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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

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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
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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
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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

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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

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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

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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

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RELEVANT AMA POLICY

Global Climate Change and Human Health H-135.938
Our AMA: … (5) Encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently, and that adaptation interventions are equitable and prioritize the needs of the populations most at risk. [CSAPH Rep. 3, I-08; Reaffirmation A-14; Reaffirmed: CSAPH Rep. 04, A-19; Reaffirmation: I-19; Modified: Res. 424, A-22; Modified: CSAPH Rep. 2, I-22]

Declaring Climate Change a Public Health Crisis D-135.966
1. Our AMA declares climate change a public health crisis that threatens the health and well-being of all individuals. 2. Our AMA will protect patients by advocating for policies that: (a) limit global warming to no more than 1.5 degrees Celsius, (b) reduce US greenhouse gas emissions aimed at a 50 percent reduction in emissions by 2030 and carbon neutrality by 2050, and (c) support rapid implementation and incentivization of clean energy solutions and significant investments in climate resilience through a climate justice lens. 3. Our AMA will consider signing on to the Department of Health and Human Services Health Care Pledge or making a similar commitment to lower its own greenhouse gas emissions. 4. Our AMA encourages the health sector to lead by example in committing to carbon neutrality by 2050. 5. Our AMA will develop a strategic plan for how we will enact our climate change policies including advocacy priorities and strategies to decarbonize physician practices and the health sector with report back to the House of Delegates at the 2023 Annual Meeting. [Res. 420, A-22; Appended: CSAPH Rep. 02, I-22]

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

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RELEVANT AMA POLICY:

Prevention of Drug-Related Overdose D-95.987
1. Our AMA: (a) recognizes the great burden that substance use disorders (SUDs) and drug-related overdoses and death places on patients and society alike and reaffirms its support for the compassionate treatment of patients with a SUD and people who use drugs; (b) urges that community-based programs offering naloxone and other opioid overdose and drug safety and prevention services continue to be implemented in order to further develop best practices in this area; (c) encourages the education of health care workers and people who use drugs about the use of naloxone and other harm reduction measures in preventing opioid and other drug-related overdose fatalities; and (d) will continue to monitor the progress of such initiatives and respond as appropriate.
2.Our AMA will: (a) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of a drug-related overdose; and (b) encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for a drug-related overdose.
3. Our AMA will support the development and implementation of appropriate education programs for persons receiving treatment for a SUD or in recovery from a SUD and their friends/families that address harm reduction measures.

4. Our AMA will advocate for and encourage state and county medical societies to advocate for harm reduction policies that provide civil and criminal immunity for the 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

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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

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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

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