 (1922).
[23] *See Brown v. Stone*, 378 So. 2d 218, 223 (Miss. 1979): "To the extent that it may conflict with the religious beliefs of a parent, however sincerely entertained, the interests of the school children must prevail."
[24] National Conference of State Legislatures. States With Religious and Philosophical Exemptions From School Immunization Requirements. https://www.ncsl.org/health/states-with-religious-and-philosophical-exemptions-from-school-immunization-requirements
[25] CDC, *Improving Vaccination Coverage Fact Sheet*, (Apr. 2015). https://www.cdc.gov/vaccines/imz-managers/laws/downloads/Improving-Vax-Coverage-Factsheet.pdf
[26] Ella Roth. The National Academy for State Health Policy. Trends in Vaccine-Related Legislation — 2023 Legislative Sessions. Accessed 6/25/24. Available at https://nashp.org/trends-in-vaccine-related-legislation-coming-out-of-2023-state-legislative-sessions.
[27] CDC, *Quadrivalent Human Papillomavirus Vaccine: Recommendations of the Advisory Committee on Immunization Practices (ACIP)*, MMWR Vol. 56 RR-2 (Mar. 23, 2007). https://www.cdc.gov/mmwr/PDF/rr/rr5602.pdf
[28] Richard Knox, *HPV Vaccine: The Science Behind the Controversy*, NPR (Spt. 19, 2011). https://www.npr.org/2011/09/19/140543977/hpv-vaccine-the-science-behind-the-controversy

[29] *See generally* S. Mollborn and B. Everett, *Correlates and Consequences of Parent-Teen Incongruence in Reports of Teens' Sexual Experience*, Journal of Sex Research 47, no. 4 (2010): 314-329; L. O'Donnell, A. Stueve, and R. Duran, et al., *Parenting Practices, Parents' Underestimation of Daughters' Risks, and Alcohol and Sexual Behaviors of Urban Girls*, Journal of Adolescent Health 42, no. 5 (2008): 496-502; B.F. Stanton, X. Li, J. Galbraith, et al. *Parental Underestimates of Adolescent Risk Behavior: A Randomized, Controlled Trial of a Parental Monitoring Intervention*, Journal of Adolescent Health 26, no. 1 (2000): 18-26.
[30] M. K. Beckett, M. N. Elliot, S. Martino, et al., *Timing of Parent and Child Communication About Sexuality Relative to Children's Sexual Behaviors*, Pediatrics 135, no. 1 (2010): 33-41.
[31] Jonathan T. Scott, *The Difficult Road to Compelling Vaccination for Sexually Transmitted Diseases – How Gardasil and Those to Follow Will Change the Way that States Require Inoculation*, Kentucky Law Journal: Vol. 97: Iss. 4, Article 5 (2009). https://uknowledge.uky.edu/klj/vol97/iss4/5
[32] *Boone v. Boozman*, 217 F. Supp. 2d 938, 954 (E.D. Ark., 2002).
[33] Sabeena, S., Bhat, P., Kamath, V., and Arunkumar, G. (2017) Possible non-sexual modes of transmission of human papilloma virus. J. Obstet. Gynaecol. Res., 43: 429–435. doi: 10.1111/jog.13248.
[34] Calo WA, Lennon RP, Ruffin Iv MT, et al. Support for HPV vaccine school-entry requirements in the United States: The role of exemption policies. Vaccine. 2022;40(51):7426-7432. doi:10.1016/j.vaccine.2022.08.019.
[35] National Conference of State Legislatures. HPV vaccine policies. Natl Conf State Legis 2021. http://www.ncsl.org/research/health/hpv-vaccinestate-legislation-and-statutes.aspx.
[36] Colgrove J, Abiola S, Mello MM. HPV vaccination mandates - Lawmaking amid political and scientific controversy. N Engl J Med 2010;363:785–91.
[37] Gostin LO. Mandatory HPV vaccination and political debate. JAMA - J Am Med Assoc 2011;306:1699–700. https://doi.org/10.1001/jama.2011.1525.
[38] Ko JS, Goldbeck CS, Baughan EB, Klausner JD. Association Between Human Papillomavirus Vaccination School-Entry Requirements and Vaccination Initiation. JAMA Pediatr. 2020 Sep 1;174(9):861-867. doi: 10.1001/jamapediatrics.2020.1852. PMID: 32597928; PMCID: PMC7325070.
[39] District of Columbia Municipal Regulations. 22-B §146 (2008).
[40] District of Columbia Municipal Regulations. 22-B §146 (2014).
[41] Rhode Island Administrative Code. 216-RICR-30-05-3 (2014).
[42] Vázquez-Otero C, Lockhart E. The adoption of the HPV vaccine school-entry requirement in Puerto Rico: How practical lessons can inform future vaccine policies. Prev Med Rep. 2022 Oct 21;30:102025. doi: 10.1016/j.pmedr.2022.102025. PMID: 36325250; PMCID: PMC9618830.
[43] RI.gov. Rhode Island Remains a Vaccination Leader Nationwide. Accessed 7/09/24. Available at https://www.ri.gov/press/view/46458#:~:text= percent22Rhode percent20Island's percent20immunization percent20success percent20is,Department percent20of percent20Health percent20(RIDOH).
[44] Washburn T, Devi Wold A, Raymond P, Duggan-Ball S, Marceau K, Beardsworth A. Current initiatives to protect Rhode Island adolescents through increasing HPV vaccination. Hum Vaccin Immunother. 2016 Jun 2;12(6):1633-8. doi: 10.1080/21645515.2016.1161460. Epub 2016 May 4. PMID: 27141954; PMCID: PMC4964674.
[45] North AL, Niccolai LM. Human Papillomavirus Vaccination Requirements in US Schools: Recommendations for Moving Forward. Am J Public Health. 2016 Oct;106(10):1765-70. doi: 10.2105/AJPH.2016.303286. Epub 2016 Aug 23. PMID: 27552264; PMCID: PMC5024362.
[46] Reagan-Steiner S, Yankey D, Jeyarajah J et al. National, regional, state, and selected local area vaccination coverage among adolescents aged 13-17 years - United States, 2014. MMWR Morb Mortal Wkly Rep. 2015;64(29):784–792.
[47] State of Rhode Island Department of Health. Immunization information for schools and child care workers. 2015. Available at: http://www.health.ri.gov/immunization/for/schools.
[48] Lindley MC, Shen AK, Orenstein WA, Rodewald LE, Birkhead GS. Financing the delivery of vaccines to children and adolescents: challenges to the current system. Pediatrics 2009; 124:S548-57; PMID:19948587; http://dx.doi.org/ 10.1542/peds.2009-1542O
[49] Rhode Island Department of Health Vaccinate Before You Graduate (VBYG) Program. Accessed 20February2016 Available at: http://www.health.ri.gov/programs/detail.php?pgm_id=1010
[50] Perkins RB, Lin M, Wallington SF, Hanchate AD. Impact of school-entry and education mandates by states on HPV vaccination coverage: Analysis of the 2009-2013 National Immunization Survey-Teen. Hum

Vaccin Immunother. 2016 Jun 2;12(6):1615-22. doi: 10.1080/21645515.2016.1150394. Epub 2016 May 6. PMID: 27152418; PMCID: PMC4964731.

[51] CDC 2013. NIS-Teen Vaccination Coverage Table Data. 2014; http://www.cdc.gov/vaccines/imz-managers/coverage/nis/teen/data/tables-2013.html.

[52] Miller K, Dilley SE, Huh WK, Lessons learned from domestic and international human papillomavirus vaccination programs: a review, American Journal of Obstetrics and Gynecology (2017), doi: 10.1016/j.ajog.2017.08.109.

[53] Thompson EL, Livingston MD 3rd, Daley EM, Zimet GD. Human Papillomavirus Vaccine Initiation for Adolescents Following Rhode Island's School-Entry Requirement, 2010-2016. Am J Public Health. 2018 Oct;108(10):1421-1423. doi: 10.2105/AJPH.2018.304552. Epub 2018 Jul 19. PMID: 30024803; PMCID: PMC6137780.

[54] Forster A, Wardle J, Stephenson J, Waller J. Passport to promiscuity or lifesaver: press coverage of HPV vaccination and risky sexual behavior J Health Commun March 2010; 15(2):205-17; PMID:20390987; http://dx.doi.org/ 10.1080/10810730903528066

[55] Forster A, Wardle J, Stephenson J, Waller J. Passport to promiscuity or lifesaver: press coverage of HPV vaccination and risky sexual behavior J Health Commun March 2010; 15(2):205-17; PMID:20390987; http://dx.doi.org/ 10.1080/10810730903528066

[56] Pitts MJ, Adams Tufts K. Implications of the Virginia human papillomavirus vaccine mandate for parental vaccine acceptance Qual Health Res May 2013; 23(5):605-17; PMID:23275459; http://dx.doi.org/ 10.1177/1049732312470871

[57] Churchill BF. How important is the structure of school vaccine requirement opt-out provisions? Evidence from Washington, DC's HPV vaccine requirement. J Health Econ. 2021 Jul;78:102480. doi: 10.1016/j.jhealeco.2021.102480. Epub 2021 Jun 12. PMID: 34218042.

[58] Ko JS, Goldbeck CS, Baughan EB, Klausner JD. Association Between Human Papillomavirus Vaccination School-Entry Requirements and Vaccination Initiation. JAMA Pediatr. 2020;174(9):861–867. doi:10.1001/jamapediatrics.2020.1852

[59] Calo, W.A., Gilkey, M. B., Shah, P. D., Moss, J.L., Brewer, N.T., 2016. Parents' support for school-entry requirements for human papillomavirus vaccination: a national study. Cancer Epidemiol. Biomarkers Prev., 25(9), 1317-1325. https://doi.org/10.1158/1055-9965.epi-15-1159.

[60] Cuff RD, Buchanan T, Pelkofski E, Korte J, Modesitt SP, Pierce JY. Rates of human papillomavirus vaccine uptake amongst girls five years after introduction of statewide mandate in Virginia. Am J Obstet Gynecol. 2016 Jun;214(6):752.e1-6. doi: 10.1016/j.ajog.2016.03.022. Epub 2016 Mar 18. PMID: 27001221; PMCID: PMC7740000.

[61] §32.1–46 of the Code of Virginia – Virginia Acts of Assembly – 2007 Reconvened Session, Chapter 858. Available at: https://lis.virginia.gov/cgi-bin/legp604.exe?071+ful+CHAP0858.

[62] Pitts MJ, Adams Tufts K. Implications of the Virginia human papillomavirus vaccine mandate for parental vaccine acceptance Qual Health Res May 2013; 23(5):605-17; PMID:23275459; http://dx.doi.org/ 10.1177/1049732312470871

[63] Centers for Disease Control and Prevention (CDC). National Immunization Survey - Teen, 2014. Available at: http://www.cdc.gov/vaccines/who/teens/vaccination-coverage.html.

[64] Pierce JY, Korte JE, Carr LA, Gaspar CB, Modesitt SC. Post approval human papillomavirus vaccine uptake is higher in minorities compared to whites in girls presenting for well-child care. Vaccines (Basel) 2013;1:250–61.

[65] Colón-López V., Medina-Laabes D.T., Abreu R.S., Díaz Miranda O.L., Ortiz A.P., Fernández M.E., Hull P.C. Understanding parents' views toward the newly enacted HPV vaccine school entry policy in Puerto Rico: a qualitative study. BMC Public Health. 2021;21(1):1938. doi: 10.1186/s12889-021-11952-w.

[66] Colón-López V., Vázquez-Otero C., Rivera-Figueroa V., Arroyo-Morales G.O., Medina-Laabes D.T., Soto-Abreu R., Díaz-Miranda O.L., Rivera Á., Cardona I., Ortiz A.P., Hull P.C. HPV vaccine school entry requirement in puerto rico: historical context, challenges, and opportunities. Prev Chronic Dis. 2021;18:E77. doi: 10.5888/pcd18.210035.

[67] Inmunizaciones Compulsorias a los Niños Pre-escolares y Estudiantes en el Estado Libre Asociado de Puerto Rico, L.P.R.A. § 182 a-l (1983).

[68] Centers for Disease Control and Prevention. TeenVaxView: 2008–2017 adolescent HPV vaccination coverage trend report. Atlanta (GA): US Department of Health and Human Services.

[69] Vázquez-Otero C, Daley EM, Vamos CA, Romero-Daza N, Beckstead J, Martinez Tyson D. The intersection of problems, policy, and politics: the adoption of an HPV vaccine school-entry requirement in Puerto Rico. Qual Health Res 2021;31(5):859–70.
[70] Albright K, Barnard J, O'Leary ST, et al. Noninitiation and noncompletion of HPV vaccine among English- and Spanish-speaking parents of adolescent girls: a qualitative study. Acad Pediatr. 2017;17(7):778–784. doi: 10.1016/j.acap.2017.03.013.
[71] Colón-López V, Hull PC, Díaz-Miranda OL, Machin M, Vega-Jimenez I, Medina-Laabes DT, Soto-Abreu R, Fernandez M, Ortiz AP, Suárez-Pérez EL. Human papillomavirus vaccine initiation and up-to-date vaccine coverage for adolescents after the implementation of school-entry policy in Puerto Rico. PLOS Glob Public Health. 2022 Nov 8;2(11):e0000782. doi: 10.1371/journal.pgph.0000782. PMID: 36962595; PMCID: PMC10021633.
[72] Birkland T.A. Taylor & Francis Group; 2019. An Introduction to the Policy Process : Theories, Concepts, and Models of Public Policy Making.
https://ebookcentral.proquest.com/lib/utsa/detail.action?docID=5793861
[73] Miech, E. J., Rattray, N. A., Flanagan, M. E., Damschroder, L., Schmid, A. A., Damush, T.M., 2018. Inside help: an integrative review of champions in healthcare-related implementation. SAGE Open Med., 6, 2050312118773261.
[74] Karafillakis E., Simas C., Jarrett C., Verger P., Peretti-Watel P., Dib F., De Angelis S., Takacs J., Ali K.A., Pastore Celentano L., Larson H. HPV vaccination in a context of public mistrust and uncertainty: a systematic literature review of determinants of HPV vaccine hesitancy in Europe. Hum. Vaccin. Immunother. 2019;15(7–8):1615–1627. doi: 10.1080/21645515.2018.1564436.
[75] Calo, W.A., Gilkey, M. B., Shah, P. D., Moss, J.L., Brewer, N.T., 2016. Parents' support for school-entry requirements for human papillomavirus vaccination: a national study. Cancer Epidemiol. Biomarkers Prev., 25(9), 1317-1325. https://doi.org/10.1158/1055-9965.epi-15-1159.
[76] Attwell K., Navin M.C., Lopalco P.L., Jestin C., Reiter S., Omer S.B. Recent vaccine mandates in the United States, Europe and Australia: a comparative study. Vaccine. 2018;36(48):7377–7384. doi: 10.1016/j.vaccine.2018.10.019.
[77] Roberts MC, Murphy T, Moss JL, Wheldon CW, Psek W. A qualitative comparative analysis of combined state health policies related to human papillomavirus vaccine uptake in the United States. Am J Public Health. 2018;108(4):493–99. doi: 10.2105/AJPH.2017.304263.
[78] Zheng L, Wu J, Zheng M. Barriers to and Facilitators of Human Papillomavirus Vaccination Among People Aged 9 to 26 Years: A Systematic Review. Sex Transm Dis. 2021 Dec 1;48(12):e255-e262. doi: 10.1097/OLQ.0000000000001407. PMID: 33783412; PMCID: PMC8594509.
[79] Omer SB, Betsch C, Leask J. Mandate vaccination with care. Nature. 2019;571(7766):469-472. doi:10.1038/d41586-019-02232-0
[80] Delamater, P. L. et al. Pediatrics 143, e20183301 (2019).
[81] Micheal Devitt. AAFP. Study Examines Fallout of California Vaccine Exemption Law. Accessed 7/15/2024. Available at https://www.aafp.org/news/health-of-the-public/20181127califvaccstudy.html.
[82] Boyce, T. et al. Eurosurveillance 24, 1800204 (2019).
[83] Gillian K. SteelFisher et al., *Has COVID-19 Threatened Routine Childhood Vaccination? Insights From US Public Opinion Polls*, Health Affairs (June 6, 2023). https://www.healthaffairs.org/content/forefront/has-covid-19-threatened-routine-childhood-vaccination-insights-us-public-opinion-polls
[84] Seither R, Laury J, Mugerwa-Kasujja A, Knighton CL, Black CL. Vaccination coverage with selected vaccines and exemption rates among children in kindergarten—United States, 2020–21 school year. MMWR Morb Mortal Wkly Rep 2022;71:561–8. https://doi.org/10.15585/mmwr.mm7116a1 PMID:35446828
[85] Santibanez TA, Black CL, Zhou T, Srivastav A, Singleton JA. Parental hesitancy about COVID-19, influenza, HPV, and other childhood vaccines. Vaccine. Published online July 2024:S0264410X24008028. doi:10.1016/j.vaccine.2024.07.040
[86] Rachel Bluth. How Covid made it nearly impossible to pass new vaccine rules. *Politico*. 06/04/2023. Available at https://www.politico.com/news/2023/06/04/how-covid-made-it-nearly-impossible-to-pass-new-vaccine-rules-00100073.
[87] AB 659. Cancer Prevention Act. (2023-2024). Available at https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB659.
[88] Holman, D. M., Benard, V., Roland, K. B., Watson, M., Liddon, N., & Stokley, S. (2014).

Barriers to human papillomavirus vaccination among US adolescents: A systematic review of the literature. JAMA Pediatrics, 168, 76–82.

[89] Burdette, A. M., Webb, N. S., Hill, T. D., & Jokinen-Gordon, H. (2017). *Race-specific trends in HPV vaccinations and provider recommendations: Persistent disparities or social progress?* Public Health, 142, 167–176.

[90] Polonijo, A. N., & Carpiano, R. M. (2013). *Social inequalities in adolescent human papillomavirus (HPV) vaccination: A test of fundamental cause theory.* Social Science & Medicine, 82, 115–125.

[91] Niccolai M.L., Hansen C.E. *Practice- and Community-Based Interventions to Increase Human Papillomavirus Vaccine Coverage: A Systematic Review*. JAMA Pediatr. 2015;169:686–692. doi: 10.1001/jamapediatrics.2015.0310.

[92] Hoff BM, Livingston III MD, Thompson EL. The association between state Medicaid expansion and human papillomavirus vaccination. Vaccine. 2020;38(38):5963–65. doi: 10.1016/j.vaccine.2020.07.024.

[93] Mary Catharine McKeithen, Melissa B. Gilkey, Wei Yi Kong, N. Loren Oh, Jennifer Heisler-MacKinnon, Rebecca Carlson, Greeshma James, Brigid K. Grabert; Policy Approaches for Increasing Adolescent HPV Vaccination Coverage: A Systematic Review. Pediatrics May 2024; 153 (5): e2023064692. 10.1542/peds.2023-064692

[94] Walling E.B., Benzoni N., Dornfeld J., Bhandari R., Sisk B.A., Garbutt J., Colditz G. *Interventions to Improve HPV Vaccine Uptake: A Systematic Review*. Pediatrics. 2016;138 doi: 10.1542/peds.2015-3863.

[95] The Community Guide. CPSTF. Vaccination Programs: Immunization Information Systems. Accessed August 1, 2023. Available at https://www.thecommunityguide.org/findings/vaccination-programs-home-visits-increase-vaccination-rates.

[96] The Community Guide. CPSTF. Vaccination Programs: Immunization Information Systems. Accessed August 1, 2023. Available at https://www.thecommunityguide.org/findings/vaccination-programs-schools-and-organized-child-care-centers.

[97] The Community Guide. CPSTF. Vaccination Programs: Immunization Information Systems. Accessed August 1, 2023. Available at https://www.thecommunityguide.org/findings/vaccination-programs-special-supplemental-nutrition-program-women-infants-children-wic.

[98] The Community Guide. CPSTF. *Vaccination Programs: Immunization Information Systems*. Accessed August 1, 2023. Available at https://www.thecommunityguide.org/media/pdf/Vaccination-Immunization-Info-Systems.pdf.

[99] American Medical Association. *Marie Brown, MD, discusses vaccination hesitancy*. Available at https://www.ama-assn.org/delivering-care/public-health/marie-brown-md-discusses-vaccination-hesitancy

[100] Sara Berg. *How to have crucial conversations with vaccine-hesitant patientsAmerican Medical Association.* Available at https://www.ama-assn.org/delivering-care/public-health/how-have-crucial-conversations-vaccine-hesitant-patients.

[101] Burd EM. *Human papillomavirus and cervical cancer.* Clin Microbiol Rev. 2003 Jan;16(1):1-17. doi: 10.1128/CMR.16.1.1-17.2003. PMID: 12525422; PMCID: PMC145302.

[102] AMA J Ethics. 2020;22(1):E36-42. doi: 10.1001/amajethics.2020.36.

[103] CDC. *Improving Vaccination Coverage Fact Sheet*. Accessed August 1, 2023. Available at https://www.cdc.gov/vaccines/imz-managers/laws/downloads/improving-vax-coverage-factsheet.pdf.

REPORT 4 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (I-24)
Reducing Sodium Intake to Improve Public Health
(Reference Committee K)

EXECUTIVE SUMMARY

BACKGROUND. At the 2023 Annual Meeting of the American Medical Association (AMA) House of Delegates, Resolution 423, "Reducing Sodium Intake to Improve Public Health," called for AMA to work with relevant partners to advocate and advise salt reduction through public outreach, which could include ad campaigns and educational programs. This resolution was referred for further study.

METHODS. English language studies and articles were selected from searches of PubMed and Google Scholar using the search terms "sodium and cardiovascular disease and/or hypertension", "sodium reduction", sodium chloride/*adverse effects", and sodium reduction policies", with a focus on articles published since 2010. Additionally, the Cochrane Database of Systematic Reviews and websites managed by government agencies and affinity organizations were searched for relevant information.

DISCUSSION. Hypertension is an important risk factor contributing to several poor health outcomes, including heart disease and stroke, vision impairment, cognitive decline, sexual dysfunction, complications in pregnancy, and kidney disease. One of the most important risk factors for hypertension is poor diet, and high sodium consumption has been described as the leading dietary risk factor for poor cardiovascular outcomes and mortality. The AMA's Council on Science and Public Health previously issued a report on reducing sodium intake to decrease the public health burden of cardiovascular disease, providing information on recommended target levels for population sodium intake, and identifying policy approaches to meet these goals. This report provides an update on the evidence regarding dietary sodium and its impact on blood pressure and cardiovascular disease as well as a summary of the effectiveness and evaluation of research on interventions and policies to reduce dietary sodium.

The overall strength of the evidence indicates a significant and linear relationship between increased sodium intake and hypertension. Interventions to reduce dietary sodium have consistently demonstrated a greater beneficial impact on those with hypertension and may have greater benefit for other subgroups, namely Black populations. High impact and effective strategies to reduce sodium intake include setting voluntary or mandatory reformulation targets for sodium in packaged food, front-of-pack labeling regulations, regulation of marketing of foods and nonalcoholic beverages to children, taxation of high-sodium food, and setting sodium limits in food served in institutional or organizational settings. Reducing sodium content in foods is feasible and should not be achieved through the addition of increased sugar content or artificial additives. While reductions in sodium must be considered with respect to the other important properties salt confers from a food technology perspective, including flavor, development of texture, fermentation, color development, and antimicrobial properties, successful international examples demonstrate that meaningful reductions are possible without noticeable changes in flavor or consumer acceptance. Additionally, sodium reduction is just one of many strategies to prevent and manage hypertension. There are multiple risk factors for hypertension and effective strategies for controlling blood pressure exist across individual, organization, community and policy levels.

CONCLUSION. Reducing dietary sodium is one of several important strategies to reduce hypertension and improve public health, and should be pursued alongside other important lifestyle, environmental, and community strategies.

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 4-I-24

Subject: Reducing Sodium Intake to Improve Public Health (Resolution 423-A-23)

Presented by: John T. Carlo, MD, Chair

Referred to: Reference Committee K

INTRODUCTION

At the 2023 Annual Meeting of the American Medical Association (AMA) House of Delegates (HOD), Resolution 423, "Reducing Sodium Intake to Improve Public Health," called for our AMA to work with relevant partners to advocate and advise salt reduction through public outreach, which could include ad campaigns and educational programs. Further, the resolution asked for our AMA to study and report back to the AMA HOD on the effectiveness and feasibility of various salt reduction strategies. This resolution was referred for study. The Reference Committee asked our AMA to review trends in evidence-based strategies that are intended to improve health via sodium reduction in key populations and to report back to HOD.

In 2006, the Council on Science and Public Health (CSAPH) issued a report on reducing sodium intake to decrease the public health burden of cardiovascular disease, providing information on recommended target levels for population sodium intake, and identifying policy approaches to meet these goals. The report summarized the existing evidence on sodium intake and blood pressure, concluding that across populations, increases in blood pressure and the prevalence of hypertension are related to salt intake, with modest but consistent findings showing the effect of salt consumption on blood pressure. The report highlights the potential public health benefits from interventions and policies that could reduce population level sodium intake, but also notes that reduced salt intake "should be only one component of a comprehensive strategy to lower blood pressure. Increasing physical activity, consuming a diet high in fruits and vegetables and low in saturated and total fat, and moderation in alcohol intake," are recommended approaches to preventing and managing hypertension. The report's recommendations, which were adopted, called for a step-wise minimum 50 percent reduction in sodium in processed foods, fast food products, and restaurant meals to be achieved over the next decade. This report provides an update on the current evidence regarding dietary sodium and its impact on blood pressure and cardiovascular disease as well as a summary of the effectiveness and evaluation research on interventions and policies to reduce dietary sodium.

BACKGROUND

Hypertension, otherwise known as high blood pressure, is a condition that develops when blood flows through arteries at higher-than-normal pressures on a consistent basis. Hypertension is an important risk factor contributing to a number of poor health outcomes, including heart disease and stroke, vision impairment, cognitive decline, sexual dysfunction, complications in pregnancy, and kidney disease.[1,2] Hypertension is an epidemic in the U.S. and affects more than an estimated 120 million adults, approximately half the adult population.[3] National Health and Nutrition Examination Survey (NHANES) data over the last 20 years shows an upward trend in hypertension

in the last few years after steady declines between 2000 and 2010 (see Figure 1).[4] In 2022, more than 850,000 people died from heart disease and stroke (combined), the first and fifth leading causes of mortality in the U.S., respectively.[5]

Additionally, hypertension and cardiovascular disease disproportionately impact some populations more than others. Non-Hispanic Black Americans are diagnosed with hypertension earlier in life and experience greater hypertension-related morbidity and mortality compared to non-Hispanic White persons.[6,7] While death rates from cardiovascular disease have generally declined since the mid-20th century, mortality rates among Black populations have remained persistently high in comparison with all other racial and ethnic groups.[7,8] Black Americans have a 30 percent higher risk of fatal stroke, 50 percent higher risk of cardiovascular mortality, and more than four times higher risk of end-stage renal disease.[6] However, Black Americans are not the only ones who face inequities in the U.S. Recent data indicate Hispanic and Indigenous populations also have a high prevalence of uncontrolled blood pressure.[9] Many factors contribute to these health disparities, but chief among them are social determinants of health, which include poor access to consistent health care, low health literacy, lower socioeconomic status, neighborhood/environment stability, reduced access to healthy food, as well as the historical context and current state of structural racism.[6,7] One of the most important risk factors for hypertension is poor diet, and high sodium consumption has been described as the leading dietary risk factor for poor cardiovascular outcomes and mortality.[10]

The most common source of sodium in the American diet comes from added salt, or sodium chloride. Sodium is a mineral that plays an important role in our body and is one of the two chemical elements found in salt (40 percent sodium, 60 percent chloride). In terms of the physiological role of sodium, our bodies require a small amount of sodium (estimated to be roughly 500 mg/daily) to conduct nerve impulses, contract and relax muscles, and maintain the proper balance of water and minerals.[11] One teaspoon of salt (about 6g or 6000 mg) is equivalent to 2300 mg of sodium, which is the recommended dietary reference limit developed by the National Academy of Medicine.[12] However, the current average consumption of sodium in the U.S. is about 3400 mg/d, approximately 50 percent more than the recommended limit of 2300 mg/d for adults and children 14 years and older.[13] More than 90 percent of people in the U.S. exceed recommended limits across almost all age groups. For example, more than 95 percent of children aged 2 to 13 years old exceed recommended limits for their age group, the consequences of which could track into adulthood and influence later health outcome (see Figure 2).[13]

The high level of salt in the American diet is primarily a result of packaged and preprepared foods, versus salt added at the point of consumption. More than 70 percent of sodium intake in the U.S. is from packaged food and food prepared away from home, including restaurants and food service operations, while just 11 percent of sodium intake is from sodium added at the table or in cooking at home (see Figure 3).[14] Even though people in the U.S. can reduce their personal use of salt, sodium levels in the U.S. food supply at the time of purchase or consumption make it extremely challenging to reduce overall sodium levels at the population level. The Centers for Diseases Control and Prevention (CDC) has outlined the top foods contributing to high sodium levels in the U.S. diet, which include rice, pasta, and other grain-based dishes; meat, poultry, and seafood dishes; pizza; soups; chips, crackers, and savory snacks; condiments and gravies; cold cuts and cured meats; and breads and tortillas.[15]

To this end, in 2016, the U.S. Food and Drug Administration (FDA) took action on reducing sodium in processed foods by publishing draft guidance on voluntary sodium reduction goals for industry with an aim to reduce U.S. daily intake from 3400 mg to 3000 mg within two years (short-term goal) and to 2300 mg within 10 years (long-term goal). In 2021, the FDA issued the final guidance with voluntary targets for reducing sodium in commercially processed, packaged and

prepared food over the next 2 and a half years.[16] Healthy People 2030 data shows that sodium consumption has decreased slightly from the baseline amount of 3,414 mg in 2013-16 to 3,346 mg in 2017-2020 (the most recent years of data), but there is a long way to go to meet the Healthy People 2030 target of 2,731 mg.[17] In August 2024, FDA published new draft guidance with updated, 3-year voluntary sodium reduction targets in foods, referred to as Phase II. The new voluntary targets, if achieved, would help support reducing sodium intake to about 2,750 mg/day in the U.S. general population.[18]

High sodium consumption and hypertension is not only an American challenge; 96 countries around the world are working to reduce sodium intake and 48 have set sodium target levels for one or more processed foods.[13] A study on the health effects of dietary risks in 195 countries across the globe estimated the proportion of disease-specific burden attributable to each dietary risk factor (also referred to as population attributable fraction) among adults aged 25 years or older and found that high sodium intake was the leading dietary risk factor attributable to approximately 3 million deaths and 70 million disability-adjusted life-years (DALYs), whereas the low intake of fruits was associated with 2 million deaths and 65 million DALYs.[19] The World Health Organization (WHO) has prioritized dietary sodium reduction and declared a 30 percent reduction in population sodium intake by 2025 global target for noncommunicable disease prevention.[20] The WHO developed a public health framework to develop a successful salt reduction strategy, called the SHAKE package, with the following key activity areas aligning to the SHAKE acronym: Surveillance, Harness Industry, Adopt standards for labelling and marketing, Knowledge, and Environment.[21] Additionally, the European Food Safety Authority recently proposed that 2000 mg sodium per day is a safe and adequate level of intake for the general population of adults.[22] Further examples of national policies to reduce sodium consumption and their effectiveness are outlined below.

METHODS

English language studies and articles were selected from searches of PubMed and Google Scholar using the search terms “sodium sensitivity”, “sodium and cardiovascular disease and/or hypertension”, “sodium reduction”, sodium chloride/*adverse effects”, and sodium reduction policies”, with a focus on articles published since 2014. Additionally, the Cochrane Database of Systematic Reviews was also searched for relevant studies. Websites managed by government agencies and affinity organizations including but not limited to National Heart Lung and Blood Institute, American Heart Association, U.S. Department of Agriculture, National Academy of Sciences, U.S. F DA, National Salt and Sugar Reduction Initiative, and the Salt Institute were searched for relevant information.

DISCUSSION

Relationship Between Sodium Intake and Health – An update on the evidence

Since the 2006 CSAPH report, there have been numerous studies that have assessed the relationship of dietary sodium intake with several health outcomes, including hypertension, stroke, cardiovascular disease, and mortality, as well as evaluation studies of different policies implemented to decrease dietary sodium. This report highlights the findings from available meta-analyses and systematic reviews as opposed to individual studies given the volume of publications since the previous report.

While there has been extensive research on this topic over the last two decades and consistent governmental calls for population level sodium reduction, there is an ongoing debate on the dose-response relationship between sodium intake and health outcomes. One side argues the relationship

is a linear one – as sodium intake increases, so does the risk of poor health outcomes – versus the other side, which argues there is more of a J- or U-shaped relationship – that with sodium intake at either end of the spectrum, either too low or very high, there is an increase in poor health outcomes.[23–26] Proponents of the linear relationship between sodium and poor health outcomes have suggested the controversy on this issue is unfounded and a result of researcher bias resulting from ties with the food and beverage industry, inappropriate research methodology, and a lack of rigor in research.[27,28] Proponents of the non-linear relationship contend that it has not been shown to be feasible to lower sodium intake in entire populations to the recommended low levels, that the evidence linking sodium consumption with cardiovascular disease has been inconsistent, and that current evidence from cohort studies suggests that an average sodium intake between three to five g/day is optimal in that it is associated with the lowest risk of death or cardiovascular disease.[25] Several recent large meta-analyses and systematic reviews generally support the linear dose-response relationship despite some variability in findings. The following research summary focuses on the relationship between sodium and hypertension, followed by a discussion of the research on the association between sodium and other cardiovascular morbidity and mortality outcomes.

Sodium and Hypertension

A 2021 systematic review and dose response meta-analysis of the relationship between sodium intake and hypertension included an analysis of available cohort studies (n = 11) that used dietary intake or urinary sodium excretion to measure sodium intake.[29] The studies included in the analysis were published between 1990 and 2017, with an overall sample size of more than 100,000 participants. The reference category was set at 2 g/day of sodium and study authors demonstrated a relative risk of hypertension equal to 1.04 (95 percent confidence interval of 0.96–1.13) and 1.21 (95 percent confidence interval of 1.06–1.37) at 4 g/day and 6 g/day, respectively. In other words, the risk of having hypertension increased by four percent at 4g/day (although it was not statistically significant) and 21 percent at 6 g/day, as compared to the reference group with an intake of 2 g/day. When the study authors removed studies that had high levels of bias or did not use the more accurate urinary excretion method, the linear relationship was clearer. The authors concluded that inappropriate exposure methodology may have biased previous study results particularly at low sodium intakes, hiding a linear relationship between exposure and blood pressure, indicating that the lower the sodium intake, the lower the risk of hypertension.[29]

In another systematic review by the same authors, they conducted a dose–response meta-analysis using a novel statistical approach, including trials with at least four weeks of follow-up; 24-hour urinary sodium excretion measurements; sodium manipulation through dietary change or supplementation, or both; and measurements of systolic and diastolic BP at the beginning and end of treatment.[30] They identified 85 eligible trials eligible for inclusion in their analysis and demonstrated an approximately linear and significant relationship between sodium intake and mean systolic as well as diastolic blood pressure, with no indication of a J-shaped relationship. Linear regression analyses from this study indicated that every 100 mmol/d reduction in urinary sodium excretion was associated with a lower mean systolic blood pressure of 5.56 mmHg (95 percent confidence interval of -4,52 to -6.59) and a lower mean diastolic blood pressure of 2.33 mmHg (95 percent confidence interval of -1.66 to -3.00). Results were similar for participants with or without hypertension, but the group with hypertension showed a steeper decrease in blood pressure after sodium reduction.[30]

A 2020 Cochrane systematic review on the effects of a low sodium versus high sodium diet assessed 195 randomized controlled trials and 27 population studies. A key takeaway from this review was that a mean salt intake reduction from 11.5 g per day to 3.8 g per day resulted in a reduction of 1.1/0 mmHg (about 0.3 percent) systolic/diastolic blood pressure in people with

normal blood pressure and 5.7/2.9 mmHg (about three percent) in people with hypertension.[31] The finding that sodium reduction had more pronounced impacts on those with hypertension is aligned with the previous mentioned studies. The Cochrane review also evaluated evidence for different populations, finding that for White people with elevated blood pressure, sodium reduction decreases blood pressure by about 3.5 percent, but in Asian and Black individuals the effect of sodium reduction was a little larger. However, the review authors note that there are too few studies to make definitive conclusions.[31]

The Cochrane review findings also highlight the effect of sodium reduction on other hormones and lipids in the body, noting that renin increased 55 percent; aldosterone increased 127 percent; adrenalin increased 14 percent; noradrenalin increased 27 percent; cholesterol increased 2.9 percent; and triglyceride increased 6.3 percent. From these results, the study authors concluded that the potentially harmful increase in hormones and lipids calls into question whether sodium reduction would have overall beneficial effects, particularly in a White population with normal blood pressure which saw only marginal reduction in blood pressure from sodium reduction.[31] Other researchers have called this an erroneous conclusion and called the inclusion of the acute metabolic studies in this Cochrane review irrelevant to the more general public health recommendations of modest reduction in sodium intake over time.[32] Meta-analyses excluding very short-term sodium restriction trials demonstrated that sodium reductions do not have adverse effects on blood lipids while having clinically significant benefits on blood pressure.[33,34] A 2013 Cochrane systematic review and meta-analysis found no significant changes in plasma concentrations of total cholesterol (0.05, $P = 0.18$), low density lipoprotein cholesterol (0.05, $P = 0.11$), high density lipoprotein cholesterol (-0.02, $P = 0.11$), or triglycerides (0.04, $P = 0.22$) but noted statistically significant increases in plasma renin activity (0.26, $P < 0.001$), aldosterone (73.20, $P < 0.001$), and noradrenaline (187, $P = 0.01$).[34]

Sodium and Cardiovascular Morbidity and Mortality

A 2014 update of a Cochrane review done in 2011 assessed the long-term effects of advice and salt substitution, aimed at reducing dietary salt, on mortality and cardiovascular morbidity and whether a reduction in blood pressure is an explanatory factor in the effect of such dietary interventions on mortality and cardiovascular outcomes.[35] Eight studies met inclusion criteria, three for normotensives and five in hypertensives or mixed populations. Risk ratios for all-cause mortality were imprecise and showed no evidence of reduction and there was weak evidence of benefit for cardiovascular mortality. However, small reductions in systolic blood pressure were found in normotensives with greater reductions in hypertensives. The authors concluded there was insufficient power to confirm clinically important effects of dietary advice and salt substitution, which highlights the importance of interventions that focus on removing sodium from the diet at a population level, versus those that focus on individual behavior changes.[35]

A 2018 dose-response meta-analysis of prospective cohort studies on the association of sodium intake with the risk of cardiovascular morbidity and mortality identified 16 relevant studies reporting on over 205,000 individuals.[36] Study authors estimated the effects for 100 mmol-day increases in sodium intake on cardiac death, total mortality, stroke, or mortality and found that an increase in sodium intake had little to no effect on the risk of cardiac death and total mortality, but the risk of stroke incidence and mortality significantly increased. The authors also found that low sodium intake (less than 3 g/day) was associated with an increased risk of cardiac death, while moderate (3-5 g/day) or heavy (greater than 5 g/day) sodium intake was associated with an increased risk of stroke mortality.[36] The findings of this meta-analysis provides some support to the proposition that the dose-response relationship between sodium and some cardiovascular outcomes have a J-shape.

Another 2020 systematic review and meta-analysis evaluated the dose-response relationship between dietary sodium intake and risk of cardiovascular disease.[37] This analysis identified 36 reports, including a total of 616,905 participants, and the study authors found a linear relationship between sodium intake and increased risk of cardiovascular disease, concluding a statistically significant relative risk of 1.06 in cardiovascular disease for every 1 gram of sodium increase.[37] Additionally, a systematic review conducted by the Agency for Healthcare Research and Quality (AHRQ) evaluated the effects of sodium and potassium intake on chronic disease outcomes and risk.[38] Reviewing 171 studies, the AHRQ study identified nearly 50 randomized controlled trial studies supporting a significant lowering effect on blood pressure from sodium reduction in adults, with a stronger effect in those with hypertension. However, the review found only a small number of randomized controlled trial studies assessing the effects of sodium reduction on longer term chronic outcomes, concluding that while sodium levels appear to be associated with all-cause mortality, the shape of the relationship could not be determined. Overall, the AHRQ report concludes that reducing sodium intake, increasing potassium intake, and the use of potassium containing salt substitutes in the diet significantly decreases blood pressure, particularly among those with hypertension. Additionally, they note that limited evidence suggests that sodium intake is associated with risk for all-cause mortality, and that reducing sodium intake may decrease the risk for cardiovascular disease morbidity and mortality.[38]

Several studies have modeled the reductions in cardiovascular disease outcomes from interventions to reduce dietary salt.[39,40] In one study, the authors used the Coronary Heart Disease Policy Model to quantify the benefits of population-wide reductions in dietary salt of up to 3 gm/day (1200 mg/day of sodium) in the U.S., estimating cardiovascular disease rates and costs in age, sex, and race subgroups.[40] The authors also compared salt reduction with other interventions to reduce cardiovascular risk and determined the cost-effectiveness of salt reduction compared with drug treatment of hypertension. The study estimated a projected 60,000–120,000 fewer new coronary heart disease cases, 32,000–66,000 fewer new strokes, 54,000–99,000 fewer myocardial infarctions, and 44,000–92,000 fewer deaths from any cause annually. Additionally, while all segments of the population were estimated to benefit, blacks would benefit more and women would particularly benefit from stroke reduction, older adults from reductions in coronary heart disease events, and younger adults from lower mortality rates. The authors note the predicted health benefits were on par with benefits achieved from reducing tobacco, obesity or cholesterol and interventions to reduce sodium would be far more cost-effective than treating hypertension with medications.[40]

The overall strength of the evidence indicates a significant and linear relationship between increased sodium intake and hypertension. While there may be lingering concerns or debate on whether low sodium intake is associated with greater cardiovascular disease and mortality risk, a growing body of research demonstrates a linear relationship versus a J- or U-shaped relationship. Interventions to reduce dietary sodium have consistently demonstrated a greater beneficial impact on those with hypertension and may have greater benefit for other subgroups, namely Black populations. Considering the high prevalence of hypertension in the U.S. adult population, and existing health disparities among racial groups, the public health benefit of population-wide sodium reductions would be substantial and could promote greater health equity, as evidenced by model estimates mentioned previously.[40]

Effectiveness Research on Interventions to Reduce Sodium Intake

Many sodium reduction strategies have been proposed and implemented both nationally and internationally. Within the U.S., sodium reduction policies have been enacted and evaluated at the organizational, local, state, and federal level. Additional examples of sodium reduction strategies

from other countries include the United Kingdom, South Korea, and Canada (to name a few). A framework has been developed to identify and evaluate the strength of existing sodium strategies, which categorized strategies intro three primary buckets: (1) reducing sodium from packaged goods, (2) reducing sodium from food prepared outside the home, and (3) reducing sodium added in the home (see Table 1 for a replication of the three categories and related examples).[41] Within the framework, a successful strategy has to (1) be scalable and sustainable, with a focus at the population level versus individual, (2) have evidence of effectiveness or innovation, such as a rigorous evaluation, and (3) have a large benefit to be worth the investment. Based on this framework and a review of the evidence, four strategies are recommended that primarily focus on reducing sodium from packaged foods and food prepared outside the home:

1. Setting voluntary or mandatory reformulation targets for sodium in packaged food,
2. Front-of-pack labeling regulations,
3. Regulation of marketing of foods and nonalcoholic beverages to children, and
4. Taxation of high-sodium food[41]

Food procurement policies in public institutions and mass media campaigns have been highlighted as worthwhile interventions, but it is worth noting that, "No single strategy is enough to reach the WHO goal of a 30 percent reduction in sodium intake by 2025, thus a multi-component package is needed."[41] In terms of mass media campaigns, while found to be effective in shaping consumer behavior, their feasibility and sustainability are questionable due to the large and sustained fiscal resources they require.[41]

Similarly, the CDC published an evaluation report on sodium reduction interventions and concluded the policies with the highest degree of evidence of effectiveness at the local and state level included:

1. Daily meal providers serving low sodium items (e.g., daily meal providers could include hospital cafeterias, worksites, nursing homes, home delivered meals, etc.);
2. Sodium limits on items served in workplaces;
3. Item and menu labeling based on sodium content (specifically front of packages – not just under nutritional labeling), and
4. Incentivizing or requiring stores (including chain grocery stores, convenience stores, corner stores, bodegas, gas stations, retailers, and markets) to limit sodium in the foods (i.e., prepared foods, packaged snacks, and/or beverages) they are selling.[42]

Menu Labeling and Sodium Warnings

Further studies of menu labeling in restaurants of high sodium items have been conducted since these two studies were published. Item and menu labeling in restaurants based on sodium content has been implemented in several cities, counties, and states across the U.S. (New York City, NY, Philadelphia, PA, King County, WA, Pierce County, WA, and California). New York City (NYC)'s sodium warning policy went into effect in 2015 with enforcement starting in 2016. This policy required a sodium warning regulation at chain restaurants, which included the placement of an icon next to any menu item containing ≥2,300 mg sodium. One study investigated whether sodium content of menu items changed following enforcement of the sodium warning icon, finding no significant differences in the sodium content of menu items following enforcement efforts, noting the difficulties of reducing sodium levels in restaurants.[43] Another study evaluated changes in sodium and sodium-potassium ratios in NYC adults from 2010 to 2018, following the enforcement of the sodium warning regulation and other local sodium reduction initiatives.[44] The study found that sodium intake did not significantly change from 2010 to 2018 in the overall

population. In fact, it increased slightly (3234 mg/d to 3292 mg/d) but it was not a statistically significant increase. However, there was a statistically significant decrease in sodium intake among adults 18-24 years old (3445 mg/d to 2957 mg/d, P = 0.05). The highest sodium-to-potassium ratios were among Black females 18-44 years old (2.0) and 45-64 years old (2.2) and Black (2.1) and Latino (2.1) males between 18 and 44 years old.[44]

Another study of the NYC sodium warning regulation evaluated changes to consumer purchases of high sodium content food (>= 2300 mg) following enforcement of the regulations in 2016.[45] Utilizing a survey and evaluating receipts for verification, consumer purchases were assessed at two full-service and two quick-service chain restaurants in both NYC and a control location that did not implement sodium menu labeling (Yonkers, NY), in 2015 and 2017. The study found mixed evidence of changes in purchasing patterns at NYC full-service restaurants following implementation of the sodium warning icon. Although decreases in purchases of high-sodium items among NYC full-service restaurant respondents were not significant relative to changes in purchases made by Yonkers respondents, both the mean sodium and calorie content of purchases made at NYC full-service restaurants declined significantly compared to Yonkers.[45] Taken together, these studies suggest the sodium warning icon has not been very effective at reducing the sodium content of foods in chain restaurants but may have had an impact on consumer behavior. However, there has been little change in consumer sodium consumption or reducing health disparities among NYC racial and ethnic minority populations.

Reducing sodium in packaged and processed foods

Limiting the level of sodium within the commercial food supply, at both the micro and macro level, is another promising and priority strategy. In the U.S., NYC has been a national leader on this front. The NYC Department of Health and Mental Hygiene initiated the National Salt Reduction Initiative (NSRI) in 2009, a partnership of about 100 health organizations and authorities, aiming to work with the food industry to set voluntary targets to reduce sodium in restaurant and processed foods.[46] The goal of NSRI was to decrease average sodium intake by 20 percent over five years (2009 through 2014) by developing stepwise reductions from 2009 base levels. More than 25 companies, including packaged food corporations and restaurants, responded to NSRI by committing to reductions in the sodium content of some of their products.[47] According to their monitoring efforts, between 2009 and 2019, there was an 8.5 percent reduction in sodium levels among NSRI categories.[46]

At the federal level, several U.S. agencies have taken recent regulatory action on reducing sodium within the food supply. Partially informed by the NSRI, in 2021, the FDA issued final guidance on voluntary targets for reducing sodium in commercially processed, packaged and prepared food over the following 2.5 years.[16] The voluntary targets cover 16 overarching categories of food with 163 subcategories, recognizing that a one-size fits all approach does not work well. The goal of the voluntary guidance is to decrease average daily intake by about 12 percent – from about 3,400 mg to 3,000 mg.[16] The second edition of this guidance, Phase II, was released for public comment in August 2024 and sets new voluntary targets to be achieved over the next three years.[18] Based on recent remarks by FDA's deputy commissioner, preliminary assessment data on the voluntary sodium targets demonstrates encouraging success at meeting sodium reduction targets in foods among many of the food categories.[48] The preliminary assessment, which compared baseline data in 2010 to the most recent available data in 2022, indicates that 40 percent of food categories had achieved the Phase I sodium targets or were within 10 percent of meeting the targets.[18]

Additionally, in 2024, the U.S. Department of Agriculture, which establishes nutritional guidelines for school meals, issued a final rule, effective as of July 1, 2024, with one gradual sodium

reduction target to be achieved over time.[49] For the next three school years, schools will maintain current sodium limits for breakfast and lunch foods (which is dependent on age/grade group), with the aim to implement an approximate 15 percent reduction for lunch and an approximate 10 percent reduction for breakfast by school year 2027-28. The final rule represents a sodium reduction target in between the first and second sodium reduction targets from the proposed rule, as this was believed to be achievable, based on stakeholder comments.[49]

The FDA voluntary sodium reduction targets are very similar to the salt reduction approach that has been implemented in the United Kingdom (UK). In 2003, the UK developed a voluntary salt reduction program, in collaboration with the food industry, which had eight steps but essentially enabled progressively lower voluntary salt targets for 80 different categories of food over time. The program developed a clear time frame for industry to achieve the desired results and was developed in tandem with a product labeling and consumer awareness campaign. Based on program evaluation, there has been a steady decrease in salt intake at a rate of approximately two percent per year since the introduction of the UK salt reduction strategy (as of 2014).[41] Over four years, this strategy successfully lowered salt intake by 15 percent, based on 24-h urinary sodium testing. Population health outcomes also improved; from 2003 to 2011, mean blood pressure was reduced by 3.0/1.4 mmHg and mortality from stroke decreased by 42 percent and ischemic heart disease by 40 percent.[50] Based on the lower blood pressure outcomes achieved by the voluntary salt reduction program, a modeling study was conducted to assess impacts on premature CVD, quality-adjusted survival, and health care and social care costs in England.[39] In comparison to a non-intervention (business as usual) scenario and assuming intake levels are maintained at 2018 levels, the study authors estimated that by 2050 the program is projected to avoid 83,140 premature ischemic heart disease cases, 110,730 premature strokes, and save 1,640 million pounds in health care costs.[39]

Despite these early successes in the UK, there are continued challenges and new targets are needed to further sodium reduction. A strong relationship and cooperation with the food industry is required to make voluntary targets successful, as well as independent and transparent monitoring. While the voluntary program has been successful, it was underpinned by sustained media pressure, and direct pressure on public health ministries and government to maintain a strong stance with the food industry. In terms of best practices, regulatory or legislative approaches may be more effective versus voluntary guidelines but the legislative approach may be complicated depending on the country.[50]

South Korea also implemented a comprehensive salt reduction program, starting in 2012, which included a consumer awareness campaign, increased availability of low-sodium foods at school and worksite meal services, increased availability of low sodium meals in restaurants, voluntary reformulation of processed foods to lower the sodium content, and development of low-sodium recipes for food prepared at home.[41] South Korea has one of the highest rates of sodium intake in the world and is much higher compared to the U.S. In 2010, the average sodium intake was 4831 mg/day. [51] The goal of this program was to reduce population sodium consumption by 20 percent, to 3900 mg/day by 2020. This multi-pronged approach in South Korea has been found to be successful. Sodium intake decreased by 19.5 percent from 2010 and 2014, which was achieved largely by reducing the sodium content in processed food. There were also concomitant reductions in population hypertension prevalence within the same time period, for both men (from 33.5 percent to 26.0 percent) and women (from 25.2 percent to 21.7 percent) aged 30 years and older that were statistically significant. From 2010 to 2014, the rate of death from cerebrovascular diseases also decreased from 53.2 to 48.2 per 100,000 population, but these changes were not statistically significant.[51]

Canada also has a similar voluntary sodium reduction strategy, implemented in 2012, which set voluntary sodium reduction targets for 94 categories of processed foods.[52] In 2018, Health Canada published an evaluation report indicating the sodium reductions in most categories of processed foods were only modest and did not meet targets. Additionally, the report notes that the voluntary efforts only resulted in an eight percent decrease in average sodium intake since 2010, with the average sodium intake of Canadians being about 2760 mg (which is lower than the current U.S. sodium intake). Health Canada has since published revised voluntary targets for processed foods and continues to work with the food industry to gradually and safely reduce sodium in their food supply.[52]

Taxes on Sodium

One of the other priority strategies identified above to lower sodium intake is taxation on high sodium foods. However, there are limited studies evaluating the effectiveness of fiscal policies to reduce salt consumption.[53] A systematic review of the available literature identified 18 relevant studies, but nearly half of them reported the effects of salt taxes through modeling, not real world implementation, and real world implementation evaluation studies were primarily found in the grey literature.[53] Despite the lack of evidence on the effectiveness of salt taxes, sugar-sweetened beverage (SSB) taxes have been more widely studied.

SSB taxes are tangentially related to proposed sodium taxes to reduce the burden of chronic diseases and improve the typical American diet. Multiple public health initiatives have called for a reduction of both dietary sodium and sugar;[54,55] however, many physicians find that patient adherence to dietary recommendations remains challenging within the clinical context.[56] There are many recognized challenges in adhering to dietary recommendations, including (but not limited to) lack of knowledge or support to make changes, confusing and misleading information provided by the media, difficulties in changing ways of cooking and in translating healthy eating messages into balanced food choices, the cost associated with healthier food options, lack of confidence in cooking skills, cultural acceptability, speed of preparation, family acceptability, and lack of access to supermarkets with fresh and whole food options (i.e., food deserts).[56,57] As such, policymakers in the U.S. and other parts of the world increasingly turn to SSB taxes to improve public health outcomes and prevent chronic disease development. SSBs are non-alcoholic beverages that contain added sweeteners such as sucrose (sugar) or high-fructose corn syrup. In the U.S., SSB taxes are levied locally and currently exist in the following jurisdictions: Boulder, Colorado; the District of Columbia; Philadelphia, Pennsylvania; Seattle, Washington; and four California cities (Albany, Berkeley, Oakland, and San Francisco).[58] No state currently has an excise tax on sugar-sweetened beverages.

Multiple studies have concluded that SSB taxes effectively change consumer shopping habits and there is strong evidence that SSB taxes can be effective in reducing the sales and intake of SSB when taxes are substantial (e.g., at least one U.S. cent per ounce).[41] A 2024 article found that SSB taxes in five U.S. jurisdictions were associated with a 33.1 percent price increase and a corresponding 33 percent reduction in purchase volume.[59] In the U.K., soft drink levies were associated with a 23 percent decrease in sugar consumption from soft drinks in children; in adults, sugar consumption from soft drinks declined by 40 percent.[60] In Mexico, SSB taxes led to similar decreases in soft drink purchases and increased water purchases.[61] Unfortunately, most SSB taxes are too new to demonstrate changes in population health outcomes such as CVD or obesity; however, modeling data suggest that SSB taxes will reduce premature mortality, increase government revenue, and reduce expenditures over time.[62] Additionally, in seven U.S. cities with SSB excise taxes, all tax revenue has been used to support community health initiatives and

community capital investments, demonstrating the potential of these policies to yield additional benefits outside of SSB consumption and to support broader community health initiatives.[63]

Feasibility of salt reduction in foods and available alternatives

Salt has played an important role in food, health, and commerce for thousands of years.[25,64] As human societies shifted towards agriculture versus hunting and gathering, salt was needed to supplement the diet and salt became one of the most important commodities across the globe.[64] In ancient Roman times, salt was used not only to supplement flavor and preserve food, but also as an antiseptic. Its overall importance at the time is exemplified by the fact that part of a Roman soldier's pay was in salt, otherwise known as solarium argentum, which formed the basis of our modern word for salary.[64] Salt's osmotic impact (the passage of a liquid through a membrane from a less concentrated solution to a more concentrated one) is responsible for its ability to help preserve foods. Salt allows water to flow through the semipermeable membrane of bacteria which leads to bacterial cell death or injury, and thus reducing bacterial growth.[65] In our modern food system, other preservative methods along with refrigeration obviates the reliance on salt as a primary preservative and the levels of sodium found in processed and prepared foods are well beyond those needed for food safety or physiological reasons.[32,50]

However, salt also affects color, texture and taste properties of food and salt has differential impacts on various food categories.[13,65] Although reducing sodium content in foods is possible, reductions must be considered with respect to the other important properties salt confers from a food technology perspective, including flavor, development of texture, fermentation, color development, and antimicrobial properties. Reformulation to reduce sodium content in foods can be a complex process, in many cases is not as straightforward as simply adding less sodium to foods and should not be achieved through the addition of increased sugar content or artificial additives, as these also have negative health impacts.[66,67] Further, when salt is reduced quickly, palatability and consumer acceptance of a product generally tends to decrease.[65] On the other hand, consumer acceptance of low sodium products can increase over time. It has been demonstrated that as sodium intake decreases, taste receptors in the mouth adapt and become more sensitive to lower concentrations, often times within a few months.[27]

One potential concern of reduced salt consumption is an increase in iodine deficiency, as salt iodization and fortification of foods with iodine have been primary intervention strategies to prevent iodine deficiency globally (although never mandated in the U.S.).[68] Iodine is required for thyroid hormone synthesis and inadequate iodine intake can result in several health concerns, including goiter and hypothyroidism.[68] However, commercially processed foods generally contain non-iodized salt and since the vast majority of salt consumed in the U.S. is via processed foods, overall reductions in the salt content of processed foods would most likely not have any appreciable effect on the prevalence of iodine deficiency within the U.S.[68]

When assessing alternatives to a high sodium diet, it is important to consider the outsized role of prepackaged and processed foods within the American diet. High sodium consumption is inextricably linked to the overconsumption of ultra-processed foods, which makes up more than half of the calories consumed in the U.S. diet.[69] While many foods go through some amount of processing, ultra-processed foods are defined as those with "formulations of ingredients, mostly of exclusive industrial use, that result from a series of industrial processes."[69] Examples of ultra-processed foods include packaged snacks, mass-produced baked goods, breakfast 'cereals,' hot dogs, sausages, pre-prepared pasta and pizza dishes. A recent study found the consumption of ultra-processed foods has grown from 53.5 percent of calories since 2001-2002 to 57 percent in 2017-

2018, while the consumption of whole foods has decreased by a similar percentage over the same period.[70]

The modern Western diet with a focus on ultra-processed foods has also led to a decrease in other physiologically important nutrients, such as potassium. Potassium is a physiologically essential nutrient, whose function is closely intertwined and related to that of sodium in our body.[12] While too much sodium has been found to raise blood pressure, too little potassium has been found to have the same effect.[71] Unlike sodium, Americans tend to not eat enough potassium in their diet, which is found naturally in vegetables, fruit, seafood, and dairy products. The National Academies of Sciences, Engineering, and Medicine concluded there is a moderate strength of evidence that potassium supplementation significantly reduces systolic and diastolic blood pressure, and the effect is even stronger among adults with hypertension.[12] Recently, one study concluded that increasing potassium intake might represent a more advantageous dietary strategy for preventing cardiovascular disease.[72] Traditional dietary cultures from across the globe, many of which are known to be associated with longer and healthier lives, are based on consumption of foods that are unprocessed or minimally processed.[69] Thus, programs and policies to increase the availability, accessibility, and affordability of whole or minimally processed foods that are culturally appropriate should be an important component of a salt reduction strategy and could also have the added benefit of increased potassium intake.

Considering the current U.S. food system context coupled with public health calls for reduced sodium consumption, there have been increasing efforts to establish salt replacement strategies that will meet consumer tastes and demands. Potassium chloride may be the most promising, however, this substitute can be problematic for populations who are required to limit their potassium intake due to health reasons, for example those with kidney disease. A study examining the effects of potassium-enriched salt on cardiovascular disease mortality among elderly veterans found a significant reduction (age-adjusted hazard ratio of 0.59) in mortality among the experimental group that was given potassium-enriched salt.[73] Other salt replacement strategies, particularly from a consumer perspective, is to include other herbs and spices that can provide an alternative method of flavoring in the absence or reduction of salt.[56,65]

Beyond potassium chloride, other viable alternatives exist for replacing sodium. For example, glutamate, a nonessential amino acid, has been used to enhance the taste and palatability of food. Food monosodium glutamate (MSG) is the most common glutamate salt and flavor enhancer used, to lower the overall sodium level in certain foods while maintaining palatability.[56] MSG contains about 12 percent sodium, which is less than one-third of that contained in table salt.[74] MSG safety concerns, namely what was once referred to as “Chinese restaurant syndrome,” have been proven to be unfounded and largely driven by a history of prejudice and discriminatory rhetoric and action against Asian cultures, specifically Chinese culture.[75] A review of the evidence on MSG’s alleged health concerns have detected serious methodological flaws with research that indicated safety issues and many of the reported negative health effects of MSG have little relevance considering the average human exposure.[76] Although MSG is the most widely used flavor enhancer in food, other effective glutamate salts, such as calcium di-glutamate, exist but do not provide as pronounced of an effect. A considerable number of studies have demonstrated that various forms of glutamate can help reduce the amount of sodium in specific foods, including soups, prepared dishes, processed meat, and dairy products, by enhancing palatability.[65,77]

Priority Strategies for Reducing Blood Pressure

Sodium reduction is just one of many strategies to prevent and manage hypertension. Priority strategies for controlling blood pressure exist across individual, organization, community and

policy levels. Lifestyle change modifications, including the promotion of increased physical activity, weight loss, moderate alcohol consumption, and a healthier diet overall (greater consumption of fruits and vegetables and lower sodium intake), as one study put it, "are the cornerstone of prevention and treatment of hypertension."[10] In 2023, the AMA and the American Heart Association published a joint scientific statement on implementation strategies to improve blood pressure control in the U.S.[9] This joint statement recommends lifestyle modification strategies as the recommended first-line therapy to control blood pressure.[9]

The Dietary Approaches to Stop Hypertension (DASH) has been highlighted in the literature and among federal agencies as a priority diet strategy to reduce blood pressure.[78–80] DASH is a dietary plan or framework that emphasizes eating vegetables, fruits and whole grains; including fat-free or low-fat dairy products, fish, poultry, beans, nuts, and vegetable oils; limiting foods that are high in saturated fat, such as fatty meats, full-fat dairy products, and tropical oils; and limiting sugar-sweetened beverages and sweets. A systematic review of the evidence on DASH to reduce blood pressure found that, compared to a control diet, the DASH diet significantly reduced both systolic blood pressure and diastolic blood pressure, with a greater effect witnessed in those with higher daily sodium intake and of younger age.[81]

Other strategic approaches to improve blood pressure control cut across different levels of interventions and include: antiracism efforts (e.g., policies to dismantle residential segregation and its impacts, policies to eliminate inequities in access to and quality of healthcare), accurate blood pressure measurement and increased use of self-measured blood pressure monitoring, team-based care, standardized treatment protocols, improved medication acceptance and adherence, improving the built environment to facilitate increased walkability and physical activity, continuous quality improvement, financial strategies that sustain the implementation of effective treatment strategies, and large-scale dissemination and implementation.[9,82] However, there are many critical implementation and dissemination gaps and challenges that make it difficult to enact these strategic approaches. A few of these include implementing and evaluating the effect of policy-level changes such as salt reduction in foods and all-payer coverage of self-measured blood pressure monitoring devices on improvement in blood pressure control; exploring and evaluating antiracism, health equity, and social determinants of health implementation strategies focused on improving blood pressure control; assessing the effects of urban planning interventions to improve walkability and increasing green spaces; and implementing culturally sensitive interventions for lifestyle changes.[9] Another challenging area is the implementation of effective lifestyle change counseling and monitoring recommendations at the clinical level, which can help be addressed through the designation of more individuals within practices who are sufficiently knowledgeable in behavior change techniques in order to support effective patient counseling.[82]

Lastly, recent research has strengthened the available evidence on the relationship between air pollution and poor air quality with all-cause cardiovascular mortality and morbidity, stroke, blood pressure, and ischemic heart diseases.[83,84] Therefore, another area of primary prevention for reducing population level hypertension could focus on improving ambient air quality by reducing reliance on fossil fuel combustion for energy generation and transportation, which could also result in numerous other public health benefits.[9,85]

EXISTING AMA POLICY

The AMA already has policy in support of many of the strategies highlighted in the literature and summarized in this report that have been shown to reduce sodium consumption. Following the previous report, Policy H-150.929, "Promotion of Healthy Lifestyles I: Reducing the Population Burden of Cardiovascular Disease by Reducing Sodium Intake," aims to reduce sodium in

processed foods, fast food products, and restaurant meals by 50 percent.[86] This policy notes that gradual but steady reductions over several years may be the most effective way to minimize sodium levels. Additionally, this policy states the AMA will work with our federal and organizational partners to educate consumers about the benefits of long-term, moderate reductions in sodium intake and recommends the FDA consider all options to promote reductions in the sodium content of processed foods.

AMA's policy H-150.945, "Nutrition Labeling and Nutritionally Improved Menu Offerings in Fast-Food and Other Chain Restaurants," supports policies at multiple levels to require fast-food and other chain restaurants with 10 or more units to provide consumers with nutrition information on menus and menu boards.[87] Nutrition information provided on menus should include sodium labeling. Further, this policy urges AMA to work with partner organizations to educate people on how to use the nutrition information provided in restaurants to make healthier food choices for themselves and their families and urges restaurants to improve the nutritional quality of their menu offerings, including the use of less sodium. AMA policy H-150.949, "Healthful Food Options in Health Care Facilities," encourages healthful food options in health care facilities, including food offerings with low sodium content, and the publishing of nutrition information with health care facility cafeterias..[88]

AMA's Improving Health Outcomes team has been actively engaged in work to help physicians and care team reduce blood pressure and improve blood pressure control rates across patient populations, with a particular focus on accurate blood pressure measurement and effective treatment of hypertension. For example, the AMA MAP™ Hypertension is a three-part framework and guide for improving hypertension control.[89] AMA's Ed Hub™ also has published educational resources on blood pressure control and management, including a CME Course entitled, "Hypertension: High Blood Pressure Management, Impact and Inequities."[90]

CONCLUSIONS

Reducing dietary sodium is one of several important strategies to reduce hypertension and improve public health. With over 20 years of research on dietary sodium and health outcomes, it is clear that reducing population level sodium intake can have beneficial public health outcomes and save millions of dollars in health care costs. Voluntary targets to reduce sodium in processed foods and other food prepared outside of the home is one of the most promising and well-evaluated large-scale policies to enact population level change in sodium intake and has been successfully implemented across the globe. Preliminary indications from FDA indicate that their voluntary program has been successful at reducing sodium levels in food, enough so that they are preparing to update their guidance, further reducing their targets. Sodium reduction is but one strategy that should be pursued alongside other important lifestyle (i.e., increasing physical activity and preferential consumption of fruits and vegetables), environmental (i.e., reducing air pollution), and community strategies (i.e., reducing structural inequities in access to health care and health promoting resources) to reduce hypertension and promote cardiovascular health.

RECOMMENDATIONS

The Council on Science and Public Health recommends that the following be adopted, and the remainder of the report be filed.

1. That Policy H-150.929, "Promotion of Healthy Lifestyles I: Reducing the Population Burden of Cardiovascular Disease by Reducing Sodium Intake" be amended by addition and deletion to read as follows:

Our AMA ~~will~~:
(1) Calls for a step-wise, minimum 50% reduction in sodium in processed foods, fast food products, and restaurant meals to be achieved over the next decade.
(2) Urges the FDA to publish future editions of their voluntary targets expeditiously to make further progress on sodium reduction.
(3) Supports federal, state, and local efforts to set robust targets for reducing sodium levels in school meals, meals in health care facilities, and other meals provided by daily meal providers.
(~~2~~4) Will advocate for federal, state, and local efforts to reduce sodium levels in products from ~~F~~ food manufacturers and restaurants ~~should review their product lines and reduce sodium levels~~ to the greatest extent possible,~~(~~without increasing levels of other unhealthy ingredients, such as added sugars or artificial ingredients~~)~~. ~~Gradual but steady reductions over several years may be the most effective way to minimize sodium levels.~~
(5) Supports federal, state, and local efforts to require front-of-package warning labels for foods that are high in sodium based on the established recommended daily value.
(~~2~~6) ~~To~~ Will assist in achieving the Healthy People 2030~~2010~~ goal for sodium consumption, by ~~will~~ working with the FDA, the National Heart Lung Blood Institute, the Centers for Disease Control and Prevention, the American Heart Association, and other interested partners to educate consumers about the benefits of ~~long-term, moderate~~ reductions in sodium intake and other dietary approaches to reduce hypertension.
(7) Supports the continuing education of physicians and other members of the health care team on counseling patients on lifestyle modification strategies to manage blood pressure, advocating for culturally relevant dietary models that reduce sodium intake.
(~~3~~8) Recommends that the FDA consider all options to promote reductions in the sodium content of processed foods.
(9) Supports further study and evaluation of national salt reduction programs to determine the viability, industry engagement, and health and economic benefits of such programs.
(Modify Current HOD Policy)

Fiscal Note: less than $1,000

FIGURES AND TABLES

Figure 1: Prevalence of Hypertension in the U.S. 1999 to 2018, NHANES

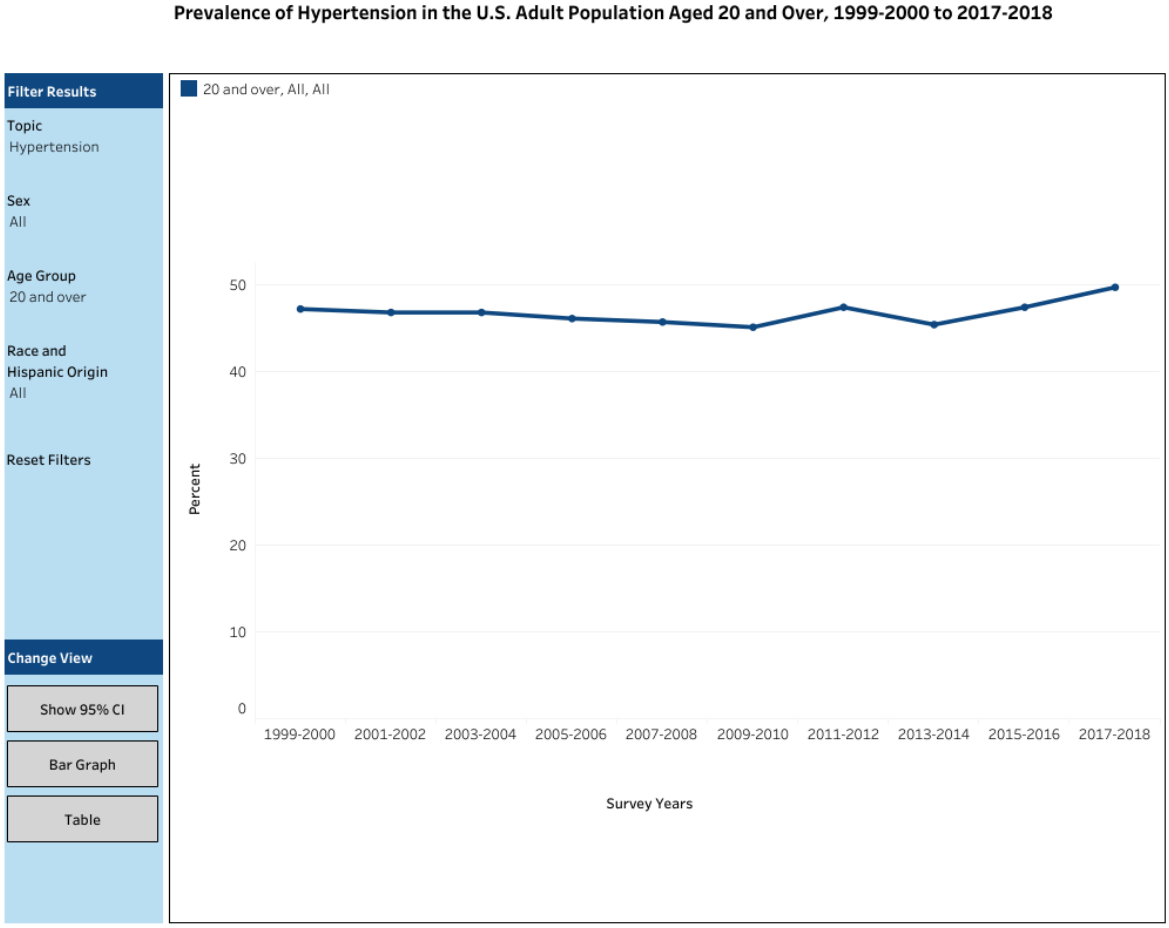


Figure 2: Population Exceeding Recommended Sodium Limit[13]

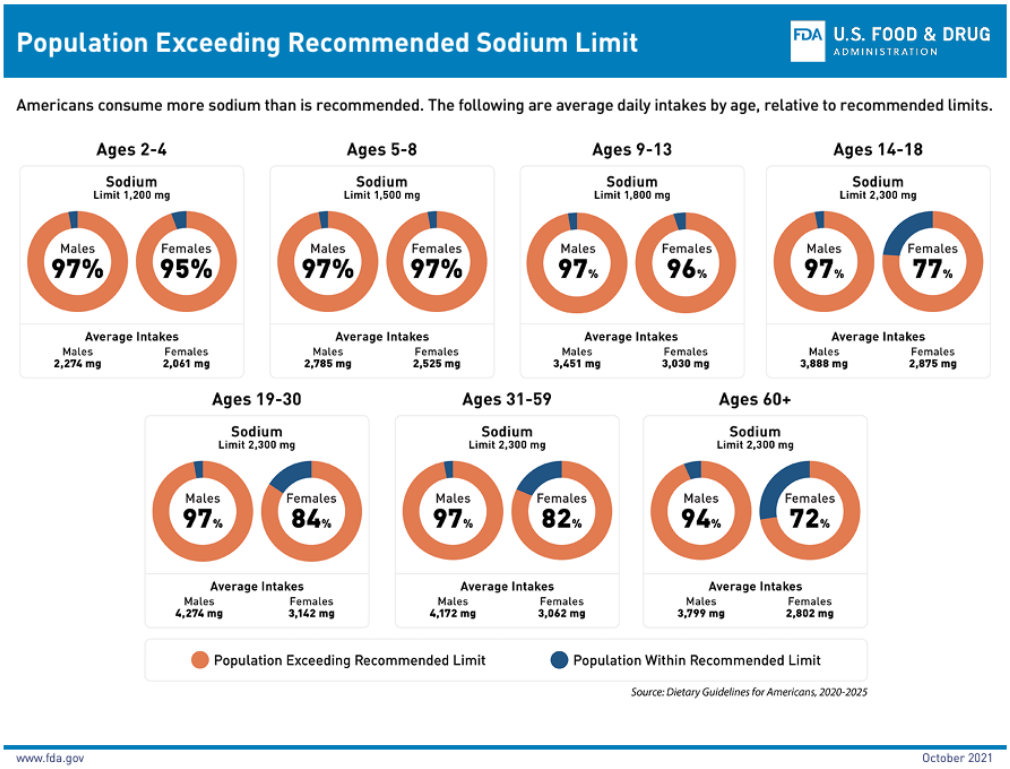


Figure 3: How sodium is consumed in the American diet[14]

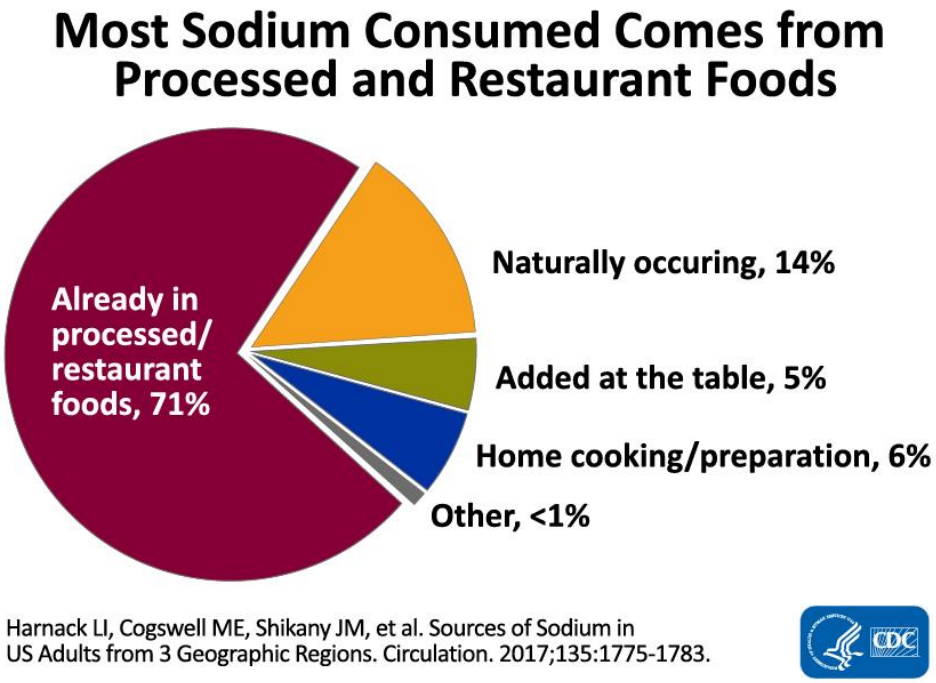


Figure 4 – Examples of J and U-shaped relationship between sodium intake and health outcomes[25]

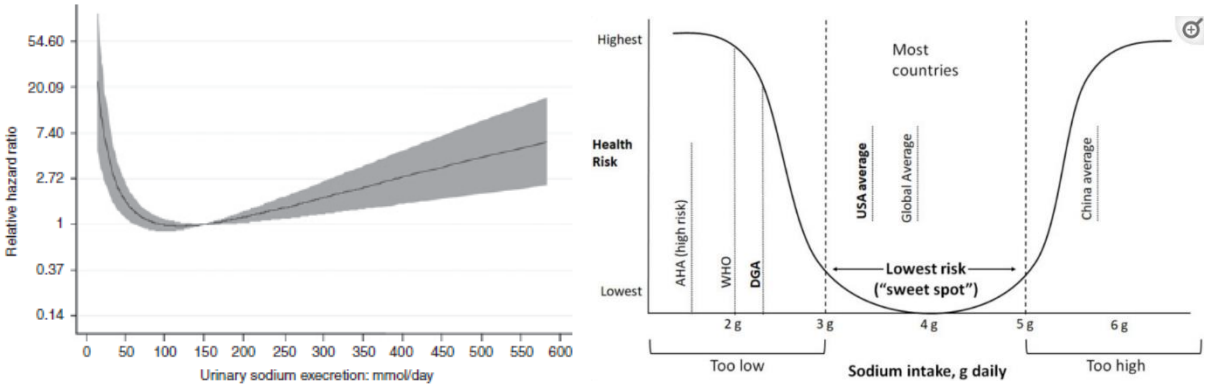


Table 1 – Existing Sodium Reduction Strategies with priority recommended strategies italicized and highlighted with an astericks[41]

Sodium from packaged foods
*Labeling: front-of-pack labeling regulations**
Labeling: mandatory nutrient declaration on labels
Labeling: regulating nutrition/health claims on food packaging
*Food reformulation targets for packaged food (voluntary or mandatory)**
*Regulation of marketing of foods and nonalcoholic beverages to children**
*Fiscal policies: taxation on high sodium foods**
Supermarket interventions using product, placement, price, or promotion strategies
Sodium from food prepared outside the home
*Standards for sodium as part of food procurement policies for public institutions**
Restaurants: menu labeling of high or low sodium items (primarily chain restaurants)
Restaurants: removal of salt shakers and high sodium condiments from tables
Restaurants: chef training on reducing sodium in food
Restaurants: requiring the provision of low sodium or no-sodium added items on menus
Restaurants: food reformulation targets for restaurants (voluntary or mandatory; primarily chain restaurants
Sodium added in the home
*Mass media campaigns**
Community education (e.g., through schools, community groups, workplaces, etc.)
Individual education and counselling (usually through primary health care)
*Increase uptake of low sodium salt (promotion, distribution, subsidies)**

REFERENCES

1. National Institutes of Health, National Heart, Lung, and Blood Institute. High Blood Pressure - What Is High Blood Pressure? April 25, 2024. Accessed July 9, 2024. https://www.nhlbi.nih.gov/health/high-blood-pressure

2. American Heart Association. Health Threats from High Blood Pressure. www.heart.org. Accessed July 9, 2024. https://www.heart.org/en/health-topics/high-blood-pressure/health-threats-from-high-blood-pressure

3. CDC. High Blood Pressure Facts. High Blood Pressure. May 20, 2024. Accessed July 9, 2024. https://www.cdc.gov/high-blood-pressure/data-research/facts-stats/index.html

4. National Center for Health Statistics. National Health and Nutrition Examination Surveys. NHANES Interactive Data Visualizations. 2023. Accessed April 8, 2024. https://www.cdc.gov/nchs/nhanes/visualization/index.htm

5. CDC, National Center for Health Statistics. FastStats, Leading Causes of Death. May 7, 2024. Accessed July 9, 2024. https://www.cdc.gov/nchs/fastats/leading-causes-of-death.htm

6. Abrahamowicz AA, Ebinger J, Whelton SP, Commodore-Mensah Y, Yang E. Racial and Ethnic Disparities in Hypertension: Barriers and Opportunities to Improve Blood Pressure Control. *Curr Cardiol Rep*. 2023;25(1):17-27. doi:10.1007/s11886-022-01826-x

7. Churchwell K, Elkind MSV, Benjamin RM, et al. Call to Action: Structural Racism as a Fundamental Driver of Health Disparities: A Presidential Advisory From the American Heart Association. *Circulation*. 2020;142(24):e454-e468. doi:10.1161/CIR.0000000000000936

8. American Heart Association. More than half of U.S. adults don't know heart disease is leading cause of death, despite 100-year reign. American Heart Association. Accessed July 9, 2024. https://newsroom.heart.org/news/more-than-half-of-u-s-adults-dont-know-heart-disease-is-leading-cause-of-death-despite-100-year-reign

9. Abdalla M, Bolen SD, Brettler J, et al. Implementation Strategies to Improve Blood Pressure Control in the United States: A Scientific Statement From the American Heart Association and American Medical Association. *Hypertension*. 2023;80(10):e143-e157. doi:10.1161/HYP.0000000000000232

10. Charchar FJ, Prestes PR, Mills C, et al. Lifestyle management of hypertension: International Society of Hypertension position paper endorsed by the World Hypertension League and European Society of Hypertension. *J Hypertens*. 2024;42(1):23. doi:10.1097/HJH.0000000000003563

11. Salt and Sodium. The Nutrition Source. July 18, 2013. Accessed July 2, 2024. https://nutritionsource.hsph.harvard.edu/salt-and-sodium/

12. National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Food and Nutrition Board; Committee to Review the Dietary Reference Intakes for Sodium and Potassium. *Dietary Reference Intakes for Sodium and Potassium*. (Oria M, Harrison M, Stallings VA, eds.). National Academies Press (US); 2019. Accessed July 3, 2024. http://www.ncbi.nlm.nih.gov/books/NBK538102/

13. U.S. Food and Drug Administration. Sodium Reduction. FDA. March 5, 2024. Accessed June 13, 2024. https://www.fda.gov/food/food-labeling-nutrition/sodium-reduction

14. Harnack LJ, Cogswell ME, Shikany JM, et al. Sources of Sodium in US Adults From 3 Geographic Regions. *Circulation*. 2017;135(19):1775-1783. doi:10.1161/CIRCULATIONAHA.116.024446

15. CDC. Sodium and Health. Centers for Disease Control and Prevention. June 6, 2023. Accessed March 12, 2024. https://www.cdc.gov/salt/index.htm

16. U.S. Food and Drug Administration. Guidance for Industry: Voluntary Sodium Reduction Goals. January 19, 2024. Accessed March 12, 2024. https://www.fda.gov/regulatory-information/search-fda-guidance-documents/guidance-industry-voluntary-sodium-reduction-goals

17. Reduce consumption of sodium by people aged 2 years and over — NWS-12 - Healthy People 2030 | health.gov. Accessed April 8, 2024. https://health.gov/healthypeople/objectives-and-data/browse-objectives/nutrition-and-healthy-eating/reduce-consumption-sodium-people-aged-2-years-and-over-nws-12

18. Center for Food Safety and Applied Nutrition, FDA. Sodium Reduction in the U.S. Food Supply 2010-2022: A Preliminary Assessment of Progress. *FDA*. Published online August 15, 2024. Accessed August 15, 2024. https://www.fda.gov/food/food-labeling-nutrition/sodium-reduction-us-food-supply-2010-2022-preliminary-assessment-progress

19. Afshin A, Sur PJ, Fay KA, et al. Health effects of dietary risks in 195 countries, 1990–2017: a systematic analysis for the Global Burden of Disease Study 2017. *The Lancet*. 2019;393(10184):1958-1972. doi:10.1016/S0140-6736(19)30041-8

20. Pan American Health Organization. Salt reduction. In: ; 2024. Accessed July 15, 2024. https://www.paho.org/en/topics/salt-reduction

21. World Health Organization. SHAKE the salt habit. Accessed June 13, 2024. https://www.who.int/publications/i/item/WHO-NMH-PND-16.4

22. EFSA Panel on Nutrition, Novel Foods and Food Allergens (NDA), Turck D, Castenmiller J, et al. Dietary reference values for sodium. *EFSA J*. 2019;17(9):e05778. doi:10.2903/j.efsa.2019.5778

23. Campbell NRC, Cappuccio FP, Tobe SW. Unnecessary Controversy Regarding Dietary Sodium: A Lot About a Little. *Can J Cardiol*. 2011;27(4):404-406. doi:10.1016/j.cjca.2011.05.003

24. Alderman MH, Cohen HW. Dietary sodium intake and cardiovascular mortality: controversy resolved? *Curr Hypertens Rep*. 2012;14(3):193-201. doi:10.1007/s11906-012-0275-6

25. Mente A, O'Donnell M, Yusuf S. Sodium Intake and Health: What Should We Recommend Based on the Current Evidence? *Nutrients*. 2021;13(9):3232. doi:10.3390/nu13093232

26. NY Times Editorial Board. Opinion | The Debate on Salty Foods, Continued. *The New York Times*. https://www.nytimes.com/2014/08/24/opinion/sunday/the-debate-on-salty-foods-continued.html. August 23, 2014. Accessed April 3, 2024.

27. Cappuccio FP, Campbell NRC, He FJ, et al. Sodium and Health: Old Myths and a Controversy Based on Denial. *Curr Nutr Rep*. 2022;11(2):172-184. doi:10.1007/s13668-021-00383-z

28. Campbell NRC, He FJ, Cappuccio FP, MacGregor GA. Dietary Sodium 'Controversy'—Issues and Potential Solutions. *Curr Nutr Rep*. 2021;10(3):188-199. doi:10.1007/s13668-021-00357-1

29. Filippini T, Malavolti M, Whelton PK, Vinceti M. Sodium Intake and Risk of Hypertension: A Systematic Review and Dose–Response Meta-analysis of Observational Cohort Studies. *Curr Hypertens Rep*. 2022;24(5):133-144. doi:10.1007/s11906-022-01182-9

30. Filippini T, Malavolti M, Whelton PK, Naska A, Orsini N, Vinceti M. Blood Pressure Effects of Sodium Reduction. *Circulation*. 2021;143(16):1542-1567. doi:10.1161/CIRCULATIONAHA.120.050371

31. Graudal NA, Hubeck-Graudal T, Jurgens G. Effects of low sodium diet versus high sodium diet on blood pressure, renin, aldosterone, catecholamines, cholesterol, and triglyceride. *Cochrane Database Syst Rev*. 2020;(12). doi:10.1002/14651858.CD004022.pub5

32. He FJ, Tan M, Ma Y, MacGregor GA. Salt Reduction to Prevent Hypertension and Cardiovascular Disease: JACC State-of-the-Art Review. *J Am Coll Cardiol*. 2020;75(6):632-647. doi:10.1016/j.jacc.2019.11.055

33. Aburto NJ, Ziolkovska A, Hooper L, Elliott P, Cappuccio FP, Meerpohl JJ. Effect of lower sodium intake on health: systematic review and meta-analyses. *BMJ*. 2013;346:f1326. doi:10.1136/bmj.f1326

34. He FJ, Li J, Macgregor GA. Effect of longer term modest salt reduction on blood pressure: Cochrane systematic review and meta-analysis of randomised trials. *BMJ*. 2013;346:f1325. doi:10.1136/bmj.f1325

35. Adler AJ, Taylor F, Martin N, Gottlieb S, Taylor RS, Ebrahim S. Reduced dietary salt for the prevention of cardiovascular disease. *Cochrane Database Syst Rev*. 2014;2014(12):CD009217. doi:10.1002/14651858.CD009217.pub3

36. Zhu Y, Zhang J, Li Z, et al. Association of sodium intake and major cardiovascular outcomes: a dose-response meta-analysis of prospective cohort studies. *BMC Cardiovasc Disord*. 2018;18(1):192. doi:10.1186/s12872-018-0927-9

37. Wang YJ, Yeh TL, Shih MC, Tu YK, Chien KL. Dietary Sodium Intake and Risk of Cardiovascular Disease: A Systematic Review and Dose-Response Meta-Analysis. *Nutrients*. 2020;12(10):2934. doi:10.3390/nu12102934

38. Newberry SJ, Chung M, Anderson CAM, et al. *Effects of Dietary Sodium and Potassium Intake on Chronic Disease Outcomes and Related Risk Factors*. Agency for Healthcare Research and Quality (AHRQ); 2018. doi:10.23970/AHRQEPCCER206

39. Alonso S, Tan M, Wang C, et al. Impact of the 2003 to 2018 Population Salt Intake Reduction Program in England: A Modeling Study. *Hypertens Dallas Tex 1979*. 2021;77(4):1086-1094. doi:10.1161/HYPERTENSIONAHA.120.16649

40. Bibbins-Domingo K, Chertow GM, Coxson PG, et al. Projected Effect of Dietary Salt Reductions on Future Cardiovascular Disease. *N Engl J Med*. 2010;362(7):590-599. doi:10.1056/NEJMoa0907355

41. Ide N, Ajenikoko A, Steele L, et al. Priority Actions to Advance Population Sodium Reduction. *Nutrients*. 2020;12(9):2543. doi:10.3390/nu12092543

42. Centers for Disease Control and Prevention. *What Is the Evidence for State and Local Laws Addressing Sodium Reduction Among the US Adult Population? A Policy Evidence Assessment Report*. Centers for Disease Control and Prevention, US Department of Health and Human Services; 2019. https://www.cdc.gov/dhdsp/pubs/docs/Sodium_PEAR_508.pdf

43. Sisti JS, Prasad D, Niederman S, et al. Sodium content of menu items in New York City chain restaurants following enforcement of the sodium warning icon rule, 2015–2017. *PLOS ONE*. 2023;18(5):e0274648. doi:10.1371/journal.pone.0274648

44. Dominianni C, Prasad D, Sharkey A, Solomon E, Seligson AL, Jasek JP. Sodium Intake and Sodium to Potassium Ratio among New York City Adults in the 2018 Heart Follow-Up Study. *Curr Dev Nutr*. 2024;8(4):102143. doi:10.1016/j.cdnut.2024.102143

45. Prasad D, Jasek JP, Anekwe AV, et al. Changes in consumer purchasing patterns at New York City chain restaurants following adoption of the sodium warning icon rule, 2015-2017. *PloS One*. 2023;18(4):e0274044. doi:10.1371/journal.pone.0274044

46. NYC Department of Health and Mental Hygiene. National Salt Reduction Initiative: Packaged and Restaurant Food. NYC Health. 2024. Accessed July 9, 2024. https://www.nyc.gov/site/doh/health/health-topics/national-salt-reduction-initiative-packaged-food.page

47. U.S. Food and Drug Administration. *Voluntary Sodium Reduction Goals: Target Mean and Upper Bound Concentrations for Sodium in Commercially Processed, Packaged, and Prepared Foods: Guidance for Industry*. U.S. Department of Health and Human Services, U.S. Food and Drug Administration; 2021. Accessed July 9, 2024. https://www.fda.gov/media/98264/download

48. Jones J. FDA's Steps to Improve Food Safety. Published online June 24, 2024. Accessed July 9, 2024. https://www.wsj.com/video/fdas-steps-to-improve-food-safety/2DC30282-55B9-425A-A58A-25ADE68714DB?page=1

49. U.S. Department of Agriculture, Food and Nutrition Service. Final Rule - Child Nutrition Programs: Meal Patterns Consistent With the 2020-2025 DGAs | Food and Nutrition Service. Accessed April 25, 2024. https://www.fns.usda.gov/cn/fr-042524

50. He FJ, Brinsden HC, MacGregor GA. Salt reduction in the United Kingdom: a successful experiment in public health. *J Hum Hypertens*. 2014;28(6):345-352. doi:10.1038/jhh.2013.105

51. Park HK, Lee Y, Kang BW, et al. Progress on sodium reduction in South Korea. *BMJ Glob Health*. 2020;5(5):e002028. doi:10.1136/bmjgh-2019-002028

52. Canada H. Voluntary sodium reduction targets for processed foods 2020-2025. December 18, 2020. Accessed June 13, 2024. https://www.canada.ca/en/health-canada/services/publications/food-nutrition/sodium-reduced-targets-2020-2025.html

53. Dodd R, Santos JA, Tan M, et al. Effectiveness and Feasibility of Taxing Salt and Foods High in Sodium: A Systematic Review of the Evidence. *Adv Nutr Bethesda Md*. 2020;11(6):1616-1630. doi:10.1093/advances/nmaa067

54. New York City Department of Health and Mental Hygiene. National Salt and Sugar Reduction Initiative (NSSRI). 2024. Accessed July 15, 2024. https://www.nyc.gov/site/doh/health/health-topics/national-salt-sugar-reduction-initiative.page

55. World Health Organization. Reduce fat, salt and sugar intake. World Health Organization - Regional Office for the Eastern Mediterranean. Accessed July 15, 2024. http://www.emro.who.int/nutrition/reduce-fat-salt-and-sugar-intake/index.html

56. Ponzo V, Pellegrini M, Costelli P, et al. Strategies for Reducing Salt and Sugar Intakes in Individuals at Increased Cardiometabolic Risk. *Nutrients*. 2021;13(1):279. doi:10.3390/nu13010279

57. Turkson-Ocran RAN, Cluett JL, Fitzpatrick SL, et al. Rationale and Design of the Groceries for Black Residents of Boston to Stop Hypertension Among Adults Without Treated Hypertension (GoFresh) Trial. *Am J Hypertens*. 2023;36(5):256-263. doi:10.1093/ajh/hpad008

58. Tax Policy Center. Briefing Book - How do state and local soda taxes work? Tax Policy Center. Accessed July 15, 2024. https://www.taxpolicycenter.org/briefing-book/how-do-state-and-local-soda-taxes-work

59. Kaplan S, White JS, Madsen KA, Basu S, Villas-Boas SB, Schillinger D. Evaluation of Changes in Prices and Purchases Following Implementation of Sugar-Sweetened Beverage Taxes Across the US. *JAMA Health Forum*. 2024;5(1):e234737. doi:10.1001/jamahealthforum.2023.4737

60. Rogers NT, Cummins S, Jones CP, et al. Estimated changes in free sugar consumption one year after the UK soft drinks industry levy came into force: controlled interrupted time series analysis of the National Diet and Nutrition Survey (2011–2019). *J Epidemiol Community Health*. Published online June 11, 2024. doi:10.1136/jech-2023-221051

61. Colchero MA, Molina M, Guerrero-López CM. After Mexico Implemented a Tax, Purchases of Sugar-Sweetened Beverages Decreased and Water Increased: Difference by Place of Residence, Household Composition, and Income Level. *J Nutr*. 2017;147(8):1552-1557. doi:10.3945/jn.117.251892

62. Alvarado M, Adams J, Penney T, et al. A systematic scoping review evaluating sugar-sweetened beverage taxation from a systems perspective. *Nat Food*. 2023;4(11):986-995. doi:10.1038/s43016-023-00856-0

63. Krieger J, Magee K, Hennings T, Schoof J, Madsen KA. How sugar-sweetened beverage tax revenues are being used in the United States. *Prev Med Rep*. 2021;23:101388. doi:10.1016/j.pmedr.2021.101388

64. TIME Magazine Staff. A Brief History of Salt. *TIME*. Published online March 15, 1982. Accessed July 2, 2024. https://time.com/3957460/a-brief-history-of-salt/

65. Nurmilah S, Cahyana Y, Utama GL, Aït-Kaddour A. Strategies to Reduce Salt Content and Its Effect on Food Characteristics and Acceptance: A Review. *Foods*. 2022;11(19):3120. doi:10.3390/foods11193120

66. CDC. Be Smart About Sugar. Healthy Weight and Growth. May 13, 2024. Accessed July 15, 2024. https://www.cdc.gov/healthy-weight-growth/be-sugar-smart/index.html

67. Trasande L, Shaffer RM, Sathyanarayana S, et al. Food Additives and Child Health. *Pediatrics*. 2018;142(2):e20181410. doi:10.1542/peds.2018-1410

68. Pearce EN. Is Iodine Deficiency Reemerging in the United States? *AACE Clin Case Rep*. 2015;1(1):e81-e82. doi:10.4158/EP14472.CO

69. Monteiro CA, Cannon G, Levy RB, et al. Ultra-processed foods: what they are and how to identify them. *Public Health Nutr*. 2019;22(5):936-941. doi:10.1017/S1368980018003762

70. Communications NW. Americans Are Eating More Ultra-Processed Foods. Accessed August 12, 2024. http://www.nyu.edu/content/nyu/en/about/news-publications/news/2021/october/ultra-processed-foods

71. CDC. Effects of Sodium and Potassium. Salt. April 5, 2024. Accessed July 3, 2024. https://www.cdc.gov/salt/sodium-potassium-health/index.html

72. O'Donnell M, Yusuf S, Vogt L, Mente A, Messerli FH. Potassium intake: the Cinderella electrolyte. *Eur Heart J*. 2023;44(47):4925-4934. doi:10.1093/eurheartj/ehad628

73. Chang HY, Hu YW, Yue CSJ, et al. Effect of potassium-enriched salt on cardiovascular mortality and medical expenses of elderly men. *Am J Clin Nutr*. 2006;83(6):1289-1296. doi:10.1093/ajcn/83.6.1289

74. Insitute of Medicine of the National Academies. *Strategies to Reduce Sodium Intake in the United States*. (Henney JE, Taylor CL, Stanton CS, eds.). The National Academies Press; 2010. https://books.google.com/books?hl=en&lr=&id=WzVkAgAAQBAJ&oi=fnd&pg=PP1&ots=ENIC-2tOZP&sig=ztvIlDEum-YwbQHFh7tfd3O2ou0#v=onepage&q&f=false

75. Wahlstedt A, Bradley E, Castillo J, Burt KG. MSG Is A-OK: Exploring the Xenophobic History of and Best Practices for Consuming Monosodium Glutamate. *J Acad Nutr Diet*. 2022;122(1):25-29. doi:10.1016/j.jand.2021.01.020

76. Zanfirescu A, Ungurianu A, Tsatsakis AM, et al. A Review of the Alleged Health Hazards of Monosodium Glutamate. *Compr Rev Food Sci Food Saf*. 2019;18(4):1111-1134. doi:10.1111/1541-4337.12448

77. dos Santos BA, Campagnol PCB, Morgano MA, Pollonio MAR. Monosodium glutamate, disodium inosinate, disodium guanylate, lysine and taurine improve the sensory quality of fermented cooked sausages with 50% and 75% replacement of NaCl with KCl. *Meat Sci*. 2014;96(1):509-513. doi:10.1016/j.meatsci.2013.08.024

78. CDC. Tips for Reducing Sodium Intake. Salt. April 6, 2024. Accessed July 15, 2024. https://www.cdc.gov/salt/reduce-sodium-intake/index.html

79. DASH Eating Plan | NHLBI, NIH. January 4, 2021. Accessed July 11, 2024. https://www.nhlbi.nih.gov/education/dash-eating-plan

80. Filippou C, Tatakis F, Polyzos D, et al. Overview of salt restriction in the Dietary Approaches to Stop Hypertension (DASH) and the Mediterranean diet for blood pressure reduction. *Rev Cardiovasc Med*. 2022;23(1):36. doi:10.31083/j.rcm2301036

81. Filippou CD, Tsioufis CP, Thomopoulos CG, et al. Dietary Approaches to Stop Hypertension (DASH) Diet and Blood Pressure Reduction in Adults with and without Hypertension: A Systematic Review and Meta-Analysis of Randomized Controlled Trials. *Adv Nutr Bethesda Md*. 2020;11(5):1150-1160. doi:10.1093/advances/nmaa041

82. Carey RM, Muntner P, Bosworth HB, Whelton PK. Prevention and Control of Hypertension. *J Am Coll Cardiol*. 2018;72(11):1278-1293. doi:10.1016/j.jacc.2018.07.008

83. de Bont J, Jaganathan S, Dahlquist M, Persson Å, Stafoggia M, Ljungman P. Ambient air pollution and cardiovascular diseases: An umbrella review of systematic reviews and meta-analyses. *J Intern Med*. 2022;291(6):779-800. doi:10.1111/joim.13467

84. Giorgini P, Di Giosia P, Grassi D, Rubenfire M, Brook RD, Ferri C. Air Pollution Exposure and Blood Pressure: An Updated Review of the Literature. *Curr Pharm Des*. 2016;22(1):28-51. doi:10.2174/1381612822666151109111712

85. Lehtomäki H, Rao S, Hänninen O. Phasing out fossil fuels would save millions of lives worldwide. *BMJ*. 2023;383:p2774. doi:10.1136/bmj.p2774

86. American Medical Association. H-150.929 Promotion of Healthy Lifestyles I: Reducing the Population Burden of Cardiovascular Disease by Reducing Sodium Intake. Accessed March 12, 2024. https://policysearch.ama-assn.org/policyfinder/detail/sodium?uri=%2FAMADoc%2FHOD-150.929.xml

87. American Medical Association. H-150.945 Nutrition Labeling and Nutritionally Improved Menu Offerings in Fast-Food and Other Chain Restaurants. Accessed July 15, 2024. https://policysearch.ama-assn.org/policyfinder/detail/H-150.945?uri=%2FAMADoc%2FHOD.xml-0-623.xml

88. American Medical Association. H-150.949 Healthful Food Options in Health Care Facilities. Accessed July 15, 2024. https://policysearch.ama-assn.org/policyfinder/detail/H-150.949?uri=%2FAMADoc%2FHOD.xml-0-627.xml

89. American Medical Association. Improving health outcomes: Hypertension publications. American Medical Association. August 16, 2023. Accessed July 15, 2024. https://www.ama-assn.org/delivering-care/hypertension/improving-health-outcomes-hypertension-publications

90. AMA Ed Hub. Hypertension: High Blood Pressure Management, Impact and Inequities. Accessed July 15, 2024. https://edhub.ama-assn.org/course/268

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (I-24)
Teens and Social Media (CSAPH 10-A-24)
(Reference Committee K)

EXECUTIVE SUMMARY

OBJECTIVE: This report examines the available evidence regarding the impacts of social media on the health of youth as well as the potential actions and interventions for government, policy makers, technology companies, researchers, parents, and children.

METHODS: English language reports were selected from searches of the PubMed and Google Scholar databases using the search terms: "teens" AND "social media" as well as "adolescents" AND "social media." Additional articles were identified by manual review of the reference lists of pertinent publications. Web sites managed by federal agencies and applicable professional and advocacy organizations were also reviewed for relevant information.

RESULTS: There is a pervasive presence of digital media, smartphones, and social media in nearly all aspects of youth and adolescent life. Despite substantial research efforts, the evidence is too weak to promote a uniform interpretation of the impact of social media on adolescent health at the population level. There are several factors contributing to the weak evidence including: (1) the reciprocal associations between social media use and health; (2) the lack of consistent and comparable methodologies; (3) entanglement of impact and exposure as a byproduct of social media's ubiquity; (4) different dynamics and trends depending on level of analysis; (5) the wide variety of interactions, behaviors, and health impacts engendered by social media; and (6) reliance on cross-sectional studies with high heterogeneity. Although the evidence is too weak to provide a uniform interpretation, there are clear positive and negative trends. There is some evidence of potential benefit in the form of improved social support, identity development, civic engagement, and self-directed learning. There is also some evidence of potential harm including negative impacts on sleep, physical activity, and mental health, as well as exposure to inappropriate content, and data privacy issues. Furthermore, it is apparent that the relative risks and benefits of social media likely depend on individual differences in: (1) engagement with social media (e.g., what kids see and do online, who they talk to, when they use social media, and how they use social media); (2) pre-exiting traits; and (3) the cultural, social, and physical environment.

CONCLUSION: Even though the evidence of harm is limited, there is an urgent need for action for two reasons. First, the lack of algorithmic transparency, privacy protections, and accountability and redress for online harassment on most platforms is concerning given the power, reach, and ubiquity of social media. Second, the potential harms are serious particularly during sensitive developmental periods, therefore, proactively creating digital environments that protect and enrich children's and adolescents' health and well-being is beneficial regardless of the evidence of harm. There are two key approaches that would likely facilitate the creation of safer, developmentally appropriate environments: (1) federal and state legislative action (e.g., expansion of the Children's Online Privacy Protection Act (COPPA), implementation of age-appropriate design, and mechanisms to address online harassment, and (2) development and widespread adoption of industry standards to benchmark platform operations, transparency, and data use. In addition to improving the digital environment, it is imperative that there are simultaneous efforts to address harms that still arise including: (1) education and training on digital media literacy and the potential harms posed by social media; (2) improved screening and support for those who experience harms (e.g., problematic internet use and online harassment); and (3) continued research of the health impacts of social media.

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 5-I-24

Subject: Teens and Social Media

Presented by: John T. Carlo MD, Chair

Referred to: Reference Committee K

INTRODUCTION

At the 2023 Annual Meeting of the American Medical Association (AMA) House of Delegates (HOD), Resolution 430, "Teens and Social Media" was adopted. The policy (H-478.976, "Teens and Social Media,") as adopted, asked that our AMA "study and make recommendations for teenage use of social media, including proposing model state and federal legislation as needed, with a report back at the 2024 Annual Meeting."

At the 2023 Interim Meeting of the AMA HOD, Resolution 915, "Social Media Impact on Youth Mental Health," was referred. The resolution asked that our AMA:

(1) work with relevant parties to develop guidelines for age-appropriate content and access and to develop age-appropriate digital literacy training to precede social media engagement among children and adolescents;

(2) amend policy D-478.965 by insertion as follows: (4) advocates for and support media and social networking services addressing and developing safeguards for users, <u>including protections for youth online privacy, effective controls allowing youth and caregivers to manage screentime content and access, and to develop age-appropriate digital literacy training</u>; and

(3) advocate that the federal government requires social media companies to share relevant data for further independent research on social media's effect on youth mental health and fund future federal research on the potential benefits and harms of social media use on youth mental health.

The Council presented the CSAPH 10-A-24, "Teens and Social Media," which addressed both Resolution 430-A-23 and Resolution 915-I-23, for consideration by the HOD. That report was referred back for additional study due to questions regarding content in the body of the report. Having clarified those questions, the Council presents this revised report for consideration.

METHODS

English language reports were selected from searches of the PubMed and Google Scholar databases using the search terms: "teens" AND "social media" as well as "adolescents" AND "social media." Additional articles were identified by manual review of the reference lists of pertinent publications. Web sites managed by federal agencies and applicable professional and advocacy organizations were also reviewed for relevant information.

BACKROUND

The co-occurrence of the growing ubiquity of social media use by adolescents and teens and the increase in poor mental health, among these same age groups, is alarming. These trends have prompted calls for action and research around adolescents and teens and their use of social media. A common theme in the research is that social media is not inherently beneficial or harmful. Instead, the effects of social media likely depend on what kids see, their pre-existing strengths and weaknesses, and their environment.[1–4] In particular, child-social media interactions may be bidirectional as users shape their experience which in turn shapes them and vice versa.[5,6] Further, many argue that it is important to move away from the false dichotomy of whether social media is hurting or helping adolescents -- instead researchers, parents, and policy makers should consider who is using social media, what are they using it for, when are they using it, and how are they using it.[7–9] The focus of this report will be on adolescents and teens aged 10-17.

Social Media Privacy, Transparency and Accountability

The American Psychological Association (APA) defines social media as, "interactive technologies that facilitate the creation and sharing of information, ideas, interests, and other forms of expression through virtual communities and networks."[10] This can include social networking, gaming, virtual worlds, video sharing sites, and blogs.[3] Social media, internet use, and screentime all fall under the umbrella of digital media - the parent category of all interactive media consumed through screens.[1] These terms are used interchangeably throughout the rest of the report, unless noted otherwise.

The different forms of social media have different possibilities for action and engagement, known as affordances. Affordances, include things like visibility, editability, persistence, replicability, searchability, scalability, and reachability and they manifest as the capacity for public posting, sharing functions, auto-scroll, gamified interaction, push notifications, private messaging, affiliations, and running counts of feedback on posts.[11–13]

Affordances can have meaningful influence on the actions of the user; therefore, many researchers advocate for an affordances approach to understanding and evaluating social media.[14] This is important because affordances are powered by and interact with computational algorithms. These algorithms moderate content by generating recommendations, ranking and removing content, and targeting ads.[3] A challenge with content moderation is that it is intrinsically subjective. The value and appropriateness of content depends on the context – the who, what, why, how, and when of the information being shared may determine if it is elevated, downplayed, or removed.

Most platforms use a mix of artificial intelligence and human editing to enforce content moderation.[3] This can create intentional manipulation of information on the part of individuals. For instance, Facebook allowed advertisers to choose to exclude whole racial, ethnic, and age groups from seeing their ads.[3,15,16] Similarly, TikTok issues separate content moderation approaches for different countries depending on the degree of social conservatism.[3,17] Many platforms can and do selectively reduce or increase the prominence of content from certain users without violating the terms of use.[3,18] There is also unintentional, or at a minimum unexplained, manipulation of information, caused by using machine learning algorithms for content modification. Machine learning algorithms are black box mechanisms that learn without explicitly being programmed. Companies know the inputs, outputs, and training data that go into their algorithms, but the internal processes by which most machine learning algorithms work are less clear. Additionally, algorithms are proprietary, so companies are reluctant to share the details they do have.[3,19,20] Consequently, the

intrinsic subjectivity of content moderation is made more opaque by machine learning algorithms as well as the platforms' lack of transparency about them.[3,21]

Relying on machine learning for content modification is not inherently harmful, but it can create recursive feedback loops that exacerbate problems with harmful content and misinformation. The algorithms send users more of the content that they engage with, thereby creating the impression that theories and behaviors they are seeing are potentially more prominent than they are. Moreover, many users do not realize that social media platforms are designed to show them content that is most likely to keep them engaged and on the platform rather than providing a comprehensive view of the content of friends and family.[3,22] There is some evidence that recursive feedback loops and echo chambers exacerbate vaccine hesitancy.[3,23–25] Similarly, content modification, and the echo chambers it creates had a significant impact on behavior during the 2016 Election.[3,26–28]

Ultimately, the current processes for content moderation introduce bias on both the front end (e.g., the training data that informs the algorithms and intentional modification of information) and on the back end (e.g., recursive feedback loops and echo chambers). Content moderation also leverages user data, often in ways the user is unaware of, which raises ethical and privacy concerns.

Furthermore, there is concern among users that companies like Facebook (now Meta) both overlook the risks posed by their product and misrepresent their internal findings when necessary to benefit the company.[3,29,30] It is for these reasons that many criticize platforms and call for evaluation of algorithm bias, transparency, justice, and accountability.[3,20]

Adolescence as a sensitive period

One of the reasons parents, clinicians, researchers, and policy makers have raised alarm about social media use among adolescents is that adolescence is a developmentally sensitive period. There are three key features of adolescent brain development that may impact how youth engage with social media: (1) heightened sensitivity to rewards and dynamic changes in the dopaminergic system;[3,31–33] (2) protracted maturation of brain networks that support cognitive function;[34] and (3) neural sensitivity to specific types of social information.[3,35] As a result, adolescence is a time of tremendous cognitive, social, emotional, and physical change that involves both opportunity for maturation and vulnerability to environmental stressors.[3,36] Evidence from developmental neuroscience illustrates that adolescence is a time of heightened risk taking, impulsivity, and sensitivity to social stimuli.[4,37] Consequently, adolescents are particularly susceptible to environmental influences like drugs, social stress, cognitive training, and likely social media.[3,4,38–41] There is some concern that constant engagement in social media in early adolescence may alter neural sensitivity to rewards and punishment.[3,42] Furthermore, changes in the reward circuit may be a factor in excessive and problematic internet and social media use.[3,43]

At the same time, self-presentation and identity exploration is an important part of adolescence that social media can support.[3,14,44,45] It is a critical time for building relationships and developing a social support system.[3] Adolescents demonstrate an increased ability to consider other perspectives, which drives empathetic and prosocial behaviors on the one hand, as well as increased social comparison on the other.[3,46] The strong desire for social connectedness demonstrated by adolescents suggests that they may be relaxed regarding privacy settings and connecting with strangers.[35,47] Online environments and social media interactions may also lower inhibitions and accelerate intimacy.[48] In this way, online environments create both benefits and risks to development of identity and social connectedness.[48] Adolescence is also a time of increased flexibility and plasticity so researchers and public health practitioners advocate leveraging the plasticity of adolescent brain for health promotion.[37]

Ultimately, the power of social media to influence well-being likely depends on developmental stage.[49] There are ethical reasons to limit marketing to children and teens as they may struggle to resist advertising.[50] At the same time, there is some evidence that the concept of adolescence should be expanded to include individuals aged 10 to 24.[40] An expanded definition of adolescence is essential for developmentally appropriate framing of laws, social policies, and service systems.

YOUTH PREVALENCE, MOTIVATIONS, AND EXPERIENCES ON SOCIAL MEDIA

According to a 2022 Pew survey, 95 percent of teens in the U.S. have a smartphone and 97 percent use the internet daily, which represents a 22 percent increase over the last eight years.[51] The omnipresence of both internet and mobile devices in how youth engage in relationships, learn, and experience milestones reflects a massive cultural shift since the early 2000s.[52] Smartphone use starts in early adolescence, with 40 percent of children ages 8 to 12 owning a smartphone and 18 percent reporting social media use every day.[53]

The 2022 Pew survey also found that 35 percent of teens report using YouTube, Instagram, TikTok, Snapchat, and Facebook almost constantly.[51] Fifty-five percent of teens thought they used social media the right amount, 36 percent thought they use social media too much, and eight percent thought they used it too little.[51] Additionally, 54 percent thought it would be somewhat hard to give up social media.[51] Findings from the Pew study mirror older studies reporting that 50 percent of teens describe themselves as constantly connected and feel that they are addicted.[1,2] There are slight demographic differences as well. Black and Hispanic teens may use online media more than their White peers.[51] Girls use social media more than boys and also report that they would have a harder time giving up social media.[51] Finally, teens over 15 use social media more than teens under 15.[51]

The most popular platform is YouTube, used every day by 95 percent of teens.[51] YouTube is followed by TikTok at 67 percent, Instagram and Snapchat at 60 percent, Facebook at 32 percent, and then Twitter, Twitch, WhatsApp, Reddit, and Tumbler.[51]

Despite widespread use among children and adolescents, robust independent safety analyses on the impact of social media on youth have not yet been conducted.[4] Currently, we do not yet have enough evidence to determine if social media is sufficiently safe for children and adolescents. Yet, the body of research about potential harm evidences the importance of understanding the possible risks and proactively creating digital environments that safeguard children's and adolescents' mental health and well-being during critical stages of development.[4]

MOTIVATIONS FOR USE

Motivations for social media use among teens include social interaction, connection, curiosity-driven learning, information sharing, entertainment, relaxation, stress relief, escapism, novelty seeking, social capital, and appearance feedback.[3,54–56] Moreover, there is evidence that the ways in which youth engage with social media can improve and enrich their lives through social support, connection, community building, identity development, civic engagement, and exposure to new ideas.[57]

Friendship, social support, and connection

Social media plays a vital role in the development and maintenance of friendships and social connectedness.[54,57,58] Communication with friends and family is often reported as the most important function of social media,[59,60] particularly when family and friends are far away.[61] Fifty-

seven percent of teens have met a new friend online.[60,62] There appear to be some gender differences in how boys and girls interact with friends on social media. Sixty-one percent of boys and 52 percent of girls made friends online, and video games play a critical role in boys' friendship development.[62] In contrast, one study found that on average, teen girls spend over two hours a day on TikTok, Snapchat, and YouTube and over 90 minutes a day on Instagram and messaging apps.[63] Roughly, 69 percent of teens feel better connected to their friends' feelings, 83 percent better connected to their friends' lives, and 68 percent receive social support during tough times from friends through social media.[62] In this way, social media may be helpful in combating social isolation and building social capital.[3,64]

There is some evidence that social media can both reduce stigma and be a venue for sharing coping strategies.[3] Social media provides a way for youth to connect with people in the same position, which can be particularly valuable to adolescents who feel excluded or otherwise lack offline support, including patients with rare diseases, individuals with disabilities, those who struggle with mental illness and/or obesity, and marginalized groups (e.g., LGTBQ+ youth).[1,4] For instance, through social media, teens who are neurodivergent can connect socially with others in a way that is manageable for them, thereby reducing loneliness.[3,65] Social media may also help teens and youth coping with grief,[66] navigating foster care,[67] dealing with cancer, diabetes, rare diseases,[68,69] and mental illness.[3,70] Sharing on social media about losses and stressors can provide a sense of connection, support, and understanding.[71] Similarly, social media can provide support and connection for young people who live in communities where sexual and gender diversity are not accepted, which may buffer them from stigma and loneliness.[3,72–74] This is particularly true for LGTBQ+ teens in rural areas that are able to find support they do not have offline by connecting with other queer youth.[3,72,75–77]

It is not clear if online and in-person relationships are equivalent; however, friendship and social connection facilitate a sense of belonging.[3,78] Moreover, friendship can reduce anxiety and improve life satisfaction in its own right.[3,79] Cross-sectional studies among undergrads provide some evidence that people who use social media to connect with a diverse friend group tend to have higher social self-efficacy.[3,80] Yet, the relative support provided by online social connection may be influenced by the individual and how they engage with social media.[3,81]

Self-expression, Identity exploration, and Independence

There is some evidence that social media can support self-expression, identity exploration, and independence.[3,14,44,45,57,60,82,83] Adolescents who communicated more with friends online had a greater self-concept clarity.[60] One systematic review found that LGBTQ+ youth negotiated and explored identity using social media to manage identities though anonymity, censoring locations and content, restricting audiences, and using multiple accounts.[72] This suggests social media may support the mental health and well-being of LGTBQ+ youth through identity management.[72] In particular, the online environment of social media creates a space to revel and express differences.[84] Similarly, many cis girls are meticulous about which platforms and accounts they use for specific tasks, because it allows them to experiment with different forms of expression and ways of presenting themselves to their peers.[3,85] Self-disclosure, a key process in asserting personal agency, may be facilitated through digital platforms.[3,81]

Self-directed learning, Creative expression, and Civic engagement

Social media can also facilitate exposure to new ideas, raise awareness about current events, increase community participation and civic engagement, and allow collaboration on schoolwork.[2] A study of teens in western countries found that social media use predicts greater ability for both

reading and navigating information online.[3,86] There is also some evidence that when social media is used for classroom writing exercises, students demonstrate less writing anxiety and increased agency.[87] Similarly, online fanfiction communities facilitate informal learning by creating a space for youth to build literary skills and support the same skills in others.[87] The same can be said for other hobbies, interests, and activities that have a social media component and roughly 70 percent of teens use social media to express their creative side.[54] The informal learning environment of social media facilitates empowerment and agency among some young people.[3,88] It has also been associated with increases in self-motivation among adolescents.[3,88]

About two-thirds of teens ages 13-18 reported using social media to learn about different points of view or show support,[54] and 64 percent of teens look for news online.[3,89] Furthermore, evidence suggests youth who engage in online political discussions also engage in offline political discussions.[3,89,90] Therefore, social media may be a vehicle to engage and utilize the social and political power of young people through civic engagement.[3,90–92] Social media can facilitate political democracy, cultural democracy, and spread of knowledge.[93] Finally, there is some evidence that adolescents both seek out and share health information on social media.[53,54] Therefore, it may be an effective tool for health interventions and health promotion.[1,94,95] On the other hand, health misinformation can exacerbate adoption of harmful behaviors.[96]

ONLINE HARASSMENT AND EXPOSURE TO INAPPROPRIATE CONTENT

Cyberbullying and online harassment

There is evidence that social media increases risk of cyberbullying among youth.[1–3,60,83,97] According to a recent Pew survey, 46 percent of U.S. teens ages 13 to 17 report ever experiencing at least one of six cyberbullying behaviors.[51] Name-calling was most common, with 32 percent of teens reporting they have been called an offensive name online or on their cellphone.[51] False rumors (22 percent), receipt of explicit images (17 percent), pervasive questions about location (15 percent), physical threats (10 percent), and the sharing of explicit images of them without their consent (seven percent) were also reported.[51] There appear to be slight demographic differences in who experiences cyberbullying. Specifically, studies have shown that black teens experience more cyberbullying that their white peers,[51,98] LGBTQ+ youth experience more cyberbullying than their cisgender and heterosexual peers,[51,98] and adolescent girls experience more cyberbullying than adolescent boys.[51,63,99,100] Evidence also suggests that relationship issues (e.g., feeling left out and interpersonal drama) were the most common reason for cyberbullying among adolescent girls.[63,100]

Studies suggest that the size and type of the network as well as anonymity of those on the network impact the likelihood of harassment, but it is not easily predicted.[3,101,102] For instance, online harassment occurs often among video game users, particularly female gamers who commonly report sexual harassment.[3,103,104] One study found that indiscreet posting, time spent on social media, and personality traits were all predictors of cyberbullying.[105] There is some evidence of a relationship across studies between cyberbullying and depression among children and adolescents; however, the evidence of the effect of cyberbullying on other mental health conditions is inconsistent.[100] Adolescents' self-view and interpersonal relationships may be affected through social comparison and negative interactions, like cyberbullying and exposure to inappropriate content.[97]

Responses to cyberbullying are most often passive, with a pervasive lack of awareness or confidence that anything can be done.[100] Despite the prevalence of cyberbullying, some evidence suggests that in-person bullying is more common.[3,106]

Exposure to inappropriate content and misinformation

One major concern of parents, clinicians, researchers, and policy makers is that poorly regulated and moderated social media can result in youth exposure to inappropriate content (e.g., alcohol, tobacco, risky sexual behaviors, cyberflashing, porn, and self-harm).[1–3,107] A survey of more than 1,300 teens aged 13 to 17 found nearly three-fourths had seen pornography online, with social media being the point of access for about 18 percent.[3,108] Moreover, average first exposure was at 12 years old and accidental exposure accounted for 40 percent of cases.[3,108] Cyberflashing – the electronic transmission of sexually explicit photos without the recipients' consent – is a particularly troubling form of online harassment.[3,109] One survey found that 37 percent of girls and 20 percent of boys aged 12 to 18 had received sexual photos online, often from strangers,[3,110] and another study found more than 6 percent reporting the first flashing incident occurred between the ages of 12 and 14.[3,111] It is difficult to evaluate brief and limited exposures; however, there is evidence that repeated exposure to inappropriate content in childhood was associated with risky sexual behavior later in life.[107] Similarly, exposure to alcohol, tobacco, or risky sexual behaviors may be associated with initiation of those behaviors.[1]

Teens and adolescents may also be uniquely vulnerable to misinformation and disinformation because their maturity and cognitive capacities are still evolving.[3,112] Misinformation and disinformation can take a variety of forms including clickbait, hoax, rumor, satire, propaganda, and conspiracy theories.[113,114] Examples include things like foreign interference, political deceit, and claims for ineffective and unproven natural remedies and medical advice.[112] Concerningly, many people lack the ability to identify misinformation and disinformation as evidenced by one study which found that the percentage of people who share fake news without the intention to mislead is five times higher than intentional spreaders.[115] A 2018–2019 survey of 3,446 U.S. high-school students demonstrated that 52 percent believed that a grainy video claiming to show ballot-stuffing in the 2016 Democratic primaries constituted 'strong evidence' of voter fraud in the U.S., and only 0.1 percent were able to track down the original video even though a quick search showed that it was actually shot in Russia.[112,116] Similarly, two-thirds could not tell the difference between news stories and 'sponsored content' (i.e. adverts) on a website.[112,116] Although teens and adolescents may be particularly vulnerable to misinformation and disinformation, there is currently very little data available to provide a clear picture of how misinformation and disinformation may affect their development, well-being, and rights.[112]

IMPACTS OF SOCIAL MEDIA ON ADOLESCENT HEALTH

To understand the impacts of social media on adolescent health, the conflicting and often reciprocal mechanisms through which online experience and health (physical and mental) influence each other must be disentangled.[3] However, there are several factors that make this extremely challenging, including:

(1) the direction of the relationship between social media and health is difficult to determine - social media use influences health and health influences social media use;
(2) the research lacks uniform, consistent, and comparable methodologies;
(3) social media is so ubiquitous it is difficult to separate the impact of exposure;
(4) different levels of analysis may reveal different dynamics – with large scale studies showing population level trends and psychological studies showing mixed, small, or no associations;
(5) social media is not a monolith, the affordances of different platforms and types of social media engender a wide variety of interactions, behaviors, and health impacts; and

(6) the heterogeneity of the literature and the primary reliance on cross-sectional studies (or meta-analysis of cross-sectional studies) make definitive conclusions and causal relationships limited. Most of the associations are qualified or limited to certain populations.[3]

Social Media and Physical Health: Sleep, Physical Activity, and Obesity.

There is evidence that social media use can disrupt sleep.[1–3,97,107,117,118] Specifically, increased duration of computer, internet, and social media exposure,[3,118] and the presence of a tv, computer, or mobile device in the bedroom in childhood were associated with fewer minutes of sleep, greater risk of sleep disturbances, longer sleep latency, worse sleep quality, and daytime dysfunction.[1,119] Gaming predicted delayed bedtimes and reduced attention the following day.[3,120] One study found that screen-based digital media use is closely associated with sleep duration and sleep quality in teens; however, they cautioned that more research was needed to determine the direction of the effect.[3,121] Another study found that smartphone use at night can delay sleep among adolescents.[3,122] In a nationally representative sample, one-third of parents of teens 12-17 had rules about smartphone use at bedtime and those kids had less daytime sleepiness.[3,123]

However, it is not clear if social media or devices more broadly are driving the relationship. There are three likely ways in which digital media use may disrupt sleep.[3,124] First, social media displaces sleep thereby delaying bedtime, disrupting sleep, and reducing sleep duration.[3,121,124] Second, devices can disrupt circadian rhythms though light emissions which heighten arousal and decrease sleepiness.[3,122,124] Third, social media may be psychologically stimulating in such a way that makes sleep difficult.[3,124,125] Determining which mechanism(s) are driving the association between digital media and poor sleep is necessary given that the cascading impacts of poor sleep and the potential harms of social media overlap significantly.

Observational studies suggest a significant association between poor sleep quality and excess social media use and negative mental health outcomes.[3,126] Therefore, the interplay between social media and sleep quality may impact mental health outcomes. Sleep loss is a risk factor for depression, mood disturbances, injuries, attention problems, and excessive weight gain.[3,127–129] Additionally, teens with restricted sleep have more problems with emotion regulation, anxiety, hostility, and fatigue.[3,130] One study also found that sleep-deprived participants showed worse mood, more social media use, and problems with concentration.[3,131] Moreover, findings from the Youth Risk Behavior Survey illustrated that teens who sleep four or fewer hours a night have 5.9 times higher odds of having a serious suicide attempt.[3,132] Some studies showed sleep quality mediating the relationship between social media use and negative mental health outcomes in youth.[126] In particular, if social media displaces sleep and hobbies, it can be predictive of anxiety and depression.[3,133] Similarly, when screen time displaces sleep and exercise it is predictive of problematic use.[3,134,135] However, the current body of evidence on the directionality and relationships between social media use, mental health, and sleep is inconclusive.[3,126]

There is some evidence that social media use may correlate to non-adequate nutrition, non-physiologic postures, weight gain, and obesity.[1,2,107,117] Excessive TV viewing in early childhood is associated with an increased risk of obesity.[1] Social media could be displacing physical activity, sleep, studying, and other hobbies, resulting in a more sedentary lifestyle and an increased risk of obesity.[3,107,136] In support of this, another study found that increased digital media use was associated with a sedentary lifestyle.[3,137] Social media use is also associated with consumption of fast food, sugary drinks, snacks, and mindless eating.[3,138] One study theorizes that this may be occurring because social media is displacing regular meals.[3,138]

Social Media and Mental Health: Anxiety, Depression, and Loneliness

The findings on the association between social media and adolescent mental health are small, inconsistent, or non-existent. Moreover, the differences in findings appear to be explained by bidirectional interactions, methodological weaknesses and differences, and/or individual rather than population differences.

Several meta-analyses, systematic reviews, and other studies have found small negative associations between social media use and depression, anxiety, psychological distress,[139] loneliness, internalizing problems, and low offline social support.[3,139–147] At the same time, numerous other studies found the relationship between social media and adolescent mental health is non-existent, mixed, or inconsistent.[148–151] Specifically, there was no significant association between social media use and depression, anxiety, and life satisfaction.[148,150,152] Additionally, there is inconsistent evidence that social media makes social comparison, envy, and well-being worse.[149] Importantly, many of these studies note that predictive relationships between social media use and well-being are reciprocal, as well as present only in certain populations, developmental windows, or among certain patterns of use.[49,141–143,151–155]

For instance, one review found that early studies show comparison and envy are common on social media and linked to ill-being, whereas recent studies find positive, person-specific, conditional, and reciprocal effects.[149] Similarly, one study found that social media use in and of itself is not a predictor of life satisfaction; rather the relationship between self-reported estimates of social media use and life satisfaction is more nuanced, reciprocal over time, gender specific, and likely dependent on analytic methods.[152] Another study found that life satisfaction is most negatively associated with social media use in younger adolescents, but also noted possible developmental windows of sensitivity -- at ages 14-15 and 19 for boys and at ages 11-13 and 19 for girls.[49] A longitudinal study that characterized subgroups based on type of social media use found that the high social media use subgroup predicted higher depressive symptoms, panic disorder, delinquent behaviors, family conflict, and lower family and friend support than the high Instagram/Snapchat and low social media subgroup.[154] Similarly, in a study of U.S. undergrads, social media use was not predictive of impaired mental health; however, "vaguebooking" -- the practice of making a post on social media that is intentionally vague but highly personal and emotional -- was predictive of suicidal ideation.[151] This suggests how individuals use social media is more important than the amount of time they spend on social media, particularly considering that perceived parent-child conflict was a stronger predictor of mental health issues than social media use.[151]

There is also some evidence that young people who report symptoms of depression are using digital tools to learn about and help their mental health problems.[155] One study found that girls and LGBTQ+ teens were more likely to seek out online resources for mental health and showed interest in stories of others with similar experiences.[155] Those who benefit most from social media appear to be those who are marginalized as well as those with chaotic home lives, suggesting the benefits of online social support are most salient when offline social support is lacking.[51,54] These findings highlight the importance of researching patterns, quality, and type of use in addition to amount of use.

Additionally, there are methodological issues that further complicate definitive conclusions. Several studies note that wide variation in methods and rigor make it difficult to synthesize findings.[139,143,154,156,157] For instance, one systematic review found a small association between self-reported social media use and depressive symptoms, but noted that the studies had high heterogeneity, which suggests that other factors are likely moderating the relationship.[143] Another systematic review argued that small associations and inconsistent results may be influenced by

choice of mental health indication (e.g., presence of well-being is not necessarily the absence of ill-being and vice versa).[149] Furthermore, the research on social media and adolescent well-being primarily comes from cross-sectional studies, therefore causal associations may be unwarranted.[49,140,152,156–158] Finally, this research should consider a person-specific approach as individual differences may explain the mixed and inconsistent results.[156]

Ultimately, the presence of small associations as well as inconsistent and conflicting results highlights that the evidence is still too weak to promote a uniform interpretation or to support the conclusion that social media causes changes in adolescent mental health at the population level.[3,159] Moreover, the fact that social media use is linked in complex and ubiquitous ways with other aspects of life means it is unclear what such a small effect demonstrates.[159] More research is needed along with improved transparency and greater appreciation for individual differences and to elucidate which features of or use patterns of social media may be beneficial and which may be harmful to mental and physical health.[4,159]

Problematic Internet Use and Internet Gaming Disorder

Internet gaming disorder is defined as persistent and recurrent use of the internet to engage in games, leading to clinically significant impairment or distress.[41] Problematic internet use is defined as internet use that creates psychological, social, school and/or work difficulties in a person's life.[160] This can include video gaming, social media use, web-streaming, and buying; however, those activities are characterized as excessive or poorly controlled preoccupations, urges, or behaviors regarding computer use and internet access that lead to impairment or distress. The key factor is that internet use becomes problematic when it causes dysfunction in daily life activities (e.g., school, sleep, exercise).[3,26,161] There appears to be significant overlap in internet gaming disorder, problematic social media use, and problematic internet use.[3,162,163] At this point it is unclear whether problematic social media use and gaming disorder are distinct or different manifestations of disordered tech use.[3]

There is some evidence that internet gaming disorder predicts depression, anxiety, social phobia, poor school performance, sleep disruption, and poor relationships with parents and peers.[3,164–167] There is also some evidence that problematic internet use is associated with depression, disturbances in sleep and mood, upward social comparisons, cybervictimization, and poor academic performance.[3,4,58,72,168–172] Problematic social media use is most common among older age groups and may be associated with irritability, nervousness, loneliness, and morning tiredness.[169] There are gender differences in internet gaming disorder, as it affects males five times more than females.[173] Moreover, there is some evidence that boys are more addicted to games whereas girls are more addicted to social media.[3,174]

Some researchers suggest that problematic internet use could explain the small negative associations between social media and youth mental health. For instance, problematic social media use mediated the association between depressive symptoms and cyberbullying.[142] Additionally, one study found that teens with problematic internet use reported more difficulty identifying and describing emotions, and there is some evidence that emotion regulation is a significant mediator in quality of parent-adolescent relationship.[175] Some researchers theorize that problematic internet use might be a coping strategy to compensate for emotion regulation deficits, which might explain why a good relationship with parents reduces problematic internet use.[175] However, problematic use is more complex than simply the amount of time spent on social media. It includes enduring preoccupation with social media, inability to stop, neglect of one’s health and other areas of one’s life.[156] Therefore, more research is needed to better understand the relationships between problematic internet use, social media, and adolescent mental health.

Attention and Learning

There is limited evidence that social media use negatively impacts attention and learning. One study found that time spent on social media predicts concentration problems in adolescent girls.[3,176] Additionally, there are small associations between both frequency of social media use and number of platforms and attention deficit hyperactivity disorder (ADHD).[3,177–179] However, it is not clear what is driving the association between social media use and decreased attention.[1]

There is some evidence that reading on screens is fundamentally distracting.[3,180] Others have suggested that multitasking is the root of the problem. High proportions of youth engage in heavy smartphone use and media multitasking.[97] Moreover, a recent meta-analysis found associations between multitasking and problems with attention, behavior regulation, impulsiveness, and memory.[3,181] Specifically, media multitasking is associated with negative effects on cognitive control, academic performance, and socioeconomic functioning.[3,97,181,182] One study found that in three hours of studying, adolescents experienced an average of 35 social media distractions that diverted attention.[3,183] Additionally, another study found that the number of social media accounts correlated with parent reports of symptoms of inattention, hyperactivity, impulsivity, oppositional defiant disorder , anxiety, and depressive symptoms, and adolescent reports of fear of missing out and loneliness.[179] Therefore, it has been suggested that the amount of time spent online can have bidirectional effects on depressive symptoms and ADHD; this risk is particularly heightened in those with pre-existing poor mental health.[126]

Body Image and Eating Disorders

Significant research exists on the association between social media use and body image, but the findings are limited, and causal factors are difficult to differentiate. There is some evidence that social media use and consequent exposure to appearance-focused content may be weakly associated with poorer body image.[3,4,184,185] A cross-sectional study found that greater levels of self-objectifying social media use predicted greater body shame among youth, and the association was mediated by an associated increase in body surveillance.[3,186] Specifically, the role of body surveillance was stronger among girls and adolescents who are particularly focused on others for approval.[186] Body image concerns may be a key mechanism underlying the associations between adolescent girls' social media use and mental health.[187]

A scoping review found that social media use may have a variety of impacts on diet, exercise, and body image.[107] Similarly, another study found that the same platform that helped some patients find recovery support was also a source of body shaming and rumination for others.[3,188] Another review found that peer influences on social media span from healthy eating and exercise to disordered eating, and that dietary information shared on social media often misaligns with national dietary standards.[189] Similarly, one study found youth had an increased ability to recall unhealthy food, beverages, and brands particularly when celebrities and influencers are promoting them.[190]

PRIVACY

Researchers have found that the growing use of social networks has led to the emergence of ethical and privacy concerns regarding the management of user data and how social networks train algorithms for economic purposes to organize the content shown to users.[1,191] The new privacy paradox is that these sites have become so ubiquitous that users feel they must disclose information on them even though these sites do not provide adequate privacy controls.[3,192] Specifically, the privacy policies used by platforms either require or allow users to review and consent to their data

collection and data use practices; however, most respondents agreed to the terms without reviewing them.[3,193,194] This could be because the policies themselves are long and technical, they do not provide consumers with meaningful choices, and people are skeptical of whether policies achieve their goals.[194] Concern over what platforms do with user data coupled with a sense of futility over having the agency to change anything may explain why a recent Pew survey found overall strong bipartisan support for more regulation of what companies can do with people's data, with 72 percent of Americans reporting that there should be more regulation than there is now.[194]

These issues may be even more salient for children. A recent Pew study found that Americans worry about kids' online privacy, with 89 percent of respondents reporting that they are very or somewhat concerned about social media platforms knowing personal information about kids.[194] Similar concern arises over how advertisers, online games, and gaming aps collect and use children's data.[194] However, respondent expectations regarding responsibility for protecting kids is placed primarily on parents at 85 percent, followed by technology companies at 59 percent and the government at 46 percent.[194]

The Children's Online Privacy Protection Act (COPPA), which was enacted in 1998, recognizes that young children cannot consent to the terms of use for data collection, and thus prohibits enticing personal disclosures through games and restricts advertising to children. TikTok was recently sued by the U.S. government for allegedly violating COPPA by failing to notify and obtain parental consent before collecting and using personal information from children under the age of 13.[195,196] Yet, COPPA only applies to kids under 13. Consequently, recent legislation has focused on age-appropriate design and proposed additional protections for adolescents.

There is mixed evidence on how adolescents and adults feel about online privacy. There is some evidence that older users are more concerned about privacy than youth.[197] Additionally, a strong desire among adolescents for social connectedness suggests that youth may be more inclined to have relaxed privacy settings and a show a greater willingness to connect with strangers.[3,35,198] However, a different study found a negative relationship between age and privacy; noting that young people are more likely to have taken action to protect their privacy than older people.[192] Therefore, it is possible that the studies finding that young people are not concerned about their privacy may be because they are taking more precautions.

POTENTIAL APPROACHES TO PROTECT CHILDREN ON SOCIAL MEDIA

Despite widespread use among children and adolescents, the evidence on the potential harms and benefits is too weak to promote a uniform interpretation of the impact of social media on adolescent health at the population level. Nonetheless, the current body of research highlights the importance of understanding the risks and benefits and utilizing developmentally appropriate design to proactively create digital environments that protect and enrich children's and adolescents' health and well-being during critical stages of development.[1–4,41]

Developmentally appropriate design focuses on: (1) centering the rights and developmental needs of children and (2) improving privacy protections and transparency by addressing and modifying what data is collected from minors, how it is collected, and how it is used. In practice this might include collecting the minimum information necessary and prohibiting the use of that information in commerce or discouraging persuasive design features (e.g., push notifications, like buttons, tones for new content, and endless scrolling).[41] Although developmentally appropriate design does not require it, involving youth in both the discussions about and solutions for social media and youth mental health is important, and it can be accomplished with youth advisory panels.[199]

Recommendations for Industry

The most common recommendations for the social media industry, which focus on developmentally appropriate design (e.g., implementation of improved privacy protections, increased transparency, and a better system of reporting inappropriate content and ill-actors), come from researchers, medical societies, policy makers, and the surgeon general.[1–4,41,200] However, the mechanisms needed to facilitate these changes are more nuanced as there has been limited success of voluntary self-governance on the part of industry and regulatory approaches face legal and logistical implementation challenges.[201]

Highlighting the success of the Global Internet Forum to Counterterrorism, the National Academy of Science, Engineering, and Medicine (NASEM) argues that the International Organization for Standardization (ISO) should convene an ongoing technical working group comprised of industry, academic, and civil stakeholders to develop standards for social media platform design, transparency, and data use.[3,202] Other researchers, professional organizations, and policy makers also advocate for development of industry standards that improve privacy, transparency, and accountability.[4,201]

The goals of the NASEM proposed work group would be to develop standards that: (1) limit the personal information companies collect, the types of content available, and the prompts to extend time on a platform; and (2) develop easy to use, universal, transparent systems for reporting, follow-up, and adjudication for cases of online harassment and abuse.[3,4,201] Specifically, efforts should be made to move to a functional privacy system that emphasizes transparency of and access to inputs and outputs. On the front-end inputs would include: (1) a clear process for content moderation and use; (2) contents of privacy agreements; and (3) mandatory disclosures to users and the ability to opt out.[3] On the back-end, standard outputs might include: (1) platform health measures (e.g., content moderation and take down policies and data at the community, group level to evaluate platform toxicity); (2) algorithmic transparency standards and summaries at the user level; and (3) reports on efforts to remediate youth mental health problems on the platform.[3,4] This would improve privacy protections and transparency by making it clear what data is collected from minors, how it is collected and used, and what the consequences of use are. Furthermore, this would give companies and researchers more straightforward guidelines for measuring data collection risks that children encounter online, as well as technical standards to benchmark platform operations, transparency, and data use.[3] Arguably social media platforms would benefit from a standard guide of assessment to evaluate how their products influence youth well-being.

Yet developing standards is insufficient unless social media companies adopt the standards both as their policy and as provisions in their terms of service.[3] There is a precedent of self-regulation in media (e.g., tv, movies, videogames, music) using industry standards, as well as early efforts at self-regulation evidenced by Facebook's Oversight Board.[3,201,203–205] However, given that the success of social media is contingent on engaging as many people for as long as possible, implementing standards aimed to reduce controversial, emotional, and inflammatory content might not be in their best interest.[206,207] Moreover, enacting a regulatory framework across jurisdictions on global companies is not always legally or logistically viable; however, voluntarily adopting standards now could reduce the likelihood of more sweeping regulatory action later.[3,201,208,209] Furthermore, evidence from political science literature on transnational governance shows that multistakeholder regulatory standards setting schemes can be a vital part of the corporate regulatory toolbox.[201] However, more research is needed to see how and if they can be implemented to protect adolescent social media users.[201]

A public statement of compliance with standards and a commitment to uphold those standards in the terms of service would be a meaningful step towards an enforceable legal structure.[3] Specifically, the Federal Trade Commission (FTC) can penalize firms that engage in unfair or deceptive business practices and has used this authority against companies that have failed to honor commitments made in their privacy policies and similar agreements.[210–212] Audit and systemic risk reports of compliance with the standards should be available to the FTC, researchers, and the public. Social media companies should make a good faith effort to ensure access to data that facilitates research on the effects of social media on child and adolescent health possibly including removal of the prohibition on researchers' use of publicly available data.[3] More transparency would allow for comparisons across platforms and over time, which would provide a better insight for the companies, the public, and the FTC. Creation of a standard would also support and inform the FTC's use of consent decrees as a regulatory tool.[3,213] Once a company agrees to a consent decree, terms of the decree determine obligations to remediate regardless of whether the terms are within the FTC's authority.[3,214] Creation of an industry standard could support the FTC's governance by consent decree, even for providers who do not explicitly adopt the standard.[3]

Once standards have been created and adopted, it would be much easier to assess and remedy harms posed by social media. For instance, standards could be used to evaluate whether the platform has age-verification processes, data encryption, and privacy policies.[3] Similarly, they could be used to determine whether a platform's content is suitable for children by evaluating the likelihood of exposure to illegal and maladaptive behavior.[41] The first step towards benchmarking is transparency and more fair competition in an opaque market.[3] For instance, ethical artificial intelligence (AI) tool kits could help facilitate more open communication among technology developers, researchers, policy makers, and civil society.[3,215] Additionally, public documentation of the provenance of the dataset used to calibrate machine learning models is gaining traction as way to mitigate harms from biased models.[3,216]

NASEM makes a persuasive case that an ongoing technical workgroup to develop industry standards, ideally facilitated by ISO, as well as near uniform industry adoption of the standards in their policies and terms of service would improve privacy protections, improve algorithmic and other transparency, and facilitate a better system of reporting inappropriate content and ill-actors. However, this is new territory and despite the ISO's strong track record of developing complex technical international standards (e.g., information security management and data protection), it is difficult to fully assess if something similar would be an effective tool to regulate social media.[3,202] Aside from the NASEM report proposing such a workgroup, there has been very little tangible movement toward such action.

Recommendations for the Federal Government

Developing and adopting social media industry standards through an ISO facilitated workgroup may be the best way to include social media companies in decisions around developmentally appropriate design particularly given that voluntarily self-regulation in the industry is very limited. A more heavy-handed approach is to improve transparency, privacy protections, and developmentally appropriate social media design through federal legislation. This is further supported by the Surgeon General's Advisory on the effects of social media on youth mental health, which urges federal legislative action to ensure social media environments are healthy and safe, and is also reiterated in his recent call for a warning label on social media platforms.[4,217]

This approach is gaining traction, as evidenced by the numerous federal child online safety bills introduced in 2023 and 2024, including the Kids Online Safety Act, Kids Off Social Media Act, and Protecting Kids on Social Media Act.[218–220] Yet, despite public outcry on the need to regulate

social media companies and relatively strong bipartisan support, none of the proposed legislation has passed. Additionally, critics of the bills raise serious concerns around privacy, surveillance, age-verification, and expansion of control over young people's rights and autonomy, as well as possible First Amendment challenges.[221,222]

An alternate federal legislative approach could be expansion of COPPA. COPPA already imposes certain requirements on operators of websites or online services directed to children under 13 years of age, and on operators of other websites or online services that have actual knowledge that they are collecting personal information online from a child under 13 years of age. Specifically, COPPA recognizes that young children cannot consent to the terms of use for data collection, and thus prohibits enticing personal disclosures through games and restricts advertising to children.[223] When companies violate COPPA by collecting data for children under the age of 13, the FTC can and has issued fines. In 2019, the FTC required Google to pay $170 million for data collection in violation of COPPA.[224] In 2021 and 2023, legislation was introduced to extend COPPA protections to kids through age 16 and also expand the scope (e.g., banning targeted advertising to children, shifting the "actual knowledge" standard to a " reasonably likely to be used by children" standard, establishing a digital marketing bill of rights, and providing tools for parents and children to delete or remove the children's personal information when feasible).[225,226] However, there has been no action on either of the bills as of July 2024.

The FTC also has authority over unfair and deceptive practices in commerce. Therefore, in response to concerns about the erosion of consumer privacy, in particular with data collection and use practices, the FTC has issued guidance documents on internet advertising.[3,227–229] Moreover, there is proposed rulemaking on commercial surveillance and data security.[3,230] Additional guidance and/or revisions from the FTC regarding how to make systems for reporting cases of online harassment and abuse that comply with COPPA would be benefical.[3]

In addition to improving children's privacy and better regulating social media providers through the FTC and COPPA, future children's online safety legislative efforts should focus on: (1) centering young people with developmentally appropriate design; (2) increasing access to mental health resources; (3) improving digital literacy and outreach; (4) improving digital tools tailored to youth users to manage content and access (e.g., turning off autoplay, removing recommended content); (5) reducing the scope of advertising on social media; (6) strong data protections and expanded federal privacy legislation; (7) improved algorithmic, data, and process transparency (e.g., impact audits); and (8) developing support programs for children and adolescents who experience digital abuse and evaluate the effectiveness of such programs.[3,221] Finally, assuming industry leaders do not voluntarily remove the prohibitions in their terms of service on the use of publicly available data for research, Congress could pass legislation to ensure researchers can access data to examine the effects of social media on child and adolescent health.[3]

Recommendations for State and Local Agencies

Increasing concerns about social media use and adolescent health coupled with limited progress on federal legislation to protect children while using the internet and social media has prompted state legislators to propose age- and developmentally-appropriate design measures.[231,232]

As of July 2024, 45 states and Puerto Rico introduced legislation around social media and youth, and 20 states enacted bills or adopted resolutions. Among the recently introduced legislation, the following aspects are the most common: (1) creating study commissions and task forces to evaluate the relationship between social media and adolescent health; (2) establishing age-appropriate design code and requiring impact assessments; (3) requiring age verification and/or parental

consent to open social media accounts; and (4) adding digital and media literacy to K-12 curriculums.[231,233] Time limits, increased data protections (e.g., limitations on what information can be collected, geolocation/biometrics, and dark patterns), advertising restrictions, restrictions on addictive features, parental consent and access, and modification to the default privacy settings are also being included in state level legislation. However, state level legislative attempts also face serious legal challenges. For instance, Utah enacted the Utah Social Media Regulation Act, which requires age verification of state residents and parental consent for those under the age of 18 to open an account.[234] It also limits the hours of access for certain users, subject to parental or guardian direction, and provides for a private right of action. Similarly, Arkansas created the Social Media Safety Act which requires age verification and parental consent for use of social media. It also establishes a mechanism for liability for failure to perform age verification for use of social media and for illegal retention of data.[235] Finally, in 2022, California passed the Age-Appropriate Design Code Act (AADC).[206] Notable obligations under California's AADC include requiring online providers to: (1) configure a high level of default privacy settings; (2) assess whether algorithms, data collection, or targeted advertising systems could harm children; and (3) use clear, age-appropriate language for user-facing information and documents.[232,236] Yet, as is becoming increasingly more common with state legislation that addresses age verification and content moderation, Utah, Arkansas, and California have faced First Amendment challenges from NetChoice, a coalition representing the country's tech companies.[207] Ultimately, Utah repealed and replaced the Utah Social Media Regulation Act with SB 194 and HB 464. SB 194 implements age assurances and is designed to prohibit harmful and addictive product features on social media, protect minors' privacy, and give parents the tools to keep their children safe. Whereas HB 464 holds social media companies accountable by creating a private right of action for harm to minors for an adverse mental health outcome arising from a minor's excessive use of a social media company's algorithmically curated social media service. Similarly, both the Arkansas and California laws are currently enjoined pending decisions by the U.S. District Court in Fayetteville, Arkansas and Ninth Circuit Court of Appeals, respectively.[206,207,237,238]

Developmentally appropriate design legislation is relatively new at the state level, so the overall impacts are unclear. Some aspects like improved data protections, digital media literacy, and continued research are rationally grounded, appear beneficial, and are likely less subject to First Amendment challenges. However, other aspects like age verification and content moderation raise concerns around privacy, surveillance, First Amendment rights, federal preemption, and expansion of control over young people's rights and autonomy.[221,222,239]

Recommendations for Parents and Kids

Parents and children are encouraged to use social media functions that facilitate social support, online companionship, emotional intimacy, and healthy socialization; particularly during periods of isolation, during stress, mental health crisis, and for marginalized groups.[41] To achieve this, it is recommended that families should collectively develop, review, and follow a family media use plan, which should outline developmentally appropriate types, times, methods, places for, and amounts of acceptable media us.[1,2,4,41] For instance, there is evidence of the impact of excessive digital technology use (e.g., screentime, tv, and social media) by adolescents on negative health impacts.[1,2,240] However, there has been a push among researchers to move away from focusing on screentime and instead to consider how, why, when, and with whom youth are engaging online. Despite this, the American Academy of Pediatrics (AAP), APA, and many other organizations and policy makers advocate for screen time limits and media-free time.[1,2] Specifically, it is recommended that adolescents abstain from using screens 1 hour before bed and that adolescents should not sleep with digital devices in their bedrooms.[7,52] Additionally, there is some evidence supporting open, non-judgmental communication between caregivers and children and some degree

of parental monitoring of social media use.[1,2,41,97] Recent surveys suggest roughly 63 percent of adolescents and 70.8 percent of parents reported parental monitoring, and 74.3 percent of adolescents reporting being friends with their parents online.[179] Open communication is helpful for teaching digital literacy, which is necessary for children to understand the limits of "free digital products" that process access in exchange for data on user demographics, politics, mental health, and sexuality generated through engagement and viewing behavior.[50]

Recommendations for Clinicians

It is recommended that clinicians be aware of and talk with children and families about the risks and benefits of social media use.[1–3,107,241] Specifically, communication with adolescents is the most effective in the context of a therapeutic alliance that is open and non-judgmental.[97] Physicians should encourage: (1) setting boundaries for screentime and social media use; (2) discuss the risks and benefits of social media, including impact of smartphones on learning and the importance of digital media literacy; and (3) encourage communication between caregivers and children and advocate use of the Family Media Toolkit and Family Media Use Plan.[1,2,58,60,97]

Recommendations for Training and Education

One way to reduce potential harm to adolescents using social media is through improved digital media literacy. Specifically, it is important to train adolescents and those teaching and advising them skills for assessing and validating information on social media and the internet more broadly.[41,50,60,97,241] Moreover, the approach to digital media literacy needs to be multi-tiered and tailored to children, parents, educators, and clinicians. Specifically, comprehensive digital media literacy should be integrated into the standards set by state boards of education. Moreover, the U.S. Department of Education should draw national attention to the importance of comprehensive digital media literacy.[3] This is necessary to create both an online environment that protects youth and social media consumers who are empowered to protect themselves. Furthermore, educators and clinicians need to be trained in digital media literacy so they can adequately teach and advise adolescents on the risks and benefits of social media.[1–4] This could include incorporation of digital media literacy requirements for licensure as well as ongoing professional development training and resources for both educators and clinicians.[3] In addition to incorporating digital media literacy into training and licensure, additional efforts to improve dissemination of health-related digital media literacy is suggested.[241]

Recommendations for Research

Currently, the research on social media and adolescent health is limited.[3,4] Therefore, federal and non-profit research funders should support a research agenda that prioritizes: (1) the health consequences of social media use and the mechanisms of harm, (2) the epidemiology of problematic use, (3) interventions and other efforts to reduce and remediate harms arising from social media, (4) the role of parents and other adults in influencing positive use, and (5) algorithmic audits.[3,4] There is a need for validated tools to measure exposure to social media affordances, data sharing, and the establishment of long-term cohort studies. Special emphasis should be given to interdisciplinary approaches and study designs that attempt to understand causal directions.

RELEVANT AMA POLICY

The AMA has existing policy that addresses social media and mental health, gun violence, internet pornography, online streaming of sexual encounters, the effects of video game and internet overuse, disinformation, cannabis marketing, and online human subjects' research. In general,

these policies advocate the use of education and legislation to: (1) increase awareness about potential risks associated with social media and internet use; and (2) reduce exposure to harmful content (e.g., gun violence, pornography, disinformation, etc.) particularly for children, adolescents, and young adults. Current policy also supports development and implementation of clinical tools for identification and treatment of harms that arise from exposure as well as continued research into potential harms and the effectiveness of screening and treatment. Detailed information on the current AMA policies can be found in the appendix.

CONCLUSION

Digital media, smartphones, and social media have a pervasive presence in nearly all aspects of youth and adolescent life. Despite substantial research efforts, the evidence is too weak to promote a uniform interpretation of the impact of social media on adolescent health at the population level. There are several factors contributing to the weak evidence including: (1) the reciprocal associations between social media use and health; (2) the lack of consistent and comparable methodologies; (3) entanglement of impact and exposure as a byproduct of social media's ubiquity; (4) different dynamics and trends depending on level of analysis; (5) the wide variety of interactions, behaviors, and health impacts engendered by social media; and (6) reliance on cross-sectional studies with high heterogeneity.

Although the evidence is too weak to provide a uniform interpretation, there are clear positive and negative trends. There is some evidence of potential benefit in the form of improved social support, identity development, civic engagement, and self-directed learning. There is also some evidence of potential harm including negative impacts on sleep, physical activity, and mental health, as well as exposure to inappropriate content, and data privacy issues. Furthermore, it is apparent that the relative risks and benefits of social media likely depend on individual differences in: (1) engagement with social media (e.g., what kids see and do online, who they talk to, when they use social media, and how they use social media); (2) pre-exiting strengths and weaknesses; and (3) the cultural, social, and physical environment.

Even though the evidence of harm is limited there is an urgent need for action for two reasons. First, the lack of algorithmic transparency, privacy protections, and accountability and redress for online harassment on most platforms is concerning given the power, reach, and ubiquity of social media. Second, the potential harms are serious, particularly during sensitive developmental periods; therefore, proactively creating digital environments that protect and enrich children's and adolescents' health and well-being is beneficial regardless of the evidence of harm. There are two key approaches that would likely facilitate the creation of safer, developmentally appropriate environments. First, federal and state legislative action (e.g., expansion of COPPA, implementation of age-appropriate design, and mechanisms to address online harassment), and second, development and widespread adoption of industry standards to benchmark platform operations, transparency, and data use. In addition to improving the digital environment, it is imperative that there are simultaneous efforts to address harms that still arise including: (1) education and training on digital media literacy and the potential harms posed by social media; (2) improved screening and support for those who experience harms (e.g., problematic internet use and online harassment); and (3) continued research of the health impacts of social media.

RECOMMENDATIONS

The Council on Science and Public Health recommends that the following be adopted, and the remainder of the report be filed:

1. That our AMA:

   (1) urges physicians to: (a) educate themselves about social media; (b) be prepared to counsel patients and/or their guardians about the potential risks and harms of social media; and (c) consider expanding clinical interviews to inquire about social media use;
   (2) encourages further clinical, epidemiological, and interdisciplinary research on the impact of social media on health;
   (3) supports education of clinicians, educators, and the public on digital media literacy and the health effects of social media;
   (4) recognizes that the relative risks and benefits of social media may depend on individual differences (e.g., social media engagement, pre-existing traits, and environment);
   (5) supports legislative, regulatory, and associated initiatives that, at a minimum, provide youth with strong data privacy protections, require platforms to be designed to align with child development, and provide transparency into the potential harms posed by platforms to young people and any steps taken to mitigate those harms; and
   (6) will collaborate with professional societies, industry, and other stakeholders to improve social media platform privacy protections, transparency (e.g., algorithmic, data, and process), data sharing processes, and systems for accountability and redress in response to online harassment. (New HOD Policy)

2. That current AMA policy D-478.965, "Addressing Social Media and Social Networking Usage and its Impacts on Mental Health" be amended by addition and deletion to read as follows:

   Our AMA: (1) will collaborate with relevant professional organizations to: (a) support the development of continuing education programs to enhance physicians' knowledge of the health impacts of social media and social networking usage; and (b) support the development of effective clinical tools and protocols for the identification, treatment, and referral of children, adolescents, and adults at risk for and experiencing health sequelae of social media and social networking usage; (2) advocates for schools to provide safe and effective educational programs ~~by which~~ so that (a) all students can learn to identify and mitigate the onset of mental health sequelae of social media and social networking usage, and (b) all students develop skills in digital literacy to serve as an individual protective foundation for interaction with various types of digital media (including social media); (3) affirms that use of social media and social networking has the potential to positively or negatively impact the physical and mental health of individuals, especially adolescents and those with preexisting psychosocial conditions; (4) advocates for and support media and social networking services addressing and developing safeguards tailored to youth users, including ensuring robust protections for youth online privacy, providing effective tools to manage screentime content and access, and promoting the development and dissemination of age-appropriate digital literacy training; and (5) advocates for the study of the positive and negative biological, psychological, and social effects of social media and social networking services use. (Modify Current HOD Policy)

Fiscal Note: $5,000 - $10,000

APPENDIX: Relevant AMA Policy

Addressing Social Media and Social Networking Usage and its Impacts on Mental Health D-478.965
Our AMA: (1) will collaborate with relevant professional organizations to: (a) support the development of continuing education programs to enhance physicians' knowledge of the health impacts of social media and social networking usage; and (b) support the development of effective clinical tools and protocols for the identification, treatment, and referral of children, adolescents, and adults at risk for and experiencing health sequelae of social media and social networking usage; (2) advocates for schools to provide safe and effective educational programs by which students can learn to identify and mitigate the onset of mental health sequelae of social media and social networking usage; (3) affirms that use of social media and social networking has the potential to positively or negatively impact the physical and mental health of individuals, especially adolescents and those with preexisting psychosocial conditions; (4) advocates for and support media and social networking services addressing and developing safeguards for users; and (5) advocates for the study of the positive and negative biological, psychological, and social effects of social media and social networking services use.

Minimizing the Influence of Social Media on Gun Violence H-478.977
1. Our American Medical Association calls upon all social media sites that allow posting of videos, photographs, and written online comments encouraging and glorifying the use of guns and gun violence to vigorously and aggressively remove such postings.
2. Our AMA strongly recommends social media sites continuously update and monitor their algorithms in order to detect and eliminate any information that discusses and displays guns and gun violence in a way that encourages viewers to act violently.
3. Our AMA will work with social media sites to provide educational content on the use of guns, inherent dangers, and gun safety in an effort to end the ongoing and devastating effects of gun violence in our communities.

Internet Pornography: Protecting Children and Youth Who Use the Internet and Social Media H-60.934
Our AMA:
(1) Recognizes the positive role of the Internet in providing health information to children and youth.
(2) Recognizes the negative role of the Internet in connecting children and youth to predators and exposing them to pornography.
(3) Supports federal legislation that restricts Internet access to pornographic materials in designated public institutions where children and youth may use the Internet.
(4) Encourages physicians to continue efforts to raise parent/guardian awareness about the importance of educating their children about safe Internet and social media use.
(5) Supports school-based media literacy programs that teach effective thinking, learning, and safety skills related to Internet and social media use.
(6) Actively support legislation that would strengthen child-centric content protection by internet service providers and/or search engines in order to limit the access of pornography to minors on the internet and mobile applications.

Addressing Public Health Disinformation Disseminated by Health Professionals D-440.914
Our AMA will collaborate with relevant health professional societies and other stakeholders:
(a) on efforts to combat public health disinformation disseminated by health professionals in all forms of media,
(b) address disinformation that undermines public health initiatives, and

(c) implement a comprehensive strategy to address health-related disinformation disseminated by health professionals that includes:
(1) Maintaining AMA as a trusted source of evidence-based information for physicians and patients.
(2) Ensuring that evidence-based medical and public health information is accessible by engaging with publishers, research institutions and media organizations to develop best practices around paywalls and preprints to improve access to evidence-based information and analysis.
(3) Addressing disinformation disseminated by health professionals via social media platforms and addressing the monetization of spreading disinformation on social media platforms.
(4) Educating health professionals and the public on how to recognize disinformation as well as how it spreads.
(5) Considering the role of health professional societies in serving as appropriate fact-checking entities for health-related information disseminated by various media platforms.
(6) Encouraging continuing education to be available for health professionals who serve as fact-checker to help prevent the dissemination of health-related disinformation.
(7) Ensuring licensing boards have the authority to take disciplinary action against health professionals for spreading health-related disinformation and affirms that all speech in which a health professional is utilizing their credentials is professional conduct and can be scrutinized by their licensing entity.
(8) Ensuring specialty boards have the authority to take action against board certification for health professionals spreading health-related disinformation.
(9) Encouraging state and local medical societies to engage in dispelling disinformation in their jurisdictions.

Television Broadcast and Online Streaming of Sexual Encounters and Public Health Awareness on Social Media Platforms H-485.994
Our AMA urges television broadcasters and online streaming services, producers, sponsors, and any associated social media outlets to encourage education about 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.
Medical and Public Health Misinformation Online D-440.915
Our AMA:
(1) encourages social media companies and organizations, search engine companies, online retail companies, online healthcare companies, and other entities owning websites to further strengthen their content moderation policies related to medical and public health misinformation, including, but not limited to enhanced content monitoring, augmentation of recommendation engines focused on false information, and stronger integration of verified health information;
(2) encourages social media companies and organizations, search engine companies, online retail companies, online healthcare companies, and other entities owning websites to recognize the spread of medical and public health misinformation over dissemination networks and collaborate with relevant stakeholders to address this problem as appropriate, including but not limited to altering underlying network dynamics or redesigning platform algorithms;
(3) will continue to support the dissemination of accurate medical and public health information by public health organizations and health policy experts; and
(4) will work with public health agencies in an effort to establish relationships with journalists and news agencies to enhance the public reach in disseminating accurate medical and public health information.

Marketing Guardrails for the "Over-Medicalization" of Cannabis Use D-95.958
Our AMA will: (1) send a formal letter to the Food and Drug Administration and Federal Trade Commission requesting more direct oversight of the marketing of cannabis for medical use; (2)

generate a formal letter for use by state medical societies requesting more direct oversight by state government of the marketing of cannabis; (3) support and encourage federal, state, and private sector research on the effects of cannabis marketing to identify best practices in protecting vulnerable populations, as well as the benefits of safety campaigns such as preventing impaired driving or dangerous use; (4) encourage state regulatory bodies to enforce cannabis-related marketing laws and to publicize and make publicly available the results of such enforcement activities; (5) encourage social media platforms to set a threshold age of 21 years for exposure to cannabis advertising and marketing and improve age verification practices on social media platforms; (6) encourage regulatory agencies to research how marketing best practices learned from tobacco and alcohol policies can be adopted or applied to cannabis marketing; and (7) support using existing AMA channels to educate physicians and the public on the health risks of cannabis to children and potential health risks of cannabis to people who are pregnant or lactating.

Principles of Human Subjects Research Shall Apply to Online Medical Research Projects H-460.898
Our American Medical Association declares social media sites' terms of service as an insufficient proxy for informed consent prior to being enrolled in any medical experiment and recommends that online social networks provide users with specific informed consent outlining the aims, risks and possible benefits of any medical experimental study prior to study enrollment.

Emotional and Behavioral Effects of Video Game and Internet Overuse H-60.915
Our AMA supports increased awareness of the need for parents to monitor and restrict use of video games and the Internet and encourage increased vigilance in monitoring the content of games purchased and played for children 17 years old and younger.

REFERENCES

1. Reid Chassiakos Y (Linda), Radesky J, Christakis D, et al. Children and Adolescents and Digital Media. *Pediatrics*. 2016;138(5):e20162593. doi:10.1542/peds.2016-2593
2. AAP Council on Communication and Media. Media Use in School-Aged Children and Adolescents. *Pediatrics*. 2016;138(5):e20162592. doi:10.1542/peds.2016-2592
3. Committee on the Impact of Social Media on Adolescent Health, Board on Population Health and Public Health Practice, Health and Medicine Division, National Academies of Sciences, Engineering, and Medicine. *Social Media and Adolescent Health*. (Galea S, Buckley GJ, Wojtowicz A, eds.). National Academies Press; 2023:27396. doi:10.17226/27396
4. *Social Media and Youth Mental Health*. U.S. Surgeon General's Advisory; 2023. https://www.hhs.gov/sites/default/files/sg-youth-mental-health-social-media-advisory.pdf
5. American Psychological Association Health Advisory on Social Media Use in Adolescence.
6. Prinstein MJ, Nesi J, Telzer EH. Commentary: An updated agenda for the study of digital media use and adolescent development – future directions following Odgers & Jensen (2020). *J Child Psychol Psychiatry*. 2020;61(3):349-352. doi:10.1111/jcpp.13219
7. Weinstein E. The social media see-saw: Positive and negative influences on adolescents' affective well-being. *New Media Soc*. 2018;20(10):3597-3623. doi:10.1177/1461444818755634
8. George M. The Importance of Social Media Content for Teens' Risks for Self-harm. *J Adolesc Health*. 2019;65(1):9-10. doi:10.1016/j.jadohealth.2019.04.022
9. Hamilton JL, Nesi J, Choukas-Bradley S. Reexamining Social Media and Socioemotional Well-Being Among Adolescents Through the Lens of the COVID-19 Pandemic: A Theoretical Review and Directions for Future Research. *Perspect Psychol Sci*. 2022;17(3):662-679. doi:10.1177/17456916211014189
10. Social media and the internet. https://www.apa.org. Accessed February 14, 2024. https://www.apa.org/topics/social-media-internet
11. Treem JW, Leonardi PM. Social Media Use in Organizations: Exploring the Affordances of Visibility, Editability, Persistence, and Association. *Ann Int Commun Assoc*. 2013;36(1):143-189. doi:10.1080/23808985.2013.11679130
12. Boyd D. Social network sites as networked publics: Affordances, dynamics, and implications. In: *A Networked Self*. Routledge; 2010:47-66.
13. Sharma D, Saha B, Sarkar UK. Affordance Lost, Affordance Regained, and Affordance Surrendered. In: Introna L, Kavanagh D, Kelly S, Orlikowski W, Scott S, eds. *Beyond Interpretivism? New Encounters with Technology and Organization*. IFIP Advances in Information and Communication Technology. Springer International Publishing; 2016:73-89. doi:10.1007/978-3-319-49733-4_5
14. Moreno MA, Uhls YT. Applying an affordances approach and a developmental lens to approach adolescent social media use. *Digit Health*. 2019;5:205520761982667. doi:10.1177/2055207619826678
15. Angwin J, Parris T. Facebook Lets Advertisers Exclude Users by Race. ProPublica. October 28, 2016. Accessed February 13, 2024. https://www.propublica.org/article/facebook-lets-advertisers-exclude-users-by-race
16. Angwin J, Tobin A, Varner M. Facebook (Still) Letting Housing Advertisers Exclude Users by Race. ProPublica. November 21, 2017. Accessed February 14, 2024. https://www.propublica.org/article/facebook-advertising-discrimination-housing-race-sex-national-origin
17. Hern A, editor AHT. TikTok's local moderation guidelines ban pro-LGBT content. *The Guardian*. https://www.theguardian.com/technology/2019/sep/26/tiktoks-local-moderation-guidelines-ban-pro-lgbt-content. September 26, 2019. Accessed February 13, 2024.
18. Gillespie T. Do not recommend? Reduction as a form of content moderation. *Soc Media Soc*. 2022;8(3):20563051221117552.

19. Foss-Solbrekk K. Three routes to protecting AI systems and their algorithms under IP law: The good, the bad and the ugly. *J Intellect Prop Law Pract*. 2021;16(3):247-258. doi:10.1093/jiplp/jpab033
20. Waddell K. Tech Companies Too Secretive About Algorithms That Curate Feeds, Study Says. Consumer Reports. February 24, 2021. Accessed February 13, 2024. https://www.consumerreports.org/consumer-protection/tech-companies-too-secretive-about-algorithms-that-curate-feeds-a8134259964/
21. Gorwa R, Binns R, Katzenbach C. Algorithmic content moderation: Technical and political challenges in the automation of platform governance. *Big Data Soc*. 2020;7(1):2053951719897945. doi:10.1177/2053951719897945
22. Eslami M, Rickman A, Vaccaro K, et al. "I always assumed that I wasn't really that close to [her]": Reasoning about Invisible Algorithms in News Feeds. In: *Proceedings of the 33rd Annual ACM Conference on Human Factors in Computing Systems*. CHI '15. Association for Computing Machinery; 2015:153-162. doi:10.1145/2702123.2702556
23. Brugnoli E, Cinelli M, Quattrociocchi W, Scala A. Recursive patterns in online echo chambers. *Sci Rep*. 2019;9(1):20118. doi:10.1038/s41598-019-56191-7
24. Dow BJ, Johnson AL, Wang CS, Whitson J, Menon T. The COVID-19 pandemic and the search for structure: Social media and conspiracy theories. *Soc Personal Psychol Compass*. 2021;15(9):e12636. doi:10.1111/spc3.12636
25. Robins-Early N. There's a reason thousands of people take quack cures for Covid. *The Guardian*. https://www.theguardian.com/commentisfree/2022/feb/17/quacks-cashed-in-world-quick-fix-covid-ivermectin-social-media-conspiracy-theories. February 17, 2022. Accessed February 13, 2024.
26. Caplan SE. Theory and measurement of generalized problematic Internet use: A two-step approach. *Comput Hum Behav*. 2010;26(5):1089-1097. doi:10.1016/j.chb.2010.03.012
27. McSherry C. Content Moderation and the U.S. Election: What to Ask, What to Demand. Electronic Frontier Foundation. October 26, 2020. Accessed February 13, 2024. https://www.eff.org/deeplinks/2020/10/content-moderation-and-us-election-what-ask-what-demand
28. Edelman G. Better Than Nothing: A Look at Content Moderation in 2020 | WIRED. WIRED. October 27, 2020. Accessed February 13, 2024. https://www.wired.com/story/content-moderation-2020-better-than-nothing/
29. Lima-Strong C. A whistleblower's power: Key takeaways from the Facebook Papers. *The Washington Post*. https://www.washingtonpost.com/technology/2021/10/25/what-are-the-facebook-papers/. October 25, 2021. Accessed February 13, 2024.
30. Dwoskin E, Newmyer T, Mahtani S. The case against Mark Zuckerberg: Insiders say Facebook's CEO chose growth over safety. *The Washington Post*. https://www.washingtonpost.com/technology/2021/10/25/mark-zuckerberg-facebook-whistleblower/. October 25, 2021. Accessed February 13, 2024.
31. Silverman MH, Jedd K, Luciana M. Neural networks involved in adolescent reward processing: An activation likelihood estimation meta-analysis of functional neuroimaging studies. *NeuroImage*. 2015;122:427-439. doi:10.1016/j.neuroimage.2015.07.083
32. Spear LP. Rewards, aversions and affect in adolescence: Emerging convergences across laboratory animal and human data. *Dev Cogn Neurosci*. 2011;1(4):390-403. doi:10.1016/j.dcn.2011.08.001
33. Wahlstrom D, Collins P, White T, Luciana M. Developmental changes in dopamine neurotransmission in adolescence: Behavioral implications and issues in assessment. *Brain Cogn*. 2010;72(1):146-159. doi:10.1016/j.bandc.2009.10.013
34. Giedd JN. Adolescent brain and the natural allure of digital media. *Dialogues Clin Neurosci*. 2020;22(2):127-133. doi:10.31887/DCNS.2020.22.2/jgiedd
35. Nelson EE, Jarcho JM, Guyer AE. Social re-orientation and brain development: An expanded and updated view. *Dev Cogn Neurosci*. 2016;17:118-127. doi:10.1016/j.dcn.2015.12.008

36. Committee on the Neurobiological and Socio-behavioral Science of Adolescent Development and Its Applications, Board on Children, Youth, and Families, Division of Behavioral and Social Sciences and Education, Health and Medicine Division, National Academies of Sciences, Engineering, and Medicine. *The Promise of Adolescence: Realizing Opportunity for All Youth*. (Bonnie RJ, Backes EP, eds.). National Academies Press; 2019:25388. doi:10.17226/25388
37. Giovanelli A, Ozer EM, Dahl RE. Leveraging Technology to Improve Health in Adolescence: A Developmental Science Perspective. *J Adolesc Health*. 2020;67(2):S7-S13. doi:10.1016/j.jadohealth.2020.02.020
38. Fuhrmann D, Knoll LJ, Blakemore SJ. Adolescence as a Sensitive Period of Brain Development. *Trends Cogn Sci*. 2015;19(10):558-566. doi:10.1016/j.tics.2015.07.008
39. Crone EA, Konijn EA. Media use and brain development during adolescence. *Nat Commun*. 2018;9(1):588. doi:10.1038/s41467-018-03126-x
40. Sawyer SM, Azzopardi PS, Wickremarathne D, Patton GC. The age of adolescence. *Lancet Child Adolesc Health*. 2018;2(3):223-228. doi:10.1016/S2352-4642(18)30022-1
41. *Health Advisory on Social Media Use in Adolescence*. American Psychological Association; 2023. Accessed February 18, 2024. https://www.apa.org/topics/social-media-internet/health-advisory-adolescent-social-media-use.pdf
42. Maza MT, Fox KA, Kwon SJ, et al. Association of Habitual Checking Behaviors on Social Media With Longitudinal Functional Brain Development. *JAMA Pediatr*. 2023;177(2):160. doi:10.1001/jamapediatrics.2022.4924
43. Wadsley M, Ihssen N. A Systematic Review of Structural and Functional MRI Studies Investigating Social Networking Site Use. *Brain Sci*. 2023;13(5):787. doi:10.3390/brainsci13050787
44. Subrahmanyam K, Šmahel D. Adolescents' Digital Worlds: An Introduction. In: Subrahmanyam K, Smahel D, eds. *Digital Youth: The Role of Media in Development*. Advancing Responsible Adolescent Development. Springer; 2011:1-25. doi:10.1007/978-1-4419-6278-2_1
45. Valkenburg PM, Schouten AP, Peter J. Adolescents' identity experiments on the internet. *New Media Soc*. 2005;7(3):383-402. doi:10.1177/1461444805052282
46. Hollarek M, Lee NC. Current understanding of developmental changes in adolescent perspective taking. *Curr Opin Psychol*. 2022;45:101308. doi:10.1016/j.copsyc.2022.101308
47. Sherman LE, Greenfield PM. Forging friendship, soliciting support: A mixed-method examination of message boards for pregnant teens and teen mothers. *Comput Hum Behav*. 2013;29(1):75-85. doi:10.1016/j.chb.2012.07.018
48. Eleuteri S, Saladino V, Verrastro V. Identity, relationships, sexuality, and risky behaviors of adolescents in the context of social media. *Sex Relatsh Ther*. 2017;32(3-4):354-365. doi:10.1080/14681994.2017.1397953
49. Orben A, Przybylski AK, Blakemore SJ, Kievit RA. Windows of developmental sensitivity to social media. *Nat Commun*. 2022;13(1):1649. doi:10.1038/s41467-022-29296-3
50. Radesky J, Chassiakos Y (Linda) R, Ameenuddin N, Navsaria D, COUNCIL ON COMMUNICATION AND MEDIA. Digital Advertising to Children. *Pediatrics*. 2020;146(1):e20201681. doi:10.1542/peds.2020-1681
51. Vogels EA, Rainie L, Nolan H. *Teens, Social Media and Technology 2022*. Pew Research Center Accessed February 17, 2024. https://www.pewresearch.org/internet/2022/08/10/teens-social-media-and-technology-2022/
52. Lenhart A. Teens and Social Media: An Overview. Pew Research Center: Internet, Science & Tech. April 10, 2009. Accessed February 13, 2024. https://www.pewresearch.org/internet/2009/04/10/teens-and-social-media-an-overview/
53. Rideout V, Peebles A, Mann S, Robb M. *The Common Sense Census: Media Use by Tweens and Teens*. Common Sense Media; 2021. Accessed February 13, 2024. https://apo.org.au/node/58360

54. Anderson M, Vogels EA, Perrin A, Rainie L. *Connection, Creativity and Drama: Teen Life on Social Media in 2022*. Pew Research Center; 2022. Accessed February 13, 2024. https://www.pewresearch.org/internet/2022/11/16/connection-creativity-and-drama-teen-life-on-social-media-in-2022/
55. Hancock JT, Liu SX, Luo M, Mieczkowski H. Social media and psychological well-being. In: *The Psychology of Technology: Social Science Research in the Age of Big Data*. American Psychological Association; 2022:195-238. doi:10.1037/0000290-007
56. Jarman HK, Marques MD, McLean SA, Slater A, Paxton SJ. Motivations for Social Media Use: Associations with Social Media Engagement and Body Satisfaction and Well-Being among Adolescents. *J Youth Adolesc*. 2021;50(12):2279-2293. doi:10.1007/s10964-020-01390-z
57. Shankleman M, Hammond L, Jones FW. Adolescent Social Media Use and Well-Being: A Systematic Review and Thematic Meta-synthesis. *Adolesc Res Rev*. 2021;6(4):471-492. doi:10.1007/s40894-021-00154-5
58. O'Reilly M. Social media and adolescent mental health: the good, the bad and the ugly. *J Ment Health*. 2020;29(2):200-206. doi:10.1080/09638237.2020.1714007
59. Allen KA, Ryan T, Gray DL, McInerney DM, Waters L. Social Media Use and Social Connectedness in Adolescents: The Positives and the Potential Pitfalls. *Aust Educ Dev Psychol*. 2014;31(1):18-31. doi:10.1017/edp.2014.2
60. Uhls YT, Ellison NB, Subrahmanyam K. Benefits and Costs of Social Media in Adolescence. *Pediatrics*. 2017;140(Supplement_2):S67-S70. doi:10.1542/peds.2016-1758E
61. Scott RA, Stuart J, Barber BL. Connecting with close friends online: A qualitative analysis of young adults' perceptions of online and offline social interactions with friends. *Comput Hum Behav Rep*. 2022;7:100217. doi:10.1016/j.chbr.2022.100217
62. Lenhart A, Smith A, Anderson M, Duggan M, Perrin A. *Teens, Technology & Friendships*. Pew Research Center; 2015. Accessed February 17, 2024. https://www.pewresearch.org/internet/2015/08/06/teens-technology-and-friendships/
63. Nesi J, Mann S, Robb MB. *Teens and Mental Health: How Girls Really Feel about Social Media*. Common Sense; 2023. https://www.commonsensemedia.org/sites/default/files/research/report/how-girls-really-feel-about-social-media-researchreport_final_1.pdf
64. Liu D, Ainsworth SE, Baumeister RF. A meta-analysis of social networking online and social capital. *Rev Gen Psychol*. 2016;20(4):369-391.
65. Sallafranque-St-Louis F, Normand CL. From solitude to solicitation: How people with intellectual disability or autism spectrum disorder use the internet. *Cyberpsychology J Psychosoc Res Cyberspace*. 2017;11(1). doi:10.5817/CP2017-1-7
66. Sofka C. Grief, Adolescents, and Social Media. In: *Understanding Child and Adolescent Grief*. Routledge; 2017.
67. Sage M, Jackson S. A Systematic Review of Internet Communication Technology Use by Youth in Foster Care. *Child Adolesc Soc Work J*. 2022;39(4):375-390. doi:10.1007/s10560-021-00738-z
68. Chou W ying S, Moskowitz M. Social media use in adolescent and young adult (AYA) cancer survivors. *Curr Opin Psychol*. 2016;9:88-91. doi:10.1016/j.copsyc.2016.01.003
69. Daniels SR, Yang CC, Toohey SJ, Willard VW. Perspectives on Social Media from Adolescents and Young Adults with Cancer. *J Pediatr Oncol Nurs*. 2021;38(4):225-232. doi:10.1177/1043454221992319
70. Naslund JA, Aschbrenner KA, Marsch LA, Bartels SJ. The future of mental health care: peer-to-peer support and social media. *Epidemiol Psychiatr Sci*. 2016;25(2):113-122. doi:10.1017/S2045796015001067
71. Hoffner CA, Bond BJ. Parasocial relationships, social media, & well-being. *Curr Opin Psychol*. 2022;45:101306. doi:10.1016/j.copsyc.2022.101306

72. Berger MN, Taba M, Marino JL, Lim MSC, Skinner SR. Social Media Use and Health and Well-being of Lesbian, Gay, Bisexual, Transgender, and Queer Youth: Systematic Review. *J Med Internet Res*. 2022;24(9):e38449. doi:10.2196/38449
73. Jenzen O. LGBTQ Youth Cultures and Social Media. In: *Oxford Research Encyclopedia of Communication*. ; 2022. doi:10.1093/acrefore/9780190228613.013.1363
74. Kaniuka A, Pugh KC, Jordan M, et al. Stigma and suicide risk among the LGBTQ population: Are anxiety and depression to blame and can connectedness to the LGBTQ community help? *J Gay Lesbian Ment Health*. 2019;23(2):205-220. doi:10.1080/19359705.2018.1560385
75. Han X, Han W, Qu J, Li B, Zhu Q. What happens online stays online? —— Social media dependency, online support behavior and offline effects for LGBT. *Comput Hum Behav*. 2019;93:91-98. doi:10.1016/j.chb.2018.12.011
76. Selkie E, Adkins V, Masters E, Bajpai A, Shumer D. Transgender Adolescents' Uses of Social Media for Social Support. *J Adolesc Health*. 2020;66(3):275-280. doi:10.1016/j.jadohealth.2019.08.011
77. Escobar-Viera CG, Choukas-Bradley S, Sidani J, Maheux AJ, Roberts SR, Rollman BL. Examining Social Media Experiences and Attitudes Toward Technology-Based Interventions for Reducing Social Isolation Among LGBTQ Youth Living in Rural United States: An Online Qualitative Study. *Front Digit Health*. 2022;4. Accessed February 13, 2024. https://www.frontiersin.org/journals/digital-health/articles/10.3389/fdgth.2022.900695
78. Bowins B. Social connectedness. *States Process Ment Health*. Published online 2021:41-48.
79. Zhou Z, Cheng Q. Relationship between online social support and adolescents' mental health: A systematic review and meta-analysis. *J Adolesc*. 2022;94(3):281-292. doi:10.1002/jad.12031
80. Kim Y, Kim B, Hwang HS, Lee D. Social media and life satisfaction among college students: A moderated mediation model of SNS communication network heterogeneity and social self-efficacy on satisfaction with campus life. *Soc Sci J*. 2020;57(1):85-100. doi:10.1016/j.soscij.2018.12.001
81. Nesi J. The Impact of Social Media on Youth Mental Health: Challenges and Opportunities. *N C Med J*. 2020;81(2):116-121. doi:10.18043/ncm.81.2.116
82. Spies Shapiro LA, Margolin G. Growing Up Wired: Social Networking Sites and Adolescent Psychosocial Development. *Clin Child Fam Psychol Rev*. 2014;17(1):1-18. doi:10.1007/s10567-013-0135-1
83. Dennen VP, Choi H, Word K. Social media, teenagers, and the school context: a scoping review of research in education and related fields. *Educ Technol Res Dev*. 2020;68(4):1635-1658. doi:10.1007/s11423-020-09796-z
84. Michikyan M, Suárez-Orozco C. Adolescent Media and Social Media Use: Implications for Development. *J Adolesc Res*. 2016;31(4):411-414. doi:10.1177/0743558416643801
85. Bell BT. "You take fifty photos, delete forty nine and use one": A qualitative study of adolescent image-sharing practices on social media. *Int J Child-Comput Interact*. 2019;20:64-71. doi:10.1016/j.ijcci.2019.03.002
86. Chen J, Lin CH, Chen G. A cross-cultural perspective on the relationships among social media use, self-regulated learning and adolescents' digital reading literacy. *Comput Educ*. 2021;175:104322. doi:10.1016/j.compedu.2021.104322
87. Galvin S, Greenhow C. Writing on Social Media: a Review of Research in the High School Classroom. *TechTrends*. 2020;64(1):57-69. doi:10.1007/s11528-019-00428-9
88. Gil Quintana J, Osuna-Acedo S. Transmedia Practices and Collaborative Strategies in Informal Learning of Adolescents. *Soc Sci*. 2020;9(6):92. doi:10.3390/socsci9060092
89. Cho A, Byrne J, Pelter Z. *Digital Civic Engagement by Young People*. UNICEF Office of Global Insight and Policy
90. Boulianne S, Theocharis Y. Young People, Digital Media, and Engagement: A Meta-Analysis of Research. *Soc Sci Comput Rev*. 2020;38(2):111-127. doi:10.1177/0894439318814190

91. Baskin-Sommers A, Simmons C, Conley M, et al. Adolescent civic engagement: Lessons from Black Lives Matter. *Proc Natl Acad Sci*. 2021;118(41):e2109860118. doi:10.1073/pnas.2109860118
92. Daiute C. Adolescent civic engagement in contemporary political and technological realities. *Handb Adolesc Dev Res Its Impact Glob Policy*. Published online 2018:84.
93. Balkin JM. How to Regulate (and Not Regulate) Social Media.
94. Hamm MP, Shulhan J, Williams G, Milne A, Scott SD, Hartling L. A systematic review of the use and effectiveness of social media in child health. *BMC Pediatr*. 2014;14(1):138. doi:10.1186/1471-2431-14-138
95. Plaisime M, Robertson-James C, Mejia L, Núñez A, Wolf J, Reels S. Social Media and Teens: A Needs Assessment Exploring the Potential Role of Social Media in Promoting Health. *Soc Media Soc*. 2020;6(1):205630511988602. doi:10.1177/2056305119886025
96. Wang ML, Togher K. Health Misinformation on Social Media and Adolescent Health. *JAMA Pediatr*. 2024;178(2):109-110. doi:10.1001/jamapediatrics.2023.5282
97. Abi-Jaoude E, Naylor KT, Pignatiello A. Smartphones, social media use and youth mental health. *Can Med Assoc J*. 2020;192(6):E136-E141. doi:10.1503/cmaj.190434
98. Park J, Hallman J, Liu XS, Hancock J. Black representation in social media well-being research: A scoping review of social media experience and psychological well-being among Black users in the United States. *New Media Soc*. Published online August 28, 2023:14614448231191542. doi:10.1177/14614448231191542
99. Alhajji M, Bass S, Dai T. Cyberbullying, Mental Health, and Violence in Adolescents and Associations With Sex and Race: Data From the 2015 Youth Risk Behavior Survey. *Glob Pediatr Health*. 2019;6:2333794X19868887. doi:10.1177/2333794X19868887
100. Hamm MP, Newton AS, Chisholm A, et al. Prevalence and Effect of Cyberbullying on Children and Young People: A Scoping Review of Social Media Studies. *JAMA Pediatr*. 2015;169(8):770-777. doi:10.1001/jamapediatrics.2015.0944
101. Machackova H. Bystander reactions to cyberbullying and cyberaggression: individual, contextual, and social factors. *Curr Opin Psychol*. 2020;36:130-134. doi:10.1016/j.copsyc.2020.06.003
102. You L, Lee YH. The bystander effect in cyberbullying on social network sites: Anonymity, group size, and intervention intentions. *Telemat Inform*. 2019;45:101284. doi:10.1016/j.tele.2019.101284
103. Kuss DJ, Kristensen AM, Williams AJ, Lopez-Fernandez O. To Be or Not to Be a Female Gamer: A Qualitative Exploration of Female Gamer Identity. *Int J Environ Res Public Health*. 2022;19(3):1169. doi:10.3390/ijerph19031169
104. McLean L, Griffiths MD. Female Gamers' Experience of Online Harassment and Social Support in Online Gaming: A Qualitative Study. *Int J Ment Health Addict*. 2019;17(4):970-994. doi:10.1007/s11469-018-9962-0
105. Giumetti GW, Kowalski RM. Cyberbullying via social media and well-being. *Curr Opin Psychol*. 2022;45:101314. doi:10.1016/j.copsyc.2022.101314
106. Przybylski AK, Bowes L. Cyberbullying and adolescent well-being in England: a population-based cross-sectional study. *Lancet Child Adolesc Health*. 2017;1(1):19-26. doi:10.1016/S2352-4642(17)30011-1
107. Bozzola E, Spina G, Agostiniani R, et al. The Use of Social Media in Children and Adolescents: Scoping Review on the Potential Risks. *Int J Environ Res Public Health*. 2022;19(16):9960. doi:10.3390/ijerph19169960
108. Robb M, Mann S. *2022 Teens and Pornography*. Common Sense Media
109. Miller BC. Fact or Phallus? Considering the Constitutionality of Texas's Cyber-Flashing Law under the True Threat Doctrine. *Tex AM Law Rev*. 2020;8:423.

110. Ringrose J, Regehr K, Whitehead S. Teen Girls' Experiences Negotiating the Ubiquitous Dick Pic: Sexual Double Standards and the Normalization of Image Based Sexual Harassment. *Sex Roles*. 2021;85(9):558-576. doi:10.1007/s11199-021-01236-3
111. Salerno-Ferraro AC, Erentzen C, Schuller RA. Young Women's Experiences With Technology-Facilitated Sexual Violence From Male Strangers. *J Interpers Violence*. 2022;37(19-20):NP17860-NP17885. doi:10.1177/08862605211030018
112. Howard PN, Neudert LM, Prakash N, Vosloo S. Digital misinformation / disinformation and children.
113. Aïmeur E, Amri S, Brassard G. Fake news, disinformation and misinformation in social media: a review. *Soc Netw Anal Min*. 2023;13(1):30. doi:10.1007/s13278-023-01028-5
114. Shu K, Bhattacharjee A, Alatawi F, et al. Combating disinformation in a social media age. *WIREs Data Min Knowl Discov*. 2020;10(6):e1385. doi:10.1002/widm.1385
115. Fake news shared on social media U.S. Statista. Accessed March 18, 2024. https://www.statista.com/statistics/657111/fake-news-sharing-online/
116. Breakstone J, Smith M, Wineburg S, et al. Students' Civic Online Reasoning: A National Portrait. Accessed March 19, 2024. https://purl.stanford.edu/gf151tb4868
117. Nagata JM, Abdel Magid HS, Pettee Gabriel K. Screen Time for Children and Adolescents During the Coronavirus Disease 2019 Pandemic. *Obesity*. 2020;28(9):1582-1583. doi:10.1002/oby.22917
118. Brautsch LAS, Lund L, Andersen MM, Jennum PJ, Folker AP, Andersen S. Digital media use and sleep in late adolescence and young adulthood: A systematic review. *Sleep Med Rev*. 2023;68:101742. doi:10.1016/j.smrv.2022.101742
119. Exelmans L, Van den Bulck J. Bedtime mobile phone use and sleep in adults. *Soc Sci Med*. 2016;148:93-101. doi:10.1016/j.socscimed.2015.11.037
120. Peracchia S, Curcio G. Exposure to video games: effects on sleep and on post-sleep cognitive abilities. A sistematic review of experimental evidences. *Sleep Sci*. 2018;11(4):302-314. doi:10.5935/1984-0063.20180046
121. Hale L, Li X, Hartstein LE, LeBourgeois MK. Media Use and Sleep in Teenagers: What Do We Know? *Curr Sleep Med Rep*. 2019;5(3):128-134. doi:10.1007/s40675-019-00146-x
122. Chang AM, Aeschbach D, Duffy JF, Czeisler CA. Evening use of light-emitting eReaders negatively affects sleep, circadian timing, and next-morning alertness. *Proc Natl Acad Sci*. 2015;112(4):1232-1237. doi:10.1073/pnas.1418490112
123. Hamilton JL, Lee W. Associations Between Social Media, Bedtime Technology Use Rules, and Daytime Sleepiness Among Adolescents: Cross-sectional Findings From a Nationally Representative Sample. *JMIR Ment Health*. 2021;8(9):e26273. doi:10.2196/26273
124. LeBourgeois MK, Hale L, Chang AM, Akacem LD, Montgomery-Downs HE, Buxton OM. Digital Media and Sleep in Childhood and Adolescence. *Pediatrics*. 2017;140(Supplement_2):S92-S96. doi:10.1542/peds.2016-1758J
125. Cain N, Gradisar M. Electronic media use and sleep in school-aged children and adolescents: A review. *Sleep Med*. 2010;11(8):735-742. doi:10.1016/j.sleep.2010.02.006
126. Alonzo R, Hussain J, Stranges S, Anderson KK. Interplay between social media use, sleep quality, and mental health in youth: A systematic review. *Sleep Med Rev*. 2021;56:101414. doi:10.1016/j.smrv.2020.101414
127. Lowry R, Eaton DK, Foti K, McKnight-Eily L, Perry G, Galuska DA. Association of Sleep Duration with Obesity among US High School Students. *J Obes*. 2012;2012:e476914. doi:10.1155/2012/476914
128. Owens JA, Weiss MR. Insufficient sleep in adolescents: causes and consequences. *Minerva Pediatr*. 2017;69(4):326-336. doi:10.23736/s0026-4946.17.04914-3
129. Paruthi S, Brooks LJ, D'Ambrosio C, et al. Consensus Statement of the American Academy of Sleep Medicine on the Recommended Amount of Sleep for Healthy Children: Methodology and Discussion. *J Clin Sleep Med*. 2016;12(11):1549-1561. doi:10.5664/jcsm.6288

130. Baum KT, Desai A, Field J, Miller LE, Rausch J, Beebe DW. Sleep restriction worsens mood and emotion regulation in adolescents. *J Child Psychol Psychiatry*. 2014;55(2):180-190. doi:10.1111/jcpp.12125
131. Mark G, Wang YDOI, Niiya M, Reich S. Sleep Debt in Student Life: Online Attention Focus, Facebook, and Mood. In: *Proceedings of the 2016 CHI Conference on Human Factors in Computing Systems*. ACM; 2016:5517-5528. doi:10.1145/2858036.2858437
132. Fitzgerald CT, Messias E, Buysse DJ. Teen Sleep and Suicidality: Results from the Youth Risk Behavior Surveys of 2007 and 2009. *J Clin Sleep Med*. 2011;07(04):351-356. doi:10.5664/JCSM.1188
133. Hökby S, Hadlaczky G, Westerlund J, et al. Are Mental Health Effects of Internet Use Attributable to the Web-Based Content or Perceived Consequences of Usage? A Longitudinal Study of European Adolescents. *JMIR Ment Health*. 2016;3(3):e31. doi:10.2196/mental.5925
134. Gentile DA, Berch ON, Choo H, Khoo A, Walsh DA. Bedroom media: One risk factor for development. *Dev Psychol*. 2017;53(12):2340-2355. doi:10.1037/dev0000399
135. Lua VYQ, Chua TBK, Chia MYH. A Narrative Review of Screen Time and Wellbeing among Adolescents before and during the COVID-19 Pandemic: Implications for the Future. *Sports*. 2023;11(2):38. doi:10.3390/sports11020038
136. Twenge JM, Joiner TE, Martin G, Rogers ML. Amount of time online is problematic if it displaces face-to-face social interaction and sleep. *Clin Psychol Sci*. 2018;6(4):456-457. doi:10.1177/2167702618778562
137. Oh C, Carducci B, Vaivada T, Bhutta ZA. Interventions to Promote Physical Activity and Healthy Digital Media Use in Children and Adolescents: A Systematic Review. *Pediatrics*. 2022;149(Supplement 6):e2021053852I. doi:10.1542/peds.2021-053852I
138. Sina E, Boakye D, Christianson L, Ahrens W, Hebestreit A. Social Media and Children's and Adolescents' Diets: A Systematic Review of the Underlying Social and Physiological Mechanisms. *Adv Nutr*. 2022;13(3):913-937.
139. Keles B, McCrae N, Grealish A. A systematic review: the influence of social media on depression, anxiety and psychological distress in adolescents. *Int J Adolesc Youth*. 2020;25(1):79-93. doi:10.1080/02673843.2019.1590851
140. Karim F, Oyewande A, Abdalla LF, Chaudhry Ehsanullah R, Khan S. Social Media Use and Its Connection to Mental Health: A Systematic Review. *Cureus*. Published online June 15, 2020. doi:10.7759/cureus.8627
141. Cataldo I, Lepri B, Neoh MJY, Esposito G. Social Media Usage and Development of Psychiatric Disorders in Childhood and Adolescence: A Review. *Front Psychiatry*. 2021;11. Accessed February 13, 2024. https://www.frontiersin.org/journals/psychiatry/articles/10.3389/fpsyt.2020.508595
142. Vidal C, Lhaksampa T, Miller L, Platt R. Social media use and depression in adolescents: a scoping review. *Int Rev Psychiatry*. 2020;32(3):235-253. doi:10.1080/09540261.2020.1720623
143. Ivie EJ, Pettitt A, Moses LJ, Allen NB. A meta-analysis of the association between adolescent social media use and depressive symptoms. *J Affect Disord*. 2020;275:165-174. doi:10.1016/j.jad.2020.06.014
144. Cunningham S, Hudson CC, Harkness K. Social Media and Depression Symptoms: a Meta-Analysis. *Res Child Adolesc Psychopathol*. 2021;49(2):241-253. doi:10.1007/s10802-020-00715-7
145. Hancock J, Liu SX, Luo M, Mieczkowski H. Psychological Well-Being and Social Media Use: A Meta-Analysis of Associations between Social Media Use and Depression, Anxiety, Loneliness, Eudaimonic, Hedonic and Social Well-Being. Published online March 9, 2022. doi:10.2139/ssrn.4053961
146. Zhang L, Li C, Zhou T, Li Q, Gu C. Social Networking Site Use and Loneliness: A Meta-Analysis. *J Psychol*. 2022;156(7):492-511. doi:10.1080/00223980.2022.2101420

147. Riehm KE, Feder KA, Tormohlen KN, et al. Associations Between Time Spent Using Social Media and Internalizing and Externalizing Problems Among US Youth. *JAMA Psychiatry*. 2019;76(12):1266. doi:10.1001/jamapsychiatry.2019.2325
148. Coyne SM, Rogers AA, Zurcher JD, Stockdale L, Booth M. Does time spent using social media impact mental health?: An eight year longitudinal study. *Comput Hum Behav*. 2020;104:106160. doi:10.1016/j.chb.2019.106160
149. Meier A, Johnson BK. Social comparison and envy on social media: A critical review. *Curr Opin Psychol*. 2022;45:101302. doi:10.1016/j.copsyc.2022.101302
150. Kreski N, Platt J, Rutherford C, et al. Social Media Use and Depressive Symptoms Among United States Adolescents. *J Adolesc Health*. 2021;68(3):572-579. doi:10.1016/j.jadohealth.2020.07.006
151. Berryman C, Ferguson CJ, Negy C. Social Media Use and Mental Health among Young Adults. *Psychiatr Q*. 2018;89(2):307-314. doi:10.1007/s11126-017-9535-6
152. Orben A, Dienlin T, Przybylski AK. Social media's enduring effect on adolescent life satisfaction. *Proc Natl Acad Sci*. 2019;116(21):10226-10228. doi:10.1073/pnas.1902058116
153. Bonsaksen T, Ruffolo M, Leung J, et al. Loneliness and Its Association With Social Media Use During the COVID-19 Outbreak. *Soc Media Soc*. 2021;7(3):20563051211033821. doi:10.1177/20563051211033821
154. Vannucci A, McCauley Ohannessian C. Social Media Use Subgroups Differentially Predict Psychosocial Well-Being During Early Adolescence. *J Youth Adolesc*. 2019;48(8):1469-1493. doi:10.1007/s10964-019-01060-9
155. Rideout V, Fox S, Trust WB. Digital Health Practices, Social Media Use, and Mental Well-Being Among Teens and Young Adults in the U.S. Published online 2018.
156. Valkenburg PM, Meier A, Beyens I. Social media use and its impact on adolescent mental health: An umbrella review of the evidence. *Curr Opin Psychol*. 2022;44:58-68. doi:10.1016/j.copsyc.2021.08.017
157. Valkenburg PM, Beyens I, Pouwels JL, van Driel II, Keijsers L. Social Media Browsing and Adolescent Well-Being: Challenging the "Passive Social Media Use Hypothesis." Published online 2021.
158. Valkenburg PM, van Driel II, Beyens I. The associations of active and passive social media use with well-being: A critical scoping review. *New Media Soc*. 2022;24(2):530-549. doi:10.1177/14614448211065425
159. Orben A. Teenagers, screens and social media: a narrative review of reviews and key studies. *Soc Psychiatry Psychiatr Epidemiol*. 2020;55(4):407-414. doi:10.1007/s00127-019-01825-4
160. Beard KW, Wolf EM. Modification in the Proposed Diagnostic Criteria for Internet Addiction. *Cyberpsychol Behav*. 2001;4(3):377-383. doi:10.1089/109493101300210286
161. Casale S, Banchi V. Narcissism and problematic social media use: A systematic literature review. *Addict Behav Rep*. 2020;11:100252. doi:10.1016/j.abrep.2020.100252
162. Moreno M, Riddle K, Jenkins MC, Singh AP, Zhao Q, Eickhoff J. Measuring Problematic Internet Use, Internet Gaming Disorder, and Social Media Addiction in Young Adults: Cross-sectional Survey Study. *JMIR Public Health Surveill*. 2022;8(1):e27719. doi:10.2196/27719
163. Kim HS, Son G, Roh EB, et al. Prevalence of gaming disorder: A meta-analysis. *Addict Behav*. 2022;126:107183. doi:10.1016/j.addbeh.2021.107183
164. Ahmed GK, Abdalla AA, Mohamed AM, Mohamed LA, Shamaa HA. Relationship between time spent playing internet gaming apps and behavioral problems, sleep problems, alexithymia, and emotion dysregulations in children: a multicentre study. *Child Adolesc Psychiatry Ment Health*. 2022;16(1):67. doi:10.1186/s13034-022-00502-w
165. Gentile DA, Anderson CA, Yukawa S, et al. The Effects of Prosocial Video Games on Prosocial Behaviors: International Evidence From Correlational, Longitudinal, and Experimental Studies. *Pers Soc Psychol Bull*. 2009;35(6):752-763. doi:10.1177/0146167209333045

166. Gentile DA, Choo H, Liau A, et al. Pathological Video Game Use Among Youths: A Two-Year Longitudinal Study. *Pediatrics*. 2011;127(2):e319-e329. doi:10.1542/peds.2010-1353
167. Teng Z, Griffiths MD, Nie Q, Xiang G, Guo C. Parent–adolescent attachment and peer attachment associated with Internet Gaming Disorder: A longitudinal study of first-year undergraduate students. *J Behav Addict*. 2020;9(1):116-128.
168. Buda G, Lukoševičiūtė J, Šalčiūnaitė L, Šmigelskas K. Possible Effects of Social Media Use on Adolescent Health Behaviors and Perceptions. *Psychol Rep*. 2021;124(3):1031-1048. doi:10.1177/0033294120922481
169. Paakkari L, Tynjälä J, Lahti H, Ojala K, Lyyra N. Problematic Social Media Use and Health among Adolescents. *Int J Environ Res Public Health*. 2021;18(4):1885. doi:10.3390/ijerph18041885
170. Boer M, Stevens GWJM, Finkenauer C, De Looze ME, Van Den Eijnden RJJM. Social media use intensity, social media use problems, and mental health among adolescents: Investigating directionality and mediating processes. *Comput Hum Behav*. 2021;116:106645. doi:10.1016/j.chb.2020.106645
171. Huang C. A meta-analysis of the problematic social media use and mental health. *Int J Soc Psychiatry*. 2022;68(1):12-33. doi:10.1177/0020764020978434
172. Bányai F, Zsila Á, Király O, et al. Problematic Social Media Use: Results from a Large-Scale Nationally Representative Adolescent Sample. Jiménez-Murcia S, ed. *PLOS ONE*. 2017;12(1):e0169839. doi:10.1371/journal.pone.0169839
173. Fam JY. Prevalence of internet gaming disorder in adolescents: A meta-analysis across three decades. *Scand J Psychol*. 2018;59(5):524-531. doi:10.1111/sjop.12459
174. Leonhardt M, Overå S. Are There Differences in Video Gaming and Use of Social Media among Boys and Girls?—A Mixed Methods Approach. *Int J Environ Res Public Health*. 2021;18(11):6085. doi:10.3390/ijerph18116085
175. Gioia F, Rega V, Boursier V. Problematic Internet Use and Emotional Dysregulation Among Young People: A Literature Review. *Clin Neuropsychiatry*. 18(1):41-54. doi:10.36131/cnfioritieditore20210104
176. Panayiotou M, Black L, Carmichael-Murphy P, Qualter P, Humphrey N. Time spent on social media among the least influential factors in adolescent mental health: preliminary results from a panel network analysis. *Nat Ment Health*. 2023;1(5):316-326. doi:10.1038/s44220-023-00063-7
177. Beyens I, Valkenburg PM, Piotrowski JT. Screen media use and ADHD-related behaviors: Four decades of research. *Proc Natl Acad Sci*. 2018;115(40):9875-9881. doi:10.1073/pnas.1611611114
178. Ra CK, Cho J, Stone MD, et al. Association of Digital Media Use With Subsequent Symptoms of Attention-Deficit/Hyperactivity Disorder Among Adolescents. *JAMA*. 2018;320(3):255-263. doi:10.1001/jama.2018.8931
179. Barry CT, Sidoti CL, Briggs SM, Reiter SR, Lindsey RA. Adolescent social media use and mental health from adolescent and parent perspectives. *J Adolesc*. 2017;61(1):1-11. doi:10.1016/j.adolescence.2017.08.005
180. Liu Z. Reading in the age of digital distraction. *J Doc*. 2021;78(6):1201-1212. doi:10.1108/JD-07-2021-0130
181. Wiradhany W, Koerts J. Everyday functioning-related cognitive correlates of media multitasking: a mini meta-analysis. *Media Psychol*. 2021;24(2):276-303. doi:10.1080/15213269.2019.1685393
182. Parry DA, Roux DB le. "Cognitive control in media multitaskers" ten years on: A meta-analysis. *Cyberpsychology J Psychosoc Res Cyberspace*. 2021;15(2). doi:10.5817/CP2021-2-7
183. Calderwood C, Ackerman PL, Conklin EM. What else do college students "do" while studying? An investigation of multitasking. *Comput Educ*. 2014;75:19-29. doi:10.1016/j.compedu.2014.02.004

184. Saiphoo AN, Dahoah Halevi L, Vahedi Z. Social networking site use and self-esteem: A meta-analytic review. *Personal Individ Differ*. 2020;153:109639. doi:10.1016/j.paid.2019.109639
185. Holland G, Tiggemann M. A systematic review of the impact of the use of social networking sites on body image and disordered eating outcomes. *Body Image*. 2016;17:100-110. doi:10.1016/j.bodyim.2016.02.008
186. Salomon I, Brown CS. The Selfie Generation: Examining the Relationship Between Social Media Use and Early Adolescent Body Image. *J Early Adolesc*. 2019;39(4):539-560. doi:10.1177/0272431618770809
187. Choukas-Bradley S, Roberts SR, Maheux AJ, Nesi J. The Perfect Storm: A Developmental–Sociocultural Framework for the Role of Social Media in Adolescent Girls' Body Image Concerns and Mental Health. *Clin Child Fam Psychol Rev*. 2022;25(4):681-701. doi:10.1007/s10567-022-00404-5
188. Pruccoli J, De Rosa M, Chiasso L, Perrone A, Parmeggiani A. The use of TikTok among children and adolescents with Eating Disorders: experience in a third-level public Italian center during the SARS-CoV-2 pandemic. *Ital J Pediatr*. 2022;48(1):138. doi:10.1186/s13052-022-01308-4
189. Chung A, Vieira D, Donley T, et al. Adolescent Peer Influence on Eating Behaviors via Social Media: Scoping Review. *J Med Internet Res*. 2021;23(6):e19697. doi:10.2196/19697
190. Kucharczuk AJ, Oliver TL, Dowdell EB. Social media's influence on adolescents′ food choices: A mixed studies systematic literature review. *Appetite*. 2022;168:105765. doi:10.1016/j.appet.2021.105765
191. Saura JR, Palacios-Marqués D, Iturricha-Fernández A. Ethical design in social media: Assessing the main performance measurements of user online behavior modification. *J Bus Res*. 2021;129:271-281. doi:10.1016/j.jbusres.2021.03.001
192. Blank G, Bolsover G, Dubois E. A New Privacy Paradox: Young People and Privacy on Social Network Sites. Published online August 13, 2014. doi:10.2139/ssrn.2479938
193. Auxier B, Anderson M, Perrin A, Turner E. *Parenting Children in the Age of Screens*. Pew Research Center; 2020. Accessed February 13, 2024. https://www.pewresearch.org/internet/2020/07/28/parenting-children-in-the-age-of-screens/
194. McClain C, Faverio M, Anderson M, Park E. *How Americans View Data Privacy*. Pew Research Center
195. Godoy J, Godoy J. US lawsuit against TikTok to focus on children's privacy. *Reuters*. https://www.reuters.com/legal/us-lawsuit-against-tiktok-focus-childrens-privacy-2024-06-21/. June 21, 2024. Accessed August 19, 2024.
196. FTC Investigation Leads to Lawsuit Against TikTok and ByteDance for Flagrantly Violating Children's Privacy Law. Federal Trade Commission. August 2, 2024. Accessed August 19, 2024. https://www.ftc.gov/news-events/news/press-releases/2024/08/ftc-investigation-leads-lawsuit-against-tiktok-bytedance-flagrantly-violating-childrens-privacy-law
197. Gambo S, Özad BO. The demographics of computer-mediated communication: A review of social media demographic trends among social networking site giants. *Comput Hum Behav Rep*. 2020;2:100016. doi:10.1016/j.chbr.2020.100016
198. Sherman LE, Hernandez LM, Greenfield PM, Dapretto M. What the brain 'Likes': neural correlates of providing feedback on social media. *Soc Cogn Affect Neurosci*. 2018;13(7):699-707. doi:10.1093/scan/nsy051
199. Youth Advisory Panel. Accessed August 21, 2024. https://www.aap.org/en/patient-care/media-and-children/center-of-excellence-on-social-media-and-youth-mental-health/youth-advisory-panel/
200. Center of Excellence on Social Media and Youth Mental Health. Accessed July 17, 2024. https://www.aap.org/en/patient-care/media-and-children/center-of-excellence-on-social-media-and-youth-mental-health/

201. Gorwa R. The platform governance triangle: conceptualising the informal regulation of online content. *Internet Policy Rev*. 2019;8(2). doi:10.14763/2019.2.1407
202. International Organization for Standardization - ISO | Genève internationale. Accessed February 15, 2024. https://www.geneve-int.ch/whoswho/international-organization-standardization-iso
203. Napoli PM. What Social Media Platforms Can Learn from Audience Measurement: Lessons in the Self-Regulation of "Black Boxes." Published online January 31, 2018. doi:10.2139/ssrn.3115916
204. Klonick K. The Facebook Oversight Board: Creating an Independent Institution to Adjudicate Online Free Expression. *Yale Law J*. 2019;129:2418.
205. Maroni M. Some reflections on the announced Facebook Oversight Board. Centre for Media Pluralism and Freedom. October 17, 2019. Accessed February 13, 2024. https://cmpf.eui.eu/some-reflections-on-the-announced-facebook-oversight-board/
206. Today's Law As Amended - AB-2273 The California Age-Appropriate Design Code Act. Accessed February 13, 2024. https://leginfo.legislature.ca.gov/faces/billCompareClient.xhtml?bill_id=202120220AB2273&showamends=false
207. NetChoice v. Bonta: The Case That Threatens the Future of Privacy. EPIC - Electronic Privacy Information Center. Accessed February 19, 2024. https://epic.org/netchoice-v-bontathe-case-that-couldthreaten-the-future-of-privacy/
208. Henderson R, Migdal A, He T. Note: Industry Self-Regulation: Sustaining the Commons in the 21st Century? Harvard Business School Background Note 315-074. March 2015. Accessed February 13, 2024. https://www.hbs.edu/faculty/Pages/item.aspx?num=48959
209. Cusumano MA, Gawer A, Yoffie DB. Social media companies should self-regulate. Now. *Harv Bus Rev*. 2021;15.
210. 15 U.S. Code § 57a - Unfair or deceptive acts or practices rulemaking proceedings. LII / Legal Information Institute. Accessed February 19, 2024. https://www.law.cornell.edu/uscode/text/15/57a
211. Privacy and Security Enforcement. Federal Trade Commission. October 31, 2018. Accessed February 19, 2024. https://www.ftc.gov/news-events/topics/protecting-consumer-privacy-security/privacy-security-enforcement
212. Federal Trade Commission 2020 Privacy and Data Security Update. Federal Trade Commission. May 25, 2021. Accessed February 19, 2024. https://www.ftc.gov/reports/federal-trade-commission-2020-privacy-data-security-update
213. Mills JL, Allende PM. FTC Consent Decrees Are Best Guide to Cybersecurity Policies. Daily Business Review. September 21, 2015. Accessed February 13, 2024. https://www.law.com/dailybusinessreview/almID/1202737711574/
214. Rosch JT. Consent Decrees: Is the Public Getting Its Money's Worth? Federal Trade Commission. July 31, 2013. Accessed February 13, 2024. https://www.ftc.gov/news-events/news/speeches/consent-decrees-public-getting-its-moneys-worth
215. Wong RY, Madaio MA, Merrill N. Seeing Like a Toolkit: How Toolkits Envision the Work of AI Ethics. *Proc ACM Hum-Comput Interact*. 2023;7(CSCW1):145:1-145:27. doi:10.1145/3579621
216. Gebru T, Morgenstern J, Vecchione B, et al. Datasheets for datasets. *Commun ACM*. 2021;64(12):86-92. doi:10.1145/3458723
217. Murthy VH. Opinion | Surgeon General: Why I'm Calling for a Warning Label on Social Media Platforms. *The New York Times*. https://www.nytimes.com/2024/06/17/opinion/social-media-health-warning.html. June 17, 2024. Accessed July 17, 2024.
218. Sen. Schatz B [D H. S.1291 - 118th Congress (2023-2024): Protecting Kids on Social Media Act. April 26, 2023. Accessed July 12, 2024. https://www.congress.gov/bill/118th-congress/senate-bill/1291

219. Sen. Blumenthal R [D C. S.1409 - 118th Congress (2023-2024): Kids Online Safety Act. December 13, 2023. Accessed July 12, 2024. https://www.congress.gov/bill/118th-congress/senate-bill/1409
220. Sen. Schatz B [D H. Text - S.4213 - 118th Congress (2023-2024): Kids Off Social Media Act. April 30, 2024. Accessed July 12, 2024. https://www.congress.gov/bill/118th-congress/senate-bill/4213/text
221. Marwick A, Smith J, Caplan R, Wadhawan M. Child Online Safety Legislation (COSL) - A Primer. *Bull Technol Public Life*. Published online May 29, 2024. doi:10.21428/bfcb0bff.de78f444
222. Steinberg S. THE MYTH OF CHILDREN'S ONLINE PRIVACY PROTECTION. *SMU LAW Rev*. Published online 2024.
223. Children's Online Privacy Protection Rule ("COPPA"). Federal Trade Commission. July 25, 2013. Accessed February 15, 2024. https://www.ftc.gov/legal-library/browse/rules/childrens-online-privacy-protection-rule-coppa
224. *Google LLC and YouTube, LLC.*(Federal Court District of Columbia 2019). Accessed February 13, 2024. https://www.ftc.gov/legal-library/browse/cases-proceedings/172-3083-google-llc-youtube-llc
225. Sen. Markey EJ [D M. Text - S.1628 - 117th Congress (2021-2022): Children and Teens' Online Privacy Protection Act. December 15, 2022. Accessed February 15, 2024. https://www.congress.gov/bill/117th-congress/senate-bill/1628/text
226. Sen. Markey EJ [D M. S.1418 - 118th Congress (2023-2024): Children and Teens' Online Privacy Protection Act. December 13, 2023. Accessed July 12, 2024. https://www.congress.gov/bill/118th-congress/senate-bill/1418
227. Advertising and Marketing on the Internet: Rules of the Road. Federal Trade Commission. December 12, 2000. Accessed February 13, 2024. https://www.ftc.gov/business-guidance/resources/advertising-marketing-internet-rules-road
228. CAN-SPAM Act: A Compliance Guide for Business. Federal Trade Commission. August 9, 2023. Accessed February 13, 2024. https://www.ftc.gov/business-guidance/resources/can-spam-act-compliance-guide-business
229. *How to Make Effective Disclosures in Digital Advertising*. Federal Trade Commission; 2013.
230. Trade Regulation Rule on Commercial Surveillance and Data Security. Federal Register. August 22, 2022. Accessed February 13, 2024. https://www.federalregister.gov/documents/2022/08/22/2022-17752/trade-regulation-rule-on-commercial-surveillance-and-data-security
231. States Search for Ways to Keep Kids Safe on Social Media. National Conference of State Legislatures. Accessed February 13, 2024. https://www.ncsl.org/state-legislatures-news/details/states-search-for-ways-to-keep-kids-safe-on-social-media
232. 2023 State Children's Privacy Law Tracker. Accessed February 14, 2024. https://www.huschblackwell.com/2023-state-childrens-privacy-law-tracker
233. Social Media and Children 2024 Legislation. Accessed September 4, 2024. https://www.ncsl.org/technology-and-communication/social-media-and-children-2024-legislation
234. SB0152. Accessed February 13, 2024. https://le.utah.gov/~2023/bills/static/SB0152.html
235. SB396 Bill Information. Accessed February 13, 2024. https://www.arkleg.state.ar.us/Bills/Detail
236. Four Key Considerations for Implementing the California Age-Appropriate Design Code. Perkins Coie. Accessed July 30, 2024. https://www.perkinscoie.com/en/news-insights/four-key-considerations-for-implementing-the-california-age-appropriate-design-code.html
237. Attorney General Bonta Continues Defense of California's Age-Appropriate Design Code Act. State of California - Department of Justice - Office of the Attorney General. December 13,

2023. Accessed February 19, 2024. https://oag.ca.gov/news/press-releases/attorney-general-bonta-continues-defense-california%E2%80%99s-age-appropriate-design
238. NetChoice, LLC v. Griffin, No. 5:2023cv05105 - Document 44 (W.D. Ark. 2023). Justia Law. July 17, 2024. Accessed July 17, 2024. https://law.justia.com/cases/federal/district-courts/arkansas/arwdce/5:2023cv05105/68680/44/
239. Chemerinsky A, Chemerinsky E. Misguided Federalism: State Regulation of the Internet and Social Media. *N C LAW Rev*. 2023;102.
240. AAP Council on Communication and Media, Hill D, Ameenuddin N, et al. Media and Young Minds. *Pediatrics*. 2016;138(5):e20162591. doi:10.1542/peds.2016-2591
241. Sadagheyani HE, Tatari F. Investigating the role of social media on mental health. *Ment Health Soc Incl*. 2020;25(1):41-51. doi:10.1108/MHSI-06-2020-0039

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 901
(I-24)

Introduced by: Medical Student Section, Washington, and Oregon

Subject: Heat Alerts and Response Plans

Referred to: Reference Committee K

Whereas, acute and chronic heat exposure has major detrimental implications for cardiovascular, renal, psychiatric, reproductive, and other health outcomes and is associated with a 126% increase in annual cardiovascular deaths by 2065 (4,300 more deaths yearly)[1-3]; and

Whereas, according to the CDC, heat response plans are prepared strategies that coordinate community efforts including heat surveillance, public health messaging, front-line health and social services, cooling centers, water and fan distribution, energy assistance, and greenspaces and have demonstrated reductions in heat-related morbidity and mortality, especially for elderly populations and communities of lower socioeconomic status[4-14]; and

Whereas, the World Meteorological Organization recommends setting heat alert thresholds based on the level of heat exposure associated with adverse health outcomes, and local National Weather Service (NWS) offices in the US issue alerts to support heat response based on NWS guidelines[11-17]; and

Whereas, however, heat-related morbidity begins at a range below current NWS heat alert thresholds, leading to discrepancies and inadequacies in heat response[4,11,15,18]; and

Whereas, the US Department of Energy recently developed an updated heat index model that more accurately incorporates temperature extremes and factors that affect perceived heat such as humidity to improve estimations of morbidity and mortality, suggesting that current NWS models may underestimate heat index by up to 20° and lead to contributing to inadequacies in heat response[12,14,19,20]; and

Whereas, the Stafford Act of 1988 does not consider extreme heat a major disaster eligible for Federal Emergency Management Agency (FEMA) assistance, and 14 state attorneys general and multiple organizations recently petitioned FEMA to change this[21-25]; therefore be it

RESOLVED, that our American Medical Association supports federal, state, and local efforts to use the most updated and evidence-based heat index formulas and other relevant factors to accurately estimate heat-related morbidity and mortality, proactively issue heat alerts, and improve implementation of response plans (New HOD Policy); and be it further

RESOLVED, that our AMA supports efforts to implement and fund comprehensive heat response plans and allow Federal Emergency Management Agency funds and resources to be used for heat response. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Date Received: 09/19/2024

REFERENCES

1. Centers for Disease Control and Prevention. "CDC's tracking network in action: extreme heat." Retrieved February 20 (2019): 2019. https://www.cdc.gov/nceh/features/trackingheat/index.html#:~:text=%20CDC's%20Tracking%20Network%20in%20Action%3A%20Extreme%20Heat,or%20death%20are%20preventable%20if%20you...%20More%20
2. Ebi, Kristie L., et al. "Hot weather and heat extremes: health risks." The Lancet 398.10301 (2021): 698-708.
3. Khatana, Sameed Ahmed, et al. "Projected Number of Cardiovascular Deaths Associated with Extreme Heat in the Contiguous United States by Mid-Century (2036-2065)." Journal of the American College of Cardiology 81.8_Supplement (2023): 1678-1678.
4. Adeyeye, T.E., et al., Estimating policy-relevant health effects of ambient heat exposures using spatially contiguous reanalysis data. 2019. 18(1): p. 35.
5. American Public Health Association, Adaptation in Action Part 2: Updated Grantee Success Stories from CDC's Climate and Health Program 2018.
6. Di Napoli, Claudia, Florian Pappenberger, and Hannah L. Cloke. "Verification of heat stress thresholds for a health-based heat-wave definition." Journal of Applied Meteorology and Climatology 58.6 (2019): 1177-1194.
7. Benmarhnia, T., et al., The heterogeneity of vulnerability in public health: a heat wave action plan as a case study. Critical Public Health, 2018. 28(5): p. 619-625.
8. US Department of Commerce, N. (2023, August 24). Wet bulb globe temperature vs heat index. National Weather Service. https://www.weather.gov/ict/wbgt
9. Yin, Qian, and Jinfeng Wang. "A better indicator to measure the effects of meteorological factors on cardiovascular mortality: heat index." Environmental Science and Pollution Research 25 (2018): 22842-22849.
10. Benmarhnia, Tarik, et al. "Quantifying the impact of changing the threshold of New York City heat emergency plan in reducing heat-related illnesses." Environmental Research Letters. August 16, 2019. Accessed March 2, 2024. https://iopscience.iop.org/article/10.1088/1748-9326/ab402e.
11. Jessica Abbinett, Paul J. Schramm, Stasia Widerynski, Shubhayu Saha, Suzanne Beavers, Margaret Eaglin, Uei Lei, Seema G. Nayak, Matthew Roach, Matt Wolff, Kathryn C. Conlon, Lauren Thie, Heat response plans. CDC's Climate and Health Technical Report Series, https://www.cdc.gov/climateandhealth/docs/HeatResponsePlans_508.pdf
12. David M Romps and Yi-Chuan Lu 2022 Environ. Res. Lett. 17 094017. August 29, 2022. Accessed March 2,2024. https://iopscience.iop.org/article/10.1088/1748-9326/ac8945.
13. Cheng, Yu-Ting, Shih-Chun Candice Lung, and Jing-Shiang Hwang. "New approach to identifying proper thresholds for a heat warning system using health risk increments." Environmental research 170 (2019): 282-292.
14. Vaidyanathan A, Saha S, Vicedo-Cabrera AM, et al. Assessment of extreme heat and hospitalizations to inform early warning systems. Proceedings of the National Academy of Sciences of the United States of America. March 4, 2019. Accessed February 10, 2024. https://www.pnas.org/doi/10.1073/pnas.1806393116
15. US Department of Commerce N. Excessive heat conditions. National Weather Service. July 20, 2018. https://www.weather.gov/phi/heatcond.
16. Hawkins, M. D., Brown, V., & Ferrell, J. (2017). Assessment of NOAA National Weather Service Methods to Warn for Extreme Heat Events. Weather, Climate, and Society, 9(1), 5-13. https://doi.org/10.1175/WCAS-D-15-0037.1
17. US Department of Commerce N. Heat watch vs. warning. National Weather Service. March 2, 2020. https://www.weather.gov/safety/heat-ww.
18. Petitti, D.B., et al., Multiple Trigger Points for Quantifying Heat-Health Impacts: New Evidence from a Hot Climate. Environmental health perspectives, 2016. 124(2): p. 176-183.
19. Kovner A. Q&A: We've been underestimating heat waves. Here's how to fix it. Berkeley Lab News Center. March 28, 2023. Accessed March 2, 2024. https://newscenter.lbl.gov/2022/08/24/no-more-underestimating-heat-waves/.
20. Lu, Y., & Romps, D. M. (2022). Extending the Heat Index. Journal of Applied Meteorology and Climatology, 61(10), 1367-1383. https://doi.org/10.1175/JAMC-D-22-0021.1
21. FEMA. How a Disaster Gets Declared. FEMA.gov. Published 2022. Accessed August 26, 2023. https://www.fema.gov/disaster/how-declared23.FEMA.
22. FEMA. Stafford Act. FEMA.gov. Published November 18, 2021. Accessed August 26, 2023. https://www.fema.gov/disaster/stafford-act.
23. Su J. FEMA Urged to Fund Disaster Response for Extreme Heat, Wildfire Smoke. Center for Biological Diversity. June 17, 2024. https://biologicaldiversity.org/w/news/press-releases/fema-urged-to-fund-disaster-response-for-extreme-heat-wildfire-smoke-2024-06-17
24. Magner M. As heat waves intensify, so does criticism of government support. Roll Call. June 24, 2024. https://rollcall.com/2024/06/24/as-heat-waves-intensify-so-does-criticism-of-government-support
25. Budryk Z. Fourteen attorneys general ask FEMA to make wildfire smoke, extreme heat eligible for major disaster aid. The Hill. July 16, 2024. https://thehill.com/policy/energy-environment/4775601-attorneys-general-fema-letter-wildfire-smoke-heat-major-disaster-aid

RELEVANT AMA POLICY

D-135.967 Advocating for Heat Exposure Protections for All Workers
Our American Medical Association 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;
Our AMA will advocate for legislation that creates federal standards for protections against heat stress and sun exposure specific to the hazards of the workplace.
Our AMA 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.
Our AMA 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.
Our AMA 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]

H-130.951 Heat-Related Illness
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]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 902
(I-24)

Introduced by: Women Physicians Section

Subject: Advancing Menopause Research and Care

Referred to: Reference Committee K

Whereas, roughly 75 million people are currently in perimenopause, menopause, or postmenopause in United States, with 6000 new people entering menopause every day[1]; and

Whereas, menopausal and postmenopausal persons face increased health risks, such as cardiovascular disease, osteoporosis, urinary incontinence, and mood disorders, due to the hormonal changes that occur during this period[2]; and

Whereas, economic costs associated with menopause and postmenopause are substantial, with an annual burden of $1.8 billion from lost work time and $26.6 billion in medical expenses[3]; and

Whereas, when surveyed, only about 30% of OBGYN program directors reported having a menopause curriculum for their residents and 80% of OBGYN residents do not feel prepared to talk to their patients about menopause[1,4]; and

Whereas, there is a severe need for additional research on menopause, and an expert panel noted there are several existing knowledge gaps regarding menopause, including pathogenesis and treatment of vasomotor symptoms, which has been shown to disproportionately affect women of color[5,6]; and

Whereas, menopause, similar to other aspects of women's health, is underfunded and lacks the appropriate infrastructure for tracking funding, such as the NIH assigned RCDC number[7]; and

Whereas, in 2023, it was estimated that menopause, which impacts nearly 50% of the population, received $259 million dollars for research in comparison to Alzheimer's, which affects approximately 10.9% of individuals 65 and older, received $4 billion dollars[8,9]; and

Whereas, on March 18, 2024, President Biden signed an executive order to support and advance women's health focusing on increasing investments in women's health research by the NIH, including establishment of a Pathways to Prevention for menopause and menopausal symptoms by the NIH to improve women's health across the lifespan, which highlights the need for ongoing advocacy and research in this area[10]; and

Whereas, in the last year, multiple bills have been introduced in Congress calling for expanded access to menopause care and funding for menopause research, including S.4246 - Advancing Menopause Care and Mid-Life Women's Health Act, H.R. 6749 - Menopause Research and Equity Act of 2023; H.R. 8347 - Improving Menopause Care for Veterans Act of 2024[11-13]; and

Whereas, the AMA has not sent any federal or state correspondence regarding menopause-related advocacy since at least 2015[14]; therefore be it

RESOLVED, that our American Medical Association advocate for increased funding for biomedical and public health research on perimenopause, menopause, and related chronic conditions (Directive to Take Action); and be it further

RESOLVED, that our AMA support expanded training opportunities for medical students, residents, and other health professions trainees to improve care, treatment, and management services for perimenopause, menopause, and related chronic conditions (New HOD Policy); and be it further

RESOLVED, that our AMA support efforts to increase awareness and education related to menopause, mid-life women's health and related conditions, treatment, and preventative services. (New HOD Policy)

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

Date Received: 09/19/2024

REFERENCES

1. What to Know. letstalkmenopause.org. Accessed August 5, 2024. https://www.letstalkmenopause.org/what-to-know
2. What is Menopause? nia.nih.org. Reviewed September 30, 2021. Accessed August 7, 2024. https://www.nia.nih.gov/health/menopause/what-menopause
3. Faubion SS, Enders F, Hedges MS, et al. Impact of Menopause Symptoms on Women in the Workplace. *Mayo Clin Proc*. 2023;98(6):833-845. doi:10.1016/j.mayocp.2023.02.025
4. Allen JT, Laks S, Zahler-Miller C, et al. Needs assessment of menopause education in United States obstetrics and gynecology residency training programs. Menopause. 2023;30(10):1002-1005. doi:10.1097/GME.0000000000002234
5. Verdonk P, Bendien E, Appelman Y. Menopause and work: A narrative literature review about menopause, work and health. *Work*. 2022;72(2):483-496. doi:10.3233/WOR-205214
6. Menopause Mindfulness: Calls for Research Funding and Addressing Stigma Related to Menopause. Published October 29, 2021. Accessed August 8, 2024. https://swhr.org/menopause-mindfulness-calls-for-research-funding-and-addressing-stigma-related-to-menopause/
7. Women's health: end the disparity in funding. *Nature*. 2023;617(7959):8. doi:10.1038/d41586-023-01472-5
8. National Institute of Health. reporter.nih.gov. Accessed August 11, 2024. https://reporter.nih.gov/search/ERB9fZVTiEaqNx2KTqOK0A/projects/charts
9. Alzheimer's Disease Facts and Figures. alz.org. Accessed August 15, 2024. https://www.alz.org/alzheimers-dementia/facts-figures
10. President Biden Issues Executive Order on Advancing Women's Health Research and Innovation. orwh.od.nih.gov. Published March 21, 2024. Accessed August 11, 2024. https://orwh.od.nih.gov/in-the-spotlight/all-articles/president -biden-issues-executive-order-on-advancing-womens-health-research-and-innovation
11. S.4246 - Advancing Menopause Care and Mid-Life Women's Health Act. congress.gov. Accessed August 8, 2024. https://www.congress.gov/bill/118th-congress/senate- bill/4246/text
12. S.4246 - Advancing Menopause Care and Mid-Life Women's Health Act. congress.gov. Accessed August 8, 2024. https://www.congress.gov/bill/ 118th-congress/senate-bill/4246/text
13. H.R.8347 - Improving Menopause Care for Veterans Act of 2024. congress.gov. Accessed August 11, 2024. https://www.congress.gov/bill/118th-congress/house-bill/8347/text?s=1&r=5&q=%7B%22search%22%3A%22menopause%22%7D
14. Federal and State Correspondence Finder. ama-assn.org. Accessed August 7, 2024. https://searchlf.ama-assn.org/finder/letter/search/*/relevant/1/

RELEVANT AMA POLICY

Sex and Gender Differences in Medical Research H-525.988

Our AMA:
(1) reaffirms that gender and sex exclusion in broad medical studies questions the validity of the studies' impact on the health care of society at large;
(2) affirms the need to include people of all sexes and gender identities and expressions in studies that involve the health of society at large and publicize its policies;
(3) supports increased funding into areas of women's health and sexual and gender minority health research;

(4) supports increased research on women's health and sexual and gender minority health and the participation of women and sexual and gender minority communities in clinical trials, the results of which will permit development of evidence-based prevention and treatment strategies for all women and sexual and gender minority individuals from diverse cultural and ethnic groups, geographic locations, and socioeconomic status;
(5) recommends that all medical/scientific journal editors require, where appropriate, a sex-based and gender-based analysis of data, even if such comparisons are negative; and
(6) recommends that medical and scientific journals diversify their review processes to better represent women and sexual and gender minority individuals;
(7) supports the FDA's requirement of actionable clinical trial diversity action plans from drug and device sponsors that include women and sexual and gender minority populations;
(8) supports the FDA's efforts in conditioning drug and device approvals on post-marketing studies which evaluate the efficacy and safety of those products in women and sexual and gender minority populations when those groups were not adequately represented in clinical trials; and
(9) supports and encourages the National Institutes of Health and other grant-making entities to fund post-market research investigating pharmacodynamics and pharmacokinetics for generic drugs that did not adequately enroll women and sexual and gender minority populations in their clinical trials, prioritizing instances when those populations represent a significant portion of patients or reported adverse drug events. [Res. 80, A-91; Appended: CSA Rep. 4, I-00; Modified: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 05, A-16; Modified: Res. 004, A-23; Modified: CSAPH Rep. 01, A-24]

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

Encouraging Research of Testosterone and Pharmacological Therapies for Post-Menopausal Individuals with Decreased Libido H-460.886
Our American Medical Association encourages expansion of research on the use of testosterone therapy and other pharmacological interventions in treatment of decreased libido in postmenopausal individuals. [Res. 522, A-22]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 903
(I-24)

Introduced by: Women Physicians Section

Subject: Improving the Identification of Intimate Partner Violence (IPV) in People with Disabilities

Referred to: Reference Committee K

Whereas, intimate partner violence (IPV) is defined as abuse or aggression by an intimate partner, including physical violence, sexual violence, psychological aggression, emotional abuse, and stalking[1,2]; and

Whereas, it has been estimated that up to 54-80% of individuals with disabilities experience some form of IPV in their lifetime, resulting in nearly double the lifetime risk of IPV compared to the general population[2,3,4]; and

Whereas, despite professional organizations recommending routine IPV screening, only 15% of women with disabilities reported being asked by healthcare providers if they have experienced IPV[,4]; and

Whereas, physician implicit bias leads to people with disabilities receiving inadequate counseling and screening for concerns related to sexual health, which may be one contributor to the lack of IPV screening in this population[5]; and

Whereas, in addition to the traditional manifestations of IPV, people with disabilities may experience different forms of IPV than people without disabilities, such as having their adaptive equipment withheld or damaged, which may be a reason IPV is not always identified by standard screening tools in this population[6,7]; and

Whereas, standard IPV screening tools are only 80% as accurate at identifying IPV in people with physical disabilities as disability-specific IPV screening tools, such as the Abuse Assessment Screen-Disability (AAS-D), contributing to the lack of identification of IPV in this population[8]; and

Whereas, the AAS-D screening tool has not yet been validated, limiting its ability to be used in clinical practice[8]; and

Whereas, it has been suggested that IPV screening tools that include disability-specific questions written in languages that can be easily understood by individuals with cognitive disabilities would be useful for IPV screening in individuals with both physical and cognitive disabilities, but currently, no such tool is commonly used[6]; and

Whereas, accurate identification of IPV in people with disabilities through the use of disability-specific screening tools, such as the AAS-D, could help guide treatment, allow for the incorporation of trauma-informed care, and ultimately decrease the morbidity associated with IPV in this population[6]; therefore be it

RESOLVED, that our American Medical Association advocate for increased research on the prevalence of intimate partner violence (IPV) in people with disabilities and the unique IPV-related issues faced by people with disabilities (Directive to Take Action); and be it further

RESOLVED, that our AMA advocated for increased research on the efficacy of population-specific intimate partner violence (IPV) screening tools that address the specific manifestations of abuse faced by people with disabilities. (Directive to Take Action)

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

Received: 09/19/2024

REFERENCES

1. Preventing Intimate Partner Violence |Violence Prevention Injury Center|CDC. www.cdc.gov. Published February 23, 2021. https://www.cdc.gov/violenceprevention/intimatepartnerviolence/fastfact.html#:~:text=IPV%20is%20common.&text=Data%20from%20CDC%27s%20National%20Intimate
2. Iudici, A., Antonello, A. & Turchi, G. Intimate Partner Violence Against Disabled Persons: Clinical and Health Impact, Intersections, Issues and Intervention Strategies. Sexuality & Culture 23, 684–704 (2019). https://doi.org/10.1007/s12119-018-9570-y
3. Muster C. The Silenced Voices of Hidden Survivors: Addressing intimate partner violence among women with disabilities through a combined theoretical approach. Affilia. 2020;36(2):156-166. doi:10.1177/0886109920944555
4. Breiding MJ, Armour BS. The association between disability and intimate partner violence in the United States. Annals of Epidemiology. 2015;25(6):455-457. doi:10.1016/j.annepidem.2015.03.017
5. Signore C. Reproductive and sexual health for women with disabilities. In: Miles-Cohen SE, Signore C, eds. Eliminating inequities for women with disabilities: An agenda for health and wellness. American Psychological Association; 2016:93-113. doi:10.1037/14943-006
6. Curry, M. A., Powers, L. E., & Oschwald, M. Development of an Abuse Screening Tool for Women with Disabilities. Journal of Aggression, Maltreatment & Trauma, 2004;8(4), 123–141. https://doi-org.online.uchc.edu/10.1300/J146v08n04_06
7. Alhusen JL, Bloom T, Anderson J, Hughes RB. Intimate partner violence, reproductive coercion, and unintended pregnancy in women with disabilities. Disabil Health J. 2020;13(2):100849. doi:10.1016/j.dhjo.2019.100849
8. McFarlane J, Hughes RB, Nosek MA, Groff JY, Swedlend N, Dolan Mullen P. Abuse Assessment Screen-Disability (AAS-D): Measuring Frequency, Type, and Perpetrator of Abuse toward Women with Physical Disabilities. Journal of Women's Health & Gender-Based Medicine. 2001;10(9):861-866. doi:https://doi.org/10.1089/152460901753285750

RELEVANT AMA POLICY

Family and Intimate Partner Violence H-515.965

(1) Our AMA believes that all forms of family and intimate partner violence (IPV) are major public health issues and urges the profession, both individually and collectively, to work with other interested parties to prevent such violence and to address the needs of survivors. Physicians have a major role in lessening the prevalence, scope and severity of child maltreatment, intimate partner violence, and elder abuse, all of which fall under the rubric of family violence. To suppor physicians in practice, our AMA will continue to campaign against family violence and remains open to working with all interested parties to address violence in US society.

(2) Our AMA believes that all physicians should be trained in issues of family and intimate partner violence through undergraduate and graduate medical education as well as continuing professional development. The AMA, working with state, county and specialty medical societies as well as academic medical centers and other appropriate groups such as the Association of American Medical Colleges, should develop and disseminate model curricula on violence for incorporation into undergraduate and graduate medical education, and all parties should work for the rapid distribution and adoption of such curricula. These curricula should include coverage of the diagnosis, treatment, and reporting of child maltreatment, intimate partner violence, and elder abuse and provide training on interviewing techniques, risk assessment, safety planning, and procedures for linking with resources to assist survivors. Our AMA supports the inclusion of questions on family violence issues on licensure and certification tests.

(3) The prevalence of family violence is sufficiently high and its ongoing character is such that physicians, particularly physicians providing primary care, will encounter survivors on a regular basis. Persons in clinical settings are more likely to have experienced intimate partner and family violence than non-clinical

populations. Thus, to improve clinical services as well as the public health, our AMA encourages physicians to: (a) Routinely inquire about the family violence histories of their patients as this knowledge is essential for effective diagnosis and care; (b) Upon identifying patients currently experiencing abuse or threats from intimates, assess and discuss safety issues with the patient before he or she leaves the office, working with the patient to develop a safety or exit plan for use in an emergency situation and making appropriate referrals to address intervention and safety needs as a matter of course; (c) After diagnosing a violence-related problem, refer patients to appropriate medical or health care professionals and/or community-based trauma-specific resources as soon as possible; (d) Have written lists of resources available for survivors of violence, providing information on such matters as emergency shelter, medical assistance, mental health services, protective services and legal aid; (e) Screen patients for psychiatric sequelae of violence and make appropriate referrals for these conditions upon identifying a history of family or other interpersonal violence; (f) Become aware of local resources and referral sources that have expertise in dealing with trauma from IPV; (g) Be alert to men presenting with injuries suffered as a result of intimate violence because these men may require intervention as either survivors or abusers themselves; (h) Give due validation to the experience of IPV and of observed symptomatology as possible sequelae; (i) Record a patient's IPV history, observed traumata potentially linked to IPV, and referrals made; (j) Become involved in appropriate local programs designed to prevent violence and its effects at the community level.

(4) Within the larger community, our AMA:

(a) Urges hospitals, community mental health agencies, and other helping professions to develop appropriate interventions for all survivors of intimate violence. Such interventions might include individual and group counseling efforts, support groups, and shelters.

(b) Believes it is critically important that programs be available for survivors and perpetrators of intimate violence.

(c) Believes that state and county medical societies should convene or join state and local health departments, criminal justice and social service agencies, and local school boards to collaborate in the development and support of violence control and prevention activities.

(5) With respect to issues of reporting, our AMA strongly supports mandatory reporting of suspected or actual child maltreatment and urges state societies to support legislation mandating physician reporting of elderly abuse in states where such legislation does not currently exist. At the same time, our AMA oppose the adoption of mandatory reporting laws for physicians treating competent, non-elderly adult survivors of intimate partner violence if the required reports identify survivors. Such laws violate basic tenets of medical ethics. If and where mandatory reporting statutes dealing with competent adults are adopted, the AMA believes the laws must incorporate provisions that: (a) do not require the inclusion of survivors' identities; (b) allow competent adult survivors to opt out of the reporting system if identifiers are required; (c) provide that reports be made to public health agencies for surveillance purposes only; (d) contain a sunset mechanism; and (e) evaluate the efficacy of those laws. State societies are encouraged to ensure that all mandatory reporting laws contain adequate protections for the reporting physician and to educate physicians on the particulars of the laws in their states.

(6) Substance abuse and family violence are clearly connected. For this reason, our AMA believes that:

(a) Given the association between alcohol and family violence, physicians should be alert for the presence of one behavior given a diagnosis of the other. Thus, a physician with patients with alcohol problems should screen for family violence, while physicians with patients presenting with problems of physical or sexual abuse should screen for alcohol use.

(b) Physicians should avoid the assumption that if they treat the problem of alcohol or substance use and abuse they also will be treating and possibly preventing family violence.

(c) Physicians should be alert to the association, especially among female patients, between current alcohol or drug problems and a history of physical, emotional, or sexual abuse. The association is strong enough to warrant complete screening for past or present physical, emotional, or sexual abuse among patients who present with alcohol or drug problems.

(d) Physicians should be informed about the possible pharmacological link between amphetamine use and human violent behavior. The suggestive evidence about barbiturates and amphetamines and violence should be followed up with more research on the possible causal connection between these drugs and violent behavior.

(e) The notion that alcohol and controlled drugs cause violent behavior is pervasive among physicians and other health care providers. Training programs for physicians should be developed that are based on

empirical data and sound theoretical formulations about the relationships among alcohol, drug use, and violence. [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) promote crisis resources for LGBTQ patients that cater to the specific needs of LGBTQ survivors of IPV; (2) encourage physicians to familiarize themselves with resources available in their communities for LGBTQ survivors of IPV; (3) advocate for federal funding to support programs and services for survivors of IPV that do not discriminate against underserved communities, including on the basis of sexual orientation and gender identity; (4) encourage research on intimate partner violence in the LGBTQ community to include studies on the prevalence, the accuracy of screening tools, effectiveness of early detection and interventions, as well as the benefits and harms of screening; and (5) encourage the dissemination of research to educate physicians and the community regarding the prevalence of IPV in the LGBTQ population, the accuracy of screening tools, effectiveness of early detection and interventions, as well as the benefits and harms of screening. [Res. 903, I-17; Modified: CSAPH Rep. 01, I-18]

Medical Care of Persons with Disabilities H-90.968
1. Our American Medical Association encourages:
    a. clinicians to learn and appreciate variable presentations of complex functioning profiles in all persons with disabilities including but not limited to physical, sensory, developmental, intellectual, learning, and psychiatric disabilities and chronic illnesses.
    b. medical schools and graduate medical education programs to acknowledge the benefits of education on how aspects in the social model of disability (e.g. ableism) can impact the physical and mental health of persons with disabilities.
    c. medical schools and graduate medical education programs to acknowledge the benefits of teaching about the nuances of uneven skill sets, often found in the functioning profiles of persons with developmental disabilities, to improve quality in clinical care.
    d. education of physicians on how to provide and/or advocate for developmentally appropriate and accessible medical, social and living support for patients with disabilities so as to improve health outcomes.
    e. medical schools and residency programs to encourage faculty and trainees to appreciate the opportunities for exploring diagnostic and therapeutic challenges while also accruing significant personal rewards when delivering care with professionalism to persons with profound disabilities and multiple co-morbid medical conditions in any setting.
    f. medical schools and graduate medical education programs to establish and encourage enrollment in elective rotations for medical students and residents at health care facilities specializing in care for the disabled.
    g. cooperation among physicians, health & human services professionals, and a wide variety of adults with disabilities to implement priorities and quality improvements for the care of persons with disabilities.
2. Our AMA seeks:
    a. legislation to increase the funds available for training physicians in the care of individuals with disabilities, and to increase the reimbursement for the health care of these individuals.
    b. insurance industry and government reimbursement that reflects the true cost of health care of individuals with disabilities.
3. Our AMA entreats health care professionals, parents, and others participating in decision-making to be guided by the following principles:
    a. All people with disabilities, regardless of the degree of their disability, should have access to appropriate and affordable medical and dental care throughout their lives.
    b. An individual's medical condition and welfare must be the basis of any medical decision. Our AMA advocates for the highest quality medical care for persons with profound disabilities; encourages support for health care facilities whose primary mission is to meet the health care needs of persons with profound disabilities; and informs physicians that when they are presented with an opportunity to care for patients with profound disabilities, that there are resources available to them.

4. Our AMA will collaborate with appropriate stakeholders to create a model general curriculum/objective that
    a. incorporates critical disability studies.
    b. includes people with disabilities as patient instructors in formal training sessions and preclinical and clinical instruction.
5. Our AMA recognizes the importance of managing the health of children and adults with developmental and intellectual disabilities as a part of overall patient care for the entire community.
6. Our AMA supports efforts to educate physicians on health management of children and adults with intellectual and developmental disabilities, as well as the consequences of poor health management on mental and physical health for people with intellectual and developmental disabilities.
7. Our AMA encourages the Liaison Committee on Medical Education, Commission of Osteopathic College Accreditation, and allopathic and osteopathic medical schools to develop and implement a curriculum on the care and treatment of people with a range of disabilities.
8. Our AMA encourages the Accreditation Council for Graduate Medical Education and graduate medical education programs to develop and implement curriculum on providing appropriate and comprehensive health care to people with a range of disabilities.
9. Our AMA encourages the Accreditation Council for Continuing Medical Education, specialty boards, and other continuing medical education providers to develop and implement continuing programs that focus on the care and treatment of people with a range of disabilities.
10. Our AMA will advocate that the Health Resources and Services Administration include persons with disabilities as a medically underserved population.
11. Specific to people with developmental and intellectual disabilities, a uniquely underserved population, our AMA encourages:
    a. Medical schools and graduate medical education programs to acknowledge the benefits of teaching about the nuances of uneven skill sets, often found in the functioning profiles of persons with developmental and intellectual disabilities, to improve quality in clinical education.
    b. Medical schools and graduate medical education programs to establish and encourage enrollment in elective rotations for medical students and residents at health care facilities specializing in care for individuals with developmental and intellectual disabilities.
    c. Cooperation among physicians, health and human services professionals, and a wide variety of adults with intellectual and developmental disabilities to implement priorities and quality improvements for the care of persons with intellectual and developmental disabilities.

[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]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 904
(I-24)

Introduced by: Women Physicians Section

Subject: Regulation of Ionized Radiation Exposure for Healthcare Workers

Referred to: Reference Committee K

Whereas, ionizing radiation is a known human carcinogen and breast tissue is particularly sensitive to radiation, with a direct linear correlation between increased exposure and heightened breast cancer risk;[1] and

Whereas, a survey of over five-hundred orthopedic residents find that 98% believed radiation safety personal protective equipment (PPE) should be provided, yet only 54.2% reported that it was made available to them;[2] and

Whereas, standard lead and lead-free aprons often leave the upper outer quadrant (UOQ) of the breast and axilla, common sites for breast cancer, exposed, and lead to increased vulnerability for radiation exposure and risk for breast cancer;[3] and

Whereas, radiation aprons that are both too tight or too loose and use C-arm X-Ray machines in the lateral projection instead of an anteroposterior projection both result in increased breast radiation dose-equivalent rates in the UOQ;[4] and

Whereas, recent studies indicate an increased risk of breast cancer among female surgeons, particularly those frequently exposed to ionizing radiation during image-guided procedures;[5] and

Whereas, in a recent study using artificial female torsos to assess radiation exposure, researchers discovered insufficient protection for the UOQ and found no statistically significant reduction in radiation dose in breast tissue when comparing standard PPE to a torso without PPE;[6] and

Whereas, research demonstrates that female orthopedic surgeons have 2.9-fold to 3.9-fold increase in the prevalence of breast cancer, compared with an age matched female population, and a recent study reports a 1.7-fold increase in breast cancer rates among female healthcare workers exposed to radiation compared to their non-exposed female healthcare worker counterparts;[5] and

Whereas, a 2022 study demonstrates a standardized prevalence ratio of invasive cancer, breast cancer, and melanoma in orthopedic surgeons to be 7.59%, 2.98%, and 1.49%, respectively, demonstrating a prevalence of cancer of 189% higher in female orthopedic surgeons than the general US female population when adjusted for age and race;[7] and

Whereas, unlike orthopedic surgeons, similar lifestyle and demographic female surgeons that are not exposed frequently to ionized radiation from image-guided techniques such as

fluoroscopy, such as plastic or urologic surgeons, do not have an increased risk compared to the general population;[8] and

Whereas, in addition to surgeons, specialists such as cardiologists and radiologists, that rely on tools like fluoroscopy, also have increased risk of cancer, with one prospective cohort study pointing to elevated risks of brain cancer, breast cancer, and melanoma in radiologic technologists;[9] and

Whereas, fields with increased exposure to ionizing radiation are increasing in popularity for women, including an increase in female applicants to orthopedic surgery residency programs from 11.7% in 2007 to 23% in 2022,[10] highlighting the increased need for re-evaluation of current radiation protective measures; and

Whereas, it has been shown that many orthopedic surgeons are currently not satisfied with current options to protect themselves from radiation;[11] therefore be it

RESOLVED, that our American Medical Association encourage public and private healthcare institutions to ensure more comprehensive coverage of different body types by providing PPE that more completely protects employees of all genders and pregnancy statuses, such as lead and lead-free aprons with capped sleeves, axillary supplements, and maternity aprons. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Date Received: 09/19/2024

REFERENCES

1. Ronckers CM, Erdmann CA, Land CE. Radiation and breast cancer: a review of current evidence. Breast Cancer Res 2005;7:21-32.t
2. Bowman JR, Razi A, Watson SL, Pearson JM, Hudson PW, Patt JC, Ames SE, Leddy LR, Khoury JG, Tubb CC, McGwin G, Ponce BA. What Leads to Lead: Results of a Nationwide Survey Exploring Attitudes and Practices of Orthopaedic Surgery Residents Regarding Radiation Safety. J Bone Joint Surg Am. 2018 Feb 7;100(3):e16.
3. Valone LC, Chambers M, Lattanza L, James MA. Breast radiation exposure in female orthopaedic surgeons. J Bone Joint Surg Am 2016;98:1808-13.
4. Van Nortwick SS, Leonard DA, Finlay AK, Chou L, Valone LC. Methods for reducing intraoperative breast radiation exposure of orthopaedic surgeons. J Bone Joint Surg Am 2021;103:1646-51.
5. Chou LB, Chandran S, Harris AHS, Tung J, Butler LM. Increased breast cancer prevalence among female orthopedic surgeons. J Womens Health (Larchmt) 2012;21:683-9.
6. Protecting female healthworkers from ionising radiation at work, The BMJ (2023).
7. Chou LB, Johnson B, Shapiro LM, et al. Increased prevalence of breast and all-cause cancer in female orthopaedic surgeons. J Am Acad Orthop Surg Glob Res Rev 2022;6:e22.00031.
8. Chou LB, Lerner LB, Harris AHS, Brandon AJ, Girod S, Butler LM. Cancer Prevalence among a Cross-sectional Survey of Female Orthopedic, Urology, and Plastic Surgeons in the United States. Womens Health Issues 2015;25:476-81.
9. Rajaraman P, Doody MM, Yu CL, Preston DL, Miller JS, Sigurdson AJ, Freedman DM, Alexander BH, Little MP, Miller DL, Linet MS. Cancer Risks in U.S. Radiologic Technologists Working With Fluoroscopically Guided Interventional Procedures, 1994-2008. AJR Am J Roentgenol. 2016 May;206(5):1101-8; quiz 1109.
10. Pinpin C, White PB, Nellans KW, Bitterman AD, Mulcahey MK, Cohn RM. Exponential Growth in Female Residency Applicants in Orthopaedic Surgery Over the Past 15 Years. JB JS Open Access. 2023;8(2):e23.00004. Published 2023 May 30.
11. Jaiman A, Prakash J, Chopra RK, Neogi DS. Time to Look for Ergonomically Viable Designs of Radiation Protection Aprons and Thyroid Shields in Orthopedic Surgery: A Survey of 416 Orthopedic Surgeons. Cureus. 2023;15(11):e48426. Published 2023 Nov 7.

Relevant AMA Policy

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

1. Our American Medical Association supports the following policy on nuclear energy and low-level ionizing radiation. Usefulness of Nuclear Energy: Energy produced by nuclear reactors makes an important contribution to the generation of electricity in the US at present, and it will continue to do so in the foreseeable future. Investigation and research

should continue in order to develop improved safety and efficiency of nuclear reactors, and to explore the potential of competing methods for generating electricity. The research should include attention to occupational and public health hazards as well as to the environmental problems of waste disposal and atmospheric pollution.

2. Research on Health Effects of Low Level Radiation: There should be a continuing emphasis on research that is capable of determining more precisely the health effects of low level ionizing radiation.
3. Uranium Mill Tailings: Uranium mill tailings should be buried or otherwise covered.
4. Radioactive Waste Disposal: There should be acceleration of pilot projects to evaluate techniques for the disposal of high-level radioactive wastes. The decommissioning of nuclear reactors is a source of nuclear waste which requires accelerated technological investigation and planning.
5. Occupational Safety: The philosophy of maintaining exposures of workers at levels "as low as reasonably achievable (ALARA)" is commended. The present federal standards for occupational exposure to ionizing radiation are adequate. The responsibilities of the various federal agencies regarding workers in the nuclear energy industry should be clarified; these agencies include the Departments of Energy, Defense, HHS, Labor and Transportation; and the NRC, VA and EPA.
6. Minimizing Exposures to Radiation: Each physician should attempt to minimize exposures of patients to ionizing radiation in accord with good medical practice.
7. Radiation Exposure Standards: The present standards for exposure of populations to ionizing radiation are adequate for the protection of the public.
8. Emergencies and Governmental Readiness: Government agencies at all levels should be prepared to respond to nuclear energy-related emergencies. There is need for improved public planning by the several federal agencies involved, including the Federal Emergency Management Agency (FEMA) and the agencies of state and local governments. Responsible officials should develop skills and undergo periodic retraining in order to be able to act appropriately during major radiation emergencies. Because emergency planning is a complex task involving aspects of health as well as problems related to utilities, state and local governments and the federal government (FEMA) would benefit from the cooperation of physicians and others in the health sciences.
9. Federal Radiation Emergency Planning Responsibilities: Federal groups such as the NRC and FEMA must work together closely to fulfill responsibilities in radiological emergency preparedness and in crisis management. There is a need for NRC and FEMA to define better the roles of community hospitals and of physicians.
10. Reactor Operators and Radiation Inspectors: There is a need for better training of operating personnel with regard to prevention and management of untoward reactor operating conditions. Selection, training, and ongoing performance evaluation of operating personnel, and of radiation inspectors, are key elements in the safety of reactor workers and of the public. Physicians should help develop methods of selecting and evaluating personnel in the nuclear power industry.
11. Radiation Training for Physicians: Physicians should be prepared to answer the questions of their patients about ionizing radiation, especially if there is a radiation emergency. Each hospital should have adequately trained physicians and a plan and protocol for receiving and caring for radiation victims.
12. Radiation Education for the Public: Further education of the public about ionizing radiation is recommended.
13. Location of Nuclear Reactors: All nuclear reactors built in the future should be placed in areas of low population density; present reactors located in low density areas should be managed so that the populations surrounding them remain small.
14. Multiple Sources of Power Generation: AMA recommends the use of a diverse set of electricity generating methods and a continuing emphasis on the conservation of energy.
15. X-Ray Security Scanners:
    1. Our AMA believes that as of June 2013, no data exist to suggest that individuals, including those who are especially sensitive to ionizing

radiation, should avoid backscatter security scanners due to associated health risks.

2. Our AMA supports the adoption of routine inspection, maintenance, calibration, survey, and officer training procedures meant to ensure that backscatter security scanners operate as intended.

[CSA Rep. A, A-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11; Appended: CSAPH Rep. 4, A-13; Modified: CSAPH Rep. 8, A-23; Modified: Res. 435, A-24]

Monitoring Patient Exposure to Ionizing Radiation H-455.976
Our American Medical Association will support public health, radiology and radiation oncology specialty societies and all other interested parties to monitor the issue of radiation exposure to the American public and develop a plan, if appropriate, to allow the ongoing monitoring and quantification of radiation exposure sustained by individual patients in medical settings. [CSAPH Rep. 8, A-23]

Ionizing Radiation Exposure in the Medical Setting H-455.977

1. Our American Medical Association will support appropriate specialty medical societies and other interested stakeholders to collaborate:
    a. For feasibility of monitoring and quantifying the cumulative radiation exposure sustained by individual patients in medical settings.
    b. Continue to educate physicians and the public on the appropriate use and risks of low linear energy transfer radiation in order to reduce unnecessary patient exposure in the medical setting.
2. Our AMA will continue to monitor the National Academy of Sciences' ongoing efforts to study the impact of low levels of low linear energy transfer radiation on human health.
3. Our AMA will support education and standards for all providers and medical personnel using ionizing and non-ionizing radiation that includes awareness of, and methods to avoid, patient over-radiation.
4. Our AMA will support policies that promote the safe use of medical imaging devices, informed clinical decision-making regarding the use of procedures that use radiation, and patient awareness of medical radiation exposure.
5. Our AMA will encourage the continued development and use of standardized electronic medical record systems that will help physicians track the number of imaging procedures a patient is receiving, in both the in-patient and out-patient settings, which will help physicians discuss the potential dangers of high level of radiation exposure with patients.

[CSAPH Rep. 8, A-23]

Effects of Electric and Magnetic Fields H-460.938

(1) Our American Medical Association will continue to monitor developments and issues related to the effects of electric and magnetic fields, even though no scientifically documented health risk has been associated with the usually occurring levels of electromagnetic fields; (2) Our AMA encourages research efforts sponsored by agencies such as the National Institutes of Health, U.S. Department of Energy, and the National Science Foundation to continue on exposures to electromagnetic fields and their effects, average public exposures, occupational exposures, and the effects of field surges and harmonics; and (3) Our AMA supports broad dissemination of findings and recommendations of authoritative, multidisciplinary committees, such as those convened under the auspices of the National Academy of Sciences, National Council on Radiation Protection, International Agency for Research on Cancer, and the National Institute for Environmental Health Sciences. [CSA Rep. 7 - I-94; Reaffirmed and Modified: CSA Rep. 6, A-04; Reaffirmed: CSAPH Rep. 1, A-14; Reaffirmed: CSAPH Rep. 01, A-24]

Advancing Gender Equity in Medicine D-65.989

1. Our American Medical Association will:

a. advocate for institutional, departmental and practice policies that promote transparency in defining the criteria for initial and subsequent physician compensation.
b. advocate for pay structures based on objective, gender-neutral criteria.
c. encourage a specified approach, sufficient to identify gender disparity, to oversight of compensation models, metrics, and actual total compensation for all employed physicians.
d. advocate for training to identify and mitigate implicit bias in compensation determination for those in positions to determine salary and bonuses, with a focus on how subtle differences in the further evaluation of physicians of different genders may impede compensation and career advancement.

2. Our AMA will recommend as immediate actions to reduce gender bias:
    a. Elimination of the question of prior salary information from job applications for physician recruitment in academic and private practice.
    b. Create an awareness campaign to inform physicians about their rights under the Lilly Ledbetter Fair Pay Act and Equal Pay Act.
    c. Establish educational programs to help empower all genders to negotiate equitable compensation.
    d. Work with relevant stakeholders to host a workshop on the role of medical societies in advancing women in medicine, with co-development and broad dissemination of a report based on workshop findings.
    e. Create guidance for medical schools and health care facilities for institutional transparency of compensation, and regular gender-based pay audits.
3. Our AMA will collect and analyze comprehensive demographic data and produce a study on the inclusion of women members including, but not limited to, membership, representation in the House of Delegates, reference committee makeup, and leadership positions within our AMA, including the Board of Trustees, Councils and Section governance, plenary speaker invitations, recognition awards, and grant funding, and disseminate such findings in regular reports to the House of Delegates and making recommendations to support gender equity.
4. Our AMA will commit to pay equity across the organization by asking our Board of Trustees to undertake routine assessments of salaries within and across the organization, while making the necessary adjustments to ensure equal pay for equal work.
5. Our AMA will:
    a. require all members elected and appointed to national and regional AMA leadership positions to complete AMA Code of Conduct and anti-harassment training, with continued evaluation of the training for effectiveness in reducing harassment within the AMA.
    b. work with the Women Physicians Section, American Medical Women's Association, GLMA: Health Professionals Advancing LGBTQ Equality, and other stakeholders to identify an appropriate, evidence-based anti-harassment and sexual harassment prevention training to administer to leadership.

[Res. 010, A-18; Modified: BOT Rep. 27, A-19; Appended: Res. 615, A-22]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 905
(I-24)

Introduced by: Women Physicians Section

Subject: Regulation and Transparency of Contaminants in Menstrual Hygiene Products

Referred to: Reference Committee K

Whereas, menstrual hygiene products (MHP), such as tampons, menstrual cups, menstrual discs, flex-cups, or menstrual sponges, are currently classified as a medical device regulated by the Food and Drug Administration (FDA) in the US;[1] and

Whereas, tampons are currently Class II medical devices and have to adhere to Good Manufacturing Practices (GMPs) and Quality System Regulations (QSR), which include general requirements to ensure product safety and quality, such as controlling contamination, which can encompass testing for various contaminants, including heavy metals and per and polyfluoroalkyl (PFAS), depending on the "risk assessment" and product specifications;[2] and

Whereas, the FDA currently recommends that tampons be free of 2,3,7,8- tetrachlorodibenzo-p-dioxin (TCDD)/2,3,7,8-tetrachlorofuran dioxin (TCDF) and any pesticide and herbicide residues, which does not represent a sufficient range of potentially harmful contaminants;[3] and

Whereas, new research found that tampons in the US contained the presence of 16 metals contaminants, including arsenic, lead, and cadmium, and reported that no previous studies have measured levels of metals in tampons;[4] and

Whereas, tampons purchased in the US were found to have statistically significantly higher levels of lead, cobalt, and cadmium than those purchased in the UK and EU;[4] and

Whereas, research has found that menstrual products contain PFAS, phthalates, and volatile organic compounds (VOC), such as terpenes and aromatic compounds like benzenes (in scented products), 1,4-dichlorobenzene, and naphthalene, which are known or suspected carcinogens;[5,6] and

Whereas, chemicals known to be allergens, preservatives, and potential carcinogens have also been found in numerous different brands of vaginal wipes;[7,8] and

Whereas, the vaginal canal is highly absorbent and has direct access to the bloodstream due to its dense network of blood vessels, allowing substances that are absorbed to bypass the digestive system and first-pass metabolism;[9] and

Whereas, though there is limited research assessing the bioavailability for vaginal absorption in tampons of contaminants specifically, vaginal vasculature has been well established as an effective and efficient method of drug absorption, leading to higher drug concentration due to steady state absorption and lack of gastrointestinal limitations;[10] and

Whereas, arsenic is a known carcinogen and is associated with cardiovascular, and respiratory and neurological disease, and in vivo research has shown vaginal arsenic exposure disrupts oxidative mechanisms in the uterus and ovaries;[11] and

Whereas, the U.S. Environmental Protection Agency (EPA) has said there is no safe level of exposure to lead in water,[12] and even low-level exposure to lead negatively impacts cognitive function; and lead accumulates in bones, substituting for calcium, and can remain in the body for decades, contributing to long-term health issues;[13] and

Whereas, cadmium is known to be a cause of kidney and cardiovascular disease;[14] and

Whereas, the FDA currently provides levels of acceptable limits of heavy metals in other drug products that have direct contact with vasculature and are made primarily of cotton, such as nonresorbable gauze (lead <10 ppm, mercury <0.5 ppm, and arsenic <1.5 ppm);[15] and

Whereas, PFAS can have half-lives of up to 8.5 years and undergo rapid hematogenous dissemination to the brain, liver, lungs, bones, and kidney and have been associated with reproductive toxicities, developmental delays in children, thyroid cancer, delayed onset of puberty in girls, and liver disease,[5] and

Whereas, some states have mandated transparency in disclosing ingredients, such as in New York,[16,17] but there remain loopholes that allow companies to protect trade secrets and omit information regarding ingredients, such as the use of certain fragrances in tampons which contain phthalates, a group of chemicals that are known estrogen disruptors;[18,19] therefore be it

RESOLVED, that our American Medical Association support more comprehensive research on contaminants in menstrual hygiene products (MHP), including but not limited to tampons, other MHPs, and vaginal wipes, and the absorption of toxins into systemic circulation in an effort to better understand their effects on health (New HOD Policy); and be it further

RESOLVED, that our AMA support regulations and legislation that mandate transparency, disclosure, and accurate labeling of contaminants in menstrual hygiene products. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Date Received: 09/19/2024

REFERENCES

1. Jin Il Kwak, Sun-Hwa Nam, Dasom Kim, Youn-Joo An, “Comparative study of feminine hygiene product regulations in Korea, the European Union, and the United States” Regulatory Toxicology and Pharmacology, Volume 107, 2019, 104397, ISSN 0273-2300.
2. Quality System (QS) Regulation/Medical Device Current Good Manufacturing Practices (CGMP). https://www.fda.gov/medical-devices/postmarket-requirements-devices/quality-system-qs-regulationmedical-device-current-good-manufacturing-practices-cgmp
3. Menstrual Tampons and Pads: Information for Premarket Notification Submissions (510(k)s) - Guidance for Industry and FDA Staff. fda.gov. Accessed August 15, 2024. https://www.fda.gov/regulatory-information/search-fda-guidance-documents/menstrual-tampons-and-pads-information-premarket-notification-submissions-510ks-guidance-industry#ft9
4. Jenni A. Shearston, Kristen Upson, Milo Gordon, Vivian Do, Olgica Balac, Khue Nguyen, Beizhan Yan, Marianthi-Anna Kioumourtzoglou, Kathrin Schilling, Tampons as a source of exposure to metal(loid)s, Environment International, Volume 190, 2024,108849, ISSN 0160-4120.
5. Zhou Y, Lin X, Xing Y, Zhang X, Lee HK, Huang Z. Per- and Polyfluoroalkyl Substances in Personal Hygiene Products: The Implications for Human Exposure and Emission to the Environment. Environ Sci Technol. 2023 Jun 13;57(23):8484-8495. doi: 10.1021/acs.est.2c08912. Epub 2023 Jun 1. Erratum in: Environ Sci Technol. 2023 Jul 18;57(28):10489. doi: 10.1021/acs.est.3c04640. Erratum in: Environ Sci Technol. 2024 Feb 6;58(5):2584-2585.

6. Lin N, Ding N, Meza-Wilson E, Manuradha Devasurendra A, Godwin C, Kyun Park S, Batterman S. Volatile organic compounds in feminine hygiene products sold in the US market: A survey of products and health risks. Environ Int. 2020 Nov;144:105740. doi: 10.1016/j.envint.2020.105740. Epub 2020 Aug 28.
7. Intimate wipes: How a little wipe does more harm than good. womensvoices.org. Accessed August 15, 2024. https://womensvoices.org/feminine-wipes-health-environment-concerns/
8. Harmful Chemicals Found in Feminine Wipes. womensvoices.org. Accessed August 15, 2024. https://womensvoices.org/harmful-chemicals-feminine-wipes/
9. 23.3: Anatomy and Physiology of the Female Reproductive System. https://med.libretexts.org. Accessed August 15, 2024. https://med.libretexts.org/Courses/Skyline_College/BIOL_250%3A_Human_Anatomy/23%3A_The_Reproductive_System/23.03%3A_Anatomy_and_Physiology_of_the_Female_Reproductive_System
10. Alexander NJ, Baker E, Kaptein M, Karck U, Miller L, Zampaglione E. Why consider vaginal drug administration? Fertil Steril. 2004 Jul;82(1):1-12.
11. Irnawati, R. Idroes, M. Akmal, E. Suhartono, A. Rusyana, I. Seriana. The effect and activity of free radical enzymes due to arsenic exposure through the vulva and vagina. Macedonian Journal of Medical Sciences., 10 (B) (2022), pp. 2279-2285.
12. Basic Information about Lead in Drinking Water. https://19january2017snapshot.epa.gov. Accessed August 15, 2024. https://19january2017snapshot.epa.gov/ground-water-and-drinking-water/basic-information-about-lead-drinking-water_.html#:~:text=The%20MCLG%20for%20lead%20is,level%20of%20exposure%20to%20lead
13. United States Department of Health and Human Services Agency for Toxic Substances and Disease Registry. Toxicological Profile for Lead. US Department of Health and Human Services;2020.
14. United States Department of Health and Human Services Agency for Toxic Substances and Disease Registry. Toxicological Profile for Cadmium. September 2012.
15. 232 ELEMENTAL IMPURITIES—LIMITS. usp.org. Accessed August 15, 2024. https://www.usp.org/sites/default/files/usp/document/our-work/chemical-medicines/key-issues/c232-usp-39.pdf
16. Period products can contain hazardous ingredients. Some states are requiring more transparent labeling. pbs.org. Accessed August 15, 2024. https://www.pbs.org/newshour/health/period-products-can-contain-hazardous-ingredients-some-states-are-requiring-more-transparent-labeling#:~:text=Even%20though%20manufacturing%20of%20scented,can't%20copy%20the%20formulas.
17. Menstrual product labeling. 399-aaaa. New York State (2019-2020). https://legislation.nysenate.gov/pdf/bills/2019/S2387B
18. Wang Y, Qian H. Phthalates and Their Impacts on Human Health. Healthcare (Basel). 2021 May 18;9(5):603. doi: 10.3390/healthcare9050603.
19. Perfluoroalkyl and Polyfluoroalkyl Substances (PFAS). niehs.nih.gov. Accessed August 15, 2024. https://www.niehs.nih.gov/health/topics/agents/pfc#:~:text=Although%20PFOS%20use%20has%20been,consistent%20evidence%20of%20liver%20damage.

RELEVANT AMA POLICY

Eliminating Lead, Mercury and Benzene from Common Household Products H-135.959
1. Our American Medical Association supports the development of standards to achieve non-hazardous levels of exposure to lead, mercury, or benzene arising from common household or workplace products.
2. Our AMA encourages efforts to minimize or eliminate mercury use in hospitals and other health care facilities.
3. Our AMA will work in coalitions with appropriate federal agencies and health care organizations to educate physicians and other healthcare professionals about suitable alternatives to the use of mercury and mercury-containing devices and the appropriate disposal of mercury and mercury-containing devices.
4. Our AMA encourages efforts to minimize or eliminate lead in all commercial and household products.
[Sub. Res. 418, I-92; Appended: Sub. Res. 410, A-00; Reaffirmation I-00; Reaffirmed A-03; Modified: CSAPH Rep. 7, A-10; Reaffirmed in lieu of Res. 522, A-12; Reaffirmed: CSAPH Rep. 1, A-22]

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.
[Res. 209, I-21]

Considering Feminine Hygiene Products as Medical Necessities H-525.974
Our AMA encourages the Internal Revenue Service to classify feminine hygiene products as medical necessities; (1) 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 (2) 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.
[Res. 218, A-18 Modified: Res. 209, I-21]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 907
(I-24)

Introduced by: Academic Physicians Section

Subject: Call for Study: The Need for Hospital Interior Temperatures to be Thermally Neutral to Humans within Those Hospitals

Referred to: Reference Committee K

Whereas, a 2022 report from the Commonwealth Fund noted that the health care industry worldwide produces as much as 4.6% of all of global "greenhouse gas" (GHG) emissions (chiefly carbon dioxide, methane and ozone), while in the United States, the health care industry contributes about 8.5% of the nation's GHG emissions[1]; and

Whereas, GHG emissions since the onset of the "Industrial Revolution" are widely understood to have contributed to a progressively increased carbon dioxide (CO2) fraction of the air, and to a progressively increased average temperature of the surface of the Earth (long-term, non-human-induced cyclical fluctuations of Earth temperatures not due to human-induced GHG emissions, such as volcanic activity and other influences notwithstanding); and

Whereas, these elevated temperatures have contributed measurably to increased morbidity and mortality of human inhabitants of the Earth, not limited to residents of warmer climates and occupational groups such as outdoor laborers; and

Whereas, these elevated temperatures are also adversely impacting the natural environment upon which all life depends in ways too numerous to list in this proposed Resolution; and

Whereas, these elevated temperatures are also clearly associated with increased numbers of extreme weather events; and

Whereas, AMA policy D-135.966, most recently modified in 2022, has declared climate change to be a public health crisis, such that the goal of 50% reduction in greenhouse gas emissions by 2030 and "carbon neutrality" by 2050 are goals endorsed by this policy; and

Whereas, hospital interiors in areas where patients and families gather are typically maintained by heating, ventilation and air conditioning (HVAC) systems that are not typically supplied by "renewable" energy sources, and thus contribute significantly to health care's GHG burden; and

Whereas, the burden of hospitals' HVAC systems upon health care's GHG burden are exacerbated when overly cool temperatures are maintained, as exemplified by, times when many patients and visitors must wear jackets or sweaters to stay warm; and

Whereas, the burden of hospitals' HVAC systems upon which health care's GHG burden are also exacerbated when overly warm temperatures are maintained, as exemplified, times when patients and visitors sometimes wear "shirtsleeve" attire to avoid becoming hyperthermic; and

Whereas, hospitals' modern HVAC systems can be controlled with sufficient precision such that patient rooms, hospital corridors, cafeterias and other common areas need not be maintained

outside of a temperature range of 21 to 25 degrees C, a range that most human beings would find to be comfortable; and

Whereas, nothing in this proposed resolution would apply to areas which must be kept at temperatures outside of this 21 degree C-25 degree C range, such as certain operating theaters and other areas of hospitals with specific patient care roles that make the specifying of such a narrow zone of indoor temperatures unwise or impractical; and

Whereas, time is running short to permit humankind to limit GHGs to a quantity not likely to disrupt life and ecosystems irreversibly with unforeseeable consequences to humans and their health; therefore be it

RESOLVED, that our American Medical Association study the potential feasibility of the creation of a hospital accreditation standard for implementation by the Centers for Medicare and Medicaid Services, through accreditation visits provided by The Joint Commission, Det Norske Veritas, and other accrediting agencies, such that hospital internal temperatures will require ongoing monitoring for compliance with a new standard for hospital internal temperatures (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that hospital “common areas” must be maintained within a temperature range across which most humans would be comfortable when dressed for the weather of the season (for example, between 21 degrees C - 25 degrees C), toward decreasing health care’s greenhouse gas impact, with a report back at the 2025 Interim Meeting of the AMA House of Delegates (Directive to Take Action); and be it further

RESOLVED, that our AMA will forward the results of this study regarding the maintaining of hospital internal temperatures within a suitably narrow range to health care journalists, hospital regulators, hospital executives, and other relevant parties, toward the eventual implementation of the findings and recommendations that are anticipated to be reached. (Directive to Take Action)

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

Received: 9/19/2024

REFERENCES

1. Commonwealth Fund "Explainer". How the U.S. Health Care System Contributes to Climate Change. Issued April 9, 2022. https://www.commonwealthfund.org/publications/explainer/2022/apr/how-us-health-care-system-contributes-climate-change. Accessed March 15, 2024.

RELEVANT AMA POLICY

D-135.966 Declaring Climate Change a Public Health Crisis

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.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 909
(I-24)

Introduced by: Medical Student Section

Subject: Support of Universal School Meals for School Age Children

Referred to: Reference Committee K

Whereas, the Community Eligibility Provisions (CEP) of the Healthy, Hunger-Free Kids Act of 2010 provides free school breakfast and lunch to schools where at least 40% of students are eligible based on income, decreasing food insecurity among low-income households[1-2]; and

Whereas, when free school meals are provided only to students who qualified financially, students that qualify for free or reduced-price meals based on financial need do not utilize these meals due to the negative stigma, judgment, and bullying[3-4]; and

Whereas, universal school meal programs, known as "Healthy School Meals for All" (HSMFA) programs, provide breakfast and lunch to all students, free of charge to the students and their families[5]; and

Whereas, the 8 states that have passed Healthy School Meals for All policies have done so through various methods, including bills, ballot measures, or state budget inclusions, allowing the state to cover the additional expenditures not already covered by national school meal programs[6]; and

Whereas, a majority of parents report that their children are not embarrassed to eat school meals through Healthy School Meals for All programs, and schools that instituted universal school meals demonstrated improved weight outcomes and increased nutrient intake amongst students[1, 7,8]; and

Whereas, organizations including American Academy of Pediatrics, Academy of Nutrition & Dietetics, American Heart Association, American Federation of Teachers, and National Education Association all support initiatives to offer free breakfast and lunch to all school-age children[9]; therefore be it

RESOLVED, that our American Medical Association advocate for federal and state efforts to adopt, fund, and implement universal school meal programs that include the provision of breakfast and lunch to all school-aged children, free of charge to families, regardless of income. (Directive to Take Action)

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

Date Received: 09/19/2024

REFERENCES
1. Hecht AA, Pollack Porter KM, Turner L. Impact of The Community Eligibility Provision of the Healthy, Hunger-Free Kids Act on Student Nutrition, Behavior, and Academic Outcomes: 2011-2019. Am J Public Health. 2020;110(9):1405-1410. doi:10.2105/AJPH.2020.305743
2. Marcus M, Yewell KG. The Effect of Free School Meals on Household Food Purchases: Evidence from the Community Eligibility Provision. J Health Econ. 2022;84:102646. doi:10.1016/j.jhealeco.2022.102646
3. Harvard T.H. Chan School of Public Health. As federal support for free school meals drops, kids' stigma may increase. hsph.harvard.edu. Published September 28, 2023. Accessed March 3, 2024. https://www.hsph.harvard.edu/news/hsph-in-the-news/free-school-meals-stigma/#:~:text=The%20stigma%20around%20free%20school,was%20free%20for%20all%20students
4. Cohen J, Gosliner W, Hecht C, et al. Impact of Massachusetts' Healthy School Meals for All Policy on Families Summary.; 2023. Accessed March 31, 2024. https://www.childnourishlab.org/_files/ugd/383bcd_45ee5fed8e224ffd8639f0f498086e31.pdf
5. Food Research & Action Center. Healthy School Meals for All. frac.org. Accessed March 3, 2024. https://frac.org/healthy-school-meals-for-all
6. Food Research & Action Center. States Show Us What Is Possible With Free Healthy School Meals for All Policies. frac.org. Published September 6, 2023. Accessed March 3, 2024. https://frac.org/blog/free-healthy-school-meals-for-all-policies
7. Adams EL, Raynor HA, Thornton LM, Mazzeo SE, Bean MK. Nutrient Intake During School Lunch in Title I Elementary Schools With Universal Free Meals. Health Educ Behav. 2022;49(1):118-127. doi:10.1177/10901981211011936
8. Andreyeva T, Sun X. Universal School Meals in the US: What Can We Learn from the Community Eligibility Provision?. Nutrients. 2021;13(8):2634. Published 2021 Jul 30. doi:10.3390/nu13082634
9. Food Research & Action Coalition. Healthy School Meals for All Coalition. frac.org. Accessed March 3, 2024. https://frac.org/wp-content/uploads/FINALJointStatementHSMFA.pdf

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 unhealthful foods and (b) harmonize SNAP food offerings with those of WIC.
3. Our AMA will actively lobby Congress to preserve and protect the Supplemental Nutrition Assistance Program through the reauthorization of the 2018 Farm Bill in order for Americans to live healthy and productive lives. [Res. 414, A-10; Reaffirmation A-12; Reaffirmation A-13; Appended: CSAPH Rep. 1, I-13; Reaffirmation A-14; Reaffirmation I-14; Reaffirmation A-15; Appended: Res. 407, A-17; Appended: Res. 233, A-18; 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]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 910
(I-24)

Introduced by: Medical Student Section

Subject: Food Insecurity Among Patients with Celiac Disease, Food Allergies, and Food Intolerance

Referred to: Reference Committee K

Whereas, the prevalence of celiac disease, food allergies, and food intolerance is increasing, disproportionately impacting children from low-income and minoritized backgrounds, who experience higher healthcare costs due to emergency visits and hospitalizations[1-9]; and

Whereas, gluten- and allergen-free food can cost more than double the price of other foods and are also not held to the same nutrient standards, leading to nutritional deficiencies, economic burden, and food insecurity for families affected by celiac and allergies[10-27]; and

Whereas, families receiving federal food assistance may especially struggle to afford gluten- and allergen-free foods and other substitutes to meet nutritional needs[23-27]; and

Whereas, other countries have taken various actions to address the affordability of gluten- and allergen-free foods and support patients adhering to elimination diets[28]; therefore be it

RESOLVED, that our American Medical Association support federal and state efforts to increase the affordability and quality of food alternatives for people with celiac disease, food allergies, and food intolerance (New HOD Policy); and be it further

RESOLVED, that our AMA support federal and state efforts to extend requirements for mandatory nutrient fortification to food alternatives for people with celiac disease, food allergies, and food intolerance (New HOD Policy); and be it further

RESOLVED, that our AMA support efforts to expand nutrition assistance eligibility and benefits to equitably meet the needs of households affected by celiac disease, food allergies, and food intolerance and increase access to food alternatives for people with celiac disease, food allergies, and food intolerance, including, but not limited to, efforts by food banks and pantries, food delivery systems, and prescription produce programs. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Date Received: 09/19/2024

REFERENCES

1. National Institute of Diabetes and Digestive and Kidney Diseases. Definition & Facts for Celiac Disease | NIDDK. National Institute of Diabetes and Digestive and Kidney Diseases. Published October 17, 2019. https://www.niddk.nih.gov/health-information/digestive-diseases/celiac-disease/definition-facts
2. Lopez CM, Mendez MD. Food Allergies. Nih.gov. Published October 30, 2019. https://www.ncbi.nlm.nih.gov/books/NBK482187/

3. Rostom A, Murray JA, Kagnoff MF. American Gastroenterological Association (AGA) Institute Technical Review on the Diagnosis and Management of Celiac Disease. Gastroenterology. 2006;131(6):1981-2002. doi:https://doi.org/10.1053/j.gastro.2006.10.004
4. Fasano A, Berti I, Gerarduzzi T, et al. Prevalence of Celiac Disease in At-Risk and Not-At-Risk Groups in the United States. Archives of Internal Medicine. 2003;163(3):286. doi:https://doi.org/10.1001/archinte.163.3.286
5. Gupta RS, Warren CM, Smith BM, Jiang J, Blumenstock JA, Davis MM, et al. Prevalence and severity of food allergies among US adults. JAMA Network Open 2019;2:e185630.
6. Gupta RS, Warren CM, Smith BM, Blumenstock JA, Jiang J, Davis MM, et al. The public health impact of parent-reported childhood food allergies in the United States. Pediatrics 2019;143:e20183835.
7. Gupta R, Holdford D, Bilaver L, Dyer A, Holl JL, Meltzer D. The Economic Impact of Childhood Food Allergy in the United States. JAMA Pediatrics. 2013;167(11):1026. doi:https://doi.org/10.1001/jamapediatrics.2013.2376
8. Tepler E, Wong KH, Soffer GK. Health disparities in pediatric food allergy. Ann Allergy Asthma Immunol. 2022 Oct;129(4):417-423. doi: 10.1016/j.anai.2022.04.022. Epub 2022 Apr 25. PMID: 35476967.
9. Bilaver LA, Kester KM, Smith BM, Gupta RS. Socioeconomic Disparities in the Economic Impact of Childhood Food Allergy. Pediatrics. 2016 May;137(5):e20153678. doi: 10.1542/peds.2015-3678. PMID: 27244806
10. Sampson HA, Aceves S, Bock SA, et al. Food allergy: a practice parameter update-2014. J Allergy Clin Immunol. 2014;134:1016–1025.e43
11. NIH Consensus Development Conference on Celiac Disease. NIH Consens State Sci Statements. 2004;21(1):1-23.
12. AGA Institute Medical Position Statement on the Diagnosis and Management of Celiac Disease. Gastroenterology. 2006;131(6):1977-1980.
13. Allen B, Orfila C. The Availability and Nutritional Adequacy of Gluten-Free Bread and Pasta. Nutrients. 2018;10(10):1370. doi:https://doi.org/10.3390/nu10101370
14. Stevens L, Rashid M. Gluten-free and regular foods: a cost comparison. Can J Diet Pract Res. 2008;69(3):147-150. doi:10.3148/69.3.2008.147
15. Lee AR, Wolf RL, Lebwohl B, Ciaccio EJ, Green PHR. Persistent Economic Burden of the Gluten Free Diet. Nutrients. 2019; 11(2):399. https://doi.org/10.3390/nu11020399
16. Ruchi S. Gupta, Elizabeth E. Springston, Manoj R. Warrier, Bridget Smith, Rajesh Kumar, Jacqueline Pongracic, Jane L. Holl; The Prevalence, Severity, and Distribution of Childhood Food Allergy in the United States. Pediatrics July 2011; 128 (1): e9–e17. 10.1542/peds.2011-0204
17. Center for Food Safety and Applied Nutrition. Food allergen labeling and consumer protection act of 2004. U.S. Food and Drug Administration. Accessed March 31, 2024. https://www.fda.gov/food/food-allergensgluten-free-guidance-documents-regulatory-information/food-allergen-labeling-and-consumer-protection-act-2004-falcpa.
18. Ruchi S. Gupta, Elizabeth E. Springston, Manoj R. Warrier, Bridget Smith, Rajesh Kumar, Jacqueline Pongracic, Jane L. Holl; The Prevalence, Severity, and Distribution of Childhood Food Allergy in the United States. Pediatrics July 2011; 128 (1): e9–e17. 10.1542/peds.2011-0204
19. Flammarion S, Santos C, Guimber D, et al. Diet and nutritional status of children with food allergies. Pediatr Allergy Immunol. 2011;22(2):161-165. doi:10.1111/j.1399-3038.2010.01028.x
20. Savage J, Johns CB. Food allergy: epidemiology and natural history. Immunol Allergy Clin North Am. 2015;35(1):45-59. doi:10.1016/j.iac.2014.09.004
21. Feng C, Kim JH. Beyond Avoidance: the Psychosocial Impact of Food Allergies. Clin Rev Allergy Immunol. 2019;57(1):74-82. doi:10.1007/s12016-018-8708-x
22. Szafron V, Anvari S, Pickett G, et al. Assessing health-related quality of life in children with food allergy and eosinophilic esophagitis. J Allergy Clin Immunol Pract. 2021;9(6):2520-2523.e2. doi:10.1016/j.jaip.2021.01.042
23. Wai HM, Middelveld R, Thörnqvist V, et al. Pediatric food allergy-related household costs are influenced by age, but not disease severity. World Allergy Organization Journal. 2019;12(9). doi:https://doi.org/10.1016/j.waojou.2019.100061
24. Coleman-Jensen A, Gregory C, Singh A. Household Food Security in the United States in 2013. SSRN Electronic Journal. 2014;309. doi:https://doi.org/10.2139/ssrn.2504067
25. Chen G, DunnGalvin A, Campbell DE. Impact of COVID-19 pandemic on quality of life for children and adolescents with food allergy. Clinical & Experimental Allergy. Published online June 28, 2021. doi:https://doi.org/10.1111/cea.13973
26. Guillaume JD, Jagai JS, Makelarski JA, et al. COVID-19-Related Food Insecurity Among Households with Dietary Restrictions: A National Survey. The Journal of Allergy and Clinical Immunology: In Practice. 2021;9(9):3323-3330.e3. doi:https://doi.org/10.1016/j.jaip.2021.06.015
27. Samuel LJ, Zhu J, Dwivedi P, et al. Food insecurity gaps in the Supplemental Nutrition Assistance Program based on disability status. Disabil Health J. 2023;16(4):101486. doi:10.1016/j.dhjo.2023.101486
28. Bronski P. How Do Other Countries Offset the Gluten-Free Premium? No Gluten, No Problem. February 7, 2013. https://nogluten-noproblem.com/2013/02/how-do-other-countries-offset-the-gluten-free-premium.html

RELEVANT AMA POLICY

H-150.937 Improvements to Supplemental Nutrition Programs

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 unhealthful 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]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 911
(I-24)

Introduced by: Senior Physicians Section

Subject: Adequate Masking and HPV Education for Health Care Workers (including those over age 45)

Referred to: Reference Committee K

Whereas, there has been an increase with human papilloma virus (HPV) associated with head and neck cancers[1]; and

Whereas, there are microbiological risks associated with inhaling surgical smoke during medical procedures which may contain HPV particles[2]; and

Whereas, Health Care Workers (HCW's) may be at risk of inhaling viral particles such as HPV from surgical smoke, during the removal of certain lesions[3,4,5,6,7]; and

Whereas, this potential occupational hazard based on suspected airborne HPV transmission requires adequate protection measures to protect HCWs from surgical smoke[8,9]; and

Whereas, there has been a resurgence of HPV and other sexually transmitted infections (STI's) in retirement villages suggesting a previously unrecognized need for vaccination in this population; and

Whereas, N-95 respirators are the preferred personal protective equipment for operating room and office personnel exposed to harmful airborne viral particles including HPV types 16 & 18 during electrosurgery[10,11,12,13]; therefore be it

RESOLVED, that our American Medical Association advocate for the provision of N-95 masks or equivalent be required for all HCWs (health care workers) and patients who have potential exposure to HPV (Directive to Take Action); and be it further

RESOLVED, that our AMA promote education for medical professionals on the importance of HPV education and professional responsibilities in these procedures (Directive to Take Action); and be it further

RESOLVED, that our AMA work with the Centers for Disease Control and Prevention (CDC), the Advisory Committee on Immunization Practices (ACIP) and the Occupational Safety and Health Administration (OSHA) along with other relevant stakeholders to address airborne transmission risks of HPV during surgical procedures and to prevent health care-related transmission. (Directive to Take Action); and be it further

RESOLVED, that our AMA Media Relations Team publicize with a press release to make physicians aware of these new policies, including those outlined in H-440.872, HPV Associated Cancer Prevention. (Directive to Take Action)

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

Received: 9/23/2024

REFERENCES

1. Tumban, E. (2019). A current update on human papillomavirus-associated head and neck cancers. *Viruses*, *11*(10), 922.
2. April 11, 2022 Surgical smoke: the microbiological risks (clinicalservicesjournal.com) Clinical Service Journal
3. Barrett, W.L. & Garber, S.M. (2003). Surgical smoke: a review of the literature, *Surg Endosc*. 17:979-987. (https://link.springer.com/ article/10.1007/s00464-002-8584-5)
4. Bree, K. et al. (2017). The Dangers of Electrosurgical Smoke to Operating Room Personnel. Workplace Health & Safety 65: (https://journals.sagepub.com/doi/ full/10.1177/2165079917691063)
5. Vortman, R. et al. (2021). State of the Science: A Concept Analysis of Surgical Smoke. *AORN J* 114:41-51. (https://doi.org/10.1002/aorn.13271)
6. Choi, S.H. et al. (2014). Surgical smoke may be a biohazard in surgeons performing laparoscopic surgery. *Surg Endosc* 28:2374-2380. (https://link. springer.com/article/10.1007/s00464-014-3472- 3)
7. Gloster, H.M. et al. (1995). Risk of acquiring human papillomavirus from the plume produced by the carbon dioxide laser in the treatment of warts. *J Am Acad Dermatol* 32:436-441. (https://pubmed.ncbi. nlm.nih.gov/7868712/)
8. Zhou, Q. et al. (2019). Human papillomavirus DNA in surgical smoke during cervical loop electrosurgical excision procedures and its impact on the surgeon. Cancer Management and Research 11:3643-3654. (https://doaj.org/article/d418733dd15f4258b45d2ff225c4cc20)
9. Hu, X. et al. (2021). Prevalence of HPV infections in surgical smoke exposed gynecologists. *Internat Arch Occupational & Environmental Health* 94:107-115. (https://link.springer.com/ article/10.1007/s00420-020-01568-9)
10. Searle, T. et al. (2020). Surgical plume in dermatology: an insidious and often overlooked hazard. *Clin & Experimental Dermatology* (https:// onlinelibrary.wiley.com/doi/10.1111/ced.14350)
11. Best, S.R. et al. (2020). Infectivity of Murine Papillomavirus in the surgical byproducts of treated tail warts. *Laryngoscope* 130: 712-717) (https:// onlinelibrary.wiley.com/doi/10.1002/lary.28026)
12. Palma S, Gnambs T, Crevenna R, Jordakieva G. (2021). Airborne human papillomavirus (HPV) transmission risk during ablation procedures: A systematic review and meta-analysis. *Environ Res*. Jan;192:110437
13. Mahdood B, Merajikhah A, Mirzaiee M, Bastami M, Banoueizadeh S. (2024). Virus and viral components transmitted through surgical smoke; a silent danger in operating room: a systematic review. *BMC Surg*. Aug 9;24(1):227.

RELEVANT AMA POLICY

H-440.810 Availability of Personal Protective Equipment (PPE)

1. Our AMA affirms that the medical staff of each health care institution should be integrally involved in disaster planning, strategy and tactical management of ongoing crises.
2. Our AMA supports evidence-based standards and national guidelines for PPE use, reuse, and appropriate cleaning/decontamination during surge conditions.
3. Our AMA will advocate that it is the responsibility of health care facilities to provide sufficient personal protective equipment (PPE) for all employees and staff, as well as trainees and contractors working in such facilities, in the event of a pandemic, natural disaster, or other surge in patient volume or PPE need.
4. Our AMA supports physicians and health care professionals and other workers in health care facilities in being permitted to use their professional judgement and augment institution-provided PPE with additional, appropriately decontaminated, personally-provided personal protective equipment (PPE) without penalty.
5. Our AMA supports the rights of physicians and trainees to participate in public commentary addressing the adequacy of clinical resources and/or health and environmental safety conditions necessary to provide appropriate and safe care of patients and physicians during a pandemic or natural disaster.
6. Our AMA will work with the HHS Office of the Assistant Secretary for Preparedness and Response to gain an understanding of the PPE supply chain and ensure the adequacy of the Strategic National Stockpile for public health emergencies.
7. Our AMA encourages the diversification of personal protective equipment design to better fit all body types, cultural expressions and practices among healthcare personnel.

[Res. 412, I-20; Appended: Res. 414, A-21; Modified: Res. 410, I-21]

H-440.872 HPV Associated Cancer Prevention

1. Our American Medical Association:
   a. urges physicians and other health care professionals to educate themselves and their patients about HPV and associated diseases, HPV vaccination, as well as routine HPV related cancer screening; and
   b. encourages the development and funding of programs targeted at HPV vaccine introduction and HPV related cancer screening in countries without organized HPV related cancer screening programs.
2. Our AMA will intensify efforts to improve awareness and understanding about HPV and associated diseases in all individuals, regardless of sex, such as, but not limited to, cervical cancer, head and neck cancer, anal cancer, and genital cancer, the availability and efficacy of HPV vaccinations, and the need for routine HPV related cancer screening in the general public.
3. Our AMA supports legislation and funding for research aimed towards discovering screening methodology and early detection methods for other non-cervical HPV associated cancers.
4. Our AMA:
   a. encourages the integration of HPV vaccination and routine cervical cancer screening into all appropriate health care settings and visits,
   b. supports the availability of the HPV vaccine and routine cervical cancer screening to appropriate patient groups that benefit most from preventive measures, including but not limited to low-income and pre-sexually active populations,
   c. recommends HPV vaccination for all groups for whom the federal Advisory Committee on Immunization Practices recommends HPV vaccination.
5. Our AMA encourages appropriate parties to investigate means to increase HPV vaccination rates by facilitating administration of HPV vaccinations in community-based settings including school settings.
6. Our AMA will study requiring HPV vaccination for school attendance.
7. Our AMA encourages collaboration with interested parties to make available human papillomavirus vaccination to people who are incarcerated for the prevention of HPV-associated cancers.

[Res. 503, A-07; Appended: Res. 6, A-12; Reaffirmed: CSAPH Rep. 1, A-22; Reaffirmation: A-22; Modified: Res. 916, I-22; BOT Action Sept 2023]

H-460.913 Screening for HPV-Related Anal Cancer

1. Our American Medical Association supports continued research on the diagnosis and treatment of anal cancer and its precursor lesions, including the evaluation of the anal pap smear as a screening tool for anal cancer.
2. Our AMA's advocacy efforts to implement screening for anal cancer for high-risk populations.
3. Our AMA's national medical specialty organizations and other stakeholders in developing guidelines for interpretation, follow up, and management of anal cancer screening results.

[Res.512, A-04; Reaffirmed: CSAPH Rep. 1, A-14; Appended: Res. 421, A-22]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 912
(I-24)

Introduced by: Senior Physicians Section

Subject: Assuring Representation of Older Age Adults in Clinical Trials

Referred to: Reference Committee K

Whereas, clinical trials are the foundation for evidence-based medicine guiding the safe and effective management of our patients; and

Whereas, traditionally, participant pools in clinical trials have underrepresented both women and older adults leading to gaps in knowledge relevant to diagnosis and treatment in these groups; and

Whereas, our American Medical Association recognizes the importance of diversity and inclusivity in clinical trials in order to promote health equity and optimal clinical outcomes; and

Whereas, our AMA has policy addressing the underrepresentation of minorities and women in clinical trials but is less specific regarding representation of older adults; and

Whereas, with demographics of our aging population and its attendant burden of chronic disease, it is imperative for clinicians to have adequate evidence to ensure optimal outcomes for their older patients; therefore be it

RESOLVED, that our American Medical Association specifically advocate for inclusion of older patients (both men and women) by amending H-460.911 as follows:

1. Our American Medical Association advocates that:
    a. The Food and Drug Administration (FDA) and National Institutes of Health (NIH) conduct annual surveillance of clinical trials by gender, race, <u>age</u> and ethnicity, ~~including consideration of pediatric and elderly populations~~, to determine if proportionate representation of women and minorities <u>including older adults and children if appropriate</u> is maintained in terms of enrollment and retention. This surveillance effort should be modeled after National Institute of Health guidelines on the inclusion of women and minority populations.
    b. The FDA have a page on its web site that details the prevalence of minorities and women <u>and older adults including those over age 75</u> in its clinical trials and its efforts to increase their enrollment and participation in this research.
    c. Resources be provided to community level agencies that work with those minorities, females, <u>older adults including those over age 75</u> 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 healthcare. These minorities include Black Individuals/African Americans, Hispanics, Asians/Pacific Islanders/Native Hawaiians, and Native Americans (Directive to Take Action); and be it further

RESOLVED, that our AMA monitor the effectiveness of H-460.911 on an annual basis (Directive to Take Action); and be it further

RESOLVED, that our AMA collaborate with AHRQ, FDA, NIH and other relevant stakeholders to increase public awareness and education on the topic of inclusivity in clinical trial participation (Directive to Take Action); and be it further

RESOLVED, that our AMA specifically submit comments to the FDA on current proposed industry guidelines for inclusion of underrepresented populations in clinical trials[1] by September 2025. (Directive to Take Action)

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

Received: 9/23/2024

REFERENCES

1. "Diversity Action Plans to Improve Enrollment of Participants from Underrepresented Populations in Clinical Studies [Draft Guidance]. https://www.fda.gov/media/179593/download

RELEVANT AMA POLICY

H-460.911 Increasing Minority, Female, and other Underrepresented Group Participation in Clinical Research

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

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 Report 4, A-08; Reaffirmed CSAPH Rep.01, A-18; Modified Resolution 016, I-22]

H-460.912 Principles for Conduct and Reporting of Clinical Trials

Our AMA: (1) endorses the Association of American Medical Colleges' "Principles for Protecting Integrity in the Conduct and Reporting of Clinical Trials"; (2) commends the AAMC, the Centers for Education and Research in Therapeutics and the BlueCross BlueShield Association for the development and dissemination of these principles; (3) supports the timely dissemination of clinical trial data for public accessibility as permitted by research design and/or regulatory protocol; (4) supports the promotion of improved data sharing and the reaffirmation and enforcement of deadlines for submitting results from clinical research studies; (5) encourages the expansion of clinical trial registrants to ClinicalTrials.gov; and (6) will sign the petition titled "All Trials Registered; All Results Reported" at Alltrials.net that supports the registration of all past, present and future clinical trials and the release of their summary reports.
[Res. 544, A-06; Appended: Res.907, I-15; BoT Action in response to referred for decision: Res. 907, I-15]

D-460.970 Access to Clinical Trial Data

Our AMA: (1) urges the Food and Drug Administration to investigate and develop means by which scientific investigators can access original source safety data from industry-sponsored trials upon request; and (2) supports the adoption of universal policy by medical journals requiring participating investigators to have independent access to all study data from industry-sponsored trials.
[Res. 503, A-14; Reaffirmed Res. 907, I-15; Reaffirmed, CSAPH Rep. 2, I-19]

H-100.968 Improving the Quality of Geriatric Pharmacotherapy

Our AMA believes that the Food and Drug Administration should encourage manufacturers to develop low dose formulations of medications commonly used by older patients in order to meet the special needs of this group; require geriatric-relevant labeling for over-the-counter medications; provide incentives to pharmaceutical manufacturers to better study medication effects in the frail elderly and oldest-old in pre- and post-marketing clinical trials; and establish mechanisms for data collection, monitoring, and analysis of medication-related problems by age group.
[CSA Rep.5, A-02; Reaffirmation, A-10; Reaffirmed: CSAPH Rep. 01, A-20]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 913
(I-24)

Introduced by: Senior Physicians Section

Subject: Sexually Transmitted Infections are on the Rise in the Senior Population

Referred to: Reference Committee K

Whereas, sexually transmitted infections (STI's) among adults aged 65 years of age and older doubled between the years of 2007 and 2017[1]; and continue to increase among adults aged 55 and above as reported by the Centers for Disease Control and Prevention (CDC)[2,3]; and

Whereas, recent research shows that misconceptions about STDs among older Americans are contributing to the rise[4]; and

Whereas, the four curable STI's – syphilis, gonorrhea, chlamydia and trichomoniasis, together account for 1 million infections each day globally[5]; and

Whereas, many seniors have not been adequately screened for or are unaware of STI's[6]; and

Whereas, physicians have a duty to reduce the spread of STI's in the senior population; therefore be it

RESOLVED, that our American Medical Association advocate and promote the U.S. Preventive Services Task Force (USPSTF) recommendations for STI screening through interested senior advocates such as AARP, specifically targeting chlamydia, gonorrhea, human immunodeficiency virus (HIV), HPV and syphilis, for the senior population who are not regularly screened (Directive to Take Action); and be it further

RESOLVED, that our AMA continue to promote discussion, collaboration, and consensus among expert groups and medical specialty societies involved in the development of practice guidelines for sexually transmitted diseases in the senior population (Directive to Take Action); and be it further

RESOLVED, that our AMA offer CME education regarding best practices for reducing sexually transmitted disease (including oral cancer risks) in the senior population through the AMA's Ed Hub as a resource to guide the delivery of clinical preventative services. (Directive to Take Action)

Fiscal Note: $80,454 Contract with third parties to develop educational content for physicians.

Received: 9/23/2024

REFERENCES

1. University Hospitals (07/23). Why STIs Are on the Rise in Older Adults https://www.uhhospitals.org/blog/articles/2023/07/why-stis-are-on-the-rise-in-older-adults
2. Pearson, C. Sexually Transmitted Infections Have Surged and Age is No Barrier. *New York Times*, May 5, 2024. https://www.nytimes.com/2024/05/03/well/live/sti-seniors-chlamydia-syphilis.html?searchResultPosition=3
3. Bendix, A. Sexually Transmitted Infection Rates have Risen Sharply Among Adults 55 and Older CDC Data Shows. https://www.nbcnews.com/health/sexual-health/sexually-transmitted-infection-rates-rose-older-people-cdc-rcna145332

4. Smith, M.L, Bergeron, C.D., Goltz, H.H., Coffey T, Boolani A. Sexually Transmitted Infection Knowledge among Older Adults: Psychometrics and Test-Retest Reliability. *Int J Environ Res Public Health*. 2020 Apr 3;17(7):2462. doi: 10.3390/ijerph17072462. PMID: 32260298; PMCID: PMC7177870.
5. World Health Organization. (2022). *Global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections for the period 2022-2030*. World Health Organization.
6. Slinkard, M. S., & Kazer, M. W. (2011). Older adults and HIV and STI screening: the patient perspective. *Geriatric Nursing*, 32(5), 341-349.

RELEVANT AMA POLICY

H-440.879 Expedited Partner Therapy (Patient-delivered Partner Therapy): An Update
Our AMA supports the Centers for Disease Control and Prevention's guidance on expedited partner therapy (EPT) that was published in its 2006 white paper, *Expedited Partner Therapy in the Management of Sexually Transmitted Diseases*.
[CSAPH Rep. 7, A-06; Reaffirmed: CSAPH Rep. 01, A-16]

H-440.979 Control of Sexually Transmitted Infections
The AMA urges increased efforts at all levels of organized medicine to bring sexually transmitted infections under control, through professional and public education, and support of the efforts of state Departments of Health, the Centers for Disease Control and Prevention, the National Institutes of Health, and other appropriate organizations.
[Res. 84, A-84; Reaffirmed by CLRPD Rep. 3, I-94; Reaffirmation A-99; Modified and Reaffirmed CSAPH Rep. 1, A-09; Reaffirmation A-10; Reaffirmed: CSAPH Rep. 01, A-20]

H-440.983 Update on Sexually Transmitted Infections
The AMA (1) urges medical students, primary care residents, and physicians in all specialties to familiarize themselves with sexually transmitted infections (STI), so that they will be better able to diagnose and treat them; (2) encourages physicians to always include a sexual history as part of their routine history and physical exam; (3) encourages STI instruction, both didactic and clinical, in all medical school and primary residency programs; (4) encourages the establishment of STI fellowships by primary care specialties in order to develop a pool of clinical and research expertise in the area; (5) encourages state and local medical societies to promote STI public service TV and radio announcements in their communities; and (6) supports continued communication of updated STI information regularly through AMA publications.
[CSA Rep. E, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmation A-99; Modified and Reaffirmed: CSAPH Rep. 1; A-09; Reaffirmed: CSAPH Rep. 01, A-19]

H-440.996 Sexually Transmitted Infection Control
Our AMA (1) supports continued action to assert appropriate leadership in a concerted program to control sexually transmitted infection;

(2) urges physicians to take all appropriate measures to reverse the rise in sexually transmitted infection and bring it under control;

(3) encourages constituent and component societies to support and initiate efforts to gain public support for increased appropriations for public health departments to fund research in development of practical methods for prevention and detection of sexually transmitted infection, with particular emphasis on control of gonorrhea; and

(4) in those states where state consent laws have not been modified, encourages the constituent associations to support enactment of statutes that permit physicians and their co-workers to treat and search for sexually transmitted infection in minors legally without the necessity of obtaining parental consent.
[Sub. Res. 6, I-72; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report A-00; Modified: CSAPH Rep. 1, A-10; Modified, CSAPH Rep. 01, A-20]

H-20.920 HIV Testing

(1) General Considerations
a) Persons who suspect that they have been exposed to HIV should be tested so that appropriate treatment and counseling can begin for those who are seropositive;
b) HIV testing should be consistent with testing for other infections and communicable diseases;
c) HIV testing should be readily available to all who wish to be tested, including having available sites for confidential testing;
d) The physician's office and other medical settings are the preferred settings in which to provide HIV testing;
e) Physicians should work to make HIV counseling and testing more readily available in medical settings.

(2) Informed Consent Before HIV Testing
a) Our AMA supports the standard that individuals should knowingly and willingly give consent before a voluntary HIV test is conducted, in a manner that is the least burdensome to the individual and to those administering the test. Physicians must be aware that most states have enacted laws requiring informed consent before HIV testing;
b) Informed consent should include the following information: (i) patient option to receive more information and/or counseling before deciding whether or not to be tested and (ii) the patient should not be denied treatment if he or she refuses HIV testing, unless knowledge of HIV status is vital to provide appropriate treatment; in this instance, the physician may refer the patient to another physician for care;
c) It is the policy of our AMA to review the federal laws including the Veteran's Benefits and Services Act, which currently mandates prior written informed consent for HIV testing within the Veterans Administration hospital system, and subsequently to initiate and support amendments allowing for HIV testing without prior consent in the event that a health care provider is involved in accidental puncture injury or mucosal contact by fluids potentially infected with HIV in federally operated health care facilities;
d) Our AMA supports working with various state societies to delete legal requirements for consent to medically indicated HIV testing that are more extensive than requirements generally imposed for informed consent to medical care.

(3) HIV Testing Without Explicit Consent
a) Explicit consent should not always be required prior to HIV testing. Physicians should be allowed, without explicit informed consent, and as indicated by their medical judgment, to perform diagnostic testing for determination of HIV status of patients suspected of having HIV infection;
b) General consent for treatment of patients in the hospital should be accepted as adequate consent for the performance of HIV testing;
c) Model state and federal legislation should be developed to permit physicians, without explicit informed consent and as indicated by their medical judgment, to perform diagnostic testing for determination of HIV status of patients suspected of having HIV infection;
d) Our AMA will work with the Centers for Disease Control and Prevention, the American Hospital Association, the Federation, and other appropriate groups to draft and promote the adoption of model state legislation and hospital staff guidelines to allow HIV testing of a patient maintaining privacy, but without explicit consent, where a health care worker has been placed at risk by exposure to potentially infected body fluids; and to allow HIV testing, without any consent, where a health care worker has been placed at risk by exposure to body fluids of a deceased patient.

(4) HIV Testing Procedures
a) Appropriate medical organizations should establish rigorous proficiency testing and quality control procedures for HIV testing laboratories on a frequent and regular basis; b) Physicians and laboratories should review their procedures to assure that HIV testing conforms to standards that will produce the highest level of accuracy;
c) Appropriate medical organizations should establish a policy that results from a single unconfirmed positive ELISA test never be reported to the patient as a valid indication of HIV infection;
d) Appropriate medical organizations should establish a policy that laboratories specify the HIV tests performed and the criteria used for positive, negative, and indeterminate test results;
e) Our AMA recommends that training for HIV blood test counselors encourage patients with an indeterminate Western blot to be advised that three-to-six-month follow-up specimens may need to be

submitted to resolve their immune status. Because of the uncertain status of their contagiousness, it is prudent to counsel such patients as though they were seropositive until such time as the findings can be resolved.

(5) Routine HIV Testing
a) Routine HIV testing should include appropriate informed consent and pre-test and post-test counseling procedures;
b) State medical associations should work to create state laws that encourage hospitals and other medical facilities to initiate routine HIV testing programs; and
c) Supports coverage of and appropriate reimbursement for routine HIV testing by all public and private payers.

(6) Opt-out HIV Testing
a) Opt-out HIV testing should be provided with informed consent for individuals who may have come into contact with the blood, semen, or vaginal secretions of an infected person in a manner that has been shown to transmit HIV infection. Such testing should be encouraged for patients for whom the physician's knowledge of the patient's serostatus would improve treatment. Opt-out HIV testing should be regularly provided for the following types of individuals who give an informed consent: (i) patients at sexually transmissible disease clinics; (ii) patients at drug abuse clinics; (iii) individuals who are from areas with a high incidence of AIDS or who engage in high-risk behavior and are seeking family planning services; and (iv) patients who are from areas with a high incidence of AIDS or who engage in high-risk behavior requiring surgical or other invasive procedures;
b) The prevalence of HIV infection in the community should be considered in determining the likelihood of infection. If opt-out HIV testing is not sufficiently accepted, the hospital and medical staff may consider requiring HIV testing.

(7) Mandatory HIV Testing
a) Our AMA opposes mandatory HIV testing of the general population;
b) Mandatory testing for HIV infection is recommended for (i) military personnel; (ii) donors of blood and blood fractions; breast milk; organs and other tissues intended for transplantation; and semen or ova for artificial conception;
c) All entrants into federal and state prisons should be offered HIV screening, but it should only be mandatory when risk factors are present;
d) Our AMA will review its policy on mandatory testing periodically to incorporate information from studies of the unintended consequences or unexpected benefits of HIV testing in special settings and circumstances.

(8) HIV Test Counseling
a) Pre-test and post-test voluntary counseling should be considered an integral and essential component of HIV testing. Full pre-test and post-test counseling procedures must be utilized for patients when HIV is the focus of the medical attention, when an individual presents to a physician with concerns about possible exposure to HIV, or when a history of high-risk behavior is present;
b) Post-test information and interpretation must be given for negative HIV test results. All negative results should be provided in a confidential manner accompanied by information in the form of a simple verbal or written report on the meaning of the results and the offer, directly or by referral, of appropriate counseling and potentially pre-exposure prophylaxis treatment;
c) Post-test counseling is required when HIV test results are positive. All positive results should be provided in a confidential face-to-face session by a professional properly trained in HIV post-test counseling and with sufficient time to address the patient's concerns about medical, social, and other consequences of HIV infection.

(9) HIV Testing of Health Care Workers
a) Our AMA supports routine voluntary HIV testing of physicians, health care workers, and students in appropriate situations;
b) Employers of health care workers should provide, at the employer's expense, serologic testing for HIV infection to all health care workers who have documented occupational exposure to HIV;
c) Our AMA opposes HIV testing as a condition of hospital medical staff privileges;

d) Physicians and other health care workers who perform exposure-prone patient care procedures should know their immune or infection status with respect to HIV.

(10) Counseling and Testing of Pregnant Women for HIV
Our AMA supports the position that there should be universal HIV testing of all pregnant women, with patient notification of the right of refusal, as a routine component of perinatal care, and that such testing should be accompanied by basic counseling and awareness of appropriate treatment, if necessary. Patient notification should be consistent with the principles of informed consent.

(11) HIV Home Test Kits
a) Our AMA does not oppose HIV home collection test kits that are linked with proper laboratory testing and counseling services, provided their use does not impede public health efforts to control HIV disease;
b) Standardized data should be collected by HIV home collection test kit manufacturers and reported to public health agencies.

(12) College Students
Our AMA encourages undergraduate campuses to conduct confidential, free HIV testing with qualified staff and counselors.
[CSA Rep.4, A-03; Appended: Res 515, A-06; Reaffirmed: BOT Rep. 1, A-07; Appended: Res. 506, A-10; Modified: CSAPH Rep. 01, A-20]

H-75.994 Contraception and Sexually Transmitted Infections
Our American Medical Association, in cooperation with state, county, and specialty medical societies, encourages physicians to educate their patients about sexually transmitted infections, including HIV disease, and condom use. While such counseling may not be appropriate for all contraception patients, physicians should be encouraged to provide this information to any contraception patient who may benefit from being more aware of the risks of sexually transmitted infections.
[BOT Rep. E, A-89; Reaffirmation A-99; Reaffirmed and Title Change: CSA Rep. 4, A-03; Reaffirmed: CSAPH Rep. 1, A-13; Modified: CSAPH Rep. 8, A-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 915
(I-24)

Introduced by: LGBTQ Section

Subject: Reducing Barriers in Sports Participation for LGBTQIA+ People

Referred to: Reference Committee K

Whereas, physical, educational and psychological benefits of exercise and sports participation are well established both during sports participation and after sports activities have concluded;[1-3] and

Whereas, LGBTQIA+ people have lower participation in physical activity and sports,[1,2,4] which is likely multifactorial including prior experiences of homophobia and transphobia in sports; and

Whereas, there are an increasing number of laws being passed in states restricting participation of transgender and gender diverse youth and people with differences of sexual development in sports;[3] and

Whereas, our American Medical Association has passed policies promoting education on the benefits of exercise in society and encourages physicians to prescribe exercise and physical activity to their patients; therefore be it

RESOLVED, that our American Medical Association will educate physicians on benefits and barriers to sports participation affecting LGBTQIA+ communities (Directive to Take Action); and be it further

RESOLVED, that our AMA will support legislative and regulatory protections to ensure access to participation in sports inclusive of LGBTQIA+ persons. (New HOD Policy)

Fiscal Note: $80,067 Contract with third parties to develop educational content for physicians.

Received: 9/23/2024

References:

1. Recommendations from LGBTQ+ adults for increased inclusion within physical activity: a qualitative content analysis. Transl Behav Med. 2022 Mar 17;12(3):454-465. doi: 10.1093/tbm/ibab154. Accessed at: https://academic.oup.com/tbm/article/12/3/454/6481597?login=false
2. LGBTQ+ Youth's Experiences and Engagement in Physical Activity: A Comprehensive Content Analysis Systematic Review Published: 18 February 2019 Volume 4, pages 169–185, (2019). Accessed at: https://shine-lab.media.uconn.edu/wp-content/uploads/sites/3321/2024/03/Parchem-et-al.-2024-Phys-Activity-and-Locker-Rooms.pdf
3. Movement Advancement Project Bans for Transgender Youth in Sports. Accessed at: https://www.lgbtmap.org/equality-maps/youth/sports_participation_bans
4. Locker-Room Experiences Among LGBTQ+ Adults. J Sport Exerc Psychol 2020 May 30;42(3):227-239. doi: 10.1123/jsep.2019-0133. Print 2020 Jun. Accessed at: https://journals.humankinetics.com/view/journals/jsep/42/3/article-p227.xml

RELEVANT AMA POLICY

Promotion of Exercise H-470.991

1. Our American Medical Association:
    a. supports the promotion of exercise, particularly exercise of significant cardiovascular benefit.
    b. encourages physicians to prescribe exercise to their patients and to shape programs to meet each patient's capabilities and level of interest.
2. Our AMA supports National Bike to Work Day and encourages active transportation whenever possible.Citation: Res. 83, parts 1 and 2, I-77; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Appended: Res. 604, A-11; Reaffirmed: CSAPH Rep. 1, A-21;

Exercise and Physical Fitness H-470.997

1. Our American Medical Association encourages all physicians to utilize the health potentialities of exercise for their patients as a most important part of health promotion and rehabilitation and urges state and local medical societies to emphasize through all available channels the need for physical activity. The AMA encourages other organizations and agencies to join in promoting physical fitness through all appropriate means.
2. Our AMA advocates for continued research towards development of structured physical activity treatment plans for the specific diagnoses of anxiety and depression, as well as longitudinal studies to examine the effects of physical activity on health outcomes, particularly later in life.
3. Our AMA encourages the education of health care professionals on the role of physical activity and/or structured exercise in treating and managing anxiety and depression; the need to screen for levels of physical activity of patients; the need to motivate and educate patients of all ages about the benefits of physical activity, including positive mental health benefits.
4. Our AMA encourages the provision of coverage by health care payers and employers for fitness club memberships and access to other physical activity programs.
5. Our AMA encourages the implementation, trending, and utilization of evidenced-based physical activity measures in the medical record for treatment prescription, counseling, coaching, and follow up of physical activity for therapeutic use.

BOT Rep. K, A-66 Reaffirmed: CLRPD Rep. C, A-88 Reaffirmed: Sunset Report, I-98 Modified and Reaffirmed: CSAPH Rep. 2, A-08 Reaffirmed: BOT Rep. 10, A-14 Modified: Res. 421, A-23 Modified: CSAPH Rep. 09, A-24

Promotion of Exercise Within Medicine and Society H-470.990

1. Our American Medical Association supports education of the profession on exercise, including instruction on the role of exercise prescription in medical practice in its continuing education courses and conferences, whenever feasible and appropriate.
2. Our AMA supports medical student instruction on the prescription of exercise.
3. Our AMA supports physical education instruction in the school system.
4. Our AMA supports education of the public on the benefits of exercise, through its public relations program.

Opposition to Requirements for Gender-Based Treatments for Athletes H-470.951

1. Our American Medical Association opposes mandatory testing, medical treatment or surgery for transgender athletes and athletes with Differences of Sex Development (DSD), and affirm that these athletes be permitted to compete in alignment with their identity.
2. Our AMA opposes the use of specific hormonal guidelines to determine gender classification for athletic competitions.
3. Our AMA oposses satisfying third-party requirements to certify or confirm an athlete’s gender through physician participation.

BOT Rep. 1, I-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 916
(I-24)

Introduced by: LGBTQ+ Section

Subject: Access to Healthcare for Transgender and Gender Diverse People in the Carceral System

Referred to: Reference Committee K

Whereas, over 6,000 transgender and gender diverse (TGD) adults are in the carceral system;[1-8] and

Whereas, a 3-year survey of TGD people who were incarcerated in 31 states found that a majority reported being denied gender-affirming medications and encountered healthcare professionals who were unprepared to address their health needs;[10] and

Whereas, in multiple court cases from 2011 to 2020, individuals in federal and state prisons have been denied access to gender-affirming medication or experienced interruptions in medication access while incarcerated, in some cases leading to severe health outcomes, suicidal behavior, and self-castration attempts;[11-17] and

Whereas, while the Prison Rape Elimination Act (PREA) set national standards for medical care for TGD people in prison, an evaluation of 21 states found that only one met PREA standards, and another study found that 19 states have no policies for TGD patients;[13,18] therefore be it

RESOLVED, that our American Medical Association advocate for readily accessible gender-affirming care to meet the distinct healthcare needs of transgender and gender diverse people in the carceral system, including but not limited to gender-affirming surgical procedures and the continuation or initiation of hormone therapy without disruption or delay. (Directive to Take Action)

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

Date Received: 9/23/2024

REFERENCES

1. Bhatt N, Cannella J, Gentile JP. Gender-affirming Care for Transgender Patients. Innov Clin Neurosci. Apr-Jun 2022. Accessed March 3, 2024. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9341318/#B5
2. Kidd J. More than 40% of transgender adults in the US have attempted suicide. UCLA School of Law Williams Institute. July 20, 2023. Accessed March 3, 2024. https://williamsinstitute.law.ucla.edu/press/transpop-suicide-press-release/.
3. Almazan AN, Keuroghlian AS. Association Between Gender-Affirming Surgeries and Mental Health Outcomes. JAMA Surgery. April 28, 2021. Accessed March 3, 2024. https://jamanetwork.com/journals/jamasurgery/article-abstract/2779429
4. Restar, A., Dusic, E.J., Garrison-Desany, H. et al. Gender affirming hormone therapy dosing behaviors among transgender and nonbinary adults. Nature News. September 1, 2022. Accessed March 3, 2024. https://www.nature.com/articles/s41599-022-01291-5#citeas
5. McCauley E, Eckstrand K, Desta B, Bouvier B, Brockmann B, Brinkley-Rubinstein L. Exploring Healthcare Experiences for Incarcerated Individuals Who Identify as Transgender in a Southern Jail. Transgender Health. Published February 1, 2018. Accessed March 3, 2024. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5831751/#B1
6. Ghandnoosh N, Stammen E. Incarcerated LGBTQ+ Adults and Youth. June 9, 2022. Accessed March 3, 2024.
7. https://www.sentencingproject.org/policy-brief/incarcerated-lgbtq-adults-and-youth/.

8. Laderman L, Aleman A, Frazer S, Saenz R. Protected & Served: 2022 Community Survey of LGBTQ+ People and People Living with HIV's Experiences with the Criminal Legal System. Accessed March 3, 2024. https://perma.cc/6ZS4-BBAJ.
9. Wilper A, Woolhander J, Boyd W, Lasser K, McCormick D, Bor D, Himmelstein D. The Health and Health Care of US Prisoners: Results of a Nationwide Survey. American Journal of Public Health. Published April 2009. Accessed March 30, 2024. https://ajph.aphapublications.org/doi/epdf/10.2105/AJPH.2008.144279.
10. Bromdal A, Mullens AB, Phillips T, Gow J. Experiences of Transgender Prisoners and their Knowledge, Attitudes, and Practices Regarding Sexual Behaviors and HIV/STIs: A Systematic Review. Published November 22, 2018. Accessed March 30, 2024. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6830990/.
11. Chestnut K, Pierce J. Advancing transgender justice. Vera Institute of Justice. February 20, 2024. Accessed March 3, 2024. https://www.vera.org/advancing-transgender-justice.
12. Adams v. Federal Bureau of Prisons. National Center for Lesbian Rights. April 14, 2020. Accessed March 3, 2024. https://www.nclrights.org/our-work/cases/adams-v-federal-bureau-of-prisons/.
13. Esseks J. A Court in Florida Affirms Dignity for Transgender People, Even in Prison. American Civil Liberties Union. February 27, 2023. Accessed March 3, 2024. https://www.aclu.org/news/lgbtq-rights/court-florida-affirms-dignity-transgender.
14. Fete E. In Need of Transition: Transgender incarcerated individuals Access to Gender Affirming Healthcare in Prison. UIC Law Review. 2022. Accessed March 4, 2024. https://repository.law.uic.edu/cgi/viewcontent.cgi?article=2882&context=lawreview.
15. Edmo v. Idaho Department of Correction. National Center for Lesbian Rights. October 14, 2020. Accessed March 3, 2024. https://www.nclrights.org/our-work/cases/edmo-v-idaho-department-of-correction/.
16. Holcombe M. A transgender woman sues the Georgia Department of Corrections over allegations of sexual assault by incarcerated individualss and staff. CNN. November 24, 2020. Accessed March 3, 2024. https://www.cnn.com/2020/11/24/us/georgia-transgender-incarcerated individuals-lawsuit/index.html.
17. Ashley Diamond to forego trial to focus on healing. Center for Constitutional Rights. January 19, 2023. Accessed March 3, 2024. https://ccrjustice.org/home/press-center/press-releases/ashley-diamond-forego-trial-focus-healing.
18. DRW v. DOC. Disability Rights Washington. November 28, 2023. Accessed March 3, 2024. https://disabilityrightswa.org/cases/drw-v-doc/.
19. Oberholtzer E. The dismal state of transgender incarceration policies. Prison Policy Initiative. November 8, 2017. Accessed March 3, 2024. https://www.prisonpolicy.org/blog/2017/11/08/transgender/#:~:text=Correctional%20staff%20may%20not%20physically,communicate%20with%20trans%20people%20respectfully.
20. H.Res.269 - 118th Congress (2023-2024): Recognizing that it is the duty of the Federal Government to develop and implement a Transgender Bill of Rights to protect and codify the rights of transgender and nonbinary people under the law and ensure their access to medical care, shelter, safety, and economic security. Library of Congress. 19 April 2023. Accessed March 30, 2024. https://www.congress.gov/bill/118th-congress/house-resolution/269.
21. H.R.15 - 118th Congress (2023-2024): Equality Act. Library of Congress. 21 June 2023. Accessed March 30, 2024. https://www.congress.gov/bill/118th-congress/house-bill/15.

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]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 917
(I-24)

Introduced by: LGBTQ Section

Subject: Mpox Global Health Emergency Recognition and Response

Referred to: Reference Committee K

Whereas, Mpox, formerly known as monkeypox, is a viral illness that is can spread via sexual contact, fomites, infected animals and most commonly manifests with a skin rash or mucosal lesions as well as fever, headache, muscle aches, back pain, or swollen lymph nodes[1,2]; and

Whereas, Mpox has two clades, of which Clade I, most often found in east and central Africa, has resulted in up to 1-10% death rates[1,3]; and

Whereas, Clade II has been identified as the cause of the global mpox outbreak among countries including the United States with 38 mpox-associated deaths identified in the U.S. between 2022 to 2023 predominantly in black cis-gendered men and those living with advanced HIV[4]; and

Whereas, studies document long term effects including severe reduction in quality of life and sexuality in those with serious mpox infection, atrophic and hypertrophic scarring, and stigma associated with diagnosis, resulting in the formal name change to mpox[5–7]; and

Whereas, the World Health Organization has recently declared mpox a public health emergency of international concern since the spread of clade Ib in the Democratic Republic of the Congo and other countries in Africa with higher incidence, severity of infection, and death rates reported already compared to prior years[8]; and

Whereas, despite current preparations for mpox employed by the Biden-Harris Administration among federal departments in 2024, the Government Accountability Office (GAO) in their report on the 2022 global outbreak of mpox report failures in response from the Department of Health and Human Services (HHS) including communication, supplies of vaccination and testing for at-risk populations, engagement with state and local leadership, and tracking of data for disease spread, similar to failures of response to the COVID-19 pandemic[9,10]; and

Whereas, a 2022 survey assessing the opinions of gay and bisexual men—the population disproportionately affected by mpox—on the U.S. response to the mpox outbreak found that nearly 50% rated it as only fair to poor, with civil unrest and dissatisfaction demonstrated through protests by LGBTQ+ activists in cities like New York and San Francisco at the peak of the outbreak[11–13]; and

Whereas, despite mpox vaccination effectiveness reported as high as 89%, research has identified lack of public-health organizational response to dispense vaccines readily, patient

perceived costs and accessibility to acquire the vaccine, and slow progress of research to develop new vaccinations all as concerns for addressing the mpox outbreak[14–16]; and

Whereas, LGBTQ+ populations encounter economic, physical, and mental health disparities and have historically been neglected in public health and governmental response to disease predominantly affecting these populations as also exemplified by the HIV/AIDS pandemic[17,18]; and

Whereas, research has identified that those with higher level of knowledge towards Mpox were more likely to receive the vaccine[19]; and

Whereas, GAO formally recommends HHS to implement a coordinated, department wide action program to include external stakeholders including federal agencies, jurisdictions, and nongovernmental partners in response and[9]; and

Whereas, WHO recommends increase surveillance in primary care and sexual health services, global commitment and cooperation, support for resource constrained settings, and implementation of a strategic and coordinated research agenda[20]; and

Whereas, the American Medical Association has historically supported policy outlining recognition and response to global pandemics similar to mpox including HIV/AIDS and COVID-19 as well as the unique healthcare needs of those identifying as LGBTQ+[21–23]; therefore it be

RESOLVED, that our American Medical Association promotes the recognition of mpox as a public health emergency and the need for ongoing surveillance, preparedness, and resource allocation to prevent future outbreaks (New HOD Policy); and be it further

RESOLVED, that our AMA strongly urges federal, state, and local agencies, in collaboration with public health organizations and medical associations, to develop and implement effective strategies for the prevention, control, and management of mpox, with particular focus on marginalized populations such as LGBTQ+ communities and those living with HIV (New HOD Policy); and be it further

RESOLVED, that our AMA supports increased public and private funding for mpox research, education, vaccination distribution, and long-term patient care, ensuring equitable access and addressing barriers to healthcare for at-risk populations (New HOD Policy); and be it further

RESOLVED, that our AMA encourages coordinated national and international efforts to address mpox, including global surveillance, resource sharing, and outreach programs that enhance public knowledge of mpox transmission, prevention, and vaccine effectiveness, particularly in resource-constrained settings (New HOD Policy); and be it further

RESOLVED, that our AMA calls for improved response by the Department of Health and Human Services (HHS) to mpox outbreaks, addressing the failures identified in the Government Accountability Office (GAO) report, including enhanced communication, distribution of vaccines and testing, and collaboration with local leaders (New HOD Policy); and be it further

RESOLVED, that our AMA advocates for the inclusion of community-driven, culturally competent prevention efforts and educational campaigns to reduce stigma, improve quality of life, and promote health equity for those disproportionately affected by mpox. (Directive to Take Action)

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

Date Received: 9/23/2024

REFERENCES

1. Mpox. Accessed September 7, 2024. https://www.who.int/news-room/fact-sheets/detail/mpox
2. How It Spreads | Mpox | Poxvirus | CDC. September 5, 2024. Accessed September 7, 2024. https://www.cdc.gov/poxvirus/mpox/if-sick/transmission.html
3. About Mpox | Mpox | Poxvirus | CDC. September 4, 2024. Accessed September 7, 2024. https://www.cdc.gov/poxvirus/mpox/about/index.html
4. Riser AP. Epidemiologic and Clinical Features of Mpox-Associated Deaths — United States, May 10, 2022–March 7, 2023. *MMWR Morb Mortal Wkly Rep*. 2023;72. doi:10.15585/mmwr.mm7215a5
5. Zeyen C, Kinberger M, Kriedemann H, et al. Clinical spectrum and long-term outcomes of mpox: a cohort study spanning from acute infection to six-month follow-up. *BMC Infect Dis*. 2024;24:317. doi:10.1186/s12879-024-09191-6
6. Sah R, Mohanty A, Reda A, Padhi BK, Rodriguez-Morales AJ. Stigma during monkeypox outbreak. *Front Public Health*. 2022;10:1023519. doi:10.3389/fpubh.2022.1023519
7. Mpox: Caring for skin. Accessed May 10, 2024. https://www.aad.org/member/clinical-quality/clinical-care/mpox/treatment
8. WHO Director-General declares mpox outbreak a public health emergency of international concern. Accessed September 7, 2024. https://www.who.int/news/item/14-08-2024-who-director-general-declares-mpox-outbreak-a-public-health-emergency-of-international-concern
9. Office USGA. Public Health Preparedness: Mpox Response Highlights Need for HHS to Address Recurring Challenges | U.S. GAO. April 18, 2024. Accessed September 7, 2024. https://www.gao.gov/products/gao-24-106276
10. U.S. GAO - Mpox Response Highlights the Risks of Repeating Past Mistakes. July 29, 2024. Accessed September 7, 2024. https://www.gao.gov/podcast/mpox-response-highlights-risks-repeating-past-mistakes
11. Bay Area activists protest slow federal response to monkeypox as cases increase. ABC7 San Francisco. July 18, 2022. Accessed September 7, 2024. https://abc7news.com/monkeypox-outbreak-vaccine-sf-protest-rally/12059559/
12. News ABC. Rising monkeypox cases alarm LGBTQ activists. ABC News. Accessed September 7, 2024. https://abcnews.go.com/Health/lgbtq-groups-slam-government-handling-monkeypox/story?id=87119869
13. Funk GP and C. Gay or bisexual men express concern about monkeypox, are critical of government's response. Pew Research Center. September 22, 2022. Accessed September 7, 2024. https://www.pewresearch.org/short-reads/2022/09/22/gay-or-bisexual-men-express-concern-about-monkeypox-are-critical-of-governments-response/
14. Wang X, Gu Z, Sheng S, Song R, Jin R. The Current State and Progress of Mpox Vaccine Research. *China CDC Wkly*. 2024;6(7):118-125. doi:10.46234/ccdcw2024.025
15. Reardon S. Mpox is spreading rapidly. Here are the questions researchers are racing to answer. *Nature*. 2024;633(8028):16-17. doi:10.1038/d41586-024-02793-9
16. Owens C, Hubach R. Health Belief Model, Demographic, and Sexual Behavioral Factors Associated with Mpox Vaccination Among Men who have Sex with Men. *Health Behav Res*. 2024;7(1). doi:10.4148/2572-1836.1210
17. Lampe NM, Barbee H, Tran NM, Bastow S, McKay T. Health Disparities Among Lesbian, Gay, Bisexual, Transgender, and Queer Older Adults: A Structural Competency Approach. *Int J Aging Hum Dev*. 2024;98(1):39-55. doi:10.1177/00914150231171838
18. How AIDS Remained an Unspoken—But Deadly—Epidemic for Years. HISTORY. August 22, 2023. Accessed September 7, 2024. https://www.history.com/news/aids-epidemic-ronald-reagan
19. Wang J, Fu L, Meng H, et al. Knowledge, concerns, and vaccine acceptance related to Mpox (Monkeypox) among university students in North and Northeast China: An online cross-sectional study. *Hum Vaccines Immunother*. 20(1):2339922. doi:10.1080/21645515.2024.2339922
20. Lewis RF, Kuppalli K, Hoxha A, Doherty MC. Emergency committee recommendations on mpox – what's next? *Bull World Health Organ*. 2023;101(5):300-300A. doi:10.2471/BLT.23.290134
21. D-440.918 COVID-19 Vaccination Rollout to Emergency Departments | AMA. Accessed September 7, 2024. https://policysearch.ama-assn.org/policyfinder/detail/covid%20emergency?uri=%2FAMADoc%2Fdirectives.xml-D-440.918.xml
22. H-20.922 HIV/AIDS as a Global Public Health Priority | AMA. Accessed September 7, 2024. https://policysearch.ama-assn.org/policyfinder/detail/monkey?uri=%2FAMADoc%2FHOD.xml-0-1262.xml
23. H-160.991 Health Care Needs of Lesbian, Gay, Bisexual, Transgen | AMA. Accessed September 7, 2024. https://policysearch.ama-assn.org/policyfinder/detail/LGBTQ?uri=%2FAMADoc%2FHOD.xml-0-805.xml

RELEVANT AMA POLICY

HIV/AIDS as a Global Public Health Priority H-20.922

In view of the urgent need to curtail the transmission of HIV infection in every segment of the population, our American Medical Association strongly urges, as a public health priority, that federal agencies (in cooperation with medical and public health associations and state governments) develop and implement effective programs and strategies for the prevention and control of the HIV/AIDS epidemic. CSA Rep. 4, A-03Reaffirmed: Res. 725, I-03Reaffirmed: Res. 907, I-08Reaffirmation I-11Appended: Res. 516, A-13Reaffirmation I-13Reaffirmed: Res. 916, I-16Modified: Res. 003, I-17Modified: Res. 414, A-23.

COVID-19 Vaccination Rollout to Emergency Departments and Urgent Care Facilities D-440.918
Our AMA will work with other relevant organizations and stakeholders to lobby the current Administration for the distribution of COVID-19 vaccinations to our nation's emergency departments and urgent care facilities during the COVID-19 public health emergency. Res. 228, A-21.

Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations H-160.991
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.CSA Rep. C, I-81Reaffirmed: CLRPD Rep. F, I-91CSA Rep. 8 - I-94Appended: Res. 506, A-00Modified and Reaffirmed: Res. 501, A-07Modified: CSAPH Rep. 9, A-08Reaffirmation A-12Modified: Res. 08, A-16Modified: Res. 903, I-17Modified: Res. 904, I-17Res. 16, A-18Reaffirmed: CSAPH Rep. 01, I-18Reaffirmed: CSAPH Rep. 08, A-24

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 918
(I-24)

Introduced by: American Association of Public Health Physicians

Subject: Healthcare in Tribal Jails

Referred to: Reference Committee K

Whereas, there are 80 jails and youth detention centers on or near tribal lands managed by the Bureau of Indian Affairs (BIA) Division of Corrections[1-3]; and

Whereas, unlike similar facilities managed by states and the federal Bureau of Prisons, on-site medical and behavioral health services are not available to this population, nor does the BIA appropriate a single dollar to the provision of healthcare to incarcerated American Indian and Alaska Native (AI/AN) persons [4-5]; and

Whereas, reliance on IHS and tribal clinics for carceral healthcare diverts already limited resources not designated for these populations, creating an unsustainable burden that results in untimely care[4]; and

Whereas, non-healthcare correctional officers at BIA facilities are responsible for the conduct of physical and mental health screenings at intake, supervision of persons in acute substance withdrawal, and disbursement of prescription medication, which jeopardizes the safety of incarcerated AI/AN persons[6-8]; and

Whereas, the U.S. Public Health Service Commissioned Corps assigns 850 physicians and allied health professionals to the federal Bureau of Prisons, but none to the BIA Division of Corrections [9-10]; and

Whereas, a Health Professional Shortage Area (HPSA) is a geographic area, population group, or health care facility that has been designated by the U.S. Health Resources and Services Administration (HRSA) as having a shortage of health professionals[11-14]; and

Whereas, facilities managed by the BIA Division of Corrections are not eligible for designation as HPSAs[12-15]; and

Whereas, designation of BIA jails as HPSAs and assignment of PHS officers to these facilities similar to their federal counterparts will likely lead to greater availability of physicians and allied health professionals for this population and is supported by regional tribal correctional healthcare coalitions and more than one hundred tribal governments[16-19]; and

Whereas, incarcerated AI/AN persons experience a wide range of health disparities, including a disproportionate burden of chronic disease attributable to the legacy of settler colonialism, suicide epidemics, and the effects of climate change on tribal lands[20-21]; and

Whereas, justice involvement among AI/AN populations is associated with an increased likelihood of substance use, mental illness, and emergency department utilization for low acuity care[22]; and

Whereas, availability of on-site health services and routine conduct of screen-to-treat programs in jail-based settings significantly decreases the burden of HIV, viral hepatitis, sexually transmitted infections, and tuberculosis in justice-involved populations[23-24]; and

Whereas, our AMA believes that AI/AN persons are entitled to the same rights and privileges as other US citizens, especially with regard to access to healthcare (H-350.976); therefore be it

RESOLVED, that our American Medical Association strongly supports carceral facilities and youth detention centers managed by the Bureau of Indian Affairs Division of Corrections being designated as Health Professional Shortage Areas and the assignment of U.S. Public Health Service Commissioned Corps officers to these facilities (New HOD Policy); and be it further

RESOLVED, that our AMA will advocate for the development, staffing, and operation of sustainable, on-site medical and behavioral health services, including evidence-based and culturally-appropriate addiction treatment, for incarcerated American Indian and Alaska Native persons (Directive to Take Action); and be it further

RESOLVED, that our AMA strongly supports routine audits and inspection of facilities managed by the Bureau of Indian Affairs Division of Correction, ensuring that these facilities abide by all standards and guidelines outlined by the National Commission on Correctional Health Care. (New HOD Policy)

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

Received: 9/23/2024

REFERENCES

1. Bureau of Justice Statistics. Jails in Indian Country, 2022. Published May 19, 2023. Last Accessed August 11, 2024. https://bjs.ojp.gov/press-release/jails-indian-country-2022
2. Office of Justice Services. U.S. Department of the Interior Bureau of Indian Affairs. Last Accessed August 11, 2024. https://www.bia.gov/bia/ojs
3. National Institute of Corrections. Indian Country Jails. Last Accessed August 11, 2024. https://nicic.gov/resources/resources-topics-and-roles/topics/indian-country-jails
4. Camplain C, Camplain R. The Unmet Health Care Needs of Indigenous People Incarcerated in Tribal Jails. JAMA. 2024;332(4):279-280. doi:10.1001/jama.2024.7392
5. U.S. Department of the Interior. Bureau of Indian Affairs FY2025 Congressional Budget Justification. Last Accessed August 11, 2024. https://www.bia.gov/sites/default/files/media_document/fy2025-508-bia-greenbook.pdf
6. Hegyi, N. Indian Affairs Promised To Reform Tribal Jails. We Found Death, Neglect And Disrepair. NPR. Published June 10, 2021. Last Accessed August 20, 2024. https://www.npr.org/2021/06/10/1002451637/bureau-of-indian-affairs-tribal-detention-centers-deaths-neglect
7. Hegyi, N. A Mother's Death In Tribal Jail Highlights Need For Medical Care On Site. Boise State Public Radio News. Published August 11, 2021. Last Accessed August 20, 2024. https://www.kuer.org/politics-government/2021-08-11/a-mothers-death-in-tribal-jail-highlights-need-for-medical-care-on-site
8. Lyon, E. Inadequate Health Services for Native American Prisoners. Prison Legal News. Published August 8, 2018. Last Accessed August 20, 2024. https://www.prisonlegalnews.org/news/2018/aug/8/inadequate-health-services-native-american-prisoners/
9. U.S. Public Health Service Commissioned Corps. Last Updated March 2022. Last Accessed August 11, 2024. https://www.usphs.gov/media/u2ul1nph/usphs_additional-faqs.pdf
10. Health Services. U.S. Bureau of Prisons. Last Accessed August 11, 2024. https://www.bop.gov/jobs/health_services.jsp
11. U.S. Health Resources Services Administration. What is Shortage Designation? Last Updated June 2023. Last Accessed August 11, 2024. https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation
12. Morris NP, Edwards ML. Addressing Shortages of Mental Health Professionals in U.S. Jails and Prisons. J Correct Health Care. 2022;28(4):209-214. doi:10.1089/jchc.21.08.0072
13. U.S. National Health Service Corps. Loan Repayment Program: Sites. Last Updated July 2024. Last Accessed August 11, 2024. https://nhsc.hrsa.gov/loan-repayment/nhsc-loan-repayment-program#sites

14. Silver IA, Semenza DC, Nedelec JL. Incarceration of Youths in an Adult Correctional Facility and Risk of Premature Death. JAMA Network Open. 2023;6(7):e2321805. Published 2023 July 3. doi:10.1001/jamanetworkopen.2023.21805.
15. U.S. National Health Service Corps. Eligibility Requirements. Last Updated May 2024. Last Accessed August 11, 2024. https://nhsc.hrsa.gov/sites/eligibility-requirements
16. Renn T, Moore J, Schultz KA, Veeh CA. Comparing Behavioral Health Outcomes and Treatment Utilization of Those With and Without Justice Involvement Within the Past Year Among American Indian and Alaska Native Adults. *J Racial Ethn Health Disparities*. 2024;11(2):685-695. doi:10.1007/s40615-023-01552-2
17. Tomhave, B, Tomhave, J. Locked Up & Forgotten The Federal Government's Failure to Fund Tribal Correctional Healthcare. Arizona Tribal Correctional Healthcare Coalition. Published June 2016. Last Accessed August 12, 2024. https://aacihc.az.gov/sites/default/files/2022-03/Locked-Up-Forgotten.pdf
18. Council delegate: Navajo Nation's correctional facilities do not have nurses or medical staff. Navajo-Hopi Observer. Published July 31, 2018. Last Accessed August 20, 2024. https://www.nhonews.com/news/council-delegate-navajo-nation-s-correctional-facilities-do-not-have-nurses-or-medical-staff/article_c9f078b0-08d0-56e8-842d-6ef538433de3.html
19. Cladoosby, B. Funding for Correctional Health Care in Tribal and BIA Facilities. National Congress of American Indians. Mid-Year 2017 Session. Resolution MOH-17-013. Adopted. Last Accessed August 20, 2024. https://midwestwww.ncai.org/resources/resolutions/funding-for-correctional-health-care-in-tribal-and-bia-facilities
20. Lee, J, Blaeser, J, Small, C. Extreme heat and decades of mismanagement are putting Indigenous inmates at deadly risk. Grist. Published May 10, 2023. Last Accessed August 11, 2024. https://grist.org/indigenous/tribal-jail-climate-change-extreme-heat/
21. Hegyi, N. Inmates continue to die in tribal jails despite promises of reform. NPR. Published May 19, 2023. Last Accessed August 11, 2024. https://www.npr.org/2023/05/19/1176999580/bureau-indian-affairs-reform-tribal-jails-inmates-progress
22. U.S. Centers for Disease Control and Prevention. Public Health Considerations for Correctional Health. Last Updated July 3, 2024. Last Accessed August 11, 2024. https://www.cdc.gov/correctional-health/about/index.html
23. Thornton KA, Deming PD, Archer GRD, et al. Expanding Hepatitis C Virus Treatment in the New Mexico State Prison System: Using the ECHO Model for Provider and Prison Peer Education. *J Viral Hepat*. Published online August 13, 2024. doi:10.1111/jvh.13997
24. Qureshi NS, Herrera SJ, Miller LG, Judge SP, Cardenas CM, Henderson SO. Gonorrhea and Chlamydia Opt-Out Screening of Justice-Involved Females During Intake at the Los Angeles County Jail: The Pivotal Role of Correctional Health Systems. *Sex Transm Dis*. Published online August 8, 2024. doi:10.1097/OLQ.0000000000002066

RELEVANT AMA POLICY

Principles of and Actions to Address Medical Education Costs and Student Debt H-305.925

The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty. To help address this issue, our American Medical Association (AMA) will:

1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy/
2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs--such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector--to promote practice in underserved areas, the military, and academic medicine or clinical research.
3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit:
    a. inclusion of all medical specialties in need, and
    b. service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.
5. ...

Continuation of the Commissioned Corps H-440.989

1. Our American Medical Association strongly supports the expansion and continuation of the Commissioned Corps of the US Public Health Service and recognizes the need for it to be adequately funded.

Health Care While Incarcerated H-430.986

1. Our American Medical Association advocates for adequate payment to health care providers, including primary care and mental health, and addiction treatment professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process from intake to re-entry into the community.
2. Our AMA advocates and requires a smooth transition including partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for juveniles and adults in the correctional system, including correctional settings having sufficient resources to assist incarcerated persons' timely access to mental health, drug and residential rehabilitation facilities upon release.
3. Our AMA encourages state Medicaid agencies to accept and process Medicaid applications from juveniles and adults who are incarcerated.
4. Our AMA encourages state Medicaid agencies to work with their local departments of corrections, prisons, and jails to assist incarcerated juveniles and adults who may not have been enrolled in Medicaid at the time of their incarceration to apply and receive an eligibility determination for Medicaid.
5. Our AMA advocates for states to suspend rather than terminate Medicaid eligibility of juveniles and adults upon intake into the criminal legal system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community.
6. Our AMA advocates for Congress to repeal the "inmate exclusion" of the 1965 Social Security Act that bars the use of federal Medicaid matching funds from covering healthcare services in jails and prisons.
7. Our AMA advocates for Congress and the Centers for Medicare & Medicaid Services (CMS) to revise the Medicare statute and rescind related regulations that prevent payment for medical care furnished to a Medicare beneficiary who is incarcerated or in custody at the time the services are delivered.
8. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of women and adolescent females who are incarcerated, including gynecological care and obstetrics care for individuals who are pregnant or postpartum.
9. Our AMA will collaborate with state medical societies, relevant medical specialty societies, and federal regulators to emphasize the importance of hygiene and health literacy information sessions, as well as information sessions on the science of addiction, evidence-based addiction treatment including medications, and related stigma reduction, for both individuals who are incarcerated and staff in correctional facilities.
10. Our AMA supports:
    a. linkage of those incarcerated to community clinics upon release in order to accelerate access to comprehensive health care, including mental health and substance use disorder services, and improve health outcomes among this vulnerable patient population, as well as adequate funding;
    b. the collaboration of correctional health workers and community health care providers for those transitioning from a correctional institution to the community;
    c. the provision of longitudinal care from state supported social workers, to perform foundational check-ins that not only assess mental health but also develop lifestyle plans with newly released people; and
    d. collaboration with community-based organizations and integrated models of care that support formerly incarcerated people with regard to their health care, safety, and social determinant of health needs, including employment, education, and housing.
11. Our AMA advocates for the continuation of federal funding for health insurance benefits, including Medicaid, Medicare, and the Children's Health Insurance Program, for otherwise eligible individuals in pre-trial detention.
12. Our AMA advocates for the prohibition of the use of co-payments to access healthcare services in correctional facilities.

13. Our AMA encourages the following qualifications for the Director and Assistant Director of the Health Services Division within the Federal Bureau of Prisons:
    a. MD or DO, or an international equivalent degree with at least five years of clinical experience at a Bureau of Prisons medical facility or a community clinical setting;
    b. knowledge of health disparities among Black, American Indian and Alaska Native, and people of color, including the pathophysiological basis of the disease process and the social determinants of health that affect disparities; and
    c. knowledge of the health disparities among individuals who are involved with the criminal justice system.
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.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 919
(I-24)

Introduced by: American College of Obstetricians and Gynecologists, Association for Clinical Oncology, South Dakota

Subject: Improving Rural Access to Comprehensive Cancer Care Services

Referred to: Reference Committee K

Whereas, approximately 15% of the United States (US) population is rural;[1] and

Whereas, rural cancer disparities are a critical public health issue requiring urgent attention and action;[2] and

Whereas, research has shown persistent disparities in cancer care and outcomes between rural and urban populations, with Centers for Disease Control and Prevention (CDC) data showing that rural counties have higher cancer deaths for all sites compared with nonmetropolitan urban and urban counties, lower rates of cancer screening and lower quality cancer care compared with nonmetropolitan urban and urban counties;[3,4] and

Whereas, rural residents tend to be older, engage in risky health behaviors, and have lower adherence to preventive care than do their urban and suburban counterparts, placing them at higher risk of cancer and other chronic diseases;[5] and

Whereas, these health disparities are further exacerbated by lack of health insurance, less awareness of cancer risks and benefits of screening, shortage of primary care physicians, oncologists and other cancer care specialists, and increased distance to a screening facility;[6] and

Whereas, women residing in rural areas are less likely to have been screened for cervical cancer[7] and breast cancer[8] compared to women residing in urban areas; and

Whereas, developing and implementing effective solutions to address rural cancer disparities requires a multilevel approach involving physicians and other health care providers, institutions, policymakers and communities,[9] as well as increased research funding and focus on rural cancer disparities;[10] and

Whereas, clinical trials such as the ENCORE (Enhancing care of rural dwellers through telehealth and engagement) are exploring telehealth intervention to connect academic medical center tumor boards with patients and clinicians in rural health care centers to improve cancer care delivery;[11] and

Whereas, rural communities may exist in digital deserts with poor high-speed internet access, limited digital literacy and lack of cultural acceptance of digital services; and

Whereas, our AMA advocates expansion of broadband and wireless connectivity to rural and under-served areas of the US;[12] and

Whereas, our American Medical Association recognizes access to broadband internet as a social determinant of health, encourages initiatives to strengthen digital literacy especially for historically marginalized and minoritized populations, and supports telehealth initiatives improving access to care;[13] therefore be it

RESOLVED, that our American Medical Association work with relevant stakeholders to develop a national strategy to eliminate rural cancer disparities in screening, treatment, and outcomes and achieve health equity in cancer outcomes across all geographic regions (Directive to Take Action); and be it further

RESOLVED, that our AMA call for increased federal and state funding to support research on rural cancer disparities in care, access, and outcomes and development of interventions to address those disparities (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for evidence-based collaborative models for innovative telementoring/teleconsultation between health care systems, academic medical centers, and community physicians to improve access to cancer screening, treatment, and patient services in rural areas. (Directive to Take Action)

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

Received: 9/23/2024

REFERENCES

1. Centers for Disease Control and Prevention. About Rural Health. Retrieved from https://www.cdc.gov/rural-health/php/about/index.html.
2. Lewis-Thames MW, Langston ME, Khan S, et al. Racial and Ethnic Differences in Rural-Urban Trends in 5-Year Survival of Patients With Lung, Prostate, Breast, and Colorectal Cancers: 1975-2011 Surveillance, Epidemiology, and End Results (SEER). JAMA Netw Open. 2022;5(5):e2212246. doi:10.1001/jamanetworkopen.2022.12246
3. Sokale IO, Raza SA, Thrift AP. Disparities in cancer mortality patterns: A comprehensive examination of U.S. rural and urban adults, 1999-2020. Cancer Med. 2023 Sep;12(18):18988-18998. doi: 10.1002/cam4.6451. Epub 2023 Aug 10. PMID: 37559501; PMCID: PMC10557857.
4. Rural Health Information Hub. Cancer Prevention and Treatment in Rural Areas. Retrieved from https://www.ruralhealthinfo.org/topics/cancer.
5. Meilleur A, Subramanian SV, Plascak JJ, Fisher JL, Paskett ED, Lamont EB. Rural residence and cancer outcomes in the United States: issues and challenges. Cancer Epidemiol Biomarkers Prev 2013;22:1657–67.
6. National Cancer Institute. GIS Portal for Cancer Research. Rural-Urban Disparities in Cancer. Retrieved from https://gis.cancer.gov/mapstory/rural-urban/index.html.
7. Borders TF, Thaxton Wiggins A. Cervical Cancer Screening Rates Among Rural and Urban Females, From 2019 to 2022. JAMA Netw Open. 2024;7(6):e2417094. doi:10.1001/jamanetworkopen.2024.17094.
8. Sprague BL, Ahern TP, Herschorn SD, et al. Identifying key barriers to effective breast cancer control in rural settings. Preventive Medicine. 2021 Nov;152(2):106741. ISSN 0091-7435. https://doi.org/10.1016/j.ypmed.2021.106741.
9. Yabroff KR, et al. Rural Cancer Disparities in the United States: A Multilevel Framework to Improve Access to Care and Patient Outcomes. JCO Oncol Pract 16, 409-413(2020). DOI:10.1200/OP.20.00352
10. AACR Cancer Disparities Progress Report 2024. Philadelphia: American Association for Cancer Research; 2024. Retrieved from http://www.CancerDisparitiesProgressReport.org/.
11. Pal, T., Hull, P.C., Koyama, T. et al. Enhancing Cancer care of rural dwellers through telehealth and engagement (ENCORE): protocol to evaluate effectiveness of a multi-level telehealth-based intervention to improve rural cancer care delivery. BMC Cancer 21, 1262 (2021). https://doi.org/10.1186/s12885-021-08949-4.
12. AMA Policy H 478.980,2022.
13. AMA Policy H 480.937, 2023.

RELEVANT AMA POLICY

H-478.980 Increasing Access to Broadband Internet to Reduce Health Disparities
Our AMA will advocate for the expansion of broadband and wireless connectivity to all rural and underserved areas of the United States while at all times taking care to protecting existing federally licensed radio services from harmful interference that can be caused by broadband and wireless services.

H-480.937 Addressing Equity in Telehealth

(1) Our American Medical Association recognizes access to broadband internet as a social determinant of health.
(2) Our AMA encourages initiatives to measure and strengthen digital literacy, with an emphasis on programs designed with and for historically marginalized and minoritized populations.
(3) Our AMA encourages telehealth solution and service providers to implement design functionality, content, user interface, and service access best practices with and for historically minoritized and marginalized communities, including addressing culture, language, technology accessibility, and digital literacy within these populations.
(4) Our AMA supports efforts to design telehealth technology, including voice-activated technology, with and for those with difficulty accessing technology, such as older adults, individuals with vision impairment and individuals with disabilities.
(5) Our AMA encourages hospitals, health systems and health plans to invest in initiatives aimed at designing access to care via telehealth with and for historically marginalized and minoritized communities, including improving physician and non-physician provider diversity, offering training and technology support for equity-centered participatory design, and launching new and innovative outreach campaigns to inform and educate communities about telehealth.
(6) Our AMA supports expanding physician practice eligibility for programs that assist qualifying health care entities, including physician practices, in purchasing necessary services and equipment in order to provide telehealth services to augment the broadband infrastructure for, and increase connected device use among historically marginalized, minoritized and underserved populations.
(7) Our AMA supports efforts to ensure payers allow all contracted physicians to provide care via telehealth.
(8) Our AMA opposes efforts by health plans to use cost-sharing as a means to incentivize or require the use of telehealth or in-person care or incentivize care from a separate or preferred telehealth network over the patient's current physicians.
(9) Our AMA will advocate that physician payments should be fair and equitable, regardless of whether the service is performed via audio-only, two-way audio-video, or in-person.

H-55.971 Screening and Treatment for Breast and Cervical Cancer Risk Reduction

(1) Our American Medical Association supports programs to screen all at-risk individuals for breast and cervical cancer and that government funded programs be available for low income individuals; the development of public information and educational programs with the goal of informing all at-risk individuals about routine cancer screening in order to reduce their risk of dying from cancer; and increased funding for comprehensive programs to screen low income individuals for breast and cervical cancer and to assure access to definitive treatment.
(2) Our AMA encourages state and local medical societies to monitor local public health screening programs to ensure that they are linked to treatment resources in the public or private sector.
(3) Our AMA encourages the Centers for Medicare and Medicaid Services to evaluate and review their current cervical cancer screening policies to ensure coverage is consistent with current evidence-based guidelines.
(4) Our AMA supports further research by relevant parties of HPV self-sampling in the United States to determine whether it can decrease health care disparities in cervical cancer screening.

D-55.997 Cancer and Health Care Disparities Among Minority Women

Our AMA encourages research and funding directed at addressing racial and ethnic disparities in minority women pertaining to cancer screening, diagnosis, and treatment.

H-350.937 Improving Healthcare of Minority Communities in Rural Areas

(1) Our American Medical Association encourages health promotion, access to care, and disease prevention through educational efforts and publications specifically tailored to minority communities in rural areas.
(2) Our AMA encourages enhanced understanding by federal, state and local governments of the unique health and health-related needs, including mental health, of minority communities in rural areas in an effort to improve their quality of life.
(3) Our AMA encourages the collection of vital statistics and other relevant demographic data of minority communities in rural areas.

(4) Our AMA will advise organizations of the importance of minority health in rural areas.
(5) Our AMA will research and study health issues unique to minority communities in rural areas, such as access to care difficulties.
(6) Our AMA will channel existing policy for telehealth to support minority communities in rural areas.
(7) Our AMA encourages our Center for Health Equity to support minority health in rural areas through programming, equity initiatives, and other representation efforts.

H-465.994 Improving Rural Health
(1) Our AMA:
    a. supports continued and intensified efforts to develop and implement proposals for improving rural health care and public health,
    b. urges physicians practicing in rural areas to be actively involved in these efforts, and
    c. advocates widely publicizing AMA's policies and proposals for improving rural health care and public health to the profession, other concerned groups, and the public.
(2) Our AMA will work with other entities and organizations interested in public health to:
    a. Encourage more research to identify the unique needs and models for delivering public health and health care services in rural communities.
    b. Identify and disseminate concrete examples of administrative leadership and funding structures that support and optimize local, community-based rural public health.
    c. 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.
    d. Advocate for adequate and sustained funding for public health staffing and programs.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 920
(I-24)

Introduced by: Mississippi

Subject: Revise FAA Regulations to Include Naloxone (Narcan) in the On-Board Medical Kit for Commercial Airlines flying within the Continental United States

Referred to: Reference Committee K

Whereas, for the past 20 years the world has been in the grips of a global opioid epidemic; and

Whereas, it is estimated that in 2021, there were around 60.4 million people engaged in non-medical opioid use worldwide, of whom 31.5 million were users of the opioid's heroin and fentanyl; and

Whereas, the estimated number of people using opioids globally has doubled from 26-36 million people in 2012 to 61.3 million in 2020; and

Whereas, over the past 2 decades, the United States has experienced a growing crisis of Substance Abuse and Addiction that has resulted in the rise of deaths from accidental drug overdoses; and

Whereas, in 2023 the CDC estimated that approximately 108,000 Americans died from accidental drug overdose; and

Whereas, it is estimated that approximately 75% or 81,000 of the 108,000 deaths were the result of opioids, primarily fentanyl; and

Whereas, the United States has the second largest air travel market in the world, with more than 853 million passengers flying in 2022; and

Whereas, the FAA does not require commercial airlines who fly in and out of the United States to have Naloxone (Narcan) or any other opioid antagonist (opioid reversal drug) to be part of the on-board medical kit; therefore be it

RESOLVED, that our American Medical Association work with the FAA and any other appropriate Federal Agency to require Naloxone (Narcan) or any other FDA approved opioid antagonist to be a component of the medical kit of any commercial airline that flies within the Continental United States (Directive to Take Action); and be it further

RESOLVED, that existing house policy "US Airlines Aircraft Emergency Kits" H-45.981 be modified as follows:

2. Our AMA will:
    a. support the addition of ~~naloxone,~~ epinephrine auto injector and glucagon to the airline medical kit.
    b. encourage airlines to voluntarily include ~~naloxone,~~ epinephrine auto injector and glucagon in their airline medical kits.

c. encourage the addition of ~~naloxone,~~ epinephrine auto injector and glucagon to the emergency medical kits of all US airlines (14CFR Appendix A to Part 121 - First Aid Kits and Emergency Medical Kits); and
d. Work with the FAA and any other appropriate Federal Agency to require Naloxone (Narcan) or any other FDA approved opioid antagonist to be a component of the medical kit of any commercial airline that flies within the Continental United States. (Modify Current Policy)

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

Received: 9/24/2024

RELEVANT AMA POLICY

Improvement in US Airlines Aircraft Emergency Kits H-45.981

1. Our American Medical Association urges federal action to require all US air carriers to report data on in-flight medical emergencies, specific uses of in-flight medical kits and emergency lifesaving devices, and unscheduled diversions due to in-flight medical emergencies; this action should further require the Federal Aviation Administration to work with the airline industry and appropriate medical specialty societies to periodically review data on the incidence and outcomes of in-flight medical emergencies and issue recommendations regarding the contents of in-flight medical kits and the use of emergency lifesaving devices aboard commercial aircraft.
2. Our AMA will:
    a. support the addition of naloxone, epinephrine auto injector and glucagon to the airline medical kit.
    b. encourage airlines to voluntarily include naloxone, epinephrine auto injector and glucagon in their airline medical kits.
    c. encourage the addition of naloxone, epinephrine auto injector and glucagon to the emergency medical kits of all US airlines (14CFR Appendix A to Part 121 - First Aid Kits and Emergency Medical Kits).
3. That our American Medical Association advocate for U.S. passenger airlines to carry standard pulse oximeters, automated blood pressure cuffs and blood glucose monitoring devices in their emergency medical kits.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 922
(I-24)

Introduced by: Resident and Fellow Section

Subject: Advocating for the Regulation of Pink Peppercorn as a Tree Nut

Referred to: Reference Committee K

Whereas, an allergy to peanuts and tree nuts is the most common cause of death due to allergic reactions in the USA, with a rising prevalence;[1] and

Whereas, the prevalence of an allergy to tree nuts is approximately 1 to 1.2% of the US population, affecting approximately 3 million people;[1,2] and

Whereas, Congress passed the Food Allergen Labeling and Consumer Protection Act of 2004 (FALCPA), identifying eight foods as major food allergens: milk, eggs, fish, Crustacean shellfish, tree nuts, peanuts, wheat, and soybeans, with sesame recently being added to the list;[3] and

Whereas, this law requires that food labels identify the food source of all major food allergens used to make the food, and the Food & Drug Administration (FDA) enforces this regulation and provides guidance on food labeling to food manufacturers;[3] and

Whereas, the “Pink Peppercorn” is often sold in peppercorn blends and has been used increasingly in food and drink products as a peppercorn, however, it is actually a dried berry from the family *Schinus terebinthifolius,* which is related to the cashew and pistachio family;[4] and

Whereas, studies have shown approximately 76% of people with a cashew (tree nut) allergy show cross reactivity to “pink peppercorn” and may have allergic reactions if consumed;[4,5] and

Whereas, the FDA does not currently regulate pink peppercorn as an allergen, therefore food and drink products including it are not labeled as including tree nuts, increasing the risk of an accidental consumption by a person with a tree nut allergy;[6,7] therefore be it

RESOLVED, that our American Medical Association ask the Food and Drug Administration (FDA), National Institute of Allergy and Infectious Diseases (NIAID), and other relevant stakeholders to develop skin antigen testing for pink peppercorn to further develop research and clinical application (Directive to Take Action); and be it further

RESOLVED, that our AMA ask the FDA, NIAID, and other relevant stakeholders to conduct appropriate studies to determine the cross-reactivity of pink peppercorn as a tree nut, with subsequent regulation, reporting, and public education as appropriate. (Directive to Take Action)

Fiscal Note: Minimal – less than $1,000

Received: 9/24/24

REFERENCES:

1. Sicherer SH, Muñoz-Furlong A, Godbold JH, Sampson HA. US prevalence of self-reported peanut, tree nut, and sesame allergy: 11-year follow-up. J Allergy Clin Immunol. 2010 Jun;125(6):1322-6. doi: 10.1016/j.jaci.2010.03.029. Epub 2010 May 11. PMID: 20462634.
2. Gupta RS, Warren CM, Smith BM, Jiang J, Blumenstock JA, Davis MM, Schleimer RP, Nadeau KC. Prevalence and Severity of Food Allergies Among US Adults. JAMA Netw Open. 2019 Jan 4;2(1):e185630. doi: 10.1001/jamanetworkopen.2018.5630. PMID: 30646188; PMCID: PMC6324316.
3. https://www.fda.gov/food/food-labeling-nutrition/food-allergies#:~:text=Food%20Labels%20and%20Allergens&text=The%20law%20requires%20that%20food,(for%20example%2C%20buttermilk).
4. Fong AT, Du Toit G, Versteeg SA, van Ree R. Pink peppercorn: A cross-reactive risk for cashew- and pistachio-allergic patients. J Allergy Clin Immunol Pract. 2019 Feb;7(2):724-725.e1. doi: 10.1016/j.jaip.2018.11.051. Epub 2018 Dec 27. PMID: 30594585.
5. Too, J. J. Y., Shek, L. P., & Rajakulendran, M. (2019). Cross-reactivity of pink peppercorn in cashew and pistachio allergic individuals. *Asia Pacific allergy*, *9*(3), e25. https://doi.org/10.5415/apallergy.2019.9.e25
6. https://baltimoretimes-online.com/latest-news/2023/10/26/pink-peppercorns-a-hidden-allergen-that-demands-attention/#:~:text=As%20a%20result%2C%20pink%20peppercorns,has%20limited%20oversight%20on%20spices.
7. https://baltimoretimes-online.com/featured/2024/01/11/popular-spice-triggers-life-threatening-allergy-attack-of-baltimore-times-publishers-grandson-i-have-lost-faith-in-our-food-safety-laws/

RELEVANT AMA POLICY:

Preventing Allergic Reactions in Food Service Establishments D-440.932
Our American Medical Association will pursue federal legislation requiring restaurants and food establishments to: (1) include a notice in menus reminding customers to let the staff know of any food allergies; (2) educate their staff regarding common food allergens and the need to remind customers to inform wait staff of any allergies; and (3) identify menu items which contain any of the major food allergens identified by the FDA (in the Food Allergen Labeling and Consumer Protection Act of 2004) and which allergens the menu item contains. [Res. 416, A-15]

Childhood Anaphylactic Reactions D-60.976
Our AMA will: (1) urge all schools, from preschool through 12th grade, to: (a) develop Medical Emergency Response Plans (MERP); (b) practice these plans in order to identify potential barriers and strategies for improvement; (c) ensure that school campuses have a direct communication link with an emergency medical system (EMS); (d) identify students at risk for life-threatening emergencies and ensure these children have an individual emergency care plan that is formulated with input by a physician; (e) designate roles and responsibilities among school staff for handling potential life-threatening emergencies, including administering medications, working with EMS and local emergency departments, and contacting families; (f) train school personnel in cardiopulmonary resuscitation; (g) adopt the School Guidelines for Managing Students with Food Allergies distributed by FARE (Food Allergy Research & Education); and (h) ensure that appropriate emergency equipment to deal with anaphylaxis and acute asthmatic reactions is available and that assigned staff are familiar with using this equipment; (2) work to expand to all states laws permitting students to carry prescribed epinephrine or other medications prescribed by their physician for asthma or anaphylaxis; (3) support increased research to better understand the causes, epidemiology, and effective treatment of anaphylaxis; (4) urge the Centers for Disease Control and Prevention to study the adequacy of school personnel and services to address asthma and anaphylactic emergencies; (5) urge physicians to work with parents and schools to ensure that all their patients with a food allergy have an individualized emergency plan; and (6) work to allow all first responders to carry and administer epinephrine in suspected cases of anaphylaxis. [CSAPH Rep. 1, A-07; Modified: CCB/CLRPD Rep. 2, A-14; Reaffirmed: CSAPH Rep. 01, A-24]

Food Allergic Reactions in Schools and Airplanes H-440.884
Our AMA recommends that all:
(1) schools provide increased student and teacher education on the danger of food allergies;
(2) schools have a set of emergency food allergy guidelines and emergency anaphylaxis kits on the premises, and that at least one member of the school administration be trained and certified in the indications for and techniques of their use; and
(3) commercial airlines have a set of emergency food allergy guidelines and emergency anaphylaxis kits on the premises, and that at least one member of the flight staff, such as the head flight attendant, be trained and certified in the indications for and techniques of their use. [Res. 415, A-04; Reaffirmed: CSAPH Rep. 1, A-14; Reaffirmed: CSAPH Rep. 01, A-24]

Dietary Supplements and Herbal Remedies H-150.954
(1) Our AMA supports efforts to enhance U.S. Food and Drug Administration (FDA) resources, particularly to the Office of Dietary Supplement Programs, to appropriately oversee the growing dietary supplement sector and adequately increase inspections of dietary supplement manufacturing facilities.
(2) Our AMA supports the FDA having appropriate enforcement tools and policies related to dietary supplements, which may include mandatory recall and related authorities over products that are marketed as dietary supplements but contain drugs or drug analogues, the utilization of risk-based inspections for dietary supplement manufacturing facilities, and the strengthening of adverse event reporting systems.
(3) Our AMA supports continued research related to the efficacy, safety, and long-term effects of dietary supplement products.
(4) Our AMA will work with the FDA to educate physicians and the public about FDA's Safety Reporting Portal (SRP) and to strongly encourage physicians and the public to report potential adverse events associated with dietary supplements and herbal remedies to help support FDA's efforts to create a database of adverse event information on these forms of alternative/complementary therapies.
(5) Our AMA strongly urges physicians to inquire about patients' use of dietary supplements and engage in risk-based conversations with them about dietary supplement product use.
(6) Our AMA continues to strongly urge Congress to modify and modernize the Dietary Supplement Health and Education Act to require that:
(a) dietary supplements and herbal remedies including the products already in the marketplace undergo FDA approval for evidence of safety and efficacy;
(b) dietary supplements meet standards established by the United States Pharmacopeia for identity, strength, quality, purity, packaging, and labeling;
(c) FDA establish a mandatory product listing regime that includes a unique identifier for each product (such as a QR code), the ability to identify and track all products produced by manufacturers who have received warning letters from the FDA, and FDA authorities to decline to add labels to the database if the label lists a prohibited ingredient or new dietary ingredient for which no evidence of safety exists or for products which have reports of undisclosed ingredients; and
(d) regulations related to new dietary ingredients (NDI) are clarified to foster the timely submission of NDI notifications and compliance regarding NDIs by manufacturers.
(7) Our AMA supports FDA postmarketing requirements for manufacturers to report adverse events, including drug interactions; and legislation that declares metabolites and precursors of anabolic steroids to be drug substances that may not be used in a dietary supplement.
(8) Our AMA will work with the Federal Trade Commission (FTC) to support enforcement efforts based on the FTC Act and current FTC policy on expert endorsements and supports adequate funding and resources for FTC enforcement of violations of the FTC Act.
(9) Our AMA strongly urges that criteria for the rigor of scientific evidence needed to support a structure/function claim on a dietary supplement be established by the FDA and minimally include requirements for robust human studies supporting the claim.
10) Our AMA strongly urges dietary supplement manufacturers and distributors to clearly label all products with truthful and not misleading information and for the product labeling to:
(a) not include structure/function claims that are not supported by evidence from robust human studies;
(b) not contain prohibited disease claims;
(c) eliminate "proprietary blends" and list and accurately quantify all ingredients contained in the product;
(d) require advisory statements regarding potential supplement-drug and supplement-laboratory interactions and risks associated with overuse and special populations; and
(e) include accurate and useful disclosure of ingredient measurement.
(11) Our AMA supports and encourages the FDA's regulation and enforcement of labeling violations and FTC's regulation and enforcement of advertisement violations of prohibited disease claims made on dietary supplements and herbal remedies.
(12) Our AMA urges that in order to protect the public, manufacturers be required to investigate and obtain data under conditions of normal use on adverse effects, contraindications, and possible drug interactions, and that such information be included on the label.
(13) Our AMA will continue its efforts to educate patients and physicians about the risks associated with the use of dietary supplements and herbal remedies and supports efforts to increase patient, healthcare practitioner, and retailer awareness of resources to help patients select quality supplements, including educational efforts to build label literacy. [Res. 513, I-98; Reaffirmed: Res. 515, A-99; Amended: Res. 501 & Reaffirmation I-99; Reaffirmation A-00; Reaffirmed: Sub. Res. 516, I-00; Modified: Sub. Res. 516, I-00; Reaffirmed: Sub. Res. 518, A-04; Reaffirmed: Sub. Res. 504, A-05; Reaffirmation A-05; Reaffirmed in lieu

of Res. 520, A-05; Reaffirmation I-09; Reaffirmed in lieu of Res. 501, A-10; Reaffirmation A-11; Reaffirmation I-14; Modified: Res. 511, A-16; Reaffirmation: A-17; Reaffirmation: A-19; Modified: CSAPH Rep. 3, I-20; Reaffirmed: Res. 510, A-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 923
(I-24)

Introduced by: Resident and Fellow Section

Subject: Updated Recommendations for Child Safety Seats

Referred to: Reference Committee K

Whereas, motor vehicle crashes are the leading cause of death in children aged 5-14 and each year, more than 2,000 children and adolescents under the age of 21 years die in motor vehicle crashes[1-3]; and

Whereas, in 2020 more than 63,000 children less than 13 years of age were injured in a motor vehicle crash with nearly 23,000 (36%) of these children not being buckled into the vehicle[4]; and

Whereas, American Indian and Alaska Native children and Black children are more likely to die in a motor vehicle crash than White children, and children in rural areas are more likely to die in a motor vehicle crash compared to urban areas[5,6]; and

Whereas, over the past decades, car seat technology has steadily improved in safety and ease-of-use features and provided higher weight and length limits at each stage; and

Whereas, multiple reasons exist for not using a car seat, one of which includes lack of access to affordable car seats[4]; and

Whereas, being unrestrained in a vehicle increases the risk of being killed in a crash; a 2021 National Highway Traffic Safety Administration Report using fatal crash data found that 30% of 0-3-year-olds and 36% of 8-12–year-olds killed in motor vehicle crashes were not buckled up[7]; and

Whereas, car safety seats and booster seats have been shown to be superior to a seatbelt alone in preventing death and serious injury for young children by reducing the risk of injury by up to 71-82% for car seats and 45% for booster seats[4]; and

Whereas, the choice of car seat, booster seat, or seat belt should be determined based on age and size of the child, which may not always be common knowledge to parents; and

Whereas, the American Academy of Pediatrics (AAP) and Center for Disease Control and Prevention (CDC) offer guidance on motor vehicle transportation of children, however, AMA policies have not been updated with newer recommendations surrounding the specific use of child safety seats[2,4]; therefore be it

RESOLVED, that our American Medical Association supports the following evidence-based principles in education and advocacy efforts around proper child safety seat use:

(1) The use of rear-facing car safety seats with a harness from birth for as long as possible, until children reach the maximum height or weight specifications of their rear-facing car seat;

(2) The use of forward-facing car safety seats from the time children outgrow rear-facing seats until they reach the maximum height or weight specifications of their forward-facing car seat;

(3) The use of belt-positioning booster seats from the time children they outgrow forward-facing car seats until a seat belt fits properly with the lap belt across the upper thighs and the shoulder belt across the center of the shoulder and chest;

(4) The use of lap and shoulder seat belts for all who have outgrown booster seats; and

(5) That all children under age 13 are seated only in the back row (New HOD Policy); and be it further

RESOLVED, that our AMA rescind policy 15.950, “Child Safety Seats – Public Education and Awareness.” (Rescind HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 9/24/2024

REFERENCES:

1. Leading causes of death and injury. Centers for Disease Control and Prevention. November 8, 2023. Accessed April 9, 2024. https://www.cdc.gov/injury/wisqars/leadingcauses.html.
2. American Academy of Pediatrics (AAP). Child Passenger Safety. Safe Environments in Early Childhood. January 4, 2022. https://www.aap.org/en/patient-care/early-childhood/early-childhood-health-and-development/safe-environments/child-passenger-safety/#:~:text
3. Traffic Safety Facts. National Highway Traffic Safety Administration.; 2023.
4. Child passenger safety: Get the facts. Centers for Disease Control and Prevention. September 11, 2023. Accessed April 9, 2024. https://www.cdc.gov/transportationsafety/child_passenger_safety/cps-factsheet.html.
5. Sauber-Schatz EK, West BA, Bergen G. Vital Signs: Restraint Use and Motor Vehicle Occupant Death Rates Among Children Aged 0–12 years — United States, 2002–2011. *MMWR Morb Mortal Wkly Rep*. 2014;63(5):113–118.
6. Shaw KM, West B, Kendi S, Zonfrillo MR, Sauber-Schatz E. Urban and rural child deaths from motor vehicle crashes: United States, 2015-2019. *J Pediatr*. 2022;S0022-3476(22)00620-5. doi:10.1016/j.jpeds.2022.07.001
7. National Highway Traffic Safety Administration (NHTSA). Traffic Safety Facts 2021 Data: Children (Report No DOT HS 813 456). Washington, DC: U.S. Department of Transportation, National Highway Traffic Safety Administration, National Center for Statistics and Analysis

RELEVANT AMA POLICY:

Child Safety Seats - Public Education and Awareness H-15.950
Our American Medical Association supports efforts to require child safety seat manufacturers to include information about the importance of rear-facing safety seats until children are at least four years of age or until they reach the maximum height or weight specifications of their car seat, at which time they should be placed in a forward-facing child safety system with a harness as recommended by the American Academy of Pediatrics. [Res. 922, I-14; Res. 922, I-14Modified: CSAPH Rep. 01, A-24]

Amending Child Restraint Laws H-440.870
Our AMA supports: (1) federal legislation that increases law enforcement standards for child safety seat use in the United States; and (2) state and federal legislation that updates child car seat violation codes from a secondary to primary law. [Res. 913, I-07; Reaffirmed: BOT Rep. 22, A-17]

Modification of Three-Point Shoulder Harness Seat Belt to Enable Use by Small Children H-15.988
The AMA (1) recognizes the value of using appropriately designed three-point safety belt restraints to reduce auto-related injuries and fatalities; (2) supports auto industry modifications in restraints for safe use by children and small adults; and (3) supports the development of standards required for such modifications by appropriate authorities. [Sub. Res. 33, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed and Modified: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 926
(I-24)

Introduced by: New Jersey

Subject: Development of Climate Health Education Tools for Physicians

Referred to: Reference Committee K

Whereas, the American Medical Association recognizes the urgent need for physicians to have access to comprehensive education and resources regarding the health impacts of climate change; and recognizes the profound impact of climate change on public health; and

Whereas, the World Health Organization (WHO) has referred to climate change as the most significant health threat facing humanity, contributing to increased morbidity and mortality from heat-related illnesses, vector-borne diseases, extreme weather events, exacerbation of chronic diseases and other climate-related health conditions climate change and environmental degradation threatens human health in myriad ways including impacts on cardiovascular and pulmonary systems, cancer, adverse birth outcomes, endocrinologic and gastroenterologic disease, neurologic and psychiatric effects, and autoimmune conditions along with changes in vector ecology and infections; and

Whereas, climate change and environmental degradation threatens human health in myriad ways including impacts on cardiovascular and pulmonary systems, cancer, adverse birth outcomes, endocrinologic and gastroenterologic disease, neurologic and psychiatric effects, and autoimmune conditions along with changes in vector ecology and infections; and

Whereas, physicians play a critical role in addressing the health impacts of climate change by providing preventive care, advocating for policies that mitigate environmental risks, and educating patients and communities on climate-related health risks; and

Whereas, studies have demonstrated the inadequacy of current medical education in preparing physicians to address climate-related health risks, with many medical students and practicing physicians reporting limited knowledge and training in this critical area the incorporation of climate health education into medical training has been shown to enhance physician preparedness to recognize, prevent, and treat climate-related health conditions, ultimately improving patient outcomes and community resilience; and

Whereas, the incorporation of climate health education into medical training has been shown to enhance physician preparedness to recognize, prevent, and treat climate-related health conditions, improving patient outcomes and community resilience; and

Whereas, incorporating climate health education into medical training can equip physicians with the knowledge and skills necessary to effectively address climate-related health challenges and promote resilience in patients and communities; and

Whereas, the development and dissemination of climate health education tools and resources tailored to the needs of physicians can facilitate the integration of climate health into medical

curricula and clinical practice, empowering healthcare providers to address the health impacts of climate change more effective; and

Whereas, the medical profession has a responsibility to prioritize climate health as an essential component of medical education and practice; therefore be it

RESOLVED, that our American Medical Association commits to developing a comprehensive suite of climate health education tools and resources for physicians, including online modules, case studies, clinical guidelines, and patient education materials (Directive to Take Action); and be it further

RESOLVED, that our AMA collaborates with subject matter experts, medical educators, and healthcare organizations to ensure the accuracy, relevance, and accessibility of climate health education materials (Directive to Take Action); and be it further

RESOLVED, that our AMA establishes a dedicated task force or working group within the AMA to oversee the development, review, and dissemination of climate health education tools, with representation from diverse medical specialties and stakeholder groups (Directive to Take Action); and be it further

RESOLVED, that our AMA encourages medical schools, residency programs, and continuing medical education providers to integrate AMA-developed climate health education resources into their curricula and training programs (New HOD Policy); and be it further

RESOLVED, that our AMA advocates for funding and support from governmental agencies, philanthropic organizations, and other stakeholders to facilitate the widespread adoption and implementation of climate health education tools within the medical community (Directive to Take Action); and be it further

RESOLVED, that our AMA advocates for funding and support from governmental agencies, philanthropic organizations, and other stakeholders to facilitate the widespread adoption and implementation of climate health education tools within the medical community (Directive to Take Action); and be it further

RESOLVED, that our AMA shall communicate this resolution to relevant stakeholders, including medical schools, residency programs, healthcare organizations, and government agencies, to mobilize support and resources for the development and dissemination of climate health education tools for physicians. (Directive to Take Action)

Fiscal Note: $765,754 Contract with third-parties to develop educational content and development of a taskforce

Received: 9/24/2024

REFERENCES

1. World Health Organization. (2018). Climate change and health. Retrieved from https://www.who.int/news-room/fact-sheets/detail/climate-change-and-health
2. cop26-special-report.pdf (who.int) Accessed March 23, 2024.
3. Vohra K, Vodonos A, Schwartz J, Marais EA, Sulprizio MP, Mickley LJ. Global mortality from outdoor fine particle pollution generated by fossil fuel combustion: Results from GEOS-Chem. Environ Res. 2021 Apr;195:110754.
4. Salas RN, Solomon CG. The Climate Crisis — Health and Care Delivery. NEJM. 2019; 381:e13.
5. Shuman EK. Global Climate Change and Infectious Diseases. NEJM. 2010; 362:1061-3.
6. Rasmussen SA, Jamieson DJ. Protecting Pregnant People and Babies from the Health Effects of Climate Change. NEJM. 2022 Sept 10. Doi:10.1056/NEJMp2210221.
7. McMichael AJ. Globalization, Climate Change, and Human Health. NEJM. 2013; 368:1335-1343.
8. Schraufnagel DE, et al. Air Pollution and Noncommunicable Diseases. Chest 2019; 155(2):409-416.
9. Sorensen C, Garcia-Trabanino R. A New Era of Climate Medicine — Addressing Heat-Triggered Renal Disease. NEJM 2019; 381:693-6.
10. Keswani A, Akselrod H, Anenberg SC. Health and Clinical Impacts of Air Pollution and Linkages with Climate Change. NEJM Evidence. 2022;1(7).
11. Rajagopalan S, Landrigan PL. Pollution and the Heart. NEJM. 2021;385:1881-1892.
12. Atwoli L, Baqui AH, Benfield T, Bosurgi R, Godlee F, Hancocks S, et al. Call for emergency action to limit global temperature increases, restore biodiversity, and protect health - The Lancet. 2021; 398(10304:939-941.
13. Maxwell, J., Blashki, G., & Lim, E. The role of medical colleges in addressing climate change and health. BMC Medical Education. 2019; 19(1), 16.
14. Patz, J. A., Frumkin, H., Holloway, T., Vimont, D. J., Haines, A., 2014. Climate Change: Challenges and Opportunities for Global Health. JAMA. 2014; 312(15), 1565–1580.
15. Maibach, E. W., Knowlton, K., & Sarfaty, M. Connecting the Dots: The Link between Health, Climate Change, and Sustainability. Environmental Health Perspectives. 2019; 127(4), 1-7.
16. Sarfaty, M., Mitchell, M., Bloodhart, B., Maibach, E. W., & Gustafson, A. (2018). American Thoracic Society member survey on climate change and health. Annals of the American Thoracic Society, 15(5), 552-560.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 928
(I-24)

Introduced by: New York Delegation

Subject: Public Safety Agencies Data Collection Enhancement

Referred to: Reference Committee K

Whereas, clinical researchers and scientists are eager to study the causes and circumstances of accidental traumatic injuries, in order to promote the safety and general welfare of the public through primary & secondary prevention thereof; and

Whereas, legislators and policymakers depend upon clinical researchers and scientists to provide valid evidence upon which data-driven legislation to protect the public may be developed and enacted. Historical examples include Standard 208 of the National Traffic and Safety Act in 1967, which required automobiles to have seatbelts, and banning tobacco advertisement on television and radio in 1971; both of which have saved millions of lives; and

Whereas, currently, Public Safety Agencies, e.g., Emergency Medical Services and Police Departments, collect limited data on vehicular accidents and injury-related events by requiring only general descriptions of location, e.g., the road names or intersection where an accident occurs, or that a fall occurred “in the home”; and

Whereas, regarding road or traffic accidents, details such as types of vehicles, including but not limited to micro-transit (scooters or motorized/electric bicycles); speed of the vehicles, and whether the event occurred in a crosswalk (zebra lines), bike lane, or main thoroughfare are relegated to non-mandatory “free-text” fields, which are not readily searchable; and

Whereas, regarding falls in the home, more specific data on location and mechanism of injury, i.e., the kitchen, bathroom or stairs, as well as, the presence of obstacles or hazards, such as clutter, are relegated to non-mandatory “free-text” fields, which are not readily searchable; and

Whereas, in order to develop data-driven, evidence-based safety and preventative policies, more specific and granular information must be reliably and searchably collected by Public Safety Agencies across the state and the nation; therefore be it

RESOLVED, that our American Medical Association shall actively collaborate with the National Emergency Medical Services Information System (NEMSIS) to promote a listing of necessary data points and variables to be added to the currently available information collection systems, in a mandatory and searchable fashion, to facilitate the required research (Directive to Take Action); and be it further

RESOLVED, that our AMA shall actively collaborate with the American College of Surgeons to promote addition of these variable fields to data collection systems of the National Trauma Data Bank (NTDB) and the Trauma Quality Improvement Program (TQIP), in a mandatory and searchable fashion, to facilitate the required research (Directive to Take Action); and be it further

RESOLVED, that our AMA shall advocate to the US Congress to mandate the collection of these data and fund the transition to and the ongoing collection of these data. (Directive to Take Action)

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

Received: 9/24/2024

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 929
(I-24)

Introduced by: New York Delegation

Subject: Safety Concerns Regarding Inadequate Labeling of Food Products Upon Ingredient Changes with Known Major Food Allergens

Referred to: Reference Committee K

Whereas, the American Medical Association is dedicated to promoting the highest standards of medical care and advocating for the well-being of patients and physicians; and

Whereas, there are millions of Americans who have food allergies and hypersensitivities; and

Whereas, the FDA has provided guidelines to the food industry consumers and stakeholders on the best ways to assess and manage allergen hazards in food; and

Whereas, the FDA has identified the following 9 items as major food allergens: milk, eggs, fish, crustacean shellfish, tree nuts, peanuts, wheat, soybeans and sesame; and

Whereas, Federal law requires that food manufacturers and sellers identify by label all of the food source of all major food allergens used to make the food; and

Whereas, there is no guidance by the FDA to ensure additional labeling requirements or notifications identifying when ingredients have been substituted with major food allergens prior to sale other than simply listing the ingredient among all the other ingredients; and

Whereas, a recent unfortunate death of a 25-year-old female due to anaphylaxis from ingesting a food item that contained a new ingredient consisting of a major food allergen which was not included in the list of ingredients on the label; and

Whereas, the cause of the mislabeling is still under investigation, the deadly ramifications of incorrectly marked ingredients is apparent especially with a food product which had been changed by the food manufacturer with the addition of a food allergen, but repackaged by the retailer without the newly added major food allergen ingredient change identified in the labeling; and

Whereas, there is an ongoing investigation to review the details of the miscommunication of a change of ingredient by the developer and the retailer when repackaging the food that now had a major food allergen as an ingredient; and

Whereas, the FDA ‘s guidelines do not suggest any “red flag” or “warning” notifications labeling, or any other method to accentuate a major food allergy addition to a previously formulated food product; therefore be it

RESOLVED, that our American Medical Association support legislation or regulation that any repackaging entity verify with the food manufacturer/distributor as an ordinary and routine

transaction of commerce that no major food allergen ingredient changes have occurred (New HOD Policy); and be it further

RESOLVED, that our AMA support legislation or regulation requiring major food allergen ingredient changes be labeled and packaged with accentuated, obvious warning labeling identifying such change. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 9/24/2024

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 930
(I-24)

Introduced by: Association for Clinical Oncology, American Society of Hematology

Subject: Economic Factors to Promote Reliability of Pharmaceutical Supply

Referred to: Reference Committee K

Whereas, pharmaceutical drug shortages are frequent, and have had serious negative effects on the health of American patients, including those with curable diseases including cancer; and

Whereas, supply of generic sterile injectable drugs faces multiple challenges, including a limited number of manufacturers, limited API (active pharmaceutical ingredient) sourcing and tracking, and limited quality control – all ultimately stemming from competition for the lowest price; and

Whereas, AMA policy H-100.956 "National Drug Shortages" establishes a framework to address drug shortages, including support for "measures designed to drive greater investment in production capacity for products that are in short supply," as well as a recommendation for analysis of economic drivers of drug shortages; and

Whereas, federal legislators have drafted potential legislation which would address some of these economic drivers of drug shortages, with interventions including federal incentives for practices to enter into contracts for time and volume commitment with stable pricing with manufacturers of generic drugs; therefore be it

RESOLVED, that our American Medical Association amend H-100.956 "National Drug Shortages" by addition of a new Resolve:

> Our AMA support federal drug shortage prevention and mitigation programs that create payer incentives to enable practitioners and participating entities to voluntarily enter contracts directly with manufacturers that will pay more than prevailing market price for generic sterile injectable drugs at high risk of shortage to promote stable manufacturing and reliability of these products. (Modify Current HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 9/24/2024

REFERENCES

1. Association for Clinical Oncology. Drug Shortages. https://society.asco.org/practice-patients/practice-support/drug-shortages
2. Brookings Institution. Federal Policies to Address Persistent Generic Drug Shortages. https://www.brookings.edu/articles/federal-policies-to-address-persistent-generic-drug-shortages
3. United States Senate Committee on Finance. Wyden and Crapo Release Draft Legislation to Combat Prescription Drug Shortages. https://www.finance.senate.gov/chairmans-news/wyden-and-crapo-release-draft-legislation-to-combat-prescription-drug-shortages
4. United States Senate Committee on Finance. Senate Finance Committee Discussion Draft: Preventing & Mitigating Generic Drug Shortages. https://www.finance.senate.gov/imo/media/doc/050124_sfc_drug_shortages_discussion_draft_one_pager.pdf

RELEVANT AMA POLICY

National Drug Shortages H-100.956
1. Our American Medical Association considers drug shortages to be an urgent public health crisis, and recent shortages have had a dramatic and negative impact on the delivery and safety of appropriate health care to patients.
2. Our AMA supports recommendations that have been developed by multiple stakeholders to improve manufacturing quality systems, identify efficiencies in regulatory review that can mitigate drug shortages, and explore measures designed to drive greater investment in production capacity for products that are in short supply, and will work in a collaborative fashion with these and other stakeholders to implement these recommendations in an urgent fashion.
3. Our AMA supports authorizing the Secretary of the U.S. Department of Health and Human Services (DHHS) to expedite facility inspections and the review of manufacturing changes, drug applications and supplements that would help mitigate or prevent a drug shortage.
4. Our AMA 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.
5. The Council on Science and Public Health shall continue to evaluate the drug shortage issue, including the impact of group purchasing organizations and pharmacy benefit managers on drug shortages, and report back at least annually to the House of Delegates on progress made in addressing drug shortages.
6. Our AMA urges continued analysis of the root causes of drug shortages that includes consideration of federal actions, evaluation of manufacturer, Group Purchasing Organization (GPO), pharmacy benefit managers, and distributor practices, contracting practices by market participants on competition, access to drugs, pricing, and analysis of economic drivers, and supports efforts by the Federal Trade Commission to oversee and regulate such forces.
7. Our AMA urges regulatory relief designed to improve the availability of prescription drugs by ensuring that such products are not removed from the market or caused to stop production due to compliance issues unless such removal is clearly required for significant and obvious safety reasons.
8. Our AMA supports the view that wholesalers should routinely institute an allocation system that attempts to fairly distribute drugs in short supply based on remaining inventory and considering the customer's purchase history.
9. Our AMA will collaborate with medical specialty society partners and other stakeholders in identifying and supporting legislative remedies to allow for more reasonable and sustainable payment rates for prescription drugs.
10. Our AMA urges that during the evaluation of potential mergers and acquisitions involving pharmaceutical manufacturers, the Federal Trade Commission consult with the FDA to determine whether such an activity has the potential to worsen drug shortages.
11. Our AMA urges the FDA to require manufacturers and distributors to provide greater transparency regarding the pharmaceutical product supply chain, including production locations of drugs, any unpredicted changes in product demand, and provide more detailed information regarding the causes and anticipated duration of drug shortages.
12. Our AMA supports the collection and standardization of pharmaceutical supply chain data in order to determine the data indicators to identify potential supply chain issues, such as drug shortages.
13. Our AMA encourages global implementation of guidelines related to pharmaceutical product supply chains, quality systems, and management of product lifecycles, as well as expansion of global reporting requirements for indicators of drug shortages.
14. Our AMA urges drug manufacturers to accelerate the adoption of advanced manufacturing technologies such as continuous pharmaceutical manufacturing.
15. Our AMA supports the concept of creating a rating system to provide information about the quality management maturity, resiliency and redundancy, and shortage mitigation plans, of pharmaceutical manufacturing facilities to increase visibility and transparency and provide incentive to manufacturers. Additionally, our AMA encourages GPOs and purchasers to contractually require manufacturers to disclose their quality rating, when available, on product labeling.
16. Our AMA encourages electronic health records (EHR) vendors to make changes to their systems to ease the burden of making drug product changes.
17. Our AMA urges the FDA to evaluate and provide current information regarding the quality of

outsourcer compounding facilities.
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.
19. Our AMA urges the Drug Enforcement Agency and other federal agencies to regularly communicate and consult with the FDA regarding regulatory actions which may impact the manufacturing, sourcing, and distribution of drugs and their ingredients.
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.
21. Our AMA supports the public availability of FDA facility inspection reports to allow purchasers to better assess supply chain risk.
22. Our AMA opposes the practice of preferring drugs experiencing a shortage on approved pharmacy formularies when other, similarly effective drugs are available in adequate supply but otherwise excluded from formularies or coverage plans.
23. Our AMA shall continue to monitor proposed methodologies for and the implications of a buffer supply model for the purposes of reducing drug shortages and will report its findings as necessary.

Resolutions Not for Consideration

Resolutions

203 Alternative Pathways for International Medical Graduates
209 Physician Liability for AI and Other Technological Advances in Medicine
224 Update the status of Virtual Credit card policy, EFT fees, and lack of Enforcement of Administrative Simplification Requirements by CMS
301 Reopening Schools Closed by the Flexner Report
303 Transparency and Access to Medical Training Program Unionization Status, Including Creation of a FREIDA Unionization Filter
307 Humanism in Anatomical Medical Education
603 Study of Grading Systems in AMA Board Reports
806 Study of the Federal Employee Health Benefit Plan (FEHBP)
816 Study of CO-OP Insurance as a Vehicle for Public Healthcare Insurance Option
906 Call for Study: Should Petroleum-Powered Emergency Medical Services (EMS) Vehicles in Urban Service Areas be Replaced by Renewably-Powered Electric Vehicles?
908 Support for Doula Care Programs
914 Protecting the Healthcare Supply Chain from the Impacts of Climate Change
921 In Support of a National Drug Checking Registry
924 Public Health Implications of US Food Subsidies
925 Improving Public Awareness of Lung Cancer Screening and CAD in Chronic Smokers
927 The Creation of Healthcare Sustainability Lecture Series

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 203
(I-24)

Introduced by: International Medical Graduates Section

Subject: Alternative Pathways for International Medical Graduates

Referred to: Reference Committee B

Whereas, the American Medical Association opposes efforts to employ graduates of foreign medical schools who have not met existing state criteria for full licensure (H-255.970); and

Whereas, the AMA supports the requirement that all medical school graduates complete at least one year of graduate medical education in an accredited U.S. program in order to qualify for full and unrestricted licensure (H-255.988); and

Whereas, the AMA encourages State Medical Boards to allow an alternate set of criteria for granting licensure in lieu of this requirement (completion of medical school and residency training outside the U.S.; extensive U.S. medical practice; and evidence of good standing within the local medical community) (H-255.988); and

Whereas, there are multiple states in the U.S. that have passed legislation allowing alternate medical licensure pathways for International Medical Graduates; and

Whereas, legislation changes in medical licensure pathways for IMGs differ between states; and

Whereas, there are no recommendations for State Medical Boards regarding the implementation of such alternative licensure pathways for IMGs; and

Whereas, a new “Advisory Commission on Alternate Licensing Models” was established by FSMB, ECFMG and ACGME with the participation of the AMA to provide guidance to the states seeking to improve access to care by streamlining the licensure of IMGs; therefore be it

RESOLVED, that our American Medical Association provides an informational report about the ongoing work around alternate licensing pathways and currently introduced laws and regulations being introduced around the country and their status during the A-25 meeting (Directive to Take Action); and be it further

RESOLVED, that, following the conclusion of the work of the Advisory Commission on Alternate Licensing Models, our AMA develop educational resources related to alternate licensing models for the AMA HOD and other interested stakeholders (Directive to Take Action); and be it further

RESOLVED, that our AMA widely distribute the Commission’s report and relevant educational content to all AMA members and other interested stakeholders (Directive to Take Action); and be it further

RESOLVED, that, following the conclusion of the work of the Advisory Commission on Alternate Licensing Models, our AMA study our existing policy pertaining to state licensure processes,

including alternate licensing pathways, and recommend updates to such policies, as appropriate, to help inform advocacy efforts by state medical societies. (Directive to Take Action)

Fiscal Note: To Be Determined

Received: 9/19/2024

RELEVANT AMA POLICY

D-255.977 - Licensure for International Medical Graduates Practicing in U.S. Institutions with Restricted Medical Licenses
Our AMA will advocate that qualified international medical graduates have a pathway for licensure by encouraging state medical licensing boards and the member boards of the American Board of Medical Specialties to develop criteria that allow: (1) completion of medical school and residency training outside the U.S.; (2) extensive U.S. medical practice; and (3) evidence of good standing within the local medical community to serve as a substitute for U.S. graduate medical education requirement for physicians seeking full unrestricted licensure and board certification. (CME Rep. 2, A-21)

H-255.970 - Employment of Non-Certified IMGs
1. Our American Medical Association will oppose efforts to employ graduates of foreign medical schools who are neither certified by the ECFMG (a member of Intealth) nor have met state criteria for full licensure.
2. Our AMA encourages states that have difficulty recruiting doctors to underserved areas to explore the expanded use of incentive programs such as the National Health Service Corps or J-1 or other visa waiver programs. (Res. 309, A-03Reaffirmed: CME Rep. 2, A-13Modified: CME Rep. 01, A-23)

H-255.988 AMA Principles on International Medical Graduates
1. Our American Medical Association supports current U.S. visa and immigration requirements applicable to foreign national physicians who are graduates of medical schools other than those in the United States and Canada.
2. Our AMA supports current regulations governing the issuance of exchange visitor visas to foreign national IMGs, including the requirements for successful completion of the USMLE.
3. Our AMA reaffirms its policy that the U.S. and Canada medical schools be accredited by a nongovernmental accrediting body.
4. Our AMA supports cooperation in the collection and analysis of information on medical schools in nations other than the U.S. and Canada.
5. Our AMA supports continued cooperation with the ECFMG and other appropriate organizations to disseminate information to prospective and current students in foreign medical schools. An AMA member, who is an IMG, should be appointed regularly as one of the AMA's representatives to the ECFMG Board of Trustees.
6. Our AMA supports working with the Accreditation Council for Graduate Medical Education (ACGME) and the Federation of State Medical Boards (FSMB) to assure that institutions offering accredited residencies, residency program directors, and U.S. licensing authorities do not deviate from established standards when evaluating graduates of foreign medical schools.
7. In cooperation with the ACGME and the FSMB, our AMA supports only those modifications in established graduate medical education or licensing standards designed to enhance the quality of medical education and patient care.
8. Our AMA continues to support the activities of the ECFMG related to verification of education credentials and testing of IMGs.
9. Our AMA supports that special consideration be given to the limited number of IMGs who are refugees from foreign governments that refuse to provide pertinent information usually required to establish eligibility for residency training or licensure.
10. Our AMA supports that accreditation standards enhance the quality of patient care and medical education and not be used for purposes of regulating physician manpower.

11. Our AMA representatives to the ACGME, residency review committees and to the ECFMG should support AMA policy opposing discrimination. Medical school admissions officers and directors of residency programs should select applicants on the basis of merit, without considering status as an IMG or an ethnic name as a negative factor.
12. Our AMA supports the requirement that all medical school graduates complete at least one year of graduate medical education in an accredited U.S. program in order to qualify for full and unrestricted licensure. State medical licensing boards are encouraged to allow an alternate set of criteria for granting licensure in lieu of this requirement:
    a. completion of medical school and residency training outside the U.S.;
    b. extensive U.S. medical practice; and
    c. evidence of good standing within the local medical community.
13. Our AMA supports publicizing existing policy concerning the granting of staff and clinical privileges in hospitals and other health facilities.
14. Our AMA supports the participation of all physicians, including graduates of foreign as well as U.S. and Canadian medical schools, in organized medicine. Our AMA offers encouragement and assistance to state, county, and specialty medical societies in fostering greater membership among IMGs and their participation in leadership positions at all levels of organized medicine, including AMA committees and councils, the Accreditation Council for Graduate Medical Education and its review committees, the American Board of Medical Specialties and its specialty boards, and state boards of medicine, by providing guidelines and non-financial incentives, such as recognition for outstanding achievements by either individuals or organizations in promoting leadership among IMGs.
15. Our AMA supports studying the feasibility of conducting peer-to-peer membership recruitment efforts aimed at IMGs who are not AMA members.
16. Our AMA membership outreach to IMGs to include:
    a. using its existing publications to highlight policies and activities of interest to IMGs, stressing the common concerns of all physicians;
    b. publicizing its many relevant resources to all physicians, especially to nonmember IMGs;
    c. identifying and publicizing AMA resources to respond to inquiries from IMGs; and
    d. expansion of its efforts to prepare and disseminate information about requirements for admission to accredited residency programs, the availability of positions, and the problems of becoming licensed and entering full and unrestricted medical practice in the U.S. that face IMGs. This information should be addressed to college students, high school and college advisors, and students in foreign medical schools.
17. Our AMA supports recognition of the common aims and goals of all physicians, particularly those practicing in the U.S., and support for including all physicians who are permanent residents of the U.S. in the mainstream of American medicine.
18. Our AMA supports its leadership role to promote the international exchange of medical knowledge as well as cultural understanding between the U.S. and other nations.
19. Our AMA supports institutions that sponsor exchange visitor programs in medical education, clinical medicine and public health to tailor programs for the individual visiting scholar that will meet the needs of the scholar, the institution, and the nation to which he will return.
20. Our AMA supports informing foreign national IMGs that the availability of training and practice opportunities in the U.S. is limited by the availability of fiscal and human resources to maintain the quality of medical education and patient care in the U.S., and that those IMGs who plan to return to their country of origin have the opportunity to obtain GME in the United States.
21. Our AMA supports U.S. medical schools offering admission with advanced standing, within the capabilities determined by each institution, to international medical students who satisfy the requirements of the institution for matriculation.
22. Our AMA supports the Federation of State Medical Boards, its member boards, and the ECFMG in their willingness to adjust their administrative procedures in processing IMG applications so that original documents do not have to be recertified in home countries when physicians apply for licenses in a second state.
23. Our AMA supports continued efforts to protect the rights and privileges of all physicians duly licensed in the U.S. regardless of ethnic or educational background and opposes any legislative efforts to discriminate against duly licensed physicians on the basis of ethnic or educational background.
24. Our AMA supports continued study of challenges and issues pertinent to IMGs as they affect our country’s health care system and our physician workforce.

25. Our AMA supports advocacy to Congress to fund studies through appropriate agencies, such as the Department of Health and Human Services, to examine issues and experiences of IMGs and make recommendations for improvements. (BOT Rep. Z, A-86; Reaffirmed: Res. 312, I-93; Modified: CME Rep. 2, A-03; Reaffirmation I-11; Reaffirmed: CME Rep. 1, I-13)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 209
(I-24)

Introduced by: Utah

Subject: Physician Liability for AI and Other Technological Advances in Medicine

Referred to: Reference Committee B

Whereas, a significant number of physicians, researchers, and medical technology companies are incorporating artificial intelligence or augmented intelligence (AI)[1]; and

Whereas, AI has significant, potential benefits for both patients and healthcare providers by decreasing cost, streamlining workflow, increasing accessibility, and improving outcomes [2,3]; and

Whereas, the use of AI in medicine has potentially detrimental effects on the practice of medicine and the physician-patient relationship[4]; and

Whereas, the use of AI in medicine has the potential to create unanticipated ambiguities in liability and accountability in healthcare delivery and patient safety[5-8]; and

Whereas, in addition to AI, physicians are using other evolving medical technological advances in their practices; therefore be it

RESOLVED, that our American Medical Association support measures to appropriately limit physician liability with current and future technological advancements in medicine. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 9/23/2024

References

1. Robeznieks A. Big majority of doctors see upsides to using health care AI. American Medical Association. January 12, 2024. Accessed August 6, 2024. https://www.ama-assn.org/practice-management/digital/big-majority-doctors-see-upsides-using-health-care-ai#:~:text=Nearly%20two%2Dthirds%20of%20the,survey%20was%20administered%20last%20summer.
2. Matheny M, Thadaney Israni S, Ahmed M, Whicher D. *Artificial intelligence in health care: the hope, the hype, the promise, the peril*. National Academy of Medicine; 2020:pages cm.
3. Health HSoP. AI in Health Care: From Strategies to Implementation. Harvard School of Public Health. Accessed August 6, 2024. https://execonline.hms.harvard.edu/artificial-intelligence-in-health-care-from-strategies-to-implementation?utm_source=Google&utm_network=g&utm_medium=c&utm_term=healthcare%20in%20ai&utm_location=9029683&utm_campaign_id=21212474098&utm_adset_id=160845325906&utm_ad_id=697082031060&gad_source=1&gclid=Cj0KCQjwtsy1BhD7ARIsAHOi4xZt8zxNl6Pgl_XrHnk8VoysUejT_oqY5Xc--NlY7Ceq6wS1-7m1hvMaAnxuEALw_wcB
4. Khan B, Fatima H, Qureshi A, et al. Drawbacks of Artificial Intelligence and Their Potential Solutions in the Healthcare Sector. *Biomed Mater Devices*. Feb 8 2023:1-8. doi:10.1007/s44174-023-00063-2
5. Cestonaro C, Delicati A, Marcante B, Caenazzo L, Tozzo P. Defining medical liability when artificial intelligence is applied on diagnostic algorithms: a systematic review. *Front Med (Lausanne)*. 2023;10:1305756-1305756. doi:10.3389/fmed.2023.1305756
6. Duffourc M, Gerke S. Generative AI in Health Care and Liability Risks for Physicians and Safety Concerns for Patients. *JAMA*. 2023;330(4):313-314. doi:10.1001/jama.2023.9630
7. Jones C, Thornton J, Wyatt JC. Artificial intelligence and clinical decision support: clinicians' perspectives on trust, trustworthiness, and liability. *Med Law Rev*. 2023;31(4):501-520. doi:10.1093/medlaw/fwad013
8. Smith H, Fotheringham K. Artificial intelligence in clinical decision-making: Rethinking liability. *Medical Law International*. 2020;20(2):131-154. doi:10.1177/0968533220945766

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 224
(I-24)

Introduced by: New York

Subject: Update the status of Virtual Credit card policy, EFT fees, and lack of Enforcement of Administrative Simplification Requirements by CMS

Referred to: Reference Committee B

Whereas, our American Medical Association adopted policies CMS Administrative Requirements D-190.970, Virtual Credit Card Payments H-190.955, Amend Virtual Credit Card and Electronic Funds Transfer Fee Policy D-190.968; and

Whereas, despite the efforts of the American Medical Association and other groups, the sneaky practices and associated costs of virtual credit cards and EFT fees have not abated; and

Whereas, these possible violations of the HIPAA administrative simplification requirements have not been remedied; and

Whereas, enforcement of these laws preventing imposition of costs for EFT requires continued vigilance by the AMA, medical societies and physicians across the country; therefore be it

RESOLVED, that our American Medical Association report at the Annual 2025 Meeting on the progress of implementation of AMA Policies D-190.970, H-190.955, and D-190.968. (Directive to Take Action)

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

Received: 9/24/2024

RELEVANT AMA POLICY

CMS Administrative Requirements D-190.970
Our AMA will: (1) forcefully advocate that the Centers for Medicare and Medicaid Services (CMS) investigate all valid allegations of HIPPPA Administrative simplification requirements thoroughly and offers transparency in its processes and decisions as required by the Administrative Procedure Act (APA);

(2) forcefully advocate that the CMS resolve all complaints related to the non-compliant payment methods including opt-out virtual credit cards, charging processing fees for electronic claims and other illegal electronic funds transfer (EFT) fees; (3) communicate its strong disapproval of the failure by the CMS Office of Burden Reduction to effectively enforce the HIPAA administrative simplification requirements as required by the law and its failure to impose financial penalties for non-compliance by health plans; and (4) through legislation, regulation or other appropriate means, advocate for the prohibition of health insurers charging physicians and other providers to process claims and make payment.

Amend Virtual Credit Card and Electronic Funds Transfer Fee Policy D-190.968
1. Our American Medical Association will advocate for legislation or regulation that would prohibit the use of virtual credit cards (VCCs) for electronic health care payments.

2. Our AMA will advocate on behalf of physicians and plainly state that it is not advisable or beneficial for medical practices to get paid by VCCs.

3. Our AMA will engage in legislative and regulatory advocacy efforts to address the growing and excessive electronic funds transfer (EFT) add-on service fees charged by payers when paying physicians, including advocacy efforts directed at: (a) the issuance of Centers for Medicare & Medicaid Services (CMS) regulatory guidance affirming physicians' right to choose and receive timely basic EFT payments without paying for additional services, (b) CMS enforcement activities related to this issue, and (c) physician access to a timely no fee EFT option as an alternative to VCCs.

Virtual Credit Card Payments H-190.955
Our American Medical Association will educate its members about the use of virtual credit cards by third party payers, including the costs of accepting virtual credit card payments from third party payers, the beneficiaries of the administrative fees paid by the physician practice inherent in accepting such payments and the lower cost alternative of electronic funds transfer via the Automated Clearing House.

2. Our AMA will advocate for advance disclosure by third-party payers of transaction fees associated with virtual credit cards and any rebates or other incentives awarded to payers for utilizing virtual credit cards.

3. Our AMA supports transparency, fairness, and provider choice in payers' use of virtual credit card payments, including: advanced physician consent to acceptance of this form of payment; disclosure of transaction fees; clear information about how the provider can opt out of this payment method at any time; and prohibition of payer contracts requiring acceptance of virtual credit card payments for network inclusion.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 301
(I-24)

Introduced by: North Carolina

Subject: Reopening Schools Closed by the Flexner Report

Referred to: Reference Committee C

Whereas, the Flexner report shut down a majority of medical schools for the training of black and minority students in the United States; and

Whereas, equity and medical apartheid issues persist to this day because of the effects of this decision; and

Whereas, medical schools dedicated to underrepresented groups can focus on research on these same groups to improve data gaps that exist for underrepresented patient populations in medical research studies; and

Whereas, on June 29, 2023, the U.S. Supreme Court ruled in Students for Fair Admissions, Inc. (SFFA) v. President & Fellows of Harvard College (Harvard) and SFFA v. University of North Carolina (UNC) that affirmative action programs in college admissions violate the 14th Amendment's Equal Protection Clause which overturned 45 years of Supreme Court precedent which means that colleges and universities can no longer consider race when deciding whether to admit students; therefore be it

RESOLVED, that our American Medical Association inquire with the historically black universities in the United States and any other interested parties in their interest in reopening the historically black medical schools shut down by the Flexner report, or the opening of new medical schools through these universities (Directive to Take Action); and be it further

RESOLVED, that our AMA assist parties in identifying experts and leaders interested in reopening historically black medical schools and provide information on accreditation and any other consultative advice needed to succeed in opening these medical schools. (Directive to Take Action)

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

Received: 9/24/2024

RELEVANT AMA POLICY

H-350.960 Underrepresented Student Access to US Medical Schools

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

3. Our AMA recognizes some people have been historically underrepresented, excluded from, and marginalized in medical education and medicine because of their race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin, and rurality, due to racism and other systems of exclusion and discrimination.
4. Our AMA is committed to promoting truth and reconciliation in medical education as it relates to improving equity.
5. Our AMA recognizes the harm caused by the Flexner Report to historically Black medical schools, the diversity of the physician workforce, and the outcomes of minoritized and marginalized patient populations.
6. Our AMA will urge medical schools to develop or expand the reach of existing pathway programs for underrepresented middle school, high school and college aged students to motivate them to pursue and prepare them for a career in medicine.
7. Our AMA will encourage collegiate programs to establish criteria by which completion of such programs will secure an interview for admission to the sponsoring medical school.
8. Our AMA will recommend that medical school pathway programs for underrepresented students be free-of-charge or provide financial support with need-based scholarships and grants.
9. Our AMA will encourage all physicians to actively participate in programs and mentorship opportunities that help expose underrepresented students to potential careers in medicine.
10. Our AMA will consider quality of K-12 education a social determinant of health and thus advocate for implementation of Policy H-350.979,
    a. encouraging state and local governments to make quality elementary and secondary education available to all.[Res. 908, I-08 Reaffirmed in lieu of Res. 311, A-15 Appended: CME Rep. 5, A-21 Appended: Res. 305, I-22]

H-460.911 Increasing Minority, Female, and other Underrepresented Group Participation in Clinical Research

1. Our American Medical Association advocates that:
    a. The Food and Drug Administration (FDA) and National Institutes of Health (NIH) conduct annual surveillance of clinical trials by gender, race, and ethnicity, including consideration of pediatric and elderly populations, to determine if proportionate representation of women and minorities is maintained in terms of enrollment and retention. This surveillance effort should be modeled after National Institute of Health guidelines on the inclusion of women and minority populations.
    b. The FDA have a page on its web site that details the prevalence of minorities and women in its clinical trials and its efforts to increase their enrollment and participation in this research.
    c. Resources be provided to community level agencies that work with those minorities, females, and other underrepresented groups who are not proportionately represented in clinical trials to address issues of lack of access, distrust, and lack of patient awareness of the benefits of trials in their health care. These minorities include Black Individuals/African Americans, Hispanics, Asians/Pacific Islanders/Native Hawaiians, and Native Americans.
2. Our AMA recommends the following activities to the FDA in order to ensure proportionate representation of minorities, females, and other underrepresented groups in clinical trials:
    a. Increased fiscal support for community outreach programs; e.g., culturally relevant community education, community leaders' support, and listening to community's needs.
    b. Increased outreach to all physicians to encourage recruitment of patients from underrepresented groups in clinical trials.
    c. Continued education for all physicians and physicians-in-training on clinical trials, subject recruitment, subject safety and possible expense reimbursements, and that this education encompass discussion of barriers that currently constrain appropriate recruitment of underrepresented groups and methods for increasing trial accessibility for patients.
    d. Support for the involvement of minority physicians in the development of partnerships between minority communities and research institutions.
    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-08 Reaffirmed: CSAPH Rep. 01, A-18 Modified: Res. 016, I-22]

D-200.985 Strategies for Enhancing Diversity in the Physician Workforce

1 Our American Medical Association, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following:

a. Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school.
b. Diversity or minority affairs offices at medical schools.
c. Financial aid programs for students from groups that are underrepresented in medicine.
d. Financial support programs to recruit and develop faculty members from underrepresented groups.

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

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

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

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

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

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

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

9 Our AMA will recommend that medical school admissions committees and residency/fellowship programs use holistic assessments of applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education with the goal of improving health care for all communities.

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

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

12. Our AMA unequivocally opposes legislation that would dissolve affirmative action or punish institutions for properly employing race-conscious admissions as a measure of affirmative action in order to promote a diverse student population.

13. Our AMA will work with the AAMC and other stakeholders to create a question for the AAMC electronic medical school application to identify previous pipeline program (also known as pathway program) participation and create a plan to analyze the data in order to determine the effectiveness of pipeline programs.

H-350.970 Diversity in Medical Education
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-99Reaffirmed: CME Rep. 2, A-09Reaffirmed in lieu of Res. 311, A-15]

AMA Support of American Indian Health Career Opportunities H-350.981
Our American Medical Association policy on American Indian health career opportunities is as follows:

1. Our American Medical Association, and other national, state, specialty, and county medical societies recommend special programs for the recruitment and training of American Indians in health careers at all levels and urge that these be expanded.
2. Our AMA supports the inclusion of American Indians in established medical training programs in numbers adequate to meet their needs. Such training programs for American Indians should be operated for a sufficient period of time to ensure a continuous supply of physicians and other health professionals, prioritize consideration of applicants who self-identify as American Indian or Alaska Native and can provide some form of affiliation with an American Indian or Alaska Native tribe in the United States, and support the successful advancement of these trainees.
3. Our AMA will utilize its resources to create a better awareness among physicians and other health providers of the special problems and needs of American Indians and particular emphasis will be placed on the need for stronger clinical exposure and a greater number of health professionals to work among the American Indian population.
4. Our AMA will continue to support the concept of American Indian self-determination as imperative to the success of American Indian programs and recognize that enduring acceptable solutions to American Indian health problems can only result from program and project beneficiaries having initial and continued contributions in planning and program operations to include training a workforce from and for these tribal nations.
5. Our AMA acknowledges long-standing federal precedent that membership or lineal descent from an enrolled member in a federally recognized tribe is distinct from racial identification as American Indian or Alaska Native and should be considered in medical school admissions even when restrictions on race-conscious admissions policies are in effect.
6. Our AMA acknowledges the significance of the Morrill Act of 1862, the resulting land-grant university system, and the federal trust responsibility related to tribal nations.[CLRPD Rep. 3, I- : Res. 221, A-07Reaffirmation A-12 Reaffirmed: CME Rep. 1, A-22 BOT Action in response to referred for decision: Res. 308, A-22 Modified: BOT Rep. 31, A-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 303
(I-24)

Introduced by: Resident and Fellow Section

Subject: Transparency and Access to Medical Training Program Unionization Status, Including Creation of a FREIDA Unionization Filter

Referred to: Reference Committee C

Whereas, housestaff in unions are represented predominantly by the Committee of Interns and Residents (CIR),[1] with other organizations including the Union of American Physicians and Dentists (UAPD), the American Federation of State, County & Municipal Employees (AFSCME), and the American Federation of Teachers (AFT); and

Whereas, given limitations of the residency and fellowship Match that limit free market competition for applicants, including ability to negotiate a contract, unionization is the sole mechanism for negotiation via collective bargaining[2,3]; and

Whereas, housestaff are vulnerable health care workers who are unable to negotiate a contract prior to employment, easily transfer jobs, or leave their job without sacrificing their career prospects; and

Whereas, current AMA policy supports the unionization of physicians (Policy H-385.946, H-385.976) and supports the study of alternative options to the current residency and fellowship Match process which would be less restrictive on free market competition for applicants (Policy D-310.944); and

Whereas, the American Medical Association has promoted unionization for housestaff through its media outlets[4]; and

Whereas, there is no existing AMA policy supporting the dissemination of existing unionized hospitals for trainees to make more informed decisions about their workplace environment during the Match process; and

Whereas, FREIDA™ is the AMA's residency/fellowship database which allows members to browse over 13,000 ACGME-accredited programs, with filters for specialty, location, application type, visas accepted, childcare options, salary, and percentage U.S. MD/DO/IMG; and

Whereas, FREIDA™ does not have a filter for program unionization; therefore be it

RESOLVED, that our American Medical Association supports transparency and access to information about medical training program unionization status (New HOD Policy); and be it further

RESOLVED, that our AMA creates and maintains an up-to-date unionization filter on FREIDA™ for trainees to make informed decisions during the Match. (Directive to Take Action)

Fiscal Note: Minimal – less than $1,000

Received: 9/24/2024

REFERENCES:

1. Committee of Interns and Residents: The National Voice of Residents. Committee of Interns and Residents/SEIU Healthcare https://www.cirseiu.org/
2. Boston Medical Center Corp., 330 N.L.R.B. 152 (N.L.R.B-BD 1999)
3. Jung v. Association of American Medical Colleges, 339 F. Supp. 2d 26 (D.D.C. 2004)
4. What I Wish I Knew in Residency About Collective Bargaining. The American Medical Association. March 21, 2024. https://www.ama-assn.org/medical-residents/residency-life/what-i-wish-i-knew-residency-about-collective-bargaining

RELEVANT AMA POLICY:

Investigation into Residents, Fellows and Physician Unions D-383.977
Our AMA will study the risks and benefits of collective bargaining for physicians and physicians-in-training in today's health care environment. [Res. 606, 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]

Political Action by Physicians 1.2.10
Like all Americans, physicians enjoy the right to advocate for change in law and policy, in the public arena, and within their institutions. Indeed, physicians have an ethical responsibility to seek change when they believe the requirements of law or policy are contrary to the best interests of patients. However, they have a responsibility to do so in ways that are not disruptive to patient care. Physicians who participate in advocacy activities should: (a) Ensure that the health of patients is not jeopardized and that patient care is not compromised. (b) Avoid using disruptive means to press for reform. Strikes and other collection actions may reduce access to care, eliminate or delay needed care, and interfere with continuity of care and should not be used as a bargaining tactic. In rare circumstances, briefly limiting personal availability may be appropriate as a means of calling attention to the need for changes in patient care. Physicians should be aware that some actions may put them or their organizations at risk of violating antitrust laws or laws pertaining to medical licensure or malpractice. (c) Avoid forming workplace alliances, such as unions, with workers who do not share physicians' primary and overriding commitment to patients. (d) Refrain from using undue influence or pressure colleagues to participate in advocacy activities and should not punish colleagues, overtly or covertly, for deciding not to participate. [AMA Principles of Medical Ethics: I,III,VI, Issued: 2016]

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]

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]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 307
(I-24)

Introduced by: Medical Student Section

Subject: Humanism in Anatomical Medical Education

Referred to: Reference Committee C

Whereas, when beginning cadaveric donor dissection, medical students commonly experience negative emotional or physical reactions which they are expected to quickly overcome, even though many continue to feel discomfort and prolonged guilt[1-2]; and

Whereas, the term *"*donor" can be more humanistic than the objectifying commonly used term "cadaver"[3,4]; and

Whereas, a diverse medical student community should nurture religious, cultural, and spiritual views towards deceased bodies[5-6]; and

Whereas, most schools conduct donor ceremonies before, during, and/or after dissection courses to convey respect and gratitude to donors and their families, but less than half of these schools include donor names in ceremonies[7-9]; and

Whereas, a survey of students who attended a donor ceremony shared more positive responses regarding their studies, reflection on death, and development of empathy compared to those not attend[10]; and

Whereas, memorial ceremonies and/or daily rituals demonstrate positive educational effects and help prevent decline of students' responsibility and respect during dissection courses[1]; and

Whereas, multiple studies show that students appreciate knowing their donors' identities, which increases positive response to working with donors[1,9]; and

Whereas, a study showed that donors supported anonymous disclosure of information after learning that students wanted to know more about their background to establish the idea of their donor as their first patient[11]; and

Whereas, another study found that "person-minded" medical students developed complex rules regarding respectful behavior towards donors, including habits that reinforced donors' humanity, in contrast to "specimen-minded" students[12]; and

Whereas, Indigenous students engaging in a cultural ceremony showed their respect and appreciation to donors, while also supporting their own spiritual and mental health[13]; therefore be it

RESOLVED, that our American Medical Association supports the incorporation of humanism in human anatomy education programs, including, but not limited to, time for HIPAA-compliant

recognition of donor backgrounds, reflection, discussion, and feedback (New HOD Policy); and be it further

RESOLVED, that our AMA supports accommodations for learners' and donors' cultural observances surrounding the deceased when appropriate (New HOD Policy); and be it further

RESOLVED, that our AMA supports donor memorial ceremonies at centers that utilize cadaveric-based human anatomy education programs. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Date Received: 09/19/2024

REFERENCES

1. Chang HJ, Kim HJ, Rhyu IJ, Lee YM, Uhm CS. Emotional experiences of medical students during cadaver dissection and the role of memorial ceremonies: a qualitative study. BMC Med Educ. 2018;18(1):255. Published 2018 Nov 12. doi:10.1186/s12909-018-1358-0
2. Chiou RJ, Tsai PF, Han DY. Impacts of a gross anatomy laboratory course on medical students' emotional reactions in Taiwan: the role of high-level emotions. BMC Med Educ. 2021;21(1):489. Published 2021 Sep 11. doi:10.1186/s12909-021-02923-1
3. Champney TH. A Bioethos for Bodies: Respecting a Priceless Resource. Anat Sci Educ. 2019;12(4):432-434. doi:10.1002/ase.1855
4. Sv S, Maria Francis Y, Karunakaran B, et al. Donor Oath: Respect to the Mortal Teacher to Learn Ethics and Humanitarian Values of Anatomy. Cureus. 2022;14(3):e22941. Published 2022 Mar 7. doi:10.7759/cureus.22941
5. Alvord LA. Medical school accommodations for religious and cultural practices. Virtual Mentor. 2013;15(3):198-201. Published 2013 Mar 1. doi:10.1001/virtualmentor.2013.15.3.ecas3-1303
6. Hadie SNH, Gasmalla HEE, Wadi MM, Zainul Abidin MA, Yusoff MSB. From generosity to gratitude: Exploring Islamic views on body donation, human dissection, and honoring the gift of life. Anat Sci Educ. Published online February 8, 2024. doi:10.1002/ase.2393
7. Halliday NL, Moon MB, O'Donoghue DL, Thompson BM, Crow SM. Transformation and Closure for Anatomical Donor Families that Meet Medical Students. Anat Sci Educ. 2019;12(4):399-406. doi:10.1002/ase.1888
8. Leeper BJ, Grachan JJ, Robinson R, Doll J, Stevens K. Honoring human body donors: Five core themes to consider regarding ethical treatment and memorialization. Anat Sci Educ. Published online January 10, 2024. doi:10.1002/ase.2378
9. Greene SJ, Rosen L. Sharing personal information about anatomical body donors: What first-year medical students want to know and how it affects emotional responses to dissection. Clin Anat. 2019;32(8):1019-1032. doi:10.1002/ca.23389
10. da Rocha AO, Maués JL, Chies GAF, da Silva AP. Assessing the Impact of a Ceremony in Honor of the Body Donors in the Development of Ethical and Humanistic Attitudes among Medical Students. Anat Sci Educ. 2020;13(4):467-474. doi:10.1002/ase.1920
11. Hasselblatt, F., Messerer, D.A.C., Keis, O., Böckers, T.M. and Böckers, A. (2018), Anonymous body or first patient? A status report and needs assessment regarding the personalization of donors in dissection courses in German, Austrian, and Swiss Medical Schools. American Association of Anatomists, 11: 282-293. https://doi.org/10.1002/ase.1744
12. Goss AL, Viswanathan VB, DeLisser HM. Not Just a Specimen: A Qualitative Study of Emotion, Morality, and Professionalism in One Medical School Gross Anatomy Laboratory. Anat Sci Educ. 2019;12(4):349-359. doi:10.1002/ase.1868
13. The University of Arizona Health Sciences. Colleges of medicine host traditional blessing ceremonies. The University of Arizona Health Sciences. August 30, 2023. Accessed March 31, 2024.https://healthsciences.arizona.edu/connect/photos/colleges-medicine-host-traditional-blessing-ceremonies.

RELEVANT AMA POLICY

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 HOUSE OF DELEGATES

Resolution: 603
(I-24)

Introduced by: Young Physicians Section

Subject: Study of Grading Systems in AMA Board Reports

Referred to: Reference Committee F

Whereas, the American Medical Association is committed to promoting the highest standards in patient care and medical practice; and

Whereas, evidence-based medicine is paramount to the decision-making processes that influence clinical practice and health policy; and

Whereas, the Grading of Recommendations Assessment, Development and Evaluation (GRADE) system is an example of an internationally recognized method for assessing the quality of evidence and the strength of recommendations in healthcare; and

Whereas, evidence of grading and assessment systems provide a transparent and systematic framework for ranking the quality of evidence and the strength of clinical recommendations; and

Whereas, the use of evidence grading and assessment systems would ensure that AMA board reports are based on the best available evidence, promoting trust and credibility among its members and the general public; and

Whereas, adopting a consistent method for analyzing medical evidence ensures fairness and uniformity across different reports and recommendations; therefore be it

RESOLVED, that our American Medical Association study the use of a system for assessing the quality of evidence and the strength of recommendations in board reports when appropriate. (Directive to Take Action)

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

Received: 09/23/2024

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 806
(I-24)

Introduced by: Louisiana

Subject: Study of the Federal Employee Health Benefit Plan (FEHBP)

Referred to: Reference Committee J

Whereas, the Federal Employee Health Benefit Plan (FEHBP) offers an expanded array of health insurance options for its beneficiaries; and

Whereas, FEHBP beneficiaries have the annual opportunity to switch plans if dissatisfied with the previous choice; and

Whereas, the FEHBP provides employees the same benefit no matter which plan they choose; therefore be it

RESOLVED, that our American Medical Association conduct a thorough study of the FEHBP to understand the successes and failures, strengths and weaknesses of the program (Directive to Take Action); and be it further

RESOLVED, that our AMA review how the FEHBP compares with AMA policy H-165.881 to see whether it might be an appropriate model to achieve private and public health system reform, with a report back to the A-25 Meeting of our House of Delegates. (Directive to Take Action)

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

Received: 9/23/2024

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 816
(I-24)

Introduced by: Bonnie Litvack, MD FACR

Subject: Exploring CO-OP Insurance for Public Healthcare

Referred to: Reference Committee J

Whereas, the rising cost of healthcare in the United States continues to be a significant barrier to access for many individuals and families and reduces job creation and economic opportunities for residents of the United States; and

Whereas, cooperative (CO-OP) insurance models have been successfully implemented in various sectors to provide affordable and accessible services through member-owned and member-governed structures; and

Whereas, the Affordable Care Act (ACA) established the Consumer Operated and Oriented Plan (CO-OP) Program to foster the creation of nonprofit, member-governed health insurance issuers to offer competitive health plans in the individual and small group markets; and

Whereas, the CO-OP Program initially provided $3.4 billion in federal loans to help establish and maintain these CO-OPs; and

Whereas, despite the potential benefits, many CO-OPs faced significant financial challenges and regulatory hurdles, leading to the closure of most of them, with only a few remaining operational; and

Whereas, CO-OPs were excluded from the employer insurance market, limiting their ability to compete and achieve financial stability; and

Whereas, changing the cost-sharing mechanisms between plans could increase the viability of CO-OPs by allowing for more flexible and sustainable financial models; and

Whereas, the American Medical Association (AMA) is committed to exploring innovative solutions to improve healthcare access and affordability for all Americans; and

Whereas, recent studies and state-based public option plans have shown that public healthcare options may reduce costs and improve access to care; and

Whereas, lowering healthcare costs for small businesses can significantly enhance their financial stability and operational viability, allowing them to thrive and contribute to the economy; and

Whereas, improving the viability of small businesses through affordable healthcare options can lead to increased job creation, economic growth, and community development; therefore be it

RESOLVED, that our American Medical Association review the feasibility and potential benefits of using CO-OP insurance models as a vehicle for creating a public healthcare insurance option

consistent with existing AMA principles of health care financing and healthcare reform (Directive to Take Action); and be it further

RESOLVED, that our AMA allocate appropriate resources to this study, including collaboration with experts in cooperative insurance, healthcare economics, and public policy (Directive to Take Action); and be it further

RESOLVED, that our AMA specifically examine the impact of allowing CO-OPs to participate in the employer insurance market and the potential benefits of changing cost-sharing mechanisms between plans to enhance the financial viability of CO-Ops (Directive to Take Action); and be it further

RESOLVED, that the findings of this study be reported to the House of Delegates with recommendations for potential implementation and advocacy at the state and federal levels no later than the Interim 2025 meeting. (Directive to Take Action)

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

Received: 9/24/2024

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 906
(I-24)

Introduced by: Academic Physicians Section

Subject: Call for Study: Should Petroleum-Powered Emergency Medical Services (EMS) Vehicles in Urban Service Areas be Replaced by Renewably-Powered Electric Vehicles?

Referred to: Reference Committee K

Whereas, a 2022 report from the Commonwealth Fund noted that the health care industry worldwide produces as much as 4.6% of all of global "greenhouse gas" (GHG) emissions (chiefly carbon dioxide, methane and ozone), while in the United States, the health care industry contributes about 8.5% of the nation's GHG emissions[1]; and

Whereas, GHG emissions since the onset of the "Industrial Revolution" are widely understood to have contributed to a progressively increased carbon dioxide (CO2) fraction of the air, and to a progressively increased average temperature of the surface of the Earth (long-term, non-human-induced cyclical fluctuations of Earth temperatures not due to human-induced GHG emissions, such as volcanic activity and other influences notwithstanding); and

Whereas, these elevated temperatures have contributed measurably to increased morbidity and mortality of human inhabitants of the Earth, not limited to residents of warmer climates and occupational groups such as outdoor laborers; and

Whereas, these elevated temperatures are also adversely impacting the natural environment upon which all life depends in ways too numerous to list in this proposed Resolution; and

Whereas, these elevated temperatures are also clearly associated with increased numbers of extreme weather events; and

Whereas, AMA policy D-135.966, most recently modified in 2022, has declared climate change to be a public health crisis[2], such that the goal of 50% reduction in greenhouse gas emissions by 2030 and "carbon neutrality" by 2050 are goals endorsed by this policy; and

Whereas, ambulances contribute significantly to health care's GHG burden, because they are large, petroleum-powered vehicles; and

Whereas, delivery vehicles powered by renewable energy (electricity) are currently being deployed in urban areas by the delivery services UPS[2] and FedEx,[3] suggesting an opportunity exists for the health care sector to replace petroleum-powered ambulances with renewable energy-powered electric ambulances of a similar size to these delivery vehicles, at least in urban areas of the United States, as older petroleum-powered ambulances are retired from service; and

Whereas, UPS is committed to “carbon neutrality” by 2050,[2] with FedEx pursuing “carbon neutrality” by 2040,[3] inclusive of their large ambulance-sized delivery vehicles, which they are already deploying for home package delivery; and

Whereas, the wide availability of petroleum-powered electrical generators at hospitals and government buildings should make concerns moot that electric-powered urban ambulances would become non-operational during widespread electrical outages such as can transiently occur with hurricanes, tornadoes, derechos and other large weather events; and

Whereas, the 15-20 minutes that an ambulance is out of service when parked at a hospital’s ambulance garage during the delivery of a patient to a hospital represents an opportunity for electric-powered ambulances to recharge their batteries, once ambulance bays became equipped with rapid recharging stations; and

Whereas, the National Health Service of Great Britain has moved beyond study of the matter, and has begun to purchase or lease only “Low Emission” and “Ultra Low Emission” vehicles as of 2021, with the goal that 90% of the NHS fleet will be low-emission or ultra-low emissions vehicles by 2028, with this specifically including electric-powered ambulances[4]; therefore be it

RESOLVED, that our American Medical Association study the potential feasibility that our nation’s urban ambulance fleet be replaced with renewably-powered electric vehicles when current petroleum-powered EMS ambulances become retired from service, with a report back at the next meeting of the AMA House of Delegates (Directive to Take Action); and be it further

RESOLVED, that our AMA will forward the results of this study to health care journalists, hospital regulators, hospital executives, EMS system leaders, and other relevant parties, toward the eventual implementation of the findings and recommendations that are anticipated to be reached. (Directive to Take Action)

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

Received: 9/19/2024

REFERENCES

1. Commonwealth Fund "Explainer". How the U.S. Health Care System Contributes to Climate Change. Issued April 9, 2022. https://www.commonwealthfund.org/publications/explainer/2022/apr/how-us-health-care-system-contributes-climate-change. Accessed March 15, 2024
2. United Parcel System. Delivering for Our Planet. https://about.ups.com/us/en/our-impact/ups-sustainability-and-social-impact-report/delivering-for-our-planet.html. Accessed March 15, 2024
3. Federal Express. FedEx Commits to Carbon-Neutral Operations by 2040. March 3, 2021. https://investors.fedex.com/news-and-events/investor-news/investor-news-details/2021/FedEx-Commits-to-Carbon-Neutral-Operations-by-2040/. Accessed March 15, 2024
4. NHS England. Delivering a "Net Zero" National Health Service. https://www.england.nhs.uk/greenernhs/wp-content/uploads/sites/51/2022/07/B1728-delivering-a-net-zero-nhs-july-2022.pdf. Accessed March 15, 2024

RELEVANT AMA POLICY

D-135.966 Declaring Climate Change a Public Health Crisis

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.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 908
(I-24)

Introduced by: Medical Student Section

Subject: Support for Doula Care Programs

Referred to: Reference Committee K

Whereas, support personnel for pregnant and postpartum patients, such as doulas, provide emotional and educational services to assist patients through their pregnancy[1-3]; and

Whereas, doulas can be associated with reductions in depression and anxiety by as much as 57%, decreased odds of cesarean section, reduced maternal morbidity and mortality, reduced prevalence of low birthweight and preterm births, and increased breastfeeding success[2-10]; and

Whereas, doulas can help address social determinants of health, health literacy, social needs, and patient empowerment and communication, especially for low-income patients, patients from marginalized and minoritized groups, and patients who are incarcerated or detained[11-19]; and

Whereas, doulas in carceral and detention settings can advocate for accommodations for patients (including unshackling and privacy when officers are present) and help patients cope with infant separation[20-22]; and

Whereas, a study of doula programs in carceral settings found that patients overwhelmingly preferred being assigned to doulas and reported high satisfaction after delivery[22]; therefore be it

RESOLVED, that our American Medical Association support access to continuous one-to-one emotional support provided by nonmedical support personnel, such as doulas, including for patients who are incarcerated or detained. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Date Received: 09/19/2024

REFERENCES

1. What is a Doula? DONA International. https://www.dona.org/what-is-a-doula-2/
2. Falconi AM, Bromfield SG, Tang T, et al. Doula care across the maternity care continuum and impact on maternal health: Evaluation of doula programs across three states using propensity score matching. eClinicalMedicine. 2022;50. doi:10.1016/j.eclinm.2022.101531
3. Approaches to Limit Intervention During Labor and Birth | ACOG. Accessed March 28, 2024. https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2019/02/approaches-to-limit-intervention-during-labor-and-birth
4. Rousseau S, Katz D, Shlomi-Polachek I, Frenkel TI. Prospective risk from prenatal anxiety to post traumatic stress following childbirth: The mediating effects of acute stress assessed during the postnatal hospital stay and preliminary evidence for moderating effects of doula care. Midwifery. 2021;103:103143. doi:10.1016/j.midw.2021.103143
5. Antoine C, Young BK. Cesarean section one hundred years 1920–2020: the Good, the Bad and the Ugly. J Perinat Med. 2021;49(1):5-16. doi:10.1515/jpm-2020-0305
6. Caughey AB, Cahill AG, Guise JM, Rouse DJ. Safe prevention of the primary cesarean delivery. Am J Obstet Gynecol. 2014;210(3):179-193. doi:10.1016/j.ajog.2014.01.026
7. Thomas MP, Ammann G, Onyebeke C, et al. Birth equity on the front lines: Impact of a community-based doula program in Brooklyn, NY. Birth. 2023;50(1):138-150. doi:10.1111/birt.12701

8. Low birth weight. Accessed March 4, 2024. https://www.who.int/data/nutrition/nlis/info/low-birth-weight
9. Preterm Birth | Maternal and Infant Health | Reproductive Health | CDC. Published October 24, 2023. Accessed March 31, 2024. https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pretermbirth.htm
10. Sobczak A, Taylor L, Solomon S, et al. The Effect of Doulas on Maternal and Birth Outcomes: A Scoping Review. Cureus. 15(5):e39451. doi:10.7759/cureus.39451
11. Kozhimannil KB, Vogelsang CA, Hardeman RR, Prasad S. Disrupting the Pathways of Social Determinants of Health: Doula Support during Pregnancy and Childbirth. J Am Board Fam Med JABFM. 2016;29(3):308-317. doi:10.3122/jabfm.2016.03.150300
12. Mallick LM, Thoma ME, Shenassa ED. The role of doulas in respectful care for communities of color and Medicaid recipients. Birth. 2022;49(4):823-832. doi:10.1111/birt.12655
13. Testa A, Jackson DB. Incarceration Exposure During Pregnancy and Infant Health: Moderation by Public Assistance. J Pediatr. 2020;226:251-257.e1. doi:10.1016/j.jpeds.2020.06.055
14. Bell JF. Jail Incarceration and Birth Outcomes. J Urban Health Bull N Y Acad Med. 2004;81(4):630-644. doi:10.1093/jurban/jth146
15. Hessami K, Hutchinson-Colas JA, Chervenak FA, et al. Prenatal care and pregnancy outcome among incarcerated pregnant individuals in the United States: a systematic review and meta-analysis. J Perinat Med. 2023;51(5):600-606. doi:10.1515/jpm-2022-0412
16. Carson EA. Prisoners in 2021 – Statistical Tables. U.S. Department of Justice; 2022.
17. Zeng Z. Jail Inmates in 2021 – Statistical Tables. Stat Tables. Published online 2021.
18. Swayer W. The Gender Divide: Tracking Women's State Prison Growth. Prison Policy Initiative; 2018. https://www.prisonpolicy.org/reports/women_overtime.html
19. Committee on Health Care for Underserved Women. Reproductive health care for incarcerated pregnant, postpartum, and nonpregnant individuals. Obstet Gynecol Obstet Gynecol. Published online April 27, 2021:e24-34.
20. Alirezaei S, Latifnejad Roudsari R. The Needs of Incarcerated Pregnant Women: A Systematic Review of Literature. Int J Community Based Nurs Midwifery. 2022;10(1):2-17. doi:10.30476/IJCBNM.2021.89508.1613
21. Wilson SH, Marsh LN, Zielinski M, Corbett A, Siegler A, Shlafer R. Enhanced Perinatal Programs for People in Prisons: A Summary of Six States' Programs. J Crim Justice. 2022;83:101965. doi:10.1016/j.jcrimjus.2022.101965
22. Shlafer R, Davis L, Hindt L, Pendleton V. The Benefits of Doula Support for Women Who Are Pregnant in Prison and Their Newborns. In: Poehlmann-Tynan J, Dallaire D, eds. Children with Incarcerated Mothers: Separation, Loss, and Reunification. SpringerBriefs in Psychology. Springer International Publishing; 2021:33-48. doi:10.1007/978-3-030-67599-8_3

RELEVANT AMA POLICY

D-420.993 Disparities in Maternal Mortality

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]

H-420.948 Classification and Surveillance of Maternal Mortality

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]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 914
(I-24)

Introduced by: Medical Student Section

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

Referred to: Reference Committee K

Whereas, 2023 was the hottest year on record, with 28 weather/climate disasters costing more than $1 billion per event, posing risks not only to human and material well-being but also directly impacting healthcare supply chains, whose facilities are located in vulnerable areas[1-10]; and

Whereas, climate-related disasters have caused shipping delays and significantly damaged plants manufacturing medical supplies, leading to longer resupply times and product shortages[12-16,21]; and

Whereas, the healthcare industry relies on a "just-in-time" system of medical product procurement relying on short-term, single-use disposables, which has made the industry susceptible to unexpected supply chain shocks[17,18]; and

Whereas, adoption of medical product reusability strategies saved hospitals $372 million in 2020 with potential for even greater savings and improved supply chain resilience through broader implementation, however hurdles in transitioning to a reusable model, include lack of incentives for manufacturers and disagreements about the safety of reusable products[19,20]; and

Whereas, as natural disasters become more common, supply chain disruptions will increasingly impede the ability of healthcare systems to deliver care, and ensuring all facilities in the supply chain are climate-resilient may require relocating them to climate-resilient areas[11]; therefore be it

RESOLVED, that our American Medical Association support the development of strategies and technologies to strengthen supply chain networks, including building climate resiliency into new or updated facilities, increasing emergency stockpiles of key products, and incentivizing the innovation and adoption of reusable medical products to resist the impact of supply chain disturbances. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Date Received: 9/23/2024

REFERENCES

1. Bateman J. 2023 was the world's warmest year on record, by far. NOAA.gov. January 12, 2024. Accessed March 3, 2024. https://www.noaa.gov/news/2023-was-worlds-warmest-year-on-record-by-far.
2. Forrest F. The impact of climate change on the Pharma Supply Chain. Pharmaceutical Technology. June 12, 2023. Accessed March 3, 2024. https://www.pharmaceutical-technology.com/sponsored/the-impact-of-climate-change-on-the-pharma-supply-chain/.
3. Extreme weather and climate change. NASA. September 27, 2023. Accessed March 3, 2024. https://climate.nasa.gov/extreme-weather/.

4. Smith AB. 2020 U.S. billion-dollar weather and climate disasters in historical context. Climate.gov. January 8, 2021. Accessed March 3, 2024. https://www.climate.gov/disasters2020?ftag=MSFd61514f.
5. Hobbins K. The effect of climate change on medical device manufacturing. MDDIOnline. May 31, 2023. Accessed March 3, 2024. https://www.mddionline.com/manufacturing/the-effect-of-climate-change-on-medical-device-manufacturing.
6. NCEI.Monitoring.Info@noaa.gov. Billion-dollar weather and climate disasters. Billion-Dollar Weather and Climate Disasters | National Centers for Environmental Information (NCEI). Accessed March 3, 2024. https://www.ncei.noaa.gov/access/billions/
7. Extreme weather and climate change. Center for Climate and Energy Solutions. January 29, 2024. Accessed March 3, 2024. https://www.c2es.org/content/extreme-weather-and-climate-change/.
8. Boyson S, Gerst MD, Guntuka L, et al. How exposed is your supply chain to climate risks? Harvard Business Review. May 6, 2022. Accessed March 3, 2024. https://hbr.org/2022/05/how-exposed-is-your-supply-chain-to-climate-risks.
9. Jewett, C. (2023, July 25). Tornado at Pfizer Warehouse Likely to Worsen Shortage of Surgical Drugs. The New York Times. https://www.nytimes.com/2023/07/25/health/pfizer-warehouse-tornado-drug-shortages.html
10. Keenan J. Flooding halts manufacturing at Alembic Pharmaceuticals' India plant. Published October 5, 2023. Accessed March 3, 2024. https://www.fiercepharma.com/manufacturing/flooding-halts-manufacturing-alembic-pharmaceuticals-india-plant
11. Mosadeghrad AM, Isfahani P, Eslambolchi L, Zahmatkesh M, Afshari M. Strategies to strengthen a climate-resilient health system: a scoping review. Globalization and Health. August 28, 2023. Accessed March 28, 2024. https://globalizationandhealth.biomedcentral.com/articles/10.1186/s12992-023-00965-2
12. Peters G. Short Supply: The Health and National Security Risks of Drug Shortages. United States Senate Committee on Homeland Security and Governmental Affairs; 2023.
13. Wong JC. Hospitals face critical shortage of IV bags due to Puerto Rico Hurricane. The Guardian. January 10, 2018. Accessed March 3, 2024. https://www.theguardian.com/us-news/2018/jan/10/hurricane-maria-puerto-rico-iv-bag-shortage-hospitals.
14. Olick D. Shipping industry could lose $10 billion a year battling climate change by 2050. CNBC. October 30, 2023. Accessed March 3, 2024. https://www.cnbc.com/2023/10/30/climate-change-to-cost-shipping-industry-10-billion-a-year-by-2050.html.
15. Leonard M. 35% of ports say demand for food, medical supplies storage increased. Supply Chain Dive. April 21, 2020. Accessed March 3, 2024. https://www.supplychaindive.com/news/coronavirus-ports-storage-demand-food-medical-supplies/576420/.
16. Verschuur J, Koks EE, Hall JW. Port disruptions due to natural disasters: Insights into port and logistics resilience. Transportation Research Part D: Transport and Environment. 2020;85:102393. doi:https://doi.org/10.1016/j.trd.2020.102393
17. MacNeill AJ, Hopf H, Khanuja A, et al. Transforming The Medical Device Industry: Road Map To A Circular Economy. Health Aff (Millwood). 2020;39(12):2088-2097. doi:10.1377/hlthaff.2020.01118
18. Mehtsun WT, Hyland CJ, Offodile AC. Adopting a Circular Economy for Surgical Care to Address Supply Chain Shocks and Climate Change. JAMA Health Forum. 2023;4(11):e233497. doi:10.1001/jamahealthforum.2023.3497
19. Colletti J. New AMDR report strengthens case for single-use medical device reprocessing. OR Manager. December 15, 2022. Accessed March 3, 2024. https://www.ormanager.com/new-amdr-report-strengthens-case-for-single-use-medical-device-reprocessing/.
20. Health Care and the Climate Crisis: Preparing America's Health Care Infrastructure. Ways & Means Committee. 2022. Accessed March 27, 2024. https://democrats-waysandmeans.house.gov/sites/evo-subsites/democrats-waysandmeans.house.gov/files/documents/eja_sxs.pdf.
21. Hahn SM. Coronavirus (covid-19) supply chain update. U.S. Food and Drug Administration. February 27, 2020. Accessed March 3, 2024. https://www.fda.gov/news-events/press-announcements/coronavirus-covid-19-supply-chain-update.

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]

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]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 921
(I-24)

Introduced by:	Resident and Fellow Section; American Academy of Addiction Psychiatry
Subject:	In Support of a National Drug Checking Registry
Referred to:	Reference Committee K

Whereas, recreational substance use is becoming increasingly more common, with 13.3% of respondents to a 2020 CDC survey reporting that they either started or increased substance use to help deal with stress related to COVID-19;[1] and

Whereas, recreational drugs have been found to be contaminated with adulterants at a rate up to nearly 80%;[2–4] and

Whereas, fentanyl was present in 77% of adolescent overdose deaths in 2021;[5] and

Whereas, nearly two-thirds of all overdose deaths in the United States from 2019-2020 involved synthetic opioids;[6] and

Whereas, drug checking services are point-of-care tests provided at events with high recreational drug use that can rapidly provide information to a user on the composition of the drug they intend to take;[7] and

Whereas, 94% of users of drug checking services reported they would not take a drug whose test results were unexpected;[8] and

Whereas, 32% of users of drug checking services reported that they would not take a drug if it was found to contain adulterants;[8] and

Whereas, a majority of users of drug checking services intended to share the results of the test with others;[9] and

Whereas, drug checking services can also serve as a point of contact with users of recreational drugs for other harm reduction services, and accessibility to these resources through drug checking services is overwhelmingly supported by the target market;[10] and

Whereas, availability of drug checking services does not lead to an increase in intent to use recreational drugs;[11] and

Whereas, drug checking services are supported by over 80% of the target population;[12] and

Whereas, the Department of Health and Human Services reports that efforts to provide drug checking services have been largely effective in changing intended and actual drug use behavior;[13] and

Whereas, drug-checking services in the United States today do not have an established way to communicate trends in their results with one another; and

Whereas, a network of drug-checking services across the country could be an alternative source of information to DEA seizures to help identify early trends in supply contamination and provide education on upcoming contamination concerns to users, such as the rise of new contaminants like xylazine;[14] therefore be it

RESOLVED, that our American Medical Association study the creation of a national drug-checking registry that would provide a mechanism whereby community-run drug-checking services may communicate their results. (Directive to Take Action)

Fiscal note: Minimal – less than $1,000

Received: 9/24/24

REFERENCES:

1. Czeisler MÉ. Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic — United States, June 24–30, 2020. *MMWR Morb Mortal Wkly Rep*.;69 . Epub ahead of print 2020. DOI: 10.15585/mmwr.mm6932a1.
2. McCrae K, Tobias S, Tupper K, et al. Drug checking services at music festivals and events in a Canadian setting. *Drug Alcohol Depend*. 2019;205:107589.
3. Karch L, Tobias S, Schmidt C, et al. Results from a mobile drug checking pilot program using three technologies in Chicago, IL, USA. *Drug Alcohol Depend*. 2021;228:108976.
4. Karamouzian M, Dohoo C, Forsting S, et al. Evaluation of a fentanyl drug checking service for clients of a supervised injection facility, Vancouver, Canada. *Harm Reduction Journal*. 2018;15:46.
5. Friedman J, Godvin M, Shover CL, et al. Trends in Drug Overdose Deaths Among US Adolescents, January 2010 to June 2021. *JAMA*. 2022;327:1398–1400.
6. O'Donnell J. Trends in and Characteristics of Drug Overdose Deaths Involving Illicitly Manufactured Fentanyls — United States, 2019–2020. *MMWR Morb Mortal Wkly Rep*.;70 . Epub ahead of print 2021. DOI: 10.15585/mmwr.mm7050e3.
7. Harper L, Powell J, Pijl EM. An overview of forensic drug testing methods and their suitability for harm reduction point-of-care services. *Harm Reduct J*. 2017;14:52.
8. Valente H, Martins D, Carvalho H, et al. Evaluation of a drug checking service at a large scale electronic music festival in Portugal. *Int J Drug Policy*. 2019;73:88–95.
9. Maghsoudi N, Tanguay J, Scarfone K, et al. Drug checking services for people who use drugs: a systematic review. *Addiction*. 2022;117:532–544.
10. Day N, Criss J, Griffiths B, et al. Music festival attendees' illicit drug use, knowledge and practices regarding drug content and purity: a cross-sectional survey. *Harm Reduct J*. 2018;15:1.
11. Murphy S, Bright SJ, Dear G. Could a drug-checking service increase intention to use ecstasy at a festival? *Drug Alcohol Rev*. 2021;40:974–978.
12. Southey M, Kathirgamalingam A, Crawford B, et al. Patterns of ecstasy use amongst live music event attendees and their opinions on pill testing: a cross sectional study. *Subst Abuse Treat Prev Policy*. 2020;15:55.
13. Pu J. Drug Checking Programs in the United States and Internationally: Environmental Scan Summary.
14. The Growing Threat of Xylazine and its Mixture with Illicit Drugs.

RELEVANT AMA POLICY:

Prevention of Drug-Related Overdose D-95.987
1. Our AMA: (a) recognizes the great burden that substance use disorders (SUDs) and drug-related overdoses and death places on patients and society alike and reaffirms its support for the compassionate treatment of patients with a SUD and people who use drugs; (b) urges that community-based programs offering naloxone and other opioid overdose and drug safety and prevention services continue to be implemented in order to further develop best practices in this area; (c) encourages the education of health care workers and people who use drugs about the use of naloxone and other harm reduction measures in preventing opioid and other drug-related overdose fatalities; and (d) will continue to monitor the progress of such initiatives and respond as appropriate.
2.Our AMA will: (a) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of a drug-related overdose; and (b) encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for a drug-related overdose.
3. Our AMA will support the development and implementation of appropriate education programs for persons receiving treatment for a SUD or in recovery from a SUD and their friends/families that address harm reduction measures.

4. Our AMA will advocate for and encourage state and county medical societies to advocate for harm reduction policies that provide civil and criminal immunity for the use of “drug paraphernalia” designed for harm reduction from drug use, including but not limited to drug contamination testing and injection drug preparation, use, and disposal supplies. [Res. 526, A-06; Modified in lieu of Res. 503, A-12; Appended: Res. 909, I-12; Reaffirmed: BOT Rep. 22, A-16; Modified: Res. 511, A-18; Reaffirmed: Res. 235, I-18; Modified: Res. 506, I-21; Appended: Res. 513, A-22; Modified: Res. 211, I-22; Appended: Res. 221, A-23; Reaffirmation: A-23; Modified: Res. 505, A-23; Reaffirmed: BOT Rep. 18, A-24]

Pilot Implementation of Supervised Injection Facilities H-95.925
Our AMA supports the development and implementation of pilot supervised injection facilities (SIFs) in the United States that are designed, monitored, and evaluated to generate data to inform policymakers on the feasibility, effectiveness, and legal aspects of SIFs in reducing harms and health care costs related to injection drug use. [Res. 513, A-17; Reaffirmation: A-23]

Harmful Drug Use in the United States - Strategies for Prevention H-95.978
Our AMA: (1) Urges the Substance Abuse and Mental Health Administration to support research into special risks and vulnerabilities, behavioral and biochemical assessments and intervention methodologies most useful in identifying persons at special risk and the behavioral and biochemical strategies that are most effective in ameliorating risk factors.
(2) Urges the Center for Substance Abuse Prevention to continue to support community-based prevention strategies which include: (a) Special attention to children and adolescents, particularly in schools, beginning at the pre-kindergarten level. (b) Changes in the social climate (i.e., attitudes of community leaders and the public), to reflect support of harmful drug and alcohol use prevention and treatment, eliminating past imbalances in allocation of resources to supply and demand reduction. (c) Development of innovative programs that train and involve parents, educators, physicians, and other community leaders in "state of the art" prevention approaches and skills.
(3) Urges major media programming and advertising agencies to encourage the development of more accurate and prevention-oriented messages about the effects of harmful drug and alcohol use.
(4) Supports the development of advanced educational programs to produce qualified prevention specialists, particularly those who relate well to the needs of economically disadvantaged, ethnic, racial, and other special populations.
(5) Supports investigating the feasibility of developing a knowledge base of comprehensive, timely and accurate concepts and information as the "core curriculum" in support of prevention activities.
(6) Urges federal, state, and local government agencies and private sector organizations to accelerate their collaborative efforts to develop a national consensus on prevention and eradication of harmful alcohol and drug use. [BOT Rep. H, A-89; Reaffirmed: CSA Rep. 12, A-99; Reaffirmation I-01; Reaffirmed: CSAPH Rep. 1, A-11; Modified: CSAPH Rep. 1, A-21; Reaffirmed: Res. 523, A-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 924
(I-24)

Introduced by: Resident and Fellow Section, American Association of Public Health Physicians, LGBTQ+ Section, Minority Affairs Section

Subject: Public Health Implications of US Food Subsidies

Referred to: Reference Committee K

Whereas, our American Medical Association is committed to promoting the betterment of public health and has long supported policies that aim to improve dietary and nutritional standards in the United States; and

Whereas, the United States government, through various subsidies, supports the production of certain agricultural commodities, which plays a role in shaping agricultural policy and food systems[1-3]; and

Whereas, US agricultural subsidies have historically favored the production of crops, including corn, soybeans, wheat, and rice, which are often processed into ingredients like high-fructose corn syrup, refined grains, and vegetable oils, commonly used in the production of processed food;[1-3] and

Whereas, overconsumption of processed foods, which are high in added sugar, unhealthy fats and refined carbohydrates, is associated with an increased risk for diabetes, obesity, and other chronic diseases;[1-5] and

Whereas, US agricultural subsidies can affect the relative prices of different foods, making some food less expensive and more accessible, while potentially making others relatively more expensive, which can influence consumer choices, potentially contributing to the consumption of less healthy foods and beverages;[2-5] and

Whereas, the availability and affordability of subsidized foods may influence dietary choices and nutritional intake, particularly among low-income populations, which may contribute to poor dietary quality and negative health outcomes;[2,4,5] and

Whereas, intensive monoculture farming is an agricultural practice supported by subsidies, which has negative environmental consequences including soil degradation, water pollution, and greenhouse gas emissions;[6] and

Whereas, environmental degradation can indirectly impact public health by compromising food and water security, contributing to climate change-related health risks[6]; and

Whereas, while agricultural subsidies are intended to support agricultural production and stabilize food prices, there are unintended consequences on public health, especially when they disproportionately benefit certain crops or food groups, and disproportionately harm low-income populations[6]; and

Whereas, there is a need for a comprehensive review of food subsidies to evaluate their impact on dietary patterns, health disparities, and overall public health, aiming for alignment with nutritional guidelines that promote wellness and disease prevention[6]; therefore be it

RESOLVED, that our American Medical Association study the public health implications of United States Food Subsidies, focusing on: (1) how these subsidies influence the affordability, availability, and consumption of various food types across different demographics; (2) potential for restructuring food subsidies to support the production and consumption of more healthful foods, thereby contributing to better health outcomes and reduced healthcare costs related to diet-related diseases; and (3) avenues to advocate for policies that align food subsidies with the nutritional needs and health of the American public, ensuring that all segments of the population benefit from equitable access to healthful, affordable food. (Directive to Take Action)

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

Received: 9/24/2024

REFERENCES:

1. Franck, C., Grandi, S., Eisenberg, M. (2013). Agricultural Subsidies and the American Obesity Epidemic. *American Journal of Preventive Medicine,* 45 (3), 327-333.
2. Brownell, K.D., & Horgen, K.B. (2004). Food Fight: The Inside Story of the Food Industry, America's Obesity Crisis, and What We Can Do About It. Chicago: Contemporary Books.
3. Nestle, M. (2013). Food Politics: How the Food Industry Influences Nutrition and Health. University of California Press.
4. Wallinga, D. (2010). "Agricultural policy and childhood obesity: a food systems and public health commentary." Health Affairs, 29(3), 405–410.
5. Wilde, P., Morgan, E. H., Roberts, S., & Schpok, A. (2012). "Relationships between food assistance programs and healthy eating vary with local food prices." Journal of Nutrition Education and Behavior, 44(6), 618-624.
6. United Nations. (2021). Most agricultural funding distorts prices, harms environment: UN report. https://news.un.org/en/story/2021/09/1099792

RELEVANT AMA POLICY:

The Health Effects of High Fructose Syrup H-150.919
Our AMA: (1) recognizes that at the present time, insufficient evidence exists to specifically restrict use of high fructose corn syrup (HFCS) or other fructose-containing sweeteners in the food supply or to require the use of warning labels on products containing HFCS; (2) encourages independent research (including epidemiological studies) on the health effects of HFCS and other added sugars, and evaluation of the mechanism of action and relationship between fructose dose and response; and (3) in concert with the Dietary Guidelines for Americans, recommends that consumers limit the amount of added sugars in their diet. [CSAPH Rep. 8, A-23]

Strategies to Reduce the Consumption of Food and Beverages with Added Sweeteners H-150.927
Our AMA: (1) acknowledges the adverse health impacts of sugar- sweetened beverage (SSB) consumption and food products with added sugars, and support evidence-based strategies to reduce the consumption of SSBs and food products with added sugars, including but not limited to, excise taxes on SSBs and food products with added sugars, removing options to purchase SSBs and food products with added sugars in primary and secondary schools, the use of warning labels to inform consumers about the health consequences of SSB consumption and food products with added sugars, and the use of plain packaging; (2) encourages continued research into strategies that may be effective in limiting SSB consumption and food products with added sugars, such as controlling portion sizes; limiting options to purchase or access SSBs and food products with added sugars in early childcare settings, workplaces, and public venues; restrictions on marketing SSBs and food products with added sugars to children; and changes to the agricultural subsidies system; (3) encourages hospitals and medical facilities to offer healthier beverages, such as water, unflavored milk, coffee, and unsweetened tea, for purchase in place of SSBs and apply calorie counts for beverages in vending machines to be visible next to the price; (4) encourages physicians to (a) counsel their patients about the health consequences of SSB consumption and food products with added sugars and replacing SSBs and food products with added sugars with

healthier beverage and food choices, as recommended by professional society clinical guidelines; and (b) work with local school districts to promote healthy beverage and food choices for students; (5) recommends that taxes on food and beverage products with added sugars be enacted in such a way that the economic burden is borne by companies and not by individuals and families with limited access to food alternatives; (6) supports that any excise taxes are reinvested in community programs promoting health and (7) will advocate for the end of tax subsidies for advertisements that promote among children the consumption of food and drink of poor nutritional quality, as defined by appropriate nutritional guiding principles. [CSAPH Rep. 03, A-17; Modified: Res. 429, A-22]

Reform the US Farm Bill to Improve US Public Health and Food Sustainability H-150.932
Our AMA supports the creation of a new advisory board to review and recommend US Farm Bill budget allocations to ensure any government subsidies are only used to help produce healthy food choices and sustainable foods, and that advisory committee members include physicians, public health officials and other public health stakeholders. [Res. 215, A-13; Reaffirmed: BOT Rep. 09, A-23]

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 925
(I-24)

Introduced by: American College of Cardiology
Society of Cardiovascular Computed Tomography

Subject: Improving Public Awareness of Lung Cancer Screening and CAD in Chronic Smokers

Referred to: Reference Committee K

Whereas, lung cancer and atherosclerotic heart disease, leading causes of death and disability in America, share many demographics and predispositions; and

Whereas, both lung cancer and atherosclerotic heart disease are increasing in incidence and effective treatments are impaired by late diagnosis of advanced disease; and

Whereas, the American Cancer Society updated lung cancer screening guidelines with a non-contrast Chest CT to include adults aged 50-80 years with a 20+ pack year smoking history in November 2023[1], and **l**ung cancer screening among chronic smokers has been shown to save lives in both large-scale randomized trials and real-world settings[2-4]; and

Whereas, among smokers, the prevalence of lung cancer related mortality and cardiovascular mortality was similar in the NLST trial (22.9% vs. 26.1%)[2] and in the NELSON trial (18.4% vs. 21.8%)[3] respectively; smoking increased the risk of coronary heart disease by 2 to 4 times[5-6] and causes one of every fourth death from cardiovascular disease[7]; and

Whereas, coronary artery disease on low dose lung cancer screening CT scans can be detected by the presence and burden of coronary artery calcification (CAC). The prevalence of CAC on low-dose lung cancer screening CT is 53%, with 15% of patients having severe CAC on visual estimation[8]. Of those who qualified for statin primary prevention, 56.8% did not report a history of statin use[9]. Compared with chronic smokers with CAC score of zero, patients with CAC score of >300 are two to five times more likely to have incident ASCVD events[10]. Detection of CAC on low-dose CT can result in change in management of 20% of patients[11]; and

Whereas, CAC is a marker of coronary atherosclerosis and represents its burden. Its role in cardiac risk stratification has been established in multiple large population studies[12-16]. Studies have shown that patients undergoing CAC assessment are more likely to have improved compliance with preventive medications (3-fold greater likelihood of aspirin and statin usage)[13] and superior coronary artery disease risk factors control[14]. CAC can be easily detected on non-contrast chest CT scans performed for various reasons; and

Whereas, the improvement in machine learning has improved detection of CAC on non-contrast chest CT[17-18], thereby improving chances of detection and early intervention in such high-risk patients[19]. Detection of CAC on non-contrast non-gated chest CT scans performed for non-cardiac reasons can provide an opportunity for an aggressive and early preventive measure in such high-risk patients; and

Whereas, lung cancer screening remains underutilized with only 4.5% of the eligible population in the US received lung cancer screening in 2022[20] and there is a critical need to increase public awareness regarding the value of undergoing a non-contrast chest CT to detect lung cancer and coronary artery disease. Although the current focus of lung cancer screening is for early detection of lung cancer, the same scans can be used to detect CAC, a marker of coronary atherosclerosis and as such, can provide an opportunity for an aggressive and early preventive cardiovascular measure in such high-risk patients. Such an approach may help to improve lung cancer and cardiovascular outcomes in such patients through early detection and intervention; therefore be it

RESOLVED, that our American Medical Association will partner with other professional and public health organizations as well as key stakeholders in cardiology, pulmonology, oncology, and imaging specialties to increase awareness amongst chronic smokers (who would benefit from appropriate lung cancer screening) regarding their risk for both lung cancer and coronary artery disease and encourage their participation in screening programs through a joint public campaign effort (Directive to Take Action); and be if further

RESOLVED, that our American Medical Association promote physician education and awareness regarding the value of chest CT in detecting both lung cancer and calcified atherosclerotic plaque and encourage reporting the extent of coronary artery calcification in non-contrast chest CT studies performed as a part of lung cancer screening program. (Directive to Take Action)

Fiscal Note: $43,166 Initiating a public health campaign

Received: 9/24/2024

REFERENCES

1. Wolf AMD, Oeffinger KC, Shih TY, Walter LC, Church TR, Fontham ETH, Elkin EB, Etzioni RD, Guerra CE, Perkins RB, Kondo KK, Kratzer TB, Manassaram-Baptiste D, Dahut WL, Smith RA. Screening for lung cancer: 2023 guideline update from the American Cancer Society. CA Cancer J Clin. 2024 Jan-Feb;74(1):50-81. doi: 10.3322/caac.21811. Epub 2023 Nov 1. PMID: 37909877.
2. Aberle, D. R., et al. Reduced lung-cancer mortality with low-dose computed tomographic screening. N Engl J Med. 2011;365(5), 395-409.
3. de Koning, H. J., et al. Reduced Lung-Cancer Mortality with Volume CT Screening in a Randomized Trial. New England Journal of Medicine. 2020;382(6), 503-513.
4. Potter, A. L., et al. Association of computed tomography screening with lung cancer stage shift and survival in the United States: quasi-experimental study. Bmj. 2022;376, e069008.
5. U.S. Department of Health and Human Services. The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014 [accessed 2017 Apr 20].
6. U.S. Department of Health and Human Services. Reducing the Health Consequences of Smoking: 25 Years of Progress. A Report of the Surgeon General. Rockville (MD): U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 1989 [accessed 2017 Apr 20].
7. U.S. Department of Health and Human Services. A Report of the Surgeon General. How Tobacco Smoke Causes Disease: What It Means to You. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2010 [accessed 2022 Feb 7].
8. Park C, Lee BC, Jeong WG, Park WJ, Jin GY, Kim YH. Coronary Artery Calcification on Low-Dose Lung Cancer Screening CT in South Korea: Visual and Artificial Intelligence-Based Assessment and Association With Cardiovascular Events. AJR Am J Roentgenol. 2024 May;222(5):e2430852.
9. Ruparel M, Quaife SL, Dickson JL, Horst C, Burke S, Taylor M, Ahmed A, Shaw P, Soo MJ, Nair A, Devaraj A, O'Dowd EL, Bhowmik A, Navani N, Sennett K, Duffy SW, Baldwin DR, Sofat R, Patel RS, Hingorani A, Janes SM. Evaluation of cardiovascular risk in a lung cancer screening cohort. Thorax. 2019 Dec;74(12):1140-1146.
10. Leigh A, McEvoy JW, Garg P, Carr JJ, Sandfort V, Oelsner EC, Budoff M, Herrington D, Yeboah J. Coronary Artery Calcium Scores and Atherosclerotic Cardiovascular Disease Risk Stratification in Smokers. JACC Cardiovasc Imaging. 2019 May;12(5):852-861.

11. Mendoza DP, Kako B, Digumarthy SR, Shepard JO, Little BP. Impact of Significant Coronary Artery Calcification Reported on Low-Dose Computed Tomography Lung Cancer Screening. J Thorac Imaging. 2020 Mar;35(2):129-135.
12. Detrano R, Guerci AD, Carr JJ, Bild DE, Burke G, Folsom AR, Liu K, Shea S, Szklo M, Bluemke DA, O'Leary DH, Tracy R, Watson K, Wong ND, Kronmal RA. Coronary calcium as a predictor of coronary events in four racial or ethnic groups. N Engl J Med. 2008 Mar 27;358(13):1336-45.
13. Taylor AJ, Bindeman J, Feuerstein I, Le T, Bauer K, Byrd C, Wu H, O'Malley PG. Community-based provision of statin and aspirin after the detection of coronary artery calcium within a community-based screening cohort. J Am Coll Cardiol. 2008 Apr 8;51(14):1337-41.
14. Rozanski A, Gransar H, Shaw LJ, Kim J, Miranda-Peats L, Wong ND, Rana JS, Orakzai R, Hayes SW, Friedman JD, Thomson LE, Polk D, Min J, Budoff MJ, Berman DS. Impact of coronary artery calcium scanning on coronary risk factors and downstream testing the EISNER (Early Identification of Subclinical Atherosclerosis by Noninvasive Imaging Research) prospective randomized trial. J Am Coll Cardiol. 2011 Apr 12;57(15):1622-32.
15. Elias-Smale SE, Proença RV, Koller MT, Kavousi M, van Rooij FJ, Hunink MG, Steyerberg EW, Hofman A, Oudkerk M, Witteman JC. Coronary calcium score improves classification of coronary heart disease risk in the elderly: the Rotterdam study. J Am Coll Cardiol. 2010 Oct 19;56(17):1407-14.
16. Miedema MD, Dardari ZA, Nasir K, Blankstein R, Knickelbine T, Oberembt S, Shaw L, Rumberger J, Michos ED, Rozanski A, Berman DS, Budoff MJ, Blaha MJ. Association of Coronary Artery Calcium With Long-term, Cause-Specific Mortality Among Young Adults. JAMA Netw Open. 2019 Jul 3;2(7):e197440.
17. Peng AW, Dudum R, Jain SS, Maron DJ, Patel BN, Khandwala N, Eng D, Chaudhari AS, Sandhu AT, Rodriguez F. Association of Coronary Artery Calcium Detected by Routine Ungated CT Imaging With Cardiovascular Outcomes. J Am Coll Cardiol. 2023 Sep 19;82(12):1192-1202.
18. Miller RJH, Killekar A, Shanbhag A, Bednarski B, Michalowska AM, Ruddy TD, Einstein AJ, Newby DE, Lemley M, Pieszko K, Van Kriekinge SD, Kavanagh PB, Liang JX, Huang C, Dey D, Berman DS, Slomka PJ. Predicting mortality from AI cardiac volumes mass and coronary calcium on chest computed tomography. Nat Commun. 2024 Mar 29;15(1):2747.
19. Parsa S, Saleh A, Raygor V, Hoeting N, Rao A, Navar AM, Rohatgi A, Kay F, Abbara S, Khera A, Joshi PH. Measurement and Application of Incidentally Detected Coronary Calcium: JACC Review Topic of the Week. J Am Coll Cardiol. 2024 Apr 23;83(16):1557-1567.
20. State of Lung Cancer | Key Findings | American Lung Association. https://www.lung.org/research/state-of-lung-cancer/key-findings

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 927
(I-24)

Introduced by: Medical Society of New Jersey

Subject: The Creation of Healthcare Sustainability Lecture Series

Referred to: Reference Committee K

Whereas, the American Medical Association recognizes the critical role of healthcare sustainability in promoting environmental stewardship, reducing healthcare costs, and improving patient outcomes; and

Whereas, the healthcare sector is a significant contributor to environmental pollution and resource depletion, with hospitals generating large amounts of waste, consuming vast quantities of energy and water, and emitting greenhouse gases; and

Whereas, healthcare institutions have the potential to lead by example in adopting sustainable practices that mitigate environmental harm, enhance community health, and foster a culture of environmental responsibility; and

Whereas, educating physicians on the principles of healthcare sustainability and climate-smart healthcare can empower them to implement environmentally conscious practices in clinical settings, advocate for sustainable healthcare policies, and contribute to the transition towards a more sustainable healthcare system; and

Whereas, the AMA's online platform serves as a valuable resource for physicians seeking continuing medical education (CME) opportunities and access to relevant educational content; therefore be it

RESOLVED, that our American Medical Association shall establish a lecture series on healthcare sustainability for physicians, hosted on the AMA's online platform, featuring presentations from experts in environmental health, sustainable healthcare practices, and climate resilience, including but not limited to: principles of sustainable healthcare, waste reduction and recycling in healthcare facilities, energy efficiency and renewable energy in healthcare operations, sustainable procurement practices, and the health co-benefits of environmental sustainability (Directive to Take Action); and be it further

RESOLVED**,** that our AMA shall promote the lecture series to physicians through various channels, including the AMA's website, email newsletters, and social media platforms, to maximize its reach and impact within the medical community and shall evaluate the effectiveness of the series through participant feedback, monitoring participation rates, and assessing changes in physician knowledge and behavior related to climate-smart healthcare (Directive to Take Action); and be it further

RESOLVED, that our AMA shall explore opportunities for collaboration with healthcare organizations, government agencies, and other stakeholders to further integrate healthcare sustainability principles into medical education and practice (Directive to Take Action); and be it further

RESOLVED, that our AMA shall communicate this resolution to relevant stakeholders, including medical schools, residency programs, healthcare institutions, and professional organizations, to raise awareness of the importance of healthcare sustainability and promote the uptake of the AMA's lecture series among physicians. (Directive to Take Action)

Fiscal Note: $261,553 Contract with third-parties to develop educational content and development of a taskforce

Received: 9/24/2024

REFERENCES

1. Eckelman, M. J., & Sherman, J. (2016). Environmental impacts of the U.S. health care system and effects on public health. Plos One. 2016; 11(6), e0157014.
2. Hospitals for a Healthy Environment. (2022). Sustainability roadmap for hospitals. Retrieved from https://practicegreenhealth.org/sustainability-roadmap-hospitals

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 10-I-24

Subject: AMA Efforts on Medicare Payment Reform

Presented by: Michael Suk, MD, JD, MPH, MBA, Chair

BACKGROUND

At the 2023 American Medical Association (AMA) Annual Meeting of the House of Delegates (HOD), the HOD adopted Policy – D-385.945, "Advocacy and Action for a Sustainable Medical Care System" and amended Policy D-390.922, "Physician Payment Reform and Equity." Together, they declare Medicare physician payment reform as an urgent advocacy and legislative priority, call on the AMA to implement a comprehensive advocacy campaign, and for the Board of Trustees (the Board) to report back to the HOD at each Annual and Interim meeting highlighting the progress of our AMA in achieving Medicare payment reform until a predictable, sustainable, fair physician payment system is achieved. The Board has prepared the following report to provide an update on AMA activities for the year to date. (Note: This report was prepared in mid-August based on approval deadlines, so more recent developments may not be reflected in it.)

AMA ACTIVITIES ON MEDICARE PHYSICIAN PAYMENT REFORM

The AMA's Medicare physician payment reform efforts were initiated early in 2022, following the development of a set of principles outlining the "Characteristics of a Rational Medicare Payment System" that was endorsed by 124 state medical associations and national medical specialty societies. These principles identified strategies and goals to: (1) ensure financial stability and predictability for physician practices; (2) promote value-based care; and (3) safeguard access to high quality care.

Subsequently, the AMA worked with Federation organizations to identify four general strategies to reform the Medicare payment system, including:

- Automatic annual payment updates based on the Medicare Economic Index (MEI);
- Updated policies governing when and how budget neutrality adjustments are made;
- Simplified and clinically relevant policies under the Merit-based Incentive Payment System (MIPS); and
- Greater opportunities for physician practices wanting to transition to advanced alternative payment models (APMs).

At the heart of the AMA's unwavering commitment to reforming the Medicare physician payment system lie four central pillars that underscore our strategic approach: legislative advocacy, regulatory advocacy, federation engagement, and grassroots, media, and outreach initiatives. Grounded in principles endorsed by a unified medical community, our legislative efforts drive the advancement of policies that foster payment stability and promote value-based care. We actively champion reform through regulatory channels, tirelessly engaging with crucial agencies such as the Centers for Medicare & Medicaid Services (CMS) and the White House to address impending challenges and ensure fair payment policies. Our federation engagement fosters unity and consensus

within the broader medical community, pooling resources and strategies to amplify our collective voice. Lastly, our continued grassroots, media, and outreach efforts bridge the gap between policymakers and the public, ensuring our mission is well-understood and supported from all quarters. Together, these pillars fortify our endeavors to achieve a more rational Medicare physician payment system that truly benefits all.

Legislative Advocacy

The AMA shares its members' long frustration over the continued cuts to Medicare payment. Congress did mitigate about half of the 2024 Medicare physician payment cuts initially implemented despite urgent calls from physicians about the impact that two decades of annual payment cuts are having on practice viability and patient access to care. Adding salt to the wound is the proposed 2025 Physician Payment Rule that includes a 2.8 percent cut. This would be the fifth consecutive year that physicians face Medicare cuts. Meanwhile, the CMS predicts that the MEI will increase by 3.6 percent in 2025. The gap between what Medicare pays physicians and the cost of delivering quality care to patients continues to widen. Further, the fiscal stability of physician practices and long-term viability of the nation's entire health care system is at stake because Medicare physician payment rates have plummeted 29 percent from 2001 to 2024 (adjusted for inflation in practice costs).

Fixing our unsustainable Medicare payment system will remain AMA's top advocacy priority until meaningful reform is achieved. The need to stop the annual cycle of pay cuts and patches and enact permanent Medicare payment reforms could not be clearer. Because of Congress' failure to reverse these cuts, millions of seniors will find it more difficult to access high quality care and physicians will find it more difficult to accept new Medicare patients. The impact of sustained, year-over-year Medicare payment cuts will become noticeable first in rural and underserved areas and with small, independent physician practices which will be highly detrimental for some of our nation's most vulnerable patients.

Summary of Recent AMA Advocacy Efforts in the 118th Congress

As a result of the continued advocacy efforts of the AMA and larger physician community and direct engagement with Congress, a collection of influential Dear Colleague letters and commonsense legislative reforms have been introduced as well as key Committee hearings and white papers released that build upon "Characteristics of a Rational Medicare Physician Payment System" including:

On May 9, 2024, the bipartisan Senate Medicare Payment Reform Working Group led by Senators Cortez Masto (D-NV), Blackburn (R-TN), Thune (R-SD), Barrasso (R-WY), Stabenow (D-MI), and Warner (D-VA) held its first provider roundtable where the AMA was invited to speak and present its consensus proposals on Medicare payment reform. The primary goal of this working group is to explore the current problems with the MPFS, propose long-term solutions, and recommend necessary updates to the Medicare Access and Chip Reauthorization Act (MACRA), which sets physician payment policies in the Medicare program. The AMA has served as a resource to the Senate working group and remains engaged with the Members and has shared important advocacy documents and consensus proposals on Medicare payment reform.

AMA and its Medicare Reform Workgroup finalized legislative language to reform MIPS in May of 2024; it was socialized with the Federation and has been circulated and discussed among key Committee and rank-and-file staff. The proposals are being incorporated into our messaging.

The new "Medicare Physician Data-Driven Performance Payment System" would: (1) simplify MIPS reporting and improve its clinical relevance; (2) reduce the potential severity of penalties (currently as much as -nine percent) for those scoring poorly under MIPS; (3) provide support to smaller practices that tend to score lower under the program; and (4) provide timely and meaningful performance feedback to physicians and expand the use of clinical data registries.

On May 17, Chairman Wyden and Ranking Member Crapo of the Senate Finance Committee issued a white paper on the Medicare Physician Fee Schedule and its impact on chronic care management. The bipartisan paper outlines policy concepts related to reforming the way physicians are paid by Medicare and meeting the needs of those with chronic illness. It includes important steps toward potential policy reforms to streamline clinician payment systems and treat chronic diseases. As Chairman Wyden noted, "The way Medicare pays doctors for their work has not kept up with the times, and if it's not working for doctors, it's not working for the patients they help."

The paper outlines a number of areas of interest that the Finance Committee sees as an opportunity for reform, including:

- Creating sustainable payment updates to ensure clinicians can own and operate their practices
- Incentivizing alternative payment models that reward providing better care at a lower cost
- Rethinking how Medicare measures quality care
- Improving primary care
- Supporting chronic care benefits in Medicare fee-for-service
- Ensuring continued access to telehealth

The paper is the follow up to the Finance Committee's hearing in April regarding how to approach updating the Medicare physician payment system, and how to ensure the treatment and management of chronic conditions is at the center of the Medicare program. The AMA submitted a Statement for the Record (PDF) for that hearing.

The AMA has been working closely with the Committee and sees the paper as a very positive development that represents a bipartisan commitment from the Finance Committee to begin the process of reforming the Medicare physician payment system. The AMA's response (PDF) to the paper encouraged the Committee to advance MACRA reform legislation to establish a permanent MEI update, reform the budget neutrality process, reform MIPS, and to maintain the APM bonuses and threshold requirements as well as to develop a more robust APM pipeline.

On May 23, the House Ways and Means Health Subcommittee held a hearing on the interconnectedness of Congress passing legislation to reform the current Medicare payment system and the ability of private practice physicians to remain a viable option for patients. The hearing, which was entitled, "The Collapse of Private Practice: Examining the Challenges Facing Independent Medicine," touched on a variety of key policy themes that will help preserve private practice, including:

- The need for Congress to pass legislation providing physicians with an annual inflationary update in Medicare tied to the Medicare Economic Index (MEI);
- Burden reduction and administrative reforms; and
- Overhauling the Merit-based Incentive Payment System (MIPS)

The AMA submitted a detailed statement for the record (PDF), which focused on many of the same policies that were discussed during the hearing, especially support for H.R. 2474, the Supporting Medicare for Patients and Providers Act, and H.R. 6371, the Provider Reimbursement Stability Act.

August Recess

In light of the upcoming August congressional recess and the July release of the CY 2025 proposed Medicare Physician Fee Schedule (MPFS) rule which proposes to cut Medicare physician payments by 2.8 percent, the AMA spearheaded a Federation letter (PDF) signed by all 50 state medical associations and 76 national medical specialty societies to congressional leadership.

The 2025 Medicare conversion factor is set to decrease for the fifth straight year by approximately 2.8 percent from $33.2875 to $32.3562. This cut is largely the result of the expiration of a 2.93 percent temporary update to the conversion factor at the end of 2024 and a zero percent baseline update for 2025 under MACRA. These cuts coincide with ongoing growth in the cost of practicing medicine as CMS projects the increase in the MEI for 2025 will be 3.6 percent.

The Federation letter warned that physician practices cannot continue to absorb increasing costs with ever-increasing inflation rates, while their payment rates dwindle year after year. Both the Medicare Payment Advisory Commission (MedPAC) and the Medicare Trustees (PDF) have issued warnings about access to care problems for America's seniors and persons with disabilities if the gap between what Medicare pays physicians and what it costs to provide high quality patient care continues to grow. Committees of jurisdiction have started conversations on reforming MACRA, and the Federation letter urged them to continue these negotiations in earnest given the cuts in the latest proposed rule and enact priority legislation.

The letter specifically urged leadership to act on bills or future legislation which reforms MACRA along four keys pillars:

1. Enacting an annual, permanent inflationary payment update in Medicare that is tied to the MEI (H.R. 2474);
2. Budget Neutrality reforms (H.R. 6371);
3. An overhaul of MACRA's Merit-based Incentive Payment System (MIPS); and
4. Modifications to Alternative Payment Models (APM) (H.R. 5013/S. 3503).

These are well vetted, consensus reforms within the physician community. In addition to the Federation letter on MACRA reform, AMA advocacy staff are continuing to meet with the House and Senate leadership and committee staff to educate them on the importance of a permanent inflation-based update tied to the MEI, MIPs reform, Budget Neutrality reform, and the need for legislation modifying APMs in any end of year health care package.

AMA advocacy staff will continue to work with Members of Congress and staff during all recess periods to build support for including elements of our reform proposal in the expected end-of-year omnibus legislation.

Physician Call to Take Action

As Congress returns home for the annual August recess, physician advocates have unique opportunities to engage with their members of Congress "back home" in the district and urge them to reform Medicare's broken physician payment system. To make these interactions with legislators as impactful as possible, the AMA developed an online "Advocacy Hub" for the August Congressional recess that serves as one-stop shop for toolkits, legislative calls to action, and information on scheduling and preparing for legislative meetings and other in-district opportunities.

Additionally, the AMA held an informative webinar on August 1st reviewing the current state of federal legislation and ways in which physician advocates can engage Congress during August and beyond. There was also a discussion of August recess advocacy best practices to help prepare physicians for in-district legislative meetings, hosting members of Congress at site visits, and engaging with legislators online.

The AMA will continue to work with Congress to build bipartisan support in Congress for a proposal that will put an end to the annual cycle of Medicare cuts that threaten seniors' access to care. Bipartisan support for the aforementioned legislative proposals continues to grow among rank-and-file Members of Congress. However, the need for further advocacy remains to push the relevant Committees and Congressional leadership to make Medicare physician payment reform a top priority.

Grassroots, Media, and Outreach

The AMA has maintained a continuous drumbeat of grassroots contacts through its Physicians Grassroots Network, Patients Advocacy Network, and its Very Influential Physicians program. Op eds have been placed in various publications from AMA leaders, as well as from "grasstops" contacts in local newspapers. Digital advertisements are running, targeted specifically to publications read on Capitol Hill, and media releases have been issued to highlight significant developments.

The AMA relaunched a dedicated Medicare payment reform web site, www.FixMedicareNow.org, which includes a range of AMA-developed advocacy resource material, updated payment graphics, and a new "Medicare basics" series of papers describing in plain language specific challenges presented by current Medicare payment policies and recommendations for reform.

From a research perspective, the AMA has also launched the Physician Practice Information Survey to update physician practice cost data utilized in the Medicare Resource-Based Relative Value Scale and the MEI. More than 10,000 physician practices have been contacted to participate in the effort. Data from the effort will be summarized in late 2024 to share with CMS and to be used in AMA advocacy efforts.

Following up on public polling and focus groups held last year, additional polling was conducted this year of physicians and patients to further test our Medicare advocacy messaging and obtain more specific information about the impact of escalating practice costs and declining payments on patient access to care.

To support the Medicare legislation cited above, the AMA has been engaged in a major grassroots campaign to engage patients and physicians in our lobbying efforts. The following statistics result from the Fix Medicare Now campaign and engagement with the Physician Grassroots Network and Patients Action Network.

- 90.9MM+ Impressions
- 1.5MM+ Engagements
- 2,000+ #FixMedicareNow Social Media Mentions
- 397k messages sent to Congress
- 504k+ FixMedicareNow.org Pageviews
- 423k+ FixMedicareNow.org Site Users

1000+ earned media stories on Medicare, including more than 50 placements giving voice to physician leaders and third parties – making the case for reforming the system and stopping/reversing the cuts. These efforts have had an organic impact on thought leaders and policy analysts who are now beginning to express similar views independently.

A good example of the campaign is a promotional series that the AMA is running at the Politico site and other influential web properties.

Activities ramping-up in the summer will continue to intensify through the fall and in anticipation of a Congressional "lame duck" session that will tackle Medicare.

These include engaging both patient and physician audiences during Congress' month-long August Recess, helping them identify opportunities to contact and meet with their federal legislators, and staff equipped with 'action kits' (that include talking points, supportive charts/data, and feedback forms) that reinforce medicine's position. Other tactics include aggressive paid promotion that hit lawmakers in Washington, D.C. and their home states/districts with a battery of messaging online, in print, radio, and TV/streaming services ensuring the issue is top-of-mind for them and their constituents ahead of critical elections in November. Additionally, earned media efforts and physician grasstops and allied influencer engagement that bring together the most influential voices to put direct/public pressure on key legislators to act will be leveraged as well.

When Congress returns in the fall and throughout their lame duck session these activities will continue to ratchet-up in addition to other potential activities including coordinated social media and phone storms/blitzes as determined necessary at key times in anticipation of Congressional action.

We do not expect H.R. 2474 (MEI legislation) to advance during the lame duck session given its potential to cost $300 billion over a ten-year period. The current national debt of $35 trillion and CBO's projections that the federal budget deficit in fiscal year 2024 will be $1.9 trillion makes it extremely difficult to advance costly legislation. The current Congress remains deeply divided and achieving consensus on spending and budgetary matters has been very challenging, often resulting in gridlock.

Despite these hurdles, significant progress has been made to advance Medicare physician payment reform as highlighted in this report. During the lame duck session, the AMA will continue to aggressively advocate for replacing the proposed 2.8 percent Medicare physician payment cut on January 1st with a payment update that reflects practice costs as well as for reforms to the budget neutrality process, MIPS program, and modifications to APMs. Passage of these incremental reforms will serve to build the foundation for more comprehensive MACRA reform in the 119th Congress.

The AMA and Federation are working to maintain and grow our coalition in support of MACRA reforms, including the allied professions community who are also negatively impacted by the broken Medicare payment system as well as the patient community concerned about continued access to care.

Finally, a key element of our MACRA reform strategy involves the continuous engagement of physicians with their legislators in the months ahead. Individual physicians back home in the state and district have the unique ability to influence their Member of Congress by developing a relationship and sharing compelling stories as to why MACRA reform is urgently needed and will preserve their constituents access to care. The AMA will continue to reach out to the physician

community in the days ahead through various channels, including the Physicians Grassroots Network, requesting their timely engagement with Congress.

CONCLUSION

The AMA will continue to engage the Federation and press Congress to develop long-term solutions to the systematic problems with the Medicare physician payment system and preserve patient access to quality care. Despite the aforementioned challenges, the continued engagement of the physician community is crucial. It is vital to continue advocating for reform, engaging with legislators, and highlighting the real-world impacts of the current, broken system on patient care and physician practices.

Please follow Advocacy Update, join the Physicians Grassroots Network, visit www.FixMedicareNow often for updated material and alerts, and follow other AMA communications vehicles to stay up to date and engaged on this topic.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 12-I-24

Subject: Eliminating Eligibility Criteria for Sperm Donors Based on Sexual Orientation (Resolution 923-I-23)

Presented by: Michael Suk, MD, JD, MPH, MBA, Chair

INTRODUCTION

At the 2023 Interim Meeting of the House of Delegates, our AMA adopted policy D-420.988, "Eliminating Eligibility Criteria for Sperm Donors Based on Sexual Orientation," which asked our AMA to "work with other interested organizations to ask the US Food and Drug Administration (FDA) to eliminate its eligibility criteria for sperm donation based on sexual orientation, with a report back at I-24." This informational report serves as a summary of our AMA's efforts in this space to accomplish this request.

Policies on donor eligibility are primarily maintained by the FDA, with one set of regulations for blood donors, and another for human cell, tissue, and cellular tissue-based product (HCT/P) donors. HCT/P is a broad category that includes bone, heart valves, ligaments, corneas, skin, semen, dura matter, and hematopoietic progenitor cells from cord blood.

Current guidelines require men who have had sex with men (MSM) to defer HCT/Ps donation for five years since their last sexual contact with a man, describing MSM as a risk factor for human immunodeficiency virus (HIV) and hepatitis B.[1] These guidelines arose out of the HIV epidemic of the 1980s and 1990s in which MSM were at higher risk of HIV transmission, and HIV tests were lacking in accuracy and precision. Modern HIV testing, however, can detect the presence of HIV as early as 10 days post-infection using nucleic acid testing, with more readily accessible antibody tests available around 23 days post-exposure.[2] The deferral period for MSM donors is also not consistent with the guidelines for other groups of comparable or higher risk. For example, only a one-year deferral period is advised for individuals who have had sex with someone known to be HIV-positive. A similar one-year deferral period is required for an individual who has had a needle-stick injury with a needle known to be infected with HIV.

MSM deferrals are not currently required for blood donation, although they have been in the past. Historically, MSM were banned entirely from donating blood between 1985 and 2015.[3] In 2015, after our AMA opposed this ban, it was replaced with a 1-year deferral period, which was then reduced to a three-month deferral period in 2020 in response to the increased need for blood donations during the COVID-19 pandemic.[4] Similarly, the U.S. Public Health Service updated its HIV risk assessment for solid organ transplantation in 2020 from a 12-month period to three-months, although they continue to use MSM as a risk criteria.[5] Finally, in May 2023, the FDA finalized its rule to rescind the blanket MSM blood donation ban and instead moved towards a personalized risk-assessment questionnaire, which included questions such as "[in the last 3 months, have you] had sexual contact with a new partner?" or "[in the last three months, have you] had an accidental needle-stick?".[6] Critics have argued that the questionnaire may still discriminate against MSM due to the inclusion of pre-exposure prophylaxis (PrEP) as a disqualifying risk factor, although this is in response to higher false-negative HIV testing rates for individuals taking PrEP.[7]

EXISTING AMA POLICY

Currently, the AMA maintains policy pertinent to HCT/Ps donations. The first, H-50.973, "Blood and Tissue Donor Deferral Criteria," which states:

1. Our American Medical Association supports the use of rational, scientifically-based deferral periods for donation of blood, corneas, and other tissues that are fairly and consistently applied to donors according to their individual risk.
2. Our AMA opposes all policies on deferral of blood and tissue donations that are not based on evidence.
3. Our AMA supports a blood and tissue donation deferral period for those determined to be at risk for transmission of HIV that is representative of current HIV testing technology.
4. Our AMA supports research into individual risk assessment criteria for blood and tissue donation.
5. Our AMA will continue to lobby the United States Food and Drug Administration to use modern medical knowledge to revise its decades-old deferral criteria for MSM (men who have sex with men) donors of corneas and other tissues.

AMA ACTIONS

While the changes in FDA policy represent a significant step forward for *blood* donation, the policy has not been expanded to HCT/Ps donation. Due to the multiple opportunities to speak on the changes in blood donor policy, our AMA has done significant outreach both directly to the FDA and in the public sphere on the need for HCT/Ps guidelines to follow those for blood.

A summary of recent communications to the FDA and media reports directly calling for revision of exclusionary donation policy (links available in online version of this report) is as follows:

- April 2nd, 2020 AMA press release on revised guidelines, urging "the FDA to take future steps to remove the categorical restrictions."
- October 20th, 2021 letter to FDA Acting Commissioner, requesting FDA "re-evaluate policy requiring a five year deferral period for [MSM] with regards to donating [HCT/Ps]."
- January, 26th, 2022 AMA Leadership Viewpoint, calling on the FDA to "evaluate all donors equally", particularly amidst an ongoing shortage.
- January 23rd, 2023 letter to FDA Director of Center for Biologics Evaluation and Research, stating "FDA's MSM [sperm donor] deferral policy is inconsistent with current evidence-based science."
- January 27th, 2023 statement to Medscape, "the current three-month deferral period singles out and bans blood donors based on their inherent attributes rather than the risk factors they present."
- March 23rd, 2023 letter to FDA Commissioner, applauding the lifting of restrictions on blood donation and "encourages expansion of these efforts to policies regarding the donation of [HCT/Ps]."
- May 11th, 2023 AMA press release on FDA removing restrictions for MSM blood donation, and calling for "the FDA to expand their work by reevaluating its donation deferral policies for [HCT/Ps] based on the latest scientific evidence."
- May 12th, 2023 video interview with MSNBC, stating "there are other deferral criteria around tissue-based products, corneas, human cells. We need to make sure those restrictions are fair."

- June 23rd, 2023 AMA news story, "Blood-donation changes bring equity. Next step: tissue rules.", which highlights AMA communications with the FDA.
- August 7th, 2023 AMA statement to NBC News, calling MSM deferral criteria "outdated categorical restrictions."
- August 8th, 2023 AMA statement to ABC News, quoting AMA policy and FDA communications.
- September 17th, 2023 coverage in USA Today, stating "it's hurtful when you should be able to do something so selfless and so important and you can't because of a bad policy decision that is based in old evidence, stigma and discrimination."
- June 27th, 2024 interview with NBC News (beginning at 34:33 of linked video), describing the FDA updates to MSM deferral periods.

CONCLUSION

While the FDA has yet to take action to align HCT/Ps donor eligibility with those of blood, there are reports suggesting that there is an FDA proposed rule in development to expand HCT/Ps donor eligibility, however it has not been made public at the time of this report's writing.[8] Given AMA policy and previous involvement on the issue, our AMA will continue to actively monitor this issue and would expect to comment if any such rule is proposed.

REFERENCES

1. U.S. Food and Drug Administration. Eligibility Determination for Donors of Human Cells, Tissues, and Cellular and Tissue-Based Products (HCT/Ps) https://www.fda.gov/media/73072/download. Updated Published 2007.
2. U.S. Centers for Disease Control and Prevention. Getting Tested for HIV. https://www.cdc.gov/hiv/testing/index.html. Updated Published 2024.
3. Bayer R. Science, politics, and the end of the lifelong gay blood donor ban. *The Milbank Quarterly.* 2015;93(2):230.
4. Park C, Gellman C, O'Brien M, et al. Blood Donation and COVID-19: Reconsidering the 3-Month Deferral Policy for Gay, Bisexual, Transgender, and Other Men Who Have Sex With Men. *Am J Public Health.* 2021;111(2):247-252.
5. Jones JM. Assessing solid organ donors and monitoring transplant recipients for human immunodeficiency virus, hepatitis B virus, and hepatitis C virus infection—US Public Health Service Guideline, 2020. *MMWR Recommendations and Reports.* 2020;69.
6. Association for the Advancement of Blood & Biotherapies. Full-Length Blood Donor History Questionnaire (DHQ) v4.0 https://www.aabb.org/docs/default-source/default-document-library/resources/dhq-v4-0/pdfs/dhq-v4-0.pdf?sfvrsn=c8022a9f_0.99 Published 2023.
7. Ambrosioni J, Petit E, Liegeon G, Laguno M, Miró JM. Primary HIV-1 infection in users of pre-exposure prophylaxis. *The Lancet HIV.* 2021;8(3):e166-e174.
8. Essley Whyte L, Dockser Marcus A. FDA to Drop Ban on Sperm Donations From Gay and Bisexual Men. *Wall Street Journal.* April 4, 2024.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 17-I-24

Subject: Environmental Sustainability of AMA National Meetings (BOT Report 25-A-24, Rec. 3)

Presented by: Michael Suk, MD, JD, MPH, MBA, Chair

At the 2024 Annual Meeting of the American Medical Association (AMA), Board of Trustee's Report 25 Environmental Sustainability of AMA National Meetings was adopted as amended to read:

1. Our AMA is committed to progression to net zero emissions for its business operations by 2030, by continuing and expanding energy efficiency upgrades, waste reduction initiatives, and the transition to renewable energy sources (New HOD Policy).
2. Our AMA will prioritize sustainable organizational practices to reduce emissions over purchasing carbon offsets (New HOD Policy).
3. Our AMA Board of Trustees will present a report at the 2024 Interim Meeting that details a timeline as to when and how to achieve our organizational carbon neutrality. (Directive to Take Action).
4. Our AMA will continue to prioritize collaboration within the health care community by sharing the learnings from our sustainability initiative to inspire our peer organizations to follow suit and adopt similar environmentally conscious practices (Directive to Take Action).
5. Our AMA will work with appropriate entities to encourage the United States health care system to decrease emissions to half of 2010 levels by 2030, achieve net zero by 2050, and remain net zero or negative (Directive to Take Action).

This report is in response to recommendation 3, that our Board present a report that details the timeline as to when and how to achieve carbon neutrality.

DISCUSSION

The AMA is committed to achieving carbon neutrality. The work to achieve net zero emissions involves not only the ongoing public health strategy per BOT Report 17-A-23 Update on Climate Change and Health – AMA Activities, but also the strategy of AMA's business operations. Below is an overview of ongoing, operational initiatives as well as the AMA's approach to this topic moving forward.

2022 to 2024 current and ongoing efforts: During and after the COVID-19 pandemic, the AMA made key infrastructure investments that mitigate carbon footprint in the following areas.

- Building Infrastructure
  - AMA headquarters updated HVAC systems and put in Merv-13 filtration on each floor, resulting in a 35 percent energy reduction.
  - Following the COVID-19 pandemic, AMA adjusted its physical footprint to align with occupancy rates, returning the 40th floor to the landlord in Q3 2023. This

consolidation led to a 20 percent reduction in storage space. AMA also created space usage guidelines, with staff onsite fewer than one day per week using new hoteling stations.

- Lighting retrofits, including adding LEDs and a daylight harvesting feature in the lobby to automatically dim the lights according to the amount of sunlight entering the building), produced a savings of two million kilowatt-hours per year, or 70 percent less energy.

- Fifty percent of AMA Plaza's roof houses a green vegetable garden, which not only reduces carbon dioxide emissions but also slows the amount of rainfall runoff that goes to Chicago's sewer system. The roof at AMA Plaza is also home to a vegetable garden and bee program, which harvests honey twice a year.

- The AMA has tenancy in three locations (Chicago, DC, and Greenville) that have implemented varying sustainability best practices including LEED Green Certification, light sensors, recycling, etc. within their building guidelines. The AMA also instituted a requirement to contract exclusively with LEED-certified conference centers for Annual and Interim meetings in 2030.

- A re-landscaping project is on track for completion by August 2024. The project will use low-maintenance, synthetic plants, which are projected to reduce energy consumption from landscaping maintenance by 20%.

- Employee Commuter Benefits
  - AMA employees are encouraged to enroll in the commuter benefit program to use pre-tax payroll deductions towards public transit costs.

  - AMA's shuttlebus service, bike area, on-site Zipcars and scooter and hybrid vehicle parking reduced carbon emissions by nine metric tons. The shuttlebuses alone save an average of 65,000 pounds in carbon dioxide emissions per month.

- Building Operations and Amenities
  - AMA's HQ café sources local food and participates in the building's compost program, which repurposes 70 percent of waste.

  - AMA staff and visiting members/meeting attendees can charge their electronics using solar-powered benches in AMA plaza.

  - The AMA does not offer disposable hot cups in any of the breakrooms.

- AMA Events
  - Following COVID-19, AMA saw a surge in remote and hybrid meetings, prompting improvements in technology, workflows, vendor lists, licenses, guidelines, and training. Staff enhanced their skills in meeting accessibility and completed PCMA Event Accessibility certifications.
  - Catering practices:
    - AMA promotes the use of water stations vs plastic water bottles when catering.
    - AMA catering is equipped to compost waste from internal meetings.
    - AMA's top three vendors for catering all have a sustainability program.

- The AMA instituted a requirement to contract exclusively with LEED-certified conference centers for Annual and Interim meetings in 2030.
  - AMA has committed to Hyatt Regency Chicago, a LEED-certified building, for AMA's Annual meeting through 2029.
  - AMA's 2027, 2029 and 2031 Interim Meetings will be held at the Gaylord Pacific (currently under construction), designed to adhere to California's energy code Title 24, surpassing the standards set by LEED certified buildings.

Timeline of future efforts

To make the most of limited resources and a shortage of benchmark emissions data, the AMA will adopt a framework from the United States Environmental Protection Agency (EPA)[1] to perform a self-review of current operations within AMA properties and AMA events. The AMA will develop sustainability guidelines based on the review and work with key partners and stakeholders on improvements to meet these guidelines. Implementation will be done with consideration of existing resources and fiscal impacts. Below is an outline of planned efforts from 2025 to 2030.

1. **By end of 2025: Collect data on carbon footprint.** The AMA will conduct an inventory of sources and amounts of emissions from business operations within AMA properties and AMA-hosted events:
   a. The AMA will follow the United States Environmental Protection Agency's (EPA) Greenhouse Gas (GHG) inventory development process to determine the proper scopes of emissions inventorying relevant to AMA's business operations.

   b. The AMA will utilize the EPA's Simplified GHG emissions Calculator[2] to identify the sources of carbon emissions and calculate emission estimates. The results will set a benchmark, against which the AMA can assess improvements towards net zero emissions from operations. While the AMA is committed to a target of net zero by 2030, certain operations might require a further target year to achieve net zero based on the calculation. The AMA would then inform the Board of Trustees of such cases. Below is a non-exhaustive list of environmental areas to examine:
      i. Waste management
      ii. Transportation (i.e. business travel, event transport, commuting)
      iii. Energy consumption
      iv. Carbon offsets

2. **By end of 2025: Develop guidelines for operational sustainability.** Based on the self-review, the AMA will establish sustainability guidelines for AMA building operations and event operations. Such guidelines will account for ways in which employees and vendors the AMA contracts with can implement and improve emission reduction practices.

3. **2026 to 2030: Implement guidelines.** The AMA will work with necessary stakeholders and vendors to implement operational improvements and measure emissions reduction against the calculated benchmarks.

4. **2026 to 2030: Leading by example within the Health Sector**
   a. Beginning in 2026, the AMA will launch an internal awareness campaign to inform and train employees on the new sustainability guidelines and improved

practices aimed at reducing emissions. The AMA will utilize the following channels:

i. Employee communications via email, SharePoint, and physical signage
ii. Programming via collaboration with Employee Resource Groups and local opportunities for volunteering with sustainability projects
iii. A digital course to educate employees on the sustainability guidelines

b. The AMA will continue to engage in the following consortiums and partnerships, not only to advance policies and interventions on climate change and health (BOT Report 17-A-23 Update on Climate Change and Health – AMA Activities) but also to share resources, information, and insights gained from the data collection, guideline development, implementation, and communication work above.
i. Medical Society Consortium on Climate Health
ii. National Academy of Medicine Action Collaborative on Decarbonizing the U.S. Health Sector
iii. The American Lung Association's Healthy Air Partners campaign
iv. American Public Health Association (APHA) Advisory Board on Climate, Health, and Equity

CONCLUSION

The AMA is committed to continuing to execute against our current initiatives, and expanding upon them, to achieve environmental sustainability. These resolutions reflect our proactive stance in reducing carbon emissions and championing sustainability initiatives within our organization and the broader health care sector. Through our efforts, we demonstrate our dedication to mitigating the environmental impact of our business operations. Additionally, our commitment to limiting carbon emissions generated by AMA events and researching opportunities for attendees to offset their environmental impact, highlights our holistic approach to sustainability. Through these initiatives, the AMA reaffirms its commitment to environmental stewardship and welcomes the opportunity to drive meaningful change within the health care ecosystem and beyond.

REFERENCES

[1] U.S. Environmental Protection Agency. (2024, April). Simplified Guide to Greenhouse Gas Management for Organizations. Retrieved from U.S. Environmental Protection Agency: https://www.epa.gov/system/files/documents/2022-09/Simplified_Guide_GHG_Management_Organizations.pdf

2 U.S. Environmental Protection Agency. (2024, May 15). *Simplified GHG Emissions Calculator.* Retrieved from U.S. Environmental Protection Agency: https://www.epa.gov/climateleadership/simplified-ghg-emissions-calculator

REPORT OF THE BOARD OF TRUSTEES

B of T Report 19-I-24

Subject: Update on Climate Change and Health AMA Activities (BOT Report 03-I-23)

Presented by: Michael Suk, MD, JD, MPH, MBA, Chair

BACKGROUND

At the Interim Meeting of the American Medical Association (AMA) House of Delegates (HOD) Board of Trustees Report 3, "Update on Climate Change and Health AMA Activities," was referred by the HOD. BOT 3-I-23 was an informational report, in which the Board reiterated its plan to address the health effects of climate change and outlined the work the AMA had accomplished since the strategy was outlined in June of 2023.

Those who testified at the Reference Committee hearing indicated that what they were expecting was a plan similar to the AMA's strategic plan to advance health equity. It was noted that this report did not meet their expectations, and it was asked that the report be referred back to the Board.

It is important to note the Board of Trustees serves as the principal planning agent for the AMA. That involves decision-making over allocation of resources and strategy development. Any strategy put forth needs to set realistic goals that the organization can reasonably achieve.

The AMA's strategic arcs are removing obstacles that interfere with patient care, confronting chronic disease and eliminating health inequities, and driving the future of medicine by reimagining medical education and lifelong learning. Each arc is powered by the cross-cutting accelerators of advocacy, equity and innovation.

Climate change is not a strategic arc nor is it a cross-cutting accelerator, rather it fits within the AMA's public health strategy along with other public health crises impacting physicians, patients, and the public. These include preventing firearm injuries and deaths, preparing for emerging and reemerging infectious disease threats, and ending the nation's drug overdose epidemic. The AMA has multiple levers it can utilize to address these public crises including advocacy, education, and collaboration with other interested organizations.

DISCUSSION

The attached document, which will be made available on the AMA website, provides a summary of the current evidence on climate change and health as well as historical context for AMA's work on both climate change and environmental health more broadly. In Section II, organizational levers for combatting the health effects of climate change are described and four priorities are described. Lastly, in Section III, key accomplishments over the past two years and proposed actions for the future are outlined. The AMA's four priorities on climate change and health are:

1. Educate physicians and trainees on the health effects of climate change.

2. Identify and disseminate information to physicians on decarbonizing the health care sector, reducing greenhouse gas emissions, as well as improving adaptation and resilience efforts.
3. Elevate the voices of physician leaders on the issue of climate change and health.
4. Collaborate with stakeholders to advance policies and interventions with a unified voice.

CONCLUSION

The AMA will continue to provide updates on activities taken to address the climate crisis in the AMA's annual public health strategy report.

Addressing the Public Health Crisis of Climate Change

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About the AMA

The American Medical Association is the powerful ally of and unifying voice for America's physicians, the patients they serve, and the promise of a healthier nation. The AMA attacks the dysfunction in health care by removing obstacles and burdens that interfere with patient care. It reimagines medical education, training, and lifelong learning for the digital age to help physicians grow at every stage of their careers, and it improves the health of the nation by confronting the increasing chronic disease burden. For more information, visit ama-assn.org.

Glossary of Terms

Term	Definition
Climate Change	Long-term shifts in temperatures and weather patterns.[1]
Greenhouse Gas Emissions (GHGs)	Gases that trap heat in the atmosphere are called greenhouse gases.[2]
Water Vapor	Water vapor is Earth's most abundant greenhouse gas. It is responsible for about half of Earth's greenhouse effect—the process that occurs when gases in Earth's atmosphere trap the Sun's heat. Greenhouse gases keep our planet livable. Without them, Earth's surface temperature would be about 59 degrees Fahrenheit (33 degrees Celsius) colder.[3]
Carbon Dioxide	Carbon dioxide enters the atmosphere through burning fossil fuels (coal, natural gas, and oil), solid waste, trees and other biological materials, and also as a result of certain chemical reactions (e.g., cement production).[1]
Methane	Methane is emitted during the production and transport of coal, natural gas, and oil. Methane emissions also result from livestock and other agricultural practices, land use, and by the decay of organic waste in municipal solid waste landfills.[2]
Nitrous Oxide	Nitrous oxide is emitted during agricultural, land use, and industrial activities; combustion of fossil fuels and solid waste; as well as during treatment of wastewater.[2]
Ozone	Ozone (O3) is a highly reactive gas composed of three oxygen atoms. It is both a natural and a man-made product that occurs in the Earth's upper atmosphere (the stratosphere) and lower atmosphere (the troposphere). Ozone contributes to what we typically experience as "smog" or haze, which still occurs most frequently in the summertime, but can occur throughout the year in some southern and mountain regions. Ozone absorbs UV light, reducing human exposure to harmful UV radiation that causes skin cancer and cataracts. When inhaled, it reacts chemically with many biological molecules in the respiratory tract, leading to many adverse health effects.[4]
Particulate Matter	Particle pollution — also called particulate matter (PM) — is made up of particles (tiny pieces) of solids or liquids that are in the air. Breathing in particle pollution can be harmful to your health.[5]
Renewable Energy	Renewable energy comes from unlimited, naturally replenished resources, such as the sun, tides, and wind. Renewable energy can be used for electricity generation, space and water heating and cooling, and transportation. Non-renewable energy, in contrast, comes from finite sources, such as coal, natural gas, and oil.[6]
Biofuels	Unlike other renewable energy sources, biomass can be converted directly into liquid fuels, called "biofuels," to help meet transportation fuel needs. The two most common types of biofuels in use today are ethanol and biodiesel, both of which represent the first generation of biofuel technology.[7]
Climate Justice	Climate justice connects the climate crisis to the social, racial and environmental issues in which it is deeply entangled. It recognizes the disproportionate impacts of climate change on low-income and BIPOC communities around the world, the people and places least responsible for the problem.[8]
Adaptation	Adaptation refers to adjustments in ecological, social or economic systems in response to actual or expected climatic stimuli and their effects. It refers to changes in processes, practices and structures to moderate potential damages or to benefit from opportunities associated with climate change.[9]
Decarbonization	Decarbonization is shorthand for finding alternative ways of living and working that reduce emissions and capture and store carbon in our soil and vegetation.[10]
IPCC	The intergovernmental panel on climate change is an intergovernmental body of the United Nations dedicated to advancing scientific knowledge about climate change. They are recognized as the global authority on climate science.[11]

Executive Summary

There is increasing evidence and near-universal consensus among the scientific community that human activities within the last 150 years are impacting the climate and causing increased global surface temperatures.[13] Even small increases in global surface temperatures can impact weather patterns, causing regional and seasonal temperature extremes, reducing snow cover and sea ice, and intensifying heavy rainfall.[12] Climate change has already caused irreversible damage, but climate change solutions can help prevent further temperature increases, provide health benefits, and mitigate negative impacts on health. The consequences of unmanaged climate change include droughts, water scarcity, rising sea levels and flooding, severe fires, melting polar ice, temperature extremes, declining biodiversity, increased vector-borne diseases, and catastrophic storms, all of which impact our health and safety.[1] Economically and socially marginalized groups are most vulnerable to climate change impacts due to structural determinants of health equity.[21]

From its inception in 1847, the American Medical Association (AMA) has been keenly aware that Americans' health was only as good as the environment they lived in, and has been actively engaged in environmental health research and policy. In 1989, the AMA issued its first report on the effects of global climate change and joined with governmental and other organizations to work on a comprehensive national policy and program to address the adverse effects of environmental pollution, including the "greenhouse effect". Within the last ten years, the AMA House of Delegates (HOD) has adopted a number of policies on climate change, air pollution, and sustainability. At the annual meeting in 2022, the AMA adopted policy declaring climate change a public health crisis that threatens the health and well-being of all individuals, with marginalized and disadvantaged populations expected to be disproportionately impacted by changing weather patterns.

To advance work in climate change and health, there are several organizational levers AMA can utilize, including education, advocacy, litigation, and collaborating with external partners. As such, the AMA has identified the following four strategic approaches to address climate change:

1. Educate physicians and trainees on the health effects of climate change.
2. Identify and disseminate information to physicians on decarbonizing the health care sector, reducing GHG emissions, as well as improving adaptation and resilience efforts.
3. Elevate the voices of physician leaders on the issue of climate change and health.
4. Collaborate with stakeholders to advance policies and interventions with a unified voice.

Section 1. Background and History

What is climate change?

Climate change refers to the long-term changes in temperature and weather patterns, primarily due to human behavior. Since the 1800s, burning fossil fuels such as coal, oil, and gas has generated greenhouse gas emissions (GHGs) that have trapped heat in the atmosphere and raised Earth's temperature by about 0.11 degrees Fahrenheit per decade.[1] However, the rate of warming has more than tripled since 1982, and in 2023, it was 2.12 degrees Fahrenheit above the 20th century average.[12] The impact of climate change does not end solely at temperature changes; climate change brings multiple weather-related changes, including intensified water cycles, increased flooding and drought in certain regions, rising sea levels, and increased rates of heat waves.[13] There is increasing evidence and near-universal consensus among the scientific community that human activities within the last 150 years are impacting the climate and causing increased global surface temperatures.[13] Even small increases in global surface temperatures can impact weather patterns, causing regional and seasonal temperature extremes, reducing snow cover and sea ice, and intensifying heavy rainfall.[12] Climate change has already caused irreversible damage, but climate change solutions can prevent further temperature increases, provide health benefits, and mitigate negative impacts on health.

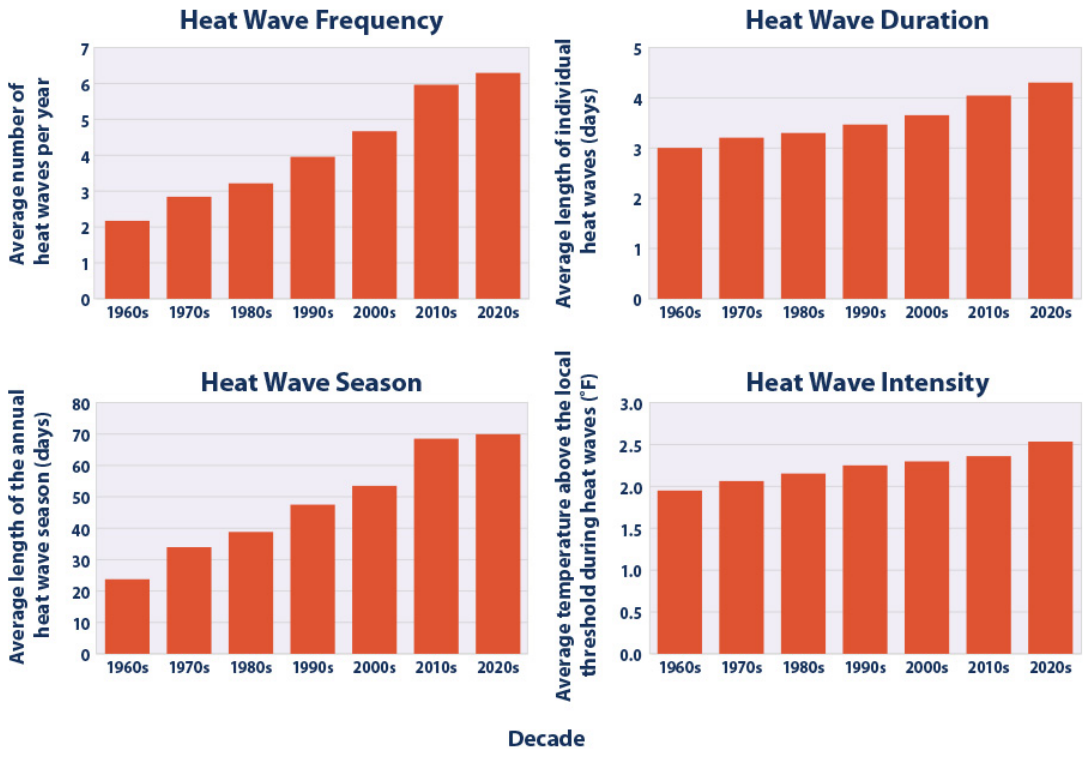
How does climate change impact health and equity?

The health impacts of climate change can be summarized as either direct or indirect **(Figure 1)**.[14]

Figure 1: Impact of climate change on health

The consequences of unmanaged climate change include droughts, water scarcity, rising sea levels and flooding, severe fires, melting polar ice, temperature extremes, declining biodiversity, and catastrophic storms, all of which impact our health and safety.[1] Heatwaves, for instance, can cause significant injury and mortality due to acute dehydration, heat exhaustion, and heat stroke, and studies have indicated that exposure to extreme heat can result in ischemic heart disease, heart failure, and arrhythmia.[15,16] Crucially, data from the United States Environmental Protection Agency (EPA) demonstrates that heat wave frequency, duration, and intensity are rising over time, and these trends are expected to continue and exacerbate health conditions for structurally vulnerable populations **(Figure 2)**.[17]

Figure 2: Heat wave trends in United States, 1961-2021



Data source: NOAA (National Oceanic and Atmospheric Administration). (2024). *Heat stress datasets and documentation* (provided to EPA by NOAA in April 2024) [Data set].

For more information, visit U.S. EPA's "Climate Change Indicators in the United States" at www.epa.gov/climate-indicators.

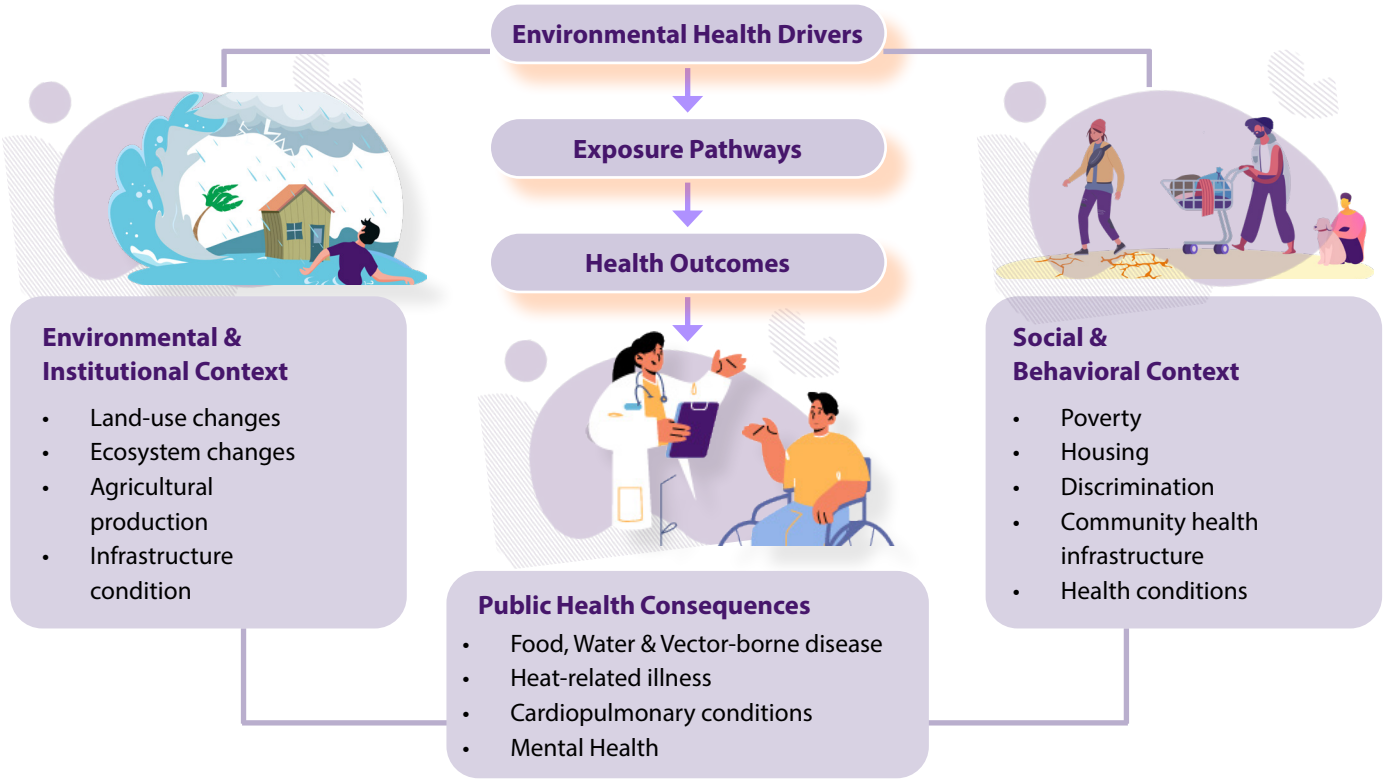
"I've seen this when I worked in hospitals in Florida, quite a bit. Obviously, one of our big things is heat, particularly in the summer months. And on those hot days, I have directly seen people coming to the ER who are in their early 20s, who are otherwise healthy and fit, no past medical history. And they're coming in with acute kidney injury because of dehydration, or heart failure or those people that have chronic illnesses. They're coming in when they hadn't been hospitalized in the two years prior or coming in with MI. Those are the direct effects of the heat for some of the patients." (Ankush Bansal, MD, FACP)

Evidence indicates that climate change impacts natural disasters, with observed changes in the intensity, frequency, and severity of extreme weather events such as monsoons, droughts, wildfires, and tropical cyclones.[13] These weather-related extreme events can cause death, destruction of people's homes, and hospitalizations due to traumatic injuries and can have lasting impacts on the environment through air and water quality.[18] Importantly, climate change impacts are not happening via one pathway, but rather, occur through various interconnected pathways across diverse social, environmental, and health contexts **(Figure 3)**. For example, nearly 4 in 10 people in the U.S., or 131.2 million people, already live in areas with unsuitable air quality.[19] Longer wildfire seasons will likely cause this number to increase, exacerbating population health inequities for people with asthma and other chronic respiratory conditions. The aftermath of these extreme events can also lead to displacement, homelessness, and post-traumatic stress disorder.[20] Economically and socially marginalized groups are most vulnerable to these poor outcomes due to structural determinants of health equity.[21]

Climate change continues to impact our food and water systems, which can indirectly worsen health outcomes by decreasing access to safe drinking water and healthy food. In 2022, 12.8 percent (17.0 million) of all households in the United States were food insecure, and in 2023, an estimated 2.2 million Americans lacked access to clean drinking water in their homes.[22]

Figure 3: Drivers of Exposure on Human Health

Climate change impacts human health through various interconnected pathways across social, environmental, and health contexts.



"I'd say we have definitely seen an increase in insect borne issues…from insects like ticks and mosquitoes. We've also seen changes with extremes of heat that negatively impact health and environmental resources…and I think that is problematic." (Maryanne Bombaugh MD, MSc, MBA, FACOG, CPE)

As climate change disrupts these systems further, it is expected that these numbers will grow. For example, IPCC models an additional 183 million people globally at risk of hunger if steps are not taken to mitigate climate change.[11] These disruptions will also increase food prices, decrease nutritional quality and food safety, and impact agricultural production levels. For individuals with less economic resources, shifts in food security could be a stress multiplier and lead to worsening health disparities and chronic disease rates.

Correspondingly, these changing weather patterns can indirectly impact health outcomes in numerous ways. Mental health experts note that the compounding factors of climate change can drastically impact mental health and increase the risk of psychiatric and neurological issues.[23] Many medications taken for managing mental health issues, except for benzodiazepines, can impair the body's ability to handle heat, raising the risk of heat exhaustion and heat stroke during extreme heat events.[24,25] Prior studies have found an association between increased temperatures and increased psychological distress, and another study identified increases in suicide deaths during wildfire events in rural America.[26, 27] While these results are not definitive and cannot establish causality, we know that climate change causes eco-anxiety and distress for 68 percent of adults, per a 2020 survey of over 2000 US adults conducted by the APA and The Harris Poll.[28] Additionally, in a global study of 10,000 children and young people, many respondents experienced at least moderate worry about climate change, and 75 percent reported feeling frightened about the future.[29] There is also evidence that children who were exposed in utero to natural disasters were significantly more likely to be diagnosed with a mood disorder or attention-deficit/disruptive behavioral disorder.[30] For many families, the stress and trauma of living through an extreme event can be substantial, long-lasting, and difficult to recover from as access to behavioral health treatment can be extremely limited.[31]

In 2023, over 200 medical journals, including the Journal of the American Medical Association (JAMA), coordinated the release of an editorial declaring climate change as a global health emergency, stating that vulnerable communities will bear the highest burden of changing climates.[32] Much like the COVID-19 pandemic, the climate crisis impacts communities of color, indigenous communities, and lower income communities at a greater scale. The legacy of systemic racism and structural violence (the social structures that put people in harm's way) means that marginalized communities face significant barriers in meeting their basic needs and accessing care.[33] For example, after Hurricane Katrina struck New Orleans in August 2005, data indicates that Black families faced significantly worse storm damages compared to white communities, with 272,000 Black individuals suffering displacement by flooding or storm damage, compared to 101,000 non-Black individuals.[34] Additionally, Louisiana autopsy data indicates that over 50 percent of storm casualties were non-Hispanic Black.[35]

"It's really looking at the dichotomy of how segregation, redlining, disinvestment in communities–and how climate plays a role in that, especially how stark the health effects are." (Joanna Bisgrove, MD)

We can uncover the root causes of these disparities using a structural violence lens: Black families in New Orleans faced wealth inequities due to intersecting systems of oppression that have prevented safety and economic resources, relegating families of color to poor, lower-lying areas without access to green space that might help absorb water.[36] Racial segregation, racism, and restrictive housing covenants ensured that Black homeowners were forced into undesirable, flood-prone areas.[37] Moreover, at the time of Hurricane Katrina, 84 percent of New Orlean's poor population was Black, making evacuation exceedingly difficult for these residents. In the end, the mortality rate for black individuals was potentially four times higher than whites; as such, scholars view racism as a primary driver in the risk of poor outcomes for such communities.[38,39] Many racial health disparities still exist today and have substantial implications on primary care, including exacerbated rates of heart disease, cancer, and new cases of HIV for Black residents of New Orleans.[40]

If action is not taken against climate change, these disparities will continue and are likely to worsen for historically marginalized communities and those at higher risk of climate-related health harms. Multiple studies in a 2022 scoping review found evidence that communities of color, including Black, Hispanic/Latinx, Native American, Pacific Islander, and Asian communities, face disproportionate impacts from climate change and extreme weather events, ranging from increased risk of stroke and cardiovascular disease during heat waves, higher risk of pregnancy complications for Hispanic women during Hurricane Sandy, and increased risk of infectious diseases such as gastrointestinal illness for American Indian and Black communities in the wake of Hurricane Florence.[41] Children and the elderly are especially vulnerable to climate disasters, as both have more limited ability to care for themselves and might be more susceptible to environmental hazards such as air pollution **(Figure 4)**.[42, 43] For Indigenous communities, climate change poses a substantial threat, as these groups often have a close relationship with the land and already face significant marginalization.[44]

The evidence is clear: Climate change is a fundamental threat to human health, and action must be taken to adapt and mitigate these impacts.

Figure 4: Climate Change and Vulnerable Populations

Impact on Children

Children are more vulnerable to the adverse health effects of climate change due to factors related to their developing physiology and metabolism, unique exposure pathways, biological sensitivities, and limits to their adaptive capacity (especially to extreme heat).

Impact on People with disabilities

Populations with mobility or cognitive disabilities are likely to experience greater vulnerability to adverse health impacts responding to, evacuating, and recovering from extreme weather events.

Impact on Older Adults

Older adults are more vulnerable during extreme events that cause power outages and/or require evacuation, as they may have limited mobility. Additionally, older adults are more likely to have other pre-existing conditions, such as hypertension, and other physiological factors that increase their risk of adverse impacts from climate change.

Impact on Communities of Color

As a result of structural and historical racism, communities of color are at increased risk from climate change due to the higher likelihood of living in risk-prone areas, areas with older or poorly maintained infrastructure, or areas with an increased burden of air pollution. Additionally, communities of color may face cumulative exposure to multiple pollutants and climate related health threats.

Impact on Low-Income Communities

Populations with limited income are more likely to live in risk-prone areas, such as urban heat islands, isolated rural areas, or coastal and other flood-prone areas. They are also more likely to have limited transportation options in the event of an evacuation and limited access to and use of health care.

The groups shown above do not represent a comprehensive list of communities that face increased climate vulnerability.
Other groups include members of the LGBTQ+ community, women, people who are incarcerated or without homes, particular occupational groups, immigrants, communities with limited English proficiency, and indigenous populations.

AMA and Environmental Health: The Historical Record

From its inception in 1847, the AMA has been keenly aware that Americans' health was only as good as the environment they lived in, evidenced by a report in 1856 on sanitation in cities that advocated for government intervention in controlling pollution of cities. While AMA's early work initially focused on air and water pollution, it soon came to encompass environmental health more broadly (see timeline of AMA environmental health policy in **Appendix A**). In the 1960s, AMA created a Committee on Environmental Health and recommended the federal government play a significant role in controlling air pollution. In 1989, four years after the discovery of a hole in the ozone layer, the AMA issued a report on the effects of global climate change and joined with governmental and other organizations to work on a comprehensive national policy and program to address the adverse effects of environmental pollution, including the "greenhouse effect". The AMA continued to advocate for restrictions on pollutants, but it was not until the early 2000's that policy was adopted calling for specific actions on climate change. In 2008, the AMA's Council on Science and Public Health (CSAPH) issued a report, *Global Climate Change and Human Health* that presented the (then) current scientific evidence on climate change, discussed predicted health effects, and provided policy recommendations, which were adopted (**See Policy H-135.938)**. Within the last ten years, the AMA HOD has adopted a number of policies on climate change, air pollution, and sustainability.

Recent AMA Policy on Climate Change

In 2016, policy was adopted in support of initiatives to promote environmental sustainability and other efforts to halt global climate change. In 2022, the AMA declared climate change a public health crisis that threatens the health and well-being of all individuals, with marginalized and disadvantaged populations expected to be disproportionately impacted by changing weather patterns. That same year, the AMA's CSAPH presented a council-initiated report on this topic "due to the significant public health threat that climate change represents and the impact on the health of patients, with marginalized populations expected to be disproportionately impacted." The CSAPH report called on the AMA to protect patients by advocating for policies that:

- Limit global warming to no more than 1.5 degrees Celsius (2.7 degrees Fahrenheit)
- Reduce US greenhouse gas emissions aimed at carbon neutrality by 2050
- Support rapid implementation and incentivization of clean energy solutions and significant investments in climate resilience through a climate justice lens

Section 2. Steps to Move AMA Forward

Levers for Change

From an organizational perspective, there are several avenues AMA can take to leverage its resources to engage in climate change and health work and address the public health crisis of climate change.

Education

Providing education is a critical component of AMA's mission to "promote the art and science of medicine," which it does as an accredited provider of continuing medical education (CME) and a driving force in the modernization of physician training. The AMA accomplishes this mission in several ways - through its online learning platform, the AMA Ed Hub™, and the publication of JAMA.

AMA's Ed Hub™ brings together almost 6,000 activities and over 2,000 CME articles, podcasts, videos, and interactive modules on a wide range of issues. There are currently over 70 resources available on the Ed Hub on the topic of climate change, which will continue to grow in the future. In the summer of 2024, the AMA released a 30-minute educational module on climate change and health. The focus of the module is to bring awareness to physicians about the impact of climate change on the nation's health and to empower physicians to begin conversations with their patients about how climate change is affecting their health and what they can do about it. Additionally, *JAMA* has announced a new Climate and Health series, intended to inform readers about the associations between climate change and health and "to stimulate improved knowledge and understanding of the health effects of climate change to help foster commitment to timely action to prevent adverse health events from climate change." Through multiple channels, AMA will continue to produce and disseminate high quality educational content on climate change and health to meet the needs of physicians and the healthcare workforce.

Advocacy

The AMA's Advocacy team has a long-standing commitment to advocating at the federal and state levels. As part of our advocacy efforts, the AMA participates in the American Lung Association's (ALA) Healthy Air Partners campaign, which is a coalition of 40 national public health, medical, nursing and health care organizations engaged in healthy air advocacy efforts. The Coalition is united in its calling for strong federal laws and policies to slash air pollution and address climate change, recognizing climate change can affect air quality, and certain air pollutants can affect climate change. AMA has participated in several comments letters as part of this coalition, which are not fully enumerated below, but a few notable cases are highlighted:

- In June 2023, AMA joined 13 other health organizations in a letter to Environmental Protection Agency (EPA) on their proposed ruling regarding Pollutant Emissions Standards for Model Years 2027 and Later Light-Duty and Medium-Duty Vehicles, urging them to pass the most stringent emission standards possible with existing technologies. In March 2024, the Biden Administration finalized this rule placing stricter limits on emissions from new cars. These new rules are a big win for public health and the planet. They will improve air quality and help prevent future health harms from climate change. The new standards will avoid more than 7 billion tons of carbon emissions and provide $13 billion of annual public health benefits due to improved air quality.
- In August 2023, AMA joined ALA and other health organizations in a letter to EPA on their proposed ruling in the Reconsideration of the National Ambient Air Quality Standards for Particulate Matter, calling for the most protective standards to protect the health of the most vulnerable populations. In February 2024, EPA finalized their particulate matter rule. While the new rule did not set particulate matter at the more protective standard as advocated for by the Coalition, the revised rule did address several of our comments and the new standards will result in significantly reduced particulate matter pollution in the future.

Through its engagement with partners and as needed on a case-by-case basis, the AMA will continue to support policy and regulatory changes that advance efforts to reduce U.S. greenhouse gas emissions and improve health.

Litigation

Through the AMA's litigation center, we work to represent the interests of the medical profession on this issue in the courts by providing support or becoming actively involved in litigation of importance to physicians. The Litigation Center has engaged in a number of issues important to public health including government interference in the physician-patient relationship, the regulation of tobacco products, and firearm violence. Recent court cases centered on climate change and health (e.g., Montana), as well as the government's role in regulating greenhouse gases, highlight an area where the AMA can potentially engage moving forward.

Collaboration with external partners

In addition to its collaboration with ALA's Healthy Air Coalition, AMA partners with several other external groups that focus on climate change and health. The AMA continues to engage in the Medical Society Consortium on Climate and Health (MSCCH), which brings together associations representing over 600,000 clinical practitioners. The AMA is represented on the executive committee of this group.

The AMA is also a sponsor of the NAM Action Collaborative on Decarbonizing the Health Sector as a member of the Steering Committee and co-lead of the Health Care Delivery Workgroup. The first phase (2021-2023) of the Action Collaborative's work was focused on identifying key opportunities and challenges to climate action, decarbonization, and building resiliency across the health sector and developing resources and tools to meet those needs. The collaborative, through the work of the members, has developed over thirty resources to accelerate climate action across the health sector. The second phase (2024-2025) is focused on accelerating a national climate and health movement, as well as advancing the successes of the existing working groups and launching an accelerator pilot program. The AMA has sent an invitation to the Federation of Medicine inviting groups to join us in accelerating the climate and health movement.

Lastly, the AMA is represented on the American Public Health Association's (APHA) Center for Climate, Health, and Equity Advisory Board. APHA's Center for Climate, Health and Equity leads public health efforts to inspire action on climate and health, advance policy and galvanize the field to address climate change. The Advisory Board assists in refining and implementing APHA's Center for Climate, Health, and Equity strategic plan.

Organizational sustainability efforts

The AMA is committed to improving its environmental sustainability and will continue to implement several ongoing initiatives but also expand upon them. AMA's Chicago headquarters are located in a LEED-Gold certified building and multiple upgrades in the building are making it even more energy efficient. The building has also implemented several water conservation programs and a composting program. AMA's robust telework policy and promotion of a hybrid working environment, utilization of a shuttlebus service, bike area, on-site Zipcars and scooter and hybrid vehicle parking contribute to carbon emission reductions. AMA has published updates on these environmental sustainability initiatives (BOT Report 25-A-24) and will do so again for the 2024 interim meeting of the AMA House of Delegates.

Strategic approaches to address climate change

The AMA's response to public health crises is typically focused on (1) ensuring physicians and trainees have the data and resources needed; (2) identifying evidence-based policies and interventions; (3) elevating the voices of physician leaders through AMA channels and platforms; and (4) convening and collaborating with stakeholders to advance priority policies and interventions. These strategic approaches overlap and dovetail well with the different levers of change identified above.

To ensure our climate change strategy is consistent with our other work on other public health crisis, the AMA has identified the following four strategic approaches to address climate change:

1. Educate physicians and trainees on the health effects of climate change.
2. Identify and disseminate information to physicians on decarbonizing the health care sector, reducing GHG emissions, as well as improving adaptation and resilience efforts.
3. Elevate the voices of physician leaders on the issue of climate change and health.
4. Collaborate with stakeholders to advance policies and interventions with a unified voice.

Measuring our effectiveness

We are committed to advancing our strategic priorities on this critical public health issue and will track our progress using several performance indicators for each of four strategic approaches. Performance measures for each of our strategic approaches will address:

1. How much did we do? (For example, the number of events and/or activities completed)
2. How well did we do it? (For example, the number of educational products or events that were of high quality)

To ensure transparency and accountability, regular updates on our progress will be provided to the House of Delegates in the AMA's annual public health strategy report.

Section 3. Key Accomplishments and Future Actions

Strategic Approach	Key Accomplishments (2022 – 2024)
Educate physicians and trainees on the health effects of climate change.	Made climate change education available via the Ed Hub™ from a variety of sources including the *AMA Journal of Ethics, JAMA*, the American Public Health Association (APHA), and UC Center for Climate, Health and Equity (Ongoing). *JAMA* announced new series on climate and health intended to inform readers about the associations between climate change and health (2024). AMA's Center for Health Equity released an episode as part of the Prioritizing Equity series featuring physicians and scholarly leaders advocating for equitable climate action to remedy the disproportionate burden of health harms climate crisis puts on historically marginalized communities (2024). AMA climate change and health module being developed to be disseminated via the AMA Ed Hub™ (Coming in 2024).
Identify and disseminate information to physicians on decarbonizing the health care sector, reducing GHG emissions, as well as improving adaptation and resilience efforts.	The Council on Science and Public Health (CSAPH) initiated a report on *Climate Change in Human Health* and resulting policy calling for a 50 percent reduction in emissions by 2030 and for the health sector to lead by example in committing to carbon neutrality by 2050 (2022). Hosted an educational session at I-23 entitled *The Climate Crisis: Pathways to Decarbonizing the U.S. Health Sector* in collaboration with the National Academy of Medicine (NAM) (2023). AMA Update episode featured Dr. Victor Dzau, President of the NAM, who discussed how the Action Collaborative on Decarbonizing the U.S. Health Sector is bringing together organizations across medicine to act on climate change (Nov. 2023). CSAPH Report on *Sustainability in the Operating Room* adopted at HOD I-23. Dissemination of materials and resources for implementation of the Inflation Reduction Act (IRA) through NAM Collaborative. CSAPH report on *Reducing Hydrofluorocarbon in Health Care* adopted at A-24. BOT report on Carbon Pricing developed for I-24.
Elevate the voices of physician leaders on the issue of climate change and health.	AMA Update video and podcast series featured Renee Salas, MD, MPH, MS, a climate and health expert and emergency medicine physician who discussed research on the intersection of health and the climate crisis (Jan. 2022). AMA Update video and podcast series featured Colin Cave, MD, medical director of external affairs, government relations and community health at Northwest Permanente who discussed the link between health and climate change, and how physicians and health systems can be a part of the solution (Aug 2022). AMA conducted listening sessions with physicians to gauge their level of knowledge on climate change and elicit feedback on AMA strategy moving forward (May 2023). AMA staff participated in a plenary panel session entitled, "Climate – Impact on Health and Health Care" at AcademyHealth's 2023 Annual Research Meeting (June 2023). AMA's Chief Health & Science Officer joined the PermanenteDocs Chat podcast on heat waves and health, with a focus on how physicians can adjust to prepare to care for heat-related conditions brought on by climate change (Aug. 2023). The AMA STEPS Forward® Podcast featured Dr. Jerry Abraham, who discussed the intersections between the social determinants of health and climate change impacts (Feb. 2024). AMA staff developed and distributed a survey to physicians to assess perceptions on climate change and health (2024).
Collaborate with stakeholders to advance policies and interventions with a unified voice.	Launched a dedicated page on the AMA website, *Advocacy in action: Combatting health effects of climate change,* to highlight AMA's position on this issue, how it is engaged, and resources for physicians (2023). Sponsored the NAM Action Collaborative on Decarbonizing the US Health Sector (2021-Present). Participated in the MSCCH, and the American Lung Association's Healthy Air Partners coalition. AMA staff member serves on APHA Climate, Health, and Equity Advisory Board. Signed three letters in support of EPA policy to reduce greenhouse gas emissions and air pollution. Joined the MSCCH and 34 other health care organizations in sending a letter to the House of Representatives Agriculture Committee on the U.S. Farm Bill reauthorization (March 2024).

Section 3. Key Accomplishments and Future Actions

Strategic Approach	Proposed Actions
Educate physicians and trainees on the health effects of climate change.	Seek funding and opportunities for collaboration to support additional educational content on climate change, environmental justice, and health. Release additional CME module or content on climate change and health.
Identify and disseminate information to physicians on decarbonizing the health care sector, reducing GHG emissions, as well as improving adaptation and resilience efforts.	Disseminate relevant resources produced by the NAM Action Collaborative to Decarbonize the Health Sector. Study issues relating to decarbonization, climate change, and environmental sustainability as requested by the HOD. Publish an updated Green Practice Guide to the AMA website. Identify additional methods of dissemination for AMA's climate-related policies and positions, such as fact sheets or podcasts.
Elevate the voices of physician leaders on the issue of climate change and health.	Disseminate results from the AMA climate change survey through peer-reviewed journal publication and/or conference presentations. Participate in relevant national meetings and elevate AMA's policies and positions on climate change. Feature physician leaders on AMA platforms addressing the topic of climate change and health.
Collaborate with stakeholders to advance policies and interventions with a unified voice.	Continue to participate in multiple coalitions on climate change and health. Advocate for laws and regulations consistent with AMA climate change policies. File amicus briefs determined to be aligned with AMA's climate change policies and of importance to physicians.

Appendix A. A History of AMA's Environmental Health Policy and Research (1856-1960)

1856

A report on sanitation of cities calls for government intervention in the pollution of cities (Report on the Sanitary Police of Cities, A-1856).

1875

AMA adopts policy calling on the chief officer of the Signal Service Corps to have the quantity of ozone in the atmosphere telegraphed and published in weather reports. At this time, scientists believed ozone was a healthy component of the environment (Minutes of the 26th Annual Meeting, A-1875).

1891

In calling for the creation of a cabinet appointment of a Secretary of Public Health, environmental protection initiatives are cited noted as being supported by such a position (Report of the Committee on the Question of a Cabinet Appointment of a Secretary of Public Health, A-1891).

1905

AMA committee on Medical Legislation notes the importance of doctors weighing in on legislation regarding the protection of streams from pollution, among other public health initiatives (Report of Committee on Medical Legislation, A-05).

1946

In an address before the HOD, Rear Admiral J.T. Boone of the US Navy decried the pollution in Appalachia caused by coal mining (Address of Rear Admiral J.T. Boone, I-46).

1949

AMA's Council on Industrial Health holds a panel on scientific developments in the field including atmospheric pollution, toxic chemical and other harmful biological exposures (Report of Council on Industrial Health, A-49).

1955

AMA supports the creation of grants intended to provide funding for research on air pollution (Report of Washington Office, I-55).

1960

The Environmental Medicine Division is formed to address socio-economic issues affecting health care. Later known as Environmental Medicine and Medical Services (EMMS), the division oversaw initiatives addressing public health and professional issues as diverse as air pollution, school health, fitness, international health, health care for jail inmates, physician placement, and practice development (BOT Report, I-60).

Appendix A. A History of AMA's Environmental Health Policy and Research (1962-1973)

1962

AMA forms a Committee on Environmental Health (Address of the President, A-62).

1963

AMA recommends the federal government play a significant role in controlling air pollution (BOT Report, A-63)

1964

AMA has its first Congress on Environmental Health Problems (BOT Report, I-64).

1965

- AMA officially recognizes the importance and complexity of air pollution and creates a medical basis for establishing standards and objectives for the guidance of groups such as government agencies, medical organizations, and industrial and private organizations (BOT Report, A-65);
- AMA's Committee on Environmental Health is elevated to the more permanent status of "council" (BOT Report, I-65).

1967

AMA supports the Air Quality Act of 1967, but advocates against the establishment of industry-wide pollution standards in favor of individualized standards depending on the location of the polluting facility (Legislative Department Annual Report, I-67).

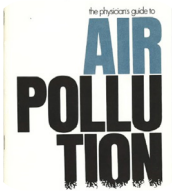
1969

AMA recognizes rapidly increasing air pollution hazards and calls on the medical profession to exert leadership in the search for effective solutions (Res. 55, I-69).

1971

AMA adopts policy calling for the Federal Environmental Protection Agency to have jurisdiction over all other federal agencies to set environmental quality standards and enforce compliance (Res. 60, I-71).

1973



AMA reaffirms support for the present levels and time schedules to reduce air pollution as promulgated by the Clean Air Act of 1970 (Res. 61, A-73).

Appendix A. A History of AMA's Environmental Health Policy and Research (1978-2009)

1978

AMA adopts policy on the hazards of nuclear, fossil, and alternative-energy generating sources. (Report of the Council on Scientific Affairs, A-78).

1989

- AMA issues a report on the effects of global climate change (Report of Council on Scientific Affairs, A-89).
- AMA joins with governmental and other organizations to achieve a comprehensive national policy and program to address the adverse effects of environmental pollution, including the "greenhouse effect". (Res. 43, A-89)
- AMA adopts policy on stewardship of the environment, calling on physicians to be spokespersons for environmental health (Report of Council on Scientific Affairs, I-89).

1992

AMA encourages physicians and environmental scientists to continue to incorporate concerns for human health into environmental research and public policy initiatives and encourages physician educators to devote more attention to environmental health issues (Report of Council on Long Range Planning and Development, I-92).

1995

AMA adopts policy calling for leadership and participation in a major education and prevention program to inform patients of the negative effects of air pollution on health (Res. 404, I-95).

2004

AMA adopts policy encouraging the Environmental Protection Agency (EPA) to finalize the most stringent feasible standards to control pollutant emissions from road engines (Res. 428, A-2004).

2008

- AMA encourages physicians to participate in regional and state decision-making regarding air pollution (Res. 408, A-2008);
- AMA supports green initiatives and anti-pollution programs (Report of the Council on Science and Public Health, I-2008);
- AMA issues a report on global climate change and concludes that human activity represents a significant contribution to the phenomenon. New policy is adopted educating the medical community on the potential adverse effects of climate change and supporting research to create evidence-based climate change policy decisions (Report of Council on Science and Public Health, I-2008).

2009

AMA issues a report on its efforts toward making the AMA "greener" (BOT Report, A-2009).

Appendix A. A History of AMA's Environmental Health Policy and Research (2010-2022)

2010

AMA policy supports the Environmental Protection Agency (EPA)'s effort to promulgate rules to regulate and control greenhouse gas emissions (Res. 925, I-2010).

2014

AMA formally supports the Environmental Protection Agency (EPA)'s regulation of carbon emissions (Res. 421, A-2014).

2015

AMA joins Royal Australasian College of Physicians Consensus Statement: Act now to reduce the damaging health impacts of climate change.

2016

- AMA adopts policy in support of initiatives to promote promote environmental sustainability and other efforts to halt global climate change (Res. 924, I-2016).
- AMA joins the Medical Society Consortium on Climate Change and Health.

2017

AMA adopts policy in support of evidence-based environmental statutes and regulations intended to regulate air and water pollution and reduce greenhouse gas emissions (Res. 523, A-2017).

2018

- AMA adopts policy to protect and maintain the Clean Air Act (Res. 917, I-2018);
-Policy calls on the AMA and its affiliated corporations to "work in a timely, incremental, and fiscally responsible manner, to the extent allowed by their legal and fiduciary duties, to end all financial investments or relationships… with companies that generate the majority of their income from… fossil fuels" (BOT Report, A-2018).

2019

-AMA adopts policy in support of teaching about climate change in undergraduate, graduate, and continuing medical education (Res. 302, A-2019);
- AMA adopts policy in support of exploring environmentally sustainable practices for *JAMA* distribution (BOT Report, I-2019).
- AMA joins the U.S. Call to Action on Climate, Health, and Equity: A Policy Action Agenda that lists ten policy recommendations and strategies for simultaneously tackling climate change, health, and equity.

2020

AMA sends a letter to President Trump declaring "there is no single step that will do more for the health of all Americans than remaining in and meeting our obligations to the Paris Climate Agreement" (AMA Press Release, 1-10-2020).

2021

AMA joins National Academy of Medicine Action Collaborative on Decarbonizing the U.S. Health Sector.

2022

- AMA declares climate change a public health crisis (Res. 420, A-2022);
- AMA calls on the health care sector to take the lead in mitigating climate change by committing to carbon neutrality by 2050 (AMA Press Release, 11-15-2022).

References

1. Nations U. What Is Climate Change? United Nations. Accessed July 17, 2024. https://www.un.org/en/climatechange/what-is-climate-change

2. US EPA O. Overview of Greenhouse Gases. Published December 23, 2015. Accessed July 23, 2024. https://www.epa.gov/ghgemissions/overview-greenhouse-gases

3. Steamy Relationships: How Atmospheric Water Vapor Amplifies Earth's Greenhouse Effect - NASA Science. Accessed July 23, 2024. https://science.nasa.gov/earth/climate-change/steamy-relationships-how atmospheric-water-vapor-amplifies-earths-greenhouse-effect/

4. US EPA O. What is Ozone? Published March 21, 2016. Accessed July 23, 2024. https://www.epa.gov/ozone-pollution-and-your-patients-health/what-ozone

5. CDC. About Air Quality. Air Quality. Published June 6, 2024. Accessed July 23, 2024. https://www.cdc.gov/air-quality/about/index.html

6. Office of Energy Efficiency and Renewable Energy. Renewable Energy. Energy.gov. Accessed July 23, 2024. https://www.energy.gov/eere/renewable-energy

7. Office of Energy Efficiency and Renewable Energy. Biofuel Basics. Energy.gov. Accessed July 23, 2024. https://www.energy.gov/eere/bioenergy/biofuel-basics

8. University of California Center for Climate Justice. What is Climate Justice? UC Center for Climate Justice. Accessed July 23, 2024. https://centerclimatejustice.universityofcalifornia.edu/what-is-climate-justice/

9. United Nations Climate Change. Introduction | UNFCCC. Accessed July 23, 2024. https://unfccc.int/topics/adaptation-and-resilience/the-big-picture/introduction

10. Decarbonization cannot wait | UNFCCC. Accessed July 23, 2024. https://unfccc.int/news/decarbonization-cannot-wait

11. Paglia E, Parker C. The Intergovernmental Panel on Climate Change: Guardian of Climate Science. In: *Guardians of Public Value: How Public Organisations Become and Remain Institutions*. Springer International Publishing; 2021:295-321. doi:10.1007/978-3-030-51701-4_12

12. Intergovernmental Panel On Climate Change (Ipcc). *Climate Change 2021 – The Physical Science Basis: Working Group I Contribution to the Sixth Assessment Report of the Intergovernmental Panel on Climate Change*. Cambridge University Press; 2023. doi:10.1017/9781009157896

13. Rebecca Lindsey, Luann Dahlman. Climate Change: Global Temperature | NOAA Climate.gov. January 18, 2024. Accessed July 17, 2024. http://www.climate.gov/news-features/understanding-climate/climate-change-global-temperature

14. American Medical Association. *Advancing Health Equity: A Guide to Language, Narrative and Concepts.*; 2021. https://www.ama-assn.org/system/files/ama-aamc-equity-guide.pdf

15. World Health Organization. *Protecting Maternal, Newborn and Child Health from the Impacts of Climate Change | A Call for Action*.; 2023. https://iris.who.int/bitstream/handle/10665/374272/9789240085350-eng.pdf?sequence=1

16. World Health Organization. Heatwaves. Health Topics | Heatwaves. Accessed July 17, 2024. https://www.who.int/health-topics/heatwaves

17. Desai Y, Khraishah H, Alahmad B. Heat and the Heart. *Yale J Biol Med*. 2023;96(2):197-203. doi:10.59249/HGAL4894

18. US EPA O. Climate Change Indicators: Heat Waves. Published February 4, 2021. Accessed July 17, 2024. https://www.epa.gov/climate-indicators/climate-change-indicators-heat-waves

19. National Institute of Environmental Health Sciences. Health Impacts of Extreme Weather. National Institute of Environmental Health Sciences. Accessed July 17, 2024. https://www.niehs.nih.gov/research/programs/climatechange/health_impacts/weather_related_morbidity

20. American Lung Association. *State of the Air 2024 Report*. https://www.lung.org/getmedia/dabac59e-963b-4e9b-bf0f-73615b07bfd8/State-of-the-Air-2024.pdf

21. United States Interagency Council on Homelessness. Homelessness and Climate Change: A Roundup of Resources for Communities Before, During, and After Disasters. Accessed July 23, 2024. https://www.usich.gov/guidance-reports-data/federal-guidance-resources/homelessness-and-climate-change-roundup-resources

22. Economic Research Service U.S. Department of Agriculture. USDA ERS - Key Statistics & Graphics. Published October 25, 2023. Accessed July 17, 2024. https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-u-s/key-statistics-graphics/

References (Continued)

23. American Psychiatric Association. Climate Change and Mental Health Connections. Published May 2023. https://www.psychiatry.org:443/patients-families/climate-change-and-mental-health-connections

24. Pappas S. How heat affects the mind. *Monit Psychol*. 2024;55(4). Accessed August 20, 2024. https://www.apa.org/monitor/2024/06/heat-affects-mental-health

25. Substance Abuse and Mental Health Services Administration. *Tips for People Who Take Medication: Coping with Hot Weather*. Accessed August 20, 2024. https://store.samhsa.gov/sites/default/files/pep23-01-01-001.pdf

26. Charlson F, Ali S, Benmarhnia T, et al. Climate Change and Mental Health: A Scoping Review. *Int J Environ Res Public Health*. 2021;18(9):4486. doi:10.3390/ijerph18094486

27. Molitor D, Mullins JT, White C. Air pollution and suicide in rural and urban America: Evidence from wildfire smoke. *Proc Natl Acad Sci U S A*. 120(38):e2221621120. doi:10.1073/pnas.2221621120

28. American Psychological Association. Majority of US adults believe climate change is most important issue today. https://www.apa.org. February 6, 2020. Accessed July 17, 2024. https://www.apa.org/news/press/releases/2020/02/climate-change

29. Hickman C, Marks E, Pihkala P, et al. Climate anxiety in children and young people and their beliefs about government responses to climate change: a global survey. *Lancet Planet Health*. 2021;5(12):e863-e873. doi:10.1016/S2542-5196(21)00278-3

30. Nomura Y, Newcorn JH, Ginalis C, et al. Prenatal exposure to a natural disaster and early development of psychiatric disorders during the preschool years: stress in pregnancy study. *J Child Psychol Psychiatry*. 2023;64(7):1080-1091. doi:10.1111/jcpp.13698

31. Rachel Nuzum, Reginald D. Williams II, Nathaniel Counts, Sara Federman, Celli Horstman. Expanding Access to Equitable Behavioral Health Services. The Commonwealth Fund. doi:10.26099/8HEZ-2R63

32. Abbasi K, Ali P, Barbour V, et al. Time to treat the climate and nature crisis as one indivisible global health emergency. *BMJ*. 2023;383:p2355. doi:10.1136/bmj.p2355

33. Farmer PE, Nizeye B, Stulac S, Keshavjee S. Structural Violence and Clinical Medicine. *PLOS Med.* 2006;3(10):e449. doi:10.1371/journal.pmed.0030449

34. Gabe T, Falk G, McCarty M, Mason VW. Hurricane Katrina: Social-Demographic Characteristics of Impacted Areas.

35. Markwell P, Ratard R. Deaths Directly Caused by Hurricane Katrina. https://ldh.la.gov/assets/oph/Center-PHCH/Center-CH/stepi/specialstudies/2014PopwellRatard_KatrinaDeath_PostedOnline.pdf

36. Thomas Frank. Flooding Disproportionately Harms Black Neighborhoods. Scientific American. June 2, 2020. Accessed July 17, 2024. https://www.scientificamerican.com/article/flooding-disproportionately-harms-black-neighborhoods/

37. Morse R. *ENVIRONMENTAL JUSTICE THROUGH THE EYE OF HURRICANE KATRINA*. Health Policy Institute https://inequality.stanford.edu/sites/default/files/media/_media/pdf/key_issues/Environment_policy.pdf

38. Lowe SR, Lustig K, Marrow HB. African American Women's Reports of Racism during Hurricane Katrina: Variation by Interviewer Race. *New Sch Psychol Bull*. 2011;8(2):46-57.

39. Brunkard J, Namulanda G, Ratard R. Hurricane Katrina deaths, Louisiana, 2005. *Disaster Med Public Health Prep.* 2008;2(4):215-223. doi:10.1097/DMP.0b013e31818aaf55

40. Peter J Fos, Peggy A Honore, Katrina P Kellum. Health and Wellness in New Orleans 15 Years After Hurricane Katrina: Implications for Primary Care. *Int J Fam Med Prim Care*. https://sph.lsuhsc.edu/wp-content/uploads/2020/10/health-and-wellness-in-new-orleans-15-years-after-hurricane-katrina-6315.pdf

41. Berberian AG, Gonzalez DJX, Cushing LJ. Racial Disparities in Climate Change-Related Health Effects in the United States. *Curr Environ Health Rep.* 2022;9(3):451. doi:10.1007/s40572-022-00360-w

42. US EPA O. Climate Change and the Health of Older Adults. March 21, 2022. Accessed July 24, 2024. https://www.epa.gov/climateimpacts/climate-change-and-health-older-adults

43. Gamble JL, Balbus J, Berger M, et al. Ch. 9: *Populations of Concern. The Impacts of Climate Change on Human Health in the United States: A Scientific Assessment*. U.S. Global Change Research Program; 2016. doi:10.7930/J0Q81B0T

44. United Nations. Climate Change | United Nations For Indigenous Peoples. Accessed July 17, 2024. https://www.un.org/development/desa/indigenouspeoples/climate-change.html

AMA
AMERICAN MEDICAL ASSOCIATION

REPORT 20 OF THE BOARD OF TRUSTEES (I-24)
2024 AMA Advocacy Efforts

EXECUTIVE SUMMARY

Policy G-640.005, "AMA Advocacy Analysis," calls on the Board of Trustees (the Board) to provide a report to the House of Delegates (HOD) at each Interim Meeting highlighting the year's advocacy activities and should include efforts, successes, challenges, and recommendations/actions to further optimize advocacy efforts. The Board has prepared the following report to provide an update on American Medical Association (AMA) advocacy activities for the year. (Note: This report was prepared in August based on approval deadlines, so more recent developments may not be reflected in it.)

In 2024, our AMA fought forcefully on behalf of physicians and patients on the most critical health care issues:

- Reforming Medicare physician payment;
- Fixing prior authorization;
- Promoting physician-led team-based care;
- Improving physician wellness and reducing burnout; and
- Making technology work for physicians.

Physicians identify these issues as the most vital to establishing and maintaining thriving practices.

The AMA is also seeking to advance AMA policy on a host of other health care issues under consideration at the federal and state levels including physician-owned hospitals; physician workforce; non-compete agreements; Medicaid/CHIP; government intrusion into clinical care; firearm violence; maternal health; the overdose epidemic; climate change; and nutrition.

Updates on all these efforts are also included in this report. HOD members are also strongly encouraged to read Advocacy Update which comes out every other Friday and provides updates on AMA legislative, regulatory, and private sector efforts. Every HOD member should be receiving Advocacy Update, but if you are not, please sign up at this link.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 20-I-24

Subject: 2024 AMA Advocacy Efforts

Presented by: Michael Suk, MD, JD, MPH, MBA, Chair

BACKGROUND

Policy G-640.005, "AMA Advocacy Analysis," calls on the Board of Trustees (the Board) to provide a report to the House of Delegates (HOD) at each Interim Meeting highlighting the year's advocacy activities and should include efforts, successes, challenges, and recommendations/actions to further optimize advocacy efforts. The Board has prepared the following report to provide an update on American Medical Association (AMA) advocacy activities for the year. (Note: This report was prepared in August based on approval deadlines, so more recent developments may not be reflected in it.)

DISCUSSION OF 2024 ADVOCACY EFFORTS

In 2024, our AMA fought forcefully on behalf of physicians and patients on the most critical health care issues:

- Reforming Medicare physician payment;
- Fixing prior authorization;
- Promoting physician-led team-based care;
- Improving physician wellness and reducing burnout; and
- Making technology work for physicians.

The AMA has prioritized these issues based on HOD-adopted policy, physician polling, their overarching nature, and the opportunity to affect change. Making progress on these issues is vital to establishing and maintaining thriving practices. The AMA is also seeking to advance AMA policy on a host of other health care issues under consideration at the federal and state levels. Updates on these additional efforts are also included in this report.

It is abundantly clear that physician practices are facing difficult headwinds on several fronts from payment cuts to administrative hurdles to government interference in the provision of care. Many physicians are highly frustrated with how policymakers are addressing or failing to address critical health care issues. AMA leadership including the Board, senior management, and frontline lobby staff share this high level of frustration and are committed to achieving meaningful progress to alleviate the untenable pressures facing physician practices.

As of August, the AMA has sent close to 150 letters to federal and state policymakers advocating for AMA policy. Many of these letters stem directly from HOD resolutions. Further, some were sign-on letters written in conjunction with the Federation of Medicine, and the AMA is grateful for the partnership. The AMA has also launched strong grassroots campaigns on several issues with more details included later in this report.

Medicare Payment Reform

The AMA shares its members' long frustration over the continued cuts to Medicare payment. Congress did mitigate about half of the 2024 Medicare physician payment cuts initially implemented despite urgent calls from physicians about the impact that two decades of annual payment cuts are having on practice viability and patient access to care. Adding salt to the wound is the proposed 2025 Physician Payment Rule that includes a 2.8 percent cut. Meanwhile, the Centers for Medicare & Medicaid Services (CMS) predicts that the Medicare Economic Index (MEI) will increase by 3.6 percent in 2025. Further, the fiscal stability of physician practices and long-term viability of the nation's entire health care system is at stake because Medicare physician payment rates have plummeted 29 percent from 2001 to 2024 (adjusted for inflation in practice costs).

Fixing our unsustainable Medicare payment system will remain AMA's top advocacy priority until meaningful reform is achieved, and the AMA has committed significant additional resources to this campaign in 2024.

The AMA has worked with the Federation to develop Medicare payment reform pillars and is advocating for legislation introduced at the behest of the AMA to address each of them.

<u>Medicare Reform: Automatic Annual Inflation-based Updates</u>
In response to AMA advocacy, Congress took an important first step last year toward Medicare reform with the introduction of H.R. 2474, "The Strengthening Medicare for Patients and Providers Act," a bipartisan bill that would provide automatic, annual payment updates to account for practice cost inflation as reflected in the MEI. Tying annual payment updates to the MEI has long been supported by the AMA because it would place physicians on equal ground with other health care providers.

<u>Medicare Payment Reform: Budget Neutrality</u>
A bill strongly supported by the AMA was introduced in the House by the co-chairs of the GOP Doctors Caucus (H.R. 6371) and is based on AMA recommendations to reform the budget neutrality policies that have been producing across-the-board payment cuts. The bill would require CMS to review actual claims data and correct flawed utilization projections that cause inappropriate conversion factor cuts or increases; raise the spending threshold that triggers a budget neutrality adjustment from $20 million to $53 million; and limit destabilizing swings in payment by limiting budget neutrality adjustments to 2.5 percent in any given year.

<u>Medicare Payment Reform: Revising the Merit-based Incentive Payment System (MIPS)</u>
Together with the Federation, the AMA has developed legislative language to improve the MIPS program. The draft would address steep penalties that are distributed unevenly and disproportionately impact small, rural, and independent practices; hold CMS accountable for providing physicians with timely and actionable data; and reform MIPS so that it is more clinically relevant and less burdensome.

Although the MIPS reform proposals were more recently introduced to policymakers, the AMA was successful in persuading the Senate Appropriations Committee to include relevant report language for its FY 2025 budget bill "urging CMS to improve timely access to MIPS feedback reports and claims data...consistent with current law." The Committee goes on to request an update from CMS next year on various issues related to national specialty society-developed quality measures and their use in clinical quality data registries.

In a further positive sign, a bipartisan coalition of U.S. Senators created a Medicare payment reform working group that has been examining proposals for long-term reforms to the physician fee schedule and updates to the Medicare Access and CHIP Reauthorization Act (MACRA). AMA has been engaging with this group and responded in detail to a physician payment reform white paper that they issued. Further, MedPAC and the Medicare Trustees have both acknowledged the unsustainability of the current system and the need for significant payment reform which is helpful as the AMA and Federation seek long-term improvements to the Medicare payment system.

The AMA has been meeting directly with key Congressional offices, particularly House and Senate leadership, committee members and staff, members of the Doctors Caucus, and other champions for medicine, as well as with CMS and MedPAC, to advocate for our reform proposals. Staff has also been instrumental this year in persuading members of Congress to circulate their own Dear Colleague sign-on letters to Congressional leadership expressing support for various reform elements, notably about the need for an annual inflation update. Bill cosponsorship campaigns have been successful, with 154 (as of early August) cosponsoring H.R. 2474, the annual MEI update legislation, despite the high cost of the proposal.

From a research perspective, the AMA has also launched the Physician Practice Information Survey to update physician practice cost data utilized in the Medicare Resource-Based Relative Value Scale and the MEI. More than 10,000 physician practices have been contacted to participate in the effort. Data from the effort will be summarized in late 2024 to share with CMS and to be used in AMA advocacy efforts.

Following up on public polling and focus groups held last year, the AMA conducted additional polling this year of physicians and patients to further test our Medicare advocacy messaging and obtain more specific information about the impact of escalating practice costs and declining payments on patient access to care.

To support the Medicare legislation cited above, the AMA has been engaged in a major grassroots campaign to engage patients and physicians in our lobbying efforts. The following statistics result from the Fix Medicare Now campaign and engagement with the Physician Grassroots Network and Patients Action Network.

- 90.9MM+ Impressions
- 1.5MM+ Engagements
- 2,000+ #FixMedicareNow Social Media Mentions
- 397k messages sent to Congress
- 504k+ FixMedicareNow.org Pageviews
- 423k+ FixMedicareNow.org Site Users
- 1000+ earned media stories on Medicare, including more than 50 placements giving voice to physician leaders and third parties – making the case for reforming the system and stopping/reversing the cuts. (These efforts have had an organic impact on thought leaders and policy analysts who are now beginning to express similar views independently.)

A good example of the campaign is a promotional series that the AMA is running at the Politico site and other influential web properties. Activities ramping-up in the summer will continue to intensify through the fall and in anticipation of a Congressional "lame duck" session that will tackle Medicare. These include engaging both patient and physician audiences during Congress' month-long August Recess, helping them identify opportunities to contact and meet with their federal legislators and staff equipped with 'action kits' (that include talking points, supportive

charts/data, and feedback forms) that reinforce medicine's position. Other tactics include aggressive paid promotion that hit lawmakers in Washington, D.C. and their home states/districts with a battery of messaging online, in print, radio, and TV/streaming services ensuring the issue is top-of-mind for them and their constituents ahead of critical elections in November. Additionally, the AMA will leverage earned media efforts, physician grasstops, and allied influencer engagement that brings together the most influential voices to put direct/public pressure on key legislators.

When Congress returns in the fall and throughout their lame duck session, these activities will continue to ratchet-up in addition to other potential activities including coordinated social media and phone storms/blitzes as determined necessary at key times in anticipation of Congressional action.

Please see Board Report 22-A-24 for more details on AMA Medicare payment reform efforts.

Prior Authorization

Prior authorization is a remarkable frustration for physicians due to its excessive use by insurance companies to delay or deny patient care, and its use directly correlates with poorer health care outcomes. According to the most recent AMA research, overuse of prior authorization leads to:

- Patient Harm - Nearly one in four physicians (24 percent) reported that prior authorization has led to a serious adverse event for a patient in their care, including hospitalization, permanent impairment, or death.
- Bad Outcomes - More than nine in 10 physicians (93 percent) reported that prior authorization has a negative impact on patient clinical outcomes.
- Delayed Care - More than nine in 10 physicians (94 percent) reported that prior authorization delays access to necessary care.
- Disrupted Care - More than three-fourths of physicians (78 percent) reported that patients abandon treatment due to authorization struggles with health insurers.
- Lost Workforce Productivity - More than half of physicians (53 percent) who cared for patients in the workforce reported that prior authorizations had impeded a patient's job performance.

The AMA has led a grassroots campaign for several years focused on "fixing prior auth" which has contributed to much of the progress that has been made on this issue. The AMA secured an important victory for physicians in the CMS final rule that requires government-regulated health plans to reduce the timeframes for prior authorization decisions and to publicly report program metrics, which will reduce care delays and improve transparency. These plans will also be required to offer electronic prior authorization technology that directly integrates with EHRs, significantly reducing unnecessary burden for physicians, resulting in an estimated $15 billion in savings over 10 years according to the Department of Health and Human Services (HHS). These changes build on new regulatory requirements that went into effect in January that ensure validity of prior authorization clinical criteria and protections for care continuity in Medicare Advantage plans.

The AMA is also advocating for the "Improving Seniors' Timely Access to Care Act" in both the House and Senate to codify and expand on prior authorization reforms finalized by CMS. This bill is even more important and is needed to memorialize the CMS rule in light of the *Loper Bright Enterprises v. Raimondo* ruling which may limit agency regulatory authority. The AMA successfully sought the reintroduction of the "Getting Over Lengthy Delays in Care as Required by Doctors (GOLD CARD) Act," which would exempt qualifying physicians from Medicare Advantage plans' prior authorization requirements.

The AMA continues to work to provide medical societies with legislative language, talking points, data, and other resources to push for important prior authorization reforms in state legislatures. The AMA is also lobbying national policymaking organizations (e.g., the National Association of Insurance Commissioners) on the importance of reform and working closely with coalitions of other impacted organizations to make the case for important patient protections from payers' utilization management requirements.

So far in 2024, 12 prior authorization reform bills have been enacted at the state level with AMA support. Broadly, state bills are aiming to decrease the growing volume of prior authorization requirements, reduce delays in patient care associated with prior authorization, improve the transparency of prior authorization rules, and increase reporting of prior authorization data.

For example, Vermont Governor Phil Scott recently signed a bill championed by the Vermont Medical Society that limits prior authorization requirements on primary care physicians and helps ensure that patients with chronic conditions will not have to continuously seek repeat approvals. The new law will also require that urgent prior authorization requests are responded to within 24 hours. Additionally, and uniquely, the law requires health plans and physicians and other health care providers to report to the legislature in coming years on the impact of the law. Additional prior authorization reform laws were enacted in California, Colorado, Illinois, Maine, Maryland, Minnesota, Mississippi, New Jersey, Oklahoma, Virginia, Wyoming, and the District of Columbia.

The AMA is also working on a host of other payer issues including continuing to address No Surprises Act implementation issues with the administration, Congress and in the courts as this issue continues to play out. Recent court decisions, initiated by the Texas Medical Association and supported by the AMA, have resulted in a fairer dispute resolution process. The AMA also assisted the state medical associations in California and North Carolina to prevent the implementation of harmful modifier 25 policies by Blue Cross Blue Shield plans in those states. Finally, the AMA is supporting bipartisan legislation to hold health plans responsible for inaccurate provider directories under Medicare Advantage.

Physician-Led Team-Based Care

The AMA strongly supports physician-led team-based care where all members of the team use their unique knowledge and valuable contributions to improve patient outcomes. Removing physicians from the care team results in higher costs and lower quality of care. Patients deserve access to a physician leading their care team.

The AMA Scope of Practice Partnership (SOPP), a coalition of 105 national, state and specialty medical associations, has been instrumental in defeating scope expansion bills across the U.S. The SOPP has awarded more than $4 million in grants to its members to fund advocacy tools and campaigns since 2007. The SOPP Steering Committee has awarded 10 grants for 2024 to the state medical associations in the following states: Alabama, Georgia, New York, Oklahoma, Pennsylvania, South Carolina, Tennessee, Texas, and Utah, plus the District of Columbia. In addition, the Mississippi State Medical Association and South Dakota State Medical Association received grants in 2023 for the 2024 legislative sessions. These grants are instrumental in providing financial assistance for on-the-ground resources necessary to help defeat inappropriate scope expansion legislation. Further, to respond to increasing scope threats, the AMA substantially increased its financial support for the SOPP, raising its annual contribution from $50,000 to $300,000 in 2023.

So far in 2024, the AMA has worked with more than 35 state medical associations and national medical specialty societies on scope of practice, securing more than 50 wins and demonstrating the collective work of organized medicine. State medical associations deserve special gratitude since they are on the ground in the statehouses each day and serve as point on these campaigns.

- At least 12 states have defeated legislation that would remove physician supervision of or collaboration with nurse practitioners or advanced practice registered nurses (APRN), including two states, Oklahoma and Wisconsin, where the Governor vetoed APRN bills;
- Bills that would have allowed optometrists to perform surgery have been defeated in at least 10 states, including California, Idaho, Kansas, Minnesota, Missouri, Nebraska, New Hampshire, Utah, Vermont, and West Virginia;
- Nurse anesthetist bills have been defeated in at least eight states including: Florida, Georgia, Illinois, Kansas, Missouri, South Carolina, Utah, and Virginia;
- Arizona, California, Illinois, Mississippi, Oklahoma, South Carolina, and West Virginia stopped pharmacist test-to-treat legislation, while Washington State defeated a bill that would have given the Pharmacy Commission the authority to identify drugs and devices that a pharmacist could prescribe;
- Alaska, Colorado, Connecticut, Florida, Indiana, Kansas, Minnesota, Missouri, New Jersey, New York, and Washington defeated legislation that would have created a license for naturopaths, allowed naturopaths to prescribe medications and perform minor surgeries, or order and interpret diagnostic tests;
- Florida, Hawaii, New York, Oklahoma, and Washington defeated psychologist prescribing bills; and
- South Dakota State Medical Association achieved a "silent" victory as a physician assistant scope expansion bill was <u>not</u> introduced this year, likely because SDSMA defeated physician assistant scope bills three times in recent years. Unfortunately, however, two scope bills passed in South Dakota this year, an optometrist surgery bill and APRN Compact bill.

The AMA also sent 18 letters to state lawmakers expressing opposition to pending scope of practice legislation and testified before state legislative bodies on five occasions expressing our opposition to inappropriate scope expansions and the importance of preserving physician-led care.

At the federal level, the AMA organized two sign-on letters to the House Ways & Means and Energy & Commerce committees, expressing medicine's strong opposition to H.R. 2713, the "Improving Care and Access to Nurses Act," or the "I CAN Act." This legislation would endanger the quality of care that Medicare and Medicaid patients receive and is expected to be the primary advocacy focus of nonphysician practitioners in the current Congress. The AMA is also organizing opposition to the "Equitable Community Access to Pharmacist Services Act," which would permit pharmacists to perform services that would otherwise be covered if they had been furnished by a physician, test and treat patients for certain illnesses (including illnesses that address a public health need or relate to a public health emergency), and also expand Medicare payment for pharmacists in limited but significant ways. Further, the AMA continues to lead a coalition to oppose the Department of Veterans Affairs Supremacy Project, which aims to set national standards of practice for all health professionals that provide care in the VA system.

Physician Wellness

The AMA has made improving physician wellness/reducing physician burnout a cornerstone of its strategic work for more than a decade, working at the system-level to remove the common barriers that interfere with patient care and often lead to burnout and dissatisfaction. Following the passage

of the "Dr. Lorna Breen Health Care Provider Act" in 2022, a bill the AMA strongly supported, the AMA continued to push for regulatory, legislative, and other solutions to direct more funding and resources to support the mental health needs of physicians. The AMA is also seeking reauthorization of the legislation in 2024.

AMA advocacy also has encompassed multiple efforts to ensure medical licensing, credentialing, and other applications do not stigmatize mental illness or substance use disorders and do not contain language mandating disclosure of past treatment or diagnosis of a mental illness or substance use disorder. In partnership with the Dr. Lorna Breen Heroes' Foundation and countless medical societies and other partners, the AMA has supported and secured multiple wins. As of July 2024, the following have removed stigmatizing language regarding physicians' mental health and wellbeing:

- 28 medicals boards: California, Connecticut, Georgia, Hawaii, Idaho, Illinois, Kansas, Louisiana, Massachusetts, Maine, Michigan, Minnesota, Missouri, Mississippi, Montana, Nebraska, New York, North Carolina, North Dakota, Ohio, Oregon, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, and Washington (the AMA is in the process of working directly with multiple other medical boards);
- More than 25 local, state and regional health systems, including Allegheny Health Network, Augusta Health, Bon Secours Mercy Health - Richmond, Centra Health, Envision, Children's Hospital of the King's Daughters, Geisinger Health, HCA Healthcare, Henry Ford Health System, Inova Health System, Mary Washington Health Care, Medstar Health, Northeastern Vermont Regional Hospital, Northwell Health, NYC Health + Hospitals, Sentara Health System, Sturdy Health, PacificSource Health Plans, UVA Health System, Valley Health System, Wooster Community Hospital, Wooster Community Hospital, Allina Health, and Fulton County Health Center. The AMA is working with more than 40 additional systems to audit and revise their credentialing applications;
- AMA advocacy efforts and partnerships also secured multiple organizations adopting policies and/or advocacy positions directly aligned with the AMA on these issues, including CDC/NIOSH, the National Association of Medical Staff Services, the Massachusetts Hospital Association, the American Dental Association, the American Society of Health System Pharmacists, and others;
- Minnesota and Virginia enacted legislation in 2024 restricting applications from having stigmatizing language and supporting "safe-haven" type programs; and
- AMA advocacy has led to the National Association of Medical Staff Services revising its Ideal Credentialing Standards to follow AMA policy. The AMA also successfully advocated for the National Center for Quality Assurance to align with AMA policy for credentialing applications to ask only about current impairment and not past diagnosis or treatment of a mental illness or substance use disorder.

The AMA has also opened a new legislative advocacy campaign to help the Federation advocate for laws protecting physicians from violence, including creating a comprehensive analysis of all state laws that protect physicians and health care practitioners from workplace violence. In addition, the AMA has also developed an extensive legislative template that the Federation can use to analyze and develop their own state legislation protecting physicians from violence in numerous settings—not simply the workplace.

Telehealth

The physician adoption rate of telehealth and digital health tools has accelerated as physicians grow increasingly optimistic about providing care virtually, which can increase access and break down barriers to care. Two years ago, the AMA won an important victory for physicians and patients with the passage of legislation extending pandemic-related Medicare telehealth flexibilities through 2024. Unless Congress acts by December 31, 2024, Medicare will no longer be able to cover and pay for most telehealth services starting January 1, 2025.

AMA strongly backs bipartisan measures to enact a permanent fix. Congress is expected to pass another extension through 2026. This is due to the cost associated with making the policy permanent. The Congressional Budget Office (CBO) is expected to score the cost of a two year extension at $2 billion per year, double the cost of the original two year extension. This is based on the CBO's current assumption that telehealth services have been additive, not substitutive to in person services, and therefore have increased Medicare utilization.

Telehealth legislation is currently making its way through the committees of jurisdiction. The House Ways and Means Committee unanimously passed H.R. 8261, the "Preserving Telehealth, Hospital and Ambulance Access Act," on May 8. The House Energy and Commerce Subcommittee on Health unanimously approved a modified version of H.R. 7625, the "Telehealth Modernization Act," on May 17. The bills are largely identical and would extend all key telehealth flexibilities through 2026 (2 years) including:

- An extension of the exemption of the geographic and originating site restrictions, plus allowing anyone to receive telehealth services both in the home and wherever they can access a telecommunications system;
- A continued moratorium on the requirement for an in-person visit within 6 months of the beneficiary receiving the first telemental health service;
- Authority to provide audio-only telehealth services; and
- An extension of the hospital at home flexibilities through 2029 (5 years).

In addition, the Energy and Commerce Committee bill would authorize:

- Medicare coverage and payment for cardiopulmonary rehabilitation services in the home through 2026; and
- Medicare coverage and payment of virtual Diabetes Prevention Program services.

The AMA was instrumental in making sure both bills were "clean" and did not include any new restrictions on coverage and payment of telehealth services such as in-person requirements. Both the House Energy and Commerce Committee and the Senate Finance Committee are expected to report out telehealth bills in September.

The AMA was also pleased with the Drug Enforcement Administration's decision to extend flexibility in prescribing of controlled substances based on telehealth patient visits through 2024 which was an AMA advocacy priority.

Further, in a final rule, CMS announced it will maintain the waiver of geographic and originating site restrictions related to telehealth through the end of 2024. The waiver, which began during the COVID-19 pandemic, allows Medicare beneficiaries to connect with physicians anywhere in the

U.S. from home. This creates flexibility in patients' access to care. CMS also finalized extending payment for audio-only telehealth services, increasing remote patient monitoring capabilities.

Cybersecurity

The AMA is deeply concerned about cybersecurity breaches including the Change Healthcare breach that threatened the viability of medical practices and jeopardized access to care for potentially millions of patients. After the Change Healthcare cyberattack, the AMA called for immediate action by UnitedHealth Group and policymakers on specific items that could help practices to survive the event:

- Advance payments;
- Restoring practices' electronic systems;
- Suspension of all prior authorization, quality reporting and similar administrative requirements;
- Broader focus on restoring function for independent physician practices;
- Prohibiting retroactive denials based on eligibility or lack of utilization management approval;
- Waivers for timely filing deadlines for claims and appeals;
- More information on the scope and the impact on patients' data; and
- Clarification that the duty to inform patients about a breach of their personal health data resides with Change Healthcare and Optum and not with individual providers.

The AMA appreciated that HHS and CMS responded to the urgency of this incident and the unprecedented disruptions to medical practices and access to care. Following the AMA's urging, HHS and CMS announced initial steps in March to support physicians experiencing financial hardships as a result of this ransomware attack. CMS announced that physicians impacted by the Change Healthcare service disruption could apply for advance Medicare payments. CMS also extended the 2023 MIPS data submission deadline to April 15.

HHS further responded to concerns from the AMA regarding difficulties physicians face in securing information and assistance from commercial health insurers in the aftermath of the Change Healthcare cybersecurity attack by releasing a resource that collates information and contacts across many health plans. The AMA submitted multiple statements for the record for congressional hearings on the Change Healthcare cyberattack. In addition, a letter cosigned by over 100 Federation groups and other stakeholders was sent in May, asking that HHS and the Office of Civil Rights publicly clarify that breach notifications are the responsibility of UnitedHealth Group and not individual physicians, hospitals, and other providers. Following this sign-on letter, the HHS Office of Civil Rights released updated FAQs specifying that covered entities can delegate to Change Healthcare the tasks of making the required Health Insurance Portability and Accountability Act breach notifications on their behalf.

The AMA also sent a letter to the National Association of Insurance Commissioners (NAIC) asking that it urge its members to take immediate action to protect physician practices from the widespread impact of the Change Healthcare cybersecurity breach. NAIC disseminated the letter to states, which have responded with their own actions. NAIC has also formed a steering committee to address this issue and has been in touch with the AMA to assess the ongoing impact on physicians. The AMA also advocated to the National Association of Medicaid Directors (NAMD) asking that it urge its members to take immediate action to assist physician practices impacted by the Change breach, including taking advantage of flexibilities provided by CMS related to state plan amendments to provide advance payments to physicians under Medicaid. NAMD responded

positively to the AMA outreach and welcomed ongoing discussions with the AMA on how the service disruption is interfering with care delivery.

The AMA has engaged with Congress, offering several recommendations to prevent or mitigate future cyber-attacks and the impact on physicians:

- Robust cybersecurity standards for health plans and health care clearinghouses;
- Federally funded cybersecurity support centers to assist physician offices and smaller health care providers with cybersecurity adoption, prevention, training, and education;
- Impacted payers and clearinghouses must provide emergency connection points to maintain business continuity with physicians' health IT systems; and
- Physicians should be explicitly exempt from any accountability, liability, or penalties if a breach of their patients' protected health information occurs without any fault on their part.

The AMA continues to closely monitor the situation and gather information on the impact of this breach and others affecting health systems and other health care stakeholders.

Augmented Intelligence

Augmented Intelligence (AI) technology holds the promise to radically transform health care for both physicians and patients. For AI to meet its potential to improve care delivery and health, the AMA has called for a whole government regulatory approach that engages the physician community to ensure necessary safeguards and protections are in place. The AMA released Principles for Augmented Intelligence Development, Deployment and Use in the fall of 2023 that will guide the organization's engagement with the administration, Congress, and industry stakeholders in discussions on the future of governance policies to regulate the development, deployment and use of health care AI. For example, transparency around health care AI design, development, and deployment processes should be mandated by law and physicians should be provided sufficient detail and information to make their own informed decisions about using AI. These principles build on existing AMA policies on AI that go back to 2018, which encourage a comprehensive government approach to AI governance policies to mitigate risks. The principles lay out an appropriate strategy for AI in health care, including:

- Above all else, health care AI must be designed, developed, and deployed in a manner which is ethical, equitable, responsible, and transparent;
- Compliance with national governance policies is necessary to develop AI in an ethical and responsible manner to ensure patient safety, quality, and continued access to care. Voluntary agreements or voluntary compliance is not sufficient; and
- Health care AI requires a risk-based approach where the level of scrutiny, validation, and oversight should be proportionate to the potential overall or disparate harm and consequences the AI system might introduce.

More information on AMA AI efforts is included in Board Report 01-A-24.

Physician-Owned Hospitals

The AMA continues to be a strong proponent of lifting the existing ban on physician-owned hospitals. Representatives Michael Burgess, MD (R-TX), Tony Cardenas (D-CA), Morgan Griffith (R-VA), and Vicente Gonzalez (D-TX) introduced, H.R. 9001, "the Physician Led and Rural Access to Quality Care Act." This bipartisan legislation would permit the establishment of select

physician-owned hospitals that meet certain criteria. More specifically, the legislation defines a "covered rural hospital" as a physician-owned hospital that is located in a rural area and more than a 35-mile drive (or a 15-mile drive in mountainous terrain or areas with only secondary roads) from another hospital or critical access hospital. The legislation also only permits these hospitals that meet this narrow definition to expand existing physician-owned hospitals. If enacted, H.R. 9001 will help foster greater competition and provide better health care access, especially in rural areas.

Physician Workforce

To address the current and growing physician workforce crisis, the AMA is emphasizing a multi-pronged solution. This includes seeking additional Graduate Medical Education (GME) slots and funding so more physicians can be trained. Legislation on this recommendation, H.R. 2389, the "Resident Physician Shortage Reduction Act," currently has more than 170 bipartisan House cosponsors. The AMA is calling for additional funding in support of programs created through the "Dr. Lorna Breen Health Care Provider Protection Act" and more loan repayment and scholarship programs for physicians, such as through the National Health Service Corps. The AMA is also urging greater access for international medical graduates through expansion of the Conrad 30 program (H.R. 4922/S. 665) and reclaiming unused employment-based visas from the past 30 years (H.R. 6205/S. S. 3211).

Non-Compete Agreements

In April, the Federal Trade Commission (FTC) approved a final rule banning all non-competes except for current non-competes involving senior executives. The rule does permit other types of clauses such as typical confidentiality agreements, non-disclosure agreements, and training repayment agreements. It is likely that the final rule will not apply to some, and perhaps many, 501(c)(3) hospitals, health systems, and other 501(c)(3) health care organizations. This means that under the final rule, many non-profit hospitals may be able to continue using non-competes while for-profit physician practices could not. In June, a federal district court judge temporarily enjoined the enforcement of the FTC noncompete rule. The injunction only applies to the plaintiffs that filed the lawsuit, which includes the U.S. Chamber of Commerce, an accounting firm, and a couple Texas business groups. The AMA continues to watch this case closely and, regardless of the court's decision, expects the ruling to be appealed to higher courts. The AMA has developed and released to the Federation a comprehensive legislative template that provides an in-depth analysis of all state non-compete laws applicable to physicians as well as key non-compete cases involving physicians.

Aligned with new HOD-adopted policy, the AMA opposes all restrictive covenants between employers and physician employees and will regularly update its state restrictive covenant legislative template. The AMA will also continue assisting the Federation in developing strategies for physician employee retention. The AMA has helped several state medical associations enact laws limiting non-competes, including Pennsylvania.

Medicaid/Children's Health Insurance Program (CHIP)

On April 22, CMS finalized two major rules to strengthen access to high-quality medical care for Medicaid and Children's Health Insurance Program (CHIP) beneficiaries and advance transparency related to quality, access, and payment rates.

The "Managed Care Rule" establishes federal maximum appointment wait-time and other standards for the first time and requires public reporting of quality and payment data for key

services. The "Access Rule" requires states to publish Medicaid fee-for-service payment rates and compare them to Medicare rates for key services and prove that any plans to restructure plans or reduce rates will not result in sufficiently diminished or insufficient access.

The AMA strongly supported many of the provisions when both rules were proposed and welcomed the historic changes in a statement, noting that the AMA has long sought changes to Medicaid payment and coverage policies to overcome longstanding barriers to care for low-income patients and advance health equity. In a statement, then-AMA President Jesse M. Ehrenfeld, MD, MPH, underscored that the AMA looks forward to working with CMS to implement these reforms to advance patient access and quality of care while emphasizing the need for common-sense protections to ensure managed care plans do not unfairly pass the burden of compliance onto safety net practices.

The AMA also continues to work with state medical associations, federal agencies, and other stakeholders to protect Medicaid beneficiaries during the Medicaid "unwinding." At the national level, the AMA has been participating in the Connecting to Coverage Coalition (CCC), which holds weekly calls. In April, the CCC issued a press release commending administration renewal actions, which included a quote from then-President Jesse M. Ehrenfeld, MD, MPH. In addition, the AMA has continued to engage with administration officials about unwinding and provided feedback on state experiences with unwinding and best practices. At the state level, the AMA has been working with state medical associations to raise awareness of coverage disruptions and distribute resources aimed at both physicians and patients to mitigate coverage losses. Speakers at the 2023 AMA State Advocacy Roundtable and 2024 State Advocacy Summit also highlighted redetermination challenges and strategized on ways physician practices and medical associations could provide direct assistance to patients and advocate for supportive policy changes with state Medicaid agencies and state legislators.

The AMA continues to work with state medical associations to increase Medicaid reimbursement rates in order to ensure patients with low-income can access the care they need. The AMA also continues to support state medical associations as they push for Medicaid expansion, in states that have not yet opted to expand eligibility under the Affordable Care Act (ACA).

Protecting Against Government Intrusion into Clinical Care

The AMA strongly opposes government interference in the practice of medicine and strongly opposes laws that prohibit physicians from providing evidence-based medical care that is in the best interest of their patients.

Abortion

The AMA supports patients' access to the full spectrum of reproductive health care options, including abortion and contraception, as a right. Physicians have an ethical obligation to help patients choose the optimal course of treatment, through shared decision-making that is fully informed by medical science and shaped by patient autonomy. Anything less puts patients at risk and undermines both the practice of medicine and our nation's health.

The AMA spoke out forcefully against court actions that undermined the U.S. Food and Drug Administration (FDA) decision-making and threaten to impact the availability of mifepristone and potentially other drugs. The AMA has also filed briefs to inform U.S. Supreme Court deliberations. The court heard oral arguments in the mifepristone case on March 26 and issued a decision in June. The decision preserved access to medication abortion but did not resolve the issue on the merits.

The AMA supported the Administration's privacy guidance that makes it clear that physicians are not required to disclose private medical information to third parties and provides patients with tips on the use of personal cell phones and tablets.

Further, the AMA is working closely with state medical associations to make sense of confusing legal obligations in restrictive states, identifying strategies to mitigate harm, and advocating against new restrictive laws. In states where abortion remains legal, the AMA is working with state medical associations to enact additional legal and professional protections for physicians in those states. In 2024, two additional states, Maine and Rhode Island, enacted shield law protections, bringing the total number of states to 19, including the District of Columbia. The AMA supported both laws.

Finally, the AMA has convened a "Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted," at the direction of the House of Delegates, to identify and create practice and advocacy resources and guide organized medicine's response to bans on abortion and gender-affirming care. Five AMA Councils, 11 national medical specialty associations, and seven state medical associations are represented on the Task Force. The Task Force will continue to meet over the next two years. More information on the Task Force's work can be found in Board Report 21-A-24.

In-Vitro Fertilization (IVF)

The AMA is deeply concerned about state activity to limit access to the full range of reproductive health services, including the Alabama Supreme Court decision earlier this year that included cryopreserved embryos created through in-vitro fertilization (IVF) in the legal definition of "children." The decision was unprecedented and the first time a court recognized embryos stored outside the human body as people. In response, the AMA HOD in June adopted policy to oppose legislation or ballot measures that could criminalize IVF. The AMA offered support to the Medical Association of the State of Alabama which played a key role in developing a legislative fix to allow IVF to continue in the state. The AMA is poised to assist other states when this issue arises.

Gender-Affirming Care

The AMA has advocated against state restrictions on evidence-based gender-affirming care in several states including Missouri, Montana, New Hampshire, and South Dakota and will continue to work closely with state medical associations across the country to oppose bans on evidence-based care. The AMA has also supported shield laws in several states, including Maine and Rhode Island in 2024, that provide legal and professional protections to physicians and other health care providers of gender-affirming care. The AMA has filed and joined briefs in multiple federal court cases supporting evidence-based gender-affirming care. The AMA is deeply concerned about increasingly hostile rhetoric and threats of violence directed at physicians who provide evidence-based gender-affirming care.

Firearm Violence

One of the AMA's top public health priorities is responding to public health crises impacting physicians, patients, and the public. Included within this bucket is preventing firearm injuries and deaths. At the 2016 Annual Meeting, following the Pulse nightclub shooting, policy was adopted declaring that "gun violence represents a public health crisis which requires a comprehensive public health response and solution." The AMA adopted policy in 2022 to establish a task force focused on firearm violence prevention, including firearm-involved suicide. The AMA has convened this task force with physician leaders and high-level staff from several national medical associations to increase collaboration on topics related to firearm safety. The AMA continues to

push lawmakers to adopt common-sense policies, broadly supported by the American public, to prevent avoidable deaths and injuries caused by firearm violence including banning assault weapons; high-capacity magazines; and other weapons of war. Our nation must also address the root causes that have fueled these mass murders and casualties. The AMA is working at the state level to encourage and assist states in implementing some of the new federal law's provisions, especially regarding passage of extreme risk protection order (ERPO) legislation. During the 2024 state legislative sessions, the AMA worked closely with state medical associations to craft ERPO legislation and to support community violence prevention strategies, as well as strengthening waiting period and background check requirements. With AMA support, two such bills—LD 2224 and LD 2238—were enacted in Maine.

The AMA has advocated for Congress to appropriate increased funding for research to prevent firearm violence. The AMA is working with national medical specialties societies, including the American Academy of Pediatrics (AAP), to support funding for the U.S. Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH), and the National Institute of Justice (NIJ) to conduct public health research on firearm morbidity and mortality prevention. The goal is to ensure at least level funding for next year; in the current environment, it is unlikely that funding will be increased but the coalition is advocating against any cuts. The AMA is also participating in the Health Professional Education and Advocacy/Policy committees of the Healthcare Coalition for Firearm Injury Prevention, (HCFIP) which is being led by American College of Physicians, with AAP, American College of Emergency Physicians, American College of Surgeons, and the Council of Medical Specialty Societies participating. HCFIP is focusing on safe storage and preventing suicide.

Maternal Health

To bolster federal and state efforts and provide recommendations to improve maternal health outcomes, the AMA has worked collaboratively over the last year with a variety of members of the Federation, including national medical societies, state medical associations, and physicians from rural areas. The AMA released a new set of concrete steps that the administration and Congress can take to improve maternal health outcomes in the U.S. The AMA also published a comprehensive document that provides extensive recommendations to policymakers and advocates. The AMA advocated for improvements to a new maternal health alternative payment model and urged CMS to consult with the AMA, the American College of Obstetricians and Gynecologists, and other interested parties prior to moving forward with an obstetrical services condition of participation. Additionally, the AMA submitted a Statement for the Record to the U.S. Senate Committee on Health, Education, Labor, and Pensions as part of the hearing entitled, "What Can Congress Do to Address the Severe Shortage of Minority Health Care Professionals and the Maternal Health Crisis?"

Overdose Epidemic

Our nation's drug-overdose epidemic continues to kill more than 100,000 Americans each year, which is why the AMA continues to call on policymakers and other stakeholders—including health insurers, pharmacy benefit management companies, and national pharmacy chains—to remove barriers to evidence-based care for opioid use disorder and for pain and increase access to harm reduction initiatives, including decriminalizing fentanyl test strips, sterile needle and syringe exchange services, and piloting overdose prevention sites as well. The AMA's 2023 Overdose Epidemic Report, released in November, shows a nearly 50 percent decrease in opioid prescribing nationwide since 2012. At the same time, the country is facing a worsening drug-related overdose epidemic, fueled by a dramatic increase in use of illicit fentanyl and fentanyl analogs, as well as

methamphetamine and cocaine. State prescription drug monitoring programs were used more than 1.3 billion times in 2022.

AMA advocacy helped lead to FDA approving the first-ever over-the-counter naloxone product in 2023. The AMA has supported multiple bills at the state level to remove barriers to opioid therapy for patients with pain, including a new Minnesota law; bills to ensure that opioid litigation settlement funds from major distributors would go to public health and treatment; and language from AMA model legislation has been included in at least 10 new laws since 2022 that remove fentanyl test strips from state drug paraphernalia laws. The Federation of State Medical Boards (FSMB) recently adopted revisions to its recommendations relating to opioids and pain care at its April 2024 Annual Meeting. The AMA was part of the FSMB Workgroup on Opioid and Addiction Treatment that helped update the proposed "Strategies for Prescribing Opioids for the Management of Pain" over a two-year period.

Climate Change

At the 2022 Annual Meeting of the House of Delegates, policy was adopted declaring "climate change a public health crisis that threatens the health and well-being of all individuals." Concern has grown in recent decades about the connection of human activities to rapid climate change, such as the burning of fossil fuels and deforestation, and the impacts on health. Climate change is adversely affecting people's physical and mental health; however, climate-related risks are not distributed equally. The AMA recognizes 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. The AMA has called for limiting global warming to no more than 1.5 degrees Celsius, as well as reducing U.S. greenhouse gas emissions aimed at a 50 percent reduction in emissions by 2030 and carbon neutrality by 2050. The AMA is developing a formal strategy to address climate change and health, with an anticipated release at the AMA I-24 meeting.

The AMA participates in the American Lung Association's (ALA) Healthy Air Partners campaign, which is a coalition of 40 national public health, medical, nursing, and health care organizations engaged in healthy air advocacy efforts. The Coalition is united in calling for strong federal laws and policies to slash air pollution and address climate change, recognizing climate change can affect air quality, and certain air pollutants can affect climate change. In 2024, the AMA joined the Coalition on a letter to the Environmental Protection Agency (EPA) on their draft Revised Technical Guidance for Assessing Environmental Justice in Regulatory Analysis, which included the addition of climate change as a factor of vulnerability when conducting environmental justice analysis. The AMA also joined the Coalition on a letter to the EPA on Waste Emissions Charges for Petroleum and Natural Gas and on a letter on CMS' Decarbonization and Resilience Initiative. The AMA sent a letter providing comments to the EPA on National Primary Drinking Water Regulations for Lead and Copper: Improvements. In addition, the AMA continues to engage in the Medical Society Consortium on Climate and Health (MSCCH or Consortium), which brings together associations representing over a million clinical practitioners. The AMA sits on the executive committee of this group. The AMA was a sponsor of the MSCCH Annual Meeting held in February 2024 in Washington, DC. The AMA joined with MSCCH in sending a letter to Congress on the farm bill. The AMA is working with the Consortium and the ALA Coalition to draft comments on proposed regulations on heat standards issued by the Occupational Safety and Health Administration.

Nutrition

The AMA is committed to preventing and reducing the burden of chronic diseases and recognizes the critical link between diet and chronic disease in America. Moreover, we recognize that access to nutritious food is not equal, and that this inequity increases incidents of chronic diseases, such as diabetes and cardiovascular disease in historically marginalized communities. The AMA submitted a comprehensive statement to the U.S. Senate Committee on Health, Education, Labor and Pensions, Subcommittee on Primary Health & Retirement Security, on the hearing entitled, Feeding a Healthier America: Current Efforts and Potential Opportunities for Food is Medicine. The AMA also joined a sign-on letter to Congress, with over 75 societies and organizations, including the MSCCH, in support of farm policy that prioritizes both affordable and nutritious food and clean air and water.

AMA ADVOCACY ONGOING UPDATES AND MEETINGS

The AMA offers several ways to stay up to date on our advocacy efforts, and we urge the HOD to avail themselves of all of them to stay informed and advance our grassroots efforts:

- Sign up for AMA Advocacy Update a biweekly newsletter that provides updates on AMA legislative, regulatory, and private sector efforts. We try to make sure all HOD members are on the email list, but if you are not receiving AMA Advocacy Update, please subscribe and encourage your colleagues to do so as well. Subscribers can read stories from previous editions here.
- Join the Physicians Grassroots Network for updates on AMA calls to action on federal legislative issues. And if you have connections with members of Congress, or are interested in developing one, the Very Influential Physician (VIP) program can help grow these relationships.
- Connect with the Physicians Grassroots Network on Facebook, Twitter, and Instagram.

The AMA also encourages HOD members to attend the State Advocacy Summit and National Advocacy Conference. The 2025 State Advocacy Summit will take place on Jan. 9-11 at the Omni La Costa Resort & Spa in Carlsbad, California. The 2025 National Advocacy Conference will occur on Feb. 10-12 at the Grand Hyatt in Washington, D.C.

CONCLUSION

The AMA and the Federation of Medicine have faced numerous legislative and regulatory challenges in 2024. There has been progress on some issues, but others remain problematic. The keys for success on these issues moving forward will be maintaining a unified message and increasing engagement. Please continue to read Advocacy Update for the latest news, look for grassroots communications as they are released to our networks, and stay engaged with other AMA news sources. The AMA needs your help as the current 118th Congress is set to wrap up in the coming months, and organized medicine begins to plan for 2025 after the dust from the upcoming elections settles.

REPORT 21 OF THE BOARD OF TRUSTEES (I-24)
Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care is Banned or Restricted

EXECUTIVE SUMMARY

American Medical Association (AMA) Policy G-605.009 entitled, "Establishing A Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted," instructs the AMA to establish a task force to, "help guide organized medicine's response to bans and restrictions on abortion, prepare for widespread criminalization of other evidence-based care, implement relevant AMA policies, and identify and create implementation-focused practice and advocacy resources." AMA Policy D-5.998 entitled, "Support for Physicians Practicing Evidence-Based Medicine in a Post Dobbs Era," requires the Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care is Banned or Restricted (Task Force) to provide an annual report to the House of Delegates (HOD) at each Interim Meeting. Accordingly, this report highlights the Task Force's activities in the past year. (Note: Because of approval deadlines, this report was prepared in July and may not include more recent developments.)

In 2024, the Task Force formed and began work to carry out the directives adopted by the HOD. There are 29 physician members serving on the Task Force, 11 representing national medical specialty societies, 10 representing AMA Councils, seven representing state medical associations, and one representing the AMA Board of Trustees. Staff from the respective medical associations are also invited to support their assigned physician members in Task Force activities.

The Task Force held an introductory virtual meeting in May and its first in-person meeting in July of this year. The July meeting examined legal issues related to abortion care, including abortion-related litigation activity across the country, legal resources for physicians, the Emergency Medical Treatment and Active Labor Act, and shield law protections for abortion care providers. Task Force members discussed each issue and raised items for further action. In accordance with policy and in preparation for a new website that will serve as a resource hub for physicians and others navigating abortion restrictions, the Task Force also reviewed implementation-focused practice and advocacy resources on a range of issues, such as, health equity, practice management, medical education, privacy, and legal issues, as well as identified resource gaps and options to fill the gaps.

In accordance with the amendment to Policy G-605.009 adopted at the AMA 2023 Interim Meeting, the Task Force has formed a subcommittee to focus on payment and reimbursement issues in gender-affirming care and anticipates holding a meeting in February 2025 dedicated to those issues.

In accordance with Policy D-425.989 entitled, "Protecting Access to IVF Treatment," this report also provides an advocacy update on governmental efforts to restrict or interfere with assisted reproductive technology.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 21-I-24

Subject: Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care is Banned or Restricted

Presented by: Michael Suk, MD, JD, MPH, MBA, Chair

This report provides an update on the activities of the Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted (Task Force) and a legislative update in accordance with Policies G-605.009, D-5.998, and D-425.989. (Note: Because of approval deadlines, this report was prepared in July and may not include more recent developments.)

BACKGROUND

American Medical Association (AMA) Policy G-605.009 entitled, "Establishing A Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted," was adopted at the 2022 Annual Meeting of the AMA House of Delegates (HOD). Policy G-605.009 instructs that:

1. Our AMA will convene a task force of appropriate AMA councils and interested state and medical specialty societies, in conjunction with the AMA Center for Health Equity, and in consultation with relevant organizations, practices, government bodies, and impacted communities for the purpose of preserving the patient-physician relationship.
2. This task force, which will serve at the direction of our AMA Board of Trustees, will inform the Board to help guide organized medicine's response to bans and restrictions on abortion, prepare for widespread criminalization of other evidence-based care, implement relevant AMA policies, and identify and create implementation-focused practice and advocacy resources on issues including but not limited to:
    a. Health equity impact, including monitoring and evaluating the consequences of abortion bans and restrictions for public health and the physician workforce and including making actionable recommendations to mitigate harm, with a focus on the disproportionate impact on under-resourced, marginalized, and minoritized communities;
    b. Practice management, including developing recommendations and educational materials for addressing reimbursement, uncompensated care, interstate licensure, and provision of care, including telehealth and care provided across state lines;
    c. Training, including collaborating with interested medical schools, residency and fellowship programs, academic centers, and clinicians to mitigate radically diminished training opportunities;
    d. Privacy protections, including best practice support for maintaining medical records privacy and confidentiality, including under HIPAA, for strengthening physician, patient, and clinic security measures, and countering law enforcement reporting requirements;

e. Patient triage and care coordination, including identifying and publicizing resources for physicians and patients to connect with referrals, practical support, and legal assistance;
f. Coordinating implementation of pertinent AMA policies, including any actions to protect against civil, criminal, and professional liability and retaliation, including criminalizing and penalizing physicians for referring patients to the care they need; and
g. Anticipation and preparation, including assessing information and resource gaps and creating a blueprint for preventing or mitigating bans on other appropriate health care, such as gender affirming care, contraceptive care, sterilization, infertility care, and management of ectopic pregnancy and spontaneous pregnancy loss and pregnancy complications.

Adopted during the AMA 2022 Interim Meeting, Policy D-5.998 entitled, "Support for Physicians Practicing Evidence-Based Medicine in a Post Dobbs Era," added a requirement for an annual report of the Task Force. Policy D-5.998(1) instructs that:

1. Our AMA Task Force developed under HOD Policy G-605.009, "Establishing A Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted," will publish a report with annual updates with recommendations including policies, strategies, and resources for physicians who are required by medical judgment and ethical standards of care to act against state and federal laws.

At the AMA 2023 Interim Meeting, the HOD amended Policy G-605.009 entitled, "Establishing A Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted," adding the creation of an ad hoc committee on payment and reimbursement issues in gender affirming care to the Task Force's directives. Specifically, the amendment instructs that:

3. Our American Medical Association will appoint an ad hoc committee or task force, composed of physicians from specialties who routinely provide gender-affirming care, payers, community advocates, and state Medicaid directors and/or insurance commissioners, to identify issues with physician payment and reimbursement for gender-affirming care and recommend d solutions to address these barriers to care.

Lastly, the HOD adopted Policy D-425.989 entitled, "Protecting Access to IVF Treatment," during the AMA 2024 Annual Meeting, directing the Task Force to report on legislation involving restrictions to assisted reproductive technology. Policy D-425.989 instructs that:

> Our AMA, through the AMA Task Force to Preserve the Patient-Physician Relationship, report back at I-24 on the status of, and AMA's activities surrounding, proposed ballot measures or legislation and pending court rulings, that (a) would equate gametes or embryos with children and/or (b) would otherwise restrict or interfere with evidence-based care for Assisted Reproductive Technology (ART).

DISCUSSION OF TASK FORCE ACTIVITIES

As directed by the HOD and in response to the U.S. Supreme Court's landmark 2022 decision in *Dobbs v. Jackson Women's Health Organization*, which held that the U.S. Constitution does not confer a constitutional right to abortion and returned the authority to regulate abortion to the states and the subsequent enactment of abortion bans in half the states, the AMA Board of Trustees'

(Board) formed the Task Force in June of 2023. With the formation of the Task Force and consistent with AMA Policies G-605.009 and D-5.998, as noted above, the Board envisioned that the Task Force would advise the Board of new and emerging threats to the provision of evidenced-based medical care and appropriate and innovative responses to protect access to care and to preserve the role of the patient-physician relationship as a central element in medical decision-making.

In accordance with the specific language of AMA Policies G-605.009 and D-5.998, in September 2023, the Chairs of the Councils on Legislation, Medical Service, Medical Education, Science and Public Health, and Ethics and Judicial Affairs each appointed two Council members to serve on the Task Force. As a result, 10 Council representatives serve on the Task Force. The then-Chair of the Board, Willie Underwood III, MD, MSc, MPH, appointed Madelyn E. Butler, MD, AMA Trustee, and Maryanne C. Bombaugh, MD, MBA, MSc, member of the Executive Committee for the AMA Council on Legislation, to serve as Co-Chairs of the Task Force.

In addition, and in accordance with underlying policy, in the spring of 2024, AMA invited 10 state medical associations and 13 national medical specialty societies to appoint a physician representative to serve on the Task Force. The organizations were selected based on their expertise, experience, and response to an AMA survey fielded in November 2022 (which was described in detail in the 2023 report on the Task Force) that asked about priorities and capacity to engage on the issues identified in AMA Policy G-605.009.

Seven state medical associations and 11 national medical specialty societies nominated a physician representative to serve on the Task Force. The participating national medical specialty societies include:

- American Academy of Child and Adolescent Psychiatry,
- American Academy of Dermatology,
- American Academy of Family Physicians,
- American Academy of Pediatrics,
- American College of Emergency Physicians,
- American College of Obstetricians & Gynecologists,
- American College of Physicians,
- American Psychiatric Association,
- American Society for Reproductive Medicine,
- American Society of Clinical Oncology, and
- The Endocrine Society.

The participating state medical associations include:

- California Medical Association,
- Idaho Medical Association,
- The Maryland State Medical Society (MedChi),
- Massachusetts Medical Society,
- Pennsylvania Medical Society,
- Texas Medical Association, and
- Medical Society of Virginia.

In total, there are 29 physician members of the Task Force.

Concurrently, staff across the AMA conducted environmental scans and gaps analyses of the issues identified in Policy G-605.009. These landscape analyses identify implementation-focused practice and advocacy resources on issues including health equity, practice management, medical education, privacy, and legal issues and identify potential resource gaps. The landscape analyses were presented to Council representatives, monthly, beginning in January of 2024 and concluding in May of 2024. The landscape analyses were used (and will continue to be used) to identify key topics of discussion for meetings of the Task Force and were distributed to all Task Force members prior to the first in-person meeting of the Task Force.

The Task Force held a virtual kick-off meeting on May 15, 2024, in which the Task Force Co-Chairs laid out the Task Force's scope, deliverables, and calendar for upcoming meetings.

The Task Force held its first in-person meeting on July 10, 2024, in Chicago. The in-person meeting focused on legal issues in abortion care and featured a range of speakers and presenters on topics all relating to legal issues in abortion care including, abortion-related litigation activity across the country, legal resources for physicians, the Emergency Medical Treatment and Active Labor Act (EMTALA), and shield law protections for abortion care providers.

Speakers included: Kyle Palazzolo, JD, Assistant General Counsel, AMA Office of General Counsel, who provided an update and analysis on recent important court decisions, including litigation impacting access to medication abortion, emergency care, state bans, and other issues; Rachel Rebouché, JD, LLM, Kean Family Dean and Peter J. Liacouras Professor of Law, Temple University Beasley School of Law, who discussed the landscape of state shield laws and protections afforded to abortion care providers under shield laws, as well as the potential impact of the Comstock Act on abortion access; Hannah Katch, Senior Advisor, Office of the Administrator, Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services, who presented the Administration's position and strategy regarding pregnant patients' rights during a medical emergency under EMTALA and the interaction of EMTALA with state abortion laws; and Brynn Weinstein, JD, Legal Defense Specialist, Resources for Abortion Delivery, who highlighted legal resources and services available to physicians providing abortion care through the Abortion Defense Network (ADN).

Following each presentation, Task Force members asked questions and discussed issues and concerns. During a working lunch, Task Force members were asked to strategize and identify resource gaps and potential deliverables for the Task Force regarding advocacy, health equity, medical education and workforce, legal issues, practice issues, and public health. The exercise generated numerous ideas for action. At the conclusions of the day, as directed by the Board and in accordance with Policies G-605.009 and D-5.998, which instruct the Task Force to identify and create implementation-focused practice and advocacy resources, the Task Force discussed existing resources and limitations of those resources, and identified gaps where resources need to be developed. Accordingly, AMA staff are in the process of developing a new website to serve as a resource hub for physicians and others navigating abortion restrictions. The website will exist separately from the AMA's website and will be available to the public. It will house resources created by the Task Force, as well as resources created and provided by Federation partners and other external organizations. Task Force members have been asked to share resources to be made available on the website.

In addition, the Task Force will host an informational session at the AMA 2024 Interim Meeting to engage AMA Delegates, Alternate Delegates, and representatives from AMA Sections, including but not limited to the Resident and Fellows Section, Medical Student Section, Women Physicians Section, Minority Affairs Section, and others. This session is an opportunity to elevate important

voices that are not members of the Task Force. Attendees of the informational session will hear about the activities of the Task Force and be asked to share their perspective on the issues being considered by the Task Force. As of the time of drafting this report, Task Force staff are working with AMA Section staff to ensure optimal engagement and the sharing of concerns and perspectives. The Board encourages all interested members to participate in this informational session in November.

In addition, and in accordance with the amendment to Policy G-605.009 adopted at the AMA 2023 Interim Meeting, the Task Force has formed a subcommittee to focus on payment and reimbursement issues in gender-affirming care. AMA staff has conducted a landscape analysis on payment and reimbursement issues that hinder access to gender-affirming care, which, like the landscape analyses on abortion, identified existing resources and gaps in those resources and will help inform discussion during in-person meetings. The Task Force anticipates holding an in-person meeting in February 2025 dedicated to these issues and as of the writing of this report in July 2024, was in the process of working with the subcommittee on an agenda.

Lastly, in addition to the Task Force meeting planned in February 2025 on gender-affirming care payment and reimbursement issues, the Task Force is planning to host an in-person meeting in July 2025 to discuss abortion-related issues in education, training, and workforce; an informational session at the 2025 Interim Meeting of the HOD; and a final, in-person meeting in February 2026 to discuss the intersection of abortion care and health equity.

LEGISLATIVE AND ADVOCACY UPDATE

Opposing third-party intrusion into the practice of medicine – including government interference with abortion, assisted reproductive technology (ART) and gender-affirming care – has long been a core priority for the AMA. The AMA continues to execute a multifaceted strategy, including engagement with policymakers at the state and federal levels, judicial advocacy, and more, to counter the deleterious impact of legislative efforts to criminalize the practice of medicine. The AMA continues to work extensively with state medical associations and national medical specialty societies, both publicly and behind-the-scenes, to oppose laws targeting reproductive health care services and evidence-based gender-affirming care.

Abortion

The AMA supports patients' access to the full spectrum of reproductive health care options, including abortion, as a right. Physicians have an ethical obligation to help patients choose the optimal course of treatment, through shared decision-making that is fully informed by medical science and shaped by patient autonomy. Anything less puts patients at risk and undermines both the practice of medicine and our nation's health.

As of the drafting of this report in July 2024, 14 states (Alabama, Arkansas, Idaho, Indiana, Kentucky, Louisiana, Mississippi, Missouri, North Dakota, Oklahoma, South Dakota, Tennessee, Texas, and West Virginia) prohibit the provision of nearly all abortions; four states (Florida, Georgia, Iowa, and South Carolina) prohibit abortion after fetal cardiac activity is detected around six weeks of pregnancy; two states (Nebraska and North Carolina) prohibit abortion after 12weeks of pregnancy; and five states (Arizona, Kansas, Ohio, Utah, and Wisconsin) between 15 and 22 weeks of pregnancy. Importantly, the status of state abortion laws is fluid. Legal challenges are ongoing and the legality of abortion in those states is subject to change.

In 2024, though dozens of new abortion restrictions were introduced in legislatures across the country, no new categorical bans on abortion were enacted. However, other troubling legislation was successful. Louisiana enacted Senate Bill (SB) 276 which reclassified mifepristone and misoprostol as Schedule IV controlled substances under the state's Uniform Controlled Dangerous Substances Law, making possession of the medication without a valid prescription a felony and increasing requirements on physicians and pharmacies that prescribe and dispense, respectively, the medications and chilling access to care. The law will take effect on October 1, 2024. Tennessee enacted SB 1971 which created the criminal offense of abortion trafficking, mirroring a law passed in Idaho in 2023 which has since been enjoined. The law prohibits an adult from recruiting, harboring, or transporting a minor for the purpose of obtaining an abortion in violation of the state's abortion ban or, if procured in another state, which would constitute a criminal abortion under the laws of Tennessee. The law took effect on July 1, 2024, and is being challenged in court. Kansas enacted House Bill (HB) 2749 which requires abortion providers and facilities to, among other things, ask patients to identify the reasons why they decided to seek an abortion and to report that information to the state. The Kansas law has been enjoined as of the writing of this report in July 2024. Given the sensitive political dynamics in these states, AMA staff provided background support to state medical associations as needed. The AMA continues to work closely with state medical associations in these and other states to make sense of confusing legal obligations, identify strategies to mitigate harm, and advocate against new restrictive laws.

In a victory for physicians and patients and thanks to the tremendous work of the Arizona Medical Association, state medical specialty associations, and other advocates in Arizona, the Arizona legislature repealed a near-total abortion ban following a decision by the Arizona Supreme Court that found the 1865 law enforceable. The state's 15-week ban, however, remains in effect.

Additionally, in 2024, two states, Maine and Rhode Island, enacted shield laws to protect abortion care providers (and providers of gender-affirming care) from extraterritorial enforcement of abortion bans in restrictive states, bringing the total number of states with shield laws to 19, including the District of Columbia. These laws protect health care professionals who provide abortion care (and gender-affirming care) from out-of-state civil, criminal, professional and other forms of liability. AMA has assisted state medical associations in supporting shield laws in many states, including providing technical assistance on both the Maine and Rhode Island bills. The AMA also sent a letter of support to Rhode Island legislators.

In November, voters in at least six states (Colorado, Florida, Maryland, Nevada, New York, and South Dakota) will decide whether to adopt state constitutional amendments to protect abortion rights in their states. As of the writing of this report, four additional ballot measures (in Arizona, Missouri, Montana, and Nebraska) to protect abortion rights are currently pending. One ballot initiative in Arkansas has been disqualified, though proponents are challenging the decision. Ballot measures to restrict abortion rights are pending in two states (Nebraska and Pennsylvania.) The AMA is closely monitoring this activity.

In addition to state advocacy, the AMA continues to fight for access to reproductive care at the federal level and in the courts. The AMA supported the Administration's privacy guidance that makes it clear that physicians are not required to disclose private medical information to third parties and provides patients with tips on the use of personal cell phones and tablets and continues to advocate to the Administration to preserve patient access to abortion care. Often through the AMA's Litigation Center, the AMA has joined dozens of court filings in state and federal courts around the country, including the United States Supreme Court, to articulate and support relevant AMA policies. The AMA spoke out forcefully against court actions that undermined the U.S. Food and Drug Administration decision-making and threaten to impact the availability of mifepristone

and potentially other drugs. The court heard oral arguments in the mifepristone case on March 26 and issued a decision in June that preserved access to medication abortion but did not resolve the issue on the merits. The AMA also urged the Supreme Court to confirm that patients in every state are entitled to prompt, complete, and unbiased emergency health care that is medically and scientifically sound and provided in compliance with EMTALA. In an opinion issued in June, the Court reinstated a pause on parts of Idaho's abortion ban, but again did not resolve the issue on the merits.

Currently, AMA litigation-related resources and activities are devoted to challenging the laws, regulations, and other barriers that interfere with the patient-physician relationship and a physician's medical judgment and ethical standards, rather than supporting the violation of those laws. In accordance with Policy D-5.998, which calls on the Task Force to identify "policies, strategies, and resources for physicians who are required by medical judgment and ethical standards of care to act against state and federal laws," the Task Force wishes to draw attention to the resources available through ADN and Resources for Abortion Delivery (RAD) which were presented to the Task Force during its meeting on July 10. ADN is a network of law firms, legal organizations, and attorneys that offer legal advice, representation, and funding to reproductive health care clinics, providers, and staff. After submitting a form on www.abortiondefensenetwork.org, physicians will be connected with an organization or law firm that can assist with legal issues on a pro bono basis. ADN also creates and shares resources for abortion providers, supporters, and seekers. State-specific guides to help medical professionals navigate their state's laws are available at www.abortiondefensenetwork.org/resources/providers. Additionally, the RAD Abortion Provider Legal Defense Fund covers legal defense costs for independent abortion providers subject to legal action for providing regulated abortion services to someone from or in a restricted state.

Assisted Reproductive Technology

The AMA supports patients' access to the full spectrum of reproductive health care options, including fertility services, as a right. The AMA was deeply concerned when, in February 2024, the Alabama Supreme Court found cryopreserved embryos created through in vitro fertilization (IVF) to be "extrauterine children" and therefore included in the definition of "minor child" under the Alabama Wrongful Death of a Minor Act. The ruling was unprecedented and the first time a court recognized embryos stored outside of the human body as people. The decision greatly increased the liability risks for clinics and physicians who provide in vitro fertilization (IVF) services in Alabama, and, in response to the court's decision, fertility clinics around the state paused services.

Following the decision, the AMA was in close communication with the Medical Association of the State of Alabama (the Medical Association) to offer assistance and coordinate the AMA's advocacy activities. As a result of the tremendous advocacy efforts of the Medical Association and others, legislation (SB 159) to protect IVF was enacted less than three weeks after the Supreme Court's decision. The legislation grants "civil and criminal immunity for death or damage to an embryo to any individual or entity when providing or receiving services related to in vitro fertilization" and provides "criminal immunity and damage calculations for death or damage to an embryo against manufacturers of goods used to facilitate the in vitro fertilization process." Following enactment of SB 159, fertility clinics in the state resumed services, though clinics still feel the impact of the Alabama Supreme Court decision.

As of the writing of this report in July 2024, no other state expressly recognizes personhood rights of cryopreserved embryos or criminalizes IVF. Following the controversy in Alabama, legislation in other states that may have threatened access to IVF was defeated, including, notably, in Iowa

(HF 2575) and Florida (HB 651). However, bills to protect IVF, including in Missouri, Kentucky, and Kansas also failed.

Many states recognize the rights of fetuses, often through laws authorizing criminal charges for fetal homicide, protecting children from abuse, neglect, or endangerment, or prohibiting abortion, for example. Some of these do not create liability for providing ART services. Laws in Alaska, Georgia, and Wyoming, for example, recognize the rights of a fetus "who is carried in the womb" and Arizona's law—which was enjoined in 2022—bars civil action against a person who performs IVF. It is unclear, however, whether courts can or will interpret other laws to restrict or prohibit IVF, though the developments in Alabama demonstrate that fetal personhood laws can have far-reaching consequences. Further, lawmakers continue to pursue fetal personhood laws and, in 2024, introduced legislation in 13 states, though none were enacted.

Despite the existence of fetal personhood laws in many states, IVF services continue, and the question remains whether the laws granting fetuses personhood rights could threaten the status of IVF. The AMA continues to closely monitor developments in this space and stands ready to work with state medical associations in legislatures and courts to protect physicians and preserve access to ART.

Gender-Affirming Care

As of the drafting of this report in July 2024, four states (New Hampshire, Ohio, South Carolina, and Wyoming) enacted bans on gender affirming care in 2024. These actions bring the total count of states to 26 (Alabama, Arizona, Arkansas, Florida, Georgia, Iowa, Idaho, Indiana, Kentucky, Louisiana, Mississippi, Montana, Missouri, North Carolina, North Dakota, Nebraska, New Hampshire, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, West Virginia, and Wyoming) that have enacted laws that prohibit the provision of gender-affirming care to minor patients, including medications to delay puberty, hormonal therapy, and surgeries. Three of those states (Arizona, Nebraska, and New Hampshire) prohibit surgical interventions on patients younger than 18 years of age but do not ban non-surgical interventions. Due to legal challenges, laws in Arkansas, Florida, Montana, and Ohio are enjoined, in whole or part.

Some, but not all, states impose criminal penalties for violations. In other states, violations are subject to professional discipline, including, in some places, mandatory revocation of the health care professional's license. Several state laws also authorize patients and their families to bring civil suits against health care professionals for decades after the care was provided.

The AMA has advocated against state restrictions on evidence-based gender-affirming care in several states including Missouri, Montana, New Hampshire, and South Dakota and will continue to work closely with state medical associations across the country to oppose bans on evidence-based care. Due to political dynamics in many states, much of the AMA's advocacy is conducted through state medical associations behind-the-scenes. The AMA has also assisted state medical associations in supporting shield laws in many states that are supportive of access to gender-affirming care, including in Maine and Rhode Island, both of which enacted shield laws in 2024. Additionally, the AMA has filed and joined briefs in multiple federal court cases supporting evidence-based gender-affirming care. The AMA and other Federation members have also been the subject of subpoenas on issues related to the patient-physician relationship, notably with respect to policies and resources around gender-affirming care. The AMA is also deeply concerned about increasingly hostile rhetoric and threats of violence directed at physicians who provide evidence-based gender-affirming care.

CONCLUSION

The Board, through the Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted, will continue to implement Policies G-605.009, D-5.998, and D-425.989, monitor and prepare for new and emerging threats to the provision of evidenced-based medical care, and work to protect access to care and preserve the role of the patient-physician relationship as a central element in medical decision-making.

OPINION OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Opinion 1-I-24

Subject: Research Handling of De-Identified Patient Data

Presented by: Jeremy A. Lazarus, MD, Chair

INTRODUCTION

At the 2024 Annual Meeting, the American Medical Association House of Delegates adopted the recommendations of Council on Ethical and Judicial Affairs Report 2-A-24, "Research Handling of De-Identified Patient Data." The Council issues this Opinion, which will appear in the next version of AMA PolicyFinder and the online edition of the *Code of Medical Ethics*.

E-3.3.4 Research Handling of De-Identified Patient Data

Within health care systems, identifiable private health information, initially derived from and used in the care and treatment of individual patients, has led to the creation of massive de-identified datasets. As aggregate datasets, clinical data takes on a secondary promising use as a means for quality improvement and innovation that can be used for the benefit of future patients and patient populations. While de-identification of data is meant to protect the privacy of patients, there remains a risk of re-identification, so while patient anonymity can be safeguarded it cannot be guaranteed. In handling patient data, individual physicians thus strive to balance supporting and respecting patient privacy while also upholding ethical obligations to the betterment of public health.

When clinical data are de-identified and aggregated, their potential use for societal benefits through research and development is an emergent, secondary use of electronic health records that goes beyond individual benefit. Such data, due to their potential to benefit public health, should thus be treated as a form of public good, and the ethical standards and values of health care should follow the data and be upheld and maintained even if the data are sold to entities outside of health care. The medical profession's responsibility to protect patient privacy as well as to society to improve future health care should be recognized as inherently tied to these datasets, such that all entities granted access to the data become data stewards with a duty to uphold the ethical values of health care in which the data were produced.

As individuals or members of health care institutions, physicians should:

(a) Follow existing and emerging regulatory safety measures to protect patient privacy.

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(b) Practice good data intake, including collecting patient data equitably to reduce bias in datasets.

(c) Answer any patient questions about data use in an honest and transparent manner to the best of their ability in accordance with current federal and state legal standards.

Health care entities, in interacting with patients, should adopt policies and practices that provide patients with transparent information regarding:

(d) The high value that health care institutions place on protecting patient data.

(e) The reality that no data can be guaranteed to be permanently anonymized, and that risk of re-identification does exist.

(f) How patient data may be used.

(g) The importance of de-identified aggregated data for improving the care of future patients.

Health care entities managing de-identified datasets, as health data stewards, should:

(h) Ensure appropriate data collection methods and practices that meet industry standards to support the creation of high-quality datasets.

(i) Ensure proper oversight of patient data is in place, including Data Use/Data Sharing Agreements for the use of de-identified datasets that may be shared, sold, or resold.

(j) Develop models for the ethical use of de-identified datasets when such provisions do not exist, such as establishing and contractually requiring independent data ethics review boards free of conflicts of interest and verifiable data audits, to evaluate the use, sale, and potential resale of clinically derived datasets.

(k) Take appropriate cyber security measures to seek to ensure the highest level of protection is provided to patients and patient data.

(l) Develop proactive post-compromise planning strategies for use in the event of a data breach to minimize additional harm to patients.

(m) Advocate that health- and non-health entities using any health data adopt the strongest protections and seek to uphold the ethical values of the medical profession.

There is an inherent tension between the potential benefits and burdens of de-identified datasets as both sources for quality improvement to care as well as risks to patient privacy. Re-identification of data may be permissible, or even obligatory, in rare circumstances when done in the interest of the health of individual patients. Re-identification of aggregated patient data for other purposes without obtaining patients' express consent, by anyone outside or inside of health care, is impermissible. (IV)

OPINION OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Opinion 2-I-24

Subject: Amendment to E-2.1.1, "Informed Consent"

Presented by: Jeremy A. Lazarus, MD, Chair

INTRODUCTION

At the 2024 Annual Meeting, the American Medical Association House of Delegates adopted the recommendations of Council on Ethical and Judicial Affairs Report 2-A-24, "Research Handling of De-Identified Patient Data." The Council issues this Opinion, which will appear in the next version of AMA PolicyFinder and the online edition of the *Code of Medical Ethics*.

E-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. Transparency with patients regarding all medically appropriate options of treatment is critical to fostering trust and should extend to any discussions regarding who has access to patients' health data and how data may be used.

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;

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(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. (I, II, V, VIII)

OPINION OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Opinion 3-I-24

Subject: Amendment to E-3.1.1, "Privacy in Health Care"

Presented by: Jeremy A. Lazarus, MD, Chair

INTRODUCTION

At the 2024 Annual Meeting, the American Medical Association House of Delegates adopted the recommendations of Council on Ethical and Judicial Affairs Report 2-A-24, "Research Handling of De-Identified Patient Data." The Council issues this Opinion, which will appear in the next version of AMA PolicyFinder and the online edition of the *Code of Medical Ethics*.

E-3.1.1 Privacy in Health Care

Protecting information gathered in association with the care of the patient is a core value in health care. However, respecting patient privacy in other forms is also fundamental, as an expression of respect for patient autonomy and a prerequisite for trust.
Patient privacy encompasses a number of aspects, including personal space (physical privacy), personal data (informational privacy), personal choices including cultural and religious affiliations (decisional privacy), and personal relationships with family members and other intimates (associational privacy).

Physicians must seek to protect patient privacy in all settings to the greatest extent possible and should:

(a) Minimize intrusion on privacy when the patient's privacy must be balanced against other factors.

(b) Inform the patient when there has been a significant infringement on privacy of which the patient would otherwise not be aware.

(c) Be mindful that individual patients may have special concerns about privacy in any or all of these areas.

(d) Be transparent with any inquiry about existing privacy safeguards for patient data but acknowledge that anonymity cannot be guaranteed and that breaches can occur notwithstanding best data safety practices. (I, IV)

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OPINION OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Opinion 4-I-24

Subject: Amendment to E-3.2.4 "Access to Medical Records by Data Collection Companies"

Presented by: Jeremy A. Lazarus, MD, Chair

INTRODUCTION

At the 2024 Annual Meeting, the American Medical Association House of Delegates adopted the recommendations of Council on Ethical and Judicial Affairs Report 2-A-24, "Research Handling of De-Identified Patient Data." The Council issues this Opinion, which will appear in the next version of AMA PolicyFinder and the online edition of the *Code of Medical Ethics*.

E-3.2.4 Access to Medical Records by Data Collection Companies

Information contained in patients' medical records about physicians' prescribing practices or other treatment decisions can serve many valuable purposes, such as improving quality of care. However, ethical concerns arise when access to such information is sought for marketing purposes on behalf of commercial entities that have financial interests in physicians' treatment recommendations, such as pharmaceutical or medical device companies.

Information gathered and recorded in association with the care of a patient is confidential. Patients are entitled to expect that the sensitive personal information they divulge will be used solely to enable their physician to most effectively provide needed services. Disclosing information to third parties for commercial purposes without consent undermines trust, violates principles of informed consent and confidentiality, and may harm the integrity of the patient-physician relationship.

Physicians who propose to permit third-party access to specific patient information for commercial purposes should:

(a) Only provide data that has been de-identified.

(b) Fully inform each patient whose record would be involved (or the patient's authorized surrogate when the individual lacks decision-making capacity) about the purpose(s) for which access would be granted.

Physicians who propose to permit third parties to access the patient's full medical record should:

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(c) Obtain the consent of the patient (or authorized surrogate) to permit access to the patient's medical record.

(d) Prohibit access to or decline to provide information from individual medical records for which consent has not been given.

(e) Decline incentives that constitute ethically inappropriate gifts, in keeping with ethics guidance.

Because de-identified datasets are derived from patient data as a secondary source of data for the public good, health care professionals and/or institutions who propose to permit third-party access to such information have a responsibility to establish that any use of data derived from health care adhere to the ethical standards of the medical profession. (I, II, IV)

OPINION OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Opinion 5-I-24

Subject: Amendment to E-3.3.2, "Confidentiality and Electronic Medical Records"

Presented by: Jeremy A. Lazarus, MD, Chair

INTRODUCTION

At the 2024 Annual Meeting, the American Medical Association House of Delegates adopted the recommendations of Council on Ethical and Judicial Affairs Report 2-A-24, "Research Handling of De-Identified Patient Data." The Council issues this Opinion, which will appear in the next version of AMA PolicyFinder and the online edition of the *Code of Medical Ethics*.

E-3.3.2, Confidentiality and Electronic Medical Records

Information gathered and recorded in association with the care of a patient is confidential, regardless of the form in which it is collected or stored.

Physicians who collect or store patient information electronically, whether on stand-alone systems in their own practice or through contracts with service providers, must:

(a) Choose a system that conforms to acceptable industry practices and standards with respect to:

(i) restriction of data entry and access to authorized personnel;

(ii) capacity to routinely monitor/audit access to records;

(iii) measures to ensure data security and integrity;

(iv) policies and practices to address record retrieval, data sharing, third-party access and release of information, and disposition of records (when outdated or on termination of the service relationship) in keeping with ethics guidance.

(b) Describe how the confidentiality and integrity of information is protected if the patient requests.

(c) Release patient information only in keeping with ethics guidance for confidentiality and privacy. (V)

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OPINION OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Opinion 6-I-24

Subject: Physicians' Use of Social Media for Product Promotion and Compensation

Presented by: Jeremy A. Lazarus, MD, Chair

INTRODUCTION

At the 2024 Annual Meeting, the American Medical Association House of Delegates adopted the recommendations of Council on Ethical and Judicial Affairs Report 4-A-24, "A Physicians' Use of Social Media for Product Promotion and Compensation." The Council issues this Opinion, which will appear in the next version of AMA PolicyFinder and the online edition of the *Code of Medical Ethics*.

E-2.3.2– Physicians' Use of Social Media for Product Promotion and Compensation

Social media—internet-enabled communication platforms—enable individual medical students and physicians to have both a personal and a professional presence online. Social media can foster collegiality and camaraderie within the profession as well as provide opportunities to widely disseminate public health messages and other health communications. However, use of social media by medical professionals can also undermine trust and damage the integrity of patient-physician relationships and the profession as a whole, especially when medical students and physicians use their social media presence to promote personal interests.

Physicians and medical students should be aware that they cannot realistically separate their personal and professional personas entirely online and should curate their social media presence accordingly. Physicians and medical students therefore should:

(a) When publishing any content, consider that even personal social media posts have the potential to damage their professional reputation or even impugn the integrity of the profession.

(b) Respect professional standards of patient privacy and confidentiality and refrain from publishing patient information online without appropriate consent.

(c) Maintain appropriate boundaries of the patient-physician relationship in accordance with ethics guidance if they interact with their patients through social media, just as they would in any other context.

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(d) Use privacy settings to safeguard personal information and content, but be aware that once on the Internet, content is likely there permanently. They should routinely monitor their social media presence to ensure that their personal and professional information and content published about them by others is accurate and appropriate.

(e) Publicly disclose any financial interests related to their social media content, including, but not limited to, paid partnerships and corporate sponsorships.

(f) When using social media platforms to disseminate medical health care information, ensure that such information is useful and accurate based on professional medical judgment. (I, II, IV)

OPINION OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Opinion 7-I-24

Subject: Short-Term Global Health Clinical Encounters

Presented by: Jeremy A. Lazarus, MD, Chair

INTRODUCTION

At the 2024 Annual Meeting, the American Medical Association House of Delegates adopted the recommendations of Council on Ethical and Judicial Affairs Report 1-A- 24, "Short-Term Global Health Clinical Encounters." The Council issues this Opinion, which will appear in the next version of AMA PolicyFinder and the online edition of the *Code of Medical Ethics*.

E-8.1.4 Short-Term Global Health Clinical Encounters

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

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

Physicians and trainees who are involved with short-term global health clinical encounters should ensure that the trips with which they are associated:

(a) Focus prominently on promoting justice and sustainability by collaborating with the host community to define project parameters, including identifying community needs, project goals, and how the visiting medical team will integrate with local health care

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professionals and the local health care system. In collaboration with the host community, short-term global health clinical encounters should prioritize efforts to support the community in building health care capacity. Trips that also serve secondary goals, such as providing educational opportunities for trainees, should prioritize benefits as defined by the host community over benefits to members of the visiting medical team or the sponsoring organization.

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

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

(d) Are organized by sponsors that embrace a mission to promote justice, patient-centered care, community welfare, and professional integrity. Physicians, as influential members of their health care systems, are well positioned to influence the selection, planning and preparation for short term encounters in global health. In addition, they can take key roles in mentoring learners and others on teams to be deployed. Physicians can also offer guidance regarding the evaluation process of the experience, in an effort to enhance and improve the outcomes of future encounters.

Sponsors of short-term global health clinical encounters should:

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

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

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

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

REPORT OF THE SPEAKERS

Speakers' Report 2-I-24

Subject:	Recommendations for Policy Reconciliation
Presented by:	Lisa Bohman Egbert, MD, Speaker; and John H. Armstrong, MD, Vice Speaker

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Policy G-600.111, "Consolidation and Reconciliation of AMA Policy," calls on your Speakers to "present one or more reconciliation reports for action by the House of Delegates relating to newly passed policies from recent meetings that caused one or more existing policies to be redundant and/or obsolete." Should other policies be identified that require updates, please email suggestions to your Speakers at hod@ama-assn.org. These will be addressed in future reconciliation reports.

Where changes to policy language will be made, additions are shown with underscore and deletions are shown with strikethrough in red font. Given the length of many of the policies, only the affected portions are reproduced.

RECOMMENDED RECONCILIATIONS

Policies to be modified

1. Through their work with the Election Task Force 2 and the Resolution Modernization Task Force, your Speakers identified policies that required corrections which would not change the intent of the policy but would update the language. The first removes a reference to a specific nationality, and the second refers to a tool that is no longer in use in our House policy making process.

   - G-610.090, "AMA Election Rules and Guiding Principles," Section V, Item 3:
     Each participant in ~~G~~group dinners, if attended by an announced candidate in a currently contested election, must ~~be "Dutch treat" - each participant~~ pay~~s~~ their own share of the expenses, with the exception that societies and delegations may cover the expense for their own members. This rule would not disallow societies from paying for their own members or delegations gathering together with each individual or delegation paying their own expense. Gatherings of 4 or fewer delegates or alternates are exempt from this rule.

   - G-600.055, "Options for Informational Reports Submitted to the House of Delegates," Item 1:
     Informational reports will be included in the AMA House of Delegates Online ~~Member Forums~~Reference Committees.

2. AMA policy H-65.942 states, "our American Medical Association will recognize the importance of using gender-neutral language such as gender neutral pronouns, terms, imagery, and symbols in respecting the spectrum of gender identity." The policy further states that policy will be amended prospectively by way of the reaffirmation and sunset processes. In addition, policy D-65.977 directs your Speakers to "review and update the language used in AMA policy and other resources and communications to ensure that the language used to describe families

and persons in need of obstetric and gynecologic care is inclusive of all genders and family structures."

In response to the House's request, your Speakers completed a policy search for the following terms: obstetric, pregnant, pregnancy, mother, father, he, she, him, her, his, man, men, woman, and women and have recommended appropriate alternate language for these terms. Ongoing review of gendered language should continue prospectively as policy states.

- Appendix A includes relevant portions of policies that contain gendered language and the recommended gender neutral alternative language.

- Appendix B contains other policies with gendered language that is relevant to the intent of the policy and would substantively change the policy if replaced with gender neutral language. Therefore, your Speakers are recommending the following policies be retained as written.

Recommended policy changes do not reset the sunset clock and will be implemented when this report is filed.

Fiscal Note: Minimal

Appendix A - Recommendations for gender neutral language

Policy Number	Title	Policy Language
D-65.984	Humanitarian and Medical Aid Support to Ukraine	2. Our AMA will advocate for an early implementation of mental health measures, including suicide prevention efforts, and address war-related trauma and post-traumatic stress disorder when dealing with Ukrainian refugees with special attention to vulnerable populations including but not limited to young children, ~~mothers~~**their parents**, pregnant ~~women~~**people**, and the elderly.
D-95.956	Cannabis Product Safety	Our American Medical Association will draft state model legislation to help states implement the provisions of AMA policies H-95.924, Cannabis Legalization for Adult Use and H-95.936, Cannabis Warnings for Pregnant and Breastfeeding ~~Women~~**People** that currently do not have such model language, including regulation of retail sales, marketing and promotion (especially those aimed at children), misleading health claims, and product labeling regarding dangers of use during pregnancy and breastfeeding.
D-290.982	State Children's Health Insurance Program Reauthorization (SCHIP)	2. Our AMA will lobby Congress to: c. Allow states to explicitly use SCHIP funding to cover eligible pregnant ~~women~~**people**. d. Allow states the flexibility to cover all eligible children residing in the United States and pregnant ~~women~~**people** through the SCHIP program without a mandatory waiting period.
D-310.950	Protecting Trainees' Breastfeeding Rights	Our AMA will: (2) work with appropriate bodies, such as the LCME, ACGME, and Association of American Medical Colleges (AAMC), to include language related to the learning and work environments for breastfeeding ~~mothers~~**people** in regular program reviews.
D-315.971	Physician Access to Their Medical and Billing Records	(2) that, where physician possession of all ~~his or her~~ billing records is not already required by state law, the employment or other contractual arrangement between a physician and entity submitting claims on behalf of the physician should specify that the physician is entitled to copies of ~~his or her~~ billing records subsequent to the termination of employment or contractual arrangement, when such records are necessary for the physician's defense in malpractice actions, administrative investigations, or other proceedings against the physician; (3) for legislation or regulation to eliminate contractual language that bars or limits the treating physician's access to ~~his or her~~ billing records and associated medical records, such as treating these records as trade secrets or proprietary.
D-383.989	Physician Freedom to Collectively Negotiate with Managed Care Plans and Health Insuring Organizations	Our AMA will: (4) speak forcefully to its membership that no member should feel compelled to sign any contractual agreement that harms ~~his/her~~ **their** ability to provide compassionate and quality care to ~~his/her~~ **their** patients; and
D-420.990	Pain Management Following Caesarean Birth	(3) supports counseling of ~~women~~**patients** who are prescribed opioid analgesics following caesarean birth about the risk of central nervous system depression in the ~~woman~~**patient** and the breastfed infant.

D-420.991	Improving Treatment and Diagnosis of ~~Maternal~~Peripartum Depression Through Screening and State-Based Care Coordination	Our AMA: (1) will work with stakeholders to encourage the implementation of a routine protocol for depression screening in pregnant and postpartum ~~women~~people presenting alone or with their child during prenatal, postnatal, pediatric, or emergency room visits; (2) encourages the development of training materials related to ~~maternal~~peripartum depression to advise providers on appropriate treatment and referral pathways; and (3) encourages the development of state-based care coordination programs (e.g., staffing a psychiatrist and care coordinator) to assure appropriate referral, treatment and access to follow-up ~~maternal~~peripartum-mental health care.
D-420.992	Research into Preterm Birth and Related Cardiovascular and Cerebrovascular Risks in ~~Women~~Pregnant People	Our AMA will advocate for more research on ways to identify risk factors linking preterm birth to cardiovascular or cerebrovascular disease in pregnant ~~women~~people.
D-440.930	Enhanced Zika Virus Public Health Action	3. Our AMA will consider collaboration with other educational and promotional entities (e.g., the AMA Alliance) to promote family-directed and community-directed strategies that minimize the transmission of Zika virus to potentially pregnant ~~women~~people.
G-600.031	Roles and Responsibilities of AMA Delegates and Alternate Delegates	(2) The roles and responsibilities of delegates and alternate delegates are as follows: (a) regularly communicate AMA policy, information, activities, and programs to constituents so ~~he/she~~they will be recognized as the representative of the AMA;
G-600.060	Introducing Business to the AMA House	5. The submission of resolutions calling for similar action to what is already existing AMA policy is discouraged. Organizations represented in the House of Delegates are responsible to search for alternative ways to obtain AMA action on established AMA policy, especially by communicating with the Executive Vice President. The EVP will submit a report to the House detailing the items of business received from organizations represented in the House which ~~he or she~~they consider~~s~~ significant or when requested to do so by the organization, and the actions taken in response to such contacts.
G-630.010	Executive Vice President	The office of the Executive Vice President shall be filled, if possible, by a Doctor of Medicine or Osteopathy who is an active member of our AMA at the time of ~~his~~their appointment and who possesses the necessary managerial qualifications.
H-5.989	Freedom of Communication Between Physicians and Patients	1. to strongly condemn any interference by the government or other third parties that causes a physician to compromise ~~his or her~~their medical judgment as to what information or treatment is in the best interest of the patient.
H-20.905	HIV/AIDS Research	(1) Information on the HIV Epidemic Our AMA: b) Requests the Secretary of the Department of Health and Human Services to make available information on HIV expenditures, services, programs, projects, and research of agencies under ~~his/her~~their jurisdiction and, to the extent possible, of all other federal agencies for purposes of study, analysis, and comment. The compilation should be sufficiently detailed that the nature of the expenditures can be readily determined;

H-20.906	Health and Disability Coverage for Health Care Workers at Risk for HIV and Other Serious Infectious Diseases	2. Disability Coverage a. each health care worker should consider the risks of exposure to infectious agents posed by ~~his/her~~**their** type of practice and the likely consequences of infection in terms of changes needed in that practice mode and select disability insurance coverage accordingly. The policy selected should contain a reasonable definition of "sickness" or "disability," an own-occupation clause, and guaranteed renewability, future insurability, and partial disability provisions; c. since there are a variety of disability insurance coverages available and a diversity of practice modes, each health care professional should individually assess ~~his/her~~**their** risk of infection and that of ~~his/her~~**their** employees and select disability coverage accordingly.
H-20.907	Financing Care for HIV/AIDS Patients	4. Our AMA supports government funding of all medical services that are deemed appropriate by both the patient and physician for pregnant seropositive ~~women~~**people** lacking other sources of funding.
H-20.910	HIV-Infected Children	2. Our AMA encourages the physician responsible for care of an HIV-infected child in a day-care, preschool, or school setting to receive information from the school on other infectious diseases in the environment and temporarily remove the HIV-infected child from a setting that might pose a threat to ~~his/her~~**their** health.
H-20.915	HIV/AIDS Reporting, Confidentiality, and Notification	(3) Contact Tracing and Partner Notification Our AMA: d) Promulgates the standard that a physician attempt to persuade an HIV-infected patient to cease all activities that endanger unsuspecting others and to inform those whom ~~he/she~~**they** might have infected. If such persuasion fails, the physician should pursue notification through means other than by reliance on the patient, such as by the Public Health Department or by the physician directly.
H-20.917	Neonatal Screening for HIV Infection	2. Our AMA favors giving consideration to rapid HIV testing of newborns, with ~~maternal~~ consent of the gestational parent, when the individual's HIV status has not been determined during pregnancy or labor.
H-20.918	Maternal HIV Screening and Treatment to Reduce the Risk of Perinatal HIV Transmission	In view of the significance of the finding that treatment of HIV-infected pregnant ~~women~~**people** with appropriate antiretroviral therapy can reduce the risk of transmission of HIV to their infants, our AMA recommends the following statements: (1) Given the prevalence and distribution of HIV infection among ~~women~~**individuals** in the United States, the potential for effective early treatment of HIV infection ~~in both women and their infants~~, and the significant reduction in perinatal HIV transmission with treatment of pregnant ~~women~~**people** with appropriate antiretroviral therapy, routine education about HIV infection and testing should be part of a comprehensive health care program for all ~~women~~**individuals**. The ideal would be for all ~~women~~**people** to know their HIV status before considering pregnancy. (2) Universal HIV testing of all pregnant ~~women~~**people**, with patient notification of the right of refusal, should be a routine component of perinatal care. Basic counseling on HIV prevention and treatment should also be provided to the patient, consistent with the principles of informed consent. (3) The final decision about accepting HIV testing is the responsibility of the ~~woman~~**patient**. The decision to consent to or refuse an HIV test should be voluntary. When the choice is to reject testing, the patient's refusal should be recorded. Test results should be confidential within the limits of existing law and the need to provide appropriate medical care for ~~the woman~~**patients** and ~~her~~**their** infant. (4) To assure that the intended results are being achieved, the proportion of pregnant ~~women~~**people** who have accepted or rejected HIV testing and

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

H-20.920	HIV Testing	(2) Informed Consent Before HIV Testing b) Informed consent should include the following information: (i) patient option to receive more information and/or counseling before deciding whether or not to be tested and (ii) the patient should not be denied treatment if ~~he or she~~they refuse~~s~~ HIV testing, unless knowledge of HIV status is vital to provide appropriate treatment; in this instance, the physician may refer the patient to another physician for care; (10) Counseling and Testing of Pregnant ~~Women~~People for HIV Our AMA supports the position that there should be universal HIV testing of all pregnant ~~women~~people, with patient notification of the right of refusal, as a routine component of perinatal care, and that such testing should be accompanied by basic counseling and awareness of appropriate treatment, if necessary. Patient notification should be consistent with the principles of informed consent.
H-30.940	AMA Policy Consolidation: Labeling Advertising, and Promotion of Alcoholic Beverages	3. Our AMA a. 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~~people, as well as the dangers of irresponsible use to all sectors of the populace).
H-35.989	Physician Assistants	2. A physician assistant should provide patient care services only in accord with the medical practice act and other applicable state law, and such law should provide that the physician assistant's utilization by a physician or group of physicians be approved by the medical licensing board. A licensed physician or group of physicians seeking to utilize a physician assistant should submit to the medical licensing board an application for utilization that identifies: the qualifications and experience of the physician assistant, the qualifications and experience of the supervising physician and a description of ~~his or her~~their practice, and a description of the manner and the health care settings in which the assistant will be utilized, and the arrangements for supervision by the responsible physician. Such an application should also specify the number of physician assistants that the physician or group of physicians plans to employ and supervise. A physician assistant should be authorized to provide patient care services only so long as the assistant is functioning under the direction and supervision of a physician or group of physicians whose application for utilization has been approved by the medical licensing board. State medical licensing boards, in their review of applications for utilization of a physician assistant, should take special care to insure that the proposed physician assistant functions not be of a type which: 4. While it is preferable and desirable that the physician assistant be employed by a physician or group of physicians so as to ensure appropriate physician supervision in the interests of the patient, where a physician assistant is employed by a hospital, the physician assistant must provide patient care services in accordance with the rules and procedures established by the organized medical staff for utilization of physician-employed physician assistants functioning in that institution, and under the direction and supervision of a designated physician who has been approved by the state medical licensing board to supervise that physician assistant in accordance with a specific utilization plan and who shall be directly responsible as the attending physician for the patient care services delegated to ~~his~~their physician assistant.

H-50.996	Blood for Medical Use	(1) Blood transfusions and the use of other bodily tissues or substances or biological substances in rendering medical care to patients are often essential to save the life of a patient or to protect ~~his~~**their** health. Protecting the welfare of patients requires that blood for transfusions and bodily tissues or substances and biological substances be available and that use when needed be encouraged and not burdened with unreasonable restrictions and increased costs.
H-60.918	Lead Contamination in Municipal Water Systems as Exemplified by Flint, Michigan	3. Our AMA will advocate for appropriate nutritional support for all people exposed to lead contaminated water with resulting elevated blood lead levels, but especially exposed pregnant ~~women~~**people**, lactating ~~mothers~~**people** and exposed children. Support should include Vitamin C, green leafy vegetables and other calcium resources so that their bodies will not be forced to substitute lead for missing calcium as the children grow.
H-60.924	Reducing Lead Poisoning	2. Our AMA will call on the United States government to establish national goals to: (b) eliminate lead exposures to pregnant ~~women~~**people** and children, so that by 2030, no child would have a blood lead level >1 µg/dL (10 ppb). 3. Our AMA will call on the United States government in all its agencies to pursue the following strategies to achieve these goals: a. adopt health-based standards and action levels for lead that rely on the most up-to-date scientific knowledge to prevent and reduce human exposure to lead, and assure prompt implementation of the strongest available measures to protect pregnant ~~women~~**people** and children from lead toxicity and neurodevelopmental impairment; f. establish an independent expert advisory committee to develop a long-term national strategy, including recommendations for funding and implementation, to achieve the national goal of eliminating lead toxicity in pregnant ~~women~~**people** and children, defined as blood lead levels above 1 µg/dL (10 ppb).
H-65.965	Support of Human Rights and Freedom	1. Our American Medical Association continues to support the dignity of the individual, human rights and the sanctity of human life, 2. Our AMA reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges and responsibilities commensurate with ~~his or her~~ individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity or transgender status, race, religion, disability, ethnic origin, national origin or age.
H-85.955	Hospice Care	4. Our AMA believes that each patient admitted to a hospice program should have ~~his or her~~**their** designated attending physician who, in order to provide continuity and quality patient care, is allowed and encouraged to continue to guide the care of the patient in the hospice program.
H-85.961	Accuracy, Importance, and Application of Data from the US Vital Statistics System	Our American Medical Association encourages physicians to provide complete and accurate information on prenatal care and hospital patient records of the ~~mother~~**birthing patient** and **their** infant, as this information is the basis for the health and medical information on birth certificates.
H-85.968	Patient Self Determination Act	(1) lend its administrative, legislative, and public relations support to assuring that the specific wishes of the individual patient as specified in ~~his or her~~**their** advance directive be strictly honored in or out of the hospital setting; (3) promote efforts to develop a national system to assist emergency medical personnel to rapidly ascertain a person's wishes with regard to resuscitation, regardless of ~~his or her~~**their** state of location.

H-95.912	Involuntary Civic Commitment for Substance Use Disorder	Our American Medical Association opposes civil commitment proceedings for patients with a substance use disorder unless: b. Judicial oversight is present to ensure that the patient can exercise ~~his or her~~their right to oppose the civil commitment. c. The patient will be treated in a medical or other health care facility that is staffed with medical professionals with training in mental illness and addiction, including medications to help with withdrawal and other symptoms as prescribed by ~~his or her~~their physician.
H-95.924	Cannabis Legalization for Adult Use (commonly referred to as recreational use)	3. Our AMA discourages cannabis use, especially by persons vulnerable to the drug's effects and in high-risk populations such as youth, pregnant ~~women~~people, and ~~women~~people who are breastfeeding. 10. Our AMA will advocate for stronger public health messaging on the health effects of cannabis and cannabinoid inhalation and ingestion, with an emphasis on reducing initiation and frequency of cannabis use among adolescents, especially high potency products; use among ~~women~~people who are pregnant or contemplating pregnancy; and avoiding cannabis-impaired driving.
H-95.952	Cannabis and Cannabinoid Research	4. Our AMA supports research to determine the consequences of long-term cannabis use, especially among youth, adolescents, pregnant ~~women~~people, and ~~women~~people who are breastfeeding.
H-95.967	Harmful Substance Use	Our AMA encourages every physician to make a commitment to join ~~his/her~~their community in attempting to reduce harmful substance use and that said commitment encourage involvement in at least one of the following roles:
H-95.976	Addiction and Unhealthy Substance Use	(2) encourages the development of addiction treatment programs, complete with an evaluation component that is designed to meet the special needs of pregnant ~~women~~people and ~~women~~parents with infant children through a comprehensive array of essential services; (3) urges physicians to routinely provide, at a minimum, a historical screen for all pregnant ~~women~~people, and those of childbearing age for substance abuse and to follow up positive screens with appropriate counseling, interventions and referrals; (7) affirms the concept that addiction is a disease and supports developing model legislation to appropriately address perinatal addiction as a disease, bearing in mind physicians' concern for the health of the ~~mother~~pregnant person, the fetus and resultant offspring; and (8) calls for better coordination of research, prevention, and intervention services for ~~women~~pregnant people and infants at risk for both HIV infection and perinatal addiction.
H-100.951	Medication Brown Bagging	2. Our AMA affirms that "brown bagged" pharmaceuticals be accepted for in-office or hospital administration only after the physician responsible for administering these medications determines that the individual patient, or ~~his or her~~their agent, is fully capable of safely handling and transporting the medication.
H-115.974	Prescription Labeling	(1) That when a physician desires to prescribe a brand name drug product, ~~he or she~~they do so by designating the brand name drug product and the phrase "Do Not Substitute" (or comparable phrase or designation, as required by state law or regulation) on the prescription; and when a physician desires to prescribe a generic drug product, ~~he or she~~they do so by designating the USAN-assigned generic name of the drug on the prescription.

H-130.937	Delivery of Health Care by Good Samaritans	3. Where there is no conflict with state or local jurisdiction protocol, policy, or regulation on this topic, our AMA supports the following basic guidelines to apply in those instances where a bystander physician happens upon the scene of an emergency and desires to assist and render medical assistance. For the purpose of this policy, "bystander physicians" shall refer to those physicians rendering assistance voluntarily, in the absence of pre-existing patient-physician relationships, to those in need of medical assistance, in a service area in which the physician would not ordinarily respond to requests for emergency assistance. e. Where voice communication is not available, the bystander physician may sign appropriate documentation indicating that ~~he/she~~they will take responsibility for the patient(s), including provision of care during transportation to a medical facility. Medical oversight systems lacking voice communications capability should consider the addition of such communication linkages to further strengthen their potential in this area. f. The bystander physician should avoid involvement in resuscitative measures that exceed ~~his or her~~their level of training or experience.
H-130.978	Billing Procedures for Emergency Care	(2) In the interest of high quality care, patients who seek medical attention on an emergency basis should have the benefit of an immediate evaluation of any indicated diagnostic studies. The physician who provides such evaluation is entitled to adequate compensation for ~~his or her~~their services. When such evaluations are provided as an integral part of and in conjunction with other routine services rendered by the emergency physician, ideally an inclusive charge, commensurate with the services provided, should be made. Where the carrier collapses or eliminates CPT-4 coding for payment purposes, the physician may be left with no realistic alternative other than to itemize. Such an itemized bill should not be higher than the amount which would be paid if the appropriate inclusive charge were recognized. The interpretation of diagnostic procedures by a consulting specialist, as a separate and independent service provided the emergency patient, is equally important to good patient care. Physicians who provide such interpretations are also entitled to adequate compensation for their services
H-140.951	Professionalism in Medicine	Our AMA believes that the primary mission of the physician is to use ~~his~~ best efforts and skill in the care of ~~his~~ patients and to be mindful of those forces in society that would erode fundamental ethical medical practice. The AMA affirms that the medical profession is solely responsible for establishing and maintaining standards of professional medical ethics and that the state neither legislate ethical standards nor excuse physicians from their ethical obligations. The AMA House of Delegates, Board of Trustees, staff, and membership rededicate themselves to professionalism such that it permeates all activities and is the defining characteristic of the AMA's identity.
H-140.970	Decisions to Forgo Life-Sustaining Treatment for Incompetent Patients	(1) Advance directives (living wills and durable powers of attorney for health care) are the best insurance for individuals that their interests will be promoted in the event that they become incompetent. Generally, it is most effective if the individual designates a proxy decisionmaker and discusses with the proxy ~~his or her~~their values regarding decisions about life support.
H-140.984	Physicians' Involvement in Commercial Ventures	Our AMA opposes an across-the-board ban on self-referrals because of benefits to patients including increased access and competition, but proposes a list of standards to ensure ethical and acceptable financial arrangements: (3) Patient Referral Requirement - No investor in the medical facility can be required or coerced in any manner to refer patients to the facility. No investor can be required to divest ~~his or her~~ investment for failure to refer patients. No investor can be required to divest because ~~he or she~~they move~~s~~ from the area or ceases practicing medicine. (5) Disclosure of Ownership Interest - A physician or other health care

		professional or provider with an ownership interest in a medical or other health care facility or service to which the physician refers patients must disclose to the patients this ownership interest. A general disclosure can be made in a manner which is appropriate to ~~his or her~~their practice situation. (6) Request for Care - Each patient of a physician with an ownership interest (or whose immediate family member has an interest) must be provided with a physician's request for ancillary care to enable the patient to select a facility for such care. However, in accordance with the physician's ethical responsibility to provide the best care for the patient, the physician must be free to recommend what in the physician's judgment is the most appropriate facility, including ~~his or her~~their own facility. (7) Notification of Ownership Interest to Payer - If the physician (or immediate family member) has an ownership interest in a medical or health care facility or service to which ~~he or she~~they refer~~s~~ patients who are Medicare beneficiaries, this physician should identify the ownership interest on the Medicare claim form. If the Medicare carrier detects a pattern suggesting inappropriate utilization, the matter could be referred to the PRO for follow-up pursuant to the existing PRO review process. Such PRO review would have to be conducted in a uniformly fair, open-minded manner.
H-140.989	Informed Consent and Decision-Making in Health Care	(6) A patient should have access to the information in ~~his or her~~their 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.
H-150.989	Weight Loss Programs	1. Our AMA encourages any person considering participation in a weight loss program to first consult ~~his or her~~their regular attending physician, or any other independent physician, for a physical examination and an objective professional evaluation of the proposed weight loss program as it relates to the individual's physical condition.
H-160.888	Urgent Care Centers	1. Our American Medical Association supports that any individual, company, or other entity that establishes and/or operates urgent care centers (UCCs) adhere to the following principles: b. UCCs must transfer a patient's medical records to ~~his or her~~their primary care physician and to other health care providers, with the patient's consent, including offering transfer in an electronic format if the receiving physician is capable of receiving it.
H-160.912	The Structure and Function of Interprofessional Health Care Teams	2. Our AMA will advocate that the physician leader of a physician-led interprofessional health care team be empowered to perform the full range of medical interventions that ~~she or he is~~they are trained to perform.
H-160.921	Retail Clinics	4. Our AMA supports that any individual, company, or other entity that establishes and/or operates retail health clinics adhere to the following principles: b. Retail health clinics must use electronic health records to transfer a patient's medical records to ~~his or her~~their primary care physician and to other health care providers, with the patient's consent;

H-160.942	Evidence-Based Principles of Discharge and Discharge Criteria	(7) The AMA endorses the following principles in the development of evidence-based discharge criteria and an organized discharge process: (c) The discharge process includes, but is not limited to: (iv) Responsibility/Accountability: Responsibility/accountability for an appropriate transition from one setting to another rests with the attending physician. If that physician will not be following the patient in the new setting, ~~he or she is~~they are responsible for contacting the physician who will be accepting the care of the patient before transfer and ensuring that the new physician is fully informed about the patient's illness, course, prognosis, and needs for continuing care. If there is no physician able and willing to care for the patient in the new setting, the patient should not be discharged. Notwithstanding the attending physician's responsibility for continuity of patient care, the health care setting in which the patient is receiving care is also responsible for evaluating the patient's needs and assuring that those needs can be met in the setting to which the patient is to be transferred.
H-160.947	Physician Assistants and Nurse Practitioners	10. The physician is responsible for clarifying and familiarizing the physician assistant with ~~his/her~~their supervising methods and style of delegating patient care.
H-165.856	Health Insurance Market Regulation	4. Strict community rating should be replaced with modified community rating, risk bands, or risk corridors. Although some degree of age rating is acceptable, an individual's genetic information should not be used to determine ~~his or her~~their premium.
H-165.877	Increasing Coverage for Children	Our AMA: (1) supports appropriate legislation that will provide health coverage for the greatest number of children, adolescents, and pregnant ~~women~~people;
H-165.920	Individual Health Insurance	(3) actively supports the principle of the individual's right to select ~~his/her~~a health insurance plan and actively support ways in which the concept of individually selected and individually owned health insurance can be appropriately integrated, in a complementary position, into the Association's position on achieving universal coverage and access to health care services. (6) supports the individual's right to select ~~his/her~~a health insurance plan and to receive the same tax treatment for individually purchased coverage, for contributions toward employer-provided coverage, and for completely employer provided coverage;
H-180.960	Insurance Company Medical Test Disclosures	AMA policy is that insurance companies must inform insurance applicants of any abnormal results that are found during an insurance health evaluation; that insurance companies should inform an applicant that if ~~he or she~~they receive~~s~~ information concerning an evaluation that has an abnormal result, ~~he or she~~they should send the results to ~~his or her~~their physician for further consultation; and that all insurance applicants should be made aware that all health information obtained from insurance evaluations is available upon an applicant's request.
H-210.996	Providing Cost Estimate with Home Health Care Order Authorization	The AMA urges physicians to request home health care providers to provide a cost estimate with the physician authorization form, when the form is sent to the physician for ~~his/her~~ signature.
H-210.998	Home Health Service Abuse	(3) urges physicians not to authorize the provision post-acute or long-term care to any patient with whom ~~he or she is~~they are not professionally involved in providing care.

H-220.977	Chief Executive Officer at Medical Staff Executive Committee	The AMA reaffirms its support for amending The Joint Commission Medical Staff Standard MS.02.01.01, Element of Performance 2, to read as follows: "That the Chief Executive Officer of the hospital or ~~his or her~~their designee may be invited to attend meetings of the Executive Committee of the medical staff."
H-225.942	Physician and Medical Staff Member Bill of Rights	IV. Our AMA recognizes that the following fundamental rights apply to individual medical staff members, regardless of employment, contractual, or independent status, and are essential to each member's ability to fulfill the responsibilities owed to ~~his or her~~their patients, the medical staff, and the health care organization:
H-225.946	Preserving Physician/Patient Relationships During Hospitalizations	1. Our AMA advocates that hospital admission processes should include: a determination of whether the patient has an existing relationship with an actively treating primary care or specialty physician; where the patient does not object, prompt notification of such actively treating physician(s) of the patient's hospitalization and the reason for inpatient admission or observation status; to the extent possible, timely communication of the patient's medical history and relevant clinical information by the patient's primary care or specialty physician(s) to the hospital-based physician; notice to the patient that ~~he/she~~they may request admission and treatment by such actively treating physician(s) if the physician has the relevant clinical privileges at the hospital; honoring requests by patients to be treated by their physician(s) of choice; and allowing actively treating physicians to treat to the full extent of their hospital privileges.
H-225.950	AMA Principles for Physician Employment	1. Addressing Conflicts of Interest d. A physician's paramount responsibility is to ~~his or her~~their patients. Additionally, given that an employed physician occupies a position of significant trust, ~~he or she~~they owe~~s~~ a duty of loyalty to ~~his or her~~their employer. This divided loyalty can create conflicts of interest, such as financial incentives to over- or under-treat patients, which employed physicians should strive to recognize and address. i. No physician should be required or coerced to perform or assist in any non-emergent procedure that would be contrary to ~~his/her~~their religious beliefs or moral convictions. ii. No physician should be discriminated against in employment, promotion, or the extension of staff or other privileges because ~~he/she~~they either performed or assisted in a lawful, non-emergent procedure, or refused to do so on the grounds that it violates ~~his/her~~their religious beliefs or moral convictions. 3. Contracting c. When a physician's compensation is related to the revenue ~~he or she~~they generate~~s~~, or to similar factors, the employer should make clear to the physician the factors upon which compensation is based. d. Termination of an employment or contractual relationship between a physician and an entity employing that physician does not necessarily end the patient-physician relationship between the employed physician and persons under ~~his/her~~their care. When a physician's employment status is unilaterally terminated by an employer, the physician and ~~his or her~~their employer should notify the physician's patients that the physician will no longer be working with the employer and should provide them with the physician's new contact information. Patients should be given the choice to continue to be seen by the physician in ~~his or her~~their new practice setting or to be treated by another physician still working with the employer. Records for the physician's patients should be retained for as long as they are necessary for the care of the patients or for addressing legal issues faced by the physician; records should not be destroyed without notice to the former employee.

		Where physician possession of all medical records of ~~his or her~~**their** patients is not already required by state law, the employment agreement should specify that the physician is entitled to copies of patient charts and records upon a specific request in writing from any patient, or when such records are necessary for the physician's defense in malpractice actions, administrative investigations, or other proceedings against the physician. 5. Peer Review and Performance Evaluations f. Upon termination of employment with or without cause, an employed physician generally should not be required to resign ~~his or her~~**their** hospital medical staff membership or any of the clinical privileges held during the term of employment, unless an independent action of the medical staff calls for such action, and the physician has been afforded full due process under the medical staff bylaws. Automatic rescission of medical staff membership and/or clinical privileges following termination of an employment agreement is tolerable only if each of the following conditions is met:
H-225.952	The Physician's Right to Exercise Independent Judgement in All Organized Medical Staff Affairs	Our American Medical Association supports the unfettered right of a physician to exercise ~~his/her~~ personal and professional judgment in voting, speaking and advocating on any matter regarding: vi. not to be deemed in breach of ~~his/her~~**their** employment or independent contractor agreement for asserting the foregoing enumerated rights; and vii. not to be retaliated against by ~~his/her~~**their** employer in any way, including, but not limited to, termination of ~~his/her~~ employment or independent contractor agreement, commencement of any disciplinary action, or any other adverse action against ~~him/her~~**them** based on the exercise of the foregoing rights.
H-225.992	Right to Relevant Information	1. The AMA advocates "timely notice" and "opportunity to rebut" any adverse entry in the medical staff member's credential file, believes that any health care organization file on a physician should be opened to ~~him or her~~**them** for inspection, and supports inclusion of these provisions in hospital medical staff bylaws. 6. The investigating individual or body shall interview the practitioner, unless the practitioner waives ~~his/her~~**their** right to be heard, to evaluate the potential charges and explore alternative courses of action before proceeding to the formal peer review process.
H-225.997	Physician-Hospital Relationships	9. Both hospitals and hospital-associated medical specialists have an obligation to serve the needs of patients and the medical staff. The primary responsibility for determining the services needed adequately to care for the needs of individual patients should be that of the attending physician subject to review by ~~his~~**their**-peers.
H-230.954	Privileging Physicians with Low Volume Hospital Activity	3. Hospitals and medical staffs should use data and references, if available, from another hospital at which the applicant physician may be active as an additional method to verify ~~his/her~~**their** competency within the hospital environment.
H-230.956	Hospital, Ambulatory Surgery Facility, Nursing Home, or Other Health Care Facility Closure: Physician Credentialing Records	1. AMA policy regarding the appropriate disposition of physician credentialing records following the closure of hospitals, ambulatory surgery facilities, nursing homes and other health care facilities, where in accordance with state law and regulations is as follows: C. Documentation of Physician Credentials: The governing body shall make appropriate arrangements so that each physician will have the opportunity to make a timely request to obtain a copy of the verification of ~~his/her~~**their** credentials, clinical privileges, CME information, and medical staff status.

H-235.961	Employment Status and Eligibility for Election or Appointment to Medical Staff Leadership Positions	1. Our American Medical Association adopted as policy the principle that a medical staff member's personal or financial affiliations or relationships, including employment or contractual relationships with any hospital or health care delivery system, should not affect ~~his or her~~ eligibility for election or appointment to medical staff leadership positions, provided that such interests are disclosed prior to the member's election or appointment and in a manner consistent with the requirements of the medical staff bylaws. 2. Our AMA will draft model medical staff bylaws provisions supporting the principle that a medical staff member's personal or financial affiliations or relationships, including employment or contractual relationships with any hospital or health care delivery system, should not affect ~~his or her~~ eligibility for election or appointment to medical staff leadership positions, provided that such interests are disclosed prior to the member's election or appointment and in a manner consistent with the requirements of the medical staff bylaws.
H-235.967	Medical Staff Legal Counsel and Conflict of Interest	There is an inherent conflict of interest when an attorney represents the hospital and the organized medical staff. Organized medical staffs should require that the following disclosures be made prior to retaining separate legal counsel to avoid any real or perceived conflicts of interest on the counsel's part and to assure ~~his or her~~**their** loyalty: (1) whether the lawyer or the firm in which ~~he or she is~~**they are** associated or employed has ever represented the hospital as a client and received payment from the hospital or another party on behalf of the hospital for the legal services provided; (2) whether the hospital has paid legal fees to the lawyer or the law firm with which ~~he or she is~~**they are** associated or employed for legal opinions or advice on matters pending before the hospital governing board and/or hospital administration; and (3) whether the lawyer or the firm with which ~~he or she is~~**they are** associated or employed has represented or provided legal opinions and advice to other hospitals in the community or to a local or state hospital association.
H-245.986	Infant Mortality in the United States	It is the policy of the AMA: (1) to continue to address the problems that contribute to infant mortality within its ongoing health of the public activities. In particular, the special needs of adolescents and the problem of teen pregnancy should continue to be addressed by the adolescent health initiative; and (2) to be particularly aware of the special health access needs of pregnant ~~women~~**people** and infants, especially racial and ethnic minority group populations, in its advocacy on behalf of its patients.
H-265.989	FDA Conflict of Interest	2. It is the position of the AMA that the FDA should undertake an evaluation of pay-later conflicts of interest (e.g., where a FDA advisory committee member develops a financial conflict of interest only after ~~his or her~~**their** initial appointment on the advisory committee has expired) to assess whether these undermine the independence of advisory committee member recommendations and whether policies should be adopted to address this issue.
H-265.994	Expert Witness Testimony	(3) Existing policy regarding the competency of expert witnesses and their fee arrangements (BOT Rep. SS, A-89) is reaffirmed, as follows: (c) The AMA supports the right to cross examine physician expert witnesses on the following issues: (iv) the frequency with which ~~he or she~~**they** testified for either plaintiffs or defendants. The AMA supports laws consistent with its model legislation on expert witness testimony.

H-265.997	AMA-ABA Statement on Interprofessional Relations for Physicians and Attorneys	(1) Medical Reports: Physicians, upon proper authorization, should promptly furnish the attorney with a complete medical report, and should realize that delays in providing medical information may prejudice the opportunity of the patient either to settle ~~his~~their claim or suit, delay the trial of a case, or cause additional expense or the loss of important testimony. The attorney should give the physician reasonable notice of the need for a report and clearly specify the medical information which he seeks. (3) Subpoena for Medical Witness: Because of conditions in a particular case or jurisdiction or because of the necessity for protecting ~~himself~~themselves or ~~his~~their client, the attorney is sometimes required to subpoena the physician as a witness. Although the physician should not take offense at being subpoenaed, the attorney should not cause the subpoena to be issued without prior notification to the physician. The duty of the physician is the same as that of any other person to respond to judicial process. (4) Arrangements for Court Appearances: While it is recognized that the conduct of the business of the courts cannot depend upon the convenience of litigants, lawyers or witnesses, arrangements can and should be made for the attendance of the physician as a witness which take into consideration the professional demands upon ~~his~~their time. Such arrangements contemplate reasonable notice to the physician of the intention to call ~~him~~them as a witness and to advise ~~him~~them by telephone after the trial has commenced of the approximate time of ~~his~~their required attendance. The attorney should make every effort to conserve the time of the physician. (5) Physician Called as Witness: The attorney and the physician should treat one another with dignity and respect in the courtroom. The physician should testify solely as to the medical facts in the case and should frankly state ~~his~~their medical opinion. He should never be an advocate and should realize that ~~his~~their testimony is intended to enlighten rather than to impress or prejudice the court or the jury. It is improper for the attorney to abuse a medical witness or to seek to influence ~~his~~their medical opinion. Established rules of evidence afford ample opportunity to test the qualifications, competence, and credibility of a medical witness, and it is always improper and unnecessary for the attorney to embarrass or harass the physician. (7) Payment of Medical Fees: The attorney should do everything possible to assure payment for services rendered by the physician for ~~himself~~themselves or ~~his~~their client. When the physician has not been fully paid, the attorney should request permission of the patient to pay the physician from any recovery which the attorney may receive in behalf of the patient.
H-265.998	Guidelines for Due Process	(1) The physician should be provided with a statement, or a specific listing, of the charges made against ~~him or her~~them. (5) The physician against whom the charges are made should have the opportunity to be present at the hearing and hear all of the evidence against ~~him or her~~them. (6) The physician is entitled to the opportunity to present a defense to the charges against ~~him or her~~them.

H-275.937	Patient/Physician Relationship and Medical Licensing Boards	(1) Without regard to whether an act or failure to act is entirely determined by a physician, or is the result of a contractual or other relationship with a health care entity, the relationship between a physician and a patient must be based on trust and must be considered inviolable. Included among the elements of such a relationship of trust are: (a) Open and honest communication between the physician and the patient, including disclosure of all information necessary for the patient to be an informed participant in ~~his or her~~their care. (5) A (name of state) physician has both medical-legal and ethical obligations to ~~his or her~~their patients. These are well established in both law and professional tradition. Some models of medical practice may result in an inappropriate restriction of the physician's ability to practice quality medicine. This may create negative consequences for the public. It is incumbent that physicians take those actions they consider necessary to assure that medical practice models do not adversely affect the care that they render to their patients.
H-275.953	The Grading Policy for Medical Licensure Examinations	2. Our AMA adopts the following policy on NBME or USMLE examination scoring: b. Numerical scores are reported to the state licensing authorities upon request by the applicant for licensure. At this time, the applicant may request a copy of ~~his or her~~their numerical scores.
H-275.994	Physician Participation in Third Party Payer Programs	The AMA opposes state laws making a physician's licensure contingent upon ~~his~~ providing services to Medicaid beneficiaries or any other specific category of patients should be opposed.
H-275.998	Physician Competence	6. Our AMA urges state medical licensing boards to report all disciplinary actions promptly to the Federation of State Medical Boards and to the AMA Physician Masterfile. (Failure to do so simply allows the incompetent or impaired physician to migrate to another state, even after disciplinary action has been taken against ~~him~~them, and to continue to practice in a different jurisdiction but with the same hazards to the public.)
H-280.968	Do Not Hospitalize Orders	(1) acknowledges that do-not-hospitalize orders in the nursing home situation, when based on the resident's (or ~~his or her~~their family's) informed consent, provide an appropriate means of promoting patient autonomy and carrying out the expressed level of treatment goals and wishes of the resident; and
H-280.999	Physician Involvement in Long-Term Care	1. Our AMA will emphasize in its communications to the medical profession, medical educators, and other professional groups concerned with long-term care the importance of increased physician understanding, supervision of, and involvement in care of the chronically ill and disabled of all ages in all care settings. The AMA believes that physicians have a central role in assuring that all residents of nursing facilities receive thorough assessments and that medical plans of care are instituted or revised to enhance or maintain the resident's physical and psychosocial functioning. The AMA endorses the following "Guidelines for Physicians Attending Patients in Long-Term Care Facilities": D. Each attending physician should designate an alternate physician or should advise ~~his~~their physician exchange of who may be called to see ~~his~~their patients for regular or emergency care when the attending physician is not available. In the event that neither the attending physician nor the designated alternate physician is available to examine and treat a patient requiring immediate attention, the medical director shall have the authority to call another physician for appropriate treatment or treat the patient ~~himself~~themself. E. Prior to or upon admission of a patient, it would be desirable for the attending physician to perform a physical examination of ~~his~~their-patient and

		provide the facility with an admitting diagnosis, statement of patient's functional status, and orders for diet, medication and initial treatment. Other patient information required by the facility may be provided at the time of admission or as soon as practical thereafter and should include a family history, past medical history, report of current medical findings, and a statement of rehabilitation potential and prognosis. The physician should also make arrangements for furnishing the facility with appropriate laboratory, x-ray, and consultation reports. F. Each attending physician is responsible for planning the medical care of ~~his~~their patient. Upon admission of ~~his~~their patient, the physician should make a medical evaluation of ~~his~~their patient's immediate and long-term care needs. This should include information about medications, treatments, rehabilitative services, diets, precautions related to activities undertaken by the patient, and plans for continuing care and, when appropriate, discharge. In developing this plan, it may be necessary for the attending physician to consult with the patient and/or the patient's family. The attending physician should review this plan at least annually and make revisions when appropriate. The plan may be reviewed by the medical director so that he may ensure consistency with the facility's policies. G. The facility should inform each attending physician of the availability of social, psychological and other non-medical aspects of care for ~~his~~their patient so that he may assure ~~himself~~themself that such care is compatible with the medical condition of the patient. H. The attending physician should be aware of the need for the medical director, in fulfilling ~~his~~ required duties, to review the records of patients in the facility and, on occasion, actually contact the patient and/or family. K. The attending physician should visit ~~his~~their patient on a schedule determined by the patient's medical needs, and which is consistent with any state or federal regulations applicable, and this schedule should be documented in the patient's record. The attending physician may review ~~his~~their schedule of visits for each patient in conjunction with an annual reevaluation of the patient's health status. L. During each visit, the attending physician should see ~~his~~their patient, sign all written changes in orders and enter a progress note in the patient's record indicating that the patient has been visited. It should be the duty of the charge nurse to call the attention of the attending physician to orders requiring renewal. Except as specifically indicated below, treatment orders should not be permitted to expire without notification to the attending physician. M. The attending physician should give all orders for treatment in writing. An order may be considered in writing if it is dictated to a licensed nurse, signed and dated by the nurse, and countersigned by the physician at the time of ~~his~~their next visit to the facility or by other acceptable arrangements. Q. The attending physician should be aware that the pharmacist may review the drug regimen of each patient at least monthly and report ~~his~~their comments to the medical director and administrator. In those instances where the medical director and the pharmacist question the appropriateness of the drug regimen, the question should be brought to the attention of the attending physician.

H-285.910	The Physician's Right to Engage in Independent Advocacy on Behalf of Patients, the Profession and the Community	In caring for patients and in all matters related to this Agreement, Physician shall have the unfettered right to exercise ~~his/her~~ independent professional judgment and be guided by ~~his/her~~ personal and professional beliefs as to what is in the best interests of patients, the profession, and the community. Nothing in this Agreement shall prevent or limit Physician's right or ability to advocate on behalf of patients' interests or on behalf of good patient care, or to exercise ~~his/her~~**their** own medical judgment. Physician shall not be deemed in breach of this Agreement, nor may Employer retaliate in any way, including but not limited to termination of this Agreement, commencement of any disciplinary action, or any other adverse action against Physician directly or indirectly, based on Physician's exercise of ~~his/her~~**their** rights under this paragraph.
H-285.952	Amendments to Managed Care Contracts	1. It is policy of our American Medical Association that: e. Our AMA opposes managed care plan mandating that physician to notify all ~~his/her~~**of their** patients. f. Our AMA opposes the preapproval of physician-developed notification letters by managed care plans required if a participating physician who is voluntarily leaving the plan chooses to inform ~~his/her~~**their** patient of the departure.
H-285.962	Anti-Psychiatry Practices of Certain Health Maintenance Organizations and Managed Care Organizations	Our AMA opposes managed care organization (MCO) requirements that a patient determined by ~~his or her~~**their** physician to be in need of specific treatment, including psychiatric treatment, be interviewed by an unqualified employee of the MCO prior to approval of the treatment.
H-285.991	Qualifications and Credentialing of Physicians Involved in Managed Care	1. AMA policy on selective contracting is as follows: (d) Prior to initiation of actions leading to termination or nonrenewal of a physician's participation contract for any reason the physician shall be given notice specifying the grounds for termination or nonrenewal, a defined process for appeal, and an opportunity to initiate and complete remedial activities except in cases where harm to patients is imminent or an action by a state medical board or other government agency effectively limits the physician's ability to practice medicine. Participation in a physician health program in and of itself shall not count as a limit on the ability to practice medicine. Our AMA supports the following appeals process for physicians whose health insurance contract is terminated or not renewed: (v) the physician or ~~his/her~~**their** representative should be able to appear in person at the hearing and present the physician's case;
H-285.998	Managed Care	5. Utilization Review The medical protocols and review criteria used in any utilization review or utilization management program must be developed by physicians. Public and private payers should be required to disclose to physicians on request the screening and review criteria, weighting elements, and computer algorithms utilized in the review process, and how they were developed. Physician of the same specialty must be involved in any decision by a utilization management program to deny or reduce coverage for services based on questions of medical necessity. All health plans conducting utilization management or utilization review should establish an appeals process whereby physicians, other health care providers, and patients may challenge policies restricting access to specific services and decisions to deny coverage for services, and have the right to review of any coverage denial based on medical necessity by a physician independent of the health plan who is of the same specialty and has appropriate expertise and experience in the field. A physician whose services are being reviewed for medical necessity should be provided the identity of the reviewing physician on request. Any physician who makes judgments or recommendations regarding the necessity

		or appropriateness of services or site of services should be licensed to practice medicine and actively practicing in the same jurisdiction as the practitioner who is proposing or providing the reviewed service and should be professionally and individually accountable for ~~his or her~~their decisions. All health benefit plans should be required to clearly and understandably communicate to enrollees and prospective enrollees in a standard disclosure format those services which they will and will not cover and the extent of coverage for the former. The information disclosed should include the proportion of plan income devoted to utilization management, marketing, and other administrative costs, and the existence of any review requirements, financial arrangements or other restrictions that may limit services, referral or treatment options, or negatively affect the physician's fiduciary responsibility to ~~his or her~~their patients. It is the responsibility of the patient and ~~his or her~~their health benefits plan to inform the treating physician of any coverage restrictions imposed by the plan. All health plans utilizing managed care techniques should be subject to legal action for any harm incurred by the patient resulting from application of such techniques. Such plans should also be subject to legal action for any harm to enrollees resulting from failure to disclose prior to enrollment any coverage provisions; review requirements; financial arrangements; or other restrictions that may limit services, referral, or treatment options, or negatively affect the physician's fiduciary responsibility to ~~his or her~~their patient. When inordinate amounts of time or effort are involved in providing case management services required by a third party payer which entail coordinating access to other health care services needed by the patient, or in complying with utilization review requirements, the physician may charge the payer or the patient for the reasonable cost incurred. "Inordinate" efforts are defined as those "more costly, complex and time-consuming than the completion of standard health insurance claim forms, such as obtaining preadmission certification, second opinions on elective surgery, certification for extended length of stay, and other authorizations as a condition of payer coverage." Any health plan or utilization management firm conducting a prior authorization program should act within two business days on any patient or physician request for prior authorization and respond within one business day to other questions regarding medical necessity of services. Any health plan requiring prior authorization for covered services should provide enrollees subject to such requirements with consent forms for release of medical information for utilization review purposes, to be executed by the enrollee at the time services requiring prior authorization are recommended by the physicians. In the absence of consistent and scientifically established evidence that preadmission review is cost-saving or beneficial to patients, the AMA strongly opposes the use of this process.
H-290.985	Monitoring Medicaid Managed Care	8. In programs where more than one plan is available, beneficiary freedom to choose ~~his/her~~their plan, enforcement of standards for marketing/enrollment practices, and clear and comparable disclosure of plan benefits and limitations including financial incentives on providers.
H-295.861	Accommodating Lactating ~~Mothers~~Individuals Taking Medical Examinations	*Title change only; no policy change*

H-295.995	Recommendations for Future Directions for Medical Education	(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.
H-295.998	Due Process	(2) In addition, to clarify and protect the rights of medical students, the AMA recommends that: (b) These policies and procedures should define the responsible bodies and their function and membership, provide for timely progressive verbal and written notification to the student that ~~his/her~~**their** academic/nonacademic performance is in question, and provide an opportunity for the student to learn why it has been questioned. (c) These policies and procedures should also ensure that when a student has been notified of recommendations by the responsible committee for nonadvancement or dismissal, ~~he/she has~~**they have** adequate notice and the opportunity to appear before the decision-making body to respond to the data submitted and introduce ~~his/her~~**their** own data.
H-315.986	Confidentiality of Patient Records	Our AMA opposes the concept that filing a claim for medical insurance coverage constitutes a blanket waiver of a patient's right to confidentiality of ~~his/her~~**their** medical records for all purposes. The AMA will engage in a major initiative to educate patients about the implications and consequences of blanket medical records releases, and educate patients about the need for possible legislative modifications.
H-315.995	Hospital Face Sheet: Physician Responsibility	The AMA believes that it is the responsibility of the attending physician to specify all diagnoses and procedures in the hospital records, and that no alteration should be made without ~~his or her~~**their** consent.
H-320.954	Post-Partum Hospital Stay and Nurse Home Visits	The AMA: (1) opposes the imposition by third party payers of mandatory constraints on hospital stays for vaginal deliveries and cesarean sections as arbitrary and as detrimental to the health of the ~~mother~~**birthing patient** and of the newborn; and (2) urges that payers provide payment for appropriate follow-up care for the ~~mother~~**birthing patient** and newborn.
H-320.968	Approaches to Increase Payer Accountability	1. Disclosure Requirements. Our American Medical Association supports the development of model draft state and federal legislation to require disclosure in a clear and concise standard format by health benefit plans to prospective enrollees of information on: c. Plan financial arrangements or contractual provisions that would limit the services offered, restrict referral or treatment options, or negatively affect the physician's fiduciary responsibility to ~~his or her~~**their** patient.
H-320.985	Economic Discharge Order for Utilization Review Committee Denial	(1) reaffirms its policy that economic considerations should not conflict with a physician's primary responsibility to serve the best interests of ~~his or her~~**their** patient and that, if a third party payer or Medicare regulation results in urging of a physician to discharge a patient against the physician's medical judgment, the patient should be so informed and the physician should protest the limitation; and

H-335.996	Spurious Medical Necessity Denials	(2) Until such time as repeal of this provision is achieved, the AMA urges CMS and Medicare Part B carriers to make further changes in the implementation of this authority to correct problems being experienced, including: (f) opposing required wording in the patient waiver form (advance exculpatory notice) that suggests that the physician is about to provide medically unnecessary services to ~~his or her~~their patients.
H-340.907	Notification When Physician Specific Information is Exchanged	Our American Medical Association will petition CMS to require notification of a physician under focused review that ~~his or her~~their name is being exchanged between any carrier and the QIOs and to identify the reason for this exchange of information.
H-340.971	Medicare Program Due Process	The AMA supports legislative and regulatory changes, as necessary, to assure the provision of PRO review with due process protections before any physician is sanctioned under the Medicare Program. Such due process should include at a minimum the following specific protections that would entitle the physician to: (1) a written statement of the charges against ~~him or her~~them; (2) adequate notice of the right to a hearing, ~~his or her~~their rights in the hearing, and a reasonable opportunity to prepare for the hearing; (3) discover the evidence and witnesses against ~~him or her~~them sufficiently in advance of the hearing to enable preparation of the defense; (6) the opportunity to be present at the hearing and hear all of the evidence against ~~him or her~~them;
H-355.975	Opposition to the National Practitioner Data Bank	6. Our AMA opposes any legislative or administrative efforts to expand the Data Bank reporting requirements for physicians, such as the reporting of a physician who is dismissed from a malpractice suit without any payment made on ~~his or her~~their behalf, or to expand the entities permitted to query the Data Bank such as public and private third party payers for purposes of credentialing or reimbursement.
H-365.997	Corporation or Employer-Sponsored Examinations	Our American Medical Association encourages employers who provide or arrange for special or comprehensive medical examinations of employees to be responsible for assuring that these examinations are done by physicians competent to perform the type of examination required. Whenever practical, the employee should be referred to ~~his or her~~their personal physician for such professional services. In the many instances in which an employee does not have a personal physician, efforts should be made to assist ~~him or her~~them in obtaining one, with emphasis on continuity of care. This effort should be aided by the local medical society wherever possible.
H-365.998	Confidentiality of Occupational Medical Records	Our American Medical Association opposes the Department of Labor's rule requiring that, without the informed written consent of the patient-employee, ~~his~~their entire medical record shall be accessible to OSHA.
H-373.995	Government Interference in Patient Counseling	2. Our AMA strongly condemns any interference by government or other third parties that compromise a physician's ability to use ~~his or her~~their medical judgment as to the information or treatment that is in the best interest of their patients.

H-375.962	Legal Protections for Peer Review	Definitions Proceedings. Proceedings include all of the activities and information and records of a peer review committee. Proceedings are not subject to discovery and no person who was in attendance at a meeting of a peer review organization shall be permitted or required to testify in any such civil action as to any evidence or other matters produced or presented during the proceedings of such organization or as to any findings, recommendations, evaluations, opinions, or other actions of such organization or any members thereof. However, information, documents, or records otherwise available from original sources are not to be construed as immune from discovery or use in any such civil action merely because they were presented during proceedings of a peer review organization, nor should any person who testifies before a peer review organization or who is a member of a peer review organization be prevented from testifying as to matters within ~~his/her~~their knowledge; but such witness cannot be asked about ~~his/her~~their testimony before a peer review organization or about opinions formed by ~~him/her~~them as a result of the peer review organization hearings.
H-375.969	Physician Access to Performance Profile Data	AMA policy is that every physician should be given a copy of ~~his/her~~their practice performance profile information at least annually by each organization retaining such physician information.
H-375.983	Appropriate Peer Review Procedures	(2) Peer review procedures and actions should, at a minimum, meet the Health Care Quality Improvement Act of 1986 standards for federal immunity: (a) In any situation where it appears that a disciplinary proceeding may be instigated against a physician that could result in the substantial loss or termination of the physician's medical staff membership and/or clinical privileges, the advice and guidance of legal counsel should be sought. The accused physician should have legal counsel separate from the health care organization or medical staff. The health care organization and the medical staff should each have separate legal counsel. The attorney of the body bringing the peer review action, be it the health care organization or the medical staff, should undertake the procedures needed to prepare for the hearing including the written notice of charges, the marshaling of evidence and the facts, and the selection of witnesses. This health care organization or medical staff attorney should be instructed that ~~his or her~~their role includes assuring that the proceedings are conducted fairly, bearing in mind the objectives of protecting consumers of health care and the physician involved against false or exaggerated charges. The attorney for the body which is not bringing the peer review action should work to ensure that proper peer review processes as outlined in the medical staff bylaws are followed. The role of the attorney for the accused physician is solely to defend ~~his or her~~their client. (h) Physicians serving on the hearing panel should receive information and training in the elements and essentials of peer review. Clinical guidelines, standards and practices used for evaluation of quality of care should be transparent and available to the extent feasible. Wherever feasible, data collection and analysis, or similar assessment instruments, and multiple reviewers should be used to increase reliability in evaluating whether peer review disciplinary proceedings are warranted. Where feasible, statistical analysis to compare with peers' performance must be used with appropriate case mix adjustments. (i) Physicians who are direct economic competitors of the physician involved may testify as witnesses, whether they are called by the physician or the hearing panel or the health care organization, but a physician should not be deprived of ~~his or her~~their privileges solely on the basis of medical testimony by economic competitors. In any proceedings that result in the

		termination of privileges, there should be testimony from one or more physicians who are not economic competitors or who do not stand to gain economically by an adverse action, but who are knowledgeable in the treatment, patient care management and areas of medical practice or judgment upon which the adverse action is based. (k) When investigation is underway and indicates that a disciplinary proceeding is warranted for the purpose of reducing, restricting, or terminating a physician's hospital privileges, ~~he or she~~they should be notified that resignation will result in a report to the National Practitioner Data Bank.
H-385.923	Definition of "Usual, Customary and Reasonable" (UCR)	1. Our American Medical Association adopts as policy the following definitions: a. "Usual; fee means that fee usually charged, for a given service, by an individual physician to ~~his~~their private patient (i.e., ~~his~~their own usual fee);
H-385.938	Most Favored Nation Clause within Insurance Contracts	Our AMA opposes the inclusion of "Most Favored Nation Clauses" into insurance contracts that require a physician or other health care provider to give a third-party payer ~~his~~their most discounted rate for medical services.
H-385.992	Reimbursement for CT scans and Other Procedures	(1) opposes denial of a physician's right to perform specific services or to be compensated for such services solely on the basis of ~~his~~their specialty designation;
H-390.877	Home Health Care Services	Our AMA urges the federal government to provide an "explanation of medical benefits" statement for post-acute and long-term care (i.e., post-hospital care for sub-acute and chronic illnesses in a variety of health care settings, such as home health agencies and skilled nursing facilities), to the responsible physician, upon ~~his or her~~their request, and to the recipient of such care when covered by Medicare; and urges the federal government to apply a beneficiary co-payment to all home health care services covered by Medicare.
H-390.888	Payment for Concurrent Care	(5) will communicate to CMS the importance of carrier understanding that more than one physician can be involved in a case and that the carrier or insurance company not expect a physician to manage a medical problem outside ~~his/her~~their area of expertise or specialty, and that both the primary care physician or other specialist be reimbursed for this care in accordance with their responsibilities; and
H-390.889	Medicare Reimbursement of Telephone Consultations	5. It is the policy of our AMA to seek enactment of legislation as needed to allow separate Medicare payment for those telephone calls that can be considered discrete and medically necessary services performed for the patient without ~~his/her~~their presence.
H-390.917	Consultation Follow-Up and Concurrent Care of Referral for Principal Care	(1) It is the policy of the AMA that: (a) the completion of a consultation may require multiple encounters after the initial consultative evaluation; and (b) after completion of the consultation, the consultant may be excused from responsibility of the care of the patient or may share with the primary care physician in concurrent care; ~~he/she~~they may also have the patient referred for care and thus become the principal care physician.
H-390.971	Hospitals Limited to Participating Physicians	3. Our AMA urges a return to the original intent of the Medicare Law (Title XVIII) as expressed in Sections 1801 and 1802 enacted in 1965 which read as follows: "Section 1801 [42 U.S.C. 1895] Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person." "Section 1802 [42 U.S.C. 1895a] Any individual entitled to insurance benefits under this title may obtain health services from any institution, agency, or

		person qualified to participate under this title if such institution, agency, or person undertakes to provide ~~him~~ such services"
H-410.971	Clinical Algorithm Impact on Patient Care	1) Clinical algorithms are guidelines established to aid a physician in the diagnosis and treatment of patients. As such, they should be used by the physicians as guidelines, but recognizing that each patient is an individual and has unique needs and problems, the physician should use ~~his or her~~their best judgment in the use of the guidelines and should never be forced to specifically follow these guidelines rigidly.
H-420.947	Support for International Aid for Reproductive Health	1. Our American Medical Association opposes restrictions on U.S. funding to non-governmental organizations solely because they provide reproductive health care internationally, including but not limited to contraception and abortion care. 2. Our AMA supports funding for global humanitarian and non-governmental organizations for ~~maternal~~obstrectric care ~~healthcare~~ and comprehensive reproductive health services, including but not limited to contraception and abortion care.
H-420.953	Improving Mental Health Services ~~for~~During Pregnan~~t~~cy and Postpartum ~~Mothers~~	*Title change only; no policy change*
H-420.954	Truth and Transparency in Pregnancy Counseling Centers	4. Our AMA advocates that any entity licensed to provide medical or health services to pregnant ~~women~~people
H-420.957	Shackling of Pregnant ~~Women~~Patients in Labor	1. Our American Medical Association 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~~a 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~~themselves, staff or others. • A substantial flight risk and cannot be reasonably contained by other means." If an inmate who is in labor or who is delivering ~~her~~a 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~~people unless flight or safety concerns exist.
H-420.962	Perinatal Addiction - Issues in Care and Prevention	Our AMA: (2) encourages the federal government to expand the proportion of funds allocated to drug treatment, prevention, and education. In particular, support is crucial for establishing and making broadly available specialized treatment programs for drug-addicted pregnant and breastfeeding ~~women~~people wherever possible; (3) urges the federal government to fund additional research to further knowledge about and effective treatment programs for drug-addicted pregnant and breastfeeding ~~women~~people, encourages also the support of research that provides long-term follow-up data on the developmental consequences of perinatal drug exposure, and identifies appropriate methodologies for early intervention with perinatally exposed children

H-420.964	Fetal Alcohol Syndrome Educational Program	Our American Medical Association supports informing physicians about Fetal Alcohol Syndrome and the referral and treatment of alcohol abuse by pregnant ~~women~~patients or ~~women~~patients at risk of becoming pregnant.
H-420.968	Universal Hepatitis B Virus (HBV) Antigen Screening for Pregnant ~~Women~~People	It is the policy of our American Medical Association to communicate the available guidelines for testing all pregnant ~~women~~people for HBV infection.
H-420.969	Legal Interventions During Pregnancy	Court Ordered Medical Treatments And Legal Penalties For Potentially Harmful Behavior By Pregnant ~~Women~~Persons: (1) Judicial intervention is inappropriate when a ~~woman~~pregnant patient has made an informed refusal of a medical treatment designed to benefit ~~her~~their fetus. If an exceptional circumstance could be found in which a medical treatment poses an insignificant or no health risk to the ~~woman~~pregnant patient, entails a minimal invasion of ~~her~~their bodily integrity, and would clearly prevent substantial and irreversible harm to ~~her~~their fetus, it might be appropriate for a physician to seek judicial intervention. However, the fundamental principle against compelled medical procedures should control in all cases which do not present such exceptional circumstances. (2) The physician's duty is to provide appropriate information, such that the pregnant ~~woman~~patient may make an informed and thoughtful decision, not to dictate the ~~woman's~~patient's decision. (3) A physician should not be liable for honoring a pregnant ~~woman's~~patient's informed refusal of medical treatment designed to benefit the fetus. (4) Criminal sanctions or civil liability for harmful behavior by the pregnant ~~woman~~person toward ~~her~~their fetus are inappropriate.
H-420.972	Prenatal Services to Prevent Low Birthweight Infants	Our American Medical Association 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~~people, particularly ~~women~~those at risk for delivering low birthweight infants.
H-420.973	Adoption	(2) support and encourage the counseling of ~~women~~people with unintended pregnancies as to the option of adoption.
H-420.978	Access to Prenatal Care	1. Our American Medical Association supports development of legislation or other appropriate means to provide for access to prenatal care for all ~~women~~, with alternative methods of funding, including private payment, third party coverage, and/or
H-420.979	AMA Statement on Family, Medical, and Safe Leave	Our American Medical Association supports policies that provide employees with reasonable job security and continued availability of health plan benefits in the event leave by an employee becomes necessary due to documented medical conditions. Such policies should provide for reasonable periods of paid or unpaid: 1. Medical leave for the employee, including pregnancy, abortion, and stillbirth. 2. Maternity leave for the employee~~mother~~. 3. Leave if medically appropriate to care for a member of the employee's immediate family, i.e., a spouse or children. 4. Leave for adoption or for foster care leading to adoption. 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.

H-420.998	Obstetrical Delivery in the Home or Outpatient Facility	(3) believes that obstetrical facilities and their staff should recognize the wishes of ~~women~~**patients** and their families within the bounds of sound obstetrical practice; and
H-435.951	Health Court Principles	AMA PRINCIPLES FOR HEALTH COURTS V. Experts Party Expert Witnesses - Health courts should only allow medical expert witnesses to testify if the expert witness is licensed as a doctor of medicine or osteopathy. - An expert witness should be trained and experienced in the same field as the defendant or has specialty expertise in the disease process or procedure performed in the case. - An expert witness should be certified by a board recognized by the American Board of Medical Specialties or the American Osteopathic Association, or by a board with equivalent standards. - An expert witness should, within five years of the date of the alleged occurrence or omission giving rise to the claim, be in active medical practice in the same field as the defendant, or have devoted a substantial portion of ~~his~~**their**-time teaching at an accredited medical school, or in university-based research in relation to the medical care and type of treatment at issue. - A person who testifies as an expert witness in a health court should be deemed to have a temporary license to practice medicine in the state for the purpose of providing such testimony and should be subject to the jurisdiction of the state medical board.
H-435.973	Report of the Special Task Force on Professional Liability and the Advisory Panel on Professional Liability	(2) Implementation of the "Loser Pays" Rule in Medical Liability Litigation: Responsibility for a prevailing party's legal expenses, including attorney fees, should not be shifted to a losing party in medical liability litigation unless (c) the rule is adopted that no losing party will be required to pay expenses including legal fees that exceed ~~his or her~~**their** own bill for such goods or services; and
H-440.863	Restoring the Independence of the Office of the US Surgeon General	(2) calls for the Office of the United States Surgeon General to be free from the undue influence of politics, and be guided by science and the integrity of ~~his/her~~**their** role as a physician in fulfilling the highest calling to promote the health and welfare of all people.
H-440.898	Recommendations on Folic Acid Supplementation	2. Our AMA will continue to encourage broad-based public educational programs about the need for ~~women~~**people** of child-bearing potential to consume adequate folic acid through nutrition, food fortification, and vitamin supplementation to reduce the risk of NTD.
H-440.970	Nonmedical Exemptions from Immunizations	1. Our American Medical Association believes that nonmedical (religious, philosophic, or personal belief) exemptions from immunizations endanger the health of the unvaccinated individual and the health of those in ~~his or her~~**their** group and the community at large.
H-470.963	Boxing Safety	(1) Relevant regulatory bodies are encouraged to: (b) develop and enforce standard criteria for referees, ringside officials, and ringside physicians to halt sparring or boxing bouts when a boxer has experienced concussive or subconcussive blows that place ~~him or her~~**them** at imminent risk of more serious injury.
H-470.978	Blood Doping	The AMA believes that a physician who participates in blood doping is deviating from ~~his~~**their** professional responsibility and that blood doping must be considered in the category of unnecessary medical services.
H-470.984	Brain Injury in Boxing	(2) Recommend to all boxing jurisdictions that the ring physician should be authorized to stop any bout in progress, at any time, to examine a contestant and, when indicated, to terminate a bout that might, in ~~his~~**their** opinion, result in serious injury for either contestant.

H-475.997	Same-Day Admission for Elective Surgery	Our American Medical Association accepts the practice of same-day admission for elective surgery, unless this practice is determined to be detrimental to the patient's health by ~~his or her~~their physician. The determination of the advisability of same-day admission and/or outpatient surgery should be based on the judgment of the patient's physician and not solely on prescribed lists of procedures.
H-480.943	Integration of Mobile Health Applications and Devices into Practice	6. Our AMA encourages physicians to alert patients to the potential privacy and security risks of any mHealth apps that ~~he or she~~they prescribe~~s~~ or recommend~~s~~, and document the patient's understanding of such risks
H-485.991	Identification of Physicians by the Media	It is the policy of our AMA to communicate to the media that when a physician is interviewed or provides commentary ~~he or she~~they be specifically identified with the appropriate initials "MD" or "DO" after ~~his or her~~their name; and that others be identified with the appropriate degrees after their names.
H-515.965	Family and Intimate Partner Violence	(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: (b) Upon identifying patients currently experiencing abuse or threats from intimates, assess and discuss safety issues with the patient before ~~he or she~~they leave~~s~~ the office, working with the patient to develop a safety or exit plan for use in an emergency situation and making appropriate referrals to address intervention and safety needs as a matter of course;
H-525.980	Expansion of AMA Policy on Female Genital Mutilation	Our AMA: (3) supports legislation to eliminate the performance of female genital mutilation in the United States and to protect young **girls** and **women** at risk of undergoing the procedure; (4) supports that physicians who are requested to perform genital mutilation on a patient provide culturally sensitive counseling to educate the patient and ~~her~~ family members about the negative health consequences of the procedure, and discourage them from having the procedure performed. Where possible, physicians should refer the patient to social support groups that can help them cope with societal mores;

Appendix B - Policies recommending being retained as written

Policy Number	Title	Policy Language
D-245.994	Infant Mortality	2. Our AMA will work with Congress and the Department of Health and Human Services to improve maternal outcomes through: (a) maternal/infant health research at the NIH to reduce the prevelance of premature births and to focus on obesity research, treatment and prevention; (b) maternal/infant health research and surveillance at the CDC to assist states in setting up maternal mortality reviews; modernize state birth and death records systems to the 2003-recommended guidelines; and improve the Safe Motherhood Program; (c) maternal/infant health programs at HRSA to improve the Maternal Child Health Block grant; (d) comparative effectiveness research into the interventions for preterm birth; (e) disparities research into maternal outcomes, preterm birth and pregnancy-related depression; and (f) the development, testing and implementation of quality improvement measures and initiatives.
H-20.903	HIV/AIDS and Substance Use	4. Our AMA urges development of educational, medical, and social support programs for persons who inject drugs and their sexual or needle-sharing partners to reduce risk of HIV infection, as well as risk of other bloodborne and sexually transmissible diseases. Such efforts must target a. pregnant people who inject drugs and those who may become pregnant to address the current and future health care needs of both mothers and newborns and
H-20.922	HIV/AIDS as a Global Public Health Priority	6. Our AMA, in coordination with appropriate medical specialty societies, supports addressing the special issues of heterosexual HIV infection, the role of intravenous drugs and HIV infection in women, and initiatives to prevent the spread of HIV infection through the exchange of sex for money or goods.
H-60.973	Provision of Health Care and Parenting Classes to Adolescent Parents	1. It is the policy of our American Medical Association: a. to encourage state medical and specialty societies to seek to increase the number of adolescent parenting programs within school settings which provide health care for infant and mother, and child development classes in addition to current high school courses; and
H-75.987	Reducing Unintended Pregnancy	Our AMA: (1) urges health care professionals to provide care for women of reproductive age, to assist them in planning for pregnancy and support age-appropriate education in esteem building, decision-making and family life in an effort to introduce the concept of planning for childbearing in the educational process;
H-245.982	AMA Support for Breastfeeding	1. Our AMA: (c) supports working with other interested organizations in actively seeking to promote increased breastfeeding by Supplemental Nutrition Program for Women, Infants, and Children (WIC Program) recipients, without reduction in other benefits; (e) encourages public facilities to provide designated areas for breastfeeding and breast pumping; mothers nursing babies should not be singled out and discouraged from nursing their infants in public places. 2. Our AMA: (e) encourages hospitals to train staff in the skills needed to implement written breastfeeding policy, to educate pregnant women about the benefits and management of breastfeeding, to attempt early initiation of breastfeeding, to practice "rooming-in," to educate mothers on how to breastfeed and maintain lactation, and to foster breastfeeding support groups and services;

		3. Our AMA: (c) recommends exclusive breastfeeding for about six months, followed by continued breastfeeding as complementary food are introduced, with continuation of breastfeeding for 1 year or longer as mutually desired by mother and infant; (d) recommends the adoption of employer programs which support breastfeeding mothers so that they may safely and privately express breast milk at work or take time to feed their infants; and (e) encourages employers in all fields of healthcare to serve as role models to improve the public health by supporting mothers providing breast milk to their infants beyond the postpartum period. 5. Our AMA's Opioid Task Force promotes educational resources for mothers who are breastfeeding on the benefits and risks of using opioids or medication-assisted therapy for opioid use disorder, based on the most recent guidelines.
H-295.890	Medical Education and Training in Women's Health	1. Our American Medical Association encourages the coordination and synthesis of the knowledge, skills, and attitudinal objectives related to women's health/gender-based biology that have been developed for use in the medical school curriculum. Medical schools should include attention to women's health throughout the basic science and clinical phases of the curriculum. 2. Our AMA does not support the designation of women's health as a distinct new specialty. 3. Our AMA supports that each specialty should define objectives for residency training in women's health, based on the nature of practice and the characteristics of the patient population served. 4. Our AMA supports surveys of undergraduate and graduate medical education, conducted by the AMA and other groups, should periodically collect data on the inclusion of women's health in medical school and residency training. 5. Our AMA encourages the development of a curriculum inventory and database in women's health for use by medical schools and residency programs. 6. Our AMA encourages physicians to include continuing education in women's health/gender-based biology as part of their continuing professional development. 7. Our AMA encourages its representatives to the Liaison Committee on Medical Education, the Accreditation Council for Graduate Medical Education (ACGME), and the various ACGME Review Committees to promote attention to women's health in accreditation standards. 8. Our AMA will work with the ACGME to protect patient access to important reproductive health services by advocating for all family medicine residencies to provide comprehensive women's health, including training in contraceptive counseling, family planning, and counseling for unintended pregnancy. 9. Our AMA encourages the ACGME to ensure clarity when making revisions to the educational requirements and expectations of family medicine residents in comprehensive women's health topics.
H-420.970	Treatment Versus Criminalization - Physician Role in Drug Addiction During Pregnancy	(2) to forewarn the U.S. government and the public at large that there are extremely serious implications of drug addiction during pregnancy and there is a pressing need for adequate maternal drug treatment and family supportive child protective services; (3) to oppose legislation which criminalizes maternal drug addiction or requires physicians to function as agents of law enforcement - gathering evidence for prosecution rather than provider of treatment; and (4) to provide concentrated lobbying efforts to encourage legislature funding for maternal drug addiction treatment rather than prosecution, and to encourage state and specialty medical societies to do the same.

H-420.971	Infant Victims of Substance Abuse	It is the policy of the AMA: (1) to develop educational programs for physicians to enable them to recognize, evaluate and counsel women of childbearing age about the impact of substance use disorders on their children; and (2) to call for more funding for treatment and research of the long-term effects of maternal substance use disorders on children.
H-420.976	Alcohol and Other Substance Abuse During Pregnancy	(3) encourages intensified research into the physical and psychosocial aspects of maternal substance abuse as well as the development of efficacious prevention and treatment modalities.
H-420.995	Medical Care for Indigent and Culturally Displaced Obstetrical Patients and Their Newborns	Our AMA (1) reaffirms its long-standing position regarding the major importance of high-quality obstetrical and newborn care by qualified obstetricians, family physicians, and pediatricians and the need to make such care available to all women and newborns in the United States; (3) favors continuing discussion of means for improving maternal and child health services for the medically indigent and the culturally displaced.
H-425.976	Preconception Care	1. Our American Medical Association supports the 10 recommendations developed by the Centers for Disease Control and Prevention for improving preconception health care that state: 1. Individual responsibility across the lifespan--each woman, man, and couple should be encouraged to have a reproductive life plan. 2. Preventive visits--as a part of primary care visits, provide risk assessment and educational and health promotion counseling to all women of childbearing age to reduce reproductive risks and improve pregnancy outcomes. 3. Interventions for identified risks--increase the proportion of women who receive interventions as follow-up to preconception risk screening, focusing on high priority interventions (i.e., those with evidence of effectiveness and greatest potential impact). 4. Inter-conception care--use the inter-conception period to provide additional intensive interventions to women who have had a previous pregnancy that ended in an adverse outcome (i.e., infant death, fetal loss, birth defects, low birth weight, or preterm birth). 5. Health insurance coverage for women with low incomes--increase public and private health insurance coverage for women with low incomes to improve access to preventive women's health and pre-conception and inter-conception care. 6. Public health programs and strategies--integrate components of pre-conception health into existing local public health and related programs, including emphasis on inter-conception interventions for women with previous adverse outcomes. 2. Our AMA supports the education of physicians and the public about the importance of preconception care as a vital component of a woman's reproductive health. 3. Our AMA supports the use of pregnancy intention screening and contraceptive screening in appropriate women and men as part of routine well-care and recommend it be appropriately documented in the medical record.
H-430.986	Health Care While Incarcerated	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.

H-430.990	Bonding Programs for **Women** Prisoners and their Newborn Children	Because there are insufficient data at this time to draw conclusions about the long-term effects of prison nursery programs on mothers and their children, Our American Medical Association supports and encourages further research on the impact of infant bonding programs on incarcerated women and their children. However, since there are established benefits of breast milk for infants and breast milk expression for mothers, the AMA advocates for policy and legislation that extends the right to breastfeed directly and/or privately pump and safely store breast milk to include incarcerated mothers. The AMA recognizes the prevalence of mental health and substance abuse problems among incarcerated women and continues to support access to appropriate services for women in prisons. The AMA recognizes that a large majority of incarcerated females who may not have developed appropriate parenting skills are mothers of children under the age of 18. The AMA encourages correctional facilities to provide parenting skills and breastfeeding/breast pumping training to all female inmates in preparation for their release from prison and return to their children. The AMA supports and encourages further investigation into the long-term effects of prison nurseries on mothers and their children.
H-525.991	Inclusion of Women in Clinical Trials	Our AMA: (1) encourages the inclusion of women, including pregnant women when appropriate, in all research on human subjects, except in those cases for which it would be scientifically irrational, in numbers sufficient to ensure that results of such research will benefit both men and women alike;