2024 AMA Medical Student Section (MSS) Interim Meeting
Orlando, FL
November 7-8

Policy Materials

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

Resolution 001 - Military Deception as a Threat to Physician Ethics
Resolution 002 - Improving Pelvic Floor Physical Therapy Access for Pregnancy
Resolution 006 - Immigrant Healthcare System Education
Resolution 008 - Parental Involvement Mandates in Reproductive Health
Resolution 010 – Transparency on Comparative Effectiveness in Direct-to-Consumer Advertising
Resolution 104 - Healthcare in Tribal Jails
Resolution 108 - Improving Choice, Competition, and Affordability in the ACA Marketplaces
Resolution 201 - Protecting In-Person Prison Visitations to Reduce Recidivism
Resolution 202 - Codification of the Chevron Deference Doctrine
Resolution 203 - Preventing Drug-Facilitated Sexual Assault in Drinking Establishments
Resolution 205 - Sexual Health Education Confidentiality and Disparities among Adolescents
Resolution 206 - Support for Aging-Out Foster Youth with Mental Health and Psychotropic Needs
Resolution 207 - Supporting and Protecting Equity in LGBTQ+ Parentage and Assisted Reproduction
Resolution 207 - Repatriation of American Indian, Alaska Native, and Native Hawaiian Remains
Resolution 208 - Addressing the Harms of Weight Bias, Stigma, and Discrimination
Resolution 209 - Timely Prenatal Appointments in Incarcerated Populations
Resolution 301 - Support for Innovative Medical School Pathways

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Resolution 302 - Abolition of Organic Chemistry, General Chemistry, Physics, and Calculus
Resolution 303 - Improvements to Burnout Prevention Programs
Resolution 304 - Improved Clinical Relevance of Standardized Exams
Resolution 305 - Support for Medical School Applicants with Alternative Undergraduate Degrees
Resolution 306 - Overemphasis on Research in Trainee Selection
Resolution 307 - Distribution of Resident Seats Commensurate with Shortages
Resolution 309 - Addressing Misuse of Professionalism Standards in Medical Training
Resolution 312 - Providing Wellness Days on Recognized Federal Holidays
Resolution 319 - Specifying Qualifications for Teaching Disability in Medical Education
Resolution 401 - Support for Changing Standards for Minors Working in Agriculture
Resolution 404 - Promoting Child Welfare and Communication Rights in Immigration Detention
Resolution 406 - Advocating for Universal Summer Electronic Benefit Transfer Program for Children (SEBTC)
Resolution 407 – Standardizing Safety Requirements for Rideshare-Based Non-Emergency Medical Transportation
Resolution 411 – Regulation and Oversight of the Troubled Teen Industry
Resolution 413 – Promoting the Use and Efficacy of Ultraviolet Protective Clothing
Resolution 416 – Allergen Labeling for Spices and Herbs
Resolution 501 – Increasing Utilization of Point-of-Care Ultrasound in Hospital Settings
Resolution 502 – Increased Cybersecurity Standards for Healthcare Entities
Resolution 503 – Emergency Preparedness in EHR Downtime and Healthcare Technology Disruptions
Resolution 504 – Healthcare Provider Data Privacy Protection
Resolution 507 – Advancing Menopause Research and Care
Resolution 509 – Opposing Unwarranted NIH Research Institute Restructuring
Resolution 601 – MSS Caucus Endorsements
Resolution 602 – MSS Study of Assembly Representation

Section reports

MSS CEQM Report - MSS Position on Alternative Payment Models
MSS CGPH MIC Report - Reducing the Harmful Impacts of Immigration Status on Health
MSS CME Report - Increased Access and Support for First-Generation College Students
MSS COLA CEQM - Insurer Accountability When Prior Authorization Harms Patients

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Informational reports

GC Report - Standing Committee Task Force I-24 Report - MSS Standing Committee Restructuring: Progress Update
ATF Report - Archives Task Force Report
Delegate Report – Policy Proceedings of the Annual 2024 House of Delegates Meeting

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 001
(I-24)

Introduced by: Nataliyah Tahir[1], Annesha Datta[2], Sweta Parija[3], Linsey Golding[1], Katayoun Khalilian[4], Mira Dani[1], Arjan Kalra[5]

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Subject: Military Deception as a Threat to Physician Ethics

Referred to: MSS Reference Committee
(Alec Calac and Andrew Norton, Co-Chairs)

Whereas, the United States Central Intelligence Agency (CIA)'s use of a fake, physician-led hepatitis immunization program to gather military intelligence in Pakistan in 2011 inadvertently undermined global efforts to eradicate polio, increasing the number of cases in Pakistan and contributing to polio's status as a public health emergency of international concern (PHEIC) to present-day[1]; and

Whereas, public knowledge of CIA's intelligence strategy in Pakistan made legitimate polio vaccination clinics a target for militant violence, with the Taliban calling for a public boycott of polio vaccines and public health workers becoming the target of attacks[2-3]; and

Whereas, the subsequent substantial decrease in polio and hepatitis vaccination rates in Pakistan is consistent with the hypothesis that the disclosure of the vaccine ruse damaged the reputation of vaccines and of formal medicine in the region[4]; and

Whereas, the WHO's declaration of polio's re-emergence as a PHEIC emphasizes the importance of public health campaigns and global medical interventions to be politically neutral in order to maintain trust in health institutions[1]; and

Whereas, growing global distrust in healthcare institutions and providers, especially in light of the Covid-19 pandemic, is a threat to global vaccine uptake and improved health outcomes[5-7]; and

Whereas, our AMA Code of Medical Ethics serves as the foundational ethical guidance for all AMA policy and a codification of expectations regarding physician conduct, including in settings of armed conflict and military intervention; and

Whereas, our AMA Principles of Medical Ethics outline the physician's "responsibility towards patients first and foremost, as well as to society, to other health professionals, and to self"; and

Whereas, our AMA Code of Medical Ethics Opinion 8.11 Health Promotion & Preventive Care states that “Health promotion should be a collaborative, patient-centered process that promotes trust”; and

Whereas, our AMA Code of Medical Ethics Opinion 1.1.1 Patient-Physician Relationships states, “[Physicians have an] ethical responsibility to place patients’ welfare above the physician’s own self-interest or obligations to others"; and

Whereas, our AMA Code of Medical Ethics Opinion 11.1.1 Defining Basic Health Care declares that “Physicians should advocate for fair, informed decision making about basic health care that: (a) is transparent” and (c) “protects the most vulnerable patients and populations, with special attention to historically disadvantaged groups”; and

Whereas, our AMA Code of Medical Ethics Opinion 1.1.3 states, "Physicians can best contribute to a mutually respectful alliance with patients by serving as their patients’ advocates and by respecting patients’ rights. These include the right: [...] (h) To be advised of any conflicts of interest their physician may have in respect to their care"; and

Whereas, our AMA Policy H-520.998 Medical Neutrality “supports medical neutrality, under the principles of the Geneva Convention, for all health care workers and the sick and wounded in all countries”; and

Whereas, our AMA Policy D-65.993 War Crimes as a Threat to Physicians' Humanitarian Responsibilities “support[s] the efforts of physicians around the world to practice medicine ethically in any and all circumstances, including during wartime, episodes of civil strife, or sanctions and condemn the military targeting of health care facilities and personnel and using denial of medical services as a weapon of war, by any party, wherever and whenever it occurs”; and

Whereas, our AMA Code of Medical Ethics Opinion 9.7 regarding physician interactions with government agencies reiterates that “physicians have civic duties, but medical ethics do not require a physician to carry out such duties when that would contradict fundamental principles of medical ethics”; and

Whereas, our AMA Code of Medical Ethics Opinion 9.7 is limited to guidance related to medical testimony, court-initiated medical treatment in criminal cases, capital punishment, interrogation, and torture;

Whereas, neither the Geneva Conventions, nor our AMA Code of Medical Ethics, nor our AMA policies provide clear ethical guidance regarding physician conduct in the context of government entities using the provision of medical, public health, and humanitarian aid for deceptive purposes related to military gain or for purposes other than patient welfare; and

Whereas, our AMA Code of Medical Ethics and AMA policies fail to provide a holistic, ethical framework that guides physician obligations during times of armed conflict and military intervention; and

Whereas, the World Medical Association (WMA), in collaboration with international entities such as the International Committee of Military Medicine (ICMM), the International Council of Nurses (ICN), and the International Pharmaceutical Federation (FIP), has endorsed a common Ethical Principles of Care in Times of Armed Conflict and Other Emergencies[8]; and

Whereas, the Ethical Principles of Care in Times of Armed Conflict and Other Emergencies declares that "Privileges and facilities afforded to health-care personnel in times of armed conflict and other emergencies are never to be used for purposes other than for health-care needs" and "If, in performing their professional duties, [physicians] have conflicting loyalties, their primary obligation, in terms of their ethical principles, is to their patients"[8]; and

Whereas, the WMA's Statement in Times of Armed Conflict and Other Situations of Violence further reaffirms that the physician must "Never use the situation and the vulnerability of the wounded and sick for personal advantage" and "Never make use of healthcare privileges and facilities contrary to their intended purposes"[9]; and

Whereas, our AMA Code of Medical Ethics promotes the prima facie duty of physicians to patient welfare, transparency about conflict of interests when rendering medical care, and the protection of trust in the patient-provider relationship, and given that the misuse of medical aid as a cover for military intelligence gathering undermines the physician duty to patients and threatens public trust of healthcare providers and institutions; therefore be it

RESOLVED, that our American Medical Association opposes the deceptive use of medical, public health, and humanitarian aid for secret or ulterior motives by military entities, including to gather national security intelligence or gain leverage in an armed conflict.

Fiscal Note: TBD

Date Received: 09/15/2024

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RELEVANT AMA POLICY

AMA Code of Medical Ethics Opinion 8.11: Health Promotion & Preventive Care

Health promotion should be a collaborative, patient-centered process that promotes trust and recognizes patients' self-directed roles and responsibilities in maintaining health.

AMA Code of Medical Ethics Opinion 1.1.1: Patient-Physician Relationships

The practice of medicine, and its embodiment in the clinical encounter between a patient and a physician, is fundamentally a moral activity that arises from the imperative to care for patients and to alleviate suffering. The relationship between a patient and a physician is based on trust, which gives rise to physicians' ethical responsibility to place patients' welfare above the physician's own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for their patients' welfare.

AMA Code of Medical Ethics Opinion 11.1.1: Defining Basic Health Care
Physicians regularly confront the effects of lack of access to adequate care and have a corresponding responsibility to contribute their expertise to societal decisions about what health care services should be included in a minimum package of care for all.

Individually and collectively as a profession, physicians should advocate for fair, informed decision making about basic health care that:

> (a) Is transparent.
> (c) Protects the most vulnerable patients and populations, with special attention to historically disadvantaged groups.

AMA Code of Medical Ethics Opinion 1.1.3: Patient Rights
The health and well-being of patients depends on a collaborative effort between patient and physician in a mutually respectful alliance. Patients contribute to this alliance when they fulfill responsibilities they have, to seek care and to be candid with their physicians.

Physicians can best contribute to a mutually respectful alliance with patients by serving as their patients' advocates and by respecting patients' rights. These include the right:

> (h) To be advised of any conflicts of interest their physician may have in respect to their care.

D-65.993 War Crimes as a Threat to Physicians' Humanitarian Responsibilities

1. Our American Medical Association will implore all parties at all times to understand and minimize the health costs of war on civilian populations generally and the adverse effects of physician persecution in particular.
2. Our AMA will support the efforts of physicians around the world to practice medicine ethically in any and all circumstances, including during wartime, episodes of civil strife, or sanctions and condemn the military targeting of health care facilities and personnel and using denial of medical services as a weapon of war, by any party, wherever and whenever it occurs.
3. Our AMA will advocate for the protection of physicians' rights to provide ethical care without fear of persecution. [BOT Action in response to referred for decision Res. 620, A-09; Modified: BOT Rep. 09, A-19; Modified: Res. 002, I-22; Reaffirmed: Res. 603, A-24]

H-520.998 Medical Neutrality
Our American Medical Association supports medical neutrality, under the principles of the Geneva Convention, for all health care workers and the sick and wounded in all countries. [Sub. Res. 72, I-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CEJA Rep. 8, A-11; Reaffirmed in lieu of Res. 601, I-13; Reaffirmed: CEJA Rep. 05, A-23]

RELEVANT MSS POLICY

250.001MSS: Medical Care in Countries in Turmoil

Medical Care in Countries in Turmoil: AMA-MSS will ask the AMA to: (1) support provision of food, medicine, and medical equipment to civilians threatened by natural disaster or military conflict within their country; (2) express concern about the disappearance of physicians, medical students, and health care professionals and withholding of medical care to the injured in such countries in turmoil; and (3) ask appropriate international health organizations to monitor the status of health care in these countries. (AMA Amended Res 133, A-83 Adopted [H-65.994]) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

250.024MSS Regulations in Times of Armed Conflict

AMA-MSS will ask the AMA to advocate that the United States use its voice in international affairs to protect medical neutrality. (MSS Res 22, A-13) (AMA Policy H-520.998 Reaffirmed in Lieu of AMA Res 601, I-13) (Amended and Reaffirmed: MSS GC Rep A, I-19)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 002
(I-24)

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Subject: Improving Pelvic Floor Physical Therapy Access for Pregnancy

Referred to: MSS Reference Committee
(Alec Calac and Andrew Norton, Co-Chairs)

Whereas, pelvic floor injuries cause chronic pelvic pain, urinary and fecal incontinence, herniation of pelvic organs, ano-genital fistula, and dyspareunia, all of which can decrease quality of life[1,2]; and

Whereas, pregnancy and childbirth are important risk factors for injuries to the pelvic floor[3,4]; and

Whereas, a woman's first vaginal delivery increases her risk of pelvic organ prolapse tenfold[4,5]; and

Whereas, by 2050, American women are expected to experience a 46% increase in pelvic organ prolapse, due to an aging pregnant population and increasing rates of comorbidities during delivery[6]; and

Whereas, pelvic floor physical therapy is recommended in the antepartum and postpartum period as a first-line, low-risk, and minimally invasive treatment for preventing and treating pelvic floor dysfunction and pelvic organ prolapse[7-9]; and

Whereas, pelvic floor muscle training antepartum and postpartum decreases urinary incontinence and related bothersome symptoms in the immediate months following childbirth and improves pelvic floor muscle strength and endurance[7-9]; and

Whereas, the prevalence of urinary incontinence (UI) in postpartum women in the Western world is 31%, yet only 25% of the people with postpartum urinary incontinence ever seek care[10]; and

Whereas, only 5% of Federally Qualified Health Centers have access to pelvic floor physical therapy and have identified cost to patient, insurance status, and wait times as barriers to care[11]; and

Whereas, Federally Qualified Health Centers provide care to one-third of all low-income women of reproductive age[12]; and

Whereas, lower income status was associated with an increased prevalence of one or more pelvic floor disorders[6]; and

Whereas, pelvic floor physical therapist providers are increasingly operating out of network or through cash based services due to low reimbursement rates and discrepancies on what insurance companies deem medically necessary[13]; and

Whereas, many pelvic floor injuries after childbirth go underdiagnosed and under-repaired with the most pertinent barrier being insurance non-coverage and time constraints[14]; and

Whereas, other barriers to pelvic floor therapy include limited education about technique and purpose from providers and minimal awareness of pelvic floor dysfunction as abnormal during and after childbirth[15-17]; and

Whereas, the American College of Obstetricians and Gynecologists considers the postpartum period to be critical to patient's long term health and recommends providers "assess for presence of urinary and fecal continence, with referral to physical therapy or urogynecology as indicated"[19,20]; and

Whereas, the AMA supports Medicaid coverage for postpartum patients for up to 12 months after pregnancy (D-290.974) and encourages the development of resources to recognize the value of comprehensive peripartum care (H-185.917); and

Whereas, the American Physical Therapy Association strongly supports the Optimizing Postpartum Outcomes Act (H.R. 2480), which aims to increase awareness of the availability and value of pelvic health services, including pelvic health physical therapy, for postpartum women under Medicaid and the Children's Health Insurance Program[21]; therefore be it

RESOLVED, that our American Medical Association supports expanding Medicaid and CHIP to cover comprehensive pelvic floor physical therapy during the antepartum and postpartum period; and be it further

RESOLVED, that our AMA supports efforts to improve educating providers and peripartum people on the risk factors of pelvic floor dysfunction during childbirth and the benefits and indications of pelvic floor physical therapy.

Fiscal Note: TBD

Date Received: 09/15/2024

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RELEVANT AMA POLICY

D-290.974 Extending Medicaid Coverage for One Year Postpartum

Our AMA will work with relevant stakeholders to: (1) support and advocate, at the state and federal levels, for extension of Medicaid and Children's Health Insurance Program (CHIP) coverage to at least 12 months after the end of pregnancy; and (2) expand Medicaid and CHIP eligibility for pregnant and postpartum non-citizen immigrants. [Res. 221, A-19; Modified: Joint CMS/CSAPH Rep. 1, I-21; Modified: Res. 701, I-21]

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:

> 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),
>
> Carefully crafted in conjunction with clinician and patient input to protect patient privacy and provide non-discrimination protections.
>
> Lead to the dissemination of best practices to guide respectful and non-coercive collection of accurate, standardized data relevant to maternal health outcomes.

6. 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.

7. 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.

8. 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.

9. 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.

10. 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.

11. 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. [Joint CMS/CSAPH Rep. 1, I-21]

RELEVANT MSS POLICY

420.007MSS: Providing Complete Maternity Care Under the Affordable Care Act
AMA- MSS will ask the AMA to advocate for expanding coverage of maternity care to dependent women under the age of 26 on their parents' large group plans. (MSS Res 13, I-13) (AMA Res 101, A-14 Adopted [H-185.997]) (Reaffirmed: MSS GC Rep A, I-19)

420.021MSS: Coverage of Pregnancy-Associated Healthcare for 12 Months Postpartum for Uninsured Patients Ineligible for Medicaid
AMA-MSS will ask the AMA to amend Policy D-290.974, Extending Medicaid Coverage for One Year Postpartum, by addition as follows:
D-290.974 – Extending Medicaid Coverage for Pregnancy One Year Postpartum 1. Our AMA will work with relevant stakeholders to support extension of Medicaid coverage to 12 months postpartum; and 2. Our AMA will work with relevant stakeholders to expand Medicaid eligibility for pregnancy and postpartum for non-citizen immigrants.
(MSS WIM CEQM Report A, A-21) (AMA Res. 701, I-I-21, Adopt as Amended [D-290.974])

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 006
(I-24)

Introduced by: Ekaterina Kravets[1], Khushbakht Shah[1], Madison Kurth[2], Jonathan Montes[1], Loga Iyer[1], Shannon Lam[1], Umida Burkhanova[1], Elsa Khan[1], Abdullah Ali[1]

Affiliations: [1]Notheast Ohio Medical University
[2]The University of Wisconsin School of Medicine and Public Health

Subject: Immigrant Healthcare System Education

Referred to: MSS Reference Committee
(Alec Calac and Andrew Norton, Co-Chairs)

Whereas, the immigrant population in the US made up about 14% of the total country population in 2022[1]; and

Whereas, 18% of lawful immigrants in the U.S. report being uninsured, as compared to less than 10% of U.S. citizens[2]; and

Whereas, immigrants in the United States, particularly those who are undocumented, have historically been burdened by the social determinants of health including poverty, food and housing insecurity, lack of educational attainment, and challenges with health care access[3]; and

Whereas, one in four children in the United States lives with an immigrant parent, and child immigrants and refugees have an increased risk for facing behavioral, developmental, and health challenges[4]; and

Whereas, despite experiencing higher rates of preventable chronic conditions, undocumented immigrants report lower usage of health care services[5]; and

Whereas, immigrant communities lack knowledge of US state and federal healthcare eligibility criteria, and are disoriented by the healthcare terminology, with this unfamiliarity contributing to poor health outcomes, particularly an increased incidence of conditions caused by lack of preventative care, including obesity, hypertension, diabetes, HIV infection, and late prenatal care entry[6,7]; and

Whereas, nearly 50% of the uninsured child population is made up of children of immigrants because low-income immigrant families have a lack of experience with health insurance programs, are distrustful of the health care system, or are uncertain regarding their child's eligibility for Medicaid or Children's Health Insurance Program coverage policy[3]; and

Whereas, refugees and undocumented migrants struggle to access healthcare due to lack of proof of ID, insurance, and other documentation[8]; and

Whereas, the AMA Code of Medical Ethics urges physicians to promote access to care for individual patients, regardless of the patient's economic means[9]; and

Whereas, according to the AMA Code of Medical Ethics, 'the medical profession must work to ensure that societal decisions about the distribution of health resources safeguard the interests of all patients and promote access to health services'[9]; and

Whereas, the population of elderly undocumented immigrants is growing in the United States, constituting a group of individuals unable to access Medicaid but in need of health care[5]; and

Whereas, possessing health insurance positively impacts health care seeking behavior and health outcomes in immigrant populations allowing for screening, prevention, and knowledge of health among families and communities[10]; and

Whereas, immigrants suffer from poorer health literacy due to cultural and language barriers which impacts their overall health, with a study demonstrating that 45.1% of participants with limited English-proficiency and limited health literacy had the highest prevalence of poor health[11,12]; and

Whereas, only 14% of the insured patients in this 2013 study were able to correctly answer and explain basic aspects of the traditional US healthcare insurance design[13]; and

Whereas, professional organizations such as AAP include practice recommendations for refugee and immigrant healthcare, and USCIS provide insurance purchase resources, such assets are lacking in healthcare system education[14,15]; therefore be it

RESOLVED, that our American Medical Association will include educational modules, within platforms such as AMA Ed Hub, on immigrants' struggles with barriers to accessing and understanding the U.S. healthcare system to promote positive clinical outcomes; and be it further

RESOLVED, that our AMA will encourage medical schools to incorporate opportunities for students to address and explore the barriers that immigrant and refugee patients face when navigating health care through the implementation of standardized clinical experiences and community partnerships with local resettlement agencies and non-profit organizations serving immigrant and refugee populations; and be it further

RESOLVED, that our AMA will collaborate with immigration and refugee services such as USCIS, the Department of Homeland Security, local consulates, resettlement agencies, and cultural centers to provide detailed information and resources to immigrants and refugees about procuring healthcare and understanding the administrative intricacies of the healthcare system; and be it further

RESOLVED, that our AMA will support relevant organizations/subcommittees in the development, amplification, and distribution of accessible online resources that describe navigation of the US healthcare system and allow for community collaboration to find solutions based on others' experiences in formats such as:

a) the distribution of an online forum for patients to pose questions and work collaboratively,
b) the creation of resource guides tailored to specific patient populations,
c) the integration of patient advocacy tools into existing healthcare platforms.

Fiscal Note: TBD

Date Received: 09/15/2024

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RELEVANT AMA POLICY

Addressing Immigrant Health Disparities H-350.957
Our AMA will recognize 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. 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. 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. [BOT Res. 804, I-09; Appended: Res. 409, A-15; Reaffirmed: A-19; Appended: Res. 423, A-19; Reaffirmed: I-19]

Public Health Care Benefits H-440.903
Our AMA actively lobby the federal and state governments to restore and maintain funding for public health care benefits for all lawfully present immigrants. [Res. 219, A-98; Reaffirmed: A-02; Reaffirmed: BOT Rep. 19, A-12l; Modified: CMS Rep. 1, A-22]

Immigration Status is a Public Health Issue D-350.975
Our AMA declares that immigration status is a public health issue that requires a comprehensive public health response and solution; our AMA recognizes interpersonal, institutional, structural, and systemic factors that negatively affect immigrants' health; our AMA will promote the development and

implementation of educational resources for healthcare professionals to better understand health and healthcare challenges specific for the immigrant population; our AMA will support the development and implementation of public health policies and programs that aim to improve access to healthcare and minimize systemic health barriers for immigrant communities. [Res. 904, I-22; Reaffirmed: Res. 210, A-23

RELEVANT MSS POLICY

Support of Health Care to Legal Immigrants 270.010MSS
AMA-MSS will ask the AMA to establish as policy its opposition to Federal and state legislation denying or restricting legal immigrants Medicaid and immunizations. [MSS Amended Sub Res 13, I-96, AMA Res 211, A-97 Adopted [H-290.983]; Reaffirmed: MSS Rep B, I-01; Reaffirmed: MSS Rep F, I-06; Reaffirmed: MSS GC Rep D, I-11; Reaffirmed: MSS GC Report A, I-16; Reaffirmed: MSS GC Report A, I-21]

350.023MSS: Amending H-350.957, Addressing Immigrant Health Disparities to Include Opposition to Legislation that Forces Decisions between Health Care and Lawful Residency Status
AMA-MSS will ask the AMA to amend H-350.957, Addressing Immigrant Health Disparities by insertion as follows: Our American Medical Association recognized the unique health needs of immigrants and refugees and encourages the exploration of issues related to immigrant and refugee health and supports legislation and policies that address the unique health needs of immigrants and refugees. [MSS Res. 07, I-19; Reaffirmed, MSS Res. 21, I-21]

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 008
(I-24)

Introduced by: Afareen Jaleel[1], Amanda Kahn[2], Mitchell Hanson[3], Kathleen Li[4], Isabel Ball[5], Alyssa Lee[6], Riya Master[7], Brianna Ma[8], Pamela Chan[1]

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Subject: Parental Involvement Mandates in Reproductive Health

Referred to: MSS Reference Committee
(Alec Calac and Andrew Norton, Co-Chairs)

Whereas, a majority of states require parental involvement in some capacity for minors to request or receive an abortion, with many requiring parental consent from one or both custodial parents or guardians, and some only requiring parental notification before a minor seeks an abortion[1-3]; and

Whereas, 27 states require parental or legal guardian consent or permission from a judge for people under the age of 19 to request or receive abortion care, including states with laws protecting abortion access[1,3,4,5]; and

Whereas, parental involvement policies adversely affect efficiency, patient-centeredness, timeliness, and equity in abortion care by requiring extensive documentation, and resulting in healthcare provider mitigation of family disagreements[6]; and

Whereas, non-traditional, lower-income families face the most difficulties in meeting parental involvement documentation requirements[6]; and

Whereas, Judicial Bypass (JB) is defined as the process of asking a judge to grant a pregnant minor the right to obtain an abortion without state-mandated parental involvement, and specific processes vary by state[7]; and

Whereas, reasons for JB include concern about being forced to continue the pregnancy, fear of losing housing and financial security, having minimal relationship with parents, and fear of abuse[8,9]; and

Whereas, one-third of minors who do not inform parents have already experienced family violence and fear it will recur[8,9]; and

Whereas, enforcement of JB leads to a significant financial burden on patients that disproportionately affects lower-income minors, and out-of-pocket costs around 20% of the household's maximum monthly income[10]; and

Whereas, minors who undergo JB often describe the process as “intimidating” and logistically challenging to navigate, including feeling that they were shamed by judges and guardians throughout[11]; and

Whereas, JB is both a time-consuming and travel-intensive process, with the JB process in Illinois and Massachusetts adding 5-6 days to adolescents’ timelines of abortion seeking, which may discourage individuals from seeking care or result in their pregnancies becoming ineligible for an abortion[7,12,13,14]; and

Whereas, delays at the individual level in obtaining an abortion through JB lead to an increased likelihood of becoming ineligible for a medication-based abortion[13]; and

Whereas, judicial bypass denials in Florida increased from 6% to 13% after switching from notification to consent laws, indicating that consent laws present greater barriers to accessing abortion care[15]; and

Whereas, recent changes in state bypass regulations have resulted in increased bypass petition denial, such as the 2016 bypass change in Texas, which resulted in a significant increase in denied bypass petitions from 2.8% in 2015 to 10.3% in 2016[16]; and

Whereas, between 2018 and 2021, approximately 15% and 10% of minors in Florida and Texas, respectively, sought judicial bypass to access abortion services, with an increasing rate of judicial bypass denials in these states highlighting growing barriers to abortion care access[15]; and

Whereas, JB has been denied for subjective reasons such as a judge believing the petitioner’s pregnancy was too far advanced, despite still being within the state’s gestational age limit, a judge deciding that the minor’s decision not to involve her parents was evidence of immaturity (circular logic), and because the petitioner made two grammatical errors during her hearing[7,11]; and

Whereas, as part of the criteria for approving JB, judges evaluate minor “maturity”, which is not defined in legal statue, and in practicality, this determination is able to be arbitrarily influenced by judge interpretation of minor personality, gender performance, academic performance, and often results in discrimination based on socioeconomic status[17]; and

Whereas, evidence from multiple studies demonstrates that parental consent laws are associated with increased adolescent pregnancy and birthrates, indicating that consent laws do not deter sexual activity and pregnancy rates in minors, and that the decreased abortion rate associated with consent laws therefore increase risk of morbidity and mortality associated with adolescent pregnancy[18]; and

Whereas, the implementation of a parental notification requirement in Illinois was associated with a decrease in the number of abortions among minors and resulted in delayed abortion care, with a larger proportion of minors obtaining second trimester care[19]; and

Whereas, the impact of parental consent laws shows trends toward later gestational ages at the time of abortion, leading to an increase in second-trimester abortions, which, while generally safe, carry a higher risk of complications as gestational age advances, thus parental involvement laws delay care thereby undermining the health and well-being of minors seeking timely abortion care[20]; and

Whereas, implementation of parental involvement laws have been associated with an increase in minors traveling out of state to obtain abortion services (10% increase in Missouri, 32% increase in Mississippi), which imposes significant financial and emotional burdens on vulnerable patients and exacerbates disparities in access to care[18]; and

Whereas, the notion that a minor is not mature enough to make the decision to terminate a pregnancy on their own but are mature enough to carry a pregnancy to term, even though the risk of death, morbidity, and medical complications associated with childbirth is higher than that with abortion is contradictory; and

Whereas, Title X program federal regulations require that Title X-supported providers guarantee the right to confidentiality for all clients seeking family planning care, including minors, in contradiction to the breach of confidentiality involved in parental involvement mandates on abortion care[21,22]; and

Whereas, current AMA policy E-2.2.3 addresses how the legal landscape on mandatory parental consent to abortion varies by jurisdiction and provides physician guidance in these situations, but does not take a position on the legal implications of the issue itself; and

Whereas, AMA policy E-4.2.7 states that a decision to terminate a pregnancy should be made privately within the relationship of trust between patient and physician and AMA policy D-5.999 opposes limitations on access to reproductive health services, but these policies do not provide a stance on the legal implications of parental consent mandates in abortion, unique circumstances of minors, and contradicts the breach of confidentiality and legal barriers brought up in E-2.2.3; therefore be it

RESOLVED, that our American Medical Association oppose legislative mandates for parental or legal guardian consent or notification for minors to request or receive sexual and reproductive health services, including abortion care.

Fiscal Note: TBD

Date Received: 09/15/2024

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RELEVANT AMA POLICY

Mandatory Parental Consent to Abortion E-2.2.3

In many jurisdictions, unemancipated minors are not permitted to request or receive abortion services without their parents' knowledge and consent. Physicians should ascertain the law in their state on parental involvement to ensure that their practices are consistent with their legal obligations. In many places, the issue of confidentiality for minors who seek an abortion implicates competing ethical concerns apart from the abortion issue itself.

When an unemancipated minor requests abortion services, physicians should:

(a) Strongly encourage the patient to discuss the pregnancy with her parents (or guardian).

(b) Explore the minor patient's reasons for not involving her parents (or guardian) and try to correct misconceptions that may be motivating the patient's reluctance to involve parents. If the patient is unwilling to involve her parents, encourage her to seek the advice and counsel of adults in whom she has confidence, including professional counselors, relatives, friends, teachers, or the clergy.

(c) Explain to the minor patient under what circumstances the minor's confidentiality will be abrogated, including:

(i) life-threatening emergency; or

(ii) when parental notification is required by applicable law.

(d) Try to ensure that the minor patient carefully considers the issues involved and makes an informed decision.
(e) Not feel or be compelled to require a minor patient to involve her parents before she decides whether to undergo an abortion.
[Issued: 2016]

Abortion E-4.2.7
Abortion is a safe and common medical procedure, about which thoughtful individuals hold diverging, yet equally deeply held and well-considered perspectives. Like all health care decisions, a decision to terminate a pregnancy should be made privately within the relationship of trust between patient and physician in keeping with the patient's unique values and needs and the physician's best professional judgment.
[Issued: 2016; Modified: CEJA Rep. 01, I-22]

Oppose the Criminalization of Self-Managed Abortion H-5.980
1. Our American Medical Association opposes the criminalization of self-managed abortion and the criminalization of patients who access abortions as it increases patients' medical risks and deters patients from seeking medically necessary services.
2. Our AMA will advocate against any legislative efforts to criminalize self-managed abortion and the criminalization of patients who access abortions.
3. Our AMA will oppose efforts to enforce criminal and civil penalties or other retaliatory efforts against these patients and requirements that physicians function as agents of law enforcement – gathering evidence for prosecution rather than as a provider of treatment.

[Res. 007, A-18; Modified: Res. 027, A-22]

Expanding Support for Access to Abortion Care D-5.996
1. Our American Medical Association will advocate for:
    a. broad and equitable access to abortion services, public and private coverage of abortion services, and funding of abortion services in public programs.
    b. explicit codification of legal protections to ensure broad, equitable access to abortion services.
    c. equitable participation by physicians who provide abortion care in insurance plans and public programs.
2. Our AMA opposes the use of false or inaccurate terminology and disinformation in policymaking to impose restrictions and bans on evidence-based health care, including reproductive health care.

[Res. 229, I-22]

Preserving Access to Reproductive Health Services D-5.999
1. Our American Medical Association recognizes that healthcare, including reproductive health services like contraception and abortion, is a human right.
2. Our AMA opposes limitations on access to evidence-based reproductive health services, including fertility treatments, contraception, and abortion.
3. Our AMA will work with interested state medical societies and medical specialty societies to vigorously advocate for broad, equitable access to reproductive health services, including fertility treatments, fertility preservation, contraception, and abortion.
4. Our AMA supports shared decision-making between patients and their physicians regarding reproductive healthcare.

5. Our AMA opposes any effort to undermine the basic medical principle that clinical assessments, such as viability of the pregnancy and safety of the pregnant person, are determinations to be made only by healthcare professionals with their patients.
6. Our AMA opposes the imposition of criminal and civil penalties or other retaliatory efforts, including adverse medical licensing actions and the termination of medical liability coverage or clinical privileges against patients, patient advocates, physicians, other healthcare workers, and health systems for receiving, assisting in, referring patients to, or providing reproductive health services.
7. Our AMA will advocate for legal protections for patients who cross state lines to receive reproductive health services, including contraception and abortion, or who receive medications for contraception and abortion from across state lines, and legal protections for those that provide, support, or refer patients to these services.
8. Our AMA will advocate for legal protections for medical students and physicians who cross state lines to receive education in or deliver reproductive health services, including contraception and abortion.

[Res. 028, A-22; Reaffirmed: Res. 224, I-22; Modified: BOT Rep. 4, I-22; Appended: Res. 317, I-22; Reaffirmation: A-23; Appended: Res. 711, A-23]

Public Funding of Abortion Services H-5.998
Our American Medical Association reaffirms its opposition to legislative proposals that utilize federal or state health care funding mechanisms to deny established and accepted medical care to any segment of the population.
[Sub. Res. 89, I-83; Reaffirmed: CLRPD Rep. 1, I-93 Reaffirmed: BOT Rep. 12, A-05; Reaffirmed: CMS Rep. 1, A-15]

RELEVANT MSS POLICY

MSS Stance on Challenges to Women's Right to Reproductive Health Care Access 5.005MSS
AMA-MSS opposes legislation that would restrict a woman's right to obtain medical services associated with her reproductive health, as defined in policy 5.001 MSS, on the grounds that they interfere with a physician's ability to provide medical care.
(MSS Res 6, A-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS Res 27, A16) (Reaffirmed: MSS Res 059, A-21)

Coverage and Reimbursement for Abortion Services 5.011MSS
AMA-MSS will ask the AMA
(1) advocate for legislation and regulation to (a) lift all restrictions on public funding for abortion services and (b) guarantee coverage of evidence-based abortion services by all plans and programs that are publicly funded or subsidized; (2) advocate for policies that guarantee evidence-based abortion services are covered without barriers by private health plans, including designating abortion services as an essential health benefit; (3) work with state medical societies to advocate for policies requiring abortion coverage in state private, public, and subsidized plans; and (4) oppose restrictions on physicians and other health professionals who provide abortion care from participating in or being reimbursed by federal and state funded or subsidized health coverage. (MSS Late Res. 002, I-22) (Combined with 5.010MSS, AMA Res. 229, Adopted [D-5.996], I-22)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 010
(I-24)

Introduced by: Daniel Brocke[1], Alyssa Peterson[1], Kyle Smith[2], Onajia Stubblefield[3]

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Subject: Transparency on Comparative Effectiveness in Direct-to-Consumer Advertising

Referred to: MSS Reference Committee
(Alec Calac and Andrew Norton, Co-Chairs)

Whereas, studies show that direct-to-consumer advertising (DTCA) significantly influences patient and provider perceptions of medications, sometimes leading to overestimation of benefits and underestimation of risks, underscoring the need for more stringent regulation and accurate representation of clinical data in drug advertisements[1]; and

Whereas, research shows that DTCA often downplays the clinical benefits of medications, leading to less informed decisions and suboptimal treatment outcomes.[2]; and

Whereas, the off-label advertisement of Olanzapine, a drug with dual use as an antipsychotic and for weight management, has led to incorrect use of the drug and worse health outcomes, emphasizing the need for stringent regulations on healthcare advertisement[3]; and

Whereas, countries such as France, Germany and Canada have assigned health technology assessment (HTA) agencies to classify drugs based on their added clinical benefit, prioritizing evidence from randomized trials that compare the new drug to an existing treatment[4-7]; and

Whereas, in a study looking at 122 ultra-expensive drugs, France and Canada's HTA agencies agree on the added clinical benefit, or lack thereof, for 85% of these drugs which supports the validity of HTAs in determining the comparative effectiveness of medications[8]; and

Whereas, between 73% and 85% of ultra-expensive drugs prescribed in 2018 for Medicare Part D beneficiaries were rated as offering low added therapeutic benefit compared to current standard of care treatments, when assessed by by France, Canada, and Germany HTAs[8]; and

Whereas, Section 1194(e) of the Inflation Reduction Act states that comparative effectiveness should be considered by the Centers for Medicare and Medicaid Services when determining

initial, revised, and final offers for the Medicare Drug Price Negotiation Program, which should extend to DTCA[9]; and

Whereas, the DTCA recommendations outlined in AMA policy H-105.988 DTC of Prescription Drugs and Implantable Devices do not include assessing or advertising the comparative effectiveness and added clinical benefit of a drug compared to drugs of the same class or for the same purpose; and

Whereas, The Effective Health Care Program funds individual researchers, research centers, and academic organizations to work with the Agency for Healthcare Research and Quality (AHRQ) to produce effectiveness and comparative effectiveness research for clinicians, consumers, and policymakers[10]; and

Whereas, by presenting comparative effectiveness data clearly and with guidance from healthcare professionals, patient education materials could improve understanding and adherence to treatment plans, enhancing care quality and helping physicians tailor drug choices to individual patient needs[11-13]; therefore be it

RESOLVED, that our American Medical Association supports designating an existing health agency, such as the Agency for Healthcare Research and Quality (AHRQ), to determine added clinical benefit and comparative effectiveness of new drugs coming to the market, prioritizing evidence from randomized clinical trials; and be it further

RESOLVED, that our AMA amends Policy H-105.988, "Direct-to-Consumer Advertising (DTCA) of Prescription Drugs and Implantable Devices," as follows

Direct-to-Consumer Advertising (DTCA) of Prescription Drugs and Implantable Devices, H-105.988

1. To support a ban on direct-to-consumer advertising for prescription drugs and implantable medical devices.
2. That until such a ban is in place, our American Medical Association opposes product-claim DTCA that does not satisfy the following guidelines:
    a. The advertisement should be indication-specific and enhance consumer education about the drug or implantable medical device, and the disease, disorder, or condition for which the drug or device is used.
    b. In addition to creating awareness about a drug or implantable medical device for the treatment or prevention of a disease, disorder, or condition, the advertisement should convey a clear, accurate and responsible health education message by providing objective information about the benefits and risks of the drug or implantable medical device for a given indication. Information about benefits should reflect the true efficacy of the drug or implantable medical device as determined by clinical trials that resulted in the drug's or device's approval for marketing.
    c. The advertisement should clearly indicate that the product is a prescription drug or implantable medical device to distinguish such advertising from other advertising for non-prescription products.

d. The advertisement should not encourage self-diagnosis and self-treatment, but should refer patients to their physicians for more information. A statement, such as "Your physician may recommend other appropriate treatments," is recommended.
e. The advertisement should exhibit fair balance between benefit and risk information when discussing the use of the drug or implantable medical device product for the disease, disorder, or condition. The amount of time or space devoted to benefit and risk information, as well as its cognitive accessibility, should be comparable.
f. The advertisement should present information about warnings, precautions, and potential adverse reactions associated with the drug or implantable medical device product in a manner (e.g., at a reading grade level) such that it will be understood by a majority of consumers, without distraction of content, and will help facilitate communication between physician and patient.
g. The advertisement should ~~not~~ make claims regarding comparative effectiveness and added clinical benefit ~~claims~~ for the product versus other prescription drug or implantable medical device products; ~~however,~~ the advertisement should also include information about the availability of alternative non-drug or non-operative management options such as diet and lifestyle changes, where appropriate, for the disease, disorder, or condition.
h. In general, product-claim DTCA should not use an actor to portray a health care professional who promotes the drug or implantable medical device product, because this portrayal may be misleading and deceptive. If actors portray health care professionals in DTCA, a disclaimer should be prominently displayed.
i. The use of actual health care professionals, either practicing or retired, in DTCA to endorse a specific drug or implantable medical device product is discouraged but if utilized, the advertisement must include a clearly visible disclaimer that the health care professional is compensated for the endorsement.
j. The advertisement should be targeted for placement in print, broadcast, or other electronic media so as to avoid audiences that are not age appropriate for the messages involved.
k. In addition to the above, the advertisement must comply with all other applicable Food and Drug Administration (FDA) regulations, policies and guidelines.

3. That the FDA review and pre-approve all DTCA for prescription drugs or implantable medical device products before pharmaceutical and medical device manufacturers (sponsors) run the ads, both to ensure compliance with federal regulations and consistency with FDA-approved labeling for the drug or implantable medical device product.
4. That the Congress provide sufficient funding to the FDA, either through direct appropriations or through prescription drug or implantable medical device user fees, to ensure effective regulation of DTCA.
5. That DTCA for newly approved prescription drug or implantable medical device products not be run until sufficient post-marketing experience has been obtained to determine product risks in the general population and until physicians have been appropriately educated about the drug or implantable medical device. The

time interval for this moratorium on DTCA for newly approved drugs or implantable medical devices should be determined by the FDA, in negotiations with the drug or medical device product's sponsor, at the time of drug or implantable medical device approval. The length of the moratorium may vary from drug to drug and device to device depending on various factors, such as: the innovative nature of the drug or implantable medical device; the severity of the disease that the drug or implantable medical device is intended to treat; the availability of alternative therapies; and the intensity and timeliness of the education about the drug or implantable medical device for physicians who are most likely to prescribe it.

6. That our AMA opposes any manufacturer (drug or device sponsor) incentive programs for physician prescribing and pharmacist dispensing that are run concurrently with DTCA.
7. That our AMA encourages the FDA, other appropriate federal agencies, and the pharmaceutical and medical device industries to conduct or fund research on the effect of DTCA, focusing on its impact on the patient-physician relationship as well as overall health outcomes and cost benefit analyses; research results should be available to the public.
8. That our AMA supports the concept that when companies engage in DTCA, they assume an increased responsibility for the informational content and an increased duty to warn consumers, and they may lose an element of protection normally accorded under the learned intermediary doctrine.
9. That our AMA encourages physicians to be familiar with the above AMA guidelines for product-claim DTCA and with the Council on Ethical and Judicial Affairs Ethical Opinion E-9.6.7 and to adhere to the ethical guidance provided in that Opinion.
10. That the Congress should request the Agency for Healthcare Research and Quality or other appropriate entity to perform periodic evidence-based reviews of DTCA in the United States to determine the impact of DTCA on health outcomes and the public health. If DTCA is found to have a negative impact on health outcomes and is detrimental to the public health, the Congress should consider enacting legislation to increase DTCA regulation or, if necessary, to prohibit DTCA in some or all media. In such legislation, every effort should be made to not violate protections on commercial speech, as provided by the First Amendment to the U.S. Constitution.
11. That our AMA supports eliminating the costs for DTCA of prescription drugs as a deductible business expense for tax purposes.
12. That our AMA continues to monitor DTCA, including new research findings, and work with the FDA and the pharmaceutical and medical device industries to make policy changes regarding DTCA, as necessary.
13. That our AMA supports "help-seeking" or "disease awareness" advertisements (i.e., advertisements that discuss a disease, disorder, or condition and advise consumers to see their physicians, but do not mention a drug or implantable medical device or other medical product and are not regulated by the FDA).
14. Our AMA will advocate to the applicable Federal agencies (including the Food and Drug Administration, the Federal Trade Commission, and the Federal Communications Commission) which regulate or influence direct-to-consumer advertising of prescription drugs that such advertising should be required to state the manufacturer’s suggested retail price of those drugs.

Fiscal Note: TBD

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RELEVANT AMA POLICY

Direct-to-Consumer Advertising (DTCA) of Prescription Drugs and Implantable Devices, H-105.988
Our AMA: … 2.That until such a ban is in place, our American Medical Association opposes product-claim DTCA that does not satisfy the following guidelines: a.The advertisement should be indication-specific and enhance consumer education about the drug or implantable medical device, and the disease, disorder, or condition for which the drug or device is used. b.In addition to creating awareness about a drug or implantable medical device for the treatment or prevention of a disease, disorder, or condition, the advertisement should convey a clear, accurate and responsible health education message by providing objective information about the benefits and risks of the drug or implantable medical device for a given indication. Information about benefits should reflect the true efficacy of the drug or implantable medical device as determined by clinical trials that resulted in the drug's or device's approval for marketing. … g.The advertisement should not make comparative claims for the product versus other prescription drug or implantable medical device products; however, the advertisement should include information about the availability of alternative non-drug or non-operative management options such as diet and lifestyle changes, where appropriate, for the disease, disorder, or condition.; (BOT Rep. 38, A-99) (Sub. Res. 513, A-99) (Reaffirmed: CMS Rep. 9, I-99) (Amended: Res. 509, I-99) (Appended & Reaffirmed: Sub. Res. 503, A-01) (Reaffirmed: Res. 522, A-02) (Reaffirmed: Res. 914, I-02) (Reaffirmed: Sub. Res. 504, A-03) (Reaffirmation A-04) (Reaffirmation A-05) (Modified: BOT Rep. 9, A-06) (Reaffirmed in lieu of Res. 514, A-07) (BOT Action in response to referred for decision: Res. 927, I-15) (Modified: BOT Rep. 09, I-16)

(Appended: Res. 236, A-17) (Reaffirmed in lieu of: Res. 223, A-17) (Reaffirmed in lieu of: Res. 112, A-19) (Reaffirmed in lieu of: Res. 810, I-22) (Reaffirmation A-23)

Direct-to-Consumer Advertisement of Prescription Drugs, 9.6.7
Direct-to-consumer advertising may raise awareness about diseases and treatment and may help inform patients about the availability of new diagnostic tests, drugs, treatments, and devices. However, direct-to-consumer advertising also carries the risk of creating unrealistic expectations for patients and conflicts of interest for physicians, adversely affecting patients' health and safety, and compromising patient physician relationships.
(Issued: 2016)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 104
(I-24)

Introduced by: Alec Calac[1]

Affiliation: UC San Diego School of Medicine

Subject: Healthcare in Tribal Jails

Referred to: MSS Reference Committee
(Alec Calac and Andrew Norton, Co-Chairs)

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:

(a) carceral facilities and youth detention centers managed by the Bureau of Indian Affairs Division of Corrections being designated as Health Professional Shortage Areas.

(b) the assignment of U.S. Public Health Service Commissioned Corps officers to these facilities

(c) federal consultation with tribal governments to estimate and promote funding needs for sustainable development, staffing, and operation of on-site medical and behavioral health services for incarcerated American Indian and Alaska Native persons.

Fiscal Note: TBD

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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.

[CME Report 05, I-18; Appended: Res. 953, I-18; Reaffirmation: A-19; Appended: Res. 316, A-19; Appended: Res. 226, A-21; Reaffirmed in lieu of: Res. 311, A-21; Modified: CME Rep. 4, I-21; Reaffirmation: A-22; Appended: CME Rep. 02, A-23; Appended: Res. 311, A-23; Reaffirmed: Res. 314, A-24]

Continuation of the Commissioned Corps H-440.989

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. [Res. 5, A-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11; Reaffirmed: CSAPH Rep. 1, A-21; Modified: CSAPH Rep. 2, I-21]

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. [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]

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 108
(I-24)

Introduced by: Ryan Englander[1], Brent Heineman[1], Sara Kazyak[2] , Shalmali Bhadkamkar[3], Alyssa Peterson[1], Shrey Shah[4], Daniel Brocke[1], Soneet Kapadia[5], Likhit Agrawal[6], Julia Hasik[7], Kyra Colston[8]

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Subject: Improving Choice, Competition, and Affordability in the ACA Marketplaces

Referred to: MSS Reference Committee
(Alec Calac and Andrew Norton, Co-Chairs)

Whereas, the Affordable Care Act (ACA) established state-based Health Insurance Marketplaces where beneficiaries can purchase insurance directly from private insurance companies on a regulated exchange, and over 21 million people are now insured through these Marketplaces[1]; and

Whereas, plans on the ACA Marketplaces are organized into different “metal tiers” which cover different proportions of enrollee healthcare costs on average; these tiers are bronze (cover 60% of costs), silver (cover 70% of costs), gold (cover 80% of costs), and platinum (cover 90% of costs)[2]; and

Whereas, tax credits that help pay for ACA plan premiums (“premium tax credits”) are available to US citizens and lawfully present immigrants who purchase Marketplace coverage with income greater than 100% of the Federal Poverty Level (FPL), are ineligible for public coverage (e.g. Medicaid, TRICARE, CHIP), and are not offered affordable employer-sponsored health insurance[3-5]; and

Whereas, ACA premium tax credits provide substantial savings of $5,534 per year on average to qualifying enrollees[6]; and

Whereas, premium tax credits are calculated by comparing an enrollee’s income to the premium of the second-lowest cost silver plan, which acts as a “benchmark plan”; for example, if the benchmark plan has a monthly premium of $1000 but the enrollee should only be paying $250 based on their income, the enrollee provides a premium tax credit of $750 that can be applied to the premium of any plan on the Marketplace[7]; and

Whereas, multiple legislators, think tanks, and policy groups have recommended increasing the benchmark plan to the second-lowest cost gold plan, which would increase premium tax credits

and reduce out-of-pocket costs for most enrollees[8,9]; and

Whereas, the premium tax credit can only be applied to the portion of a plan's premium that covers Essential Health Benefits (EHBs), which are federally-defined health benefits that exclude essential healthcare services like dental benefits, routine eye exams, and certain forms of long-term care[10,11]; and

Whereas, limiting premium tax credit application to EHBs significantly limits plan choice and competition in the ACA Marketplaces, and artificially limits access to care for benefits that are not considered EHBs[12-15]; and

Whereas, when a patient's premium tax credit exceeds the premium for the selected plan, the difference is lost, leading to reduced financial support for lower-income enrollees selecting cheaper plans[10]; and

Whereas, automatically placing leftover ACA premium tax credits into a Health Savings Account (HSA) when a selected plan's premium is lower than the premium tax credit would expand plan choice, competition, and affordability by rewarding instead of punishing enrollees for choosing cheaper plans[16]; and

Whereas, fixing these quirks of the ACA Marketplaces would expand competition and choice while improving affordability for patients, moving the United States closer to universal, equitable health coverage; and

Whereas, H-165.824 states that our AMA will support expanding premium tax credit and cost-sharing reduction eligibility, but no current policy outlines support for specific mechanisms to increase ACA Marketplace choice, competition, affordability, and savings through modifications to premium tax credits or metal tiers; therefore be it

RESOLVED, that our American Medical Association support expanding choice and competition on ACA Marketplaces, including by:

1. Allowing ACA premium tax credits to be applied to the entire premium for qualifying Marketplace health plans, including the portion of the premium attributable to benefits that are not considered Essential Health Benefits; and
2. Automatically placing leftover ACA premium tax credits into a Health Savings Account when a selected plan's premium is lower than the premium tax credit.

; and be it further

RESOLVED, that our AMA support improving the benchmark plan on the ACA Marketplaces from the second-lowest cost silver plan to at least the second-lowest cost gold plan.

Fiscal Note: TBD

Date Received: 09/15/2024

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RELEVANT AMA POLICY

Individual Health Insurance H-165.920

Our AMA will: (3) actively supports the principle of the individual's right to select his/her 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. (4) will identify any further means through which universal coverage and access can be achieved; (14) believes that refundable, advanceable tax credits inversely related to income are preferred over public sector expansions as a means of providing coverage to the uninsured. [BOT Rep. 41, I-93; CMS Rep. 11, I-94; Reaffirmed by Sub. Res. 125 and Sub. Res. 109, A-95; Amended by CMS Rep. 2, I-96; Amended and Reaffirmed by CMS Rep. 7, A-97; Reaffirmation A-97; Reaffirmed: CMS Rep. 5, I-97; Res. 212, I-97; Appended and Amended by CMS Rep. 9, A-98; Reaffirmation I-98; Reaffirmation I-98; Res. 105 & 108, A-99Reaffirmation A-99; Reaffirmed: CMS Rep. 5 and 7, I-99; Modified: CMS Rep. 4, CMS Rep. 5, and Appended by Res. 220, A-00Reaffirmation I-00; Reaffirmed: CMS Rep. 2, I-01; Reaffirmed CMS Rep. 5, A-02; Reaffirmation A-03; Reaffirmed: CMS Rep. 1 and 3, A-02; Reaffirmed: CMS Rep. 3, I-02; Reaffirmed: CMS Rep. 3, A-03; Reaffirmation I-03Reaffirmation A-04; Consolidated: CMS Rep. 7, I-05; Modified: CMS Rep. 3, A-06; Reaffirmed in lieu of Res. 105, A-06; Reaffirmation A-07Appended and Modified: CMS Rep. 5, A-08; Modified: CMS Rep. 8, A-08; Reaffirmation A-10; Reaffirmed: CMS Rep. 9, A-11; Reaffirmation A-11; Reaffirmed: Res. 239, A-12; Appended: Res. 239, A-12; Reaffirmed: CMS Rep. 6, A-1; 2Reaffirmed: CMS Rep. 9, A-14; Reaffirmed in lieu of: Res. 805, I-17]

Improving Affordability in the Health Insurance Exchanges H-165.824

1. Our American Medical Association will: (a) support adequate funding for and expansion of outreach efforts to increase public awareness of advance premium tax credits. (b) support expanding eligibility for premium tax credits up to 500 percent of the federal poverty level. (c) support providing young adults with

enhanced premium tax credits while maintaining the current premium tax credit structure which is inversely related to income. (d) encourage state innovation, including considering state-level individual mandates, auto-enrollment and/or reinsurance, to maximize the number of individuals covered and stabilize health insurance premiums without undercutting any existing patient protections. 2. Our AMA supports: (a) eliminating the subsidy "cliff", thereby expanding eligibility for premium tax credits beyond 400 percent of the federal poverty level (FPL). (b) increasing the generosity of premium tax credits. (c) expanding eligibility for cost-sharing reductions. (d) increasing the size of cost-sharing reductions. [CMS Rep. 02, A-18; Appended: CMS Rep. 02, A-19; Reaffirmed: CMS Rep. 3, I-21]

RELEVANT MSS POLICY

Developing a Comprehensive Plan for Health System Reform 165.024 MSS
AMA-MSS supports the following vision for health systems reform as incremental steps toward a single payer system:
(a) further expansion of fully refundable tax credits for patients to purchase individual insurance, including those intended to reduce premiums and those intended to reduce cost-sharing requirements; (MSS Res. 058, A-21)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 201
(I-24)

Introduced by: Laura Hult[1], Courtney Noetzel[2], Anna Conner[3]

Affiliations: [1]University of Utah Spencer Fox Eccles School of Medicine
[2] Sam Houston State University College of Osteopathic Medicine
[3] University of Tennessee Health Science Center College of Medicine

Subject: Protecting In-Person Prison Visitations to Reduce Recidivism

Referred to: MSS Reference Committee
(Alec Calac and Andrew Norton, Co-Chairs)

Whereas, overcrowded prison conditions are associated with violence, limited programming and educational opportunities, and inadequate medical and mental health care[1,2,3]; and

Whereas, reducing recidivism improves public safety, lowers taxpayer costs, and helps formerly incarcerated people reintegrate into society[4]; and

Whereas, recidivism is a costly practice such that in California, the annual cost of housing prisoners is over $14.5 billion per year[5]; and

Whereas, inmates with in-person visitations had a 13% reduction in felony reconvictions and 25% reduction in technical violations[,6]; and

Whereas, seeing family members in person is associated with a 25% reduction in misconduct while incarcerated and a 26% decrease in recidivism[7, 8]; and

Whereas, those visiting an incarcerated family member in person have improved mental health outcomes and an increased likelihood of long-term reunion[9]; and

Whereas, the U.S. Department of Justice recognizes that positive, close family relationships reduce recidivism, improve an inmate's chances of finding and keeping a job after leaving prison, and ease harm inflicted on family members who are separated from their loved ones[10]; and

Whereas, an estimated 684,500 U.S. state and federal prisoners are parents of at least one minor child, including 47% of state prisoners and 57% of federal prisoners[11]; and

Whereas, reducing recidivism amongst prisoners who are mothers benefits their children as a mother’s incarceration is associated with a greater likelihood of a child being arrested, a higher number of arrests, and arrest at an earlier age[12]; and

Whereas, there is a significant positive association between a child's frequency of visits with their incarcerated parent and the quality of the child-parent relationship, thus promoting healthy psychological health later in life[13]; and

Whereas, the Bureau of Justice Assistance, the National Institute of Corrections, and the U.S Department of Health and Human Services partnered in 2016 to support a $1 million effort to develop family-strengthening policies that could be implemented in correctional facilities to reduce the traumatic impact of parental incarceration on children, including family-friendly visiting policies and procedures[10]; and

Whereas, eliminating in-person visits in place of video visits to see loved ones has become a national trend in the United States[14]; and

Whereas, researchers estimate at least 600 jails and prisons in America have instituted video visitation programs and that 74% of these correctional facilities either reduced or eliminated in-person visits[15]; and

Whereas, in March 2024, two ongoing lawsuits were filed against Michigan counties alleging that the video-only policy violated the civil rights of families, arguing that abolition of a child's "right to hug" their parent through contact visits "akin to torture"[14]; and

Whereas, private telecommunications companies promote video visitation systems as a cheap and easy alternative to in-person visitations, a major expense for correctional agencies, as well as a profitable means of generating revenues[16]; and

Whereas, video visits help eliminate barriers that in-person visitation presents; however, most advocates and groups, including the American Correctional Association, agree that video visitation should only supplement in-person visitation, rather than replace it entirely, as it fails to replicate the psychological experience, and therefore benefits, of in-person visitation[9]; and

Whereas, limits of video visits include the inability to replicate in-person visiting, dissatisfaction with poor video quality, confusion with technology for visitors: especially for young children, those with developmental delays, or individuals who lack computer skills, and fees that can make video visiting unaffordable[17]; and

Whereas, the average number of in-person monthly visits increased when both in-person visitation and video calling were available[9]; and

Whereas, numerous states, such as Massachusetts, California, and Illinois, approved legislature that protects in-person visits for people in jail and prison[18]; and

Whereas, California's pending bill AB 2709 would ensure that state prisoners are not prevented from receiving personal visits, including family visits, unless necessary for legitimate security and safety concerns[19], and

Whereas, several barriers limit the frequency of visitations including the location of prison or jail, transportation accessibility, the willingness of a caregiver to take a child to visit their parent, times in which visits are permitted, and policies of the correctional facility[20]; and

Whereas, 63% of people in state prison are serving time over 100 miles away from their families, even though distance from home is a strong predictor for whether a prisoner will receive a monthly visit[21]; and

Whereas, prison visitation policies vary greatly across states: North Carolina allows one visit per week with a two hour limit; New York allows those in maximum security 365 days of visiting; Arkansas and Kentucky require visitors to provide a social security number; Arizona charges visitors a one-time $25 background check fee to visit[21]; and

Whereas, less than 50% of inmates receive visitations despite strong evidence supporting the effects of recidivism risk reduction. Therefore, correctional facilities could improve access to visitations by clearly posting visiting hours, reducing/eliminating visiting fees, or creating more child-friendly environments[22]; therefore be it

RESOLVED, that our American Medical Association support federal and state policies that protect and improve accessibility to in-person prison visitations as a way to reduce recidivism.

Fiscal Note: TBD

Date Received: 09/15/2024

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RELEVANT AMA POLICY

Improving Care to Lower the Rate of Recidivism H-430.978
Our AMA will advocate and encourage federal, state, and local legislators and officials to increase access to community mental health facilities, community drug rehabilitation facilities, appropriate clinical care, and social support services (e.g., housing, transportation, employment, etc.) to meet the needs of indigent, homeless, and released previously incarcerated persons.
Our AMA will advocate and encourage federal, state, and local legislators and officials to advocate prompt reinstatement in governmental medical programs and insurance for those being released from incarceration facilities. [Res. 244, A-23; Reaffirmed: CSAPH Rep. 07, A-24]

Reducing the Burden of Incarceration on Public Health D-430.992
Our AMA will support efforts to reduce the negative health impacts of incarceration, such as: (1) Implementation and incentivization of adequate funding and resources towards indigent defense systems. (2) Implementation of practices that promote access to stable employment and laws that ensure employment non-discrimination for workers with previous non-felony criminal records. (3) Housing support for formerly incarcerated people, including programs that facilitate access to immediate housing after release from carceral settings.
Our AMA will partner with public health organizations and other interested stakeholders to urge Congress, the Department of Justice, the Department of Health and Human Services, and state officials and agencies to minimize the negative health effects of incarceration by supporting programs that facilitate employment at a living wage, and safe, affordable housing opportunities for formerly incarcerated individuals, as well as research into alternatives to incarceration. [Res. 902, I-22]

Standards of Care for Inmates of Correctional Facilities H-430.997
Our AMA believes that correctional and detention facilities should provide medical, psychiatric, and substance 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]

RELEVANT MSS POLICY

Reducing Burden of Incarceration on Public Health 440.120MSS
AMA-MSS will ask that our AMA (1) support efforts to reduce the negative health impacts of incarceration, such as (a) implementation and incentivization of adequate funding and resources towards indigent defense systems; (b) implementation of practices that promote access to stable employment and laws that ensure employment non-discrimination for workers with previous non-felony criminal records; (c) housing support for formerly incarcerated people, including programs that facilitate access to immediate housing after release from carceral settings; and (2) partner with the American Public Health Association and other stakeholders to urge Congress, the Department of Justice, and the Department of Health & Human Services to minimize the negative health effects of incarceration by supporting programs that facilitate employment and housing opportunities for formerly incarcerated individuals as well as research into alternatives to incarceration. (MSS COLA CGPH Rep A, A-22)

Support for Children of Incarcerated Parents 60.026MSS
AMA-MSS will ask the AMA to support legislation and initiatives that provide resources and support for children of incarcerated parents. (MSS Res 03, I-18) (AMA Res 503, combined with Res 531, A-19, Adopted as amended, [H-60.903])

Federal Health Insurance Funding for People Experiencing Incarceration 290.008MSS
(1) Our AMA-MSS will ask the AMA to advocate for the continuation of federal funding for health insurance benefits, including Medicaid, Medicare, and the Children's Health Insurance Program, for otherwise eligible individuals in pre-trial Detention. (2) Our AMA-MSS will ask the AMA to amend policy H-430.986 by addition and deletion as follows:
HEALTH CARE WHILE INCARCERATED, H- 430.986
1. Our AMA advocates for adequate payment to health care providers, including primary care and mental health, and addiction treatment professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process from intake to re-entry into the community.
2. Our AMA supports partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for juveniles and adults in the correctional system.
3. Our AMA encourages state Medicaid agencies to accept and process Medicaid applications from juveniles and adults who are incarcerated.
4. That our AMA encourage state Medicaid agencies to work with their local departments of corrections, prisons, and jails to assist incarcerated juveniles and adults who may not have been enrolled in Medicaid at the time of their incarceration to apply and receive an eligibility determination for Medicaid.
5. That our AMA advocate for the repeal of the Medicaid Inmate Exclusion Policy.
~~5~~6. Our AMA encourages states not to ~~suspend rather than t~~erminate Medicaid eligibility of juveniles and adults upon intake into the criminal justice system and throughout the incarceration process, and to reinstate coverage when the

individual transitions back into the community.
~~6~~7. Our AMA urges Congress, the Centers for Medicare & Medicaid Services (CMS), and state Medicaid agencies to provide Medicaid coverage for health care, care coordination activities and linkages to care delivered to patients up to 30 days before the anticipated release from adult and juvenile correctional facilities in order to help establish coverage effective upon release, assist with transition to care in the community, and help reduce recidivism.
~~7~~8. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of incarcerated women and adolescent females, including gynecological care and obstetrics care for pregnant and postpartum women.
~~8~~9. Our AMA will collaborate with state medical societies and federal regulators to emphasize the importance of hygiene and health literacy information sessions for both inmates and staff in correctional facilities.
~~9~~10. Our AMA supports: (a) linkage of those incarcerated to community clinics upon release in order to accelerate access to comprehensive health care, including mental health and substance abuse disorder services, and improve health outcomes among this vulnerable patient population, as well as adequate funding; and (b) the collaboration of correctional health workers and community health care providers for those transitioning from a correctional institution to the community.
(MSS Res. 076, Nov. 2020)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 202
(I-24)

Introduced by: Sharon Zeldin[1], Rajadhar Reddy[2], Eva Yarsky[1]

Affiliations: [1] Rutgers New Jersey Medical School
[2] Baylor College of Medicine

Subject: Codification of the Chevron Deference Doctrine

Referred to: MSS Reference Committee
(Alec Calac and Andrew Norton, Co-Chairs)

Whereas, regulatory statutes that are passed by Congress frequently contain ambiguities and gaps, whether they arise intentionally (to allow federal agencies interpretive leeway), unintentionally (as a result of poor drafting or lack of foresight), or due to a lack of consensus on the particulars; and

Whereas, the Administrative Procedure Act (APA) of 1946 forms the bedrock of administrative law, serving as a framework to define the scope, operation, and review of federal agencies and providing safeguards to ensure that separation of powers is adequately maintained [1,2]; and

Whereas, the basic purposes of the APA are: (1) To require agencies to keep the public informed of their organization, procedures and rules; (2) To provide for public participation in the rulemaking process (e.g., via public comments); (3) To establish uniform standards for the conduct of formal rulemaking and adjudication; and (4) to define the scope of judicial review [1]; and

Whereas, an enacting Congress is aware that statutory ambiguities will necessarily arise, and occasionally chooses to explicitly delineate an entity responsible for resolving those uncertainties (e.g., the courts or a federal agency) when passing legislation, but in most cases does not choose to do so; and

Whereas, in U.S. jurisprudence, courts utilize a substantial number of key presumptions to decide how to act in the case of statutory ambiguities in many domains (unless there is a clear legislative indication to the contrary), including the presumption against extraterritoriality (U.S. laws apply only within the U.S.), the presumption against retroactivity (U.S. laws apply only prospectively), and the presumption against repeal of statutes by implication (more recent laws do not displace earlier laws unless explicitly indicated); and

Whereas, the landmark 1984 Supreme Court of the United States (SCOTUS) decision in *Chevron v Natural Resources Defense Council* formally established the Chevron Deference Doctrine, a key presumption which required courts to defer to regulatory agency interpretation of vague

regulatory statutes after exhausting all traditional tools of inquiry to find a single, unambiguous interpretation of Congressional intent [3]; and

Whereas, Chevron Deference allows key regulatory bodies, such as the Environmental Protection Agency (EPA), Centers for Disease Control and Prevention (CDC), National Institutes of Health (NIH), Federal Trade Commission (FTC), Food & Drug Administration (FDA), and Centers for Medicare & Medicaid Services (CMS), to use their subject-matter expertise to inform critical regulatory decisions that profoundly influence public health and medicine in the United States [4]; and

Whereas, 70 SCOTUS cases and over 17,000 lower court cases that pertain to multiple regulatory domains affecting vast swathes of American life explicitly rely on Chevron Deference, and Congress has not seen fit to reverse these decisions through legislative action [5]; and

Whereas, the degree of granularity required to accurately and effectively implement federal regulations requires substantial technical and implementational expertise, investigative and compliance resources, and organizational infrastructure, which federal agencies possess, but legislatures and courts lack [3,6]; and

Whereas, under the Public Health Service Act, the FDA is empowered to regulate "biological products," including "proteins," but there is substantial ambiguity as to what distinguishes a "protein" (such as a required number, sequence, or arrangement of amino acids) from a "drug", which is regulated differently under the Food, Drugs, and Cosmetics Act [7–9]; and

Whereas, by law, Medicare physician and hospital reimbursements are adjusted to reflect "differences in hospital wage levels" across "geographic areas," but statute does not specify how that area is measured (e.g., by census tract, city, county, metropolitan area, state, or multi-state area), with profound financial implications for healthcare systems and physician reimbursement depending on how these ambiguities are interpreted [10–12]; and

Whereas, in June 2024, the holding in the SCOTUS cases *Loper Bright Enterprises v. Raimondo* and *Relentless Inc. v. Dept. of Commerce* explicitly overturned *Chevron*, leaving the judiciary as the final arbiter of the interpretation of ambiguous statutes, including regulations that pertain to specific and highly technical matters over a vast number of domains [13–15]; and

Whereas, the fallback standards of *Skidmore* Deference (which allows courts to consider agency opinions but does not mandate agency deference for adjudicating ambiguous regulatory statutes) and *Auer* Deference (similar to *Skidmore*, but applied to ambiguous regulations issued by federal agencies) lead to substantial uncertainty about the outcome of litigation pertaining to regulatory statutes and federal regulations [16,17]; and

Whereas, this decision shifts the burden of a large number of regulatory determinations that often require significant technical expertise, careful consideration of evidence, and substantial operational knowledge from expert agencies to the legislature (for explicit codification) and the judiciary (for interpretation of statutory ambiguities), leaving them more vulnerable to partisan influence [18]; and

Whereas, this exacerbates the combinatorial complexity of the legislative process (including constituent feedback, fact-finding, drafting of legislation, committee hearings and approval, negotiations, and passage), substantially increasing workload and slowing the passage of legislation in Congress, which is increasingly mired by partisan gridlock [19,20]; and

Whereas, many scenarios that fall under federal agency purview, including pandemics and natural disasters, require rapid mobilization and pivoting on the order of hours or days, which would be significantly impaired should these require legislative or judicial intervention; and

Whereas, in June 2024, the holding in SCOTUS case *Corner Post v. Federal Reserve* greatly expanded the statute of limitations for plaintiffs to sue federal agencies over federal regulations, leaving nearly all existing federal regulation subject to potentially hostile litigation and threatening to massively increase caseloads for already overburdened judicial systems [21,22]; and

Whereas, the demise of *Chevron* sets a dangerous precedent for the gradual erosion of regulations governing environmental policy, healthcare, public health, and civil rights [6,15,23]; and

Whereas, legal challenges are already mounting against current regulations established by the Securities and Exchange Commission (SEC), the Internal Revenue Service (IRS), the EPA, the FTC, and the Department of Health and Human Services (HHS) [24]; and

Whereas, a federal judge in Mississippi, citing *Loper Bright*, ruled that the Biden Administration cannot enforce new HHS anti-discrimination rules protecting patients from discrimination based on gender identity or sexual orientation [25]; and

Whereas, these decisions create substantial uncertainty for the future of regulatory agencies, challenge evidence-based practices that are often defined by experts in their respective fields and shifts extensive power to the judicial branch; and

Whereas there are 94 Federal district courts and 13 courts of appeals, and the decision in *Loper Bright* removes the ability to standardize federal rulemaking using a set of pre-established regulatory standards, potentially leading to inconsistent rulings that greatly increase confusion and costs for all healthcare stakeholders [6,13,26]; and

Whereas, this dynamic may fundamentally destabilize the relationship between federal agencies and regulated industries, leading to substantial risk aversion and slowing the pace of innovation in the pharmaceutical and healthcare technology sectors [6]; and

Whereas, the demise of *Chevron* substantially impacts AMA advocacy on a vast range of key priorities (including Medicare physician payment reform) and imperils our AMA's mission to promote the art and science of medicine and the betterment of public health; and

Whereas, the AMA, along with other medical societies, submitted an amicus brief in support of the FDA's approval of mifepristone, arguing that the current, evidence-based regulatory process allows for the consideration of the weight of decades of medical research and "enhanced the quality and availability of essential reproductive care" [27]; and

Whereas, American Academy of Pediatrics (AAP), American Cancer Society, and many other medical societies and professional organizations filed an amicus brief in *Loper Bright* in support of Chevron deference and warning of "the tremendous disruption that overruling *Chevron* would cause to publicly funded health insurance programs specifically, to the stability of this country's healthcare system generally, and to the health and wellbeing of the patients and consumers we serve" [28]; and

Whereas, although petitioners to SCOTUS challenged *Chevron* deference as unconstitutional under Article III of the Constitution, the holding in *Loper Bright* overruled *Chevron* on the basis of Section 706 of the APA, not on constitutional grounds [13,29,30]; and

Whereas, this holding leaves Congress the ability to explicitly define the scope of agency and judicial purview of ambiguous regulatory statutes by passing federal legislation (including the formal codification of Chevron deference, if they so choose) [13,30]; and

Whereas, the Congressional Review Act requires federal agencies to submit proposed rules to Congress, which is empowered to veto rules by enacting a resolution of disapproval, allowing for another opportunity to review agency rules and providing a key constitutional check on the power of federal agencies [31,32]; and

Whereas, the APA still allows for judicial review of agency interpretations of ambiguous regulatory statutes even in the context of Chevron Deference on the basis of whether they may be "arbitrary and capricious," retaining a key constitutional check on the power of federal agencies [2,33]; and

Whereas, there is currently proposed federal legislation (H.R. 1507 / S. 4749, the *Stop Corporate Capture Act*) in both the House and the Senate to codify agency deference by amending Section 553 of the Administrative Procedure Act to allow for "reasonable" agency interpretation, as under *Chevron* [34–36]; and

Whereas, most states have their own precedent of agency deference, but at least twelve states have weakened or eliminated it [37,38]; therefore be it

RESOLVED, that our American Medical Association support codification of the Chevron deference doctrine at the federal and state levels, which would: (1) generally leave reasonable interpretation of ambiguous regulatory statutes to the purview of the executive branch, including agencies comprised of scientific and medical experts evaluating robust evidence and (2) generally prioritize legislative oversight and modification of ambiguous regulatory statutes and agency rules, instead of deferring to the judicial branch for this function.

Fiscal Note: TBD

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RELEVANT AMA POLICY

CMS Use of Regulatory Authority to Implement Reimbursement Policy H-385.942
The AMA urges the Centers for Medicare and Medicaid Services, a federal agency which may be affected by the recent *Loper* decision, to consult relevant medical professional societies before making decisions about physician reimbursement that will affect the practice of medicine. [Res. 124, A-98; Modified and Reaffirmed: CMS Rep. 4, A-08; Reaffirmed: CMS Rep. 01, A-18; Reaffirmed: Res. 105, A-18]

Evidence-Based Standard Requirement for Governmental Regulation H-270.956
Our American Medical Association supports federal mandates that all federal health care regulatory agencies (e.g., the FDA, the DEA, and the CMS) must demonstrate the benefit of existing regulations and new regulations within three years of implementation; and that the demonstration of benefit must employ evidence-based standards of care; and that any regulations that do not show measurable improved patient outcomes must be revised or rescinded. [BOT Rep. 7, A-11; Reaffirmed: BOT Rep. 7, A-21]

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 203
(I-24)

Introduced by: Mitchell Hanson[1], Soneet Kapadia[2], Yatin Srinivash Ramesh Babu[3], Maha Fathali[4], Alyssa Lee[5], Joice Thekkethottiyil[6]

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Subject: Preventing Drug-Facilitated Sexual Assault in Drinking Establishments

Referred to: MSS Reference Committee
(Alec Calac and Andrew Norton, Co-Chairs)

Whereas, the National Sexual Violence Resource Center reports that 1 in 5 women experienced completed or attempted rape and 1 in 4 men have experienced some variation of sexual violence in their lifetime, with nearly 11 million women having endured these acts while under the influence of drugs or alcohol[1]; and

Whereas, the Center for Disease Control and Prevention (CDC) reports that nearly half of all sexual assaults involve alcohol consumption by the survivor, perpetrator, or both, and research indicates that DFSA is a growing concern on college campuses and in nightlife settings[2,3]; and

Whereas, alcohol is identified as the most commonly detected substance in drug-facilitated sexual assaults (DFSA) globally, with a significant portion of survivors reporting the use of substances such as MDMA, GHB, ketamine, methamphetamine, and Rohypnol by perpetrators[4–7]; and

Whereas, college students and young adults are particularly vulnerable to DFSA, with surveys indicating that over 60% of DFSA incidents occur at parties, bars, or clubs, highlighting the importance of targeted interventions in these environments[8,9]; and

Whereas, experiences of DFSA are notoriously underreported, with estimates suggesting that only 20% of survivors report their assaults, often due to impaired memory, fear, or shame associated with the use of substances during the incident, underscoring the urgent need for preventive measures to reduce the occurrence of these crimes[10,11]; and

Whereas, most benzodiazepines are only detectable in the blood for up to 48 hours and in the urine until 96 hours and due to the prolonged time frame between an assault and its reporting, testing of drink samples has been found to grant investigators much-needed insight[12]; and

Whereas, current research, including field-testing in 2007 and ongoing studies, shows promise in the development of drug detection devices aimed at preventing DFSA in establishments that sell alcohol[13–15]; and

Whereas, various drug detection devices, such as GHB and ketamine test kits, Drink Check Wristbands, and Personal Drink IDs, have been developed and sold at relatively low costs for the express purpose of preventing DFSA[16–18]; and

Whereas, one study analyzing the efficacy of Drink Safe Technology Version 1.2, a color-change reagent test for GHB and ketamine in drinks, found the test to have an efficiency of 65.1%, a sensitivity of 50%, and a specificity of 91.6% and any spiked drinks identified could potentially save lives[13]; and

Whereas, cities such as San Diego have recognized the importance of preventing DFSA by requiring alcohol-selling establishments to have drug detection devices available under Assembly Bill No. 1013, reflecting a growing trend in policy aimed at proactive prevention rather than reactive response[19]; and

Whereas, published reviews of evaluations of college rape prevention education programs and reviews of sexual assault prevention programs suggest favorable effects in rape-supportive attitudes[20–24]; and

Whereas, the AMA can garner further support for various organizations, such as the Rape, Abuse & Incest National Network (RAINN) and the National Sexual Violence Resource Center (NSVRC), that have been actively advocating for education and prevention strategies regarding drug-facilitated sexual assault[9,25]; and

Whereas, the AMA has existing policy addressing sexual assault prevention on college campuses and education on sexual assault prevention and violence and the AMA MSS has existing policy supporting research on DFSA and addressing sexual assault on school campuses but lacks policy supporting efforts to prevent DFSA; therefore it be

RESOLVED, that our American Medical Association support federal, state, and local efforts to prevent drug-facilitated sexual assault, including provision of drug detection equipment in establishments that sell alcohol and through public education campaigns.

Fiscal Note: TBD

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RELEVANT AMA Policy

Addressing Sexual Assault on College Campuses H-515.956

“Our AMA: (1) supports universities' implementation of evidence-driven sexual assault prevention programs that specifically address the needs of college students and the unique challenges of the collegiate setting; (2) will work with relevant stakeholders to address the issues of rape, sexual abuse, and physical abuse on college campuses;...” [Res. 402, A-16; Appended: Res. 424, A-18]

Preventing, Identifying and Treating Violence and Abuse 8.10

Our AMA advocate for mechanisms to direct physicians to community or private resources that might be available to aid their patients.
Our AMA:... (l) Support research in the prevention of violence and abuse and collaborate with public health and community organizations to reduce violence and abuse. Issued: 2016

RELEVANT MSS Policy

460.021MSS Researching Drug Facilitated Sexual Assault Testing

AMA-MSS will ask the AMA to study the feasibility and implications of offering drug testing at point of care for date rape drugs, including but not limited to rohypnol, ketamine, and gamma- hydroxybutyrate, in cases of suspected non-consensual, drug-facilitated sexual assault. (MSS Res 69-I-17) (HOD Res. 505, A-18, Not Adopt) (Reaffirmed: MSS GC Report A, A-23)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 205
(I-24)

Introduced by: Mitchell Hanson[1], Rachel Rezabek[2], Shannon Lam[3], Samyukta Karthik[4], Nneoma Uzoukwu[5], Alyssa Lee[6], Joice Thekkethottiyil[7]

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Subject: Sexual Health Education Confidentiality and Disparities among Adolescents

Referred to: MSS Reference Committee
(Alec Calac and Andrew Norton, Co-Chairs)

Whereas, comprehensive sexual education reduces rates of sexually transmitted infections (STIs) and teen pregnancy among adolescents [1,2]; and

Whereas, the American Academy of Pediatrics (AAP) states that “healthy sexuality is a core developmental milestone for child and adolescent health” and, along with the World Health Organization (WHO), recommends that sexual education for adolescents include a wide range of topics, including reproductive rights, contraception, pregnancy, prenatal care, abortion, STIs, HIV/AIDS, sexual abuse, assault, and violence, all within the contexts of law, consent, confidentiality, and independent decision-making[3–5]; and

Whereas both teachers' embarrassment in delivering sex and relationships education (SRE) can affect its quality, and students' discomfort inhibits engagement, while maintaining confidentiality improves access to health services yet legislation on gender reporting and disclosures has increased significantly remains inconsistent among states [6–9]; and

Whereas, protecting students' privacy and confidentiality regarding their gender identity and sexual orientation is essential for fostering a supportive and inclusive school environment, which has been shown to positively impact students' mental health and academic performance [10];

Whereas research shows that forced disclosure policies increase mental health issues among LGBTQ+ students and jeopardize privacy and safety whereas policies respecting confidentiality protect student wellbeing, enhance trust, and reduce stigmatization, especially among LGBTQ students[10–13]; and

Whereas, AMA supports confidential care for adolescents without requiring parental consent except in life-threatening situations (H-60.965) and advocates for comprehensive sexual education, led by individuals addressing LGBTQ+ youth needs, but lacks emphasis on confidentiality (H-170.968); and

Whereas, the Black Girls Equity Alliance in 2019 revealed that sexual health education in Pennsylvania was less structured in predominantly Black schools, contributing to disparities in education quality[14]; and

Whereas, LGBTQ+ students of color report inadequate sexual health education due to feeling unrepresented, unsupported, stigmatized, and bullied[15]; and

Whereas, non-Hispanic Black male adolescents and Hispanic male adolescents were less likely to receive formal education about STIs and birth control than their non-Hispanic White males adolescent counterparts[16]; and

Whereas, increased rates of STIs among men who have sex with men and minority populations, including Black and Hispanic communities, are linked to disparities in sexual health education and access to care, with the most effective interventions being programs and initiatives that will address these knowledge gaps and behaviors within sexual networks among these communities[1,17]; and

Whereas, Senate H.R.2701 “Youth Access to Sexual Health Services Act of 2019” supports the Department of Human and Health Services to award grants that address sexual health education disparities among marginalized youth[18]; and

Whereas, the AMA already recognizes the importance of sexual health education programs in schools remaining inclusive of communities of color, sexual/gender minorities, and those in high risk situations in H-170.968 as well as education of physicians and medical students on LGBTQ+ healthcare in H-160.991 but fail to address supporting programs that target sexual health education disparities; therefore it be

RESOLVED, that our American Medical Association opposes policies that force educators to disclose the gender identity or sexual orientation of their students; and further be it

RESOLVED, that our AMA supports local, state, and federal programs that address disparities in sexual health education by race, ethnicity, and sexual and gender identity.

Fiscal Note: TBD

Date Received: 09/15/2024

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RELEVANT AMA Policies

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

Our AMA:...Appropriately and comprehensively address the sexual behavior of all people, inclusive of sexual and gender minorities.

Our AMA will work with the United States Surgeon General to design programs that address communities of color and youth in high-risk situations within the context of a comprehensive school health education program. [CSA Rep. 7 and Reaffirmation I-99; Reaffirmed: Res. 403, A-01; Modified Res. 441, A-03; Appended: Res. 834, I-04; Reaffirmed: CSAPH Rep. 7, A-09; Modified: Res. 405, A-16; Appended: Res. 401, A-16; Appended: Res. 414, A-18; Appended: Res. 428, A-18; Modified: Res. 413, A-22; Reaffirmation: Res. 413, A-24]

Confidential Health Services for Adolescents H-60.965

Our American Medical Association reaffirms that confidential care for adolescents is critical to improving

their health. [CSA Rep. A, A-92; Reaffirmed by BOT Rep. 24, A-97; Reaffirmed by BOT Rep. 9, A-98; Reaffirmed: Res. 825, I-04; Reaffirmation A-08; Reaffirmed: CMS Rep. 2, I-14; Appended: Res. 226, I-21]

Eliminating Health Disparities - Promoting Awareness and Education of Sexual Orientation and Gender Identity Health Issues in Medical Education H-295.878
Our AMA:…(3) encourages medical education accreditation bodies to both continue to encourage and periodically reassess education on health issues related to sexual orientation and gender identity in the basic science, clinical care, and cultural competency curricula in undergraduate and graduate medical education. [Res. 323, A-05; Modified in lieu of Res. 906, I-10; Reaffirmation A-11; Reaffirmation A-12; Reaffirmation A-16; Modified: Res. 16, A-18; Modified: Res. 302, I-19]

Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations H-160.991
Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBTQ people. [CSA Rep. C, I-81; Reaffirmed: CLRPD Rep. F, I-91; CSA Rep. 8 - I-94; Appended: Res. 506, A-00; Modified and Reaffirmed: Res. 501, A-07; Modified: CSAPH Rep. 9, A-08; Reaffirmation A-12; Modified: Res. 08, A-16; Modified: Res. 903, I-17; Modified: Res. 904, I-17; Res. 16, A-18; Reaffirmed: CSAPH Rep. 01, I-18; Reaffirmed: CSAPH Rep. 08, A-24]

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 206
(A/I-24)

Introduced by: Gabrielle Caron[1], Ariella Wagner[2], Marianne Estrada[3], Sirapa Vichaikul[4], Samyukta Karthik[5], Megi Maci[6], Julia Silverman[1]

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Subject: Support for Aging-Out Foster Youth with Mental Health and Psychotropic Needs

Referred to: MSS Reference Committee
(Alec Calac and Andrew Norton, Co-Chairs)

Whereas, foster care youth are 62% more likely to have serious mental health issues from adverse childhood experiences (ACEs)[1]; and

Whereas, psychotropic polypharmacy is common in foster youth, with 41% prescribed at least three medications, with 16% on four or more, without proper protocol and monitoring[2,3]; and

Whereas, mental health monitoring in foster youth is hindered by inconsistent medical history documentation and a child psychiatrist shortage for medication management[2,4]; and

Whereas, youth “age-out” of foster care at 18-25, as mandated by the Department of Children and Families (DCF), and are vulnerable to dependence on psychotropic medications, which can hinder future independence[5,6]; and

Whereas, a data shortage exists on continued mental health services for former foster children with complex mental health histories and psychotropic polypharmacy[7]; and

Whereas, only 10% of Connecticut’s Department of Mental Health and Addiction Services funding aids youths aging-out of foster care, representing a small fraction of voluntary enrollees transitioning to adulthood[8]; and

Whereas, youths aging-out of foster care may lack the insight or motivation to seek mental health services and struggle with navigating Medicaid, despite eligibility, due to limited experience and understanding of healthcare services[5,9]; and

Whereas, the John Chafee program relies on federal funding and oversight to support states, territories, and Indian tribal entities in helping youth transition out of foster care, requiring a 20% in-kind state match, 5-year budget plans, and annual federal approval for funding[10,11]; and

Whereas, the John Chafee program mandates that states use funds to implement programs that offer education assistance, employment services, financial guidance, housing, and life skills training[10]; and

Whereas, 77% of eligible youths aging-out don't utilize the John Chafee program due to low awareness of offerings, inadequate time for navigating transition services, learned helplessness, and lack of trust[12–14]; and

Whereas, despite the John Chafee program's expansion, a significant gap in mental health interventions remains, with only 1.27% of all programs focused on aging-out youth and 13% rated for effectiveness[15]; and

Whereas, existing federally funded programs lack comprehensive mental health support for aging-out foster youths[10,14,15]; and

Whereas, several community organizations support vulnerable aged-out foster youth who opt out of ongoing services, citing federal programs' inability to address their needs or show lasting benefits[7]; and

Whereas, refusal of indicated mental health services is associated with poverty, unemployment, and homelessness[5,16]; and

Whereas, California's use of the Chafee program, along with the state's Transitional Housing Program, successfully supports aging-out foster youth mental health, with 70% of these youth showing improved outcomes as they transition to adulthood[16]; and

Whereas, in Massachusetts, agencies overseeing Chafee funds have collaborated with the Department of Mental Health to increase access for transition-age youth to mental health and substance use treatment[17]; and

Whereas, recent House of Ways and Means Committee discussions have underscored issues with the John Chafee program's accessibility and underutilization, as well as negative outcomes for youths transitioning out of foster care[18]; therefore be it

RESOLVED, that our American Medical Association supports federal and state initiatives aimed at increasing funding and enhancing accessibility to services designed to help youths as they transition out of foster care, such as the John Chafee program; especially for youths requiring mental health support and access to psychotropic medications.

Fiscal Note: TBD

Date Received: 09/15/2024

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RELEVANT AMA POLICY

Improved Foster Care Services for Children H-60.897:
Our American Medical Association will (a) encourage and support state, territorial, and tribal activities to implement changes to the child welfare system directed toward keeping children with their families when appropriate and the children's safety is assured, (b) support federal and state efforts to expand access to evidence-based treatment, counseling, mental health services, substance use disorder treatment, in-home parent skills-based services, and other services, (c) encourage and support state efforts expanding use of kinship and family foster care placement and state efforts to eliminate the use of non-therapeutic congregate foster care placement, (d) support both federal and state funding for improvements to the child welfare system which minimize harm to the child and help provide additional services to families that will safely prevent child separation from the family, (e) support government maintenance of a continuously updated and comprehensive list of evaluated and tested prevention services and for families at risk for entry into the child welfare system. [Res. 216, A-23]

Addressing Healthcare Needs of Children in Foster Care H-60.910: Our American Medical Association advocates for comprehensive, and evidence-based, trauma-informed care that addresses the specific mental, developmental, and physical health care needs of children in foster care. [Res. 907, I-17 Modified: Res. 420, A-23]

Addressing the Longitudinal Healthcare Needs of American Indian Children in Foster Care D-350.977:
Our American Medical Association (a) recognizes the Indian Child Welfare Act of 1978 as a model in American Indian and Alaska Native child welfare legislation, (b) supports federal legislation preventing the removal of American Indian and Alaska Native children from their homes by public and private agencies without cause, (c) will work with local and state medical societies and other relevant stakeholders to support legislation preventing the removal of American Indian and Alaska Native children from their homes by public and private agencies without cause, (d) supports state and federal funding opportunities for American Indian and Alaska Native child welfare systems, (e) will support the construction of health information systems to enhance information exchange between both tribal and non-tribal child welfare agencies and health care professionals, (f) will advocate for the designation of medical teams,

and/or committees to longitudinally follow children in foster care, including to ensure the provision of continuity of care for children who are at the age of transition out of foster care, (g) will advocate for oversight of local, tribal, and state child welfare systems by physicians with expertise in pediatrics and child psychiatry, (h) will promote existing medical homes which provide continuity of care to children in foster care when feasible, (i) will support the appointment of a licensed pediatrician or family medicine physician (with substantial pediatric experience) in each state with experience in child welfare to the position of medical director of child welfare and a psychiatrist with substantial child and adolescent psychiatric experience to the position of psychiatric medical director of child welfare for each Title IV-E agency. [Res. 443, A-22Appended: Res. 930, I-22]

RELEVANT MSS POLICY

Addressing Healthcare Accessibility for Current and Aged-Out Youth in the Foster Care System 60.037MSS:
Our AMA advocates for comprehensive and evidence-based care that addresses the specific health care needs of children and youth in foster care, and (2) advocates that all youth currently in foster care remain eligible for Medicaid or other publicly funded health coverage in their state until at least 26 years of age. [MSS Res. 097, Nov. 2020]

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 207
(I-24)

Introduced by: Shalmali Bhadkamkar [1], Ty Thompson [2], Isabel Ball [3], Bhavana Gunda [4], Renee Dreher [5], Eileen Enriquez [6], Maya Seshan [7]

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Subject: Supporting and Protecting Equity in LGBTQ+ Parentage and Assisted Reproduction

Referred to: MSS Reference Committee
(Alec Calac and Andrew Norton, Co-Chairs)

Whereas, nationally, up to 30% of LGBTQ parents are either not legally recognized as parents, or are unsure about their legal status as a parent of one or more children [1]; and

Whereas, disparities in accessing assisted reproductive technologies and legal recognition of parentage for LGBTQ+ couples contribute to systemic inequities, necessitating advocacy and policy reforms to ensure equal access and protection[2]; and

Whereas, Section 1557 of the Affordable Care Act (ACA) prevents married and unmarried couples of any gender or sexual identity from being discriminated against when accessing assisted reproductive care [3]; and

Whereas, assisted reproduction for two individuals with female reproductive anatomy can involve insemination with donor sperm, In Vitro Fertilization (IVF), or reciprocal IVF (rIVF); and non-medically assisted reproduction can involve at-home insemination using known donor sperm resulting in only one partner at maximum with a biological and legal link to the child [4,5]; and

Whereas, in IVF and rIVF, establishing parentage for the non-biological parent requires additional legal steps, such as second-parent adoption or confirmatory parentage orders, especially in states that do not automatically recognize the non-biological parent as a legal parent, even if the couple is married [6]; and

Whereas, due to Obergefell v. Hodges and Pavan v. Smith, all married LGBTQ+ parents have the marital presumption of parentage, whereby the spouse of a married couple who did not birth the child is automatically treated as the child's parent [7,8]; and

Whereas, the presumption of parentage for unmarried LGBTQ+ and heterosexual couples can vary significantly depending on state laws and this lack of uniformity can create legal uncertainty and administrative barriers, as some states provide automatic legal recognition of both partners and others may require additional legal steps to ensure both partners have equal rights and responsibilities [9]; and

Whereas, many individuals assume that a legal birth certificate gives parental rights but they in fact are administrative records and do not necessarily provide legal parental rights in all jurisdictions [8]; and

Whereas, the 2002 update to the Uniform Parentage Act (UPA), created a streamlined, non-judicial process to establish paternity rights for unmarried fathers of children [10]; and

Whereas, to establish these parental rights, unmarried couples have to sign a “Voluntary Acknowledgement of Paternity” (VAP) form which must be provided in hospitals and agencies managing state birth records [11]; and

Whereas, VAP forms have historically only been given to men in heterosexual couples as they are written only to establish paternity, and more recently, Voluntary Acknowledgement of Parentage forms are presently only available to LGBTQ+ parents in 11 states [12-22]; and

Whereas, as VAPs are not always available to unmarried LGBTQ+ parents, some LGBTQ+ couples may utilize second-parent adoption or co-parent adoption after birth; however this method is only available in 20 states and sometimes only to couples who are married or in legally recognized relationships [23]; and

Whereas, adoption is not an equitable alternative to a VAP, as adoption price (which varies by state) can be as much as 3000 dollars and can include attorneys and home visits; a significant expense in addition to the cost of assisted reproduction or IVF [24]; and

Whereas, a Judgement of Parentage can be sought in courts of some states to establish legal parentage before and after a child’s birth for medical decision-making and premature birth scenarios, especially for unmarried couples [25]; and

Whereas, unequal legal recognition of LGBTQ+ parents increases worry about family discrimination, and parental stress, and decreases disclosure and normalization of LGBTQ+ identity [26]; and

Whereas, recently in Oklahoma, the parental rights of an LGBTQ+ couple has been terminated even with a signed birth certificate and marital status at the time of birth due to the couple using non-medically assisted insemination, indicating the necessity for establishing clear pathways to parental rights [27,28]; and

Whereas, legislative and regulatory changes in reproductive healthcare are often influenced by political ideologies, resulting in a patchwork of policies that can create confusion and barriers for individuals seeking reproductive healthcare services [29,30.] and

Whereas, the evolving nature of reproductive technologies requires ongoing review and adjustment of parentage laws to ensure that diverse family structures, created through assisted reproduction are protected [9,31.] and

Whereas, according to the ASRM, we have an ethical duty to ensure that all families, regardless of their structure, have equal access to reproductive health and family building services and the legal recognition to support their family stability [32]; therefore be it

RESOLVED, that our American Medical Association supports the recognition of the legal parent-child relationship as the source of many rights and protections for children and as important to child stability and well-being; and be it further

RESOLVED, that our AMA supports ensuring there are mechanisms to secure parentage for all children regardless of the marital status, gender, or sexual orientation of their parents or the circumstances of a child's birth, including children born through assisted reproduction and surrogacy; and be it further

RESOLVED, that our AMA supports equity in expansion of mechanisms to secure parentage for individuals using any method of assisted reproduction including but not limited to, voluntary acknowledgement of parentage forms with gender inclusive terminology; and be it further

RESOLVED, that our AMA advocates for all states to develop and make available a voluntary acknowledgment of parentage form for children born through assisted reproduction, including gamete donation.

Fiscal Note: TBD

Date Received: 09/15/2024

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RELEVANT AMA POLICY

Partner Co-Adoption H-60.940
Our American Medical Association supports legislative and other efforts to allow the adoption of a child by the non-married partner who functions as a second parent or co-parent to that child. [Res. 204, A-04; Modified: CSAPH Rep. 1, A-14; Reaffirmed: BOT Rep. 09, A-24]

Equal Access for Adoption in the LGBTQ Community D-60.964
(1)Our American Medical Association will advocate for equal access to adoption services for LGBTQ individuals who meet federal criteria for adoption regardless of gender identity or sexual orientation. (2) Our AMA encourages allocation of government funding to licensed child welfare agencies that offer adoption services to all individuals or couples including those with LGBTQ identity. [Res. 007, A-22]

Health Care Disparities in Same-Sex Partner Households H-65.973
(1) Our American Medical Association recognizes that denying civil marriage based on sexual orientation is discriminatory and imposes harmful stigma on gay and lesbian individuals and couples and their families. (2) Our AMA recognizes that exclusion from civil marriage contributes to health care disparities affecting same-sex households. (3) Our AMA will work to reduce health care disparities among members of same-sex households including minor children… [CSAPH Rep. 1, I-09; BOT Action in response to referred for decision Res. 918, I-09: Reaffirmed in lieu of Res. 918, I-09; BOT Rep. 15, A-11; Reaffirmed in lieu of Res. 209, A-12; Reaffirmed: CSAPH Rep. 1, A-22]

Preserving Access to Reproductive Health Services D-5.999

Our AMA: …(7) will advocate for legal protections for patients who cross state lines to receive reproductive health services, including contraception and abortion, or who receive medications for contraception and abortion from across state lines, and legal protections for those that provide, support, or refer patients to these services; and (8) will advocate for legal protections for medical students and physicians who cross state lines to receive education in or deliver reproductive health services, including contraception and abortion.[Res. 028, A-22; Reaffirmed: Res. 224, I-22; Modified: BOT Rep. 4, I-22; Appended: Res. 317, I-22]

4.2.1 Assisted Reproductive Technology
"...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… (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.

RELEVANT MSS POLICY

Same-Sex and/or Opposite Sex Non-Married Partner 65.009MSS
AMA-MSS will ask the AMA to support legislative and other efforts to allow the adoption by the same-sex and/or opposite sex non-married partner who functions as a second parent or co-parent of children who are born to or adopted by one member. (MSS Res 24, I-03) (AMA Res 204, A-04 Adopted [H-60.940]) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B-I-13) (Reaffirmed: MSS GC Rep A, I-19)

Marriage-Based Health Disparities Among Gay, Lesbian, Bisexual, and Transgender Families 65.013MSS
AMA-MSS supports AMA efforts to evaluate existing data concerning same-sex couples and their dependent children and report back to the House of Delegates to determine whether there is evidence of health care disparities for these couples and children because of their exclusion from civil marriage or (joint) adoption. (MSS Res 5, A-08) (Reaffirmed: GC Rep B, I-13) (Amended and Reaffirmed: MSS GC Rep A, I-19)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 208
(I-24)

Introduced by: Alexandra Diaz[1], Jessica Rosenblum[1], Emily Doucette[1], Jackie Liu[2], Alexandra Wactor[1], Hailey Greenstone[1]

Affiliations: [1] Tufts University School of Medicine
[2] Harvard Medical School

Subject: Addressing the Harms of Weight Bias, Stigma, and Discrimination

Referred to: MSS Reference Committee
(Alec Calac and Andrew Norton, Co-Chairs)

Whereas, weight bias refers to situations where "individuals receive negative or unreasonable judgements about their person based on their body size or weight, with prejudice being a potential outcome" [1]; and

Whereas, weight stigma refers to "individuals' social devaluation and denigration due to their body weight, leading to negative attitudes, stereotypes, prejudice, and discrimination" [2]; and

Whereas, weight discrimination refers to "negative, unequal treatment of people because of their body size"[3]; and

Whereas, in a large multinational 2021 study, two-thirds of participants who reported a history of weight stigma reported experiencing this stigma from doctors[4]; and

Whereas, studies have found that between 39 to 74 percent of large national samples of medical students exhibited implicit weight bias, and between 33 to 67 percent exhibited explicit weight bias[5-6]; and

Whereas, physicians also display strong implicit and explicit weight bias, which can lead to discriminatory and inequitable treatment, as evidenced by refusals to complete and provide comprehensive medical care, disrespecting patient autonomy, and misdiagnosing patients[7-9]; and

Whereas, studies consistently find that physicians view larger-bodied patients as lazy, stupid worthless, and a waste of their time[10-12]; and

Whereas, primary care providers, on average, spend less time with and practice less patient-centered care towards patients with obesity[13]; and

Whereas, weight bias increases the risk of poor health outcomes through primary biological pathways such as, increased oxidative stress and hypothalamic-pituitary-adrenal axis activation, and psychosocial factors including lower quality of care and healthcare avoidance[14-15]; and

Whereas, weight discrimination at every BMI has been associated with lipid and metabolic dysregulation, impaired glucose metabolism, and inflammation, increased risk of substance use disorder and mood disorder, and increased mortality[15-18]; and

Whereas, internalized weight bias worsens mental health outcomes, such as depression, anxiety, body dissatisfaction, disordered eating, and quality of life, regardless of body size[19]; and

Whereas, an over-reliance on weight loss as a clinical goal/treatment modality without exploring other underlying causes can result in misdiagnosis or delayed diagnosis (including cancer), worsening health outcomes for larger-bodied people[20-21]; and

Whereas, people who reported experiencing weight discrimination had a 60% increased risk of dying independent of BMI and other factors [22-23]; and

Whereas weight bias, stigma, and discrimination can affect individuals of all BMIs, such as metabolic issues in patients with normal BMI that can be overlooked due to the societal assumption that their smaller body makes them healthy[24]; and

Whereas, existing AMA policy D-440.954 (Addressing Adult and Pediatric Obesity) mentions weight bias in healthcare settings, it does so in the context of promoting weight loss and eliminating obesity, further perpetuating weight bias, stigma, and discrimination by healthcare providers; and

Whereas, current AMA policy only addresses weight bias against patients in the obese BMI category, and does not address those in underweight, normal weight, or overweight BMI categories; and

Whereas, current AMA policy focuses on changing the body size of the patient rather than providing whole-person care centered in respecting the bodily autonomy of the patient in front of them; and

Whereas, all patients deserve freedom from size-based bias, stigma, and discrimination, regardless of their BMI and whether they are interested or able to seek weight-loss treatment; and

Whereas, the AMA has enacted policies specifically to protect patients from other forms of bias, such as gender (H-410.946) and racial (H-350.974) bias and discrimination, which sets a precedent for a standalone policy to protect patients from weight bias; and

Whereas, given the substantial negative impact weight bias has on patient health outcomes and quality of care as referenced above, specific policy aimed at reducing such discriminatory practice is warranted; and

Whereas two states (MI and WA) and several cities (including New York City, San Francisco, and Washington, D.C.) have passed laws prohibiting discrimination based on body size, with similar legislation pending in other states (VT, NY, MA, NJ) but discrimination based on a person's body size remains legal in most of the country (in housing, employment, healthcare access, etc.)[25]; and

Whereas, the AMA Journal of Ethics July 2023 theme issue "How we Over Rely on BMI" includes an article titled "Five Ways Health Care Can Be Better for Fat People," which claims "at the institutional level -in acute and long-term settings, ambulatory clinics, medical schools, and regulatory authorities – weight bias must be explicitly included in anti-discrimination policies…"[36]; and

Whereas, weight-normative or weight-centric approaches to care place "emphasis on weight loss when defining health and well-being" and weight-neutral (also referred to as weight-inclusive) approaches to care place "emphasis on viewing health and well-being as multifaceted while directing efforts toward improving health access and reducing weight stigma,"[26]; and

Whereas, weight-neutral approaches to care are "grounded in mindfulness skills and emphasize intuitive eating, self-care, pleasurable exercise, and size-acceptance" [43]; and

Whereas, compared to weight-centric approaches, several studies have shown that weight-neutral approaches to patient care are just as or even more effective at improving physical, psychological, and behavioral health outcomes[27, 37-46]; and

Whereas, there is consensus that mitigating weight bias and stigma is expected to improve patient care and health outcomes[28]; and

Whereas, weight bias reduction training and interventions in medical settings are not widespread, even though the problem is pervasive[29]; and

Whereas, research has shown that training can successfully reduce implicit and explicit weight bias amongst healthcare professionals, for example through curriculum emphasizing causes of obesity such as genes/environment rather than a lack of exercise/diet, roleplaying activities placing students in the shoes of obese patents, and didactic workshops explicitly targeting weight bias and body diversity[30-32]; and

Whereas, given the rising public and legislative interest in this topic, the AMA should have policies in place to protect the rights of people of all sizes, including equitable access to healthcare, which can currently be denied based on a healthcare provider's disinterest in treating larger patients[33-35]; therefore be it

RESOLVED, that our AMA-MSS recognizes that weight bias, stigma, and discrimination are pervasive in the healthcare system and lead to worsened, inequitable quality of care and health outcomes; and be it further

RESOLVED, that our American Medical Association supports educating physicians and physicians-in-training on the harms of weight bias, stigma, and discrimination, including by incorporating these topics into existing institutional implicit bias trainings; and be it further

RESOLVED, that our AMA supports the use of size-accessible medical and diagnostic equipment such that patients of all sizes can receive adequate and accurate care as well as the display of medical imagery in healthcare offices and spaces that promotes size inclusivity and discourages weight stigma; and be it further

RESOLVED, that our AMA supports weight-neutral approaches to care as alternative, evidence-based approaches to healthcare delivery.

Fiscal Note: TBD

Date Received: 09/15/2024

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RELEVANT AMA POLICY

Addressing Adult and Pediatric Obesity D-440.954

Our AMA: … (5) will leverage existing channels within AMA that could advance the following priorities:

- Promotion of awareness amongst practicing physicians and trainees that obesity is a treatable chronic disease along with evidence-based treatment options.
- Advocacy efforts at the state and federal level to impact the disease obesity.
- Health disparities, stigma and bias affecting people with obesity.
- Lack of insurance coverage for evidence-based treatments including intensive lifestyle intervention, anti-obesity pharmacotherapy and bariatric and metabolic surgery.
- Increasing obesity rates in children, adolescents and adults
- Drivers of obesity including lack of healthful food choices, over-exposure to obesogenic foods and food marketing practices. [BOT Rep. 11, I-06; Reaffirmation A-13; Appended: Sub. Res. 111, A-14; Modified: Sub. Res. 811, I-14; Appended: Res. 201, A-18; BOT Action in response to referred for decision: Res. 415, A-22; Modified: Res. 818, I-22]

Advocacy Against Obesity-Related Bias by Insurance Providers H-440.801

1. Our AMA will urge individual state delegations to directly advocate for their state insurance agencies and insurance providers in their jurisdiction to:
    a) Revise their policies to ensure that bariatric surgery are covered for patients who meet the appropriate medical criteria.
    b) Eliminate criteria that place unnecessary time-based mandates that are not clinically supported nor directed **by** the patient's medical provider.

   c) Ensure that **insurance** policies in their states do not discriminate **against** potential metabolic surgery patients based on age, gender, race, ethnicity, socioeconomic status.
   d) Advocate for the cost-effectiveness of all obesity treatment modalities in reducing healthcare costs and improving patient outcomes.
2. Our AMA will support and provide resources to state delegations in their efforts to advocate for the reduction of bias against patients that suffer from obesity for the actions listed. [Res. 224, A-23]

Person First Language for Obesity H-440.821
Our AMA: (1) encourages the use of **person-first language** (patients with **obesity**, patients affected by **obesity**) in all discussions, resolutions and reports regarding **obesity**; (2) encourages the use of preferred terms in discussions, resolutions and reports regarding patients affected by **obesity** including weight and unhealthy weight, and discourage the use of stigmatizing terms including obese, morbidly obese, and fat; and (3) will educate health care providers on the importance of **person-first language for** treating patients with **obesity**; equipping their health care facilities with proper sized furniture, medical equipment and gowns **for** patients with **obesity**; and having patients weighed respectfully. [Res. 402, A-17; Modified: Speakers Rep., I-17]

Support for Evidence-Based Use of BMI as a Measure in Medicine H-440.797
1. Our American Medical Association recognizes the issues with using body mass index (**BMI**) **as a** measurement because:
   a. **of** the historical harm **of BMI**;
   b. **of** the **use of BMI for** racist exclusion; and
   c. **BMI** cutoffs are based primarily on data collected from previous generations **of** non-Hispanic White populations and does not consider **a** person's gender or ethnicity.
2. Our AMA recognizes the significant limitations associated with the widespread **use of BMI in** clinical settings and suggests its **use** be **in a** conjunction with other valid measures **of** risk such **as**, but not limited to, measurements **of**:
   a. visceral fat;
   b. body composition;
   c. waist circumference; and
   d. genetic/metabolic factors. [CSAPH Rep. 7, A-23; Modified: CSAPH Rep. 03, A-24]

Recognizing and Taking Action in Response to the Obesity Crisis D-440.980
1. Our American Medical Association will advocate for **the** creation of a multidisciplinary federal task force, including representation from **the** medical profession, **to** review **the** public health impact of **obesity and** recommend measures **to**:
   a. Better recognize **and** treat **obesity** as a chronic disease.
   b. Confront **the** epidemic of **obesity and** its root causes, particularly among populations with disproportionally high incidence.
2. Our AMA will actively pursue, **in** collaboration **and** coordination with programs **and** activities of appropriate agencies **and** organizations, **the** creation of a "National **Obesity** Awareness Month".
3. Our AMA will strongly encourage through a media campaign **the** re-establishment of meaningful physical education programs **in** primary **and** secondary education as well as family-oriented education programs on **obesity** prevention.
4. Our AMA will promote **the** inclusion of education on **obesity** prevention **and the** medical complications of **obesity in** medical school **and** appropriate residency curricula.
5. Our AMA will make Council on Medical Education Report 3, A-17, **Obesity** Education, available on **the** AMA website for use by medical students, residents, teaching faculty, **and** practicing physicians. [Res. 405, A-03; Reaffirmation A-04; Reaffirmation A-07; Appended; Sub. Res. 315, A-15; Modified: CME Rep. 03, A-17; Modified - BOT Action in response to referred for decision: Res. 403, A-21]

RELEVANT MSS POLICY

Childhood Obesity as a Public Health Epidemic 440.018MSS
AMA-MSS urges physicians to work with appropriate federal agencies, medical specialty societies, and public health organizations to overcome cultural, temporal, and economic barriers to exercise prescription by developing and demonstrating the effectiveness of culturally appropriate and necessary tools, including mass media based efforts, to help physicians more effectively counsel obese and overweight children and their families with special emphasis on targeting high risk groups. (MSS Sub Res 5, I-02) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I-12) (Reaffirmed: MSS GC Report A, I-17) (Reaffirmed: MSS GC Report A, A-23)

Obesity as a Chronic Disease 440.013MSS
AMA-MSS will ask the AMA to: (1) recognize childhood and adult obesity as a major public health problem; and (2) work with other public and private organizations to develop ethical and evidence- based recommendations regarding education, prevention, and treatment of obesity. (MSS Amended Sub Res 33, A-98) (AMA Amended Res 423, A-98 Adopted [H-440.902]) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13) (Reaffirmed: MSS GC Rep A, I-19)

Childhood Obesity as a Public Health Epidemic 440.018MSS
AMA-MSS urges physicians to work with appropriate federal agencies, medical specialty societies, and public health organizations to overcome cultural, temporal, and economic barriers to exercise prescription by developing and demonstrating the effectiveness of culturally appropriate and necessary tools, including mass media based efforts, to help physicians more effectively counsel obese and overweight children and their families with special emphasis on targeting high risk groups. (MSS Sub Res 5, I-02) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I-12) (Reaffirmed: MSS GC Report A, I-17) (Reaffirmed: MSS GC Report A, A-23)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 209
(I-24)

Introduced by: Rohini Kambhampati[1], Priscilla McElhinney[1], Katherine Hofmann[2], Jordan Karten[1], Amy Pham[2]

Affiliations: 1 Chobanian & Avedisian School of Medicine
2 University of Miami Miller School of Medicine

Subject: Timely Prenatal Appointments in Incarcerated Populations

Referred to: MSS Reference Committee
(Alec Calac and Andrew Norton, Co-Chairs)

Whereas, access to timely prenatal appointments is vital to maternal health and proper fetal development, and the current prenatal appointment guidelines established by the American College of Obstetricians and Gynecologists (ACOG) are:

- Weeks 4 to 28 — One prenatal visit every four weeks
- Weeks 28 to 36 — One prenatal visit every two weeks
- Weeks 36 to 40 — One prenatal visit every week[1]; and

Whereas, appointments consist of prenatal education, substance use treatment, bloodwork, blood pressure checkups, HIV screening, and assessing prenatal vitamin use - all extremely important for a healthy pregnancy[2]; and

Whereas, access to timely prenatal appointments is a vital component of prenatal care; and

Whereas, higher-risk patients, such as those with preexisting hypertension, diabetes, or a history of early pregnancy loss, may require additional supplemental prenatal visits to ensure the health of the mother and baby[3]; and

Whereas, infants of mothers who do not get proper prenatal care are three times more likely to be low birth weight and five times more likely to die[4]; and

Whereas, it is estimated that approximately 58,000 pregnant women are admitted to jails and prisons annually in the United States, with thousands giving birth or experiencing other outcomes while still incarcerated[5]; and

Whereas, incarcerated individuals have a significant amount of unmet needs compared to non-incarcerated individuals who are pregnant, such as treatment for substance use disorders and assessment for mental health needs which can result in improper fetal development[6]; and

Whereas, there are additional barriers when incarcerated, such as lack of transportation to prenatal appointments and being in an uncontrollable environment which can affect sleep schedules, both vital to prenatal health and ensuring timely arrival to prenatal appointments[7]; and

Whereas, incarcerated pregnant women are more likely to have risk factors associated with poor perinatal outcomes compared to women in the general population, including miscarriage, preterm infants, and infants who are small for their gestational age[8,9] ; and

Whereas, current ACOG guidelines outline necessary components of prenatal care which must be in line with care for non-incarcerated populations, including guidelines for vaccinations, STI testing, and pelvic examinations[10]; and

Whereas, the 1976 U.S. Supreme Court Case *Estelle v. Gamble* established that incarcerated individuals have a constitutional right to receive medical care, however, standards and oversight were not established, contributing to variability in access and quality of reproductive healthcare, including prenatal care, across prisons, jails, and detention centers[10]; and

Whereas, the incarceration setting, characterized by rapid turnover of incarcerated individuals and unpredictable timing of jail and detention releases, hinders continuity of care and healthcare delivery for incarcerated individuals[10]; and

Whereas, this is a human rights issue given the lack of care in this vulnerable population compared to non-incarcerated individuals; and

Whereas, a 2016-17 study that surveyed 22 state prisons and six jails found that a third of the prisons and half of the jails did not have accredited healthcare services[11]; and

Whereas, only twelve states have standards that mention prenatal health care and only twenty-one states have standards for health care for pregnant individuals[12,13]; and

Whereas, a study that categorized correctional facilities from 15 US states as usual prenatal care (PRISON), exceptional prenatal care (PRISON+), and exceptional prenatal care with infant co-residence post birth (PRISON++) revealed that prisons in PRISON+ and PRISON++ categories resulted in the best birth outcomes[14]; and

Whereas, the Federal Bureau of Justice Statistics reports that in 2016, although 91% of pregnant women in state prisons and 86% in federal prisons received an obstetric exam, only 50% of pregnant women in state prisons and 46% in federal prisons reported receiving some form of prenatal care[5,15]; and

Whereas, a study conducted by the National Women's Law Center analyzed prenatal care, shackling policies, and family-based treatment alternatives in prisons, revealing that only 30 states received passing grades, while 21 states were graded D or F[13], revealing deficits in care; and

Whereas, the American Civil Liberty Union (ACLU) reports that 23 out of 50 state prison policies do not provide screening or treatment for high-risk pregnancies and only 26 out of 50 state prisons have established protocols for labor and delivery[8]; and

Whereas, the ACLU reports that among 42 jurisdictions with pregnancy-specific laws or correctional policies, only 12 have standards that mention prenatal healthcare[12]; and

Whereas, of those 42 jurisdictions, 12 specifically include medical examinations as part of prenatal care, 19 mention prenatal nutrition counseling, and 16 provide screening or specialized care for high-risk pregnancies[12]; and

Whereas, current AMA policy H-430.986 advocates for staff training and programs to address obstetrics care for incarcerated individuals, and H-420.978 supports the development of legislation to provide all women access to prenatal care; however there is no existing AMA policy that specifically addresses the unique needs of incarcerated pregnant individuals by supporting the implementation of standardized protocols to ensure timely prenatal appointments in accordance with ACOG guidelines across prisons and jails for this vulnerable population; therefore be it

RESOLVED, that our American Medical Association supports the provision of timely and appropriate prenatal appointments for incarcerated individuals, in alignment with established national guidelines, by recommending standardized implementation protocols across all correctional facilities.

Fiscal Note: TBD

Date Received: 09/15/2024

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RELEVANT AMA POLICY

Health Care While Incarcerated H-430.986
Our AMA:…(8) advocates for necessary programs and staff training to address the distinctive health care needs of women and adolescent females who are incarcerated, including gynecological care and

obstetrics care for individuals who are pregnant or postpartum. [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]

Access to Prenatal Care H-420.978
Our AMA: …(1) supports development of legislation or other appropriate means to provide for access to prenatal care for all women, with alternative methods of funding, including private payment, third party coverage, and/or governmental funding, depending on the individual's economic circumstances. [Res. 33, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmation A-05; Reaffirmation A-07; Reaffirmed: Res. 227, A-11; Reaffirmed: BOT Rep. 7, A-21]

Support for Health Care Services to Incarcerated Persons D-430.997
Our AMA: …(6) will support an incarcerated person's right to:

a. accessible, comprehensive, evidence-based contraception education.
b. access **to** reversible contraceptive methods.
c. autonomy over the decision-making process without coercion.

[Res. 440, A-04; Amended: BOT Action in response to referred for decision Res. 602, A-00; Reaffirmation I-09; Reaffirmation A-11; Reaffirmed: CSAPH Rep. 08, A-16; Reaffirmed: CMS Rep, 02, I-16; Appended: Res. 421, A-19; Appended: Res. 426, A-19; Reaffirmed: CSAPH Rep. 06, A-23; Reaffirmed: CSAPH Rep. 07, A-24]

RELEVANT MSS POLICY

Advocating for the Delivery of Standardized Perinatal Care and Monitoring of Healthcare Outcomes for Incarcerated Pregnant Individuals 65.049MSS
AMA-MSS will ask the AMA to (1) encourage research efforts to characterize the health needs for pregnant inmates, including efforts that utilize data acquisition directly from pregnant inmates; and (2) support legislation requiring all correctional facilities, including those that are privately-owned, to collect and publicly report pregnancy-related healthcare statistics with transparency in the data collection process. (MSS Res. 045, A-21)

Continuing the Fight to Lower Infant Mortality in the United States 245.012MSS
AMA-MSS supports the reduction of the rate of infant mortality in the United States through the promotion of access to prenatal and infant care, education on healthy choices to reduce risks, and research on how to best reduce infant mortality. AMA-MSS will communicate to the AMA Health Disparities Initiative and/or AMA Chief Health Equity Officer the importance of reducing infant mortality in the United States, and specifically where this problem manifests as racial or ethnic disparities in health indicators. (MSS Res 26, I-03) (Reaffirmed: MSS Rep E, I-08) (Modified: GC Rep B, I-13) (Amended and Reaffirmed: MSS GC Rep A, I-19)

Support for Children of Incarcerated Parents 60.026MSS
AMA-MSS will ask the AMA to support legislation and initiatives that provide resources and support for children of incarcerated parents. (MSS Res 03, I-18) (AMA Res 503, combined with Res 531, A-19, Adopted as amended, [H-60.903])

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 301
(I-24)

Introduced by: Kayla Tran[1], Sarah Jiang[2], Soneet Kapadia[3], Rajadhar Reddy[4], Natalie Bachir[5], Samyukta Karthik[6], Amanda Felty[7]

Affiliations:
[1] Rosalind Franklin University Chicago Medical School
[2] University of Missouri Kansas City School of Medicine
[3]Baylor College of Medicine
[4]University of Texas Health Science Center San Antonio Long School of Medicine
[5]Philadelphia College of Osteopathic Medicine
[6]Pennsylvania State University College of Medicine - University Park Regional Campus
[7]College of Osteopathic Medicine of the Pacific - Northwest

Subject: Support for Innovative Medical School Pathways

Referred to: MSS Reference Committee
(Alec Calac and Andrew Norton, Co-Chairs)

Whereas, as rising tuition and living costs have led to an average medical student debt of $202,453, accelerated three-year programs help students save on tuition, enter the workforce earlier, and address the projected shortage of 21,100 to 55,200 primary care physicians by 2032[1,2,3]; and

Whereas, in the last decade, the number of three-year medical school pathways has increased from 8 to 35 with several more in consideration, reflecting growing interest in accelerated medical education[4,5,6]; and

Whereas, by shortening preclinical curriculum and starting clinical exposure earlier, three-year students meet all graduation requirements while condensing 10-20 weeks of educational time, which typically aligns with the 'downtime' of fourth-year students[4]; and

Whereas, some three-year programs prioritize residency positions for students entering primary care, psychiatry, or practice in under-resourced or rural areas, which also helps shorten curricula and saves students the time, stress, and finances needed to apply to residency[4,7]; and

Whereas, 75% of programs in the Consortium of Accelerated Medical Pathway Programs have explicit missions to recruit, mentor, and nurture students in underserved areas and specialties with shortages such as primary care[8]; and

Whereas, exemplar programs such as NYU GLISOM, UC Davis, and Kaiser Permanente have shown higher rates of students going into family medicine and primary care (50-70%) than the national average of 9% for allopathic schools and 23% for osteopathic schools[9,10,11]; and

Whereas, some schools have shortened their preclinical curriculum to 12 months, while others have considered shifting to this structure and reducing live lectures due to the advent of students increasingly using asynchronous external online resources[12]; and

Whereas, shortened preclinical curricula transition students to clerkships 6 to 12 months earlier and allow three-year programs to maintain or even increase clinical exposure[12,13,14]; and

Whereas, three-year programs experience high enrollment from underrepresented groups, who may be deterred by the length and cost of four-year programs[8]; and

Whereas, a 2016 analysis of three-year graduates found no difference in residency milestone progress, Step 3 performance, or appointment to chief resident compared to four-year graduates[4]; and

Whereas, a 2023 study evaluating academic performance of three-year graduates found that they achieved equivalent clinical performance ratings during critical clerkships and rotations suggesting that three-year medical school curriculums effectively prepare students for residency[15]; therefore be it

RESOLVED, that our American Medical Association support the following efforts to innovate undergraduate medical education:

a. accelerated three-year pathways;
b. pathways that prioritize residency positions for students entering primary care, OBGYN, psychiatry, and practice in under-resourced and rural areas (including the Indian Health Service);
c. pathways that emphasize clinical exposure and shorten preclinical education, including via the use of virtual/asynchronous resources (as informed by student perspectives) in lieu of live lectures;
d. efforts to promote the above pathways to underrepresented populations.

Fiscal Note: TBD

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RELEVANT AMA POLICY

Accelerating Change in Medical Education: Strategies for Medical Education Reform H-295.871
Our AMA continues to recognize the need for transformation of medical education across the continuum from premedical preparation through continuing physician professional development and the need to involve multiple stakeholders in the transformation process, while taking an appropriate leadership and coordinating role. [CME Rep. 13, A-07; Reaffirmed: CME Rep. 01, A-17]

Competency Based Medical Education Across the Continuum of Education and Practice D-295.317
1. Our American Medical Association Council on Medical Education will continue to study and identify challenges and opportunities and critical stakeholders in achieving a competency-based curriculum across the medical education continuum and other health professions that provides significant value to those participating in these curricula and their patients.
2. Our AMA Council on Medical Education will work to establish a framework of consistent vocabulary and definitions across the continuum of health sciences education that will facilitate competency-based curriculum, andragogy and assessment implementation.
3. Our AMA will continue to explore, with the Accelerating Change in Medical Education initiative and with other stakeholder organizations, the implications of shifting from time-based to competency-based medical education on residents' compensation and lifetime earnings. [CME Rep. 3, A-14; Appended: CME Rep. 04, A-16; Reaffirmed: CME Rep. 04, A-23]

Principles of and Actions to Address Medical Education Costs and Student Debt H-305.925
12. Encourage medical schools to: (a) study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, and combined baccalaureate/MD or DO programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education; [CME Report 05, I-18; Appended: Res. 953, I-18; Reaffirmation: A-19; Appended: Res. 316, A-19; Appended: Res. 226, A-21; Reaffirmed in lieu of: Res. 311, A-21; Modified: CME Rep. 4, I-21; Reaffirmation: A-22; Appended: CME Rep. 02, A-23; Appended: Res. 311, A-23]

Principles of and Actions to Address Primary Care Workforce H-200.949
1. Our patients require a sufficient, well-trained supply of primary care physicians--family physicians, general internists, general pediatricians, and obstetricians/gynecologists--to meet the nation's current and projected demand for health care services.
2. To help accomplish this critical goal, our American Medical Association (AMA) will work with a variety of key stakeholders, to include federal and state legislators and regulatory bodies; national and state

specialty societies and medical associations, including those representing primary care fields; and accreditation, certification, licensing, and regulatory bodies from across the continuum of medical education (undergraduate, graduate, and continuing medical education).
3. Through its work with these stakeholders, our AMA will encourage development and dissemination of innovative models to recruit medical students interested in primary care, train primary care physicians, and enhance both the perception and the reality of primary care practice, to encompass the following components: a) Changes to medical school admissions and recruitment of medical students to primary care specialties, including counseling of medical students as they develop their career plans; b) Curriculum changes throughout the medical education continuum; c) Expanded financial aid and debt relief options; d) Financial and logistical support for primary care practice, including adequate reimbursement, and enhancements to the practice environment to ensure professional satisfaction and practice sustainability; and e) Support for research and advocacy related to primary care.
4. Admissions and recruitment: The medical school admissions process should reflect the specific institution's mission. Those schools with missions that include primary care should consider those predictor variables among applicants that are associated with choice of these specialties.
5. Medical schools, through continued and expanded recruitment and outreach activities into secondary schools, colleges, and universities, should develop and increase the pool of applicants likely to practice primary care by seeking out those students whose profiles indicate a likelihood of practicing in primary care and underserved areas, while establishing strict guidelines to preclude discrimination.

RELEVANT MSS POLICY

295.204MSS Evaluating the Use of Third-Party Resources in Medical Education
AMA-MSS supports the augmentation of traditional medical curricula with third-party, noninstitutional resources, as well as continued research into innovative methods of incorporating these resources into medical education curricula. (MSS Res. 35, I-19)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 302
(I-24)

Introduced by: Sharon Zeldin[1] and Raj Reddy[2]

Affiliations: [1]Rutgers New Jersey Medical School
[2]Baylor College of Medicine

Subject: Abolition of Organic Chemistry, General Chemistry, Physics, and Calculus

Referred to: MSS Reference Committee
(Alec Calac and Andrew Norton, Co-Chairs)

Whereas, while medical schools differ in their requirements, most medical schools require a year of Organic Chemistry, General Chemistry, Physics, and Calculus for admission to medical school[1]; and

Whereas, in 1904, the American Medical Association (AMA) created a Council on Medical Education to standardize the preliminary requirements for entry into medical school[5]; and

Whereas, after surveying medical schools, Abraham Flexner published a report regarding necessary knowledge for medical school, stating that competency in subjects such as botany, biology, physics, and chemistry was required[6]; and

Whereas, by 1930, admission to medical school required 60 hours (2 years) of college with 8 hours (2 semesters) each of general chemistry, physics, and biology; 1 semester of organic chemistry; and 6 hours of English composition were required [7,8]; and

Whereas, since then, the only changes have been the addition of a math/calculus requirement, and the required organic chemistry has increased from 1 semester to 1 year[15]; and

Whereas, many scholars have advocated for the removal or adaptation of these requirements, comparing them to hazing rituals [9, 10, 11, 15]; and

Whereas, in Barr et al (2008), authors found that underrepresented minorities (URM) students had a larger decline than non-URM students and women having a large drop than men, with the principal reason being a chemistry course[12]; and

Whereas, among students mentioning chemistry courses that resulted in their loss of interest, the majority attributed it to organic chemistry[12]; and

Whereas, the sheer amount of requirements disproportionately impacts lower socioeconomic status (SES) students, resulting in reduced study time, a lower GPA, and reduced time to participate in extracurricular activities culminating in a discriminatory system that ultimately favors the wealthy[2] ; and

Whereas, students who perform poorly in their prerequisite courses must take post-baccalaureate courses to compensate for the GPA, despite data suggesting that individuals in post-baccalaureate programs were often older, underrepresented in medicine, and social science majors [14]; and

Whereas, students who participate in post-baccalaureate programs did not show an improved performance on preclinical medical school exams compared to the students who did not take the post-baccalaureate course[14]; and

Whereas, of students who chose to forego a career in medicine because of poor grades, 78% of them named their organic chemistry course as a sole factor[4] ; and

Whereas, many of these required courses serve as “weed-out” courses for aspiring pre-medical; students [13] ; and

Whereas, much of this content, namely physics, general, and organic chemistry is assessed on the MCAT, independent of a student’s coursework[3] ; and

Whereas, the sheer amount of requirements hinders exploration of other equally important topics for physicians, such as social justice, ethics, or courses in topics of passion ; therefore be it

RESOLVED, that our American Medical Association support the removal of organic chemistry, physics, and calculus as prerequisite college coursework for medical school applicants and support that any remaining premedical prerequisites be relevant to readiness for clinical practice as a physician; and be it further

RESOLVED, that our AMA supports the ability to fulfill premedical prerequisites via college credit earned in high school or community college (including Advanced Placement and dual enrollment programs) without stigma, to prevent pressure on premedical applicants to repeat previously completed coursework.

Fiscal Note: TBD

Date Received: 09/15/2024

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 303
(I-24)

Introduced by: Isabel Nguyen[1], Soneet Kapadia[2], Paaras Kumar[3], Ellis Jang[4], Caroline Cassidy[5], Gabrielle Li[6], Amandine Roure[7], Rajadhar Reddy[8]

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Subject: Improvements to Burnout Prevention Programs

Referred to: MSS Reference Committee
(Alec Calac and Andrew Norton, Co-Chairs)

Whereas, ICD-11 defines "burnout" as a syndrome resulting from chronic workplace stress that is characterized by "feelings of energy depletion or exhaustion; increased mental distance from one's job, or feelings of negativism or cynicism related to one's job; and reduced professional efficacy"[1]; and

Whereas, surveys indicate 42% of physicians report feeling burnout at a rate significantly higher than the general population; causes for burnout including excess bureaucracy, long working hours, insufficient compensation, and a lack of clinical autonomy[2-3]; and

Whereas, prevalence of burnout among residents is significantly associated with difficulty meeting professionalism milestones, with up to half of residents reporting burnout or emotional exhaustion[4-7]; and

Whereas, medical students report similar or better mental health than non-medical peers until the first year of medical school, after which nearly 50% of medical students report burnout symptoms due to factors like lack of psychosocial support and pressures to engage in professional development while balancing medical school curricula[8-9]; and

Whereas, the Liaison Committee on Medical Education (LCME) mandates that medical schools support their medical students through the development and institution of "programs to promote their well-being and to facilitate their adjustment to the physical and emotional demands of medical education"[10]; and

Whereas, inflexible burnout prevention programs can paradoxically increase stress and workload among physicians and medical students rather than alleviate it, and punitive measures

associated with these programs can create a negative atmosphere which discourages participation and exacerbates stress[11]; and

Whereas, inflexible burnout prevention programs that include mandatory assignments, punitive measures, and suboptimal scheduling of sessions fail to accommodate individual needs and are likely to be ineffective, even leading to exacerbation of burnout[12-13]; and

Whereas, leisure time and self-care are crucial components of effective burnout prevention programs and lack of such has been directly linked to higher levels of stress and burnout among physicians and medical students[14]; and

Whereas, evidence-based burnout prevention programs prioritize participant autonomy and provide multiple options for completing requested activities, leading to increased effectiveness, improved job satisfaction, and reduced burnout among medical professionals[12,14]; and

Whereas, the implementation of mindfulness-based interventions within burnout prevention programs has led to significant reductions in subjective stress in medical students and residents compared to peers without similar burnout prevention programs[14]; and

Whereas, adopting organization-directed approaches towards burnout prevention bolsters the existing benefits of burnout intervention programs catered to physicians, reinforcing the need to address burnout prevention at the individual and community levels[16-17]; and

Whereas, allotting unmonitored time for individuals to prioritize the cultivation of relationships (e.g., with self, others, religious and/or spiritual connections) is important and essential to sustain personal wellness and prevent burnout[14,18]; and

Whereas, effective burnout prevention programs are characterized by flexibility and participant-driven approaches, allowing individuals to choose activities that best suit their needs and schedules[13-14,19]; and

Whereas, integrating different types of burnout prevention programming into a medical education curriculum has generated beneficial effects, including reduction of student anxiety, increased ability to complete required sessions, improved psychological well-being while completing coursework[14-15,20]; therefore be it

RESOLVED, that our American Medical Association discourage physician, resident/fellow, and medical student burnout prevention programs which impose inflexible requirements, mandatory assignments, or punitive measures; and be it further

RESOLVED, that our AMA support evidence-based burnout prevention programs that:

A. prioritize personal time for participants;
B. facilitate voluntary participation in activities relating to personal values, leisure, hobbies, group and peer engagement, and self-care; and
C. are integrated directly into medical school and residency program curricula, and;
D. provide multiple options to complete any expectations or activities flexibly.

Fiscal Note: TBD

Date Received: 09/15/2024

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RELEVANT AMA POLICY

Physician and Medical Student Burnout D-310.968

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.

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.

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.
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.
Our AMA will continue to monitor this issue and track its progress, including publication of peer-reviewed research and changes in accreditation requirements.
Our AMA encourages the utilization of mindfulness education as an effective intervention to address the problem of medical student and physician burnout.
Our AMA will encourage medical staffs and/or organizational leadership to anonymously survey physicians to identify local factors that may lead to physician demoralization.
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.
Our AMA will continue to:
address the institutional causes of physician demoralization and burnout, such as the burden of documentation requirements, inefficient work flows and regulatory oversight.
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]

Study of Medical Student, Resident, and Physician Suicide D-345.983
Our American Medical Association will explore the viability and cost-effectiveness of regularly collecting National Death Index (NDI) data and confidentially maintaining manner of death information for physicians, residents, and medical students listed as deceased in the AMA Physician Masterfile for long-term studies.
Our AMA will monitor progress by the Association of American Medical Colleges, the American Association of Colleges of Osteopathic Medicine, and the Accreditation Council for Graduate Medical Education (ACGME) to collect data on medical student and resident/fellow suicides to identify patterns that could predict such events.
Our AMA will support the education of faculty members, residents and medical students in the recognition of the signs and symptoms of burnout and depression and supports access to free, confidential, and immediately available stigma-free mental health and substance use disorder services.
Our AMA will collaborate with other stakeholders to study the incidence of and risk factors for depression, substance misuse and substance use disorders, and attempted and completed suicide among physicians, residents, and medical students.
Our AMA will work with appropriate stakeholders to explore the viability of developing a standardized reporting mechanism for the collection of current wellness initiatives that institutions have in place to inform and promote meaningful mental health and wellness interventions in these populations. [CME Rep. 06, A-19; Modified: Res. 326, A-22]

Inclusion of Medical Students and Residents in Medical Society Impaired Physician Programs H-295.993
Our AMA: (1) recognizes the need for appropriate mechanisms to include medical students and resident physicians in the monitoring and advocacy services of state physician health programs and wellness and other programs to prevent impairment and burnout; and (2) encourages medical school administration and students to work together to develop creative ways to inform students concerning available student assistance programs and other related services. [Sub. Res. 84, I-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed and appended: CME Rep. 4, I-98; Reaffirmed: CME Rep. 2, A-08; Modified: CME Rep. 01, A-18]

RELEVANT MSS POLICY

Pharmaceutical Drug Pricing: Parameters Around Medicare Negotiation & Government Manufacturing of Generic Drugs 155.011MSS
(1) AMA-MSS supports the use of the international drug price indices and averages, which may include data from countries regardless of structure of healthcare system or any price controls used, in determining the price and payment for drugs; and
(2) AMA-MSS will ask the AMA to support the formation of a non-profit government pharmaceutical manufacturer to produce generic drugs to address market failures, including the existence of small markets for generics, the absence of generics in the market after expiration of patents and exclusivity, and shortages of necessary medications. (MSS Res. 36, I-21)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 304
(I-24)

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Subject: Improved Clinical Relevance of Standardized Exams

Referred to: MSS Reference Committee
(Alec Calac and Andrew Norton, Co-Chairs)

Whereas, while exam questions relating to rarer conditions are important to include to some degree, USMLE Step 1 often over-emphasizes rarer conditions that physicians regardless of specialty may seldom encounter relative to more prevalent clinical conditions, such as diabetes or depression, which are inappropriately under-emphasized[1,2]; and

Whereas**,** cardiovascular disease is the number one cause of death in the US, but cardiovascular questions only comprise a maximum of 11% of Step 1 content[1-3]; and

Whereas, physicians and trainees are increasingly concerned by the disproportionate focus of standardized exams on less prevalent conditions compared to conditions such as diabetes and cardiovascular disease, highlighting the need to shift to more clinically relevant examination content that better aligns with competencies for effective patient care[4,5]; and

Whereas, despite medical curriculum covering all USMLE Step 1 content, clerkship directors do not believe medical students receive adequate preparation in key competency areas including life-cycle stages, epidemiology/probabilistic thinking, and systems of care[5,6]; and

Whereas, medical students often feel unprepared to apply preclinical knowledge during clinical clerkships and report that this lack of preparation is partially due to the disconnect between preclinical and clinical curricula[7-9]; and

Whereas, preclinical exams emphasizing knowledge that is decontextualized and not integrated with clinical knowledge in practice contribute to the difficult transition of medical students between preclerkship and clerkship years[9,10]; and

Whereas, a comparison of pre-clerkship and post-clerkship for both basic sciences test scores and USMLE Step 1 scores showed a significant increase in scores after clerkship, underlying a lack of knowledge that is filled during the clerkship[10-12]; and

Whereas, Step 1 is widely known as an inaccurate predictor of success in clinical practice, with no strong correlation with in-training exam performance in residency[13]; and

Whereas, poor integration of basic sciences with clinical practice may undermine these subjects' relevance and impede knowledge retention and application[14]; and

Whereas, among medical students, interns, residents, and experienced clinicians, test performance is positively correlated with perceived relevance of examination material[14]; and

Whereas, the evolving landscape of medical practice necessitates that standardized exams be regularly reviewed and updated to ensure that they test knowledge and skills directly relevant to current clinical practice, thus maintaining their validity as indicators of competency[15]; and

Whereas, AMA Policy H-275.929 adopted at A-04 opposes additions to USMLE and COMLEX exams that "lack predictive validity for future performance as a physician", setting a precedent for necessary revisions to the structure of national standardized exams for medical students and residents; and

Whereas, AMA Policy H-275.924 on Continuing Board Certification adopted at A-09 states that "activities and measurement should be relevant to clinical practice," and the AMA Council on Medical Education is strongly engaged with the American Board of Medical Specialties on efforts to reform maintenance of certification to improve clinical relevance[16]; therefore be it

RESOLVED, that our American Medical Association support efforts and work with relevant entities, such as NBME and NBOME, to:

A. improve the clinical relevance of national standardized examinations for medical students,
B. remove questions that do not reflect readiness for clinical practice, and
C. adjust frequency of questions based on their proportional relevance to general clinical knowledge expected for a medical degree and competence in diagnosing and managing conditions, while still including a minimum number of questions for rarer conditions and basic science concepts.

Fiscal Note: TBD

Date Received: 09/15/2024

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RELEVANT AMA POLICY

Oppose Additions to United States Medical Licensure Examination and Comprehensive Osteopathic Medical Licensure Examination H-275.929
Our American Medical Association opposes additions to the United States Medical Licensing Examination and Comprehensive Osteopathic Medical Licensure Examination that lack predictive validity for future performance as a physician. [Res. 308, A-04; Reaffirmed: CME Rep. 2, A-14; Modified: CME Rep. 01, A-24]

Continuing Board Certification H-275.924
Our American Medical Association Principles on Continuing Board Certification
(1) Changes in specialty-board certification requirements for CBC programs should be longitudinally stable in structure, although flexible in content…(4) Any changes in the CBC process should not result in significantly increased cost or burden to physician participants (such as systems that mandate continuous documentation or require annual milestones). (5) CBC requirements should not reduce the capacity of the overall physician workforce. It is important to retain a structure of CBC programs that permits physicians to complete modules with temporal flexibility, compatible with their practice responsibilities… (12) CBC should be based on evidence and designed to identify performance gaps and unmet needs, providing direction and guidance for improvement in physician performance and delivery of care. (13) The CBC process should be evaluated periodically to measure physician satisfaction, knowledge uptake and intent to maintain or change practice. (14) CBC should be used as a tool for continuous improvement… (18) CBC activities and measurement should be relevant to clinical practice. (19) The CBC process should be reflective of and consistent with the cost of development and administration of the CBC components, ensure a fair fee structure, and not present a barrier to patient care. (20) Any assessment should be used to guide physicians' self-directed study. (21) Specific content-based feedback after any assessment tests should be provided to physicians in a timely manner. (22) There should be multiple options for how an assessment could be structured to accommodate different learning styles… (27) Our AMA will continue to

work with the national medical specialty societies to advocate for the physicians of America to receive value in the services they purchase for Continuing Board Certification from their specialty boards. Value in CBC should include cost effectiveness with full financial transparency, respect for physicians' time and their patient care commitments, alignment of CBC requirements with other regulator and payer requirements, and adherence to an evidence basis for both CBC content and processes. [CME Rep. 16, A-09; Reaffirmed: CME Rep. 11, A-12; Reaffirmed: CME Rep. 10, A-12; Reaffirmed in lieu of Res. 313, A-12; Reaffirmed: CME Rep. 4, A-13; Reaffirmed in lieu of Res. 919, I-13; Appended: Sub. Res. 920, I-14; Reaffirmed: CME Rep. 2, A-15; Appended: Res. 314, A-15Modified: CME Rep. 2, I-15; Reaffirmation A-16; Reaffirmed: Res. 309, A-16; Modified: Res. 307, I-16; Reaffirmed: BOT Rep. 05, I-16; Appended: Res. 319, A-17; Reaffirmed in lieu of: Res. 322, A-17; Modified: Res. 953, I-17; Reaffirmation: A-19; Modified: CME Rep. 02, A-19; Reaffirmed: Res. 310, I-22; Reaffirmed in lieu of: Res. 302, A-24; Reaffirmed in lieu of: Res. 316, A-24]

RELEVANT MSS POLICY

295.182MSS USMLE Step 1 Timing:
AMA-MSS will ask the AMA to ask the NBME to track USMLE Step 1 exam timing and subsequently publish aggregate data to determine the significance of advanced clinical experience on Step 1 exam performance. (MSS Res 20, A-14) (AMA Res 911, I-14 Adopted as Amended [D-275.958]) (Reaffirmed: MSS GC Rep A, I-19)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 305
(I-24)

Introduced by: Jessica MacIntyre[1], Christian Tallo[1], Priya Gupta[1], Aaron Kiel[1], Rajadhar Reddy[2], Sarah Jiang[3], Zi Yae Kang[4], Austine Peng[5]

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Subject: Support for Medical School Applicants with Alternative Undergraduate Degrees

Referred to: MSS Reference Committee
(Alec Calac and Andrew Norton, Co-Chairs)

Whereas, community college and associate degrees (AS/AA) are a large source of education throughout the United States, but almost all medical schools require a bachelor's degree (BS/BA) to apply[1]; and

Whereas, the need to gain a BS/BA may force many students to select a four-year college, pursue post baccalaureate programs, and take on additional academic, administrative, and financial burden when they would not have done so otherwise; and

Whereas, in 2024, the average cost of attendance for an AS/AA at a 2-year in-district institution is $34,878 compared to $108,584 for a BS/BA at a 4-year public in-state institution, a price which may be even higher at an out-of-state or private institution[2]; and

Whereas, people with higher socioeconomic status (SES) are more likely to attend a 4-year college while people with lower SES are more likely to attend a 2-year program[2];

Whereas, allowing admission to medical school with an AS/AA in place of a bachelor's degree would reduce barriers to medical school for those with lower SES, making it a more equitable, affordable, and inclusive process for a group who remains significantly underrepresented in medicine[3,4]; and

Whereas, the AMA has made it a priority to address medical education costs and student debt through policy H-305.925[5]; and

Whereas, many community colleges offer all mandatory prerequisites for medical school, including organic chemistry, biochemistry, and advanced biology courses such as anatomy and genetics, and for those that do not, students can take these prerequisites at local universities at a lower total cost than attending a four-year BS/BA[6]; and

Whereas, schools that award AS/AAs are audited and accredited by the same governing bodies that accredit BS/BA degree programs and are held to the same accreditation standards as

BS/BA programs, indicating that equivalent academic standards are met between both type of degree programs[7]; and

Whereas, some students initially enroll in a less expensive AS/AA program because they are unsure of their career path, and then have to return to school later and pay for more courses than necessary, delaying their entry in medical school[8]; and

Whereas, allowing applicants with alternative undergraduate degrees to apply can allow applicants to spend more time gaining clinical and research experience since fewer years would be spent meeting credit requirements for their program's degree; and

Whereas, people with an AS/AA still have opportunities to receive a well-rounded education, meet all required pre-medical prerequisites, and demonstrate the same academic rigor as BS/BA graduates, especially with the recent growth of research opportunities at community colleges[9]; and

Whereas, 31% of dental schools and 96% of pharmacy schools do not require a BS/BA as there is no national admissions requirement[10,11]; and

Whereas, all applicants, regardless of their degree, would still take the Medical School Admissions Test (MCAT), a universal standardized admission assessment tool[12]; and

Whereas, considering students with AS/AA degrees is more closely aligned with the holistic review process that promotes equity and diversity in the medical profession[13]; therefore be it

RESOLVED, that our American Medical Association work with relevant parties to support removal of the expectation of a bachelor's degree for medical school admission, provided other prerequisite criteria are satisfied, and support holistic consideration of applicants without bachelor's degrees.

Fiscal Note: TBD

Date Received: 09/15/2024

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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. [...] (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. [...] (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.

Accelerating Change in Medical Education: Strategies for Medical Education Reform H-295.871
Our AMA continues to recognize the need for transformation of medical education across the continuum from premedical preparation through continuing physician professional development and the need to involve multiple stakeholders in the transformation process, while taking an appropriate leadership and coordinating role.

Strategies for Enhancing Diversity in the Physician Workforce D-200.985
(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. [...] (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).

RELEVANT MSS POLICY

5.093MSS: Reducing Complexity in the Public Service Loan Forgiveness
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

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 306
(I-24)

Introduced by: Samantha Thomas[1], Khushbakht Shah[2], Michael Karo[3], Carlene Kranjac[4], Alex Pedowitz[5], Maha Fathali[6], Mitch Hanson[7], Ishaan Rischie[8], Amber Shirley[9], Shalmali Bhadkamkar[10], Sara Kazyak[11], Sanjay Neerukonda[12], Raj Reddy[13]

Affiliations: [1]Creighton University SOM, [2]Northeast Ohio Medical University, [3]Kirk Kerkorian School of Medicine, [4]Medical College of Wisconsin, [5]University of Miami Miller SOM, [6]California University of Science and Medicine, [7]Medical College of Georgia, [8]University of Virginia SOM, [9]Lincoln Memorial University DeBusk COM, [10]University of Toledo, [11]Wayne State University School of Medicine, [12]McGovern Medical School at UTHealth, [13]Baylor COM Houston Campus

Subject: Overemphasis on Research in Trainee Selection

Referred to: MSS Reference Committee
(Alec Calac and Andrew Norton, Co-Chairs)

Whereas, the AAMC has developed a Holistic Review Model that encourages residency programs to "select/rank a cohort of learners encompassing the complementary experiences, qualities, and characteristics needed to achieve their institutional and program mission and goals."[6]; and

Whereas, our AMA already recommends 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 (policy finder)[4]; and

Whereas, the Accreditation Council for Graduate Medical Education (ACGME) has already specified the need for advocacy to be taught in residency curricula, while no such requirements exist for medical school accreditation by the Liaison Committee on Medical Education (LCME)[3,14]; and

Whereas, although residency programs such as Pediatrics, Internal Medicine, Family Medicine, and Psychiatry have begun to incorporate formal advocacy curricula into their training, many programs continue to cite barriers to implementation, including curricular rigidity and lack of faculty experience[1,3,12]; and

Whereas, more than half of Family Medicine program directors believe that advocacy should be considered an essential skill[5]; and

Whereas, the major healthcare challenges in the United States require a physician workforce skilled in advocacy to improve health and health equity[8]; and

Whereas, despite a general endorsement of advocacy, many physicians do not actively engage in these efforts, indicating a need for a more sustained commitment to health equity beyond learning about social determinants of health[8]; and

Whereas, program directors desire applicants with research experiences because they demonstrate transferable skills like critical thinking and curiosity that can be similarly developed through significant advocacy and leadership activities[11]; and

Whereas, disproportionate focus on research and publications by residency programs may discount applicants who have demonstrated their passion for the field through other equally valuable avenues including volunteer work, clinical experiences, or leadership roles[2]; and

Whereas, the current sections of the ERAS application place a greater emphasis on research compared to other domains of interest in that ERAS lists “Research” as 1 of 8 Experience Types while combining “Volunteer/service/advocacy” into 1 category, conflating “service” and “advocacy” and implying that “advocacy” is the least important in that list; and

Whereas, the majority of medical student research were reviews, cross-sectional studies, case reports, case-control studies, and cohort studies with 59% of those articles not being cited[7]; and

Whereas, competitive specialty applicants, such as dermatology, neurosurgery, and plastic surgery have 20 research items on average when applying to residency[10]; and

Whereas, the average number of publications for prospective otolaryngology applicants has increased from less than 7 to 17.2 from 2014 to 2022[15]; and

Whereas, the average unmatched applicant in 2022 had more research experience than the average matched applicant in 2012, yet there is little to no evidence of association between medical student research and clinical performance in residency[10]; and

Whereas, the excess emphasis on research in medical school has encouraged publication misrepresentation and academic disintegrity in medical students[9]; and

Whereas, emphasis on advocacy, in addition to research, volunteering, and other experiences, fosters the growth of well-rounded individuals who are adequately prepared for residency and a career in medicine[13]; therefore be it

RESOLVED, that our American Medical Association support efforts and work with relevant parties to:

a. improve the holistic and equitable consideration of research, advocacy, service, teaching mentorship, and other non-research domains in medical school and residency/fellowship selection alongside research; and
b. reduce the emphasis on research expectations for applicants; and
c. allow applicants without significant research experience to showcase the domains that most align with their experiences and career goals.

Fiscal Note: TBD

Date Received: 09/15/2024

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RELEVANT AMA POLICY

D-200.985 Strategies for Enhancing Diversity in the Physician Workforce
"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."

H-460.930 Importance of Clinical Research
"(4) Our AMA continues to encourage medical schools a) to support clinical research; b) to train and develop clinical researchers; c) to recognize the contribution of clinical researchers to academic medicine; d) to assure the highest quality of clinical research; and e) to explore innovative ways in which clinical researchers in academic health centers can actively involve practicing physicians in clinical research."

RELEVANT MSS POLICY

295.044MSS Effective Education for the Future of Medicine:
The AMA-MSS Governing Council will continue to identify opportunities to present timely and relevant health policy information to medical students

295.153MSS Health Policy Education in Medical Schools:
AMA-MSS will monitor progress on the development of the Association of American Medical College's behavioral and social science core competencies and report back upon release of the competencies.

295.171MSS Health Policy Education in Medical Schools:
(1) AMA-MSS encourages medical schools to implement teaching strategies that promote outcome based development of behavioral and social science foundations for medical students; and (2) AMA-MSS

encourages the AAMC to engage in appropriate follow-up research based on the implementation of its behavioral and socioeconomic report competencies.

295.173MSS Policy and Advocacy Rotations for Medical Students:
AMA-MSS will ask the AMA to (1) support the recognition and incorporation of elective advocacy and health policy rotations and fellowships for medical students within the US medical curriculum; and (2) work with state and specialty societies, the AAMC, AACOM, COCA, LCME, and other interested organizations to implement health advocacy rotations and fellowships, and develop a set of model guidelines and curricular goals to be used by state and specialty societies.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 307
(I-24)

Introduced by: Rajadhar Reddy[1], Jon Bernard[2], Neha Patel[3], Lilly Deljoo[4], Gabrielle Li[5]

Affiliations:
[1] Baylor University College of Medicine - Houston
[2] University of Cincinnati College of Medicine
[3] University of Texas Medical Branch John Sealy School of Medicine
[4] University of Louisville School of Medicine
[5] Indiana University School of Medicine

Subject: Distribution of Resident Seats Commensurate with Shortages

Referred to: MSS Reference Committee
(Alec Calac and Andrew Norton, Co-Chairs)

Whereas, by 2036, the Health Resources & Services Administration (HRSA) projects an overall shortage of 139,940 physicians[1]; and

Whereas, AMA Policy H-200.949, “Principles of and Actions to Address Primary Care Workforce,” includes general internal medicine, family medicine, pediatrics, and OB/GYN as "primary care” specialties; and

Whereas, the National Health Service Corps considers general internal medicine, family medicine, pediatrics, OB/GYN, as well as psychiatry as specialties in shortage that preferentially receive scholarship support and loan repayment[2]; and

Whereas, by 2036, HRSA projects a shortage of 33,100 family medicine physicians, 30,080 general internal medicine physicians, an additional 1,740 family or internal medicine geriatricians, 3,100 pediatricians, 6,610 OBGYNs, and 42,130 psychiatrists, a total of 116,760 physicians across these specialties[1]; and

Whereas, according to HRSA projections, family medicine, internal medicine, pediatrics, OB/GYN, and psychiatry comprise 83% of the overall physician shortage[1]; and

Whereas, preventive medicine physicians are another smaller primary care specialty not formally included in projections whose clinical scope can also help reduce the primary care shortage, in addition to their highly important role bolstering our public health workforce[3]; and

Whereas, our elderly population of over age 64 has been growing at the fastest rate since the 1800s, with an estimate of 55.8 million people, which represents a 38.6% increase in the last 10 years, resulting in increased demand for primary care services[4]; and

Whereas, primary care and psychiatry physician shortages are even more drastic than projected, because estimates like those from the HRSA assume that a large number of

physician assistants and nurse practitioners will be hired instead of physicians to meet need[1]; and

Whereas, far more primary care physicians would be needed if our system was not so dependent on nonphysicians[5]; and

Whereas, in both developing and developed countries, a sufficient primary care and psychiatry workforce has been associated with increased access to healthcare services, better health outcomes and decrease use in hospitalization and ED visits[6]; and

Whereas, based on HRSA data, the bipartisan Senate Finance Committee Medicare GME Working Group recently proposed allocating 25% of new Medicare GME slots to primary care and 15% to psychiatry, which are reasonable distributions considering that shortages in those fields are far more drastic[7]; and

Whereas, the AMA, in response to the Senate Finance Committee Medicare GME Working Group's proposal, opposed preferential allocation of residency positions to primary care and psychiatry, stating: "The AMA recognizes that there are shortages of primary care physicians and psychiatrists that currently exist and understands the desire to cultivate more physicians in these specialty areas. However, we do not believe that slots should be specialty-specific. Instead, slots should be able to go to the specialty that is in need or desired by the area. Moreover, we are concerned that by highlighting certain specialties over others it could lead to future shortages in those specialties that are not currently prioritized"[8]; and

Whereas, the AMA also cosigned the GME Advocacy Coalition's comments similarly stating: "Our coalition is a diverse group representing primary care and specialty groups alike...We remain strongly concerned about shortages across both primary care and specialties"[9]; and

Whereas, the AMA's position does not align with the data on the extreme shortages in primary care and psychiatry, as the proposal's respective 25% and 15% slot allocations are far below their respective 53% and 30% shares of the physician shortage[1]; and

Whereas, hospitals needing other specialties can still apply for 60% of new Medicare GME seats, far exceeding those specialties' 17% share of the overall physician shortage[1]; and

Whereas, the Working Group also proposed the creation of a GME Policy Council, "consisting of members representing academic medical institutions, hospitals that serve rural areas and underserved communities, medical students, and health care workforce experts", to help determine allocation of new residency positions to primary care, psychiatry, and other specialties and to rural areas[7]; and

Whereas, proposals to solve the unmatched graduates problem have also included the idea of increasing the number of preliminary and transition year positions to allow students to SOAP into these while they figure out their next steps, which can also help support our general medicine workforce for that year[10]; and

Whereas, currently, preliminary medicine, preliminary surgery, and transition year programs have different implications on federal financing for subsequent years of GME, and a resident who completes a preliminary medicine year is only eligible for 2 additional years of federally funded residency GME (not counting fellowship), while a resident who completes a preliminary

surgery year is eligible for 4 additional years, and a resident who completes a transitional year has no limit[11, 12]; and

Whereas, this disparity disadvantages residents, especially those in preliminary medicine years, as programs considering them for second-year positions may not receive full federal funding for their training and may perceive them as a less desirable candidate for financial reasons rather than on their merits, exacerbating the unmatched problem[12]; therefore be it

RESOLVED, that our American Medical Association support preferential distribution of residency seats to general internal medicine, family medicine, preventive medicine, pediatrics, obstetrics and gynecology, and psychiatry, commensurate with their relative need and expected shortages; and be it further

RESOLVED, that our AMA support increasing the number of available preliminary and transition year residency positions; and be it further

RESOLVED, that our AMA support that a preliminary year resident entering a full residency be eligible for GME funds for the duration of their program comparable to their peers; and be it further

RESOLVED, that our AMA-MSS amend MSS Position 200.003MSS, "AMA Opposition to Primary Care Quotas," by addition and deletion as follows; and be it further

200.003MSS Primary Care and Psychiatry Workforce ~~AMA Opposition to Primary Care Quotas~~

AMA-MSS ~~will ask the AMA to: (1) strongly oppose primary care quota systems; (2) oppose efforts by federal and state governments that would arbitrarily further control specialties for which medical students may qualify; and (3) continue to support and promote the identification of and funding for incentives to~~ supports funds and incentives to increase the number of ~~primary care~~ physicians in primary care (general internal medicine, family medicine, preventive medicine, pediatrics, and obstetrics and gynecology) and psychiatry.

RESOLVED, that our AMA-MSS amend MSS Position 200.006MSS, "National Physician Workforce Planning," by addition and deletion as follows:

200.006MSS National Body to Allocate Residency Positions ~~Physician Workforce Planning~~

AMA-MSS supports the implementation of a ~~will ask the AMA to support the concept that the Council on Graduate Medical Education and/or any equivalent~~ national ~~workforce planning~~ body to allocate residency positions based on patient need and health equity considerations and that this body includes voting members who are medical students, residents, fellows, and attending physicians ~~should be solely advisory in nature and be appointed in a manner that ensures bipartisan representation, including adequate physician representation~~.

Fiscal Note: TBD

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RELEVANT AMA POLICY

Principles of and Actions to Address Primary Care Workforce H-200.949
1. Our patients require a sufficient, well-trained supply of primary care physicians--family physicians, general internists, general pediatricians, and obstetricians/gynecologists--to meet the nation's current and projected demand for health care services. [CME Rep. 04, I-18]

RELEVANT MSS POLICY

200.003MSS AMA Opposition to Primary Care Quotas
AMA-MSS will ask the AMA to: (1) strongly oppose primary care quota systems; (2) oppose efforts by federal and state governments that would arbitrarily further control specialties for which medical students may qualify; and (3) continue to support and promote the identification of and funding for incentives to increase the number of primary care physicians. (AMA
Sub Res 306, I-92 Adopted in Lieu of Res 325, I-92) (Reaffirmed: MSS Rep B, I-00)
(Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS
GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

200.006MSS National Physician Workforce Planning
AMA-MSS will ask the AMA to support the concept that the Council on Graduate Medical Education and/or any equivalent national workforce planning body should be solely advisory in nature and be appointed in a manner that ensures bipartisan representation, including adequate physician representation. (AMA Res 320, I-93 Referred) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 309
(I-24)

Introduced by: Eduardo Soto[1], Eileen Enriquez[1] , Sean Nguyen[2], Onajia Stubblefield[3], Eli Schantz[4], Linsey Golding[1], Jared Boyce[5], Mira Dani[1], Natilyah Tahir[1], Raj Reddy[6], Micah Char[1], Isabelle Avenido[1], Avni Joshi[1]

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Subject: Addressing Misuse of Professionalism Standards in Medical Training

Referred to: MSS Reference Committee
(Alec Calac and Andrew Norton, Co-Chairs)

Whereas, professionalism is defined as a set of standards of beliefs about how one should operate in the workplace or as “the state or practice of doing one’s job with skill, competence, ethics and courtesy”[1,2]; and

Whereas, the ambiguous definition of professionalism creates uncertainty among students and preceptors leading to the assessment of “professional behavior” based on subjective opinion creating many opportunities for harm and discrimination[2,3]; and

Whereas, medical education centers the importance of professionalism in course syllabi, clinical evaluations, and residency reference letters, resulting in the subjective grading of professionalism having direct effects on medical students' future career[4-6]; and

Whereas, biases and Eurocentric standards in defining professionalism have led to unfair evaluations of students, particularly underrepresented minorities, and it is crucial to establish a uniform, equitable definition of professionalism that respects diverse identities and promotes fair assessments[7-9]; and

Whereas, professionalism standards frequently reference "appropriateness" in areas such as speech and dress without clearly defining what is considered appropriate, leaving subjective interpretation to administrations whose judgments can vary significantly, resulting in inconsistent and potentially biased enforcement[2,3]; and

Whereas, undergraduate and graduate medical trainees are disproportionately the targets of unprofessionalism charges despite them enduring higher rates of bullying and harassment themselves[10]; and

Whereas, the phenomenon of racial weathering, characterized by the cumulative effects of chronic stress and discrimination, disproportionately impacts students of color in medical schools, leading to significant physical and mental health challenges[11-14]; and

Whereas, the pressure to conform to the dominant cultural norms within medical institutions exacerbates these stressors, often forcing students from underrepresented backgrounds to suppress their identities and experiences, further contributing to their mental and physical unwellness[12-16]; and

Whereas, these compounded effects of racial weathering and forced conformity have been shown to impair academic performance, increase burnout, and lead to higher rates of anxiety, depression, and other health issues among medical students of color[11-16]; and

Whereas, previous encounters of professionalism violations have not explicitly addressed the concerns for which an individual was unprofessional, but rather the concept itself was cited as the reason, which allows a method of weaponization as institutions do not have to acknowledge their rationale, further manifesting a cyclical nature of abuse [2]

Whereas, medical professionalism standards have historically been shaped by male-dominated perspectives, thus inadvertently causing harm to women and gender minorities[3,9,17,18]; and

Whereas, the phenomenon known as the double bind occurs, when women adopt “masculine” traits in order to be perceived as competent, are then more likely to be viewed as aggressive and less likable[3,9,17,18]; and

Whereas, these professionalism standards can harm women from obtaining administrative roles due to being perceived as less competent and as less professional compared to their male counterparts[3,9,17,18]; and

Whereas, despite women physicians being seen as unprofessional, they have the same if not better patient outcomes and satisfaction ratings[19,20]; and

Whereas, amongst our responsibilities is to advocate for humanity, and our roles as community leaders is the general consensus amongst institutions and organizations, it should be that we are not punished for utilizing our privileges and doing our jobs as advocates[21-23]; and

Whereas, advocating for every person is advocating for every patient [21-23]; and

Whereas, even in contemporary times, the advocacy of individuals has been met with penalization, even though they are protected under the Supreme Court ruling of Healy v James (1972) [24-26]; and

Whereas, it is expected of medical personnel to treat every human with respect and dignity, and with the acknowledgment that we are accepting them for who they are, the same notion should be applied to medical personnel so that their race, background, religion, forms of self-expression are not being utilized as a form of unprofessionalism[27]; and

Whereas, the assumption that professionalism standards automatically improve patient care jeopardizes genuine competence and compassion in exchange for conformity—pressuring medical trainees to adhere to superficial or arbitrary standards of behavior that do not necessarily correlate with better patient outcomes, leading to poorer patient-based care[3,14,28,29,30]; and

Whereas, emphasis on professionalism discourages open communication between doctors and patients by forcing trainees may become overly concerned with projecting a certain image rather

than engaging in authentic human centered interactions, limiting diversity and inclusion of diverse perspectives originally encouraged in medical practice[14,31-33], and

Whereas, professionalism standards should be guided by persistent themes (such as morality, communication skills, emotional intelligence, competency, ethics, i.e.) that patients, colleagues, and any other member of medicine will benefit from[27,30-34], and

Whereas, the varying expectations for professionalism amongst physicians, and even patients, notes how professionalism can be subjective[34]; and

Whereas, professionalism standards exclusively determined by those in the healthcare profession exclude patient and community priorities; and

Whereas, a more nuanced and inclusive approach is needed to uphold optimal patient care and outcomes while exercising true competence, empathy, and authenticity in the medical practice and supporting diversity of character, background, and thought in the field of medicine; therefore be it

RESOLVED, that our American Medical Association acknowledges that professionalism standards are not fixed but rather dynamic and constantly evolving with shifts in society, so that institutions have their standards periodically reevaluated to ensure that they remain culturally relevant and equitable and do not lead to discriminatory practices; and be it further

RESOLVED, that our AMA encourages medical schools to work with diverse and representative institutional stakeholders, including institutional DEI offices, to (i) support a study of the influence of bias in the content and implementation of professionalism policies, particularly in cases involving students from underrepresented backgrounds, and (ii) support that professionalism policies are written and applied in an equitable and inclusive manner which respects the diversity of race, religion, culture, sexual orientation, and gender identity of students; and be it further

RESOLVED, that our AMA supports the ACGME and the AAMC to establish guidelines for medical school professionalism policies which require the creation of clear and equitable standards that do not make reference to (i) appropriateness, reasonability, or suitability, (ii) unarticulated standards of the medical profession, or (iii) circularly reference the notion of professionalism; and be it further

RESOLVED, that our AMA advocates for AAMC and ACGME to support measures that enforce medical schools and residency programs to not use professionalism violations as a means to stop student advocacy measures

RESOLVED, that our AMA collaborates with the ACGME and the AAMC to ensure there is consistency with application of professionalism policies and that institutions responses to professionalism concerns are commensurate with the seriousness of the concern, and that all institutions uphold the already existing LCME’s process which allows students to report concerns, present their case before actions are taken and appeal decisions where appropriate.

Fiscal Note: TBD

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RELEVANT AMA POLICY

Decreasing Bias in Assessments of Medical Student Clinical Clerkship Performance H-295.851
Our AMA will encourage and support UME institutions' investment in
a. developing more valid, reliable, and unbiased summative assessments for clinical clerkships, including development of assessors' awareness regarding structural inequities in education and wider society, and
b. providing standardized and meaningful competency data to program directors.
Our AMA will encourage institutions to publish information related to clinical clerkship grading systems and residency match rates, with subset data for learners from varied groups, including those that have been historically underrepresented in medicine or may be affected by bias.

Decreasing Bias in Evaluations of Medical Student Performance D-295.307
Our American Medical Association will work with appropriate stakeholders to promote efforts to evaluate methods for decreasing the impact of **bias** in medical student performance evaluation as well as reducing the impact of **bias** in the review of disciplinary actions.

Fostering Professionalism During Medical School and Residency Training D-295.983
(1) Our AMA, in consultation with other relevant medical organizations and associations, will work to develop a framework for fostering professionalism during medical school and residency training. This planning effort should include the following elements:
(a) Synthesize existing goals and outcomes for professionalism into a practice-based educational framework, such as provided by the AMA's Principles of Medical Ethics.
(b) Examine and suggest revisions to the content of the medical curriculum, based on the desired goals and outcomes for teaching professionalism.
(c) Identify methods for teaching professionalism and those changes in the educational environment, including the use of role models and mentoring, which would support trainees' acquisition of professionalism.
(d) Create means to incorporate ongoing collection of feedback from trainees about factors that support and inhibit their development of professionalism.
(2) Our AMA, along with other interested groups, will continue to study the clinical training environment to identify the best methods and practices used by medical schools and residency programs to fostering the development of professionalism, to include an evaluation of professional behavior, carried out at regular intervals and employing methods shown to be valuable in adding to the information that can be obtained from observational reports. An ideal system would utilize multiple evaluation formats and would build

upon educational experiences that are already in place. The results of such evaluations should be used both for timely feedback and appropriate interventions for medical students and resident physicians aimed at improving their performance and for summative decisions about progression in training.

Professionalism in the Use of Social Media E-2.3.2
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.

RELEVANT MSS POLICY

Supporting the Establishment of Guidelines Regarding Online Professionalism 140.019 MSS
AMA-MSS will ask the AMA to (1) initiate discussions with partner organizations towards developing a consensus for online professionalism in the medical community that may be used by medical schools to guide the development of policies outlining expectations of professionalism on the Internet for students; and (2) during its efforts to update and modernize the AMA Code of Medical Ethics, include a section regarding online professionalism.

Teaching and Evaluating Professionalism in Medical Schools 295.123 MSS
AMA-MSS will ask
the AMA to: (1) strongly urge the Liaison Committee on Medical Education to promptly create and enforce uniform accreditation standards that require all LCME-accredited medical schools to evaluate professional behavior regularly as part of medical education; (2) strongly urge the Liaison Committee on Medical Education to develop competencies for professional behavior and a mechanism for outcome assessment at least every four years in the accreditation process, examining teaching and evaluation of the competencies at LCME-accredited medical schools; (3) recognize that evaluation of professionalism is best performed by medical schools and should not be used in evaluation for licensure of graduates of LCME-accredited 295.126MSS medical schools; continue its efforts to teach and evaluate professionalism during medical education; and (4) actively oppose, by all available means, any attempt by the NBME and/or FSMB to add separate, fee-based examinations of behaviors of professionalism to the United States Licensing Examinations.

Requiring Blinded Review of Medical Student Performance 295.210 MSS
AMA-MSS will ask the AMA to work with appropriate stakeholders, such as the Liaison Committee on Medical Education (LCME) and the Commission on Osteopathic College Accreditation (COCA) to support: (1) increased diversity and implementation of implicit bias training to individuals responsible for assessing medical students' performance, including the evaluation of professionalism and investigating and ruling upon disciplinary matters involving medical students, and (2) that all reviews of medical student professionalism and academic performance be conducted in a blinded manner when doing such does not interfere with appropriate scoring. (MSS CME Report A, I-19)

Research the Ability of Two-Interval Grading of Clinical Clerkships to Minimize Racial Bias in Medical Education 295.217 MSS
Our AMA-MSS will research various approaches to grading of clinical clerkships, which may minimize racial bias in medical education. (MSS Res. 067, Nov. 2020)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 312
(I-24)

Introduced by: Priya Gupta[1], Aaron Kiel[1], Christian Tallo[1], Jessica MacIntyre[1], Soneet Kapadia[2]

Affiliations: [1]University of Connecticut School of Medicine
[2]University of Texas San Antonio Long School of Medicine

Subject: Providing Wellness Days on Recognized Federal Holidays

Referred to: MSS Reference Committee
(Alec Calac and Andrew Norton, Co-Chairs)

Whereas, burnout is defined as emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness[1]; and

Whereas, the AMA recognizes that burnout in medical students is a significant problem that needs to be addressed as seen in policies D-310.968 and H-405.948[1,2]; and

Whereas, studies have shown that medical students develop burnout during the course of medical school, with the prevalence of burnout among medical school students estimated to be 37%[3,4].; and

Whereas, studies have shown that rates of burnout in medical students decrease following a summer break, suggesting that providing breaks is one way to help alleviate burnout[5]; and

Whereas, lack of sufficient time off and rest can lead to decreased cognitive function and poor decision-making, which are crucial for medical students during their education and training[6]; and

Whereas, the utilization of federal holidays as scheduled time off for medical students would not limit access to educational opportunities as annually, there are only 11 federal holidays recognized by the government, with no more than 2 federal holidays occurring in any one month[7]; and

Whereas, 10 out of the 11 holidays recognized by the federal government are secular holidays not associated with any specific religion, and thus, these wellness days can be provided to all students in addition to allowing individual trainees to take personal days on specific religious and cultural holidays as policy H-310.923 provides[7,8]; and

Whereas, providing medical students with expected time off on specified holidays in advance will allow students to make plans for the days off, including participating in family or cultural traditions on days when many friends and family members may also have time off; and

Whereas, it has been found that 54% of healthcare professionals say their stress, a contributing factor to burnout, increases during the holiday season, but healthcare workers have increased

incentive to work on holidays through the federal requirement of premium pay on federal holidays, while medical students similarly face increased stress and may miss out on holiday events without any equivalent incentive[10]; and

Whereas, current AMA policy H405.948 acknowledges that stress and long work hours both contribute to burnout in medical students, suggesting that the increased stress and hours from working holidays can heighten levels of burnout[2]; and

Whereas, staffing shortages on holidays also leave resident and attending physicians less time available to properly teach medical students, which may negatively impact the educational value of these days for medical student, whose primary purpose in clinical settings is to learn rather than to be responsible for providing clinical care[11,12]; and

Whereas, some medical schools already have policies in place so that medical students on clinical rotations will have all official holidays recognized by the university off, regardless if the student's team is on call, and thus establishing a uniform policy across all medical schools regarding time off on the same federal holidays can help to standardize wellness practices, ensuring all students have equal opportunities for rest and recuperation during their education[12]; and

Whereas, medical students may still choose to use these wellness days for educational enhancement opportunities such as shadowing, volunteering, participating in electives, or studying; therefore be it

RESOLVED, that our American Medical Association encourage the AAMC to work with appropriate parties to create time-off policies that provide medical students with wellness days free from any required commitments on recognized federal holidays.

Fiscal Note: TBD

Date Received: 09/15/2024

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RELEVANT AMA POLICY

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.

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.

Resident/Fellow Clinical and Educational Work Hours H-310.907
Our American Medical Association adopts the following Principles of Resident/Fellow Clinical and Educational Work Hours, Patient Safety, and Quality of Physician Training: (1) Our AMA supports the 2017 Accreditation Council for Graduate Medical Education (ACGME) standards for clinical and educational work hours (previously referred to as “duty hours”). (2) Our AMA will continue to monitor the enforcement and impact of clinical and educational work hour standards, in the context of the larger issues of patient safety and the optimal learning environment for residents. [...] (9) Our AMA will actively participate in ongoing efforts to monitor the impact of clinical and educational work hour limitations to ensure that patient safety and physician well-being are not jeopardized by excessive demands on post-residency physicians, including program directors and attending physicians.

Eliminating Religious and Cultural Discrimination from Residency and Fellowship Programs and Medical Schools H-310.923
Our American Medical Association encourages residency programs, fellowship programs, and medical schools to: (1) Allow trainees to take leave and attend religious and cultural holidays and observances, provided that patient care and the rights of other trainees are not compromised. (2) Explicitly inform applicants and entrants about their policies and procedures related to accommodation for religious and cultural holidays and observances.

RELEVANT MSS POLICY

295.063MSS Student Workhour Reform
AMA-MSS will ask the AMA to work diligently toward medical education reform that will train its future physicians in a more effective and humanistic environment. (MSS Rep E, A-95, Adopted in Lieu of Res 23, A-95 and Res 19, I-93) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed:
MSS GC Rep B, A-21)

295.126MSS Medical Student Clinical Training and Education Conditions
AMA-MSS will ask the AMA to: (1) commend the LCME for addressing the issue of the medical student learning environment including student clerkship hours; (2) urge the LCME to adopt specific medical student clinical training and educational guidelines for the clerkship years including: (a) No more than one

night on call every three nights; (b) No more than 80 hours total of clinical training and education time per week averaged over four weeks; and (c) No more than 24 consecutive hours on call; and (2) recommend that the LCME revisit the issue of medical student clinical training and education conditions every five years for revision. (MSS Res 16, I-03 Referred) (AMA Res 310, A-04 Referred) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13) (Reaffirmed: MSS GC Rep A, I-19)

295.221MSS Guaranteed Time Off on Election Days at Medical Schools
Our AMA-MSS will ask the AMA to work with appropriate stakeholders to guarantee a full day off on Election Days at Medical Schools. (MSS Res. 112, Nov. 2020)

295.212MSS Support for Institutional Policies for Personal Days for Undergraduate Medical Students
Our AMA-MSS will ask the AMA to (1) encourage medical schools to accept flexible uses for excused absences from clinical clerkships; and (2) support a clearly defined number of easily accessible personal das for medical schools per academic year, which should be explained to students at the beginning of each academic year and a subset of which should be granted without requiring an explanation on the part of the students. (MSS Res. 001/COLRP CME Report A, November 2020) (AMA Res. 314, Referred, A-22)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 319
(I-24)

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Subject: Specifying Qualifications for Teaching Disability in Medical Education

Referred to: MSS Reference Committee
(Alec Calac and Andrew Norton, Co-Chairs)

Whereas, persons with disabilities face worse health outcomes including, for example, higher rates of cardiovascular disease by 3 to 4 times the general population and diabetes by 5 times the general population;[1] and

Whereas, data from the Center for Disease Control and Prevention (CDC) shows that in the United States 12.4% of people with disabilities (PWD) have cardiovascular disease compared to 3.4 in people without disabilities, 28.8% of PWD smoke compared to 18%, and in the past year 27% of PWD were unable to see a doctor due to cost compared to 12.1%;[1] and

Whereas, persons with disabilities are less likely to receive preventative care measures like cancer screenings compared to their non-disabled counterparts;[1] and

Whereas, disparities in PWD have gone largely unrecognized at the national level until 2023 when the National Institutes of Health (NIH) declared PWD a group experiencing health disparities;[2] and

Whereas, according to the National Council on Disability, a lack of formal training on the care of disabled patients is one barrier to care for PWD;[3] and

Whereas, only 40.7% of physicians were comfortable providing quality care to PWD, and just 56.6% were welcoming to those with a disability;[14] and

Whereas, a lack of or improper medical education on the topic of disability reinforces ableist views, impairs the delivery of high quality patient care, and discourages PWD from seeking care in the future;[1,5,9, 10] and

Whereas, formal medical education on disability is implemented inconsistently across United States medical schools, with many institutions providing no education on the topic;[4] and

Whereas, a 2017 study found that only 52% of surveyed US allopathic and osteopathic medical schools included disability awareness curriculum;[4] and

Whereas, there are some institutions that have robust disability education programs, including University of Rochester, University of Michigan, and University of Hawaii, which may serve as models in the development of other programs;[15, 16, 17] and

Whereas, a study of practicing physicians in the United States found that 82.4% thought PWD had a worse quality of life, but this was not the case when surveying those with disabilities, thus highlighting a disconnect between clinical teaching and clinical reality;[5] and

Whereas, PWD are invaluable to discussions and education on disability, but due to a lack of accommodations or a lack of comfort, PWD are often excluded from public health discussions and education circles;[1] and

Whereas, a lack of PWD in curriculum and the presence of ableism are compounded by severe constraints in curricular time, an issue affecting many social justice reforms of medical education;[7,8] and

Whereas, ensuring high quality education on the care for PWD in medical school is crucial to undoing much of the injustice that has been inflicted on this historically disparaged group;[1,3,5,7] and

Whereas, given that curricular time for diversity, equity, and inclusion topics is limited, we must ensure high quality lessons on the topic of disability in medicine as it may be students only chance for formal disability training;[1,3,5,7] and

Whereas, clear guidance on who should be tasked with teaching disability curricula does not exist currently;[11] and

Whereas, existing AMA policy, Medical Care of Persons with Disabilities H-90.968, does not specify qualifications, desirable characteristics, or other guidance on who should be teaching disability;[12] and

Whereas, by providing guidance a large group of qualified individuals, such as trained educators and those with lived experiences, will be included in the planning and implementation of disability studies in medical schools;[13] and

Whereas, given the lack of guidance an appropriate definition for qualifications or characteristic that would make for a quality teacher would be formal degrees or training in disability studies, prior experience in the field, collaboration with those who have formal training, or lived experience as a person with disabilities[13]; therefore be it

RESOLVED, that our American Medical Association amend policy H-90.968, “Medical Care of Persons with Disabilities,” as follows:

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. <u>b. encourages the recruitment of teachers of disability in medicine that have qualifications such as formal degrees or training in disability studies, prior experience in the field,</u>

collaboration with those who do have formal training, or lived experience as a person with disabilities.

~~b~~. c. 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.

Fiscal Note: TBD

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RELEVANT AMA POLICY

Continued Support for Diversity in Medical Education, D-295.963
6. Our AMA will advocate for resources to establish and maintain DEI offices at medical schools that are staff-managed and student- and physician-guided as well as committed to longitudinal community engagement. [BOT Rep. 31, A-24]

Evaluate Barriers to Medical Education for Trainees with Disabilities, D-90.990
2. Our AMA urges all medical schools and GME institutions to: a. make available to students and trainees a designated, qualified person or committee trained in the application of the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act of 1973, and available support services. b. encourage students and trainees to avail themselves of any needed support services. c. foster a supportive and inclusive environment where students and trainees with disabilities feel comfortable accessing support services. 7. Our AMA will collaborate with key stakeholders to raise awareness regarding the process for applying and preparing for examinations, inclusive of requests for accommodations. [Res. 302, I-23]

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 401
(I-24)

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Subject: Support for Changing Standards for Minors Working in Agriculture

Referred to: MSS Reference Committee
(Alec Calac and Andrew Norton, Co-Chairs)

Whereas, child labor regulations differ between agricultural and non-agricultural sectors, with agricultural work being exempt from certain provisions of the federal Fair Labor Standards Act (FLSA)[1]; and

Whereas, under federal law, child farmworkers, including children under the age of 12, may legally work in agriculture with no limits on hours worked per day or days worked per week[1,10]; and

Whereas, in non-agricultural work, the FLSA mandates that minors aged 14 and 15 are restricted to working no more than 3 hours on school days and 18 hours during a school week, agricultural workers of the same age face no such limitations on hours worked[6]; and

Whereas, children aged 16 and older are permitted to work in hazardous jobs in agriculture that involve dangerous machinery, exposure to pesticides, hazardous environments, and strenuous labor, while workers in all other industries must be 18 years and older to undertake similarly classified hazardous work[1,10]; and

Whereas, the safety of child workers in agriculture, beyond the small protections provided by federal law, is subject to the discretion of individual states, resulting in significant variability in child labor protections across the country [1,6]; and

Whereas, 21 states do not have a minimum age to begin work in agriculture, while the other 29 states allow work starting between 10-14 years old[1,6]; and

Whereas, 35 states allow hired children to work seven days a week in agriculture, 15 states require just a single day off, and 23 states allow youth to work at night, with no limits on work hours[1,6]; and

Whereas, the Child Labor Coalition estimates that in the United States, 333,000 children younger than 16 years old are employed in agriculture, including 80,000 children younger than 10, with an estimated 90% of these young hired workers being people of color[1]; and

Whereas, The National Children's Center for Rural and Agricultural Health and Safety in the United States reported that from 2001 to 2015, 48% of all fatal injuries to young workers occurred in agriculture[2]; and

Whereas, The National Children's Center for Rural and Agricultural Health and Safety in the United States estimated that a death occurs every 3 days, and 33 children are injured daily in agricultural work[2]; and

Whereas, in North Carolina, which adheres only to federal regulations regarding child farm workers, a survey showed that 29% of farmworkers aged 10-17 sustained musculoskeletal injuries, including those affecting the knees and ankles[3]; and

Whereas, a study of child farmworkers in North Carolina found these children were exposed to multiple pesticides, including organophosphates, which have been proven to cause adverse health and neurodevelopmental outcomes in children[4]; and

Whereas, a study of child farmworkers in North Carolina found these children are at higher risk and suffer from heat-related illnesses due to factors such as the intensity and pace of farm tasks, extended work hours, limited control over their work environment, and the absence of regulatory frameworks in agriculture[5]; and

Whereas, child farmworkers often experience educational disruptions due to the demands of agricultural labor, leading to lower academic achievement and higher dropout rates compared to their peers in other industries, perpetuating cycles of poverty and limited opportunities[12]; and

Whereas, the physical and mental demands of agricultural work, combined with poor living conditions for many child farmworkers, contribute to significant mental health challenges, including anxiety, depression, and stress-related disorders, which are often unaddressed due to limited access to healthcare services[13]; and

Whereas, the Children's Act for Responsible Employment and Farm Safety Care Bill (CARE Act) was introduced in 2023 to amend the Fair Labor Standards Act to raise labor standards and protections for child farmworkers to the same level set for all children in other occupations[7-11]; and

Whereas, the CARE Act closes loopholes in current law relating to age, work restrictions, and expanding workplace health and safety standards that protect against exposure to dangerous pesticides and unsafe equipment [7-11]; and.

Whereas, the CARE Act also strengthens existing regulations and imposes increased penalties on employers that consistently violate child labor laws in agriculture [7-11]; and

Whereas, child agricultural employment for all children is legal and exempt from provisions of child labor laws. The AMA policy Enforcement of Child Labor Laws H-60.962 covers the illegal employment of children but does not support the expansion of protection for all children legally working in agriculture; therefore be it

RESOLVED, that our American Medical Association strongly supports federal and state efforts to ensure that child labor protections uniformly apply to children working in agriculture, including raising the minimum age of employment, work hour restrictions, and extending workplace health and safety standards against exposures to dangerous pesticides and unsafe equipment.

Fiscal Note: TBD

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RELEVANT AMA POLICY

Farm Related Injuries H-10.984
Our AMA (a) emphasizes the need for more complete data on farm-related and other types of traumatic and occupational injuries; (b) reaffirms its support of regional medical facilities and programs having well-trained medical personnel and emergency care facilities capable of responding effectively to farm-related and other types of injuries; (c) advises manufacturers to improve machinery and farm implements so they are less likely to injure operators and others. Safety instructions should accompany each sale of a machine such as a power auger or tractor. Hazard warnings should be part of each power implement; (d) encourages parents, teachers, physicians, agricultural extension agencies, voluntary farm groups, manufacturers, and other sectors of society to inform children and others about the risks of agricultural injuries and about approaches to their prevention; (e) endorses the concept of making injury surveillance and prevention programs ongoing activities of state and local departments of public health; (f)encourages the inclusion of farm-related injury issues as part of the training program for medical students and residents involved in a rural health experience. [BOT Rep. U, A-91Reaffirmed: Sunset Report, I-01Reaffirmed: CSAPH Rep. 1, A-11Reaffirmed: CSAPH Rep. 1, A-21]

US Efforts to Address Health Problems Related to Agricultural Activities H-365.986
Our AMA supports the endeavors of the U.S. Surgeon General and the National Institute of Occupational Safety and Health of CDC to address health problems related to agricultural activities. [Res. 212, A-91Reaffirmed: Sunset Report, I-01Reaffirmed: CSAPH Rep. 1, A-11Reaffirmed: BOT Rep. 7, A-21]

Enforcement of Child Labor Laws H-60.962
Our AMA will work in conjunction with all appropriate organizations and specialty societies to enhance physician awareness of the problems and dangers associated with the illegal employment of children. [Sub. Res. 222, I-92 Reaffirmed by BOT Rep. 24, A-97 Reaffirmed: BOT Rep. 33, A-07 Reaffirmed: BOT Rep. 22, A-17]

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 404
(I-24)

Introduced by: Jared Boyce[1], Nicholas Wilson[2], Austin Le[3], Uma Reddy[4], Madison Kurth[1], Ria Ravi[5], Katherine Foote[6], Riya Master[7], Zi Yae Kang[8]

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Subject: Promoting Child Welfare and Communication Rights in Immigration Detention

Referred to: MSS Reference Committee
(Alec Calac and Andrew Norton, Co-Chairs)

Whereas, detention facilities have been recognized as harmful, transitional holding areas for undocumented individuals which negatively impact their health across their lifespan[1,2]; and

Whereas, unaccompanied minors often remain detained longer than 20 days, the maximum allowable detention period, and face limited access to basic, quality healthcare services[3,4]; and

Whereas, detention centers have been shown to increase the risk of depression, anxiety, Post-Traumatic Stress Disorder, injury and abuse, Adverse Childhood Experiences, and chronic conditions exacerbated by lack of access to care amongst detainees[5-8]; and

Whereas, maternal deprivation and separation of minors from their families through institutionalization significantly increases stress response in children and infants, but gentle touch and hugging have been demonstrated to attenuate this stress response while promoting healthy brain development and resilience[9-14]; and

Whereas, the separation of children from their families and the lack of socioemotional support in detention settings can lead to attachment disorders and hinder their ability to form healthy relationships in the future[15-17]; and

Whereas, daily affective (emotionally comforting) touch was effective in balancing cortisol levels in institutionalized (foster care and orphanage) minors compared to their non-institutionalized counterparts[18]; and

Whereas, despite there being no explicit policies that prevent detained youth and siblings from hugging each other, reports have highlighted accounts of detention agents falsely believing that

no-touch policies exist, resulting in the inability of detained youth to console or comfort each other[19,20]; and

Whereas, blanket application of no-touch policies fails to recognize the unique needs of an influx of detained youth, who require comfort and physical affection to mitigate the severe trauma caused by their separation from their family[21]; and

Whereas, the United Nations High Commission for Human Rights has acknowledged that minors have the right to play[22,23]; and

Whereas, peer play in minors as young as three years old improves social and motor skill development, formation of social connections, self-regulation and emotion processing, while reducing the risk of future psychiatric diseases and mitigating against the effects of long-term exposure to stress[24-28]; and

Whereas, the American Academy of Pediatrics has stated that the conditions in immigration detention centers are not appropriate for children and can lead to significant psychological and emotional distress[29]; and

Whereas, as noted by the American Academy of Pediatrics, American Academy of Child & Adolescent Psychiatry, and several studies, minors separated from their families at the Southern border experience worse mental and physical health outcomes[30-34]; and

Whereas, due to current overcrowding in detention facilities and limited transparency in the immigration court process, many detained individuals in detention centers suffer from cramped living quarters and are unaware of their status in the court proceedings[35,36]; and

Whereas, Office of Refugee Resettlement (ORR) policy mandates placing unaccompanied minors in “the least restrictive setting that is in the best interests of the child” with consideration for special needs, but children with disabilities are disproportionately housed in ORR’s most restrictive placement settings[37]; and

Whereas, immigration detention centers previously allowed free phone calls for detained individuals; however, recent ICE policy changes have caused detainees to pay for phone access despite the nearly nonexistent income of many detained individuals, thus effectively losing access to external communication with social support networks and legal services, a barrier that may impede the detained individual’s right to a fair trial[38-40]; and

Whereas, regular contact with familial and social support networks have been shown to mitigate the many adverse mental health outcomes of detained individuals in detention facilities, such as depression, anxiety, and post-traumatic stress disorder[41]; and

Whereas, prior advocacy work includes Physicians’ for Human Rights (PHR) writing a letter to the Department of Health and Human Services’ Office of Refugee Resettlement advocating for increased phone time for minors in detention[42]; and

Whereas, The National Institutes of Corrections suggests that people in correctional facilities should have free, unfettered access to telephone and mail communication to their family members, support system, and legal counsel[43]; and

Whereas, current AMA policy prioritizes health disparities faced by immigrant communities (H-350.957); and

Whereas, the limited communication access offered to detainees based on payment of monetary fees exacerbates the unique health conditions in immigrants, especially those in detention facilities[44]; therefore be it

RESOLVED, that our American Medical Association support all actions, policies, and conditions that permit detained children to engage in activities including, but not limited to play, nurturing physical contact such as hugging, and other developmentally appropriate socioemotional behaviors and interactions among all children and families who are detained in the custody of federal agencies, specifically Immigration and Customs Enforcement and Office of Refugee Resettlement; and be it further

RESOLVED, that our AMA support access to free, unfettered communication access for detained individuals, including but not limited to phone calls, video calls, and letters; and be it further

RESOLVED, that our AMA oppose all policies, legislation, and practices that limit appropriate physical contact and play among detained children, as well as, unfettered communication access for detained individuals; and be it further

RESOLVED, that our AMA will advocate for Immigration and Customs Enforcement and Office of Refugee Resettlement centers to:

a) Implement policies and practices that are child-friendly and culturally sensitive, trauma-informed, and inclusive of children with special needs.
b) Advocate that all concerns and accusations of child abuse or neglect in detention centers be reported and investigated.
c) Advocate for the development of accountability mechanisms to ensure that detention facilities uphold and implement a child-friendly, culturally sensitive, trauma-informed, and inclusive environment, monitored and reviewed in all the facilities.

Fiscal Note: TBD

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RELEVANT AMA POLICY

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.

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.
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Presence and Enforcement Actions of Immigration and Customs Enforcement (ICE) in Healthcare D-160.921

Our AMA: (1) advocates for and supports legislative efforts to designate healthcare facilities as sensitive locations by law; (2) will work with appropriate stakeholders to educate medical providers on the rights of undocumented patients while receiving medical care, and the designation of healthcare facilities as sensitive locations where U.S. Immigration and Customs Enforcement (ICE) enforcement actions should not occur; (3) encourages healthcare facilities to clearly demonstrate and promote their status as sensitive locations; and (4) opposes the presence of ICE enforcement at healthcare facilities.

Patient and Physician Rights Regarding Immigration Status H-315.966

Our AMA supports protections that prohibit U.S. Immigration and Customs Enforcement, U.S. Customs and Border Protection, or other law enforcement agencies from utilizing information from medical records to pursue immigration enforcement actions against patients who are undocumented.

Improving Medical Care in Immigrant Detention Centers D-350.983

Our AMA will: (1) issue a public statement urging U.S. Immigrations and Customs Enforcement Office of Detention Oversight to (a) revise its medical standards governing the conditions of confinement at detention facilities to meet those set by the National Commission on Correctional Health Care, (b) take necessary steps to achieve full compliance with these standards, and (c) track complaints related to substandard healthcare quality; (2) recommend the U.S. Immigrations and Customs Enforcement refrain from partnerships with private institutions whose facilities do not meet the standards of medical, mental, and dental care as guided by the National Commission on Correctional Health Care; and (3) advocate for access to health care for individuals in immigration detention.

Opposing Office of Refugee Resettlement's Use of Medical and Psychiatric Records for Evidence in Immigration Court H-65.958

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

Immigration Status is a Public Health Issue D-350.975

- Our American Medical Association declares that immigration status is a public health issue that requires a comprehensive public health response and solution.
- Our AMA recognizes interpersonal, institutional, structural, and systemic factors that negatively affect immigrants' health.
- Our AMA will promote the development and implementation of educational resources for healthcare professionals to better understand health and healthcare challenges specific for the immigrant population.
- Our AMA will support the development and implementation of public health policies and programs that aim to improve access to healthcare and minimize systemic health barriers for immigrant communities.

Ensuring Access to Health Care, Mental Health Care, Legal and Social Services for Unaccompanied Minors and Other Recently Immigrated Children and Youth D-60.968
Our American Medical Association will work with medical societies and all clinicians to (i) work together with other child-serving sectors to ensure that new immigrant children receive timely and age-appropriate services that support their health and well-being, and (ii) secure federal, state, and other funding sources to support those services.

RELEVANT MSS POLICY

Advocating for Alternatives to Immigrant Detention Centers that Respect Human Dignity 65.039MSS
Our AMA-MSS will ask our AMA to advocate for the preferential use of community-based, non-custodial Alternatives to Detention programs within the United States that respect the human dignity of immigrants, migrants, and asylum-seekers who are in the custody of federal agencies.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 406
(I-24)

Introduced by: Jared Boyce[1], Courtney Noetzel[2], Amanda Kahn[3], Nicholas Wilson[4], Sara Kazyak[5], Alison Blodgett[6], Emma Ableman[7], Jessy Silfer[8], Brooke Taylor[9], Adrienne Nguyen[10], Meghan Mallya[11], Jade Bowers[12]

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[8] Case Western Reserve University School of Medicine
[9] University of South Carolina School of Medicine Greenville
[10] Des Moines University
[11] The University of Texas Medical Branch
[12] Florida State University

Subject: Advocating for Universal Summer Electronic Benefit Transfer Program for Children (SEBTC)

Referred to: MSS Reference Committee
(Alec Calac and Andrew Norton, Co-Chairs)

Whereas, in 2022, 8.8% of all food-insecure U.S. households included children with 7.8% of these children having low food security and 1% having very low food security[1,2]; and

Whereas, overall food insecurity increased from 10.2% to 12.8% in 2021 and 2022, respectively, affecting an additional 4.1 million children[1,3]; and

Whereas, school aged children experience higher rates of food insecurity during the summer months[4]; and

Whereas, food insecurity has been associated with developmental concerns reported by parents via the Parents Evaluation of Developmental Status (PEDS) screening test[5,6]; and

Whereas, food insecurity disproportionately affects children with disabilities, Black, Native American/Alaska Native, other children of color, and children with low socioeconomic status while also being a toxic stressor and recognized as an Adverse Childhood Experience[7-10]; and

Whereas, access to healthy food early in life promotes good nutrition and provides significant health benefits to children across all developmental stages by reducing the risk of developing psychiatric diseases, cognitive deficits, dopaminergic neuron dysfunction, asthma, anemia, and scoring lower testing and reading scores when compared to their peers[9,11-14,17-19]; and

Whereas, access to Supplemental Nutrition Assistance Program (SNAP) attenuates these behavioral consequences, and infants and children in families participating in SNAP are more likely to regularly see a primary care physician for checkups and have improved long-term health as adults[14]; and

Whereas, critics of universal free school meal programs argue that such policies are unnecessary due to high childhood obesity rates, but evidence shows that such programs reduce BMI or have no adverse effects, while also improving school attendance and academic performance[14-19]; and

Whereas, research findings have shown that the USDA-Funded Summer Feeding programs have improved food security, diet quality, and child nutrition in low-income school-aged children[20, 21]; and

Whereas, a pilot of the Summer Electronic Benefits Transfer for Children (SEBTC) program reduced the prevalence of food insecurity by one-third and improved nutritional intake[22];

Whereas, the SEBTC program is expected to benefit more than 29 million children across the U.S., providing $40 each summer month per eligible child[23, 24]; and

Whereas, the American Academy of Pediatrics (AAP) recently adopted a resolution advocating for SEBTC and has released several policies combating childhood food insecurity, including “Promoting Food Security For all Children” which highlights the need for pediatricians to collaborate with local and federal government to ensure equitable access to healthy and nutritious food for all children[25]; and

Whereas, as of 2024, only 37 states have enacted SEBTC, and 10 of the 13 states that did not have food insecurity levels at or above the U.S. average are among the worst in prevalence of childhood food insecurity[23,26,]; therefore be it

RESOLVED, that our American Medical Association will advocate for all states to adopt programs that reduce childhood food insecurity, including but not limited to the Summer Electronic Benefits Transfer for Children program; and be it further

RESOLVED, that our AMA will support advocacy efforts from state medical societies engaging in efforts to reduce childhood food insecurity in their respective state; and be it further

RESOLVED, that our AMA-MSS include the aforementioned resolved clauses in HOD transmittal 13, “Support of Universal School Meals for School Age Children”.

Fiscal Note: TBD

Date Received: 09/15/2024

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Relevant AMA Policies

Improvements to Supplemental Nutrition Programs H-150.937
Our American Medical Association 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.

Sustainable Food D-150.978

Our AMA: (1) supports practices and policies in medical schools, hospitals, and other health care facilities that support and model a healthy and ecologically sustainable food system, which provides food and beverages of naturally high nutritional quality; (2) supports sustained funding for evidence-based policies and programs to eliminate disparities in healthy food access, particularly for populations vulnerable to food insecurity, through measures such as tax incentive programs, community-level initiatives and federal legislation; and (3) will consider working with other health care and public health organizations to educate the health care community and the public about the importance of healthy and ecologically sustainable food systems.

Food Environments and Challenges Accessing Healthy Food H-150.925

Our AMA (1) encourages the U.S. Department of Agriculture and appropriate stakeholders to study the national prevalence, impact, and solutions to 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.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 407
(I-24)

Introduced by: Isabel Nguyen[1], Harrison Jennings[2], Michael Chen[1], Nancy Bachir[3], Alex Pedowitz[4], Patrick Lee[1], Kyra Colston[5], Harshini Selvakumar[1], Sarvesh Palaniappan[6], Justin Chang[1], David Lee[2]

Affiliations:
[1] Western University of Health Sciences, College of Osteopathic Medicine of the Pacific
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Subject: Standardizing Safety Requirements for Rideshare-Based Non-Emergency Medical Transportation

Referred to: MSS Reference Committee
(Alec Calac and Andrew Norton, Co-Chairs)

Whereas, each year, approximately 6 million Americans delay medical care due to lack of transportation, and transportation barriers are estimated to contribute to at least 25% of all missed clinic appointments annually[1-4]; and

Whereas, lack of physical access to healthcare institutions and limited transportation options lead to delayed medical care, worsening health outcomes, and accelerated progression of chronic diseases[3-4]; and

Whereas, the transportation-disadvantaged population disproportionately features patients from racial and ethnic minorities, lower socioeconomic status, rural locations, and/or with a history of disability, frailty, or existing chronic conditions[5]; and

Whereas**,** addressing transportation-related barriers to facilitate timely access to necessary healthcare services is critical for improving health outcomes and reducing health disparities in vulnerable populations[6]; and

Whereas, traditional Non-Emergency Medical Transportation (NEMT) programs provide Medicaid beneficiaries insured transportation via taxi, van, or city bus to any location providing covered health care services[7]; and

Whereas, NEMT programs are a vital source of insured transportation to healthcare services for vulnerable populations, including individuals with disabilities, elderly individuals, solitary individuals, and individuals in rural communities[8]; and

Whereas, access to NEMT services fosters community support for patients and significantly increases feelings of independence, empowerment, social connectedness, and self-care[9-11]; and

Whereas**,** users of traditional NEMT reported common issues like limited coverage of rides, late pick-ups, and absent drivers; as such, the inconsistent quality of service discourages traditional NEMT use[12]; and

Whereas**,** optimizing existing NEMT systems can improve continuity of care by reducing emergency room visits, hospitalizations, and additional preventable healthcare expenses disproportionately experienced by vulnerable populations[13-14]; and

Whereas, rideshare-based NEMT (RB-NEMT) programs hire rideshare drivers to use personal vehicles to provide NEMT services, broadening NEMT's accessibility[15]; and

Whereas, the District of Columbia and 14 states allowed for broad use of RB-NEMT as first-choice NEMT providers in 2021, and other states cover rideshare use as back-up NEMT in the event of driver no-shows or lack of traditional NEMT options[16]; and

Whereas**,** compared to traditional NEMT, RB-NEMT options increase patient attendance at health appointments, while decreasing average wait times and costs per ride[17-18]; and

Whereas, traditional NEMT spending is projected to reach $14 billion in 2024, while RB-NEMT is estimated to save $268 per member per year, totaling $537 million in annual costs[11,19]; and

Whereas**,** RB-NEMT offers on-demand scheduling, electronic records for transparent monitoring, more direct routes, and greater reliability while maintaining higher patient satisfaction rates[19]; and

Whereas, patients have reported safety concerns related to the unpredictability and variability of transportation services (e.g., advance notice of vehicle or driver, availability of accessible vehicles, presence of medically certified drivers)[11]; and

Whereas**,** rideshare companies hire RB-NEMT drivers as independent contractors who are typically trained identically to non-NEMT drivers, provided limited or no training in patient confidentiality or basic life support, and offered little agency to transport patients[19]; and

Whereas**,** despite established partnerships between digital transportation network companies and NEMT brokers, there is a lack of standardized trainings for drivers, as well as concerns ranging from credentialing to information sharing to medical liability[17,20]; therefore be it

RESOLVED, that our American Medical Association support efforts to use rideshare-based non-emergency medical transportation (RB-NEMT) for insurer-covered NEMT and reduce inefficiencies and patient barriers in NEMT systems; and be it further

RESOLVED, that our AMA support minimum safety requirements for RB-NEMT drivers, including but not limited to criminal background checks, initial drug testing, CPR/BLS certification, HIPAA training, and vehicle safety and accessibility inspections.

Fiscal Note: TBD

Date Received: 09/15/2024

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RELEVANT AMA POLICY

Non-Emergency Patient Transportation Systems H-130.954

Our AMA: (1) supports the education of physicians, first responders, and the public about the costs associated with inappropriate use of emergency patient transportation systems; and (2) encourages the development of non-emergency patient transportation systems that are affordable to the patient, thereby ensuring cost effective and accessible health care for all patients.

Community Mobility Devices H-90.978
The AMA urges physicians, who treat patients with impaired mobility outside the home, to work with state medical associations and appropriate medical specialty societies to identify state agencies and community service organizations that provide local transportation assistance to disabled individuals, and that such information be made readily accessible to disabled patients.

Health Promotion and Disease Prevention H-425.993
The AMA 5) advocates that health be considered one of the goals in transportation planning and policy development including but not limited to the establishment, expansion, and continued maintenance of affordable, accessible, barrier-free, reliable, and preferably clean-energy public transportation;

Cost of Medically Related Services and Supplies H-330.960
Our American Medical Association legislative or other appropriate department will seek a requirement that CMS and/or their contracted home health agencies, durable medical equipment suppliers, and non-emergency transportation services, provide cost estimates to physicians, to be provided along with the physician authorization form.

RELEVANT MSS POLICY

160.037MSS Mitigating the Transportation Barrier for Accessibility of Healthcare for the Medicaid Population
AMA-MSS (1) supports the research efforts to assess the utility and feasibility of state-funded support of Non-Emergency Medical Transportation programs and (2) supports the maintenance of funding for transportation services in state Medicaid programs.

160.024MSS Transportation and Accessibility to Free Medical Clinics
AMA-MSS will ask the AMA to encourage initiatives that address transportation as a barrier to utilization of those institutions addressing the healthcare needs of the underserved in local communities.

290.006MSS Expanding Medicaid Transportation to Include Health Grocery Destinations:
Our AMA-MSS will ask the AMA to: (1) support the implementation and expansion of transportation services for accessing healthy grocery options; and (2) support inclusion of supermarkets, food banks and pantries, and local farmers markets as destinations offered by Medicaid transportation at the federal level; and (3) support efforts to extend Medicaid reimbursement to non-emergent medical transportation for healthy grocery destinations.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 411
(I-24)

Introduced by: Stephen Kwong[1], Eileen Enriquez[2], Alexander Le[1], Jerry Liu[1], Genichiro Fujioka[1]

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Subject: Regulation and Oversight of the Troubled Teen Industry

Referred to: MSS Reference Committee
(Alec Calac and Andrew Norton, Co-Chairs)

Whereas, the Troubled Teen Industry encompasses a broad range of youth residential programs, including residential treatment centers, wilderness programs, boot camps, and therapeutic boarding schools, which are marketed towards struggling teenagers[1,2]; and

Whereas, as of 2020, approximately 120,000-200,000 adolescents were reside in some type of group home, residential treatment center, boot camp, or correctional facility with approximately 50,000 of those youths having been placed privately by their parents[11]; and

Whereas, under the 2018 Family First Prevention Services Act these programs are only required to adhere to federal and scientific standards if they receive federal funding or are run by the state[1,14]; and

Whereas, these programs are often privately run and are therefore not required to adhere to scientifically accepted therapies, leading to the use of unproven and potentially harmful practices[1]; and

Whereas, regulation of these programs have thus far largely been left to the discretion of state legislatures, leading to inconsistent and oftentimes insufficient oversight and enforcement[10]; and

Whereas, furthermore, many states completely exempt religious boarding schools from licensing requirements and from oversight from education and child welfare authorities[11]; and

Whereas, a large proportion of children are sent out of state by local and state government entities which affects monitoring and accountability by non-profit organizations that have limited cross-state resources[7]; and

Whereas, instead of providing evidence-based treatments, such as cognitive behavioral therapy or trauma-informed care, many programs within this industry rely on punitive, archaic methods that have resulted in documented cases of physical, emotional, and sexual abuse[1]; and

Whereas, there are thousands of allegations against these programs that include: false imprisonment, forced labor, kidnapping, solitary confinement, and other severe abuses, contributing to long-lasting trauma and, in some cases, death[1-6]; and

Whereas, ProPublica reported in 2015, that at least 145 youths have died in residential programs over 3 decades prior to said review[12]; and

Whereas, the Troubled Teen Industry as a whole has a disproportionate impact on BIPOC children, children with disabilities and children who identify as part of the LGBTQ+ community[7,8]; and

Whereas, despite these serious concerns, there is a significant lack of oversight and regulation at local, state, and national levels, leaving vulnerable adolescents at risk of harm[1]; and

Whereas, recent documentaries, such as *The Program*, *Hell Camp*, and *The Last Stop*, and Paris Hilton's own personal testimony and advocacy have highlighted these issues, bringing them into public consciousness[13]; and

Whereas, despite this, significant federal legislation on this issue, such as the Stop Child Abuse in Residential Programs for Teens Act, has tried and failed to pass almost every year in Congress for over a decade[16]; and

Whereas, this issue has again been recently been brought before Congress as (H.R. 2955), or the Stop Institutional Child Abuse Act, which seeks to establish "an interagency Federal Work Group on Youth Residential Programs to support and implement best practices regarding the health and safety, care, treatment, and appropriate placement of youth in youth residential programs"[9]; and

Whereas, Congressional bill H.R. 2955, introduced to the US House of Representatives on 04/27/2023, has been introduced to the floor and subsequently referred to committee where it has remained for the past year, showing significant political interest in this topic, but a need for increased advocacy[9]; and

Whereas, current advocacy for youth residential programs does not necessarily extend to other aspects of the Troubled Teen Industry including but not limited to wilderness therapy programs; and

Whereas, wilderness therapy programs are an often-overlooked aspect of the Troubled Teen Industry that is not often included in regulatory efforts seeking to regulate youth residential

programs and are often less regulated than other residential programs as they are classified separately as shorter-term solutions in comparison to longer residential programs[13]; and

Whereas, in the United States, there are about 40 wilderness therapy programs – part of 2,000 overall "troubled teen" programs[13]; and

Whereas, the New York Times reported in 2001 that in youth wilderness programs alone, there had been at least 31 deaths since 1980, with many other cases being reported since then[13,17]; and

Whereas, California has recently passed and will soon implement California's Accountability in Children's Treatment Act, which expanded current regulations on residential facilities to include short term residential therapeutic programs, like wilderness therapy programs[15]; and

Whereas, current AMA policy Youth Residential Treatment Program Regulation (H-60.896) specifically advocates for regulation of youth residential facilities which also does not account for all aspects of the Troubled Teen Industry; therefore be it

RESOLVED, that our that our American Medical Association amends "Youth Residential Treatment Program Regulation (H-60.896) by addition as follows:

Youth Residential and Other Treatment Program Regulation

1. Our American Medical Association recognizes the need for licensing standards for all youth residential treatment facilities (including private and juvenile facilities) as well as other treatment facilities (including wilderness therapy programs and other programs aimed at treating behavioral and mental health issues in youths) to ensure basic safety and well-being standards for youth.
2. Our AMA supports recommendations including, but not limited to, patient placement criteria and clinical practice guidelines, as developed by of nonprofit health care medical associations and specialty societies, as the standard for regulating youth residential treatment and other relevant youth programs.
3. Our AMA opposes the use of any non-evidence-based therapies and abusive measures in Youth Residential and Other Treatment Programs and supports that only appropriately qualified professionals provide services to participants, and support oversight and review by and participant access to physicians (especially psychiatrists) and other healthcare professionals (especially mental health professionals).
4. Our AMA supports increasing reporting and transparency regarding the number of children placed in for-profit and state-run residential facilities, disaggregated by placement location, demographic data, incident reports and law enforcement referrals, and funding source(s) and amount in a publically available, centralized database.
5. Our AMA supports federal, state, local, territorial and tribal efforts that facilitate uniform standards for preventing child abuse in residential facilities

Fiscal Note: TBD

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Relevant AMA/Policy:

Youth Residential Treatment Program Regulation H-60.896

1. Our American Medical Association recognizes the need for licensing standards for all youth **residential treatment** facilities (including private and juvenile facilities) to ensure basic safety and well-being standards for youth.
2. Our AMA supports recommendations including, but not limited to, patient placement criteria and clinical practice guidelines, as developed by of nonprofit health care medical associations and specialty societies, as the standard for regulating youth **residential treatment** programs.

Role of Physicians in Improving Adolescent Health H-170.972
The American Medical Association supports programs that encourage teen **health** and supports the involvement **of** medical students, residents, and other **physicians in** educational efforts to enhance teen **health**.

H-95.965 Residential Treatment for Women with Substance Use Disorder
Our AMA encourages state medical societies to support an exemption in public aid rules that would allow for the coverage of residential drug treatment programs for women with child-bearing potential.

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

Family Violence-Adolescents as Victims and Perpetrators H-515.981
1. Our American Medical Association:
    a. encourages physicians to screen adolescents about a current or prior history of maltreatment. Special attention should be paid to screening adolescents with a history of alcohol **and** drug misuse, irresponsible sexual behavior, eating disorders, running away, suicidal behaviors, conduct disorders, or psychiatric disorders for prior occurrences of maltreatment.
    b. urges physicians to consider issues unique to adolescents when screening youths for abuse or neglect.
2. Our AMA encourages state medical society violence prevention committees to work with child protective service agencies to develop specialized services for maltreated adolescents, including better access to health services, improved foster care, expanded shelter **and** independent living facilities, **and** treatment programs.
3. Our AMA will investigate research **and** resources on effective parenting of adolescents to identify ways in which physicians can promote parenting styles that reduce stress **and** promote optimal development.
4. Our AMA will alert the national school organizations to the increasing incidence of adolescent maltreatment **and** the need for training of school staff to identify **and** refer **victims** of maltreatment.
5. Our AMA urges youth correctional facilities to screen incarcerated youth for a current or prior history of abuse or neglect **and** to refer maltreated youth to appropriate medical or mental health treatment programs.
6. Our AMA encourages the National Institutes of Health **and** other organizations to expand continued research on adolescent initiation of violence **and** abuse to promote understanding of how to prevent future maltreatment **and family** violence.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 413
(I-24)

Introduced by: Mitchell Hanson[1], Nancy Bachir[2], Yatin Srinivash Ramesh Babu[3] Onajia Stubblefield[4], Austin Le[5], Natalie Bachir[6], Margaret Mercante[7]

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Subject: Promoting the Use and Efficacy of Ultraviolet Protective Clothing

Referred to: MSS Reference Committee
(Alec Calac and Andrew Norton, Co-Chairs)

Whereas, despite an increase in sunscreen use and sunscreen education programs over the last several decades, the incidence of melanoma continues to rise[1]; and

Whereas, the U.S. Department of Health and Human Services Centers for Disease Control and Prevention Results from the School Health Policies and Practices Study in 2016 showed that of all school districts only 24% recommended sunglasses use in the sun, 38.5% recommended use of hats and visors while in the sun, 39% encouraged students to wear UVP clothing, and 33.2% scheduled outdoor activities outside of peak sun hours during the school day[2]; and

Whereas, the Surgeon General's Call to Action to Prevent Skin Cancer recommended UVP clothing use in schools, especially among males who may avoid sunscreen, with barriers noted as policies prohibiting ultraviolet protective (UVP) clothing including hats and sunglasses among schools[3]; and

Whereas, while SPF provides UV protection, UVP clothing may be more suitable for individuals with allergies to ingredients included in sunscreens such as fragrances and oxybenzone[4]; and

Whereas, UVP clothing may be more popular and suitable for people with skin of color seeking maximum sun protection, especially for photo exacerbated conditions without cosmetic and skin incompatibility of physical barrier sunscreens[5,6]; and

Whereas, the use of UV protective clothing can decrease the price of sun protection by 33% for families of four and furthermore, may be more cost effective than sunscreen long term[7,8]; and
Whereas, UVP clothing relatively novel with its first approval in the United States by the Food and Drug Administration in 1992 and can provide substantial UV protection with a UPF 50 fabric blocking 98 percent of the sun's rays and allowing two percent (1/50th) to penetrate[9,10]; and

Whereas, sunglasses use has been associated with a lower risk of cataracts, macular degeneration, vision loss, and skin cancers[11–14]; and

Whereas, sun-protective clothing has been recommended by studies suggesting a lower risk of sunburns and lifelong development of nevi[15,16]; and

Whereas, national organizations such as the Centers for Disease Control and Prevention, the American Cancer Society, the American Academy of Dermatology, and nonprofits like Sunsmart and the Skin Cancer Foundation recommend the use of UVP clothing, hats, sunglasses, and long sleeves to reduce the risk of skin cancer[17–20]; and

Whereas, sunscreen use was equivalent in those both diagnosed with melanoma and those melanoma free but use of UVP clothing was significantly higher among those who are melanoma-free and furthermore, only UVP clothing compared to sunscreen use was significantly associated with decreased odds of sunburn development [21]; and

Whereas, UVP clothing offers superior, full-spectrum protection compared to broad-spectrum sunscreens in blocking both UVA and UVB rays, suggesting that UVP clothing should be considered the cornerstone of UV protection[22]; and

Whereas, while sunscreen use and sunscreen education programs have increased despite rising melanoma rates, UVP clothing rates have remained the same if not decreased despite increasing market representation[23–25]; and

Whereas, current AMA policy distinctly recognizes sun protective behaviors including sunscreen and hazards of tanning parlors with special considerations among communities of color in policies H-440.839 and H-55.972 but fails to recognize UV protective clothing equally as an effective method of UV protection and skin cancer prevention; therefore it be

RESOLVED**,** that our American Medical Association (AMA) support efforts to promote the development of ultraviolet protective (UVP) clothing that provides protection against both UVA and UVB rays, including standardized labeling of UPF (ultraviolet protection factor) ratings, so consumers can understand the level of protection offered by these products; and be it further

RESOLVED**,** that our AMA advocate for the recognition of UVP clothing as an equally effective method of sun protection alongside broad-spectrum sunscreen, encouraging innovation and public awareness campaigns to highlight its role in comprehensive sun safety strategies.

Fiscal Note: TBD

Date Received: 09/15/2024

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RELEVANT AMA POLICY

H-440.841 Permitting Sunscreen in Schools

1. Our AMA supports the exemption of sunscreen from over-the-counter medication possession bans in schools and encourages all schools to allow students to bring and possess sunscreen at school without restriction and without requiring physician authorization.
2. Our AMA will work with state and specialty medical societies and patient advocacy groups to provide advocacy resources and model legislation for use in state advocacy campaigns seeking the removal of sunscreen-related bans at schools and summer camp programs. Res. 403, A-13Appended: Res. 422, A-16

H-440.839 Protecting the Public from Dangers of Ultraviolet Radiation

Our AMA… "as part of a successful skin cancer prevention strategy, supports free public sunscreen programs that: (a) provide sunscreen that is SPF 15 or higher and broad spectrum; (b) supply the sunscreen in public spaces where the population would have a high risk of sun exposure; and (c) protect the product from excessive heat and direct sun." CCB/CLRPD Rep. 3, A-14Appended: Res. 403, A-14Appended: Res. 404, A-19Appended: Res. 905, I-19

RELEVANT MSS POLICY

60.011MSS Sun Protection Programs and Education in K-12 Schools:

AMA-MSS will support working with the National Association of State Boards of Education, the Centers for Disease Control and Prevention, and other appropriate entities to encourage schools to incorporate sun protection policies and sun safety education curricula. (MSS Res 16, A-04) (Reaffirmed: MSS Res 16,

I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Appended: MSS Res. 072, Nov. 2020) (Reaffirmed: MSS GC Rep B, A-21)

440.044MSS Sunscreen and Sun Protection Counseling by Physicians
AMA-MSS will ask the AMA to encourage physicians to counsel their patients on sun-protective behavior. (MSS Res 26, I-13) (Reaffirmed: MSS GC Rep A, I-19)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 416
(I-24)

Introduced by: Eileen Enriquez[1], Sierra McCarty [1], Onajia Stubblefield [2], Eduardo Soto [1]

Affiliations: [1] Kirk Kerkorian School of Medicine at University of Nevada, Las Vegas
[2] University of Louisville School of Medicine

Subject: Allergen Labeling for Spices and Herbs

Referred to: MSS Reference Committee
(Alec Calac and Andrew Norton, Co-Chairs)

Whereas, food allergies are prevalent worldwide, with an estimated 33 million Americans affected by food allergies[1]; and

Whereas, food allergies impose a significant burden on individuals, including increased risk of severe reactions, diminished quality of life, and substantial economic costs due to medical care and avoidance measures[2,3,4]; and

Whereas, the Food and Drug Administration (FDA) mandates food manufacturers to list ingredients and specify common allergens contained in food products[5,6,7,8]; and

Whereas, allergy labels are crucial in preventing unwanted allergic reactions by providing essential information to individuals with food allergies[1,9,10,11]; and

Whereas, the FDA currently allows food manufacturers to label food seasonings and food products with vague terms such as “spices and herbs”, which can include a wide range of aromatic and vegetable components, thus not providing complete ingredient information[6,7]; and

Whereas, food manufacturers are not responsible for reporting changes in their blends of aromatic vegetable substances that fall under the FDA definition of “spices” and “herbs”[10,11]; and

Whereas, individuals with existing allergies may experience cross-reactivity to compounds found in spices and herbs[9,11]; and

Whereas, cross-reactivity occurs because the allergenic compound is not species-specific, but rather an epitope found in multiple related families and genera, such that it is possible for an individual with a food allergy to experience a reaction when consuming foods that are thought to be free of allergens [11,12]; and

Whereas, the FDA considers the leaves, seeds, and roots of aromatic vegetables to be “spices,” plants such as fenugreek, which is an ingredient in many cultural spice blends, is from the same botanical family as peanuts, generating anaphylactic cross-reactivity in individuals with known peanut allergies[11]; and

Whereas, the same cross-reactivity phenomenon has also been observed in individuals with common allergies such as peanuts and tree nuts[11,13]; and

Whereas, aeroallergens such as pollen can also share these allergenic epitopes, leading to sensitization to food allergens following exposure to these aeroallergens, such that a "pollen-food syndrome" has been described [12,14]; and

Whereas, pollen-food syndrome is known to involve allergic reactions to spices of the family *Apiaceae*, due to cross-reactivity between these spices and birch and mugwort pollens, indicating a propensity for the edible plants of the *Apiaceae* family to be allergenic [2,12]; and

Whereas, an estimated 1.3 million Americans are affected by spice allergies, making it particularly challenging for affected individuals to avoid allergic reactions due to ambiguous labeling and the risk of cross-contamination in food preparation environments[2,9,15]; and

Whereas, members of the *Apiaceae* family of vegetables, which includes celery, carrot, anise, cumin, coriander, caraway seed, and others, have been known to be highly allergenic, producing severe anaphylactic reactions[9]; and

Whereas, under the Fair Packaging and Labeling Act, food manufacturers have a right to "trade secrets" such as spice blends, they continue to be responsible for providing consumers with complete and accurate information regarding potential allergens that may pose a risk to health and safety [16,17]; and

Whereas, there have been successes in improving labeling transparency through the Food Allergen Labeling and Consumer Protection Act (FALCPA) and the recent FASTER Act, which allows consumers with allergies to more confidently minimize their risk of an allergic reaction[10,18,19,20,21,22]; and

Whereas, increased transparency in food labeling will help physicians increase their diagnostic accuracy when identifying allergens in a patient's diet and will improve their ability to educate patients on allergen avoidance[15,20]; and

Whereas, clearer labeling would greatly benefit individuals with spice allergies by reducing the risk of accidental exposure and improving their ability to make informed food choices; therefore be it[9,10,11,15,23]

RESOLVED, that our American Medical Association supports efforts to require specific and transparent disclosure of individual ingredients included under aggregate categories, such as "spices and herbs", and be it further

RESOLVED, that our AMA urges the Food and Drug Administration to regularly evaluate their lists of spices and herbs exempted from labeling requirements through the use of emerging scientific evidence of cross-reactivity and evolving allergens, and require their explicit disclosure when appropriate.

Fiscal Note: TBD

Date Received: 09/15/2024

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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.

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.

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.

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.

RELEVANT MSS POLICY

Increasing Customer Awareness of Nutritional Information and Ingredient Lists in Restaurants and Schools 150.015MSS
AMA-MSS will ask the AMA to (1) support the adoption of regulations by the U.S. Food and Drug Administration requiring restaurants with menu items that are standard to multiple locations provide standard nutrition labels for all applicable items, available to their customers on request and (2) support the adoption of regulations by the U.S. Food and Drug Administration requiring all restaurants, school, and work cafeterias to have ingredient lists and nutritional information, including total fat, trans fat, sugar content, and sodium, for all menu items, available to their customers on request. (MSS Res 22, I-03) (AMA Sub Res 411, A-04 Adopted in Lieu of Res 411 and 430 [H-150.948]) (Reaffirmed: MSS Rep E, I-08) (Amended: MSS Res 31, A-11) (AMA Res 914, I-11 Referred) (Reaffirmed: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 501
(I-24)

Introduced by: Aaron Kiel[1], Priya Gupta[1], Jessica MacIntyre[1], Christian Tallo[1], Courtney Noetzel[2], Naveed Chowdry[2]

Affiliations: [1]University of Connecticut School of Medicine, [2]Sam Houston State University College of Osteopathic Medicine

Subject: Increasing Utilization of Point-of-Care Ultrasound in Hospital Settings

Referred to: MSS Reference Committee
(Alec Calac and Andrew Norton, Co-Chairs)

Whereas, point-of-care ultrasound (POCUS) is the utilization of ultrasound at patient bedside for diagnostic purposes and procedures in inpatient, outpatient, and urgent care settings[1]; and

Whereas, POCUS is a cost-effective, accessible, non-invasive diagnostic technology that can be utilized in resource-limited settings[1,2]; and

Whereas, diagnostic timing decreases and accuracy increases when POCUS is incorporated into clinical examination and procedures, and its implementation has been demonstrated to improve patient outcomes and satisfaction[1,2]; and

Whereas, the incorporation of ultrasound training in medical school curricula has more than doubled since 2014, emphasizing an increasing number of physicians that are already experienced in utilizing this technology[3]; and

Whereas, after brief training, primary care residents were able to correctly identify 4 abdominal aortic aneurysms (AAA) in 79 patients with 100% specificity and sensitivity after minimal training[4]; and

Whereas, POCUS has been established as a sensitive test for diagnosis of certain medical conditions, including: pericardial effusion, deep vein thrombosis, pulmonary edema, cholecystitis, and pulmonary edema[5]; and

Whereas, the use of POCUS by emergency physicians provides excellent sensitivity and has a high negative predictive value to rule out ectopic pregnancies in multiple geographic settings[6]; and

Whereas, using POCUS for diagnostic purposes and procedures offers further benefits for certain populations, such as pregnant patients and pediatric patients, who may be sensitive to radiation and/or contrast from other forms of imaging[7]; and

Whereas, POCUS in inpatient settings has been shown to positively impact patient care by improving diagnostic decision-making and contributing to reduced length of hospital stays[8]; and

Whereas, despite having many clinical advantages, POCUS remains underutilized in the hospital setting, limited by numerous barriers including a lack of extensively trained physicians, a lack of POCUS-related continuing medical education (CME) programs for medical professionals, a lack of standards for diagnosis and assessment of certain conditions, and a lack of resources in low income areas[2]; and

Whereas, a study of Veterans Affairs (VA) hospitals found that POCUS was only used in 64% of hospital medicine groups[9]; an

Whereas, the implementation of POCUS has been calculated to save privately insured patients $1,134.31, out-of-network or uninsured patients $2,826.31, and Medicare or Medicaid patients $181.63 per encounter in which POCUS was used[10]; and

Whereas, using POCUS guidance for procedures, such as central line placement, lumbar puncture, and foreign body removal, only slightly increases reimbursement at amounts that do not allow for the sustainment of purchasing and maintaining POCUS machines[11]; and

Whereas, the implementation of POCUS within the healthcare system has been limited by lower rates of billing, with use being difficult to justify by many institutions due to the cost of the units and a lack of ability to bill for a return on investment[7]; and

Whereas, there are no clear definitions for billing, causing most reimbursement filings to be denied due to this complex system[12]; and

Whereas, Medicare reimbursement for diagnostic ultrasound has decreased by 22.9% from 2007-2019 when accounting for inflation, meanwhile total Medicare physician reimbursement per beneficiary has only decreased by 2.3% from 2005-2021 when adjusting for inflation[13,14]; and

Whereas, it has been suggested that increased reimbursement for POCUS-guided exams will allow for increased implementation of POCUS in the healthcare system[7]; and

Whereas, physicians who received increases in office-based reimbursements were more likely to provide in-office care and also increased the volume of in-office services provided, so it is seen that reimbursements guide services provided[15]; therefore be it

RESOLVED, that our American Medical Association will support increased insurance reimbursement for inpatient use of point of care ultrasound (POCUS) in an effort to increase its utilization in the inpatient setting; and be it further

RESOLVED, that our AMA will work with relevant stakeholders to study barriers to POCUS utilization and advocate for increased POCUS utilization in the inpatient setting.

Fiscal Note: TBD

Date Received: 09/15/2024

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RELEVANT AMA POLICY

Reimbursement for Office-Based or Outpatient Ultrasound Imaging H-385.934
Our AMA supports reimbursement for ultrasound imaging performed by appropriately trained physicians

Privileging for Ultrasound Imaging H-230.960
(1) AMA affirms that ultrasound imaging is within the scope of practice of appropriately trained physicians; (2) AMA policy on ultrasound acknowledges that broad and diverse use and application of ultrasound imaging technologies exist in medical practice; (3) AMA policy on ultrasound imaging affirms that privileging of the physician to perform ultrasound imaging procedures in a hospital setting should be a function of hospital medical staffs and should be specifically delineated on the Department's Delineation of Privileges form; and (4) AMA policy on ultrasound imaging states that each hospital medical staff should review and approve criteria for granting ultrasound privileges based upon background and training for the use of ultrasound technology and strongly recommends that these criteria are in accordance with recommended training and education standards developed by each physician's respective specialty

Diagnostic Ultrasound Utilization and Education H-480.950
Our American Medical Association affirms that ultrasound imaging is a safe, effective, and efficient tool when utilized by, or under the direction of, appropriately trained physicians and supports the educational efforts and widespread integration of ultrasound throughout the continuum of medical education.

AMA Efforts on Medicare Payment Reform D-400.982
(1)Our American Medical Association will increase media awareness around the 2024 AMA Annual meeting about the need for Medicare Payment Reform, eliminating budget neutrality reductions, and instituting annual cost of living increases. (2)Our AMA will step up its public relations campaign to get more buy-in from the general public about the need for Medicare

payment reform. (3)Our AMA will increase awareness to all physicians about the efforts of our AMA on Medicare Payment Reform. (4)Our AMA will advocate for abolition of all MIPS penalties in light of the current inadequacies of Medicare payments.

RELEVANT MSS POLICY

480.004MSS Ultrasound Imaging
AMA-MSS (a) affirms that ultrasound imaging is within the scope of practice of appropriately trained physicias; (b) acknowledges that broad and diverse use and application of ultrasound imaging technologies exists in medical practice; (c) affirms that privileging of the physician to perform ultrasound imaging procedures in a hospital setting should be a function of hospital medical staff and should be specifically delineated on the Department's Delineation of Privileges form; and (d) believes that each hospital medical staff should review and approve criteria for granting ultrasound privileges based upon background and training for the use of ultrasound technology and ensure that these criteria are in accordance with recommended training and education standards developed by each physician's respective specialty society. (MSS Emergency Resolution 1, I-99) (Reaffirmed: MSS Rep A, I-04) (Reaffirmed: MSS GC Report B, I-09) (Modified: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 502
(I-24)

Introduced by: Manasvi Khullar[1], Harsimran Kaur[1], Madeline Evan[2], Onajia Stubblefield[3], Kyra Colston[4]

Affiliations:
[1] Touro University California
[2] Northeast Ohio Medical University
[3] University of Louisville
[4] Indiana University

Subject: Increased Cybersecurity Standards for Healthcare Entities

Referred to: MSS Reference Committee
(Alec Calac and Andrew Norton, Co-Chairs)

Whereas, healthcare increasingly relies on electronic infrastructure in the form of Electronic Health Records (EHR) systems, telehealth platforms, implantable devices, patient monitoring devices, and billing systems[1,2]; and

Whereas, healthcare's digital infrastructure is vulnerable, with the frequency of cyberattacks and data breaches doubling from 2016 to 2021[3]; and

Whereas, cyberattacks lead to errors in care, significant delays, and increased hospital mortality for patients that are already receiving care, with minority patients more likely to have adverse outcomes[4–8]; and

Whereas, regulation of cybersecurity in healthcare is scarce, with few ways to detect fraud and a variety of optional industry standards[9,10]; and

Whereas, the largest cyberattack in U.S. health care history at Change Healthcare, affecting one-third of all medical records in the country, was reportedly due to a lack of multi-factor authentication (MFA), an industry-standard security measure that verifies the identity of users with multiple methods[10–12]; and

Whereas, MFA is a simple and effective tool that can block 99.9% of automated cyberattacks, which can significantly reduce healthcare data breaches[13]; and

Whereas, lack of original equipment manufacturer (OEM) support and timely updates to the operating system, firmware, applications, and hardware are often key vulnerabilities in cyberattacks[2,14,15]; and

Whereas, encryption is the process of converting data to an unrecognizable form to transfer it securely and although disk encryption is already built into Microsoft and Apple devices with no additional cost, it is not the standard for all medical devices[16–19]; and

Whereas, many solo practitioners and rural hospitals do not have the resources to take on the burden of cybersecurity such as updating old infrastructure or staffing of IT departments, while independent software vendors (ISV), independent hardware vendors (IHV), and OEMs that create and maintain our electronic infrastructures often have the revenue and resources to do so as evidenced by recent initiatives from Google and Microsoft[20–24]; and

Whereas, many government agencies are regulating the healthcare cybersecurity space, for example the Food and Drug Administration (FDA) recently introduced updated minimum requirements for medical devices while the Department of Health and Human Services (HHS) invested heavily in cybersecurity initiatives[25,26]; and

Whereas, mandatory cybersecurity regulations in healthcare are an area of active regulatory interest with The White House specifically recommending minimum standards in their recent National Cybersecurity Strategy, representing a timely moment for reform[27–29]; therefore be it

RESOLVED, that our American Medical Association support the establishment of minimum cybersecurity standards, including, but not limited to, the use of multi-factor authentication, timely updates, and encryption for HIPAA covered entities.

Fiscal Note: TBD

Date Received: 09/15/2024

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RELEVANT AMA POLICY

Establish a Cyber-Security Relief Fund D-478.957
Our American Medical Association, through appropriate channels, advocates for a 'Cyber Security Relief Fund" to be established by Congress. Our AMA advocates that the "Cyber Security Relief Fund" be funded through contributions from health insurance companies and all payers - as a mandated requirement by each of the payer. Our AMA advocates that the "Cyber Security Relief Fund" only be utilized for 'uninterrupted' payments to all providers- in a structured way, in the event of future cyber-attacks affecting payments. [Res. 235, A-24]

Protecting Physicians and Other Healthcare Workers in Society H-515.950
Our American Medical Association acknowledges and will act to reduce the incidence of antagonistic actions against physicians as well as other health care workers including first responders and public health officials, outside as well as within the workplace, including physical violence, intimidating actions of word or deed, and cyber-attacks, particularly those which appear motivated simply by their identification as health care workers. [Res. 413, I-20 Reaffirmed: CSAPH Rep. 7, I-23]

Ransomware Prevention and Recovery D-478.959
Our AMA will: (1) work with other stakeholders to seek legislation or regulation that supports resources to cover cyberattack prevention and recovery expenses for physician practices, hospitals, and healthcare entities to ensure continuity of optimal patient care; and (2) in collaboration with appropriate stakeholders, develop a toolkit for physician practices, hospitals, and healthcare entities to include best practices on preventing cyberattacks and a plan of action for when such an attack happens to their practice or institution; the toolkit should include guides to financial resources. [Res. 240, I-21]

Ransomware and Electronic Health Records D-478.960
Our American Medical Association acknowledges that healthcare data interruptions are especially harmful due to potential physical harm to patients and calls for prosecution to the fullest extent of the law for perpetrators of ransomware and any other malware on independent physicians and their practices, healthcare organizations, or other medical entities involved in providing direct and indirect care to patients. Our AMA will: (a) advocate for federal legislation which provides for the prosecution of perpetrators of ransomware and any other malware on any and all healthcare entities, involved in direct and indirect patient care, to the fullest extent of the law; (b) encourage health care facilities and integrated networks that are under threat of ransomware attacks to upgrade their cybersecurity and to back up data in a robust and timely fashion; (c) advocate that the security of protected healthcare information be

considered as an integral part of national cybersecurity protection; and (d) seek inclusion of federal cybersecurity resources allocated to physician practices, hospitals, and health care entities sufficient to protect the security of the patients they serve, as part of infrastructure legislation. [Res. 210, A-21 Reaffirmation: Res. 241, A-24]

3.3.3 Breach of Security in Electronic Medical Records
When there is reason to believe that patients' confidentiality has been compromised by a breach of the electronic medical record, physicians should: (a) Ensure that patients are promptly informed about the breach and potential for harm, either by disclosing directly (when the physician has administrative responsibility for the EMR), participating in efforts by the practice or health care institution to disclose, or ensuring that the practice or institution takes appropriate action to disclose. (b) Follow all applicable state and federal laws regarding disclosure. [Issued: 2016]

RELEVANT MSS POLICY

315.006MSS Improving Cybersecurity in Healthcare Facilities
AMA-MSS supports the development of new cybersecurity resources for providers that go beyond HIPAA compliance in order to adequately protect patient health information against new cybersecurity threats, such as ransomware, as they emerge. (MSS Res 07, I-16) (Reaffirmed: MSS Res. 101, Nov. 2020)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 503
(I-24)

Introduced by: Afareen Jaleel[1], Richard Tran[1], Trevor Nguyen[2], Benjamin Blittschau[3], Shannon Lam[4]

Affiliations [1]University of Massachusetts School of Medicine
[2]University of Texas Southwestern Medical Center
[3]University of Oklahoma College of Medicine
[4]Northeast Ohio Medical University

Subject: Emergency Preparedness in EHR Downtime and Healthcare Technology Disruptions

Referred to: MSS Reference Committee
(Alec Calac and Andrew Norton, Co-Chairs)

Whereas, on July 19, 2024, CrowdStrike, a cybersecurity firm, released an update to its Falcon product that caused devices and systems running on Microsoft's Windows operating system to crash and go offline[1]; and

Whereas, Microsoft estimated that the CrowdStrike update affected 8.5 million Windows devices[2]; and

Whereas, the disruption affected networks and devices in healthcare, including electronic health records and computers used for medical purposes, such as in operating rooms, systems to deliver radiotherapy treatments, 911 emergency service, equipment sterilization procedures, radiology software, and routine bloodwork processing[1,3,4]; and

Whereas, the American Hospital Association stated that the Crowdstrike outage resulted in clinical procedure delays and cancellations at affected hospitals and health systems, and implementation of downtime protocols to minimize the extent of disruption to patient care[5]; and

Whereas Mass General Brigham, RWJBarnabas Health, Penn Medicine, and Seattle Children's Hospital canceled all non-urgent surgeries, procedures, and medical visits as a result of the CrowdStrike global IT outage[1,3]; and

Whereas, at Michigan Medicine, 15 to 60% of computers were not working depending on the unit, and at Providence Health, 15,000 of the organization's servers, with restoration of systems estimated to take weeks[1,3]; and

Whereas, U.S.-based Fortune 500 healthcare sector companies lost close to $1.94 billion due to the CrowdStrike outage[6]; and

Whereas, while the impact of the Crowdstrike outage on patient outcomes is still unknown, prior data has shown hospital time-to-electrocardiogram increased by 2.7 minutes and 30-day acute myocardial infarction mortality increased by 0.36 percentage points following a data breach,

indicating particular considerations for effects of technology failures on time-sensitive medical emergencies like myocardial infarction[11]; and

Whereas, previous studies have demonstrated that during electronic medical record downtime, laboratory testing results are delayed by an average of 62% compared to normal operations, which can affect the evaluation of inpatients' statuses [7,8]; and

Whereas, computer failures can lead to patient safety issues like delays in prescribing medications and delayed discharge due to lab testing disruptions[3]; and

Whereas, between 2012 to 2018, over 166 U.S. hospitals experienced 701 days of downtime altogether from 43 events, and almost half of these events were caused by a cyber-attack[9]; and

Whereas, a cyberattack at the University of Vermont Medical Center resulted in a total EMR downtime of 25 days and resulted in a 53.4% decrease in total weekday in room operative time compared to a matched period one year prior[10]; and

Whereas, a survey of hospital emergency managers in the United States indicated that a majority (52.6%) denied mentioning cybersecurity in their Emergency Operations Plans, even though 57.4% ranked cybersecurity as a top priority and 24.5% previously activated an emergency response for a cybersecurity incident[12]; and

Whereas, 46% of downtime reports indicated that downtime procedures were either not followed or not in place, and only 27% of reports indicated downtime procedures were successfully executed[13]; and

Whereas, vital devices such as IV pumps, blood pressure monitors, and ventilators should be on internal networks isolated from the Internet, however, it is not commonplace to regularly test potential computer disruption impact on these devices[3]; and

Whereas, at Michigan Medicine, a strategic priority sequence had been developed which allowed for focusing on which software tools needed to be fixed first out of over 1000 different applications[3]; and

Whereas, the increasing reliance on technology and sheer number of devices, networks, data systems, and software applications in healthcare necessitates developing prioritization strategies to assist hospitals and healthcare practices in emergencies[3]; and

Whereas, diversification of the technology ecosystem such as diverse cloud computing environments and technology systems, staggering upgrades, and improving non-technology-based alternative protocols may improve healthcare system responses to EHR emergencies[3]; therefore be it

RESOLVED, that our American Medical Association support emergency preparedness for unexpected downtime and software disruptions, and support guidelines for how to prevent mass technology outages such as through downtime drills, priority identification protocols, and manual documentation trainings; and be it further

RESOLVED, that our AMA amend Policy D-315.977, "Indemnity for Breaches in Electronic Health Record Cybersecurity," as follows.

Indemnity for Breaches in Electronic Health Record Cybersecurity, D-315.977

Our AMA will advocate for indemnity or other liability protections for physicians whose electronic health record data and other electronic medical systems become the victim of security compromises or unintended technology failures, regardless of intent.

Fiscal Note: TBD

Date Received: 09/15/2024

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RELEVANT AMA POLICY

Ransomware and Electronic Health Records D-478.960

(1) Our American Medical Association acknowledges that healthcare data interruptions are especially harmful due to potential physical harm to patients and calls for prosecution to the fullest extent of the law for perpetrators of ransomware and any other malware on independent physicians and their practices, healthcare organizations, or other medical entities involved in providing direct and indirect care to patients.

(2) Our AMA will:

a. advocate for federal legislation which provides for the prosecution of perpetrators of ransomware and any other malware on any and all healthcare entities, involved in direct and indirect patient care, to the fullest extent of the law;

b. encourage health care facilities and integrated networks that are under threat of ransomware attacks to upgrade their cybersecurity and to back up data in a robust and timely fashion;

c. advocate that the security of protected healthcare information be considered as an integral part of national cybersecurity protection; and
d. seek inclusion of federal cybersecurity resources allocated to physician practices, hospitals, and health care entities sufficient to protect the security of the patients they serve, as part of infrastructure legislation.

[Res. 210, A-21; Reaffirmation: Res. 241, A-24]

Indemnity for Breaches in Electronic Health Record Cybersecurity D-315.977
Our AMA will advocate for indemnity or other liability protections for physicians whose electronic health record data and other electronic medical systems become the victim of security compromises. [Res. 221, I-15]

Electronic Health Records and Meaningful Use D-478.971
Our AMA: …(2) will compile and continue to educate physicians on the available guidance related to different types of EHRs, system downtime, and technology failures, including mitigation strategies, continuity training solutions, and contracting solutions. [BOT Rep. 10, A-16]

RELEVANT MSS POLICY

Improving Cybersecurity in Healthcare Facilities 315.006MSS
AMA-MSS supports the development of new cybersecurity resources for providers that go beyond HIPAA compliance in order to adequately protect patient health information against new cybersecurity threats, such as ransomware, as they emerge. (MSS Res 07, I-16) (Reaffirmed: MSS Res. 101, Nov. 2020)

Enabling a Contiguous, National Electronic Health Record Network 315.003MSS
AMA-MSS (1) supports collaboration with appropriate federal government agencies and industry partners to develop and promote legislative and policy initiatives that require the interoperability of independent healthcare systems such that electronic health records data be entirely transferable; and (2) will ask the AMA to study private and public sector initiatives regarding efforts to establish a nationwide health information network and other relevant interoperability initiatives. (MSS Res 12, A-13) (Reaffirmed: MSS GC Rep A, I-19)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 504
(I-24)

Introduced by: Afareen Jaleel[1], Onajia Stubblefield[2], Isabel Ball[3]

Affiliations: [1]University of Massachusetts School of Medicine
[2]University of Louisville School of Medicine
[3]Tufts University School of Medicine

Subject: Healthcare Provider Data Privacy Protection

Referred to: Reference Committee
(Alec Calac and Andrew Norton, Co-Chairs)

Whereas, the American Medical Association (AMA) is the largest and only national professional organization for physicians across the United States that convenes over 190 state and specialty medical societies and represents physicians with a unified voice in courts and legislative bodies across the nation[1]; 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, 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, 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, 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=13]; 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=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[14=13]; 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=13]; 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 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=16]; and

Whereas, data broker companies profit off of selling information due to lack of industry regulation, and once doxxed, attempts to remove personal information from the internet are costly expenses[10,13=10,17]; 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=16]; 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 who experience doxxing, and support nondiscrimination and privacy protection for employees, and the availability of resources on doxxing; and be it further

RESOLVED, that our AMA support data privacy and anti-doxxing laws to prevent harassment, threats, and non-consensual publishing of information; and be it further

RESOLVED, that our AMA support institutions, employers, and state medical societies in providing legal resources and support to individuals affected by doxxing and prophylactically prevent doxxing through training and education on the issue.

Fiscal Note: TBD

Date Received: 09/15/2024

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RELEVANT AMA POLICY

Supporting Improvements to Patient Data Privacy D-315.968
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.
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]

Addressing Inflammatory and Untruthful Online Ratings D-445.997
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
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.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 507
(I-24)

Introduced by: Kylie Ruprecht[1], Laurie Lapp[1], Angela Hsu[1], Sidra Jabeen[1], and Sara Kazyak[2]

Affiliations: [1]University of Wisconsin School of Medicine and Public Health
[2]Wayne State University School of Medicine

Subject: Advancing Menopause Research and Care

Referred to: MSS Reference Committee
(Alec Calac and Andrew Norton, Co-Chairs)

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 pathways to prevention for 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 advocates for increased funding for biomedical and public health research on perimenopause, menopause, and related chronic conditions; and be it further

RESOLVED, that our AMA supports 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; and be it further

RESOLVED, that our AMA supports efforts to increase awareness and education relating to menopause, mid-life women's health and related care, treatment, and preventative services.

Fiscal Note: TBD

Date Received: 09/15/2024

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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.

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.

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.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 509
(I-24)

Introduced by: Afareen Jaleel[1], Onajia Stubblefield[2], Elise Santacruz[1], Pamela Chan[1]

Affiliations: [1]University of Massachusetts School of Medicine
[2]University of Louisville School of Medicine

Subject: Opposing Unwarranted NIH Research Institute Restructuring

Referred to: MSS Reference Committee
(Alec Calac and Andrew Norton, Co-Chairs)

Whereas, the House Energy and Commerce Committee released an NIH Reform Report in June 2024 recommending the restructuring of the National Institutes of Health (NIH), which would reduce the number of institutes from 27 to 15[1]; and

Whereas, the proposed restructuring would eliminate several key institutes, including the National Heart, Lung, and Blood Institute (NHLBI), National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), National Institute of Allergy and Infectious Diseases (NIAID), National Eye Institute (NEI) and others, which play critical roles in addressing specific medical conditions and public health challenges[1,2,3]; and

Whereas, the proposed new structure introduces institutes with broader, less defined focuses, diminishing the emphasis on research for rare diseases and specialized medical conditions that require targeted scientific inquiry[1]; and

Whereas, the elimination and reorganization of existing institutes may lead to a shift in NIH funding priorities, potentially undermining ongoing research efforts that are essential to advancing the understanding and treatment of a wide range of clinical diseases[1]; and

Whereas, the restructuring eliminates the National Institute on Minority Health and Health Disparities and National Institute of Environmental Health Sciences, which may compromise the ability of the NIH to support research that represents and reflects the diversity of the patient populations and communities served by physicians, thereby risking the progress made in addressing health disparities[1]; and

Whereas, having larger research institutes, as proposed by the consolidation of NIH institutes in the June 2024 report, does not necessarily lead to greater research productivity, and in converse, although the Fogarty International Center (FIC) had the smallest budget among NIH's 27 institutes and centers, FIC grantees have been among the most productive in publishing peer-reviewed manuscripts, publishing over 20 manuscripts per $1 million annual budget compared to 6 manuscripts per $1 million average for 5 top institutes[4]; and

Whereas, the Fogarty International Center (FIC), one of the institutes that would be consolidated under the June 2024 report and that was previously attempted to be removed in 2018, funds more than 500 projects involving about 100 American universities, and plays a role in international collaborations for infectious disease in low- and middle-income countries, a U.S.-Colombian collaboration on early-onset Alzheimer's disease that led to discoveries for the first clinical trial of a U.S. anti-amyloid therapy, and biodiversity projects to identify new therapeutic agents, thus removing this institute may affect these important partnerships[4,5,6]; and

Whereas, public investment in the NIH led to the creation of nearly half a million jobs and produced more than $68 billion in new economic activity across the United States, indicating the direct impact with biotech and pharmaceutical industry economic activity[7]; and

Whereas, reducing the NIH budget allocation results in elimination of research awards which subsequently affects jobs and research productivity[8]; and

Whereas, mechanisms for interdisciplinary research efforts such as the NIH Common Fund programs already exist at the NIH, making such institution consolidation unnecessary to these efforts[9]; and

Whereas, up to 47% of drugs approved by the Food and Drug Administration between 1988 and 2005 benefitted from public sector support, including pivotal discoveries improving patient care[10]; and

Whereas, maintaining the current NIH structure is crucial to preserving the breadth and depth of medical research that drives innovation and improves health outcomes across diverse populations and disease areas[1]; therefore be it

RESOLVED, that our American Medical Association oppose efforts to decrease NIH funding overall or restructure the NIH without direct supporting input from the physician and scientific communities, particularly researchers and academics.

Fiscal Note: TBD

Date Received: 09/15/2024

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RELEVANT AMA POLICY

Viability of Clinical Research Coverages and Reimbursement H-460.965
Our AMA…(9) believes that funding of biomedical research by the federal government should reflect the present opportunities and the proven benefits of such research to the health and economic well being of the American people.
[CSA Rep. F, I-89 Reaffirmed: Joint CMS/CSA Rep., I-92 Reaffirmed: BOT Rep.40, I-93 Reaffirmed: CSA Rep. 13, I-99 Reaffirmation A-00 Reaffirmed: CMS Rep. 4, A-02 Reaffirmed: CMS Rep. 4, A-12 BOT Action in response to referred for decision: Res. 813, I-15 BOT Action in response to referred for decision: Res. 823, I-15 Reaffirmation: I-18 Modified: Res. 226, A-22]

Support for Careers in Research H-460.994
Our AMA: (1) supports joining with other public and private bodies in encouraging multiple approaches at local, state and national levels in support of the development of physician-investigators, and specifically encourages research and training grants without a pay-back provision; (2) encourages the several specialty boards through the Interspecialty Advisory Board to allow one or more years of clinical investigative training, as long as it has some relevance to that specialty, in lieu of a year of post-doctoral clinical experience, where appropriate; and (3) encourages the NIH to increase the stipends for NIH research traineeships and fellowships without reducing the actual number of available positions. [CSA Rep. G, A-80 Reaffirmed: CLRPD Rep. B, I-90 Reaffirmed: Sunset Report, I-00 Reaffirmation A-09 Reaffirmed: CSAPH Rep. 01, A-19]

Support for NIH Research Facilities H-460.975

1. Our American Medical Association urges the enactment of federal legislation which would grant to the National Institutes of Health (NIH) funding authority to expand, remodel, and renovate existing biomedical research facilities and to construct new research facilities.
2. Our AMA urges that the authority be granted to the NIH Director and not fragmented at the categorical institute level.
3. Our AMA urges that institutions be required to match federal funding for this program in a systematic way.

[BOT Rep. S, I-88 Reaffirmed: Sunset Report, I-98 Reaffirmation A-00 Reaffirmed: BOT Rep. 6, A-10 Reaffirmed: BOT Rep. 7, A-21]

RELEVANT MSS POLICY

Preserving the Role of Physicians and Patients in the Evolution of Health Information Technology 480.012MSS
AMA-MSS supports increasing the number of funded positions at all levels of graduate, medical, and allied health professional training in medical informatics to a level commensurate with current Health Information Technology (HIT) spending through mechanisms including, but not limited to, student research positions funded by National Institutes of Health (NIH) T and F programs. (MSS Res 14, I-12) (Reaffirmed: MSS GC Report A, I-17) (Reaffirmed: MSS GC Report A, A-23)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 601
(I-24)

Introduced by: Laurie Lapp[1] and Raj Reddy[2]

Affiliations: [1]University of Wisconsin School of Medicine and Public Health
[2]Baylor College of Medicine

Subject: MSS Caucus Endorsements

Referred to: MSS Reference Committee
(Alec Calac and Andrew Norton, Co-Chairs)

Whereas, after years of uncertainty over whether the MSS Caucus could endorse candidates for elections in the House of Delegates (HOD), at A-24 the MSS Caucus revisited the discussion of candidate endorsements and ultimately decided to seek the explicit approval of the MSS Assembly on specific endorsement guidelines prior to making endorsements; and

Whereas, the MSS Caucus comprises an influential group of ~30 votes in the HOD, about 4% of all votes, and election margins are frequently around this number or less; and

Whereas, many HOD delegations make candidate endorsements, including several AMA Sections (APS, IMGS, MAS, RFS, WPS, and YPS), with widely varying processes utilized by each of the Sections; and

Whereas, the MSS Caucus, as a politically astute body in HOD, is well equipped to thoughtfully consider strategic rationales with the appropriate nuance when deciding possible Caucus endorsements and their ultimate individual votes; and

Whereas, endorsements are highly sought after and may sway voters who don't want to bet on a losing candidate or who wish to align with another delegation; and

Whereas, several HOD leaders who are frequently involved in campaigns and are influential in elections have expressed that an MSS Caucus endorsement would be a significant and desirable endorsement for many candidates"; and

Whereas, offering candidate endorsements may build camaraderie with candidates who we want to support and succeed; and

Whereas, with winning candidates often running for re-election, the potential to not grant a re-endorsement gives the MSS Caucus the opportunity to critically evaluate whether incumbents have adequately aligned with and elevated MSS interests during their previous term when deciding whether to reissue an endorsement; and

Whereas, currently in the absence of an MSS endorsement, many in the HOD misinterpret the Young Physician Section endorsements (determined solely by their Governing Council) as also delivered on behalf of the Resident & Fellow Section (RFS) and MSS, even though these endorsements may not necessarily align with the preferred candidates of many MSS Caucus members; and

Whereas, concerns have been raised over whether an MSS endorsement may actually be politically demeaning to a candidate, however, this is rectified by offering candidates the opportunity to seek the MSS endorsement if they so choose, recognizing that they would then accept any possible advantage or disadvantage such an endorsement would confer; and

Whereas, concerns have been raised that endorsement of one candidate over another would lose favor with the candidate who did not receive the endorsement (and by extension their delegation), however, the many other delegations that make endorsements also take on this same risk; and

Whereas, currently, candidates who either win or lose elections cannot confirm whether they were generally supported by MSS Caucus members or not, leading to uncertainty in whether candidates are likely to elevate our interests if they win or potentially believe that the MSS Caucus is the reason why they lost, indicating that the MSS Caucus already and inevitably accepts significant political risk at status quo, even without issuing endorsements; and

Whereas, MSS IOP 9.2.5 provides precedent for using a higher threshold for MSS Caucus votes that cannot be easily justified based on MSS positions, stating, “When an item of business is before the AMA HOD that is of significant importance to the MSS, but for which no MSS policy exists, any member of the MSS Caucus may move that the MSS take a position on the item. Such a motion requires a second by another Caucus member and a two-thirds (⅔) majority vote of a quorum of the MSS Caucus to pass,”[1]; and

Whereas, MSS Position 645.033MSS, “Additional Caucus Operations,” also uses a ⅔ vote threshold for the MSS Caucus to cosponsor a resolution in HOD; and

Whereas, use of a ⅔ vote indicates that a supermajority of the Caucus quorum feels strongly enough about a decision to move forward; and

Whereas, if the Caucus does decide to offer endorsements, equal consideration of candidates is critical to prevent any potential perception of bias on the part of the Caucus if they were to only selectively offer the opportunity for endorsement; therefore be it

RESOLVED, that our AMA-MSS amend MSS Position 645.033MSS, “Additional MSS Caucus Operations” be amended by addition as follows by the MSS Governing Council and Assembly:

1. The MSS Section Delegates have the ability to nominate existing policies in the MSS Digest of Actions to the queue to be transmitted to a future HOD meeting, based on strategic considerations. These nominations must be approved by a majority vote of the MSS Caucus.

2. The MSS Caucus can co-sponsor resolutions in the name of the MSS with another HOD delegation.
    a. Co-sponsoring a resolution authored by another delegation must be approved by a ⅔ vote of the MSS Caucus.
    b. The MSS Section Delegates have the authority to add other delegations as co-sponsors of MSS-authored resolutions.

3. The MSS Caucus can decide by a ⅔ vote in any given election cycle whether it wants to offer the opportunity to seek an MSS endorsement to candidates for elections in the AMA House of Delegates, and this vote shall apply to all candidates in all elections for that cycle. Once a candidate for an election in the AMA House of Delegates confirms they are seeking an MSS endorsement, the MSS Caucus can endorse that candidate by a ⅔ vote. The MSS Caucus may also withdraw an endorsement of a candidate by a ⅔ vote.

Fiscal Note: TBD

Date Received: 09/15/2024

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RELEVANT MSS POLICY

645.033MSS, "Additional MSS Caucus Operations" The MSS Section Delegates have the ability to nominate existing policies in the MSS Digest of Actions to the queue to be transmitted to a future HOD meeting, based on strategic considerations. These nominations must be approved by a majority vote of the MSS Caucus.

1. The MSS Caucus can co-sponsor resolutions in the name of the MSS with another HOD delegation.
    a. Co-sponsoring a resolution authored by another delegation must be approved by a ⅔ vote of the MSS Caucus.
    b. The MSS Section Delegates have the authority to add other delegations as co-sponsors of MSS-authored resolutions

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 602
(I-24)

Introduced by: Rajadhar Reddy[1]; Bolatito Adeyeri[1]; Neha Patel[2]

Affiliations: [1] Baylor College of Medicine - Houston
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Subject: MSS Study of Assembly Representation

Referred to: MSS Reference Committee
(Alec Calac and Andrew Norton, Co-Chairs)

Whereas, in the MSS Assembly, each “separate campus” of a medical school, also known as an “associated administrative campus” or a “satellite campus,” is granted an voting delegate and alternate delegate in addition to the voting delegate and alternate delegate representing the “central campus”[1]; and

Whereas, per AMA Bylaw 7.3.3.2, last amended at HOD A-08, a “separate campus is defined as an administrative campus separate from the central campus where a minimum of 20 members of the medical student body are assigned for some portion of their instruction over a period of time not less than an academic year”;[1] and

Whereas, due to the increase in new medical schools, schools often do not have adequate clinical locations for their students in the vicinity of their central campus and technically establish “separate campuses” for a small group of students only for clinical rotations; and

Whereas, each subset of 20 students at a clinical site is allotted their own delegate and alternate delegate in the MSS Assembly, even though they are only separated from their central campus, student body, and AMA MSS chapter for their clinical rotations for 1 year; and

Whereas, while well-intentioned, Bylaw 7.3.3.2 does not reflect the current landscape of new medical schools and results in inequitable representation for medical schools in the MSS; and

Whereas, for example, a medical school with 200 students per class year all housed at the same central campus has 1 MSS Assembly delegate and 1 alternate delegate, but a school with 200 students per class year, who are together for preclinical and only divided for clinical rotations across 5 sites, is allotted 5 delegates and 5 alternate delegates; and

Whereas, this senatorial structure inadvertently results in over-representation of some medical schools in the MSS Assembly, disproportionately weighting their votes on important resolutions before the MSS and in MSS elections; and

Whereas, because satellite campuses are currently included in quorum calculations, the bylaw also affects the MSS Assembly's ability to meet quorum, due to difficulty identifying delegates from satellite campuses with very small populations of students on their clinical rotations (which also reduces their availability); and

Whereas, quorum places pressure on schools where a single student body is split across satellite campuses for clinical rotations to identify and fund additional delegates; and

Whereas, some medical schools do have separate campuses that serve a separate long-term student body, who receives a medical education experience over the course of multiple years distinct from that of the central campus student body, such as Baylor College of Medicine's 4-year regional satellite campus in Temple, TX; and

Whereas, students at Baylor Temple are geographically separate from students at Baylor Houston for 4 years, similar to the situation at independently accredited 4-year medical schools that administratively exist under the same university system, such as tUniversity of Texas at Austin Dell Medical School and University of Texas Rio Grande Valley School of Medicine; and

Whereas, Baylor Temple enrolls 40 students per class year, similar to the 50 students per class year enrolled at UT Austin and UTRGV; and

Whereas, as an alternative to disproportionately over-representing satellite campuses, the MSS could instead proportionately increase the number of delegates and alternate delegates at large medical to more democratically represent large student bodies; and

Whereas, currently medical schools with student bodies greater than 999 (excluding students from satellite campuses) are granted an additional delegate and alternate delegate, which applies to around 10 MD schools; and

Whereas, the 50th percentile MD school size is 614 (mean 623), so half of MD schools are larger and half are smaller, and the 75th percentile is 782;[2] and

Whereas, a cutoff for granting an additional delegate and alternate delegate at 799 instead of 999 would approximate the 75th percentile of MD school size, a reasonable standard that would still only apply to particularly large medical schools; and

Whereas, reducing the cutoff to 799 more proportionately and democratically represents large student bodies than satellite campus representation;[2] and

Whereas, data on DO school sizes also needs to be factored into these considerations, and an MSS study could explore various options in greater detail; therefore be it

RESOLVED, that our AMA-MSS study possible approaches to amend AMA Bylaws regarding delegate representation in the MSS Assembly to:

a) change the definition of satellite campuses to address disproportionate overrepresentation of some medical schools; and
b) adjust the threshold at which a medical school is granted more than 1 voting delegate and 1 alternate delegate.

Fiscal Note: TBD

Date Received: 09/15/2024

REFERENCES

1. Proceedings of the American Medical Association House of Delegates, 157th Annual Meeting, June 14-17, 2008 (p227). AMA. https://ama.nmtvault.com/jsp/PsImageViewer.jsp?doc_id=1ee24daa-2768-4bff-b792-e4859988fe94%2Fama_arch%2FHOD00005%2F00000010
2. Association of American Medical Colleges. Total Enrollment by U.S. MD-Granting Medical School and Gender, 2019-2020 through 2023-2024. November 26, 2023. https://www.aamc.org/media/6101/download

RELEVANT AMA POLICY

7.3.3.1 Representatives.
The AMA medical student members of each educational program as defined in Bylaw 1.1.1 may select one representative and one alternate representative. An educational program as defined in Bylaw 1.1.1 that has a total student population (excluding students at associated administrative satellite campuses) greater than 999 may select one additional representative and one additional alternate representative.

7.3.3.2 Medical School Separate Campus.
The AMA medical student members of an educational program as defined in Bylaw 1.1.1 that has more than one campus may select a representative and an alternate representative from each campus. A separate campus is defined as an administrative campus separate from the central campus where a minimum of 20 members of the medical student body are assigned for some portion of their instruction over a period of time not less than an academic year. The Governing Council shall establish appropriate rules, subject to approval of the Board of Trustees, for credentialing all representatives.

REPORT OF THE MEDICAL STUDENT SECTION
COMMITTEE ON ECONOMICS AND QUALITY IN MEDICINE

MSS CEQM Report
(I-24)

Introduced by: MSS Committee on Economics and Quality in Medicine

Subject: MSS Position on Alternative Payment Models

Referred to: MSS Reference Committee

(Alec Calac and Andrew Norton, Co-Chairs)

INTRODUCTION

At the Interim 2022 (I-22) MSS Assembly the MSS asked CEQM to study the potential impact on APM's (Alternative Payment Models) and the ramifications of APM utilization on healthcare delivery. The Reference Committee specifically asked that this report include APMs (Alternative Payment Models) as a whole, and not only address Direct Contracting Entities, which is already being studied by AMA CMS.

The original resolution Res 010 "Against Direct Contracting Entities" submitted for the I-22 meeting resolved:

RESOLVED, That our AMA oppose any attempts to implement Direct Contracting Entities, such as Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) program, and their relationship with Medicare; and be it further

RESOLVED, That our AMA develop educational materials for physicians regarding Direct Contracting Entities, such as Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) program so that they are aware of the implications of their individual or their employer's participation in this program; and be it further

RESOLVED, That this resolution be immediately forwarded to the AMA House of Delegates.

Adopted as amended with title change, "Monitoring of Alternative Payment Models within Traditional Medicare":

RESOLVED, That our AMA monitor the Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) program for its impacts on patients and physicians in Traditional Medicare, including the quality and cost of healthcare and patient/provider choice, and report back to the House of Delegates on the impact of the ACO REACH demonstration program annually until its conclusion; and be it further

RESOLVED, That our AMA advocate against any Medicare demonstration project that denies or limits coverage or benefits that beneficiaries would otherwise receive in Traditional Medicare; and be it further

RESOLVED, That our AMA develop educational materials for physicians regarding the Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) program to help physicians understand the implications of their or their employer's participation in this program and to help physicians determine whether participation in the program is in the best interests of themselves and their patients; and be it further

RESOLVED, That our AMA-MSS study alternative payment models in Medicare to identify principles to guide the MSS when considering Medicare demonstration projects or their expansion, including but not limited to assessments of the demonstration program's impact on quality, cost, patient/provider choice, and transparency; and be it further

RESOLVED, That this resolution be immediately forwarded to the AMA House of Delegates.

This report is the direct result of clause 4 of the amended resolution above.
Furthermore, the resolution was directly forwarded as noted in resolved clause 5 above.
Resolved clauses1-3 were referred for report back at I-23 by the House of Delegates.

Your Governing Council assigned this report to the Committee for Economics and Quality in Medicine with the following possible questions for consideration:

1. What is the most common payment model utilized by healthcare systems, and how does it work?

2. What are alternative payment models, and how do they influence the delivery of healthcare in America?

3. What are some of the unique benefits and drawbacks of the most prominent alternative payment models?

4. What are some of the major challenges and considerations during the integration of alternative payment models into healthcare systems?

In the following clauses and subsequent discussion, we provide an overview of the traditional fee-for-service model, alternative payment models, and the differences in structure between the two concepts. We also lay the framework for the potential impact of these payment models and their ensuing ramifications.

WHEREAS CLAUSES (EVIDENCE & RATIONALE)

Whereas, it is resolved that our AMA-MSS study alternative payment models in Medicare to identify principles to guide the MSS when considering Medicare demonstration projects or their expansion, including but not limited to assessments of the demonstration program's impact on quality, cost, patient/provider choice, and transparency

Whereas, in a FFS (fee for service) model, doctors and other healthcare professionals are paid for each individual service performed, such as office visits, laboratory tests, and imaging.[1]

Whereas, there is evidence to suggest that FFS reimbursement incentivizes the provision of high-volume, low-value healthcare services, compromising quality of care, exacerbating health inequities, and driving outsized national health expenditures.[3,17]

Whereas, value-based care models, also known as "alternative payment models" (APMs), attempt to incentivize providers to provide more cost-effective care through payment schemes which move away from narrow, service-based payments and towards models that explicitly or implicitly link payment to measures of quality or cost.[3]

Whereas, there are three broadly discussed "classes" of APMs commonly defined in the medical literature and which have been deployed in a widespread fashion: episode-based payments (bundled payments), ACOs (also known as "population based payments"), and full capitation; examples of widely deployed models in these classes include the Medicare Shared Savings Program (MSSP), the Pioneer ACO model, the Comprehensive Care for Joint Replacement (CJR) model, the Bundled Payments for Care Improvement (BPCI) model, and many others.

Whereas, APMs have now become a staple of the U.S. healthcare system, with over 15 million Medicare lives covered by an APM as of 2021. [52]

Whereas, tested ACO models have typically shown modest net savings of ~1% with no observable reduction in quality, though concerns about study design and literature interpretation remain.[4]

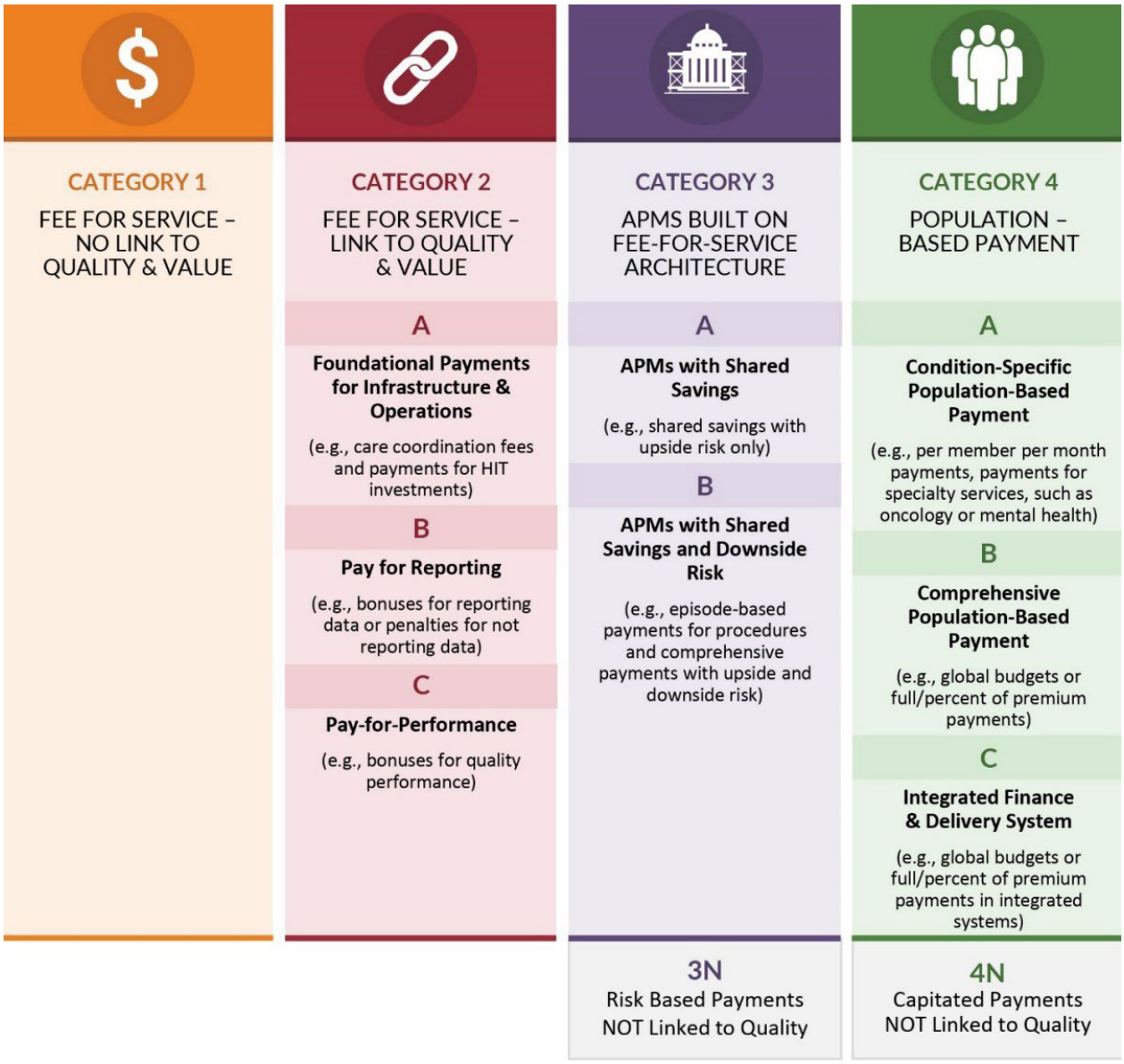
Whereas, key methodological issues in interpreting ACO savings includes the choice of benchmark spending rates and the nature of participation in the project (randomized & mandatory participation as compared to non-randomized and non-mandatory).

Whereas, tested bundled payments models were also associated with modest net decreases in spending with no significant changes to quality.[29]

Whereas, since all APMs require providers to bear some degree of financial risk, a universal design question for APMs is the choice of risk adjustment methodologies to account for influences on patient outcomes outside of the providers' control.[16]

Whereas, evidence suggests current risk adjustment methods may not be sufficiently sophisticated to reliably distinguish poor quality care or cost inefficiencies from high medical and/or social risk, and thus further improvement to risk adjustment methodologies is necessary.[15,16]

FURTHER DISCUSSION



Source: **https://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf**

Glossary

Fee for Service (FFS): a method in which doctors and other health care providers are paid for each service performed, and where services are defined narrowly
Alternative Payment Models (APMs): payment models that are designed to reward health care providers and systems for delivering high quality and/or coordinated care

Capitation: a payment method through which a provider is paid a set amount for each enrolled patient for a set period of time, regardless of the care those patients seek
MIPS: merit based incentive payment system; a specific form of APM
ACOs: accountable care organizations; a specific form of APM
MSSPs: medicare shared savings program; a specific form of APM
Prospective EPMs: a bundled payment distributed prior to provision of services
Retrospective EPMs: a bundled payments distributed following the provision of services
AAPM: advanced alternative payment model; APM models that include quality measures comparable to MIPS, EHR requirements, and increased provider financial risk
Population Based APMs: alternative payment models designed to compensate healthcare organizations based on the anticipated number of patients they serve
Episode Based APMs: alternative payment models designed to compensate healthcare organizations based on a defined "episode of care"
Episode triggers: A defined medical event (generally a diagnosis or procedure) that causes the disbursement of a payment, especially in episode based APMs
BPCI: bundled payments for care improvement, a type of episode based payment

Introduction

In a fee-for -service (FFS) model, doctors and other healthcare professionals are paid for each individual service performed, such as office visits, laboratory tests, and imaging.[17] Modern FFS reimbursement in the U.S. traces its roots to the creation of Blue Cross Blue Shield insurance in the 1930s, and was firmly entrenched as the primary mode of healthcare payment in 1965 with the establishment of Medicare and Medicaid. The FFS model has attracted significant criticism throughout the intervening decades. A range of policy experts have argued that FFS reimbursement incentivizes low-value healthcare services, compromises quality of care, exacerbates health inequities, and drives outsized national health spending. Notably, the U.S.'s long-time reliance on FFS payment is viewed by many as a significant factor contributing to the U.S. poor performance on metrics of health system efficiency and health outcomes. The U.S. far outspends other countries in terms of total yearly healthcare expenditures and per capita: according to CMS National Health Expenditure data, the U.S. spent $4.5 trillion (17.3% of the country's GDP) and $13,493 per person on health spending in 2022, far outpacing other country's spending.[18,19] Despite this high level of spending, the U.S. has a lower life expectancy when looking at comparative nations (77.5 years in the U.S. compared to 82 years for a comparable nation average).[18,19] Additionally, compared to other countries, the U.S. has worse maternal health outcomes (especially for women of color), fewer practicing physicians per person, and a higher reported number of patients skipping appointments due to cost according to the same KFF report.[19] Experts often condemn the stark differences in access to care in the US healthcare system by socioeconomic status under the FFS model.[20.]

Growing recognition of high costs and inefficiencies in the U.S. healthcare system has prompted a gradual shift away from FFS payment and toward a range of alternative payment models (APMs) that aim to deliver "Value Based Care". APMs, which can apply to specific clinical conditions, care episodes, or populations, are a catch-all term which broadly refers to payment approaches that are intended to promote high-quality and cost-efficient care by moving away from a FFS-model of payment and directly linking provider compensation to the quality and cost of care they deliver. In this sense, in APMs, providers accept risk and are held accountable for the outcomes - be it quality or cost based outcomes - that the patients assigned to them experience. The spectrum of APMs includes alternative payment models such as bundled payments, population-based payments, and capitation. Capitation and 'bundled payments' were two specific APMs that were some of the earliest models to emerge. Introduced in the 1980s, under capitation payment models, healthcare providers receive a predictable, upfront, set amount of money to cover the predicted cost of all or some of the health care services for a specific patient over a certain period of time. Bundled payments, on the

other hand, consist of single, overall payments to cover all predetermined allowable costs for discrete episodes of care. The first use of what could be considered bundled payments began with the creation of Diagnosis Related Groups (DRGs) for the Medicare program in the 1980s, which covered discrete episodes of care in discrete settings (e.g., inpatient care for a specific diagnosis). Since then, bundled payment models have expanded to encompass discrete episodes of care that span sites (e.g., inpatient and rehabilitation). The U.S. healthcare system's payment reform efforts were accelerated by the passage of the 2010 Affordable Care Act (ACA). The ACA established the Center for Medicare and Medicaid Innovation (CMMI), which was charged with testing APMs intended to improve quality while reducing costs within Medicare and Medicaid. Various types of APMs, including Merit Based Incentive Payment System (MIPS) APMs, Advanced APMs, and All-Payer/Other Payer APMs, have been designed, implemented, and tested by CMMI since its inception. The ACA also established the Medicare Shared Savings Program (MSSP), a national program centered on Accountable Care Organizations (ACOs), which are groups of healthcare providers and suppliers that assume financial responsibility for the quality, cost, and experience of care of an assigned Medicare FFS beneficiary population. While still partially built on a "chassis" FFS system of reimbursement, ACOs also generally receive prospective payments and aim to control costs and improve care quality: in this model, group participants are financially rewarded when specified quality metrics are met and costs are maintained below a preset benchmark and/or penalized when expenditures exceed said benchmark.

This discussion section will aim to accomplish three goals. First, it will review the two most common forms of APMs that have been used in the U.S. healthcare system: ACOs and bundled payment models. We will review the basic concepts these payment models use, discuss variants of the model that can exist, and discuss the results that have been seen with the use of these models. Additionally, we will discuss two issues in the design of alternative payment models that are applicable to all future APM programs.

Accountable Care Organizations (ACOs)

An accountable care organization (ACO) is a specific type of alternative payment model in which a group of providers voluntarily agree as a group to assume some degree of risk for the total spending of a group of patients that is attributed to the providers. While the details of specific ACOs vary greatly, in nearly all cases, the ACO's physicians are rewarded if the total costs of care for their attributed patients fall underneath a benchmark for total spending, thus sharing in the savings they generate, conditional on the groups' ability to meet quality standards. ACOs are an important APM to analyze because to-date, they remain the most widely deployed APM in the U.S. healthcare system.

However, the details of these models vary greatly depending on the specific model being considered. In general, there are several design elements in which an ACO may differ. First, the degree of risk-sharing. Some ACOs use a one-sided risk model, where providers share in savings but are not liable for losses. Others use a two-sided risk model, where providers share in both savings and potential financial losses if they exceed spending benchmarks.[25,26] Second, ACOs differ in their mechanism of patient attribution. Attribution can be prospective, where patients are assigned at the start of the performance year, or retrospective, where patients are assigned based on their care utilization at the end of the performance year. Third, ACOs often differ based on their leadership structure. Hospital-led ACOs are typically structured around a hospital or hospital system, while PCP-led ACOs, center on primary care practices, emphasizing preventive care, population health management, and outpatient services.[25,26] There are innumerable other differences in areas such as how spending benchmarks are set, the quality metrics used, etc.

To orient the reader to the proliferation of ACOs, we begin with a brief history of the various ACO models which have been deployed since the passage of the Affordable Care Act in 2010. The history

of major ACO models began in 2012 with the launch of the Medicare Shared Savings Program (MSSP), the first and most widespread ACO model. MSSP was designed to incentivize providers to lower healthcare costs while improving quality, offering both one-sided and two-sided risk options for ACOs, making it accessible for organizations with varying levels of risk tolerance. In contrast, the Pioneer ACO Model, introduced the same year, targeted more experienced organizations by requiring them to take on higher financial risk in exchange for potentially greater rewards. In 2016, the Next Generation (NetGen) ACO Model emerged, building on the lessons from the Pioneer program and offering greater flexibility. NetGen allowed for a broader range of risk-sharing arrangements, including capitation, and provided more tools for managing care, such as telemedicine and expanded care coordination services. The proliferation of ACOs in Medicare has been brisk. In 2012, the first year the MSSP program operated, 220 ACOs participated in the program, covering 1.1 million lives. That number has grown, and as of 2021, of the estimated 58 million Medicare beneficiaries, over 13 million were attributed to an ACO and CMMI has a stated goal of increasing the number to 28 million by 2030. More recently, at the conclusion of the NextGen model in 2021, CMMI has begun to implement two new ACO models the Global and Professional Direct Contracting (GPDC) model, and the Accountability Care Organizations Realizing Equity, Access, and Community Health (ACO REACH) Model.[27] The latter model was a modified ACO model which attempts to directly focus on extending ACOs to underserved populations. Please see the specific section on the GPDC and the ACO REACH models.

Despite the brisk pace of ACO diffusion, evidence that ACOs have caused net savings has been controversial and elusive in part due to concerns regarding the proper methodology to measure savings. Therefore, we analyze the historical performance of ACOs in two parts. We first analyze the stated performance of ACOs, taking the analysis in these reviews as given. We then will discuss the methodological issues in analyzing savings that have resulted in significant controversy.

Reports on the spending performance of ACO typically originate in two groups of literature. First, CMS provides internal estimates of the savings attributable to ACOs. Second, independent researchers attempt to validate CMS reports of savings. Overall, many of the studies in the second category have found that ACOs have reduced spending, albeit modestly. For example, when studying the MSSP program from 2014-2017, several groups found that ACOs resulted in savings for Medicare that grew over the study period. This finding has been replicated by at least 5 major research groups, though the magnitude of spending varies from ~<$100-$350 per patient per year which in total accounted for ~$200 million in savings (equivalent to for <1-2% of total Medicare spending).[42-48] CMS's own internal estimates have varied, sometimes understating and sometimes overstating ACO progress. Consensus estimates suggest that early CMS estimates of savings in the 2012-2017 period understated net savings, but that more recent estimates have overestimated savings due to methodological concerns. However, even if analyzed with a positive interpretation, savings induced by ACOs have been modest, a very small fraction of the ~$700 billion that is spent annually by Medicare. Similar findings have been reported for other ACO models, including the Pioneer ACO, NextGen models. For example, in each case, these modest savings are driven by activities that are consistent with the theory that ACOs reduce wasteful utilization, for example, through reduction in post-acute care. Additionally, an interesting consistent finding that has emerged from this literature notes that physician-group ACOs, as opposed to hospital-led ACOs, have been significantly more effective in lowering utilization, which reflects their more clearly aligned incentives to avoid high-cost hospital care.[39]

Perhaps the most important methodological issue in determining the effect of ACOs on spending has been the role of benchmarks. As noted previously, CMS sets benchmarks for an ACO spending, usually based on historical projections, and then compares the ACO's *actual* spending to that benchmark. In fact, the differences between benchmark spending and actual spending are referred to by CMS as "savings" in public disclosures. However, researchers note that the true comparison is a counterfactual in which one compares the cost of care an ACO would have produced without the

ACO in place, and that CMS's benchmarks do not form valid counterfactuals. Another key methodological issue is the role of selection effects. ACO programs are voluntary to enter, and to exit, and therefore it is difficult to disentangle whether reported savings represent true improvements in care efficiency or whether they represent the effects of selection. At least one group of researchers has argued that the "savings" from ACOs mostly represent the exit of poor performers from the ACO program, meaning that ACOs have not actually reduced costs but in reality high-cost providers selectively exiting the program artificially create the appearance of ACOs achieving savings.[49] However, this belief is not universally shared.[50] However, this challenge also reflects the lack of truly experimental or quasi-experimental evidence on the efficacy of ACOs.

A secondary concern raised about all types of APMs is their effect on health equity concerns. Specifically, there have been concerns that population-based APMs could exacerbate disparities facing low-income individuals and racial minorities by encouraging provider selection (e.g., providers choosing to avoid ACO participation altogether to avoid high-risk or costly patients) or patient selection (e.g., upon participation, providers selecting or cherry-picking which patients to care for or focus on under ACOs).[33] This concern has some support in the literature, as at least one cross-sectional analyses demonstrated that ACOs are less likely to form in higher-poverty areas with more racial minorities and poorly educated individuals, as compared with more affluent areas with fewer of these individuals, and that the characteristics of groups needed to form ACOs, particularly group size, were correlated with no improvement in racial disparities.[33, 34] However, differing evidence exists as well, with some studies demonstrating that private-market ACOs (specifically, the Alternative Quality Contract used by BCBS) caused greater improvement in quality in lower-income areas.[51] It is also important to note that while ACOs may have mixed effects on disparities to date, CMMI has explicitly leveraged the experience of early ACOs to increase emphasis on ACO formation in areas which have been underserved. Therefore, the ACO model is flexible enough to be changed moving forward, while, as noted previously, FFS systems also provide poor incentives for health equity.

The ACO-REACH and GPDC Programs

For interested readers, we provide some details about the ACO-REACH and GPDC programs, which were the initial subject of resolution motivating this report. As noted previously, at the conclusion period of the NextGen ACO model in 2021, CMMI has begun to implement two new ACO models: the Global and Professional Direct Contracting (GPDC) Model and the Accountability Care Organizations Realizing Equity, Access, and Community Health (ACO REACH) Model.[27]

The GPDC model was proposed in order to address a concern that emerged in previous ACO models related to selection effects and risk adjustment. Specifically, ACO benchmarks are calculated relative to risk of their patient cohort. If an ACO has patients that are more likely to require care, whether that be due to their existing health conditions or various demographic factors, they are considered higher risk.[22] For accepting this risk, ACOs are compensated with higher reimbursements. The adjustment of reimbursement based on risk presents a perverse incentive: if patients look sicker but are in fact healthy, an organization can attain outsized financial gain. To avoid this conflict, the prior proposal of Global and Professional Direct Contracting (GPDC) was to cap risk score growth at 3%. However, while well-intentioned, this model then received criticism due to the risk that ACOs would then be incentivized to not take on sicker patients, as their risk score could only rise 3% regardless of how much riskier their patient cohort becomes.[25] To address concerns of ACOs only treating healthier patients to achieve better outcomes, the new ACO model, Accountability Care Organizations Realizing Equity, Access, and Community Health (ACO REACH), incorporated a revision to the risk score growth cap.[22] Instead of a simple 3% cap on risk score growth, if the demographic risk score for an ACO rises above 3%, the risk score may also risk above 3%, in proportion to the change seen in the demographic

score. This ensures that ACO REACH organizations are properly incentivized to serve a broad patient cohort of various demographics.[28]

In addition to these changes, there were additional changes made to the nature of risk sharing and payments in these models. Within ACO REACH, organizations now have several options to customize their payment calculations. First, organizations can choose between two risk arrangements. The "Global Option" is a full risk choice where 100% of the shared savings and shared losses belong to the participating organization. The "Professional Option" is a lower risk option with only 50% of shared savings and shared losses belonging to the organization. This is slightly different compared to Next Generation ACOs where the risk options were 80% or 100% of shared savings and losses.[38] Additionally, organizations are able to choose between three options for their capitation payments. Total Care Capitation (TCC) is available to Global Option ACOs and is expected to cover the total cost for Part A and B Medicare services from participant providers. Primary Care Capitation (PCC) is available to both risk agreements and offers capitation for any estimated primary care services. Capitation payments under PCC are generally set at 7% of the total expected care costs for the organizations' members. For any ACOs which chooses PCC, the Advanced Payment Option (APO) is available to offer advanced payment for fee-for-service non-primary care services.[38]

Data on the performance of these programs is not available at this time, given their recency.

Bundled Payment Models

Bundled payment models, also known as episode payment (EPMs), pay providers a lump sum for distinct episodes of care. While in original models, including the Diagnosis Related Group (DRG) implemented by Medicare in 1982, payments were fixed for a specific diagnosis in a specific site of care (e.g., would only cover inpatient costs for a specific diagnosis), newer models cover a broader swathe of sites and time, e.g., all acute and post-acute care for a condition or medical event during a fixed period of time. Some common episodes of care that have been studied include joint replacement or labor and delivery. These types of episodes may involve stakeholders such as hospitals, physicians, nursing facilities, physical therapists, and pharmacies. Other episodes of care involved in bundled payments include myocardial infarction, urinary tract infections, congestive heart failure, stroke, and sepsis.

There are two versions of EPMs: retrospective and prospective. In retrospective models, if cumulative costs exceed the cost limit, payments to providers are reduced. If cumulative costs are less than the cost limit, the providers share in the savings. In prospective models, payers set cost limits for each episode based on historical data and then distribute payments to providers upfront.[29,30]

CMS tested bundled payments with the Acute Care Episode (ACE) Demonstration from 2009 to 2012, covering cardiac and orthopedic inpatient surgical services and procedures. The ACE Demonstration yielded some cost saving for post-acute care payments without compromising quality, so CMS continued to test bundled payments. Following the passage of the Affordable Care Act, CMS piloted the Bundled Payments for Care Improvement (BPCI) Initiative from 2013 to 2017. This was a voluntary program that covered clinical episodes and tested four models covering the acute and/or post-acute period with retrospective or prospective EPMs. Although BPCI was not associated with short-term changes in Medicare payments for episodes except for lower extremity joint replacements, it was associated with modest longer-term savings for medical episodes.[29,31]

Given the savings for lower extremity joint replacements, CMS launched the Comprehensive Care for Joint Replacement (CJR) model in 2016, which covers the acute and post-acute periods of hip and knee replacements with retrospective payments. Unlike BPCI, CJR mandated hospital

participation in randomly assigned urban markets. In 2018, CMS launched BPCI Advanced (BPCI-A), which is a voluntary program that covers inpatient and outpatient episodes of care. Unlike BPCI, cost targets account for hospital and patient characteristics, historical hospital costs, and regional costs. Additionally, there are fewer conditions to choose from and quality measures are integrated into the program to adjust reconciliation payments. CJR and BPCI-A are ongoing programs expected to end in 2024 and 2025, respectively.[29]
Bundled payments are intended to incentivize integrated care along a continuum and across providers and sites, while lowering costs and delivering high quality care. However, in practice they can be hard to administer given competing interests of providers and sites and do not necessarily address the financial incentives that determine the appropriateness of initiating an episode of care.[30]

Studies to-date have found that bundled payments were associated with no significant changes in quality and a significant decrease in Medicare payments for lower extremity joint replacements.[32] However, no significant differences in Medicare payments have been found for other clinical episodes.[1] These differences may be attributed to the differences in patient populations opting for procedures and the risk associated with each episode of care. Elective hip replacements typically are less risky, and may represent more young and active patients, whereas a hip replacement following a fracture may be associated with more risk and represent patients that have several comorbidities.[1] In this way, bundled payments for an episode of care would need further disaggregation, since the former would likely incur less costs than the latter scenario. By adjusting how bundles are priced in a context-specific way, bundled payments can ensure patients continue to receive quality care while better predicting healthcare expenditure. Enrollment and analyses of CJR and BPCI-A are still underway, but evidence to date suggests they are associated with modest reductions in Medicare payments.[23] Bundled payments do offer direct benefits for patients. Beyond the improved quality of care conferred through increased care coordination, patients should also benefit from simplified billing and transparency around pricing for their episode of care.

CONCLUSION

We have found both theory and empirical evidence supporting the notion that the FFS payment models contribute to excess utilization and provision of cost-ineffective care in the United States. Therefore, efforts to alter payment structures to limit wasteful care should continue to be piloted, trialed, and studied. We do not believe the existing evidentiary base supports universal limitation on programs which attempt to devise and test novel APM structures as significant harm to patients has not been manifested. However, current evidence also demonstrates that existing APMs have only had modest effects on reducing utilization, though there has not been any measured decline in quality. Therefore, it is also premature to recommend widespread adoption of further APMs at this time given their lack of success in meeting their stated goals of significantly reducing healthcare utilization and improving quality.

As a result of these findings, your Committee on Economics and Quality in Medicine recommends that MSS Position 160.046MSS, “Monitoring of Alternative Payment Models Within Traditional Medicare,” be amended by addition and deletion as follows:

160.046MSS ~~Monitoring of~~ Alternative Payment Models within Traditional Medicare

AMA-MSS asked ~~will ask~~ the AMA to (1) monitor the Accountable Care Organization Realizing Equity, Access and Community Health (ACO-REACH) program for its impacts on patients and physicians in Traditional Medicare, including the quality and cost of healthcare and patient/provider choice, and report back to the House of Delegates on the impact of the ACO-REACH demonstration program annually until its conclusion; ~~(2) advocate against any Medicare demonstration project that denies or limits coverage or benefits that beneficiaries would otherwise receive in Traditional Medicare;~~ and (3) develop educational materials for physicians regarding the Accountable Care

Organization Realizing Equity, Access, and Community Health (ACO REACH) program to help physicians understand the implications of their employers participation in this program and to help physicians determine whether participation in the program is in the best interests of themselves and their patients. (4) ~~AMA MSS study alternative payment models in Medicare to identify principles to guide the MSS when considering Medicare demonstration projects or their expansion, including but not limited to assessments of the demonstration program's impact on quality, cost, patient/provider choice, and transparency for report back to the MSS Assembly by the Interim 2024 Meeting.~~

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REPORT OF THE MEDICAL STUDENT SECTION
COMMITTEE ON GLOBAL AND PUBLIC HEALTH AND
MINORITY ISSUES COMMITTEE

MSS CGPH MIC Report
(I-24)

Introduced by: MSS Committee on Global and Public Health and Minority Issues Committee

Subject: Reducing the Harmful Impacts of Immigration Status on Health

Referred to: MSS Reference Committee
(Alec Calac and Andrew Norton, Co-Chairs)

INTRODUCTION

At the Annual 2024 (A-24) MSS Assembly, MSS Resolution 213, "Undocumented Worker Protections" asked the AMA to support increased awareness of the abuses undocumented workers face, the development of interventions, and the removal of immigration status as eligibility criteria, due to concerns over the effects of these abuses on the physical and mental health of undocumented immigrants. The resolution, with the following resolved clauses, was referred for study:

> RESOLVED, that our AMA-MSS support awareness of abuse in undocumented workers and the development of health-related interventions, such as occupational safety trainings and provisions of workplace safety equipment; and be it further
>
> RESOLVED, that our AMA-MSS supports Medicare expansion to undocumented workers through removal of immigration status as eligibility criteria.

The MSS Reference Committee recommended not to adopt for the resolution with the following rationale:

> VRC testimony was split between support and opposition to the resolution as written. Your Reference Committee agrees with testimony that the evidence presented in the whereas clauses is not enough to support the asks of the resolution. We agree with testimony that the first resolve clause is not actionable as supporting awareness is not a clear advocacy effort. Additionally, the second resolve clause is unlikely to result in meaningful advocacy at this time.

During the MSS Assembly, the item was extracted by the authorship team and the following discussion took place.

- Most testimony supported the authorship team's decision to extract the first revolved clause of asking the AMA-MSS to study health-related interventions for undocumented worker abuse. Testimony also supported the second resolved clause of internally supporting Medicare expansion to undocumented workers. The assembly voted to agree with testimony.
- The authors intended to propose amended language in lieu of the original resolve clauses and asked the Assembly to vote in opposition to not adopt to allow their language to be proposed.

- The Assembly voted to refer the first resolved clause of the resolution and voted to adopt the second resolved clause as an internal MSS stance. The assembly voted to adopt the following resolved clauses:
  - RESOLVED, that our AMA-MSS will study potential health-related interventions aimed at reducing the rates of abuse present in the undocumented worker community; and be it further
  - RESOLVED, that our AMA-MSS supports Medicare expansion to undocumented workers through removal of immigration status as eligibility criteria.

Your Governing Council assigned this report to the Committee on Global and Public Health (CGPH) and Minority Issues Committee (MIC) with the following possible questions for consideration: what abuses do undocumented workers face? What are the effects of these abuses? What allows these abuses to go unnoticed or unaddressed? What efforts are in place to prevent these abuses from happening, identify when they occur, and stop these practices? Why are these efforts not enough? What policies or actions, if any, has the AMA been taking to address the plights faced by undocumented workers? Why are these efforts, if they exist, not enough?

In the following whereas clauses and subsequent discussion, we provide an overview of undocumented worker abuse and sought to determine current protections in place for this demographic as well as any gaps in AMA policy.

WHEREAS CLAUSES (EVIDENCE & RATIONALE)

Whereas, Undocumented workers are individuals who are employed in a country without legal authorization or documentation while migrant workers are defined as individuals who move to another country for any variety of reasons, including economic, and may have legal authorization to work in the host country[1,2]; and

Whereas, An asylum-seeker is an individual whose asylum protection claim is being processed while a refugee is an individual who has left their country of origin for fear of persecution and has been granted legal status in the host country[2]; and

Whereas, Undocumented workers accounted for 8.3 million of the U.S. workforce in 2022, primarily contributing to the agriculture, construction, administrative support, and tourism/hospitality/food industries[3-6]; and

Whereas, As of 2021, there are roughly 346,000 undocumented workers in healthcare who contribute over $5 billion in federal tax contributions[7]; and

Whereas, Undocumented workers often face wage theft from withheld payments, poor working conditions, and a lack of health insurance as well as workplace bullying including teasing, insults, verbal and/or physical assaults[1,8]; and

Whereas, Strenuous physical labor demands, constricting work conditions, and limited access to basic human rights such as fair monetary compensation, food, water, and breaks have been shown to increase rates of alcoholism depression and anxiety, and social isolation among undocumented workers[9-12]; and

Whereas, Despite facing systemic human rights violations, undocumented workers are often unable to assert fundamental rights due to fear of deportation, limited legal protections, and policies that violate international standards for workplace equality[13]; and

Whereas, The Department of Labor has determined that migrant workers, but not necessarily undocumented workers, have the rights to form and join a union, be paid minimum wage, be paid on time, have a safe work environment, be treated without discrimination or harassment in the workplace, question the employer's pay or workplace practices, and file a claim without retaliation regardless of immigration status[14]; and

Whereas, Undocumented workers face barriers to employment, thus impacting their socioeconomic status, access to healthcare, and quality of life; and

Whereas, Verification methods such as the E-Verify system mandates that employers must check their employee's immigration status before they begin employment and have prevented over 300,000 legal workers from working due to erroneous database information, thus barring employment for U.S. citizens[15]; and

Whereas, States that used E-Verify have not found any significant reductions in the number of employed undocumented workers since the identification of legal workers may be borrowed by undocumented workers, and E-Verify implementation has demonstrated a reduction in wages earned by undocumented workers, causing undocumented workers to work longer for the loss in income[16]; and

Whereas, The use of immigration enforcement at the workplace by employers has been demonstrated to create an atmosphere of coercion and exploitation for undocumented workers[9]; and

Whereas, Undocumented worker vulnerability extends beyond the workplace, with their immigration status affecting access to housing, healthcare, and other basic needs, allowing for workplace exploitation[17]; and

Whereas, The cycle of exploitation and abuse faced by undocumented workers is perpetuated by systemic inequities, such as inadequate legal protections and economic disparities, which leaves this demographic susceptible to workplace abuse and victimization with few options for recourse or recovery due to limited healthcare options[18,19]; and

Whereas, Undocumented workers have limited options to seek care through community health clinics and federally qualified health centers, which often operate on limited resources and may not be able to serve the comprehensive needs of undocumented workers due to lack of healthcare options outside of working hours, translation services, cultural competency, and lack of funding[20,21]; and

Whereas, Among immigrant adults who have received care in the U.S., many report a lack of culturally-competent care with one in four reporting being treated unfairly by a health care provider because of their insurance status or ability to pay, accent or ability to speak English, and/or their race, ethnicity, or skin color[21]; and

Whereas, Despite their tax contributions and funding of the Medicare Trust Fund, around half of the undocumented immigrants present in the U.S. are uninsured since their immigration status makes them ineligible for health coverage through Medicaid, CHIP, Medicare or the Affordable Care Act Marketplace[22,23]; and

Whereas, Through the Emergency Medical Treatment and Labor Act (EMTALA), undocumented people have access to emergency medical treatment via emergency Medicaid[23]; and

Whereas, The federal government spent $974 million on emergency services for undocumented people and $3.3 trillion dollars in total national healthcare expenditures[23]; and

Whereas, Immigration status has been demonstrated to have a significant effect on the health outcomes of patients, with undocumented patients often having higher rates of mortality relative to their peers with citizenship[24,45]; and

Whereas, Due to their ineligibility for federal health coverage, undocumented people do not have access to treatment for chronic conditions such as routine dialysis, instead relying on the emergency department for these life sustaining services and costing 3.5 times the amount of routine scheduled outpatient dialysis while also resulting in increased mortality[26]; and

Whereas, Increasing access to healthcare coverage for undocumented people leads to a significant decrease in emergency room utilization rates and a decrease in overall healthcare spending[20]; and

Whereas, An intervention study performed in New York City found that the provision of primary care appointments to undocumented people resulted in a significant reduction in emergency department utilization and increased rates of chronic condition diagnosis and preventive screenings performed, thus potentially reducing future healthcare spending from advanced complications of diseases[27]; and

Whereas, Several governing bodies have worked to extend protections to undocumented workers such as the Occupational Safety and Health Administration (OSHA) which provides legal protections for undocumented workers who are victims of employment abuse or human trafficking by issuing certifications in support of applications for U- and T- visas, which grant them temporary visa status to prevent fear of retaliation[28]; and

Whereas, National organizations such as National Employment Law Project's Immigrant Worker Justice Program and state organizations such as the Virginia Legal Aid Justice Center advocate for policy changes that keep immigration enforcement out of the workplace, enhance enforcement of the rights of migrant and undocumented workers, and improve labor laws[29,30]; and

Whereas, Community and legal organizations as well as national organizations such as the National Council for Occupational Safety and Health (National COSH) provide undocumented workers with education on their legal rights to safe workplaces, resources to report safety hazards, free legal services, and access to local COSH groups for conducting outreach programs and safety training workshops, aiming to prevent abusive practices[31-36]; and

Whereas, The various workshops geared towards increasing civic rights knowledge, legal aid, and outreach efforts aimed at helping undocumented workers can sometimes fail to reach these communities, especially in more isolated or rural environments, where many undocumented workers remain unaware of their rights, resources, and lack representation[37,38]; and

Whereas, Despite existing legal protections, the threat of deportation continues to prevent undocumented workers from reporting labor rights violations to OSHA, the Department of Labor, or local labor boards[1]; and

Whereas, Deportation and the threat of deportation has been shown to potentiate adverse mental health outcomes and psychological distress amongst immigrant parents and children and has demonstrated an increased likelihood of poverty and erosion in child safety[40-43]; and

Whereas, Deferral of deportation, or deferred action, postpones a non-U.S. citizen's deportation for a specified period of time which can keep families united during the immigration process and allows access to legal assistance, work authorization, and life-saving medical treatment that may be limited in their home country [44,45]; and

Whereas, The Department of Homeland Security (DHS) offers a streamlined and expedited deferred action process that serves to protect non-citizen workers from immigration-related retaliation from their employers[46]; and

Whereas, There are many limitations to the DHS's deferred action process, including its complex application process, language barrier, limited protection for a two year period, and lack of protection for non-citizen workers from harassment and termination while their deferred action is pending[44]; and

Whereas, Undocumented children may qualify for Deferred Action for Childhood Arrivals (DACA), but there is no direct citizenship pathway for DACA recipients[47]; and

Whereas, Access to legalization and documentation reduces the risk of victimization, but legal pathways for undocumented individuals are limited and further constrained by the scarcity of U.S. Customs and Border Protection (CBP) asylum appointments available through the CBP One App[48]; and

Whereas, Those who are undergoing the legalization process face several barriers including high costs for necessary documentation such as identification, restrictions on legal status for those who entered the U.S. illegally, long backlogs for work visas and asylum, limited humanitarian protection, and restrictive regulations[49-51]; and

Whereas, According to the UN High Commissioner for Refugees (UNHCR), those escaping persecution have a right to seek asylum, however, this right has been limited during high volumes of asylum-seekers at the U.S.-Mexico border, which increases the risk of undocumented worker influx and potential abuse[52,53]; and

Whereas, By being granted asylum, refugees are afforded legal protection, workers' compensation, and healthcare, which are, for the most part, severely limited for undocumented workers[54]; and

Whereas, An additional legalization route, family reunification programs, serve to reunite recently documented, legalized immigrants with immediate family members from their original country, thus alleviating the mental health consequences of familial separation that many undocumented workers experience[55]; and

Whereas, Undocumented children make up a significant portion of the undocumented worker population and are often unaccompanied without a legal guardian, with most navigating the challenges of obtaining citizenship with limited assistance[56]; and

Whereas, Since 2021, over 400,000 unaccompanied minors have entered the U.S. illegally to escape poverty and violence in their home country, with the majority working in agricultural or industrial jobs that lack proper safety oversight due to negligent safety inspections, placing them at an increased risk of workplace injury and mortality[57]; and

Whereas, Unaccompanied minors often face legal uncertainty and restricted access to essential services, such as case management or healthcare, due to lack of formal processing or parental

guidance, and they are exposed to stressors without protective mediators including education or familial support[58]; and

Whereas, Children who are separated from their parents due to immigration status are more likely to experience delayed socioemotional development, depression and anxiety, stroke, diabetes, and heart disease[59,60]; and

Whereas, Starting in 2014, the Central American Minors (CAM) program provides qualified children and some family members who are nationals of Honduras, El Salvador, and Guatemala, refugee status and relocation status in the U.S., helping over 5,000 individuals in obtaining refugee or parolee status[61,62]; and

Whereas, The growing demand for laborers in destination countries and increasing income and health inequality between and within countries will allow abuses against undocumented workers to continue occurring if unaddressed[63]; and

Whereas, Several advocacy organizations have produced meaningful work in advocating for immigrant populations which the AMA, a supporter of immigrants' rights, may benefit from partnership with since these organizations regularly interface with immigrant communities; and

Whereas, Coalitions, such as Refugee Council USA which includes Amnesty International and OXFAM as members, can amplify advocacy efforts and allow the AMA to streamline its advocacy efforts and broaden its reach by collaborating on initiatives to healthcare access and policy reform for immigrant populations[64]; therefore be it

CURRENT AMA POLICY & EFFORTS

Current AMA policy both has a historical precedent of strong advocacy for the healthcare of immigrants within the U.S. regardless of immigration status (D-350.975, H-350.957). Furthermore, the AMA is a staunch supporter of increased legalization pathways for medical trainees and physicians while also opposing policies that limit issuance of visas to people based on country of origin. The AMA also encourages studying mandated reporting of domestic violence in the undocumented immigrant population to identify potential barriers to care (D-515.979). Furthermore, the Code of Ethics (Section 8.10) and AMA policy (H-430.976) support the cause of reducing abuse and providing workplace training for incarcerated peoples, respectively. Specifically, policy H-65.938 from the AMA prevents work-related diseases and injuries for migrant workers by giving them greater access to quality primary health care necessities. Although current AMA policy is profound in the protection of workers (D-135.935, D-135.974, H-135.935, H-490.413) and acknowledges immigration status as a determinant of health, there is no specific language in regards to the protection of undocumented workers against workplace-related safety or even during public health crises.

CONCLUSION

Based on our review of the evidence in the resolution provided below, we find that the abuses faced by undocumented workers are disproportionate relative to their legal counterparts. Several interventions have been found to ameliorate these abuses, yet the most significant aid was legalization or citizenship. In being provided this designation, undocumented workers can be afforded healthcare, financial assistance, case management, and other benefits. While the AMA has extensive policy on health coverage of immigrants and migrants, there is little policy in regards to citizenship of this demographic. Given the report moves away from solely the protection of undocumented workers and advocates for increased legalization pathways, CGPH

and MIC authors have decided to rename this report from “Protecting Undocumented Workers” to “Reducing the Harmful Impacts of Immigration Status on Health”. As such, this report finds that barriers to legalization and citizenship remain the biggest obstacle in achieving health equity for undocumented people within the U.S.

RECOMMENDATION

Your Committee on Global & Public Health (CGPH) and Minority Issues Committee (MIC) recommend that the following recommendations are adopted in lieu of Resolution 213 and the remainder of this report be filed:

1. RESOLVED, that our American Medical Association supports increased pathways for migrants and undocumented immigrants to appropriately apply for asylum, work visas for industries dependent on migrants and undocumented workers, and other legal mechanisms, including increasing the number and physical sites of appointments offered for interviewing for asylum; and be it further
2. RESOLVED, that our AMA support the protection of the human right to seek asylum; and be it further
3. RESOLVED, that our AMA support pathways to citizenship for all undocumented immigrants who entered the US as minors, including DACA recipients and Dreamers; and be it further
4. RESOLVED, that our AMA support family reunification pathways for children and certain adult immigrants from other countries if their parent/guardian, spouse, or child/dependent has documented status in the U.S.; and be it further
5. RESOLVED, that our AMA support deferral of deportation (and if applicable, employment authorization, driver’s licenses, and identification documents) for people with disabilities and significantly limiting chronic illness, people who work in healthcare and social care, relatives of people with documented or DACA status, and people without violent felonies; and be it further
6. RESOLVED, that our AMA support federal and state efforts to remove immigration enforcement from workplaces and employment consideration, including the removal of E-Verify mandates; and be it further
7. RESOLVED, that our AMA join a coalition of organizations working to support immigrant rights and health, such as Refugee Council USA, to establish collaborations with partners and amplify our advocacy on these issues.

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RELEVANT AMA AND AMA-MSS POLICY

Intimate Partner Violence Policy and Immigration D-515.979
Our AMA: (1) encourages appropriate stakeholders to study the impact of mandated reporting of domestic violence policies on individuals with undocumented immigrant status and identify potential barriers for survivors seeking care; and (2) will work with community based organizations and related stakeholders to clarify circumstances that would trigger mandated reporting of intimate partner violence and provide education on the implications of mandatory reporting on individuals with undocumented immigrant status.

Guiding Principles for the Healthcare of Migrants H-65.938
1. Our American Medical Association advocates for the development of adequate policies and / or legislation to address the healthcare needs of migrants and asylum seekers in cooperation with relevant legislators and stakeholders based on the following guiding principles, adapted from the High-level meeting of the Global Consultation on Migrant Health, i.e. the “Colombo Statement.”
2. Our AMA recognizes that migration status is a social determinant of health.
3. Our AMA affirms the importance of multi-sectoral coordination and inter-country engagement and partnership in enhancing the means of addressing health aspects of migration.
4. Our AMA recognizes that the enhancement of migrants’ health status relies on an equitable and non-discriminatory access to and coverage of health care and cross-border continuity of care at an affordable cost avoiding severe financial consequences for migrants, as well as for their families.
5. Our AMA recognizes that investment in migrant health provides positive dividends compared to public health costs due to exclusion and neglect, and therefore underscore the need for financing mechanisms that mobilize different sectors of society, innovation, identification and sharing of good practices in this regard.
6. Our AMA recognizes that the promotion of the physical and mental health of migrants as defined by the following select objectives from the World Health Organization’s 72nd World Health Assembly, Global action plan on promoting the health of refugees and migrants, 2019-2023, is accomplished by

a. Ensuring that essential components, such as vaccination of children and adults and the provision of health promotion, disease prevention, timely diagnosis and treatment, rehabilitation and palliative services for acute, chronic and infectious diseases, injuries, mental and behavioral disorders, and sexual and reproductive health care for women, are addressed.
b. Improving the quality, acceptability, availability and accessibility of health care services, for instance by overcoming physical, financial, information, linguistic and other cultural barriers, with particular attention to services for chronic conditions and mental health, which are often inadequately addressed or followed up during the migration and displacement process, and by working to prevent occupational and work-related diseases and injuries among migrant workers and their families by improving the coverage, accessibility and quality of occupational and primary health care services and social protection systems.
c. Ensuring that the social determinants of migrants' health are addressed through joint, coherent multisectoral actions in all public health policy responses, especially ensuring promotion of well-being for all at all ages, and facilitating orderly, safe, and responsible migration and mobility of people, including through implementation of planned and well-managed migration policies, as defined in the Sustainable Development Goals of the United Nations.
d. Ensuring that information and disaggregated data at global, regional and country levels are generated and that adequate, standardized, comparable records on the health of migrants are available to support policy-makers and decision-makers to develop more evidence-based policies, plans and interventions.
e. Providing accurate information and dispelling fears and misperceptions among migrant and host populations about the health impacts of migration and displacement on migrant populations and on the health of local communities and health systems.

OSHA Standards for Lead H-135.935
Our AMA will advocate with American College of Occupational and Environmental Medicine and other professional organizations to change the Occupational Safety & Health Administration legal standard for temporary medical removal from all lead work environments, regardless of the airborne lead concentrations, which result in workers' blood lead levels exceeding 20 mcg/dL on any two consecutive blood tests, or any single value exceeding 30 mcg/dL, as recommended by a subgroup of an expert panel convened by the Association of Occupational and Environmental Clinics (2007) and by Cal/OSHA (2009).

Support Stricter OSHA Silica Permissible Exposure Limit Standard D-135.974
Our AMA: (1) supports the Department of Labor's Occupational Safety and Health Administration's (OSHA's) proposed rule to establish a stricter permissible exposure limit (PEL) for respirable crystalline silica; (2) supports OSHA's proposed rule to establish a stricter standard of exposure assessment and medical surveillance requirements to identify adverse health effects in exposed populations of workers; and (3) will submit comments, in collaboration with respiratory and occupational health medical societies, in support of a stricter silica PEL.

Smoke-Free and Vape-Free Environments and Workplaces H-490.913

On the issue of the health effects of environmental tobacco smoke (ETS), passive smoke, and vape aerosol exposure in the workplace and other public facilities, our American Medical Association:

1.
    a. Supports classification of ETS as a known human carcinogen.
    b. Concludes that passive smoke exposure is associated with increased risk of sudden infant death syndrome and of cardiovascular disease.
    c. Encourages physicians and medical societies to take a leadership role in defending the health of the public from ETS risks and from political assaults by the tobacco industry.
    d. Encourages the concept of establishing smoke-free and vape-free campuses for business, labor, education, and government.
2.
    a. Honors companies and governmental workplaces that go smoke-free and vape-free.
    b. Will petition the Occupational Safety and Health Administration (OSHA) to adopt regulations prohibiting smoking and vaping in the workplace, and will use active political means to encourage the Secretary of Labor to swiftly promulgate an OSHA standard to protect American workers from the toxic effects of ETS in the workplace, preferably by banning smoking and vaping in the workplace.
    c. Encourages state medical societies (in collaboration with other anti-tobacco organizations) to support the introduction of local and state legislation that prohibits smoking and vaping around the public entrances to buildings and in all indoor public places, restaurants, bars, and workplaces.
    d. Will update draft model state legislation to prohibit smoking and vaping in public places and businesses, which would include language that would prohibit preemption of stronger local laws.
3.
    a. Encourages state medical societies to:
        i. Support legislation for states and counties mandating smoke-free and vape-free schools and eliminating smoking and vaping in public places and businesses and on any public transportation.
        ii. Enlist the aid of county medical societies in local anti-smoking and anti-vaping campaigns.
        iii. Through an advisory to state, county, and local medical societies, urge county medical societies to join or to increase their commitment to local and state anti-smoking and anti-vaping coalitions and to reach out to local chapters of national voluntary health agencies to participate in the promotion of anti-smoking and anti-vaping control measures.
    b. Urges all restaurants, particularly fast food restaurants, and convenience stores to immediately create a smoke-free and vape-free environment.
    c. Strongly encourages the owners of family-oriented theme parks to make their parks smoke-free and vape-free for the greater enjoyment of all guests and to further promote their commitment to a happy, healthy life style for children.
    d. Encourages state or local legislation or regulations that prohibit smoking and vaping in stadia and encourages other ball clubs to follow the example of

banning smoking in the interest of the health and comfort of baseball fans as implemented by the owner and management of the Oakland Athletics and others.
   e. Urges eliminating cigarette, pipe and cigar smoking and vaping in any indoor area where children live or play, or where another person's health could be adversely affected through passive smoking inhalation.
   f. Urges state and county medical societies and local health professionals to be especially prepared to alert communities to the possible role of the tobacco industry whenever a petition to suspend a nonsmoking or non-vaping ordinance is introduced and to become directly involved in community tobacco control activities.
   g. Will report annually to its membership about significant anti-smoking and anti-vaping efforts in the prohibition of smoking and vaping in open and closed stadia.
4. Calls on corporate headquarters of fast-food franchisers to require that one of the standards of operation of such franchises be a no smoking and no vaping policy for such restaurants, and endorses the passage of laws, ordinances and regulations that prohibit smoking and vaping in fast-food restaurants and other entertainment and food outlets that target children in their marketing efforts.
5. Advocates that all American hospitals ban tobacco and supports working toward legislation and policies to promote a ban on smoking, vaping, and use of tobacco products in, or on the campuses of, hospitals, health care institutions, retail health clinics, and educational institutions, including medical schools.
6. Will work with the Department of Defense to explore ways to encourage a smoke-free and vape-free environment in the military through the use of mechanisms such as health education, smoking and vaping cessation programs, and the elimination of discounted prices for tobacco products in military resale facilities.
7. Collaborates with local and state medical societies and tobacco control coalitions to work with
   a. Native American casino and tribal leadership to voluntarily prohibit smoking and vaping in their casinos.
   b. Legislators and the gaming industry to support the prohibition of smoking and vaping in all casinos and gaming venues.

Immigration Status is a Public Health Issue D-350.975
1. Our AMA declares that immigration status is a public health issue that requires a comprehensive public health response and solution.
2. Our AMA recognizes interpersonal, institutional, structural, and systemic factors that negatively affect immigrants' health.
3. Our AMA will promote the development and implementation of educational resources for healthcare professionals to better understand health and healthcare challenges specific for the immigrant population.
4. Our AMA will support the development and implementation of public health policies and programs that aim to improve access to healthcare and minimize systemic health barriers for immigrant communities. [Res. 904, I-22; Reaffirmed: Res. 210, A-23]

Addressing Immigrant Health Disparities H-350.957
1. Our American Medical Association recognizes the unique health needs of refugees, and encourages the exploration of issues related to refugee health and support legislation and policies that address the unique health needs of refugees.
2. Our AMA: (A) urges federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology; (B) advocates for and publicizes

medically accurate information to reduce anxiety, fear, and marginalization of specific populations; and (C) advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees.
3. Our AMA will call for asylum seekers to receive all medically-appropriate care, including vaccinations in a patient centered, language and culturally appropriate way upon presentation for asylum regardless of country of origin. [Res. 804, I-09; Appended: Res. 409, A-15; Reaffirmation: A-19; Appended: Res. 423, A-19; Reaffirmation: I-19]

Opposition to Regulations That Penalize Immigrants for Accessing Health Care Services D-440.927
Our AMA will, upon the release of a proposed rule, regulations, or policy that would deter immigrants and/or their dependents from utilizing non-cash public benefits including but not limited to Medicaid, CHIP, WIC, and SNAP, issue a formal comment expressing its opposition. [Res. 254, A-18; Reaffirmed: Res. 259, A-23]

Protecting Workers During Catastrophes D-365.995
1. Our American Medical Association will advocate for legislation that creates federal standards of safety and protection of workers during natural or man-made catastrophes.
2. Our AMA will advocate that the United States Department of Labor, the Occupational Safety and Health Administration (OSHA), and other appropriate parties develop and enforce evidence-based policies, guidelines, and protections for workers at their place of employment during catastrophes. [Res. 411, A-23]

Opposing the Detention of Migrant Children H-60.906
Our AMA: (1) opposes the separation of migrant children from their families and any effort to end or weaken the Flores Settlement that requires the United States Government to release undocumented children “without unnecessary delay” when detention is not required for the protection or safety of that child and that those children that remain in custody must be placed in the “least restrictive setting” possible, such as emergency foster care; (2) supports the humane treatment of all undocumented children, whether with families or not, by advocating for regular, unannounced, auditing of the medical conditions and services provided at all detention facilities by a non-governmental, third party with medical expertise in the care of vulnerable children; and (3) urges continuity of care for migrant children released from detention facilities. [Res. 004, I-18; Reaffirmed: Res. 234, A-22]

Patient and Physician Rights Regarding Immigration Status H-315.966
Our AMA supports protections that prohibit U.S. Immigration and Customs Enforcement, U.S. Customs and Border Protection, or other law enforcement agencies from utilizing information from medical records to pursue immigration enforcement actions against patients who are undocumented. [Res. 018, A-17]

Opposition to Criminalization of Medical Care Provided to Undocumented Immigrant Patients H-440.876
1. Our AMA: (a) opposes any policies, regulations or legislation that would criminalize or punish physicians and other health care providers for the act of giving medical care to patients who are undocumented immigrants; (b) opposes any policies, regulations, or legislation requiring physicians and other healthcare providers to collect and report data regarding an individual patient's legal resident status; and (c) opposes proof of citizenship as a condition of providing health care. 2. Our AMA will work with local and state medical societies to immediately, actively and publicly oppose any legislative proposals that would criminalize the provision of health care to undocumented residents. [Res. 920, I-06; Reaffirmed and Appended: Res. 140, A-07; Modified: CCB/CLRPD Rep. 2, A-14]

Advocating for Heat Exposure Protections for All Workers D-135.967
Our AMA: (1) will advocate for all workers to have access to preventive cool-down rest periods in shaded, ventilated, and/or cooled areas for prevention of injury from sun exposure and heat injury as well as appropriate access to emergency services when signs and symptoms of heat exposure injury; (2) will advocate for legislation that creates federal standards for protections against heat stress and sun exposure specific to the hazards of the workplace; (3) supports policy change at the federal level via legislation or administrative rule changes by the Occupational Safety and Health Administration (OSHA) that would require that workers receive health educational materials about prevention and recognition of heat exhaustion and heat exposure injury that is in the worker's primary language: (4) will work with the United States Department of Labor, OSHA, and other appropriate federal stakeholders to develop and enforce evidence-based policies, guidelines, and protections against heat injury for workers independent of legal status; and (5) recognizes there are particular medical conditions and medications, including but not limited to psychotropics, which increase an individual’s vulnerability to the negative impacts of heat and sun exposure and advocate for recognition of this, as well as additional protections as part of any guidelines, legislation or other policies. [Res. 502, I-21]

Action Regarding Illegal Aliens H-130.967
Our AMA supports the legislative and regulatory changes that would require the federal government to provide reasonable payment for federally mandated medical screening examinations and further examination and treatment needed to stabilize a condition in patients presenting to hospital emergency departments, when payment from other public or private sources is not available. [BOT Rep. MM, A-89; Reaffirmed by BOT Rep. 17 - I-94; Reaffirmed by Ref. Cmt. B, A-96; Reaffirmation A-02; Reaffirmation A-07; Reaffirmed: BOT Rep. 22, A-17]

Health Care Payment for Undocumented Persons D-440.985
Our AMA shall assist states on the issue of the lack of reimbursement for care given to undocumented immigrants in an attempt to solve this problem on a national level. [Res. 148, A-02; Reaffirmation A-07; Reaffirmed: CMS Rep. 01, A-17; Reaffirmation: A-19; Reaffirmation: I-19]

Options to Maximize Coverage under the AMA Proposal for Reform H-165.823
1. That our AMA advocate for a pluralistic health care system, which may include a public option, that focuses on increasing equity and access, is cost-conscious, and reduces burden on physicians.
2. Our AMA will advocate that any public option to expand health insurance coverage must meet the following standards:
a. The primary goals of establishing a public option are to maximize patient choice of health plan and maximize health plan marketplace competition.
b. Eligibility for premium tax credit and cost-sharing assistance to purchase the public option is restricted to individuals without access to affordable employer-sponsored coverage that meets standards for minimum value of benefits.
c. Physician payments under the public option are established through meaningful negotiations and contracts. Physician payments under the public option must be higher than prevailing Medicare rates and at rates sufficient to sustain the costs of medical practice.
d. Physicians have the freedom to choose whether to participate in the public option. Public option proposals should not require provider participation and/or tie physician participation in Medicare, Medicaid and/or any commercial product to participation in the public option.
e. The public option is financially self-sustaining and has uniform solvency requirements.
f. The public option does not receive advantageous government subsidies in comparison to those provided to other health plans.

g. The public option shall be made available to uninsured individuals who fall into the “coverage gap” in states that do not expand Medicaid – having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credits – at no or nominal cost.
3. Our AMA supports states and/or the federal government pursuing auto-enrollment in health insurance coverage that meets the following standards:
a. Individuals must provide consent to the applicable state and/or federal entities to share their health insurance status and tax data with the entity with the authority to make coverage determinations.
b. Individuals should only be auto-enrolled in health insurance coverage if they are eligible for coverage options that would be of no cost to them after the application of any subsidies. Candidates for auto-enrollment would, therefore, include individuals eligible for Medicaid/Children’s Health Insurance Program (CHIP) or zero-premium marketplace coverage.
c. Individuals should have the opportunity to opt out from health insurance coverage into which they are auto-enrolled.
d. Individuals should not be penalized if they are auto-enrolled into coverage for which they are not eligible or remain uninsured despite believing they were enrolled in health insurance coverage via auto-enrollment.
e. Individuals eligible for zero-premium marketplace coverage should be randomly assigned among the zero-premium plans with the highest actuarial values.
f. Health plans should be incentivized to offer pre-deductible coverage including physician services in their bronze and silver plans, to maximize the value of zero-premium plans to plan enrollees.
g. Individuals enrolled in a zero-premium bronze plan who are eligible for cost-sharing reductions should be notified of the cost-sharing advantages of enrolling in silver plans.
h. There should be targeted outreach and streamlined enrollment mechanisms promoting health insurance enrollment, which could include raising awareness of the availability of premium tax credits and cost-sharing reductions, and establishing a special enrollment period.
4. Our AMA: (a) will advocate that any federal approach to cover uninsured individuals who fall into the“coverage gap” in states that do not expand Medicaid--having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credit eligibility--make health insurance coverage available to uninsured individuals who fall into the coverage gap at no or nominal cost, with significant cost-sharing protections; (b) will advocate that any federal approach to cover uninsured individuals who fall into the coverage gap provide states that have already implemented Medicaid expansions with additional incentives to maintain their expansions; (c) supports extending eligibility to purchase Affordable Care Act (ACA) marketplace coverage to undocumented immigrants and Deferred Action for Childhood Arrivals (DACA) recipients, with the guarantee that health plans and ACA marketplaces will not collect and/or report data regarding enrollee immigration status; and (d) recognizes the potential for state and local initiatives to provide coverage to immigrants without regard to immigration status. [CMS Rep. 1, I-20; Appended: CMS Rep. 3, I-21; Reaffirmation: A-22; Reaffirmed: CMS Rep. 3, A-22; Reaffirmed: Res. 122, A-22; Modified: Res. 813, I-22; Reaffirmed: CMS Rep. 5, I-23]

Opposing the Use of Vulnerable Incarcerated People in Response to Public Health Emergencies H-430.976
1. Our AMA acknowledges that systemic racism is a root of incarcerated labor policies and practices.
2. Our AMA supports:
(a) Efforts to ensure that all work done by individuals who are incarcerated in correctional facilities is fully voluntary.

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

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

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

3. Our AMA encourages:

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

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

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

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

4. Our AMA encourages:

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

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

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

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

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

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

165.023MSS Medicare Eligibility at Age 60

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

170.001MSS Prevention & Health Education

AMA-MSS supports the following principles: (1)Health education should be a required part of primary and secondary education; (2)Private industry should be encouraged to provide preventive services and health education to employees; (3) All health care professions should be utilized for the delivery of preventive medicine services and health education; (4) Greater

emphasis on preventive medicine should be incorporated into the curriculum of all health care professionals; (5) A sufficient number of training programs in preventive medicine and associated fields should be established, and adequate funding should be provided by government if private sources are not forthcoming; (6) Financing of medical care should be changed to include payment for preventive services and health education; (7) Appropriate legislation should be passed to protect the health of the population from behavioral and environmental risk factors, including, but not limited to, the following: (a) handgun control, (b) antismoking, (c) enforcement of drunk driving laws, (d) mandatory use of seat belts, (e) environmental protection laws, (f) occupational safety, and (g) toxic waste disposal; and 8) Preventive health services should be made available to all population segments, especially those at high risk.
(MSS Rep C, I-82) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep C, A-04) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

170.004MSS Health Education
AMA-MSS will ask the AMA to urge all state medical societies to urge their respective state departments of education to implement model health education curricula, act as clearinghouses for data on curriculum development, work with local school districts to implement health education programs and seek funding for these programs. These health education programs should contain provisions for educator training and development of local community health advisory committees. (AMA Sub Res 417, I-91 Adopted [H-170.980]) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

365.007MSS Advocating for Heat Exposure Protections for Outdoor Workers
AMA-MSS will: (1) support advocating for outdoor workers to have access to preventive cool-down rest periods in shaded areas for prevention of heat exhaustion and health educational materials in their primary language; (2) support legislation creating a federal standard for protections against heat stress specific to the hazards of the workplace; and (3) support working with the United States Department of Labor, the Occupational Health and Safety Administration, and other appropriate federal stakeholders to develop and enforce evidence-based policies, guidelines, and protections against heat injury for outdoor workers independent of legal status. (MSS Res. 05, I-21)

365.008MSS Protecting Workers During Catastrophes
AMA-MSS will ask (1) that our AMA advocate for legislation that creates federal standards of safety and protection of workers during natural or man-made catastrophes and (2) that our AMA advocate that the United States Department of Labor, the Occupational Safety and Health Administration (OSHA), and other appropriate stakeholders to develop and enforce evidence-based policies, guidelines, and protections for workers at their place of employment and traveling to and from their place of employment during catastrophes. (MSS Res. 040, A-22) (AMA Res. 411, Adopt as Amended, A-23)

165.012MSS Covering the Uninsured as AMA's Top Priority
AMA-MSS will ask the AMA to make the number one priority of the American Medical Association comprehensive health system reform that achieves reasonable health insurance for all Americans and that emphasizes prevention, quality, and safety while addressing the broken medical liability system, flaws in Medicare and Medicaid, and improving the physician practice environment. (MSS Res 10, I-05) (AMA Amended Res 613, A-06 Adopted [H-165.847]) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Report D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

REPORT OF THE MEDICAL STUDENT SECTION
COMMITTEE ON MEDICAL EDUCATION

MSS CME Report
(I-24)

Introduced by: Committee on Medical Education

Subject: Increased Access and Support for First-Generation College Students

Referred to: MSS Reference Committee
(Alec Calac and Andrew Norton, Co-Chairs)

INTRODUCTION

At the Annual 2024 (A-24) MSS Assembly, MSS Resolution 308, "Expanding Medical Education Access and Support for First-Generation Students" asked the AMA to collaborate with stakeholders to increase measures to support first-generation students while attending medical school. It also sought to amend the existing AMA policy H-200.951 "Strategies for Enhancing Diversity in the Physician Workforce" to include first-generation status as one of the underserved categories addressed in that policy. The resolution, with the following resolve clauses, was referred for study:

> RESOLVED, that our American Medical Association collaborate with appropriate stakeholders, such as the AAMC, to increase population-specific supportive measures for first-generation students throughout medical school; and be it further
>
> RESOLVED, that our AMA amend Policy H-200.951, "Strategies for Enhancing Diversity in the Physician Workforce," as follows:
>
> > **Strategies for Enhancing Diversity in the Physician Workforce, H-200.951**
> > Our AMA: (1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin, ~~and~~ rurality, and first-generation status; (2) commends the Institute of Medicine (now known as the National Academies of Sciences, Engineering, and Medicine) for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes; (3) encourages the development of evidence-informed programs to build role models among academic leadership and faculty for the mentorship of students, residents, and fellows underrepresented in medicine and in specific specialties; (4) encourages physicians to engage in their communities to guide, support, and mentor high school and undergraduate students with a calling to medicine; (5) encourages medical schools, health care institutions, managed care and other appropriate groups to adopt

and utilize activities that bolster efforts to include and support individuals who are underrepresented in medicine by developing policies that articulate the value and importance of diversity as a goal that benefits all participants, cultivating and funding programs that nurture a culture of diversity on campus, and recruiting faculty and staff who share this goal; and (6) continue to study and provide recommendations to improve the future of health equity and racial justice in medical education, the diversity of the health workforce, and the outcomes of marginalized patient populations.

The MSS Reference Committee recommended not adopt for this resolution with the following rationale:

VRC testimony was opposed to the resolution. Your Reference Committee appreciates the spirit of the resolution, but we agree with testimony that the first resolve clause is covered under existing policy H-200.951 and would not result in intended additional advocacy. We agree with testimony on the second resolve clause that opening up previously passed AMA policy to amendments and discussion given current DEI controversies may result in unintended consequences. Your Reference Committee further reviewed the late testimony provided by the authorship team, and while we appreciate the efforts by the authors to strengthen this resolution, we do not believe that the new ask was supported by the whereas clauses. Thus, your Reference Committee recommends Resolution 308 not be adopted.

During the MSS Assembly, the item was extracted by the authors and the following discussion took place: Several individuals and groups were in opposition to the recommendation to not adopt by the Reference Committee, while there were also several individuals who were in favor of the recommendation. Ultimately, the motion to not adopt as proposed by the Reference Committee was defeated. The authors proposed new language that removed the second resolved clause that altered existing policy H-200.951. They also amended their first resolved clause to alter it to "first-generation college students" rather than "medical students". The motion to amend with the authors' amendments passed, but then the motion to refer the resolution to study was proposed and passed.

- This language was submitted to the MSS Governing Council after Assembly concluded:
  - RESOLVED, that our American Medical Association collaborate with appropriate stakeholders, such as the AAMC, to increase population-specific supportive measures for first-generation students throughout medical school; and be it further
  - RESOLVED, that our AMA amend Policy H-200.951, "Strategies for Enhancing Diversity in the Physician Workforce," as follows:

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

    Our AMA: (1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin, ~~and~~ rurality, and first-generation status; (2) commends the Institute of Medicine (now known as the National Academies of Sciences, Engineering, and Medicine) for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care

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

Your Governing Council assigned this report to the Committee of Medical Education with the following possible questions for consideration: What is the definition of “first generation status” and what support is currently in place for this population of students?

In this following whereas clauses and subsequent discussion, we provide an overview of current support that is available for first-generation college students who are pursuing medical school. We describe potential areas in which our AMA could expand its advocacy on this topic before ultimately delivering our recommendation on the referred clauses.

WHEREAS CLAUSES (EVIDENCE & RATIONALE)

Whereas, a first-generation college student (FGCS) is defined as someone whose parent(s) did not complete a 4-year college degree, regardless of other family members’ levels of education[1]; and

Whereas, there appears to be no standard term for students who are first in their family to attend a medical or graduate program, regardless of their parents’ undergraduate education experience or lack thereof, and

Whereas, one recent study in 2023 loosely defined first-generation medical students as FGCS who are attending medical school[2], and

Whereas, FGCSs are not explicitly included in the AAMC definition of underrepresented in medicine, which is defined as racial and ethnic populations that are underrepresented in the medical profession relative to their numbers in the general population[3]; and

Whereas, according to the United States Census Bureau, as of 2021, 23.5% of adults aged 25 and older hold a college degree from a 4-year college or university,[4] and

Whereas, according to data from the National Center for Education Statistics, as of 2020, 54% of college graduates in the United States are considered to hold first-generation college student status[5], and

Whereas, in 2022, 2.015 million students graduated with a bachelor's degree from a 4-year college or university, and 78,676 students applied to either MD or DO medical schools, and 32,764 were accepted[6,7,8], and

Whereas, the number of students who applied and were accepted to medical school also encompasses students who graduated previously and took one or more gap years prior to matriculating into medical school, and

Whereas, according to the AAMC, the proportion of FGCSs comprised 12.4% of 2021-2022 matriculants to MD-granting medical schools, up from 10.4% in 2019[9], and

Whereas, there has historically been a limited amount of data regarding the prevalence of FGCS in medical school, so the AAMC initiated the question regarding FGCS status in 2018 in allopathic medical school applications to begin addressing this issue[10], and

Whereas, while FGCSs who sat for the MCAT were less likely than continuing-generation graduates to apply and be accepted to an LCME-accredited medical school, but FGCSs were equally as likely as their continuing-generation peers to matriculate after receiving an acceptance[11]; and

Whereas, FGCSs exhibit diverse intersectional identities in terms of gender, sexual orientation, race, ethnicity, immigration status, and socioeconomic status, often at a higher proportion than their non-FGCS counterparts,[11,12] and

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

Whereas, professional medical societies, such as the AAMC, AMCAS, and select medical colleges highlight the need to increase support and enrollment for FGCSs into medicine[15]; and

Whereas, there is limited data indicating FGCS status impact on performance in medical school and whether medical school performance is directly impacted by FGCS status; and

Whereas, although the AMA supports enhancing diversity in medicine through pipeline programs, educational support programs, and financial support in H-200.951, these policies do not explicitly include FGCS status; and

Whereas, the AMA supports enhancing diversity in medicine through pipeline programs, educational support programs, and financial support in H-200.951, though, these policies do not explicitly include FGCS status; and

Whereas, there is significant overlap in AMA diversity efforts and efforts that would support FGCS, therefore be it

OPTIONAL SECTION: FURTHER DISCUSSION

The definition of FGCS was heavily debated and discussed by members of the MSS upon initial evaluation of the resolution this report was referred to. The definition of FGCS used in this report was derived from FirstGen Forward, an organization dedicated to providing support to FGCS. While this was the definition that we found most encompassing of the authors' intent, we want to make note that throughout literature there was not a consensus on this definition. In this report, we only included resources with definitions that aligned with our own.

The literature regarding FGCS matriculation into medical school as well as performance in medical school was very limited. Due to this lack of evidence, as well as the overlap of intersectional identities that FGCS often exhibit, we did not find enough evidence to classify FGCS as a status that should be explicitly included in the AAMC definition of underrepresented in medicine. There is evidence that FGCS matriculation into medical school is increasing, however more primary literature is needed to determine the unique challenges that FGCS face as well as interventions that would benefit FGCS. We feel at this time that until that literature is more comprehensive, we cannot make a recommendation.

There was discussion of adopting a recommendation "that our AMA collaborate with appropriate stakeholders to include data collection of first-generation college status to all relevant medical school, residency, and fellowship application services." While we agree that this would be an effective method of collecting data, we do not believe that this would be an effective ask to bring to HOD. This is because asking multiple organizations to alter their application service in order to begin to collect primary data on a certain population is out of the scope of the AMA, especially when there is little data in the literature to back up why this data collection is important.

Although we as the Committee on Medical Education recognize subjectively that there are unique challenges that FGCS and students who are first in their families to attend medical school face, we cannot ignore the fact that objective data is insufficient in this topic area at this time. We highly recommend the original authors, or any others who seek to see actionable change with regards to this topic, to seek alternative means of advocacy within the AMA and other relevant stakeholders with specific objectives and aims in mind, rather than a change in policy that is unlikely to effect any change in these efforts within the AMA.

CURRENT AMA POLICY & EFFORTS

Current AMA-MSS Positions:

- "Marginalized and Minoritized Medical Student Recruitment and Retention Programs" 350.001MSS
- 350.003MSS: Minority Representation in the Medical Profession
- 350.011MSS Continued Support for Diversity in Medical Education
- 350.014MSS: Youth Health Pipeline Programs Initiative

Current AMA Policy:

- Supporting Women and Underrepresenting Minorities in Overcoming Barriers to Positions of Medical Leadership and Competitive Specialties D-200.975
- Recommendations for Future Directions for Medical Education H-295.995
- Strategies for Enhancing Diversity in the Physician Workforce D-200.985
- Continued Support for Diversity in Medical Education D-295.963

CONCLUSION

Based on our review of the evidence in the resolution provided below, we believe that there is extensive policy that already enables the original asks of the resolution to be enacted on through an MSS Action Item or other avenues of advocacy within or outside of the AMA. While we believe that all underrepresented students deserve to utilize resources that are intended to aid them as they navigate medical school, we do not feel as though there is enough literature to qualify First Generation College Graduates as a distinct group that is "underrepresented in medicine" as defined by the AMA. Additionally, there is little evidence that differentiates between medical students who are first generation college graduates, first general medical students, defined as those who have not had a parent(s) graduate from an LCME- or COCA- accredited medical school, nor first generation doctoral students, defined as those who have not had a parent(s) graduate from any institution that awards a doctoral degree. Due to the lack of concrete differentiation between these different types of students and the availability of current AMA policy and AMA-MSS positions on the topic, we do not feel as though further policy on this topic will enact any meaningful changes to the AMA's advocacy efforts.

RECOMMENDATION

Your Committee on Medical Education recommends that Resolution 308 "Expanding Medical Education Access and Support for First-Generation Students" not be adopted and the remainder of this report be filed.

ACKNOWLEDGEMENTS

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*Conflict of Interest Disclosure: Please note that Priya Gupta is also an author of the original resolution in addition to the report.

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RELEVANT AMA AND AMA-MSS POLICY

Marginalized and Minoritized Medical Student Recruitment and Retention Programs 350.001MSS

AMA-MSS will ask the AMA to encourage medical schools to continue and/or develop programs to expose students from first generation and lower socioeconomic backgrounds to the career of medicine; special summer programs to bring students facing financial barriers to medical schools for an intensive exposure to medicine; and conduct retention programs for marginalized and minoritized medical students who may need assistance. (AMA Res 35, I-79 Referred) (CME Rep T, I-79, Adopted) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS Res 4, I-14) (Reaffirmed: MSS Res 27, I-15) (Reaffirmed: MSS Res 19, I-17) (Amended: MSS GC Report A, A-23)

Supporting Women and Underrepresenting Minorities in Overcoming Barriers to Positions of Medical Leadership and Competitive Specialties D-200.975

Our American Medical Association will advocate for increased research on changes in specialty interests throughout medical education, including both undergraduate and graduate medical education, specifically in competitive specialties, with a focus on student demographics.

Our AMA will maintain allocated yearly funding for AMA-MSS national meeting attendance and maintain concrete and standing mechanisms for increasing participation for medical students within our AMA-MSS from medical schools with classically low national meeting attendance, which will be defined as less than five students per national AMA-MSS meeting over a period of five consecutive years, having one or more of the following characteristics:
Identify with group(s) underrepresented and disadvantaged in medicine.
Are from medically underserved areas.
Are first generation college graduates, as a mechanism to create more exposure to leadership and networking opportunities for these students.

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.

Strategies for Enhancing Diversity in the Physician Workforce D-200.985

(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.

Continued Support for Diversity in Medical Education D-295.963

(1) Our American Medical Association will publicly state and reaffirm its support for diversity in medical education and acknowledge the incorporation of DEI efforts as a vital aspect of medical training.
(2) Our AMA will request that the Liaison Committee on Medical Education regularly share statistics related to compliance with accreditation standards IS-16 and MS-8 with medical schools and with other stakeholder groups.
(3) Our AMA will work with appropriate stakeholders to commission and enact the recommendations of a forward-looking, cross-continuum, external study of 21st century medical education focused on reimagining the future of health equity and racial justice in medical education, improving the diversity of the health workforce, and ameliorating inequitable outcomes among minoritized and marginalized patient populations.
(4) Our AMA will advocate for funding to support the creation and sustainability of Historically Black College and University (HBCU), Hispanic-Serving Institution (HSI), and Tribal College and University (TCU) affiliated medical schools and residency programs, with the goal of achieving a physician workforce that is proportional to the racial, ethnic, and gender composition of the United States population.
(5) Our AMA will directly oppose any local, state, or federal actions that aim to limit diversity, equity, and inclusion initiatives, curriculum requirements, or funding in medical education.
(6) Our AMA will advocate for resources to establish and maintain DEI offices at medical schools that are staff-managed and student- and physician-guided as well as committed to longitudinal community engagement.
(7) Our AMA will investigate the impacts of state legislation regarding DEI-related efforts on the education and careers of students, trainees, and faculty.
(8) Our AMA will recognize the disproportionate efforts by and additional responsibilities placed on minoritized individuals to engage in diversity, equity, and inclusion efforts.
(9) Our AMA will collaborate with the Association of American Medical Colleges, the Liaison Committee on Medical Education, and relevant stakeholders to encourage academic institutions to utilize Diversity, Equity, and Inclusion activities and community engagement as criteria for faculty and staff promotion and tenure.

REPORT OF THE MEDICAL STUDENT SECTION
COMMITTEE ON LEGISLATION AND ADVOCACY AND
COMMITTEE ON ECONOMICS AND QUALITY OF MEDICINE

MSS COLA CEQM Report
(I-24)

Introduced by: MSS Committee on Legislation and Advocacy and Committee on Economics and Quality of Medicine

Subject: Insurer Accountability When Prior Authorization Harms Patients

Referred to: MSS Reference Committee (Alec Calac and Andrew Norton, Co-Chairs)

INTRODUCTION

At the Interim 2023 (I-23) MSS Assembly, MSS Resolution OF#068, "Insurer Accountability When Prior Authorization Harms Patients," asked the AMA-MSS to study the feasibility and efficacy of legal accountability to identify principles to guide the MSS when considering avenues for accountability of insurers and other payers when prior authorization leads to patient harm. The resolution, with the following resolve clause, was referred for study:

RESOLVED, That our AMA-MSS amend Policy 120.012MSS by addition and deletion as follows:

> Prior Authorization Reform 120.012MSS
> AMA-MSS supports prescription prior authorization reform that prioritizes timely response guidelines, disclosure of medications requiring prior authorization to physicians, transparency in denial of prior authorization requests or rescission of authorization, portability of prior authorization, ~~and~~ exceptions for urgent care access, and increased legal accountability of insurers and other payers when prior authorization leads to patient harm, including but not limited to the prohibition of mandatory pre-dispute arbitration and limitation on class action clauses in beneficiary contracts.

The MSS Reference Committee recommended referral of the resolution with the following rationale:

> "We recommend further study on legal accountability to establish an MSS stance when prior authorization leads to patient harm. An MSS Committee Report may seek to answer (1) Does the broader literature support alternative prior authorization reform strategies? and (2) What is understood by 'legal' liability? Your Reference Committee recommends Resolution OF068 be adopted as amended."

During the MSS Assembly, no one extracted the item, so the Reference Committee Recommendation to refer passed via the consent calendar.

Your Governing Council assigned this report to the Committee on Legislation and Advocacy (COLA) and Committee on Economics and Quality of Medicine (CEQM) with the following possible questions for consideration: What principles of the feasibility and efficacy of legal

accountability should guide the MSS when considering avenues for accountability of insurers and other payers when prior authorization leads to patient harm?

In the following whereas clauses and subsequent discussion, we provide an overview of prior authorization, its history and legislative context, the harms it can cause, other perspectives on prior authorization, relevant AMA policy, and how to address the issue.

WHEREAS CLAUSES

Whereas, Prior authorization (PA) is a process managed by health plans to control costs through mandates that healthcare professionals receive approval from the insurer before prescribing or administering healthcare services to the patient and subsequent payment qualification;[1] and

Whereas, the introduction of Medicare and Medicaid by President Lyndon B. Johnson in the 1960s coincided with the Utilization Review (UR) process conducted by registered nurses following the administration of a medication or medical service to ensure high-quality care, reduce waste, allocate resources, and eliminate costs through continuous evidence-based improvement throughout the duration of a patient's hospital stay;[2] and

Whereas, the PA process was invented as a prospective UR process in order to decrease costs and eliminate misuse of resources prior to the prescribing or administration of healthcare services to the patient;[2] and

Whereas, PA is used as a healthcare utilization management tool by payers to deny payment for covered benefits when the payer deems the benefit clinically unnecessary, with a 2023 AMA PA study finding that more than 1 in 3 physicians reported that PA criteria are rarely or never evidence-based, and 1 in 4 physicians report that PAs are often or always declined;[1] and

Whereas, the same 2023 survey found that nearly 1 in 4 physicians have reported that PA has led to serious adverse events for patients under their care, contributing to devastating consequences for patient outcomes, productivity, continuity of care, physician burnout, and unnecessarily creates additional financial expenses for patients;[1] and

Whereas, the same 2023 physician survey found that 94% of patients requiring PA for treatment experienced a delay in access to necessary care, with 78% reporting patients abandoning their treatment plan;[1] and

Whereas, a 2023 study published in JAMA Network Open found that 73% of cancer patients who encountered prior authorization experienced delays of two weeks or more, leading to increased anxiety and reduced trust in the healthcare system[36]; and

Whereas, a 2023 review in the Journal of the American College of Cardiology reported that prior authorization processes often lead to significant delays in patient care, increasing the risk of adverse clinical outcomes, including preventable hospitalizations and deterioration of patient health[11]; and

Whereas, A 2023 Kaiser Family Foundation (KFF) survey found that 16% of all surveyed insured adults experienced PA problems (such as denied claims or authorization delays), with higher rates for those that had more than 10 physician visits in the past year (31%), those seeking care for mental health conditions (26%), and those seeking care for diabetes (23%);[3] and

Whereas, The process of PA reviews, which health plans have been observed to delegate to third-party contractors, causes significant delays in appropriate patient care that can lead to prolonged suffering and unnecessary deaths;[4] and

Whereas, PA has been shown to constitute a significant financial burden for patients, typically within the range of $35 to $100 per occurrence;[5] and

Whereas, In a survey conducted by the St. Louis Metropolitan Medical Society (SLMMS), 92% of physicians either agreed or strongly agreed that their ability to practice medicine appropriately was influenced by PA and 93% somewhat agreed or strongly agreed that restrictions from an insurance provider caused them to alter a patient's treatment plan;[6] and

Whereas, The average cost of PA approval specifically on primary care practices, which is significant since the majority of individuals will see primary care physicians in their lifetimes, ranged from $2,161 to $3,430 annually per full-time physician in 2013;[7,8] and

Whereas, the Centers for Medicare & Medicaid Services finalized the "CMS Interoperability and Prior Authorization Final Rule CMS-0057-F," beginning January 1, 2026, that will require only limited identified payers to increase transparency with patients and providers regarding PA metrics, denial rationale, and adherence to urgent request PA decision turn-around of 72 hours and non-urgent requests up to a seven-day mandate;[9] and

Whereas, the CMS final prior authorization regulation on PA decision turnarounds only applies to medical items and services, explicitly failing to provide regulations on PA requests for medications, failing to address delayed treatment for patients;[10] and

Whereas, the Centers for Medicare & Medicaid Services (CMS) does not have jurisdiction over large private employer plans governed by the Employee Retirement Income Security Act (ERISA) under the Department of Labor, leaving the existing prior authorization requirements unchanged for the majority of Americans that are covered by large insured and self-insured employer programs;[10] and

Whereas, the American College of Cardiology Prior Authorization Reporting Tool collects data regarding PA declinations, with data demonstrating more than 50% of denied services do not result in peer discussion or remain denied regardless of submitted appeals;[11] and

Whereas, Other surveys by the American Society of Clinical Oncologists (ASCO), the American Cancer Society Cancer Action Network (ACS CAN), and the American Society for Radiation Oncology (ASTRO) have reported similar findings, with nearly all oncologists in the 2023 ASCO reporting a patient experienced harm due to PA, including 35% who specifically attributed a patient's loss of life to prior authorization requirements;[7,12,13] and

Whereas, Capitated payment models like Medicaid Managed Care and Medicare Advantage Organizations (MAOs), in which private companies are paid fixed amounts per enrollee based on expected costs regardless of the enrollee's actual incurred cost, create an incentive to minimize enrollee services and maximize PA denials;[14] and

Whereas, Reporting by the Office of the Inspector General (OIG) for the United States Department of Health and Human Services has consistently shown that many denials were inappropriate, with a 2022 report finding that 13% of PA denials met Medicare coverage requirements and 18% of payment denials met Medicare coverage rules and internal reimbursement guidelines;[14] and

Whereas, a 2024 KFF study identified that the frequency of denial for all PA requests submitted to Medicare Advantage has increased from 5.6% in 2020 to 7.4% of all requests, or about 3.4 million requests, in 2022;[15] and

Whereas, A 2023 KFF study, as well as two separate OIG reports, found that although just 11% of PA denials by MAOs are appealed, the vast majority of appeals were either completely or partially overturned, and that this constituted a delay in patient access to treatment agreed to be necessary by both the prescribing clinician and the payer;[16–18] and

Whereas, a 2023 KFF survey outlines that 69% of patients with denied insurance claims do not know that they have appeal rights, meaning a majority of patients rely on their providers' knowledge of the appeals process to have a denied claim addressed;[19] and

Whereas, The KFF study and OIG reports noted that their findings were particularly concerning because the appeals process was vastly underutilized by beneficiaries and providers, with only 1% to 27% of initial denials ever being appealed, meaning insurers are incentivized to deny coverage under the assumption that only a tiny portion of PA decisions will be formally appealed; [16–18] and

Whereas, despite increasing evidence of inappropriate PA denials by insurers, there currently is no consensus on how to hold insurers liable for denials that result in preventable injury to patients, with largely unsuccessful litigation strategies ranging from lousy faith breach of contract to negligent breach of duty, and at least one effort in Texas preempted by the Employment Income & Retirement Act of 1974 (ERISA);[4,20,21] and

Whereas, In a recent New York case in which a delayed PA approval resulted in the preventable, rapid progression of a woman's cancer, the U.S. District Court for the Southern District of New York ruled against the woman when it held that existing New York law does not impose a duty of reasonable care on insurance companies that engage in PA review, highlighting the need for aggressive state legislative reform to increase liability for state-regulated insurers;[22] and

Whereas, Efforts to hold insurers liable for PA denials that result in preventable injury have been slowed by the increasing use of mandatory arbitration clauses in beneficiary contracts, which require beneficiaries to settle claims disputes by arbitration and often include waivers that prevent beneficiaries from bringing class action suits;[23,24] and

Whereas, a 2019 review of arbitration clauses used by Fortune 100 companies found that many of the nation's largest health insurance companies, including UnitedHealth Group, Anthem, Aetna, and Cigna, impose mandatory arbitration clauses with class waivers on consumers;[25] and

Whereas, mandatory arbitration clauses are particularly insidious in health insurance contracts given the wide gap in bargaining power between the insurance company and beneficiary and limited selection of alternate insurers as a result of increasing consolidation in insurance markets;[24,26] and

Whereas, while some individuals may prefer arbitration, awards data suggests it is generally bad for consumers, as the median award for medical malpractice claims in Kaiser Permanente's arbitration program is nearly $400,000 less than median awards for medical malpractice jury trials in California;[27] and

Whereas, in 2023 71 medical societies and 47 state medical associations collectively signed a letter petitioning the Centers for Medicare & Medicaid Services to institute reforms to PA specifically for Medicare Advantage patients including ensuring PA is never used to delay or

discourage care, ensuring PA approvals remain valid for the duration of the course of treatment, and supporting gold-carding programs to exempt physicians with high PA approval;[28] and

Whereas, in addition to the federal Improving Seniors' Timely Access to Care Act (H.R.3173), nearly 90 prior authorization reform bills have been proposed in current state legislatures, many of which draw on our AMA's model legislation, but none of these proposed bills that have received AMA support address insurers' legal liability when patients are harmed by prior authorizations;[29,30] and

Whereas, our AMA has failed to support several federal bills – including the Forced Arbitration Injustice Repeal Act (S.1376), the Justice for Patients Act (H.R.3947), and the Mental Health Matters Act (H.R.7780) – that have been proposed in recent Congressional sessions that aim to prohibit mandatory arbitration clauses, thereby improving the ability of patients to participate in class action lawsuits related to their health insurance plans;[31–33] and

Whereas, current AMA Policy on ERISA (H-285.915) establishes a precedent for AMA advocacy for federal and state legislation that establishes legal accountability for harm to patients resulting from negligent utilization management policies, but this is limited to self-insured health benefits plans;[34] and

Whereas, though the AMA has advocated extensively for PA reform, its efforts have focused mainly on streamlining the process and providing greater oversight rather than creating or enforcing legal liability for PA denials that injure patients;[35] and

Whereas, the AMA HOD passed Policy D-320.974 during the Annual AMA Meeting 2024 which asks for increased insurer accountability when prior authorization harms patients, thus, making this resolution redundant.[37]

CURRENT AMA POLICY & EFFORTS

Current AMA policy does address the legal accountability of insurers and suggests some redundancy of the proposed AMA-MSS resolution. According to resolved 1 from policy D-320.974, which was last modified in 2024, AMA "advocates for increased legal accountability of insurers and other payers when delay or denial of prior authorization leads to patient harm, including but not limited to the prohibition of mandatory pre-dispute arbitration regarding prior authorization determinations and limitation on class action clauses in beneficiary contracts." This language is extremely close to the underlined clause in the AMA-MSS resolution. In addition to D-320.974, various AMA policies ensure that health plans and insurers are held legally accountable should patient outcomes and/or rights to care be interfered with or undermined. Within AMA policy regarding ERISA, legal accountability is directed toward and upheld against self-insured plans' negligent utilization management (H-285.915). In the context of government benefit plans, AMA asks for state societies to work for legislation that includes the "liability of review entities for injury to beneficiaries" (H-155.976). AMA is also committed to helping reduce patient harm from delays in care, negative outcomes, or treatment abandonment due to prior authorization (D-320.978). The AMA has previously set forth a policy on acquiring the data behind barriers to patient care caused by prior authorization, illustrating their multi-angle approach within policy to tackle the issues mentioned in Res OF068 (H-320.939).

CONCLUSION

Based on our review of the evidence in the resolution provided, we find that this policy advocates for appropriately increased legal accountability of insurers when prior authorization leads to negative patient outcomes. However, as the AMA HOD has already passed this resolution during I-24 through another delegation, this resolution is now redundant with current AMA policy.

RECOMMENDATION

Your Committee on Legislation and Advocacy (COLA) and Committee on Economics and Quality of Medicine (CEQM) recommend(s) that Resolution OF068 not be adopted and the remainder of this report be filed.

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RELEVANT AMA POLICY

Insurer Accountability When Prior Authorization Harms Patients D-320.974

1. Our American Medical Association advocates for increased legal accountability of insurers and other payers when delay or denial of prior authorization leads to patient harm, including but not limited to the prohibition of mandatory pre-dispute arbitration regarding prior authorization determinations and limitation on class action clauses in beneficiary contracts.
2. Our American Medical Association advocates that low-cost noninvasive procedures that meet existing standard Medicare guidelines should not require prior authorization.
3. Our AMA supports that physicians be allowed to bill insurance companies for all full time employee hours required to obtain prior authorization.
4. Our AMA supports that patients be allowed to sue insurance carriers which preclude any and all clauses in signed contracts should there be an adverse outcome as a result of an inordinate delay in care.
(Res. 711, A-24)

AMA Policy on ERISA H-285.915

1. Our AMA will seek, through amendment of the ERISA statute, through enactment of separate federal patient protection legislation, through enactment of similar state patient protection legislation that is uniform across states, and through targeted elimination of the ERISA preemption of self-insured health benefits plans from state regulation, to require that such self-insured plans: (a) Ensure that plan enrollees have access to all needed health care services; (b) Clearly disclose to present and prospective enrollees any provisions restricting patient access to or choice of physicians, or imposing financial incentives concerning the provision of services on such physicians; (c) Be regulated in regard to plan policies and practices regarding utilization management, claims submission and review, and appeals and grievance procedures; (d) Conduct scientifically based and physician-directed quality assurance programs; (e) Be legally accountable for harm to patients resulting from negligent utilization management policies or patient treatment decisions through all available means, including proportionate or comparative liability, depending on state liability rules; (f) Participate proportionately in state high-risk insurance pools that are financed through participation by carriers in that jurisdiction; (g) Be prohibited from indemnifying beneficiaries against actions brought by physicians or other providers to recover charges in excess of the amounts allowed by the plan, in the absence of any provider contractual agreement to accept those amounts as full payment; (h) Inform beneficiaries of any discounted payment arrangements secured by the plan, and base beneficiary coinsurance and deductibles on these discounted amounts when providers have agreed to accept these discounted amounts as full payment; (i) Be subject to breach of contract actions by providers against their

administrators; and (j) Adopt coordination of benefits provisions applying to enrollees covered under two or more plans.

2. Our AMA will continue to advocate for the elimination of ERISA preemption of self insured health plans from state insurance laws consistent with current AMA policy.
(CMS Rep. 6, I-96) (Reaffirmation A-97) (Reaffirmed: Rules and Cred. Cmt., I-97) (Reaffirmed by Sub. Res. 202, A-98) (Reaffirmation I-98) (Reaffirmation A-99) (Reaffirmed: Res. 238, A-00) (Renumbered: CMS Rep. 7, I-05) (Reaffirmed and Modified: Res. 223, I-10) (Reaffirmed in lieu of Res. 235, A-11: BOT action in response to referred for decision Res. 235, A-11) (Reaffirmed: CMS Rep. 6, A-12) (Reaffirmed in lieu of: Res. 235, A-17) (Reaffirmed: Res. 206, I-20)

Prior Authorization-Patient Autonomy D-478.958
Our AMA will advocate that patients and physicians should be given access to an electronic **prior authorization** system by their health plans with the ability to monitor the electronic **prior authorization** process in any model legislation and as a basis for advocacy for **prior authorization** reforms.
(Res. 731, A-22)

Prior Authorization and Utilization Management Reform H-320.939
Our AMA will: (1) 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) 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) 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; and (4) 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.
(CMS Rep. 08, A-17) (Reaffirmation: I-17) (Reaffirmed: Res. 711, A-18) (Appended: Res. 812, I-18) (Reaffirmed in lieu of: Res. 713, A-19) (Reaffirmed: CMS Rep. 05, A-19) (Reaffirmed: Res. 811, I-19) (Reaffirmed: CMS Rep. 4, A-21) (Appended: CMS Rep. 5, A-21) (Reaffirmation: A-22)

Fair Reimbursement for Administrative Burdens D-320.978
Our AMA will: (1) 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) 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) oppose inappropriate payer policies and procedures that deny or delay medically necessary drugs and medical services; and (4) advocate for fair reimbursement of established and future CPT codes for administrative burdens related to (a) the **prior authorization** process or (b) appeals or denials of services (visits, tests, procedures, medications, devices, and claims), whether pre- or post-service denials.
(Res. 701, A-22)

Managed Care Cost Containment Involving Prescription Drugs H-285.965
(2) Physicians should be particularly vigilant to ensure that formulary decisions adequately reflect the needs of individual patients and that individual needs are not unfairly sacrificed by decisions based on the needs of the average patient. Physicians are ethically required to advocate for additions to the formulary when they think patients would benefit materially and for exceptions to the formulary on a case-by-case basis when justified by the health care needs of particular patients. Mechanisms to appeal formulary exclusions should be established. Other cost-containment mechanisms, including prescription caps and **prior authorization**, should not unduly burden physicians or patients in accessing optimal drug therapy.
(CEJA Rep. 2, A-95) (Res. 734, A-97) (Appended by Res. 524 and Sub. Res.714, A-98) (Reaffirmed: Res. 511, A-99) (Modified: Res. 501, Reaffirmed: Res. 123 and 524, A-00) (Modified: Res. 509, I-00) (Reaffirmed: CMS Rep. 6, A-03) (Reaffirmation I-04) (Reaffirmed: Sub. Res. 529, A-05) (Reaffirmation A-08) (Reaffirmation A-10) (Reaffirmed in lieu of Res. 822, I-11) (Reaffirmation A-14) (Reaffirmed: CMS Rep. 05, A-19) (Reaffirmed: CMS Rep. 6, I-20)

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 and;(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
(Res. 202, A-90) (CMS Rep. A, A-90) (Reaffirmed: BOT Rep. 40, I-93) (CMS Rep. 12, A-95) (Appended: Res. 715, I-02) (Reaffirmation A-07) (Reaffirmed in lieu of Res. 828, I-08) (Reaffirmation I-11) (Reaffirmation: A-17)

Abuse of Preauthorization Procedures H-320.945
1. Our American Medical Association opposes the abuse of preauthorization by advocating the following positions: Preauthorization should not be required where the medication or procedure prescribed is customary and properly indicated, or is a treatment for the clinical indication, as supported by peer-reviewed medical publications or for a patient currently managed with an established treatment regimen.

2. Third parties should be required to make preauthorization statistics available, including the percentages of approval or denial. These statistics should be provided by various categories, e.g., specialty, medication or diagnostic test/procedure, indication offered, and reason for denial.
(Sub. Res. 728, A-10) (Reaffirmation I-10) (Reaffirmation A-11) (Reaffirmed: Res. 709, A-12) (Reaffirmed: CMS Rep. 08, A-17) (Reaffirmed: Res. 125, A-17) (Reaffirmation A-17) (Reaffirmation I-17) (Reaffirmed: CMS Rep. 4, A-21) (Reaffirmation A-22) (Reaffirmed: CMS Rep. 06, A-24)

Utilization Review, Medical Necessity Determination, Prior Authorization Decisions D-320.977
a) Our American Medical Association will advocate for implementation of a federal version of a **prior authorization** "gold card" law, which aims to curb onerous prior authorization practices by many state-regulated health insurers and health maintenance organizations. b) Our AMA will advocate that health plans should offer physicians at least one physician-driven, clinically-based alternative to **prior authorization**, including a "gold-card" or "preferred provider program."
(Res. 727, A-22) (CEJA Rep. 01, A-23)

Prior Authorization Reform D-320.982
Our American Medical Association will explore emerging technologies to automate the **prior authorization** process for medical services and evaluate their efficiency and scalability, while advocating for reduction in the overall volume of prior authorization requirements to ensure timely access to medically necessary care for patients and reduce practice administrative burdens.
(Res. 704, A-19) (Reaffirmation A-22)

RELEVANT MSS POLICY

Prior Authorization Reform 120.012MSS
AMA-MSS supports prescription prior authorization reform that prioritizes timely response guidelines, disclosure of medications requiring prior authorization to physicians, transparency in denial of prior authorization requests or rescission of authorization, portability of prior authorization, and exceptions for urgent care access.
(MSS Res 13, I-15) (Reaffirmed: MSS GC Rep B, A-21)

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REPORT OF THE MEDICAL STUDENT SECTION
ARCHIVES TASK FORCE

MSS ATF Report
(I-24)

Introduced by: MSS Archives Task Force

Subject: MSS Archives Task Force Preliminary Report

Referred to: MSS Reference Committee
(Alec Calac and Andrew Norton, Co-Chairs)

INTRODUCTION & BACKGROUND

At the 2024 Annual AMA Medical Student Section (MSS) Meeting, the MSS assembly voted to adopt the 2023-2024 Archives Task Force (ATF) Report with the following recommendations that call for new resource development and maintenance of an Archives Task Force with report back at I-24 and A-25:

1. *RESOLVED, that our AMA-MSS maintain a MSS Positions Compendium containing (1) all current MSS positions, outcomes of resolutions that were sent to the AMA House of Delegates (HOD), and actions taken by the AMA as a result of AMA Policy originally proposed by the MSS and (2) a separate section for rescinded MSS positions with accompanying rationale for their rescission; and be it further*
2. *RESOLVED, That our AMA-MSS maintain a MSS Resolutions Archive that will include at minimum authorship information, links to the original resolution, final language adopted by the MSS, final language adopted by the HOD, links to the HOD Policy Finder, implementation notes regarding AMA actions, and links to media coverage resulting from the resolution; and be it further*
3. *RESOLVED, That our AMA-MSS report information to the original MSS resolution and/or report authors regarding outcomes of resolution forwarded to HOD and implementation of associated adopted AMA policy; and be it further*
4. *RESOLVED, that our AMA-MSS produce an annotated reference committee report indicating the final assembly outcome at each meeting in lieu of a summary of actions; and be it further*
5. *RESOLVED, that our AMA-MSS produce and maintain confidential archives of notes on information gathered regarding other delegations stances on MSS items and actions taken by the MSS Caucus at HOD; and be it further*
6. *RESOLVED, that our AMA-MSS maintain a guide on how to cite resolutions and represent organized medicine involvement on CVs and residency application materials; and be it further*

7. *RESOLVED, That our AMA-MSS develop and maintain a current membership archive accessible to MSS Staff, GC, and Regional Executive Councils that tracks local campus section leadership who consent to sharing their contact information; and be it further*
8. *RESOLVED, That our AMA-MSS develop and maintain a database of MSS alumni who consent to share their information to serve as resources for the MSS; and be it further*
9. *RESOLVED, That our AMA MSS maintain an Archives Task Force which will continue to investigate strategies for (a) preserving institutional memory, (b) reporting this information to the MSS, and (c) monitor the implementation of changes adopted as a result of the A-24 Archives Task Force Report and will work with GC to report back to the MSS Assembly at I-24 and A-25; and be it further*
10. *RESOLVED, that our AMA MSS Archives Task Force will work with relevant stakeholders to outline recommendations for establishing collaborations with JAMA and state-to-state policy and advocacy collaborations and report back to the MSS Assembly during their A-25 report.*

The MSS Governing Council (GC) evaluated the recommendations assigned tasks to appropriate parties.

Staff Implementation of Positions & Actions Archives:
Resolved 1 and 4 calling for updates to the MSS Positions Compendium and production of an Annotated Reference Committee Report were immediately implementable and will henceforth be accomplished by the MSS Staff.

Staff is currently in the process of converting the MSS Digest of Actions into the official version of the new MSS Positions Compendium (draft version) and will update the MSS when the new resource is finalized.

The MSS Summary of Actions sheet will remain a resource for all actions taken prior to A-24 at both the MSS Assembly and AMA House of Delegates (HOD). Actions taken at A-24 and after by the MSS Assembly, will be found in the MSS Annotated Reference Committee Report. Actions taken at A-24 and after at the HOD, will be found in the MSS Archive of HOD Proceedings - "Membrick".

All of these resources will be officially stored on the MSS Policymaking Webpage.

Guide to Representation of Organized Medicine on Residency Applications and CVs:
The MSS Committee on Medical Education and GC are collaborating to address Resolved 6 which involves updating the current Organized Medicine Guide to ERAS. In addition, the workgroup is exploring possible avenues for collaboration with the Resident and Fellow Section (RFS) Committee on Medical Education, AMA Medical Education Business Unit, and AAMC for both improved guidance as well as potential improvements to the residency application questions themselves.

Archives Task Force:
The 2024 - 2025 Archives Task Force (ATF) was assembled to address Resolves 2, 3, 5, 7, 8, 9, and 10. In order to accomplish these tasks the following five ATF committees were developed:

- Policy & Outcomes Archives: This committee will address Resolves 2, 3, and 5. Primary tasks include reviewing and recording implementation outcomes for MSS positions that have previously passed the HOD. The committee will collaborate with the MSS Standing Committee on Long Range Planning (COLRP) as necessary. They will also collaborate with the MSS Section Delegates to determine best methods of tracking original MSS resolution and report authors and maintaining confidential archives of notes taken at HOD.
- Big Wins: This committee will focus on addressing Resolved 9 reviewing historical MSS positions based on topic areas and discuss methods of reporting big wins to the MSS and public and produce promotional materials. They will collaborate with MSS Standing Committee on Membership, Engagement, and Recruitment (MERC) and Committee on Impact, Policy, and Action (IMPACT) as necessary.
- Membership & Engagement: This committee will address Resolved 7 and 8 by developing mechanisms to best track MSS membership, events, and leadership positions held by medical students. They will also aim to highlight the events and work produced from standing committees and region leaders. This committee will also develop mechanisms for members to track MSS members involvement including resolutions authored, reviewed, and testified on. Finally, they will suggest mechanisms for tracking and engaging MSS alumni. They will collaborate with MSS Standing Committees and Region leadership as necessary.
- State Advocacy Collaboration: This committee will address Resolved 10 by formalizing state advocacy collaboration frameworks including, but not limited to, identifying leaders of this initiative, developing resolution templates, and developing programming ideas. The committee will collaborate with the MSS Standing Committee on Legislation and Advocacy (COLA) and COLRP as necessary.
- JAMA Collaboration: This committee will address Resolved 10 by developing a formal proposal to submit to JAMA to consider collaborating with the MSS.

DISCUSSION

The discussion of this report is organized by ATF committee and addresses actions taken thus far and plans to address the tasks assigned by the A-24 ATF Report.

Policy & Outcomes Archives

The Policy & Outcomes Archives Committee was tasked with the following Resolved clauses below:

> *1. RESOLVED, that our AMA-MSS maintain a MSS Positions Compendium containing (1) all current MSS positions, outcomes of resolutions that were sent to the AMA House of Delegates (HOD), and actions taken by the AMA as a result of AMA Policy originally proposed by the MSS and (2) a separate section for rescinded MSS positions with accompanying rationale for their rescission;*

2. RESOLVED, That our AMA-MSS maintain a MSS Resolutions Archive that will include at minimum authorship information, links to the original resolution, final language adopted by the MSS, final language adopted by the HOD, links to the HOD Policy Finder, implementation notes regarding AMA actions, and links to media coverage resulting from the resolution; and be it further

3. RESOLVED, That our AMA-MSS report information to the original MSS resolution and/or report authors regarding outcomes of resolution forwarded to HOD and implementation of associated adopted AMA policy;

5. RESOLVED, that our AMA-MSS produce and maintain confidential archives of notes on information gathered regarding other delegations stances on MSS items and actions taken by the MSS Caucus at HOD;

While the MSS Policy Analyst will be in charge of the official conversion of the MSS Digest of Actions to the MSS Positions Compendium which will include all active MSS Positions and rescinded positions for reference, the Policy & Outcomes Archives Committee will review the final document. In addition, they will be using this document among others to build the back archive of the MSS Resolutions Archive.

Pursuant of Resolve 2, the 2023-2024 ATF created a prototype of a MSS Resolutions Archive that contained all of the necessary information called for by this resolved clause. One of the main bottleneck areas to creating this document was tracking of authorship. In fact, prior to the November 2020 meeting, if a region sponsored a resolution, only the region would be listed on the resolution and authors from that resolution would be removed. This is why some of the information is redundant in the current prototype The 2024-2025 Section Delegates have been working on building upon the previous work to develop a more sustainable way of collecting authorship information that can be easily shared with regions for internal archives. Pursuant of this goal, the MSS Resolution Final Submission form has been updated to separate authors by region.

Meanwhile, in the A-24 Delegate Report B, the 2023-2024 MSS Section Delegates created the MSS Archive of HOD Proceedings (colloquially referred to as “the Membrick”), with the intent of making this document publicly available to all MSS members. The Membrick contains records of all HODs moving forward in a single easily accessible location. The intent is that this document shall be a living archive which future Section Delegates can easily use in the creation of their Delegate Report, and that the general MSS membership may use it as a tool to learn the history of the MSS and further the advocacy of our Section. The Policy & Outcomes Archive sub-committee is working to create a sustainable system for the maintenance of the useful and digestible MSS Resolutions Archives for both leadership and general membership.

Previous work to update original MSS resolution and report authors of the outcomes of resolutions sent to the HOD was not undertaken in a substantial way outside of previous iterations of Section Delegate Reports until last year, when the 2023-2024 Section Delegates made a concerted effort to update relevant parties immediately after HOD meetings by various MSS communication channels. The sub-committee shall consider the best methods for similar communications in the future, recognizing the additional work that crafting and disseminating these communications placed on the MSS Section Delegates. The ATF and MSS Section Delegates hope that the **improved MSS Resolution Archives and authorship tracking** will help regions take ownership of resolutions with authors from their regions. More information on communication plans can be found in the Big Wins section of this report.

Finally, with regard to Resolve 5, the sub-committee shall consider the most prudent way to maintain the notes gathered by the MSS Caucus at HOD. Of note, these notes already exist from the last several years of meetings, from the time that the MSS Caucus began taking notes in the "Caucus Microbrick". While this microbrick shares a name with the MSS Assembly Microbrick, these are very different documents. Most notably, the Caucus Microbrick has changed from meeting to meeting depending on the preferences of the MSS Section Delegates at the time. This sub-committee is tasked with efficiently maintaining and consolidating these records in a way that minimizes the duplicity of work and creates a sustainable system for record-keeping moving forward. This sub-committee will consider the most efficacious way to accomplish this task without curtailing the Section Delegates ability to enhance the functions and notetaking of the MSS Caucus.

Big Wins

The Big Wins committee was tasked to generate resources that would preserve our experiences and ensure they are advertised properly to our members and external parties. Please see below the Resolved clause and the various projects that this committee is currently working on:

> *9. RESOLVED, That our AMA MSS maintain an Archives Task Force which will continue to investigate strategies for (a) preserving institutional memory, (b) reporting this information to the MSS, and (c) monitor the implementation of changes adopted as a result of the A-24 Archives Task Force Report*

Powerpoints & Other Resources for Public Presentation

Your ATF discussed the utilization of pre-made powerpoints to highlight our AMA MSS big wins for presentations and other formal meetings. The creation and maintenance of these powerpoints will be useful when meeting with potential members, other organizations, and standing committees to highlight what the AMA MSS has achieved and provide inspiration for the future. Your ATF also discussed giving big wins a special designation in the policy archives, and linking these powerpoints to the archives for easy access.

There are already multiple pre-made powerpoint presentations that MSS leaders and staff have created reflecting some of our big wins, and we hope to utilize and systematically expand upon these resources for wider use and availability. We also are discussing the idea of poster templates/flyers to put up during activity fairs/membership engagement events to also promote our big wins.

We are discussing recommendations for remade powerpoints with big wins from:

a. Historical big wins throughout the lifespan of the MSS
b. Big wins from the last meeting/year
c. Big wins pertaining to specific issues/policy priorities that would be of interest to:
    i. General potential new members
    ii. National Medical Student Organizations
    iii. Standing committees
    iv. Members with specific passions
d. Regional/chapter big wins
    i. Big wins stored at a regional level

e. Local chapter templates in powerpoint and poster formats that chapters can easily take slides they think their chapters would be most interested in and easily insert big wins attributable to their chapter.

Your ATF also discussed the timeline at which these resources would be updated. In order to keep them current, we discussed all of them being reviewed and updated after each meeting, with the exception of historical big wins being reviewed each year.

Your ATF recommends that the AMA-MSS GC delegate and assign the appropriate parties to be responsible for reviewing and updating these resources on an ongoing basis. We discussed potential parties that would be appropriate to assign these responsibilities. Notably, your ATF discussed and agreed with the recommendation in the previous A-24 ATF report that the logistics convention committee or a new archives convention committee be assigned these responsibilities. Other parties that could be assigned these responsibilities include standing committees on topics relevant to their committee, an archival subcommittee of IMPACT or another new entity, and region committees or leaders for region policies. At this time it is our recommendation that GC delegate to these parties or any other party that they see fit in performing these responsibilities.

Social Media

Given the current rise in social media as a form of news disbursement and the AMA's trend towards solidifying their social media presence, your ATF believes that maximizing this push is key. For this reason, one way we intend to promote MSS Big Wins is via social media. Specifically, we hope to collaborate with the official @amermedicalassn Instagram account to do the following:

a. Post historical big wins that are associated with the monthly awareness topics:
    i. For example, in February (Black History Month), we would aim to get an Instagram post describing the MSS win that empowered the AMA to stand by the fact that racism is a threat to public health.
        1. Please see this link for an example of what an Instagram post highlighting this idea would look like.
    ii. We hope that with this example and future dissemination of historical big wins, individuals associated with and those not associated with the AMA will have a better understanding of the impact the medical student section has.
b. Utilize collaboration posts to display the current wins from our MSS chapters across the country:
    i. We believe that this will induce a ripple effect of inspiration, galvanizing chapters in other regions to continue their efforts and see that state and national work is still being conducted, even outside of biannual meetings.
    ii. We also believe that this will aid in relationship development among chapters, outside of biannual meetings, further strengthening the voice of the MSS

Your ATF discussed ensuring posterity of these potential initiatives. Current plans focus on Big Wins maintaining ownership of drafting these Instagram posts through a subcommittee. We also considered branching into other social media platforms, i.e. LinkedIn and X (Twitter), but believe that developing a brand on Instagram *first* should be the priority. **We would appreciate any**

feedback on this topic and look forward to improving and better featuring MSS Big Wins to our members and the public.

Membership & Engagement

The Membership & Engagement committee was tasked to create an accurate member list of all AMA-MSS leaders along with starting an alumni database. Please see the associated Resolved clauses and the projects they plan to work on below:

> *7. RESOLVED, That our AMA-MSS develop and maintain a current membership archive accessible to MSS Staff, GC, and Regional Executive Councils that tracks local campus section leadership who consent to sharing their contact information*
>
> *8. RESOLVED, That our AMA-MSS develop and maintain a database of MSS alumni who consent to share their information to serve as resources for the MSS*

Comprehensive Member List
The committee has conducted initial outreach to region leaders to begin collecting contact information of local campus section leaders. Additionally, the committee will work to update the MSS Leadership Contact 2024-2025 Contact Sheet, which your ATF is recommending that a copy be made of at the end of each year and the same sheet be updated to maintain links and ease of access for members. The committee will work on creating a centralized location for the past, current, and future leadership contact information so that it is accurately stored for future leaders.

MSS Alumni Database
The committee will work on this project likely after I-24 when the current leadership contact information is collected. The committee is currently brainstorming ways to collect this information, what information we want to collect, where it will be stored, and how to best utilize this information. We are open to any ideas and feedback if you have any!

State Advocacy Collaboration

The State Advocacy Collaboration committee is currently working on the following resolved clause:

> 10. RESOLVED, that our AMA-MSS [...] pursue and promote efforts that encourage state to state collaboration within policy and advocacy [...].

The 2023-2024 MSS Governing Council facilitated the first ever State Leaders Summit in January that was focused on building connections with State leaders (Medical Students who serve on their State Medical Societies and State Medical Student Sections) and the AMA. Prior to the Summit, information was collected from 93 state leaders from 36 states indicating potential interest in attending a State Leaders Summit and topics they would like discussed, and recent successes and challenges faced by their state level medical student section. During the Summit,

a summary of the results were presented along with other presentations from national leadership and interactive breakout sessions focused on topics relevant to students involved in state medical society leadership that can be seen in Table 1 below and on the official presentation sides can also be viewed here.

State Leadership Summit January 28, 2024 12:00 PM - 2:00 PM CST	
12:00 PM - 12:15 PM	**The Powers and Pitfalls of Student Engagement in State Medical Associations** *Natasha Topolski, AMA MSS Chair & Anand Singh, AMA MSS Chair-Elect*
12:15 PM - 12:45 PM	**Breakout & Workshop #1: Building a Successful State Society Medical Student Section** *Laurie Lapp, AMA MSS Alternate Delegate*
12:45 PM - 12:50 PM	Transition
12:50 PM - 1:10 PM	**Student Advocacy & How Resolutions Make a Difference** ***Resolution Sharing & Launching the State Resolution Collaborative*** *Raj Reddy, MSS Section Delegate & Justin Magrath, Former MSS Section Alternate Delegate* ***So My Resolution was Adopted at the House of Delegates - What Happens Next?*** *Aliya Siddiqui, AMA Trustee* ***Grassroots Advocacy & Mobilizing Students*** *Jessica McAllister, AMA Government Relations & Advocacy Fellow*
1:10 PM - 1:40 PM	**Breakout & Workshop #2: Launching the State Resolution Collaborative & Facilitating Advocacy Within & Beyond State Societies**
1:45 PM - 1:50 PM	Transition
1:50 PM – 2:00 PM	**Closing & Next Steps** *Physicians of the Future Summit - Abbigayle Willgruber, MSS At-Large Officer* *Closing & Next Steps - Natasha Topolski, AMA MSS Chair & Anand Singh, AMA MSS Chair-Elect*

Table 1: 2024 State Leadership Summit Agenda

Feedback regarding the summit was positive but limited. Respondents agreed that the summit was useful and that topic sessions were appropriate. Ideas for the future included extending the allotted time to provide for longer breakout sessions and more time to share ideas.

Two outcomes from the Summit were the generation of both a State Leaders GroupMe and a State Leaders resource folder. Several state leaders hosted meetings in April 2024 in order to begin addressing some of the issues brought to light at the Summit. These included:

1. *State/Region Resolution and Policy Project*: creating a formal structure/pipeline for resolutions, templates and guides to writing resolutions at the states/regions level for state level initiatives, and compile state specific information related to the policy cycle to better direct MSS efforts at the state level;

2. *State Advocacy Efforts and Region Collaborations*: working with the Regions on how to better integrate State level activities within the Region umbrella;

3. *Away Rotation Housing Spreadsheet*, working on something that will allow people traveling for rotations, identifying people who can act as points of contact, housing options, information about the schools, parking, etc… that would help people feel welcome and alleviate some degree of stress that inevitably comes with away rotations;

4. *Determining Priorities*: Going through the notes and outlining some clear objectives and priorities for us as a group and what we should be doing and off-loading to other groups;

5. *Engagement and Structure Moving Forward*: Creating a structure so that this continues beyond who may be in a role at that time, and how to support engagement at the state, region, and MSS level as a group. While these efforts were started and discussed, only the Away Rotation Spreadsheet was created and completed following the Annual meeting and leading up to the fall.

Following Annual and the passage of the First ATF report, the State Leaders group met and outlined objectives prior to the start of the new ATF in order to outline potential ideas they would like to see the ATF and themselves address. During that meeting, they touched base and confirmed that little effort had been made regarding the topics and that, given the new ATF forming a State Advocacy Collaboration, our efforts could be moved beneath it to provide a formal structure and to keep accountability and actions moving forward. With that occurring, the topics were condensed into the following:

1. *State Resolution and Advocacy Collaborative*: combination of the resolution and advocacy topics from previous conversations
2. *Away Rotation Student Welcome and Spreadsheet*

The Committee has broken down its objectives into 2 phases, one during I-24 cycle and one during A-25 cycle. During the I-24 cycle, the Committee has planned to have conversations and receive feedback from relevant stakeholders regarding the following topic areas:

1. State Resolution Collaborative, Advocacy Collaborative
2. State Leader Tracking and Documentation
3. Building Connections between States & Region Partnerships
4. Building Connections between State Efforts with Standing Committees.

In addition, the Committee will also address

1. State Leadership Summit event timing, location, and overarching details and goals and
2. Away Rotations Spreadsheet to update the spreadsheet and determine the best structure and practices to roll out this resource.

During the A-25 cycle, the Committee plans to incorporate the feedback into a report outlining the processes and structures that can be created to address all the topics and areas of feedback received, finish and clarify the projects that were started during the I-24 cycle, and address any concerns and comments brought to light during both the I-24 policy cycle and review process. The Committee has outlined the I-24 specific objectives below.

Collaborative Conversations Regarding the Objectives for I-24

Discussing Outlined Objectives for I-24 with Interested Parties

Our outcomes for I-24 are focused on increasing collaborative conversations between student leaders within and between states across the country. This will be accomplished by:

1. developing a series of questions that will help ascertain the current needs and goals of state leaders
2. compiling questions into a Google Form
3. distributing this Google Form to relevant state and region leaders
4. analyzing the results of the survey to guide subsequent action after the I-24 meeting and
5. meeting with interested parties to receive direct feedback regarding more targeted questions.

Contacts for Collaborative Conversations:

Contacts for the current State Leads for each state will be determined by contacting current contacts for each state in order to update all current state leads. This will also assist in forming connections for the development of a mechanism to update and track this information in the future. These contacts, in conjunction with current Region Leaders contacts and other interested parties, will be invited to complete a Google Form with questions detailed below. In addition, some contacts, Leaders, and stakeholders will be asked to be present during in-person conversations about objectives they have outlined, our current objectives, and ways to best integrate feedback and ideas in order to create a structure that works for everyone involved with regards to addressing goals for the A-25 cycle.

Google Form and Questions

A Google Form will be utilized in order to better assess the needs of interested parties, including, but not limited to, state leaders, region leaders, the AMA-MSS Governing Council, the MSS Caucus, and AMA organizations. The Google Form will also be utilized to assist in determining most meaningful avenues for engagement, collaboration, and resource delivery. Questions on the Google Form will be intended to help to elicit questions, concerns, and current needs from state leaders. Potential questions may include, but are not limited to the following:

- Questions regarding connectivity of sections:
    - What is your state's relationship with your State Medical Society?

        - What is the status of your state's delegation to the AMA?
    - Questions based on the "Challenges" section of responses from the 2024 State Leadership Summit Registration survey:
        - What challenges is your state currently facing?
        - What support would be helpful to you in tackling these challenges?
    - Current processes in place:
        - Can/How do students submit resolutions to state society meetings?
        - What opportunities for active engagement currently exist in your state?

We are open to feedback! What are other questions you would like to see that are not currently in development?

Analysis of Responses

Answers to the Google Form will undergo thematic analysis with subsequent identification of objectives for the Committee.

Furthermore, responses from the Google Form will be used in combination with responses from the 2024 State Leadership Summit Registration Survey to delineate state leadership into four groups: (1) those without a current and/or active medical student section within their State Medical Society and no intent to create one at this time, (2) those without a current and/or active medical student section within their State Medical Society that are currently in the process of developing one, (3) those with a State Medical Society medical student section that is deemed "underactive" by members, and (4) those with a State Medical Society medical student section that is deemed "adequately active" by members.

A report will be generated from the results and will be made readily available to the aforementioned stakeholders by A-25.

Meetings with Relevant Stakeholders

Meetings will then be scheduled with representatives from the ATF State Advocacy Collaborative Sub-Committee and state leadership for each of the aforementioned groups to review feedback received and further discuss the outlined objectives for A-25: State Resolution Collaborative, Advocacy Collaborative, State Leader Tracking and Documentation, Building Connections via State & Region Partnerships and State Efforts with Standing Committees. Additional goals for these meetings may be elicited through the Google Form as we determine what priorities various stakeholders hold with regards to the State Advocacy Collaborative, and if discovered, they will be included in these meetings as relevant.

Future Meetings of State Medical Student Leaders

Future State Leadership Summit

The State Advocacy Collaborative Committee of the Archives Task Force will outline goals and best practices for future meetings of state medical student leaders (Medical Students who serve in their state medical societies and state medical student sections as leaders). Questions that the Committee plans to address in the final draft report include:

- When should a state leadership summit be held?

- Who should host the event?
- What will be the topics of discussion, who determines them, and should they change?
- How frequently should state leaders meet?
- How will the AMA-MSS maintain up-to-date contact information with state leaders?

Preliminary answers for these questions are based on experiences from the 2024 State Leadership Summit, but participant feedback was very limited. Attendees agreed that the event should occur at least once per year, possibly twice. The event was hosted by the 2023-2024 AMA-MSS Governing Council. The agenda was set by the Governing Council with input from an attendee survey sent with the RSVP. State leader attendees were identified based on current AMA-MSS records and personal outreach.

By I-24, the Committee will review each of these aspects of the state leadership conference and generate feedback. The task force will reach out to attendees via the contact information in their reservation to again solicit feedback regarding the first summit. The task force will also reach out via the state leaders' GroupMe, which began around the State Leadership Summit in Spring of 2024.

State Leaders Contacts

To maintain current state contacts, the task force will determine best practices to update the state leadership contact list in perpetuity. Possibilities include relying on individuals to update with their successors information, or placing the responsibility on either the Governing Council or region membership chairs, should they choose to accept. This task seems most appropriate for region membership chairs, as they are already in contact with chapter-level leaders. This reduces administrative burden on the Governing Council, and does not require outgoing leaders to remember to update their contact information. Initially, the Taskforce will compile a list of state leadership transition times by I-24, so that region membership chairs know best when to check in and update contact information.

<u>Away Rotation Housing and Welcome</u>

Away Rotation Spreadsheet

Another goal of the ATF is to help facilitate a long-standing spreadsheet that will serve as a central location for students to be able to connect with one another regarding housing options for away rotations. With the cost of medical school as high as it is, we hope to reduce the financial strain of away rotations by providing a space for students to share their own spaces available for rent, request information for housing options students may have knowledge about in different areas of the country, or request roommates that will be in the same location and are willing to share costs.

Spreadsheet Specifics

This spreadsheet will be available by the start of Spring 2025. This spreadsheet will be provided to region and state leaders to disseminate annually to their respective regions and states to allow those seeking away rotation housing enough time to connect with others and find housing options. As a Taskforce, we intend to compile links to relevant housing opportunities for away rotations, format the

spreadsheet in a well-organized fashion to ensure it can function as a long-standing space for students to share personal housing information or requests, and disseminate the drafted spreadsheet to relevant stakeholders for feedback before the final publication in Spring 2025. Once published, this information will be shared throughout both AMA and non-AMA channels for all individuals to utilize, with individuals being able to update the information themselves. Information will be monitored by the taskforce to make sure that information is up to date.

Away Rotation Welcome

Another important aspect of away rotations is the idea that these sites are potentially going to be the place at which students may spend their time in residency. Should graduates wish to proceed in their organized medicine and advocacy endeavors, it is also crucial that they understand the advocacy climate of the areas they are moving to for residency.

State Information and Welcome

Your ATF plans to incorporate information necessary for reaching out to and contacting relevant state members (current MSS leaders, RFS contact, and state medical society contact information and website) so that they can begin to form connections and determine how to grow relationships with those individuals. In addition, your ATF plans to include this information on the away rotation spreadsheet so that it is all centralized to one location. This will allow students to not only find housing, but form connections with the states they are rotating in.

JAMA Collaboration

The JAMA Collaboration Committee is working on the following resolved clause below.

RESOLVED, that our AMA MSS Archives Task Force will work with relevant stakeholders to outline recommendations for establishing collaborations with JAMA and state to state policy and advocacy collaborations and report back to the MSS Assembly during their A-25 report.

JAMA Network Journal for Medical Trainees

Your ATF proposes the creation of a JAMA Network Journal for Medical Trainees. This journal would be run by an editorial board featuring medical students, residents, fellows, and at least one senior physician mentor. The first iteration of the editorial board would feature medical students selected by the MSS Governing Council and residents and fellows selected by the RFS Governing Council, all of whom must submit an application for consideration. Every subsequent iteration of the editorial board would be selected by the members of the previous editorial board using the same application process. All editorial board members must be approved by the JAMA Office. The size of the editorial board, term length of editorial board members, and application process and timeline will be determined at a later date following further discussions with JAMA.

For the first year of its existence, the Journal for Medical Trainees would publish biannually and feature poster showcase abstracts and adopted MSS standing committee reports from the AMA annual and interim meetings. At the time of poster showcase abstract submission, the authors of the abstracts would have the opportunity to indicate whether they would like their work to be

published in the journal, and all accepted abstracts would be published unless an author declined the opportunity for publication. Similarly, all authors of adopted MSS standing committee reports would have the opportunity to accept or decline publication after the report is adopted, and the report would only be published if all authors agreed to publication. The resulting issue of the journal, including all published abstracts and reports, would be assigned a single digital object identifier (DOI) number.

Following the first year, the journal could expand to potentially publish quarterly, with two issues featuring the poster showcase abstracts and adopted standing committee reports as stated above, and two issues featuring original research and commentary pieces submitted by medical trainees who are members of the AMA. Alternatively, depending on interest and member bandwidth, the original research and commentaries could be added to the annual and interim publications. In addition, the journal could accept artwork submissions for each issue, with the editorial board selecting one work of art to serve as the cover for that issue of the journal. All medical trainees who are AMA members would be eligible to submit their work to the journal free of charge. Each original research and commentary piece that is published would be assigned its own unique DOI number.

JAMA Medical Student Editorial Positions

Your ATF proposes the creation of a one-year medical journalism fellowship program that would allow medical students to serve on the editorial board for specialty JAMA Network journals. This would include one 1-year student fellowship for each of the following journals: JAMA Cardiology, JAMA Dermatology, JAMA Internal Medicine, JAMA Neurology, JAMA Oncology, JAMA Ophthalmology, JAMA Otolaryngology-Head & Neck Surgery, JAMA Pediatrics, JAMA Psychiatry, and JAMA Surgery. Selected students would work directly with the editorial board for the journal and could fulfill the responsibilities of the position concurrently with their medical education. Any medical student member of the AMA would be eligible to apply for these fellowships, and the editorial board for each journal would select the fellow. Each fellow would receive a stipend of $3,000 for their year of service on the editorial board, concordant with the stipend provided to Editorial Fellows for the AMA Journal of Ethics.

CONCLUSION

The 2024 - 2025 Archives Task Force was created to implement mechanisms for preserving MSS institutional memory for MSS initiatives ranging from policy to membership and engagement. Plans to accomplish the goals set forth at A-24 are outlined above and a final report with progress on initiatives and new resources will be presented at A-25.

RECOMMENDATIONS

Your Archives Task Force recommends that no actions be taken at this time and the remainder of this report be filed.

Acknowledgements

We would like to acknowledge our ATF Co-Chairs, Anand Singh and Natasha Topolski. Additionally, we would like to acknowledge our MSS Staff members Shane Mcgoey and Sarah Langill for their support. Finally, we would like to acknowledge our wonderful ATF members below:

Policy & Outcomes Archiving:

Leads: Laurie Lapp, Alyssa Lee, Kate Abe-Ridgway

Members: Muhammad Zulfiqar, Chidinma Ikonte, Isabel Ball, Priya Gupta, Haley Wymbs, Ben Close, Kelly Ngo, Joanna Tao, Hassan Zagloul, Julia Hasik, Shestruma Parajuli, Brooke Taylor, Clayton Rawson, Suraj Joshi

Big Wins:

Leads: Rianna McNamee, Kylie Ruprecht, Chidinma Ikonte

Members:
Christian Tallo, Giselle Ghabussi, Hassan Zagloul, Kelly Ngo, Suraj Joshi, Archana Venkatesan, Alyssa Lee, Hailey Greenstone

Membership & Engagement:

Leads: Julia Shi, Archana Venkatesan

Members: Caitlin Blaukovitch, Meghana Sharma, Joanna Tao, Marissa Canty

State Advocacy Collaboration:

Leads: Andrew Norton, Rusty Hawes, Hailey Greenstone

Members: Clayton Rawson, Caitlin Blaukovitch, Shestruma Parajuli, Annesha Datta, Ben Close, Julia Hasik, Allen Kuncheria, Haley Wymbs, Priya Gupta, Laurie Lapp

JAMA Collaboration

Leads: Jay Devineni, Brooke Taylor

Members: Kylie Ruprecht, Marissa Canty, Sarina Nikzad, Alyssa Lee, Matt Linz (RFS Liaison), Meghana Sharma, Andrew Norton, Joanna Tao, Clayton Rawson

REPORT OF THE MEDICAL STUDENT SECTION
GOVERNING COUNCIL

MSS GC Report
(I-24)

Introduced by: MSS Governing Council

Subject: MSS Standing Committee Restructuring: Progress Update

Referred to: MSS Reference Committee
(Alec Calac and Andrew Norton, Co-Chairs)

INTRODUCTION & BACKGROUND

At the 2024 Annual AMA Medical Student Section (MSS) Meeting, the MSS assembly voted to adopt with amendments the 2023-2024 Standing Committee Task Force (SCTF) Report with the following recommendations that call for the following actions with report back at I-24 and A-25:

1. *RESOLVED, that the AMA-MSS Governing Council (a) implement the recommendations adopted by the MSS Assembly from the Standing Committee Task Force to restructure the Standing Committee framework and leadership model, (b) clarify Standing Committee responsibilities and objectives, and (c) enhance operational efficiency; and be it further*

2. *RESOLVED, that the AMA-MSS Governing Council (a) restructure the existing Standing Committees into the delineated structure below with flexibility for Standing Committees to create additional subcommittees as appropriate and (b) include a timeline and requirements for leadership selection; and be it further*
    a. *Committee on Health Economics & Coverage (CHEC)*
    b. *Committee on Humanism & Ethics in Medicine (CHEIM)*
    c. *Committee on Civil Rights (CCR)*
    d. *Committee on Public Health (CPH)*
    e. *Committee on Science & Technology (CST)*
    f. *Committee on Medical Education (CME)*
    g. *Committee on Gender & Sexual Health (CGSH)*
        Subcommittee on Women in Medicine
        Subcommittee on LGBTQ+ Affairs
    h. *Committee on Health Justice (CHJ)*
        Subcommittee on Disability Affairs
        Subcommittee on Minority Affairs
        Subcommittee on Tribal Affairs

3. *RESOLVED, that the AMA-MSS Governing Council restructure the Committee on Long Range Planning to serve in an advisory capacity led by the MSS GC Chair, who will appoint members to the committee based on applications demonstrating significant previous AMA experience, including, but not limited to, considering applications from former Governing Council and BOT members as well as current and former Councilors; and be it further*

4. *RESOLVED, that the AMA-MSS Governing Council restructure the Committee on Impact, Policy, and Action (IMPACT) to serve as a group led by the MSS Section Delegates, to assist with resolution review responsibilities as needed, document HOD results and implementation actions related to MSS resolutions for the MSS archives, participate in the sunset and consolidation processes for MSS positions, and emphasize training for new MSS members; and be it further*

5. *RESOLVED, that every Standing Committee leadership team develop a detailed strategic plan at the beginning of their terms; and be it further*

6. *RESOLVED, that the AMA-MSS Governing Council develop a leadership and membership review and recall system and outline this system in the I-24 report; and be it further*

7. *RESOLVED, that our AMA-MSS retain the current committee structure for the 2024-2025 term and implement the new committee structure, including a new timeline where the Governing Council elects Standing Committee chairs and vice chairs prior to the Annual meeting for the 2025-2026 term.*

8. *RESOLVED, that a new Standing Committee Task Force will be formed to review the functioning of the new structure and write an informational report regarding the progress of transitions at the I-25 meeting. They will also write a final report with any recommendations at the A-26 meeting; and be it further*

9. *RESOLVED, that the revision and implementation of changes to Standing Committee structures and functions are exclusively done at four-year intervals after the completion of the 2025-2026 task force with the next report due at A-30.*

10. *RESOLVED, that the AMA-MSS rescind 640.008MSS and 640.017MSS and amend 640.001MSS, 640.013MSS, and 640.014MSS as outlined in Appendix B.*

11. *RESOLVED, that the MSS Standing Committees execute, at minimum, the following functions under the direction of the MSS Governing Council:*

    a) Provide recommendations for the policies reviewed as part of the AMA-MSS sunset and consolidation mechanisms under the coordination of the MSS Chair, Vice Chair, and Section Delegates;

    b) Assist in the resolution review process under the coordination of the Section Delegates and Vice Chair;

    c) Host resolution onboarding twice a year led by appropriate Standing Committee leadership to ensure Standing Committee members are all adequately trained to review resolutions.

    d) Author reports requested by the MSS Assembly and/or MSS Governing Council, with reports expected at the next MSS Assembly meeting.

    e) One report extension can be granted without question with further extensions will be granted upon approval of appropriate Governing Council members. This timeline will be shared with Assembly at the original deadline meeting;

    f) Produce whereas clauses to facilitate the transfer of any adopted report and, if applicable, to MSS-sponsored resolutions submitted to the AMA House of Delegates.

    g) Monitor federal legislation, regulation, and litigation relating to their subject area and work with other MSS members and the MSS Governing Council to organize student-led advocacy efforts and request actions by AMA staff as appropriate;

h) Organize educational programming and advocacy initiatives as necessary and appropriate; and be it further
i) Author comments for AMA Council reports, as directed by the MSS Section Delegates; and be it further
j) Support the MSS Governing Council and Staff in tracking and publicizing outcomes and implementation of MSS authored items at the AMA House of Delegates in the Standing Committee area of expertise; and be it further

12. *RESOLVED, that our MSS remove specific reference to the Committee on Long Range Planning (COLRP) from the MSS IOPs during its next scheduled revision, to allow for flexibility as our Standing Committee structure continues to evolve and prevent possible incongruence between the IOPs and future MSS practice, without compelling the MSS to maintain COLRP simply because it is outlined in the IOPs.*

The MSS Governing Council determined that for the I-24 Report, they would mainly address Resolved Clauses 1, 2, 3, 4, 5, 6, and 7 for the I-24 Report. Please see the Discussion section below to see what the Governing Council has accomplished on these recommendations.

DISCUSSION

Resolved Clause 1:

RESOLVED, that the AMA-MSS Governing Council (a) implement the recommendations adopted by the MSS Assembly from the Standing Committee Task Force to restructure the Standing Committee framework and leadership model, (b) clarify Standing Committee responsibilities and objectives, and (c) enhance operational efficiency; and be it further

To achieve the directives outlined in Resolved Clause 1, our MSS Governing Council has prioritized the development of new Standing Committee Charters that align with the revised structure recommended by the Standing Committee Task Force (SCTF) in the A-24 Report. These charters aim to clearly define the objectives, scope, and operational guidelines for each committee, ensuring that their work is aligned with the MSS's broader mission of advocacy, education, and professional development.

While the Governing Council initially aimed to finalize these charters by the I-24 report, we recognize the need for thorough review and input from various stakeholders to ensure comprehensive and effective guidelines. Therefore, we anticipate completing the final charters by Mid-March 2025, in time for leadership applications. Below is a summary of the newly proposed committee descriptions derived from the A-24 Report:

Committee on Health Economics & Coverage:
This committee addresses the intersection of healthcare economics and management, with a focus on advocating for systemic improvements in healthcare delivery, coverage, and access. The committee's primary goals include promoting understanding, proposing innovative and cost-effective advocacy solutions, and ensuring equitable access to quality care. By leveraging expertise from relevant stakeholders, including the AMA Council on Medical Service (CMS) and Students for a National Health Program (SNaHP), the CHEC committee aims to be a leading voice in shaping equitable healthcare policies.

Committee on Humanism & Ethics in Medicine (CHEIM):
This Committee identifies gaps in clinical practice guidelines and emerging best practices for engaging with communities with unmet health needs. Special focuses of this Committee include

civil rights, mental health services reform, and medical ethics. Given the current review subject categories, this Committee would generally review topics from the Clinical Practice and Ethics Forum. This Committee shall interface with the AMA Council on Medical Service (CMS) and the AMA Council on Ethics and Judicial Affairs (CEJA). This Committee will be encouraged to interface with the AMA Journal of Ethics and students that serve as editorial fellows.

Committee on Civil Rights (CCR):
This Committee considers the legal jurisprudence and feasibility of policy issues taken up by the MSS, including implications of federal policy and AMA advocacy on local, state, territorial, and tribal governments. Special focuses of this Committee include civil rights and trust responsibility between the United States and Tribal governments as it relates to health care delivery. Given the current review subject categories, this Committee would generally review topics from the Civil Rights and Social Policy and Public Health categories however, would likely have significant overlap with some of the other forums as well. This Committee shall interface with the AMA Council on Legislation (COL), the student representative to the American Medical Political Action Committee (AMPAC), and the Governmental Relations and Advocacy Fellow (GRAF).

Committee on Public Health (CPH):
This Committee is focused on current and emerging public health issues in and outside the US. Special focuses of this Committee include infectious diseases, climate change, war, immigration, domestic gun violence, nutrition, trauma and accident avoidance, and substance use. Given the current review subject categories, this Committee would generally review topics from the Public Health Forum. This Committee shall interface with the AMA Council on Science and Public Health (CSAPH). In addition, this Committee may also interface with the Medical Students for a Sustainable Future (MS4SF), International Federation of Medical Student Organizations (IFMSA), and other relevant National Medical Student Organizations.

Committee on Science & Technology (CST):
This Committee is focused on scientific and technological advancements as well as the impact of these advancements on academic research, medical education, and bioethics. Special focuses of this Committee include mobile and digital health applications, health information management, climate change, pharmaceutical development, and sports. Given the current review subject categories, this Committee would generally review topics from the Science And Technology Forum. This Committee shall interface with the AMA Council on Ethical and Judicial Affairs (CEJA), the AMA Council on Science and Public Health (CSAPH), and the student representative from the American Physician Scientists Association. This Committee will also take on the tasks associated with the MSS Poster Showcases at Annual and Interim meetings, as well as the AMA's Virtual Research Challenge. This Committee will be encouraged to interface with the Journal of the AMA (JAMA) and explore opportunities for medical students with this entity.

Committee on Medical Education (CME):
This Committee is focused on medical education, not only at the medical school level, but also amongst residents, fellows, and continuing education for attendings. Special focuses of this Committee include physician equity, trainee equity, licensure, and discipline. Given the current review subject categories, this Committee would generally review topics from the Medical Education Forum. This Committee shall interface with the AMA Council on Medical Education (CME), National Resident Matching Program (NRMP), Liaison Committee on Medical Education (LCME), National Board of Medical Examiners (NBME), Association of American Colleges (AAMC), and First Generation and Low Income in Medicine (FGLIMed), Student Osteopathic Medical Association (SOMA), Council of Osteopathic Student Government Presidents (COGSP).

Committee on Gender & Sexual Health (CGSH):
Subcommittee on Women in Medicine

Subcommittee on LGBTQ+ Affairs

This Committee is focused on LGBTQ+ affairs, women's health, and reproductive rights. There is a significant amount of overlap across these and related topics, so this combination of topic areas will allow for a more comprehensive evaluation of important issues within these areas. Given the current review subject categories, this Committee would likely review topics from across all the categories addressing issues of gender, sexuality and reproduction. This Committee shall interface with the AMA Women Physician Section Student Representative, AMA LGBTQ+ Section Student Representative, and student representatives from the American Medical Women's Association, Medical Student Pride Alliance, GLMA, and Medical Students for Choice.

Committee on Health Justice (CHJ):
Subcommittee on Disability Affairs
Subcommittee on Minority Affairs
Subcommittee on Tribal Affairs

This Committee is focused on racial equity and issues that disproportionately affect minority groups and historically marginalized populations. Special focuses of this Committee include ethical, social, legal, and health concerns affecting these populations, as well as the health management and payer systems most utilized by these respective populations, and advocacy for civil and human rights, and mental health. Given the current review subject categories, this Committee would generally review topics from the Civil Rights and Social Policy Forum. This Committee shall interface with NMSOs such as Student National Medical Association (SNMA), Association of Native American Medical Students (ANAMS), Asian Pacific American Medical Student Association (APAMSA), South Asian Medical Student Association (SAMSA), Latino Medical Student Association (LMSA), Medical Students with Disability and Chronic Illness (MSDCI), the AMA Minority Affairs Section (MAS), and the AMA Disability Advisory Group.

The restructuring of these Standing Committees represents a significant step forward in streamlining the work of the MSS and ensuring each committee's objectives align with the broader goals of our AMA. The clear delineation of roles and responsibilities will enhance the ability of committees to collaborate effectively, reduce redundancy, and focus on impactful advocacy and education efforts.

The MSS Governing Council remains committed to finalizing the charters and operational guidelines for these new committees and welcomes feedback from MSS members to ensure these changes serve the best interests of the organization and its constituents.

<u>Resolved Clause 2:</u>

RESOLVED, that the AMA-MSS Governing Council (a) restructure the existing Standing Committees into the delineated structure below with flexibility for Standing Committees to create additional subcommittees as appropriate and (b) include a timeline and requirements for leadership selection;

a) Committee on Health Economics & Coverage (CHEC)
b) Committee on Humanism & Ethics in Medicine (CHEIM)
c) Committee on Civil Rights (CCR)
d) Committee on Public Health (CPH)
e) Committee on Science & Technology (CST)
f) Committee on Medical Education (CME)
g) Committee on Gender & Sexual Health (CGSH)

Subcommittee on Women in Medicine
Subcommittee on LGBTQ+ Affairs
h) Committee on Health Justice (CHJ)
Subcommittee on Disability Affairs
Subcommittee on Minority Affairs
Subcommittee on Tribal Affairs

The Governing Council met with each 2024-2025 Standing Committee leadership team offering them the opportunity to provide any feedback on whether they would like to provide any changes to the subcommittees. With regards to the restructure of the existing standing committees, the MSS Governing Council has implemented a compiled Google Drive with all Standing Committee documents. Therefore, the MSS Governing Council will collaborate with the Standing Committee leaders to ensure they understand a transition plan prior to A-25 on how they want their documents to be transferred over into the new structure. At this time, no changes are recommended to the Subcommittees. However, this may change depending on further feedback. Please see the discussion under Resolved Clause 7 for leadership selection timeline and requirements.

Current Standing Committees and where their function will be restructured to after A-25:

1. Committee on American Indian Affairs → Committee on Health Justice (Subcommittee on Tribal Affairs) & Committee on Civil Rights
2. Committee on Bioethics & Humanities → Committee on Humanism & Ethics in Medicine
3. Committee on Disability Affairs → Committee on Health Justice (Subcommittee on Disability Affairs)
4. Committee on Economics & Quality in Medicine → Committee on Health Economics & Coverage
5. Committee on Global and Public Health → Committee on Public Health
6. Committee on Health Information Technology → Committee on Science & Technology
7. Committee on Impact, Policy, & Action → Committee on Impact, Policy, & Action
8. Committee on Legislation & Advocacy → Committee on Civil Rights & Regional Committees on Legislation & Advocacy
9. Committee on LGBTQ+ Affairs → Committee on Gender & Sexual Health (Subcommittee on LGBTQ+ Affairs)
10. Committee on Long Range Planning → Committee on Long Range Planning
11. Committee on Medical Education → Committee on Medical Education
12. Committee on Scientific Issues → Committee on Science & Technology
13. Community Service Committee → Interim/Annual Convention Committee
14. Membership, Engagement, & Recruitment Committee → Membership Consortium (Region Leaders & MSS At-Large Officer)
15. Minority Issues Committee → Committee on Health Justice (Subcommittee on Minority Affairs)
16. Women in Medicine Committee → Committee on Gender & Sexual Health (Subcommittee on Women in Medicine)

<u>Resolved Clause 3:</u>

RESOLVED, that the AMA-MSS Governing Council restructure the Committee on Long Range Planning to serve in an advisory capacity led by the MSS GC Chair, who will appoint members to the committee based on applications demonstrating significant previous AMA experience, including, but not limited to, considering applications from

former Governing Council and BOT members as well as current and former Councilors; and be it further

The MSS Governing Council has been working with the new COLRP Chairs to incorporate them into their new role serving as an advisory capacity. For example, the COLRP chairs have helped the Vice Chair complete Strategic Plan reviews. As the Governing Council approaches the A-25 policy cycle, there will be other GC reports that COLRP will help with. Finally, COLRP has played a key role in the Archives Task Force as well. Beginning in the 2025-2026 year, the new application and selection process as outlined by the Resolved Clause will be implemented.

Resolved Clause 4:

RESOLVED, that the AMA-MSS Governing Council restructure the Committee on Impact, Policy, and Action (IMPACT) to serve as a group led by the MSS Section Delegates, to assist with resolution review responsibilities as needed, document HOD results and implementation actions related to MSS resolutions for the MSS archives, participate in the sunset and consolidation processes for MSS positions, and emphasize training for new MSS members;

The MSS Governing Council worked diligently to continue and enhance the structure of IMPACT so that it falls under the purview of the Section Delegates moving forward. For the I-24 policy cycle, the IMPACT chairs have been working directly with the Section Delegates to emphasize training for new MSS members by creating mentor/mentee relationships to foster longitudinal connections and growth, as well as enhancing current strategies to optimally integrate IMPACT into the MSS policy process, including resolution review responsibilities. Additionally, IMPACT leadership has been collaborating with the MSS Committee on Long Range Planning and other MSS leaders to develop training workshops on MSS functions beyond resolution review, including Parliamentary Procedure and HOD operations.

Moving forward, they will begin to discuss how to document HOD results and implementation actions related to MSS resolutions and the possibility of participating in the new sunset and consolidation process. Of note, the 2024-2025 Archives Task Force (ATF) is currently exploring these issues as well and more information on these topics can be found in the ATF report.

In the past, applications to join IMPACT were part of the general Standing Committee applications. This will continue to be the case with the implementation of the new structure with the possibility of additional application opportunities outside of the general standing committee application timeline to allow for First-Year medical students to join IMPACT and begin their MSS experience. The 2025-2026 IMPACT Chairs will be selected following the same timeline as outlined under Resolved Clause 7 similar to other Standing Committee leaders.

Resolved Clause 5:

RESOLVED, that every Standing Committee leadership team develop a detailed strategic plan at the beginning of their terms;

The MSS Governing Council met with the 2024-2025 Standing Committee leaders to discuss onboarding and develop a strategic plan for the year. All Standing Committees have created a strategic plan for the year and are currently being reviewed by the Committee on Long Range Planning and the MSS Vice Chair. In addition, a Standing Committee Events Calendar for the year was generated to ensure we offer robust programming year round to our members.

Resolved Clause 6:

> *RESOLVED, that the AMA-MSS Governing Council develop a leadership and membership review and recall system and outline this system in the I-24 report;*

The adoption of this resolved clause reflects the need for a standardized, transparent process to manage situations where Standing Committee leaders or members fail to meet their responsibilities. The system aims to provide guidance in difficult situations where an individual's performance or conduct does not align with the expectations of their role, ensuring that Standing Committees can function effectively and uphold their commitments to the MSS.

Medical students often face significant time constraints and pressures, and while the MSS recognizes these challenges, the effective operation of Standing Committees is essential. Therefore, the 2023-2024 Standing Committee Task Force recommended establishing a structured review and recall system. This system is designed to provide a fair and equitable approach for addressing concerns, supporting both committee members and leaders who may find themselves uncertain or uncomfortable with initiating such conversations.

During the Spring 2023 review of Region Bylaws, regions were provided with model language for handling similar situations. The Standing Committee Task Force felt it was appropriate to extend a similar option to Standing Committees, giving them the flexibility to adopt and adapt these guidelines to their specific needs.

Below an example of how a standing committee leadership review and recall systems can function:

1. **Recall of Standing Committee Leaders (Committee & Subcommittee Leaders)**
    - 1.1.1. The following section relates to leaders who are unwilling to leave their position, but have failed to fulfill their responsibilities.
    - 1.1.2. If a Standing Committee leader fails to fulfill their responsibilities after repeated and consistent requests from any Standing Committee member:
        - 1.1.2.1. The Governing Council liaison and other Standing Committee leaders can call for a meeting between the Standing Committee leader in question and the other Standing Committee leaders and Governing Council liaison to discuss concerns.
        - 1.1.2.2. The Standing Committee leader experiencing issues will be able to provide any information regarding their situation and will develop a plan with the other leaders to improve the situation moving forward.
        - 1.1.2.3. If responsibilities continue to remain unmet for at least four weeks, the other Standing Committee leaders may make a motion to recall the Standing Committee leader from their leadership position(s). The Standing Committee leaders and Governing Council liaison can vote to carry forward said motion. The motion will require a two-thirds (⅔) vote.
    - 1.1.3. Upon receipt of a motion for recall, the Standing Committee leadership shall promptly notify the Governing Council of the AMA-MSS and the member against whom the motion for recall has been made and convene an Internal Hearing of the Standing Committee leaders within 14 days.
        - 1.1.3.1. A member of the MSS Governing Council in addition to the Governing Council liaison to the Standing Committee must be present at the Internal Hearing and shall oversee all proceedings. Members of the Standing Committee leadership team with significant conflicts of interest must recuse themselves from the Internal Hearing.

1.1.3.2. The member against whom the motion for recall has been made shall be given the opportunity to be heard and defend themselves.
1.1.3.3. After the member has been heard, the Leadership Team and Governing Council liaison shall deliberate on the motion without the member in question present.
1.1.3.4. A two-thirds (⅔) majority vote of the remaining members of the Standing Committee leadership team and Governing Council liaison shall be required to recall the member from their Standing Committee leadership position(s).

1.1.4. Upon the passing of a motion for recall for the position of Standing Committee leader, an Internal Hearing of the Executive Council shall be convened within 14 days.
1.1.4.1. Internal Hearing Procedure as outlined in Section 1.1.3. shall be followed.

1.1.5. If a Standing Committee leader is recalled, they shall immediately be removed from their position. The resulting vacancy shall be filled by the MSS Governing Council with feedback from current Standing Committee leaders.

1.1.6. The member who has been recalled may appeal the decision to the AMA-MSS Governing Council within 14 days of the decision. The appeal must be made in writing to the AMA-MSS Vice Chair. The MSS Governing Council shall vote on the appeal at its next meeting, and a two-thirds majority vote of the MSS Governing Council shall be required to overturn the decision of the Standing Committee. In the case of a decision being overturned, the MSS Governing Council will work with Standing Committee Leadership to create a plan for next steps.

1.2. **Resignation of Leaders**

1.2.1. Any Committee or Subcommittee leader of the Standing Committee may resign from office by notifying the rest of their Standing Committee leadership team by providing a minimum of two (2) weeks notice before they plan to stop responsibilities.

1.2.2. The resulting vacancy shall be filled through discussion with the MSS Governing Council and current Standing Committee leadership team.

1.3. **Filling of Vacancies**

1.3.1. In the event of a vacancy for an office of the Standing Committee leadership the MSS Governing Council shall appoint an individual to fill that vacancy with feedback from Standing Committee leadership

1.3.2. A vacancy must be filled within 60 days.

Below an example of how a standing committee general membership review and recall systems can function:

2. Recall of General Standing Committee Members

2.1.1. The following section relates to general members who are unwilling to leave their position, but have failed to fulfill their responsibilities.

2.1.2. If a Standing Committee member fails to fulfill their responsibilities after repeated and consistent requests from any Standing Committee member or leader:
2.1.2.1. The Governing Council liaison, Standing Committee leaders, and respective Subcommittee leaders can call for a meeting between the Standing Committee member in question and the other Standing Committee leaders and Governing Council liaison to discuss concerns.
2.1.2.2. The Standing Committee member experiencing issues will be able to provide any information regarding their situation and will develop a plan with the other leaders to improve the situation moving forward.

2.1.2.3. If responsibilities continue to remain unmet for at least four weeks, the Standing Committee leaders may make a motion to remove the Standing Committee member from the Committee. The Standing Committee leaders, respective subcommittee leaders, and Governing Council liaison can vote to carry forward said motion. The motion will require a two-thirds (⅔) vote.

2.1.3. Upon receipt of a motion for recall, the Standing Committee leadership (Standing Committee and Subcommittee leaders) shall promptly notify the Governing Council of the AMA-MSS and the member against whom the motion for recall has been made and convene an Internal Hearing of the Standing Committee leaders within 14 days.

2.1.3.1. A member of the MSS Governing Council in addition to the Governing Council liaison to the Standing Committee must be present at the Internal Hearing and shall oversee all proceedings. Members of the Standing Committee leadership team with significant conflicts of interest must recuse themselves from the Internal Hearing.

2.1.3.2. The member against whom the motion for recall has been made shall be given the opportunity to be heard and defend themselves.

2.1.3.3. After the member has been heard, the Leadership Team and Governing Council liaison shall deliberate on the motion without the member in question present.

2.1.3.4. A two-thirds (⅔) majority vote of the members of the Standing Committee leadership team and Governing Council liaison shall be required to recall the member from their Standing Committee leadership position(s).

2.1.4. Upon the passing of a motion for recall for the position of general member, an Internal Hearing of the Executive Council shall be convened within 14 days.

2.1.4.1. Internal Hearing Procedure as outlined in Section 2.1.3. shall be followed.

2.1.5. If a member of the Standing Committee is recalled, they shall immediately be removed from their position.

2.1.6. The member who has been recalled may appeal the decision to the AMA-MSS Governing Council within 14 days of the decision. The appeal must be made in writing to the AMA-MSS Vice Chair. The MSS Governing Council shall vote on the appeal at its next meeting, and a two-thirds majority vote of the MSS Governing Council shall be required to overturn the decision of the Standing Committee. In the case of a decision being overturned, the MSS Governing Council will work with Standing Committee Leadership to create a plan for next steps.

2.2. **Resignation of Members**

2.2.1. Any general member may resign from the committee by notifying the rest of their Standing Committee leadership team by providing a minimum of two (2) weeks notice before they plan to stop responsibilities.

2.2.2. The resulting vacancy shall be filled at the discretion of the MSS Governing Council with consultation from the Standing Committee leadership team.

2.3. **Filling of Vacancies**

2.3.1. Vacancies of general members can be filled in any timeline deemed appropriate by the MSS Governing Council with consultation from the Standing Committee Leadership team.

Although early in the stages of planning, the MSS Governing Council sent an unofficial poll to the 2024-2025 Standing Committee leaders to determine whether they would like to have a mandated uniform leadership and membership review and recall system process across all Standing Committees or if they would like the opportunity to develop their own processes for individual Standing Committees. Although the response rate was relatively low of 21 total responses, a majority of responses from Standing Committee leaders favored developing an individualized process for each Standing Committee.

Therefore, at this time, the Governing Council plans to continue generating a general leadership and membership review and recall system as seen above that can be utilized by Standing Committees if they choose. However, the Governing Council does not plan to mandate use of this system and is considering allowing Standing Committees to develop their internal guidelines to handle leadership and membership review systems. If a Standing Committee does choose to use a different leadership and membership review and recall system, this should be reported to the Standing Committee's Governing Council liaison and the MSS Vice Chair at the beginning of the year.

For example, leadership review system could include quarterly check-ins among a Standing Committees leadership to ensure they are all meeting their set expectations from the strategic plan they created for the year. Additionally, membership review can be done on a similar quarterly timeline and be conducted by the leaders of the committee based on attendance, engagement, or any other criteria. Ideally, the initial recall system for leaders and members would be focused on handling the situation internally with the other standing committee leaders and guidance from the Governing Council liaison.

If a member/leader would like to appeal a decision, they can follow the process outlined below:

Uniform Appeals Process for Leadership and Membership Recall Decisions

1. Initial Notification and Filing of an Appeal:

- The member who has been subject to a recall decision (whether a committee leader or general member) must submit a written appeal within 14 days of the recall decision. The appeal should be directed to the AMA-MSS Vice Chair and must include:
    - A clear statement of the grounds for the appeal.
    - Any supporting evidence or documentation.
    - A preferred resolution or desired outcome from the appeal.

2. Formation of an Appeals Review Panel:

- Upon receipt of an appeal, an Appeals Review Panel shall be convened within 14 days. The panel will consist of:
    - Two members of the AMA-MSS Governing Council not directly involved with the Standing Committee in question.
    - One Standing Committee chair from a different committee who is familiar with committee processes but has no conflict of interest.
    - The MSS Vice Chair, who will oversee and facilitate the process but not vote.
- All members of the panel must disclose any conflicts of interest before proceeding. Any conflicts may result in replacement by another impartial member.

3. Review of the Appeal:

- The Appeals Review Panel will meet to evaluate the appeal. This review will include:
    - A presentation of the original recall decision and the rationale behind it by the Standing Committee leadership.
    - The appellant's opportunity to present their case, including any supporting evidence and explanations.

    - A review of the recall process followed by the Standing Committee to ensure compliance with established guidelines.
- Both sides will have an opportunity to respond to questions from the panel.

4. Deliberation and Decision:

- Following the review meeting, the panel will deliberate in a closed session. The decision will be based on:
    - Whether the recall decision adhered to established procedures.
    - The fairness and appropriateness of the decision based on the evidence presented.
    - Whether there were any procedural errors or biases that could have impacted the outcome.
- The panel's decision will require a two-thirds majority to overturn the original recall decision.

5. Communication of the Decision:

- The panel's decision will be communicated in writing to both the appellant and the Standing Committee leadership within 7 days of the deliberation. The decision will include:
    - A clear statement of the panel's ruling (uphold, overturn, or modify the recall decision).
    - The rationale behind the decision.
    - Any recommended actions for the Standing Committee or Governing Council moving forward.

6. Implementation of the Decision:

- If the appeal is upheld and the recall is overturned, the member will be reinstated immediately, and the Standing Committee leadership will collaborate with the Governing Council to ensure a smooth transition back into their role. The member or leader will be eligible to join an alternate standing committee, pending availability confirmation from other standing committees.
- If the appeal is denied, the recall stands, and any resulting vacancy will be filled according to the Standing Committee's established internal procedures.
- In cases where the decision is modified (e.g., a recall is upheld but with certain conditions), the panel's recommendations will guide next steps.

7. Finality and Recordkeeping:

- The decision of the Appeals Review Panel is final and cannot be appealed further.
- All documentation related to the appeal, including the panel's final report, will be retained by the AMA-MSS Vice Chair for future reference and process improvement reviews.

Process for Declaring Conflicts of Interest (COI) in Appeals:

1. **Initial COI Disclosure Requirement:**

- Once an appeal is filed, the member in question (i.e., the individual being recalled) will be notified of the Appeals Review Panel members. Upon notification, the appellant has **7 days** to review the panel composition and disclose any potential conflicts of interest.
- The member must submit a formal written statement identifying any COI concerns, providing specific reasons (e.g., personal, financial, or professional relationships) that could compromise the impartiality of any panel member.

2. **COI Review and Determination:**
   - Upon receiving the COI disclosure, the MSS Vice Chair will review the claim to determine its validity. This review will involve assessing:
     - The nature and extent of the conflict.
     - The potential impact of the conflict on the fairness of the process.
   - If a COI is confirmed, the panel member in question will be recused and promptly replaced by another impartial member. The substitution process will occur within **7 days** of the determination to avoid delays in the appeal.
3. **Timing and Consequences of Non-Disclosure:**
   - If the appellant fails to disclose a known conflict within the designated **7-day period**, it may be considered a waiver of the right to challenge the panel's impartiality later in the process, unless new information emerges that justifies a delayed disclosure.
   - If a previously undisclosed COI is identified during or after the appeal review, it may result in a re-evaluation of the decision or the formation of a new panel, depending on the severity of the conflict.
4. **Recordkeeping and Transparency:**
   - All COI disclosures and determinations will be documented and retained for future reference. This ensures that the appeals process remains transparent and that any COI management is consistently applied.

Resolved Clause 7:

> *RESOLVED, that our AMA-MSS retain the current committee structure for the 2024-2025 term and implement the new committee structure, including a new timeline where the Governing Council elects Standing Committee chairs and vice chairs prior to the Annual meeting for the 2025-2026 term.*

Current Standing Committee Timeline & Phase Out: As outlined in this resolved clause, the current Standing Committees will remain operational until A-25. During this period, the final half-cycle terms for current Standing Committees will be open for applications in November following the I-24 meeting. It is important to note that while the application process will be available, Standing Committees are not obligated to accept new members. The MSS Vice Chair will actively collaborate with each of the existing committees throughout the spring of 2025 to ensure a smooth transition of their ongoing work to the new Standing Committee structure before the official changeover at A-25. This proactive approach is intended to maintain continuity and avoid any disruption to committee operations during the transition.

New Standing Committee Leadership Requirements: To be eligible to serve in Standing Committee leadership, applicants should:

- Applicants should have prior experience serving on a Standing Committee or possess relevant experience that clearly distinguishes them as a strong candidate for leadership.

Of note, MSS IOP 7.4 states that Standing Committee leadership shall have a term limit of service no greater than two (2) years total on any combination of Standing Committees. This shall only apply to Standing Committee Chairs and Vice Chairs and will not apply to subcommittee leadership.

New Standing Committee Timeline for 2025 - 2026: The MSS Governing Council agreed with the 2023-2024 Standing Committee Task Force that the optimal time for selecting new Standing Committee leaders including both chairs and vice chairs would be in the Spring prior to A-25. This ensures that selected individuals are not impacted by potential AMA Council selection and allows them time to prepare frameworks for the new Standing Committees. In addition, earlier selection will allow for general members to be selected earlier and have more time to be onboarded and prepare for the fall policy cycle reviews. Therefore, we plan to solicit anonymous feedback from Standing Committee leaders regarding members' leadership potential in early March as per MSS IOP 7.3 and recommend doing a call for Standing Committee leadership applications in mid March - mid April. The Standing Committee leaders would be selected by the end of April and onboarded and oriented in May for the upcoming 2025-2026 year.

Applications for Standing Committee general membership and subcommittee leadership will close following the A-25 meeting and Standing Committee leaders will select their members.

However, we acknowledge that there are differing opinions particularly regarding the subcommittee leadership timeline. Therefore, we are open to hearing feedback on how the Governing Council should set this timeline.

CONCLUSION

Here is a summary of what the Governing Council has accomplished and plans to do:

1. Met with all Standing Committee leaders to discuss the 2025-2026 Standing Committee leadership structure and create a strategic plan.
2. Section Delegates are working with IMPACT to create a smooth transition.
3. The Governing Council will review feedback from this report and determine the best next steps regarding the approach to the Standing Committee Leadership and Membership Review and Recall System(s) development.
4. The Governing Council will work with staff and current Standing Committee leaders to develop preliminary charters for the new Standing Committees prior to release of leadership applications. However, the Governing Council recommends that these charters be reviewed and updated by the new Standing Committee's inaugural leadership.
5. The Governing Council recommends that the 2025-2026 Standing Committee leadership application period be open between mid March - mid April with leaders selected by end of April. Onboarding of these leaders will be in May.

Questions for reviewers to consider:

1. How should the Governing Council approach development of a leadership and membership recall system? A uniform mandated system? A template optional system or

a couple options Standing Committees can choose from? How involved should the Governing Council be? If we do create an appeals process to the Governing Council, should we have a uniform process of handing appeals?

2. Do you want any additional Subcommittees generated within the Standing Committee structure? When do we want to select Subcommittee leadership and who should be responsible for selecting Subcommittee leaders?
3. What should be the requirements to be selected as a standing committee leader?

RECOMMENDATIONS

Your MSS Governing Council recommends that this report be filed.

ACKNOWLEDGMENTS

We extend our thanks to our Standing Committee leaders for their foundational insights crucial to the development of this report. We're also deeply grateful for the invaluable feedback from our MSS Staff, Shane McGoey and Sarah Langill. Finally, we acknowledge the 2022-2023 Governing Council, 2023-2024 Governing Council, and 2023-2024 Standing Committee Task Force for entrusting us with this significant aspect of our MSS.

REPORT OF THE MEDICAL STUDENT SECTION DELEGATES

SD Report
(I-24)

Introduced by: Druv Bhagavan, Section Alternate Delegate; Priya Desai, Section Delegate; Dakota Hitchcock, RefCom AC&B Lead; Lizzie Suschana, RefCom A Lead; Jade Cook, RefCom B Lead; Alex Soltany, RefCom D Lead; Andrew Norton, RefCom D Lead; Samantha Thomas, RefCom F Lead; Amber Shirley, RefCom F Lead

Subject: Delegate Report: Policy Proceedings of the Annual 2024 House of Delegates Meeting

Referred to: MSS Reference Committee
(Alec Calac and Andrew Norton, Co-Chairs)

INTRODUCTION

The following report details the actions taken by the MSS Caucus at the Annual 2024 Meeting of the AMA House of Delegates, pursuant to MSS Internal Operating Procedure (IOP) 9.3, which states,

> "9.3 Reporting of Caucus Actions. The Section Delegates shall be responsible for authoring a report of actions taken, which shall be presented to the MSS Assembly at the next national meeting. This report will list the resolved clauses of all AMA HOD items of business for which the MSS took a position, and will specifically identify those items of business for which the MSS Caucus took a position that was not grounded in existing internal policy."

Per the MSS IOPs, positions of the MSS Caucus are decided in the following manner:

Amended MSS Internal Operating Procedure 9.2, "Determining MSS Caucus Positions" states:

> "9.2 Determining MSS Caucus Positions.
>
> 9.2.1 For all MSS Caucus activities requiring a vote, all members of the MSS Caucus shall be given one vote.
>
> 9.2.2 A quorum of at least one half of voting members must participate for a vote to be valid.
>
> 9.2.3 In the AMA HOD, the MSS Caucus must take positions on items of business that are consistent with the existing policy of the MSS as defined in the MSS Digest of Actions whenever relevant MSS policy exists.
>
> 9.2.4 In areas where relevant MSS policy exists, but the interpretation is uncertain, a majority vote of a quorum of MSS Caucus will determine the MSS Caucus's interpretation.
>
> 9.2.5 When an item of business is before the AMA HOD that is of significant importance to the MSS, but for which no MSS policy exists, any member of the MSS Caucus may move that the MSS take a position on the item. Such a motion requires a second by another Caucus member and a two-thirds (⅔) majority vote of a quorum of the MSS Caucus to pass.
>
> 9.2.5.1 Positions set using these procedures are only valid for the duration of that AMA HOD meeting.
>
> 9.2.6 The MSS Caucus may not take positions that are contrary to existing MSS policy."

In an effort to make this report more usable and enduring for institutional memory purposes, the 2023-2024 Section Delegates structured this report such that it contained only links to all resolutions and the final recommendations from the annotated Reference Committee reports. Your 2024-2025 Section Delegates, in an ongoing effort to streamline this report's structure and wield this as a tool to improve the institutional memory of the MSS, have utilized a similar structure for this report. In addition, we have updated the MSS

Archive of HOD Proceedings (colloquially referred to as "the Membrick"), which is publicly available to all MSS members (current and future) and will contain records of all HODs moving forward in a single easily accessible location. In efforts to continue to streamline this report, the Membrick link is provided to serve as an official record of HOD proceedings in lieu of your Section Delegates copying and pasting rows from the Membrick as an appendix to this report.

MSS RESOLUTIONS AT HOD A-24

The MSS transmitted a total of **33** resolutions to the House of Delegates. As some resolutions resulted in multiple outcomes, the total outcomes sum to over 33:

- Adopted: **5**
- Adopted as Amended: **17**
- Adopted in Lieu: **4**
- Referred for Decision: **0**
- Referred for Study: **8**
- Reaffirmed in Lieu: **0**
- Not Adopted: **2**

As part of our ongoing efforts to establish and strengthen connections with other delegations, the MSS was able to successfully route five (5) resolutions that have previously passed the MSS Assembly through other delegations for transmission to the A-24 House of Delegates meeting. While not officially listed as co-authors on these resolutions, the MSS gave these resolutions the same degree of support given to other MSS-authored items. Of these five resolutions, two (2) were ultimately Adopted, and three (3) were Adopted as Amended. These items are as follows:

- 019 Supporting the Health of our Democracy
- 020 Voter Protections During and After Incarceration
- 021 Opposition to Capital Punishment
- 305 Public Service Loan Forgiveness Reform
- 411 Missing and Murdered Indigenous Persons

The MSS Archive of HOD Proceedings contains the final HOD Actions taken pursuant to each MSS-authored and MSS-originated resolution as their final outcome. For all MSS resolutions, the MSS Delegates supported the items as their original authors. Items that were successfully transmitted through other delegations were similarly supported. Resolutions are listed in order of HOD Action, with the five resolutions transmitted through other delegations listed at the end. Each resolution is linked to its original transmittal. Each outcome is linked to the final outcome in the HOD Annotated Reference Committee Reports, its final language in PolicyFinder, or other outcome, as applicable.

NON-MSS ITEMS AT HOD I-23

There were **269** items of business at the HOD A-24 Meeting, including informational reports. Of the **236** items not authored by the MSS, the MSS took an active position on **78** items. The MSS Archive of HOD Proceedings contains the MSS actions and HOD actions for each item of business. Resolutions are listed in order of HOD Action. Each resolution is linked to its original transmittal. Each outcome is linked to the final outcome in the HOD Annotated Reference Committee Reports, its final language in PolicyFinder, or other outcome, as applicable.

MSS POSITIONS UPDATE

Furthermore, per clauses 9-11 of 630.044MSS "Review and Revision of the MSS Positions Compendium via the Sunset and Consolidation Mechanisms" (as modified by A-24 MSS GC Report A):

> "(9) in their report on the previous HOD's proceedings, the Section Delegates will recommend changes to any MSS positions that amend AMA Policy and were considered by HOD, in order to summarize the amendment's ask and simplify the language; and
>
> (10) any MSS positions written as "MSS will ask the AMA" will be automatically converted to past tense ("asked the AMA") after consideration by HOD as either a resolution or an amendment; and

(11) any MSS position (or portion of a position) requesting an AMA or MSS study will automatically sunset after the study is completed by either the AMA or MSS or after consideration of the study request by HOD."

Your Section Delegates have provided recommendations at the end of this report that propose modifications to MSS positions in accordance with the actions taken at the Annual 2024 Meeting of the AMA House of Delegates. Please note that your Section Delegates have incorporated MSS positions that will be converted to the past tense in accordance with Clause (10) of 630.044MSS for the sake of completeness and transparency. However, we acknowledge that future versions of this report need not include these recommendations, as they will be implemented automatically.

RECOMMENDATIONS:

Your MSS Section Delegates recommend the adoption of the recommendations for MSS positions outlined in Appendices A and B of this report and the remainder of the report be filed.

ACKNOWLEDGEMENTS
Your Section Delegates would like to extend our gratitude to our incredible A-24 MSS Caucus RefCom Leads as listed at the beginning of this report who assisted in updating the "Membrick" on HOD proceedings for their respective Reference Committees. We would also like to extend our profound gratitude to Sarah Langill, our MSS Policy Analyst, for being amazing, as always.

APPENDIX A – RECOMMENDATIONS FOR MSS POSITIONS

RECOMMENDED FOR RETENTION WITH AMENDMENTS: PAST TENSE

Your MSS Section Delegates recommend that the external asks of the following MSS positions be converted to the past tense to reflect their transmittal to and consideration by the AMA House of Delegates:

1. 550.009MSS “Abolishment of the Resolution Committee”
2. 165.027MSS “Indian Health Service - Purchased and Referred Care Expansion and Review of Experimental and Excluded Services”
3. 290.010MSS “Support for Vision Screenings and Visual Aids for Adults Covered by Medicaid”
4. 290.015MSS “Reforming Medicaid Estate Recovery”
5. 180.030MSS “Improving Medigap Protections”
6. 65.063MSS “Supporting Academic Medical-Legal Partnerships to Address Social Determinants of Health”
7. 160.055MSS “Indian Health Service Youth Regional Treatment Centers”
8. 100.034MSS “Supporting Policies which Increase Biosimilar Penetration”
9. 440.125MSS “Strengthening Federal Nutrition Programs”
10. 270.050MSS “Supporting the Health of Our Democracy”
11. 160.051MSS “American Indian and Alaska Native Language Revitalization and Elder Care”
12. 160.051MSS “Addressing the Health Impacts of Discrimination and Rejection on LGBTQ+ Youth in Foster Care”
13. 440.129MSS “Humanitarian Efforts to Resettle Refugees”
14. 65.058MSS “Conservatorship and Guardianship Reform”
15. 445.003MSS “Sexually Exploitative Advertising to Physicians”
16. 440.124MSS “Opposing Pay-to-Stay Incarceration Fees”
17. 135.026MSS “Indian Water Rights”
18. 135.024MSS “Hazardous Pollutant Exposure”
19. 65.067MSS “Increasing Access to Public Restrooms”
20. 135.027MSS “Addressing the Health Risks of Extreme Heat”
21. 160.045MSS “Promoting a Fragrance-Free Health Care Environment”
22. 460.017MSS “Maximizing Patient Outcomes through Public Access to all Past, Present and Future Clinical Trials”
23. 440.130MSS “Mitigating the Harms of Colorism and Skin Bleaching Agents”
24. 480.032MSS “Augmented Intelligence – Integrated Software Manipulation Detection”
25. 295.240MSS “Incorporating Holocaust Education in Medical Schools on International Remembrance Day”
26. 65.068MSS “End Attacks on Health and Human Rights in Palestine and Israel”
27. 165.031MSS “Opposing the Hospital Readmissions Reduction Program”
28. 65.036MSS “Enfranchisement of Incarcerated Persons”
29. 350.039MSS “Missing and Murdered Indigenous Persons”

RECOMMENDED FOR RETENTION WITH AMENDMENTS: SUMMARIZE AND/OR UPDATE LANGUAGE (TABLE 1)

Your MSS Section Delegates recommend that the following MSS positions be amended to update language, summarize language asking to modify AMA policy, and reflect their transmittal to and consideration by the AMA House of Delegates:

1. 660.038MSS “Amending Bylaws”
2. 180.023MSS “National Fertility Coverage Mandate”
3. 180.025MSS “Medicaid Hearing Coverage”
4. 290.009MSS “Establishing Comprehensive Dental Benefits Under State Medicaid Programs”
5. 440.050MSS “Support for Paid Sick Leave”
6. 255.009MSS “Ensuring Fair Opportunities for International Medical Students”

7. 160.048MSS “Encouraging Increased Accessibility and Utilization of Occupational Pulmonary Lung Disease Screenings”
8. 145.026MSS “Addressing Default Proceed Sales of Firearms”
9. 145.073MSS “Support for Comprehensive Safe Firearm Storage Legislation”
10. 350.037MSS “Racial Misclassification”
11. 270.035MSS “Opposition to Capital Punishment”
12. 305.087MSS “Voluntary Service-Payback and Loan Repayment Programs”

APPENDIX B

TABLE 1: RECOMMENDED FOR RETENTION WITH AMENDMENTS: SUMMARIZE AND/OR UPDATE LANGUAGE			
Position #	**Title**	**Original Position**	**Final Summarized Language & Rationale**
660.038MSS	Amending Bylaws	AMA-MSS will ask the AMA to amend Bylaw 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 Board of Trustees, Councils, the Medical Student Section Governing Council, and as Section Representatives on other Governing Councils for up to 200 days after graduation. MSS Timeline: (MSS Delegate Report A, I-23) HOD Timeline: (AMA Res. 003-A-24, Adopted as Amended, A-24)	AMA-MSS asked the AMA to allow Medical Students to serve on the Board of Trustees, Councils, the Medical Student Section Governing Council, and as Section Representatives on other Governing Councils for up to 200 days after graduation and not extending past the Annual Meeting following graduation.
180.023MSS	National Fertility Coverage Mandate	That 180.023MSS "National Fertility Coverage Mandate" be amended by addition and deletion as follows: AMA-MSS will ask that our AMA amend Policy H-185.990, "Infertility and Fertility Preservation Insurance Coverage" by addition and deletion to read as follows: 1. Our AMA ~~encourages third party payer health insurance carriers to make available insurance benefits~~ <u>supports federal protections that ensure insurance coverage by all payers</u> for the diagnosis and treatment of recognized ~~male and female~~ infertility. 2. Our AMA supports payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician, and will lobby for	AMA-MSS asked the AMA to: (1) Support federal protections that ensure insurance coverage by all payers for the diagnosis and treatment of recognized infertility. (2) Work with interested organizations to encourage the Indian Health Service to cover infertility diagnostics and treatment for patients seen by or referred through an Indian Health Service, Tribal, or Urban Indian Health Program. **Rationale:** The request for study in clause (3) was struck by the HOD and is therefore being sunset.

TABLE 1: RECOMMENDED FOR RETENTION WITH AMENDMENTS: SUMMARIZE AND/OR UPDATE LANGUAGE			
Position #	**Title**	**Original Position**	**Final Summarized Language & Rationale**
		appropriate federal legislation requiring payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician. 3. Our AMA will study feasibility of insurance coverage for fertility preservation for reasons other than iatrogenic infertility. 4. Our AMA will work with interested organizations to encourage the Indian Health Service to cover infertility diagnostics and treatment for patients seen by or referred through an Indian Health Service, Tribal, or Urban Indian Health Program. MSS Timeline: (MSS WIM CEQM Rep B, A-22) (MSS Res. OF031, Appended, I-23) HOD Timeline: (AMA Res. 101-A-24, Adopted as Amended, A-24)	
180.025MSS	Medicaid Hearing Coverage	AMA-MSS will ask that the AMA amend H-185.929 "Hearing Aid Coverage" by addition to read as follows: Hearing Aid Coverage H-185.929 1. Our AMA supports public and private health insurance coverage that provides all hearing-impaired infants and children access to appropriate physician-led teams and hearing services and devices, including digital hearing aids. 2. Our AMA supports hearing aid coverage for children that, at minimum, recognizes the need for replacement of hearing aids due to maturation, change in hearing ability and normal wear and tear. 3. Our AMA encourages private health plans to offer optional riders that allow their members to add hearing benefits to	AMA-MSS asked the AMA to advocate that hearing exams, hearing aids, cochlear implants and aural rehabilitative services be covered in all Medicaid programs and any new public payers.

TABLE 1: RECOMMENDED FOR RETENTION WITH AMENDMENTS: SUMMARIZE AND/OR UPDATE LANGUAGE			
Position #	**Title**	**Original Position**	**Final Summarized Language & Rationale**
		existing policies to offset the costs of hearing aid purchases, hearing-related exams and related services. 4. Our AMA supports coverage of hearing tests administered by a physician or physician-led team as part of Medicare's Benefit. 5. Our AMA supports policies that increase access to hearing aids and other technologies and services that alleviate hearing loss and its consequences for the elderly. 6. Our AMA encourages increased transparency and access for hearing aid technologies through itemization of audiologic service costs for hearing aids. 7. Our AMA supports the availability of over-the-counter hearing aids for the treatment of mild-to-moderate hearing loss. 8. Our AMA advocate that hearing exams, hearing aids, cochlear implants and aural rehabilitative services be covered in all Medicaid programs and any new public payers. MSS Timeline: (MSS Res. 016, I-22) HOD Timeline: (AMA Res. 102-A-24, Adopted as Amended, A-24)	
290.009MSS	Establishing Comprehensive Dental Benefits Under State Medicaid Programs	AMA-MSS will ask the AMA to amend Policy H-330.872, "Medicare Coverage for Dental Services" by addition and deletion as follows: Medicare, Medicaid, and Other Public Health Insurance Coverage for Dental Services, H-330.872 Our AMA supports: (1) continued opportunities to work with the American Dental Association and other interested national organizations to	AMA-MSS asked the AMA to support dental coverage for Medicaid beneficiaries and other public payer beneficiaries.

TABLE 1: RECOMMENDED FOR RETENTION WITH AMENDMENTS: SUMMARIZE AND/OR UPDATE LANGUAGE			
Position #	**Title**	**Original Position**	**Final Summarized Language & Rationale**
		improve access to dental care for Medicare, ~~and~~ Medicaid, and other public payer beneficiaries; and (2) initiatives to expand health services research on the effectiveness of expanded dental coverage in improving health and preventing disease among ~~in both~~ Medicare, ~~and~~ Medicaid, and other public payer beneficiaries ~~populations~~, the optimal dental benefit plan designs to cost-effectively improve health and prevent disease ~~in both~~ among Medicare, ~~and~~ Medicaid, and other public payer beneficiaries ~~populations~~, and the impact of expanded dental coverage on health care costs and utilization. MSS Timeline: (MSS Res. 026, A-21) HOD Timeline: (AMA Res. 102-A-24, Adopted as Amended, A-24)	
440.050MSS	Support for Paid Sick Leave	AMA-MSS will ask the AMA to: (1) recognize the positive impact of paid sick leave on health and support legislation that offers paid sick leave; (2) work with appropriate entities to build on the current body of evidence by studying the health and economic impacts of newly enacted legislation; and (3) amend Policy H440.823 by addition and deletion as follows to include that: Paid Sick Leave H-440.823 Our AMA: (1) recognizes the public health benefits of paid sick leave and other discretionary paid time off; (2) supports employer policies that allow employees to accrue paid time off and to use such time to care for themselves or a family member; and	AMA-MSS asked the AMA to advocate for federal and state policies that guarantee employee access to protected paid sick leave.

TABLE 1: RECOMMENDED FOR RETENTION WITH AMENDMENTS: SUMMARIZE AND/OR UPDATE LANGUAGE			
Position #	**Title**	**Original Position**	**Final Summarized Language & Rationale**
		(3) supports employer policies that provide employees with unpaid sick days to use to care for themselves or a family member where providing paid leave is overly burdensome.; and (4) advocates for federal and state policies that guarantee employee access to protected paid sick leave. MSS Timeline: (MSS Res 28, I-14) (AMA Res 202, A-15 Referred) (Reaffirmed: MSS GC Rep A, I19) (MSS Res. OF071, Appended, "Measuring the Effect of Paid Sick Leave (PSL) on Health-Care Outcomes," I-23) HOD Timeline: (AMA Res. 214-A-24, Adopted as Amended, A-24)	
255.009MSS	Ensuring Fair Opportunities for International Medical Students	AMA-MSS will ask the AMA to (1) encourage additional medical schools to consider applications from and to admit international students to their programs alongside domestic students; (2) amend policy H-255.968 "Advance Tuition Payment Requirements for International Students Enrolled in US Medical Schools"; and be it further Advance Tuition Payment Requirements for International Students Enrolled in US Medical Schools H-255.968 Our AMA: 1. supports the autonomy of medical schools to determine optimal tuition requirements for international students; 2. encourages medical schools and undergraduate institutions to fully inform international students interested in medical education in the US of the limited options available to them for tuition assistance;	AMA-MSS asked the AMA to: (1) Encourage additional medical schools to consider applications from and to admit international students to their programs alongside domestic students; (2) Support efforts to re-evaluate and minimize the use of pre-payment requirements specific to international medical students; and (3) Advocate for increased scholarship and funding opportunities for international students accepted to or currently attending United States medical schools.

TABLE 1: RECOMMENDED FOR RETENTION WITH AMENDMENTS: SUMMARIZE AND/OR UPDATE LANGUAGE			
Position #	**Title**	**Original Position**	**Final Summarized Language & Rationale**
		3. supports the Association of American Medical Colleges (AAMC) in its efforts to increase transparency in the medical school application process for international students by including school policy on tuition requirements in the Medical School Admission Requirements (MSAR); and 4. supports efforts to re-evaluate and minimize the use of pre-payment requirements specific to international medical students; and 5. encourages medical schools to explore alternative means of prepayment, such as a letter of credit, ~~for four years~~ for covering the costs of medical school. And (3) advocate for increased scholarship and funding opportunities for international students accepted to or currently attending United States medical schools. MSS Timeline: (MSS Res. 056, I-22) HOD Timeline: (AMA Res. 301-A-24, Referred for Study, A-24)	
160.048MSS	Encouraging Increased Accessibility and Utilization of Occupational Pulmonary Lung Disease Screenings	AMA-MSS will ask the AMA to amend Policy 365.988 "Integration of Occupational Medicine, Environmental Health, and Injury Prevention Programs into Public Health Agencies" by insertion as follows: Integration of Occupational Medicine, Environmental Health, and Injury Prevention Programs into Public Health Agencies, H-365.988 Our AMA: ~~supports:~~ (1) supports the integration of occupational health and environmental health and injury prevention programs within existing health departments at the state and local level;	AMA-MSS asked the AMA to: (1) Recognize barriers to accessibility and utilization of occupational health, environmental health and injury prevention programs; (2) Recognize inequities in occupational health screenings for pulmonary lung disease and supports efforts to increase accessibility of these screenings in marginalized communities; and (3) Encourage utilization of accessible screenings for other at-risk occupational groups.

TABLE 1: RECOMMENDED FOR RETENTION WITH AMENDMENTS: SUMMARIZE AND/OR UPDATE LANGUAGE			
Position #	**Title**	**Original Position**	**Final Summarized Language & Rationale**
		(2) supports taking a leadership role in assisting state medical societies in implementation of such programs; ~~and~~ (3) supports working with federal agencies to ensure that "health" is the primary determinant in establishing environmental and occupational health policy; (4) recognizes barriers to accessibility and utilization of such programs; (5) recognizes inequities in occupational health screenings for pulmonary lung disease and supports efforts to increase accessibility of these screenings in marginalized communities; and (6) encourages utilization of accessible screenings, such as those used in the NIOSH Coal Workers Health Surveillance Program, for other at risk occupational groups and utilization of these free screenings. MSS Timeline: (MSS Res. 046, I-22) HOD Timeline: (AMA Res. 403-A-24, Adopted as Amended, A-24)	
145.026MSS	Addressing Default Proceed Sales of Firearms	That our AMA amend "Firearm Availability H-145.996" by addition as follows: Firearm Availability H-145.996 1. Our AMA: (a) advocates a waiting period and background check for all firearm purchasers; (b) encourages legislation that enforces a waiting period and background check for all firearm purchasers; (c) opposes firearm sales to individuals for whom a background check has not been completed;	AMA-MSS asked the AMA to: (1) Oppose firearm sales to individuals for whom a background check has not been completed and oppose destruction of any incomplete background checks; (2) Advocate for public annual reporting by relevant agencies on inappropriate firearm sales, including number of default proceed sales; number of firearms retrieved from individuals after these sales through criminal investigations, across state

TABLE 1: RECOMMENDED FOR RETENTION WITH AMENDMENTS: SUMMARIZE AND/OR UPDATE LANGUAGE			
Position #	**Title**	**Original Position**	**Final Summarized Language & Rationale**
		(d) opposes destruction of any incomplete background checks for firearm sales; and (e) advocates for public annual reporting by relevant agencies on inappropriate firearm sales, including number of default proceed sales; number of firearms retrieved from individuals after these sales through criminal investigations, across state lines, via or other means; and average time passed between background check completion and retrieval.; and (f~~e~~) urges legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic, ceramics, or other nonmetallic materials that cannot be detected by airport and weapon detection devices. 2. Our AMA supports requiring the licensing/permitting of firearms-owners and purchasers, including the completion of a required safety course, and registration of all firearms. 3. Our AMA supports "gun violence restraining orders" for individuals arrested or convicted of domestic violence or stalking, and supports extreme risk protection orders, commonly known as "red-flag" laws, for individuals who have demonstrated significant signs of potential violence. In supporting restraining orders and "red-flag" laws, we also support the importance of due process so that individuals can petition for their rights to be restored. 4. Our AMA advocates for (a) federal and state policies that prevent inheritance, gifting, or transfer of ownership of firearms without adhering to all federal and state requirements for background checks, waiting periods, and licensure; (b) federal and state policies to prevent "multiple sales" of firearms, defined as the sale of multiple firearms to the same purchaser within five business days; and (c) federal and state policies implementing background checks for ammunition purchases.	lines, via or other means; and average time passed between background check completion and retrieval.

TABLE 1: RECOMMENDED FOR RETENTION WITH AMENDMENTS: SUMMARIZE AND/OR UPDATE LANGUAGE			
Position #	**Title**	**Original Position**	**Final Summarized Language & Rationale**
		MSS Timeline: (MSS Res. OF001, I-23) HOD Timeline: (AMA Res. 405-A-24, Adopted, A-24)	
145.073MSS	Support for Comprehensive Safe Firearm Storage Legislation	AMA-MSS will ask the AMA to amend "Prevention of Firearm Accidents in Children" H-145.990 by addition to read as follows: Prevention of Firearm Accidents in Children H-145.990 1) Our AMA (a) supports increasing efforts to reduce pediatric firearm morbidity and mortality by encouraging its members to (i) inquire as to the presence of household firearms as a part of childproofing the home; (ii) educate patients to the dangers of firearms to children; (iii) encourage patients to educate their children and neighbors as to the dangers of firearms; and (iv) routinely remind patients to obtain firearm safety locks, to store firearms under lock and key, and to store ammunition separately from firearms; (b) encourages state medical societies to work with other organizations to increase public education about firearm safety; (c) encourages organized medical staffs and other physician organizations, including state and local medical societies, to recommend programs for teaching firearm safety to children; and (d) supports enactment of Child Access Prevention laws <u>and other types of comprehensive safe storage laws</u> that are consistent with AMA policy.	AMA-MSS asked the AMA to support the enactment of Child Access Prevention laws and other types of comprehensive firearm safe storage laws that are consistent with AMA policy.

TABLE 1: RECOMMENDED FOR RETENTION WITH AMENDMENTS: SUMMARIZE AND/OR UPDATE LANGUAGE			
Position #	**Title**	**Original Position**	**Final Summarized Language & Rationale**
		2) Our AMA and all interested medical societies will (a) educate the public about: (b) best practices for firearm storage safety; (c) misconceptions families have regarding child response to encountering a firearm in the home; and (c) the need to ask other families with whom the child interacts regarding the presence and storage of firearms in other homes the child may enter. MSS Timeline: (MSS Res. OF076, I-23) HOD Timeline: (AMA Res. 405-A-24, Adopted, A-24)	
350.037MSS	Racial Misclassification	AMA-MSS will ask the AMA to amend "Improving Death Certification Accuracy and Completion" H-85.953 by addition as follows: Improving Death Certification Accuracy and Completion H-85.953 1. Our AMA: (a) acknowledges that the reporting of vital events is an integral part of patient care; (b) urges physicians to ensure completion of all state vital records carefully and thoroughly with special attention to the use of standard nomenclature, using legible writing and accurate diagnoses; and (c) supports notifying state medical societies and state departments of vital statistics of this policy and encouraging their assistance and cooperation in implementing it. 2. Our AMA also: (a) supports the position that efforts to improve cause of death statistics are indicated and necessary;	AMA-MSS asked the AMA to support HIPAA-compliant data linkages between Native Hawaiian and Tribal Registries, population-based and hospital-based clinical trial and disease registries, and local, state, tribal, and federal vital statistics databases aimed at minimizing racial misclassification on death certificates and statistics and all vital records and statistics.

TABLE 1: RECOMMENDED FOR RETENTION WITH AMENDMENTS: SUMMARIZE AND/OR UPDATE LANGUAGE			
Position #	**Title**	**Original Position**	**Final Summarized Language & Rationale**
		(b) endorses the concept that educational efforts to improve death certificates should be focused on physicians, particularly those who take care of patients in facilities where patients are likely to die, namely in acute hospitals, nursing homes and hospices; and (c) supports the concept that training sessions in completion of death certificates should be (i) included in hospital house staff orientation sessions and clinical pathologic conferences; (ii) integrated into continuing medical education presentations; (iii) mandatory in mortality conferences; and (iv) included as part of in-service training programs for nursing homes, hospices and geriatric physicians. 3. Our AMA further: (a) promotes and encourages the use of ICD codes among physicians as they complete medical claims, hospital discharge summaries, death certificates, and other documents; (b) supports cooperating with the National Center for Health Statistics (NCHS) in monitoring the four existing models for collecting tobacco-use data; (c) urges the NCHS to identify appropriate definitions, categories, and methods of collecting risk-factor data, including quantification of exposure, for inclusion on the U.S. Standard Certificates, and that subsequent data be appropriately disseminated; and (d) continues to encourage all physicians to report tobacco use, exposure to environmental tobacco smoke, and other risk factors using the current standard death certificate format. 4. Our AMA further: (a) supports HIPAA-compliant data linkages between Native Hawaiian and Tribal Registries, population-based and hospital-based clinical trial and disease registries, and local,	

TABLE 1: RECOMMENDED FOR RETENTION WITH AMENDMENTS: SUMMARIZE AND/OR UPDATE LANGUAGE			
Position #	**Title**	**Original Position**	**Final Summarized Language & Rationale**
		state, tribal, and federal vital statistics databases aimed at minimizing racial misclassification. MSS Timeline: (MSS Res. 033, A-23) HOD Timeline: (AMA Res. 407-A-24, Adopted, A-24)	
270.035MSS	Opposition to Capital Punishment	AMA-MSS opposes all forms of capital punishment. MSS Timeline: (MSS Res 34, A-17) (Reaffirmed: MSS GC Report A, A-23) HOD Timeline: (AMA Res. 407-A-24, Adopted, A-24)	AMA-MSS asked the AMA to oppose all forms of capital punishment.
305.087MSS	Voluntary Service - Payback and Loan Repayment Programs	The AMA-MSS supports the following principles regarding voluntary service-payback and loan repayment programs: 1. The AMA-MSS will ask the AMA to support legislation to continue the National Health Service Corps scholarship and field programs and support the development of other voluntary programs that finance medical students through their undergraduate training in exchange for their service in underserved areas. 2. The AMA-MSS will ask the AMA to advocate for the inclusion of physicians trained in preventive medicine among those who qualify for participation in the National Health Service Corps Loan Repayment Program.	The AMA-MSS asked the AMA to: (1) Continue and encourage the development of more scholarships and programs that finance medical students through their undergraduate training in exchange for their service in underserved areas. (2) Advocate for the inclusion of physicians trained in preventive medicine among those who qualify for participation in the National Health Service Corps Loan Repayment Program. (3) Make compensation scales for Indian Health Service (IHS) physicians competitive with those of other federal agencies and non-governmental

TABLE 1: RECOMMENDED FOR RETENTION WITH AMENDMENTS: SUMMARIZE AND/OR UPDATE LANGUAGE			
Position #	**Title**	**Original Position**	**Final Summarized Language & Rationale**
		3. The AMA-MSS will ask the AMA to amend "Indian Health Service" H-350.977 by addition and deletion as follows: Indian Health Service H-350.977 The policy of the AMA is to support efforts in Congress to enable the Indian Health Service to meet its obligation to bring American Indian health up to the general population level. The AMA specifically recommends: (1) Indian Population: (a) In current education programs, and in the expansion of educational activities suggested below, special consideration be given to involving the American Indian and Alaska native population in training for the various health professions, in the expectation that such professionals, if provided with adequate professional resources, facilities, and income, will be more likely to serve the tribal areas permanently; (b) Exploration with American Indian leaders of the possibility of increased numbers of nonfederal American Indian health centers, under tribal sponsorship, to expand the American Indian role in its own health care; (c) Increased involvement of private practitioners and facilities in American Indian care, through such mechanisms as agreements with tribal leaders or Indian Health Service contracts, as well as normal private practice relationships; and (d) Improvement in transportation to make access to existing private care easier for the American Indian population. (2) Federal Facilities: Based on the distribution of the eligible population, transportation facilities and roads, and the availability of alternative nonfederal resources, the AMA	service, increase compensation for specialty and primary care in remote areas, and provide continuing education opportunities for this professionals; (4) Maintain appropriate IHS allied health professional staffing without detracting from physician compensation. (5) Call for an immediate change in the Public Service Loan Forgiveness Program to allow physicians to receive immediate loan forgiveness when they practice in an Indian Health Service, Tribal, or Urban Indian Health Program.

TABLE 1: RECOMMENDED FOR RETENTION WITH AMENDMENTS: SUMMARIZE AND/OR UPDATE LANGUAGE			
Position #	**Title**	**Original Position**	**Final Summarized Language & Rationale**
		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 ~~Manpower~~: (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 ~~manpower~~ and the level of professional expertise available for consultation; (d) Allied health professional staffing of Service facilities should be maintained at a level appropriate to the special needs of the population served 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	

TABLE 1: RECOMMENDED FOR RETENTION WITH AMENDMENTS: SUMMARIZE AND/OR UPDATE LANGUAGE			
Position #	**Title**	**Original Position**	**Final Summarized Language & Rationale**
		adjacent to Service facilities, that the appropriate medical societies should explore the possibility of increased formal liaison with local Indian Health Service physicians. Increased support from organized medicine for improvement of health care provided under their direction, including professional consultation and involvement in society activities should be pursued. (5) Our AMA also support the removal of any requirement for competitive bidding in the Indian Health Service that compromises proper care for the American Indian population. (6) Our AMA will advocate that the Indian Health Service (IHS) establish an Office of Academic Affiliations responsible for coordinating partnerships with LCME- and COCA-accredited medical schools and ACGME-accredited residency programs. (7) Our AMA will encourage the development of funding streams to promote rotations and learning opportunities at Indian Health Service, Tribal, and Urban Indian Health Programs. <u>(8) Our AMA will call for an immediate change in the Public Service Loan Forgiveness Program to allow physicians to receive immediate loan forgiveness when they practice in an Indian Health Service, Tribal, or Urban Indian Health Program.</u> MSS Timeline: (MSS GC Rep A, I-17) (Reaffirmed: MSS GC Report A, A-23) (MSS Res. OF084, Appended, I-23) HOD Timeline: (AMA Res. 305-A-24, Adopted as Amended, A-24)	