

Memo to: Delegates, Alternate Delegates  
Executive Directors, Member Organizations of the House of Delegates

From: Bruce A. Scott, MD, Speaker, House of Delegates  
Lisa Bohman Egbert, MD, Vice Speaker, House of Delegates

Date: October 30, 2020

Subject: Handbook Addendum - Supplemental Business and Information

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We are pleased to provide the attached report and resolutions that were received after the Delegates' Handbook resolution deadline:

### **Reports**

- BOT Report 18 - Specialty Society Representation in the House of Delegates - Five Year Review

### **Resolutions**

- 309 - Preserve and Increase Graduate Medical Education Funding
- 407 - Full Commitment by our AMA to the Betterment and Strengthening of Public Health Systems
- 509 - Hydroxychloroquine and Combination Therapies – Off-Label Use
- 510 - Access to Opioid Agonist Treatment for Incarcerated Persons

Finally, your Speakers wish to inform you that the charts listing actions taken in follow-up to resolutions and report recommendations from the 2019 Interim and the June 2020 Special Meetings will be posted on the [November 2020 Meeting website](#).

REPORT OF THE BOARD OF TRUSTEES

B of T Report 18, November 2020

Subject: Specialty Society Representation in the House of Delegates -  
Five-Year Review

Presented by: Russ Kridel, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws  
(Charles J. Rainey, MD, JD, Chair)

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1 The Board of Trustees (BOT) has completed its review of the specialty organizations seated in the  
2 House of Delegates (HOD) scheduled to submit information and materials for the 2020 American  
3 Medical Association (AMA) Annual Meeting and the 2020 Interim Meeting in compliance with the  
4 five-year review process established by the HOD in Policy G-600.020, "Summary of Guidelines  
5 for Admission to the House of Delegates for Specialty Societies," and AMA Bylaw 8.5, "Periodic  
6 Review Process."

7  
8 Organizations are required to demonstrate continuing compliance with the guidelines established  
9 for representation in the HOD. Compliance with the five responsibilities of professional interest  
10 medical associations and national medical specialty organizations is also required as set out in  
11 AMA Bylaw 8.2, "Responsibilities of National Medical Specialty Societies and Professional  
12 Interest Medical Associations."

13  
14 The following organizations were reviewed in anticipation of the 2020 Annual Meeting:

15  
16 American Academy of Otolaryngic Allergy  
17 American Association for Geriatric Psychiatry  
18 American College of Legal Medicine  
19 American College of Mohs Surgery  
20 American College of Obstetricians and Gynecologists  
21 American College of Physicians  
22 American College of Preventive Medicine  
23 American College of Radiology  
24 American College of Surgeons  
25 American Society of Breast Surgeons  
26 American Society of Retina Specialists  
27 American Vein and Lymphatic Society  
28 Heart Rhythm Society  
29 International Academy of Independent Medical Evaluators  
30 Society of Hospital Medicine  
31 Undersea and Hyperbaric Medical Society  
32

33 The following organizations were also reviewed in anticipation of the 2020 Annual Meeting,  
34 having failed to meet the requirements at the 2019 Annual Meeting:

35  
36 American Society for Aesthetic Plastic Surgery

1 American Society of Interventional Pain Physicians  
2 Association of University Radiologists  
3 Infectious Diseases Society of America  
4 International Society for the Advancement of Spine Surgery  
5

6 The following organizations were reviewed in anticipation of the 2020 Interim Meeting:  
7

8 American College of Occupational and Environmental Medicine  
9 American Gastroenterological Association  
10 American Geriatrics Society  
11 American Orthopaedic Association  
12 American Psychiatric Association  
13 American Roentgen Ray Society  
14 American Society of Abdominal Surgeons  
15 The Triological Society  
16

17 Each organization was required to submit materials demonstrating compliance with the guidelines  
18 and requirements along with appropriate membership information. A summary of each group's  
19 membership data is attached to this report (Exhibit A). A summary of the guidelines for specialty  
20 society representation in the AMA HOD (Exhibit B), the five responsibilities of national medical  
21 specialty organizations and professional medical interest associations represented in the HOD  
22 (Exhibit C), and the AMA Bylaws pertaining to the five-year review process (Exhibit D) are also  
23 attached.  
24

25 The materials submitted indicate that: American Academy of Otolaryngic Allergy, American  
26 Association of Geriatric Psychiatry, American College of Legal Medicine, American College of  
27 Mohs Surgery, American College of Obstetricians and Gynecologists, American College of  
28 Occupational and Environmental Medicine, American College of Physicians, American College of  
29 Preventive Medicine, American College of Radiology, American College of Surgeons, American  
30 Gastroenterological Association, American Geriatrics Society, American Orthopaedic Association,  
31 American Psychiatric Association, American Roentgen Ray Society, American Society of Breast  
32 Surgeons, American Society of Interventional Pain Physicians, American Society of Retina  
33 Specialists, American Vein and Lymphatic Society, Association of University Radiologists, Heart  
34 Rhythm Society, Infectious Disease Society of America, International Society for the Advancement  
35 of Spine Surgery, Society of Hospital Medicine, The Triological Society and the Undersea and  
36 Hyperbaric Medical Society meet all guidelines and are in compliance with the five-year review  
37 requirements of specialty organizations represented in the HOD.  
38

39 The materials submitted also indicated that the American Society for Aesthetic Plastic Surgery and  
40 the International Academy of Independent Medical Examiners did not meet all guidelines and are  
41 not in compliance with the five-year review requirements of specialty organizations represented in  
42 the HOD.  
43

44 The American Society of Abdominal Surgeons did not submit materials and is therefore not in  
45 compliance.  
46

#### 47 RECOMMENDATIONS 48

49 In light of the cancellation of the 2020 Annual and Interim Meetings and with an intention to  
50 continue compliance with the five-year review process, the Board of Trustees recommends that the  
51 following be adopted, and the remainder of this report be filed:

- 1 1. That the American Academy of Otolaryngic Allergy, American Association of Geriatric  
2 Psychiatry, American College of Legal Medicine, American College of Mohs Surgery,  
3 American College of Obstetricians and Gynecologists, American College of Occupational and  
4 Environmental Medicine, American College of Physicians, American College of Preventive  
5 Medicine, American College of Radiology, American College of Surgeons, American  
6 Gastroenterological Association, American Geriatrics Society, American Orthopaedic  
7 Association, American Psychiatric Association, American Roentgen Ray Society, American  
8 Society of Breast Surgeons, American Society of Interventional Pain Physicians, American  
9 Society of Retina Specialists, American Vein and Lymphatic Society, Association of  
10 University Radiologists, Heart Rhythm Society, Infectious Disease Society of America,  
11 International Society for the Advancement of Spine Surgery, Society of Hospital Medicine,  
12 The Triological Society and the Undersea and Hyperbaric Medical Society retain  
13 representation in the American Medical Association House of Delegates. (Directive to Take  
14 Action)  
15
- 16 2. Having failed to meet the requirements for continued representation in the AMA House of  
17 Delegates as set forth in AMA Bylaw B-8.5, the International Academy of Independent  
18 Medical Evaluators and the American Society of Abdominal Surgeons be placed on probation  
19 and be given one year to work with AMA membership staff to increase their AMA  
20 membership. (Directive to Take Action)  
21
- 22 3. Having failed to meet the requirements for continued representation in the AMA House of  
23 Delegates as set forth in AMA Bylaw B-8.5 after a year's grace period to increase membership,  
24 the American Society for Aesthetic Plastic Surgery not retain representation in the House of  
25 Delegates. (Directive to Take Action)

Fiscal Note: Less than \$500 to implement.

**APPENDIX**

***Exhibit A - Summary Membership Information***

<b>Organization</b>	<b>AMA Membership of Organization's Total Eligible Membership</b>
American Academy of Otolaryngic Allergy	259 of 997 (26%)
American Association for Geriatric Psychiatry	233 of 829 (28%)
American College of Legal Medicine	52 of 176 (30%)
American College of Mohs Surgery	306 of 1,088 (28%)
American College of Obstetrician and Gynecologists	13,123 of 43,410 (30%)
American College of Occupational and Environmental Medicine	646 of 2,633 (25%)
American College of Physicians	33,190 of 102,042 (32%)
American College of Preventive Medicine	326 of 1,193 (27%)
American College of Radiology	7,370 of 34,011 (22%)
American College of Surgeons	5,869 of 29,938 (20%)
American Gastroenterological Association	1,273 of 7,791 (16%)
American Geriatrics Society	724 of 2,750 (26%)
American Orthopaedic Association	387 of 1,665 (23%)
American Psychiatric Association	6,837 of 25,719 (27%)
American Roentgen Ray Society	2,533 of 13,859 (18%)
American Society for Aesthetic Plastic Surgery	330 of 1,888 (17%)
American Society of Abdominal Surgeons	no data
American Society of Breast Surgeons	609 of 2,473 (25%)
American Society of Interventional Pain Physicians	652 of 2,587 (25%)
American Society of Retina Specialists	575 of 2,154 (26%)
American Vein and Lymphatic Society	238 of 957 (25%)
Association of University Radiologists	179 of 861 (20%)

<b>Organization</b>	<b>AMA Membership of Organization's Total Eligible Membership</b>
Heart Rhythm Society	656 of 3,040 (22%)
Infectious Disease Society of America	1062 of 3,515 (30%)
International Academy of Independent Medical Evaluators	61 of 139 (44%)
International Society for the Advancement of Spine Surgery	109 of 369 (29%)
Society of Hospital Medicine	2,389 of 12,827 (19%)
The Triological Society	123 of 534 (23%)
Undersea and Hyperbaric Medical Society	123 of 586 (21%)

***Exhibit B - Summary of Guidelines for Admission to the House of Delegates for Specialty Societies (Policy G-600.020)***

Policy G-600.020

1. The organization must not be in conflict with the Constitution and Bylaws of the American Medical Association with regard to discrimination in membership.
2. The organization must:
  - (a) represent a field of medicine that has recognized scientific validity;
  - (b) not have board certification as its primary focus; and
  - (c) not require membership in the specialty organization as a requisite for board certification.
3. The organization must meet one of the following criteria:
  - (a) a specialty organization must demonstrate that it has 1,000 or more AMA members; or
  - (b) a specialty organization must demonstrate that it has a minimum of 100 AMA members and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA; or
  - (c) a specialty organization must demonstrate that it was represented in the House of Delegates at the 1990 Annual Meeting and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA.
4. The organization must be established and stable; therefore it must have been in existence for at least five years prior to submitting its application.
5. Physicians should comprise the majority of the voting membership of the organization.
6. The organization must have a voluntary membership and must report as members only those who are current in payment of dues, have full voting privileges, and are eligible to hold office.
7. The organization must be active within its field of medicine and hold at least one meeting of its members per year.
8. The organization must be national in scope. It must not restrict its membership geographically and must have members from a majority of the states.
9. The organization must submit a resolution or other official statement to show that the request is approved by the governing body of the organization.
10. If international, the organization must have a US branch or chapter, and this chapter must be reviewed in terms of all of the above guidelines.

*Exhibit C*

**8.2 Responsibilities of National Medical Specialty Societies and Professional Interest Medical Associations.** Each national medical specialty society and professional interest medical association represented in the House of Delegates shall have the following responsibilities:

- 8.2.1** To cooperate with the AMA in increasing its AMA membership.
- 8.2.2** To keep its delegate(s) to the House of Delegates fully informed on the policy positions of the society or association so that the delegates can properly represent the society or association in the House of Delegates.
- 8.2.3** To require its delegate(s) to report to the society on the actions taken by the House of Delegates at each meeting.
- 8.2.4** To disseminate to its membership information as to the actions taken by the House of Delegates at each meeting.
- 8.2.5** To provide information and data to the AMA when requested.

***Exhibit D – AMA Bylaws on Specialty Society Periodic Review***

**8 - Representation of National Medical Specialty Societies and Professional Interest Medical Associations in the House of Delegates**

**8.5 Periodic Review Process.** Each specialty society and professional interest medical association represented in the House of Delegates must reconfirm its qualifications for representation by demonstrating every 5 years that it continues to meet the current guidelines required for granting representation in the House of Delegates, and that it has complied with the responsibilities imposed under Bylaw 8.2. The SSS may determine and recommend that societies currently classified as specialty societies be reclassified as professional interest medical associations. Each specialty society and professional interest medical association represented in the House of Delegates must submit the information and data required by the SSS to conduct the review process. This information and data shall include a description of how the specialty society or the professional interest medical association has discharged the responsibilities required under Bylaw 8.2.

**8.5.1** If a specialty society or a professional interest medical association fails or refuses to provide the information and data requested by the SSS for the review process, so that the SSS is unable to conduct the review process, the SSS shall so report to the House of Delegates through the Board of Trustees. In response to such report, the House of Delegates may terminate the representation of the specialty society or the professional interest medical association in the House of Delegates by majority vote of delegates present and voting, or may take such other action as it deems appropriate.

**8.5.2** If the SSS report of the review process finds the specialty society or the professional interest medical association to be in noncompliance with the current guidelines for representation in the House of Delegates or the responsibilities under Bylaw 8.2, the specialty society or the professional interest medical association will have a grace period of one year to bring itself into compliance.

**8.5.3** Another review of the specialty society's or the professional interest medical association's compliance with the current guidelines for representation in the House of Delegates and the responsibilities under Bylaw 8.2 will then be conducted, and the SSS will submit a report to the House of Delegates through the Board of Trustees at the end of the one-year grace period.

**8.5.3.1** If the specialty society or the professional interest medical association is then found to be in compliance with the current guidelines for representation in the House of Delegates and the responsibilities under Bylaw 8.2, the specialty society or the professional interest medical association will continue to be represented in the House of Delegates and the current review process is completed.

**8.5.3.2** If the specialty society or the professional interest medical association is then found to be in noncompliance with the current guidelines for representation in the House of Delegates, or the responsibilities under Bylaw 8.2, the House may take one of the following actions:

**8.5.3.2.1** The House of Delegates may continue the representation of the specialty society or the professional interest medical association in the House of Delegates, in which case the result will be the same as in Bylaw 8.5.3.1.

**8.5.3.2.2** The House of Delegates may terminate the representation of the specialty society or the professional interest medical association in the House of Delegates. The specialty society or the professional interest medical association shall remain a member of the SSS, pursuant to the provisions of the Standing Rules of the SSS. The specialty society or the professional interest medical association may apply for reinstatement in the House of Delegates, through the SSS, when it believes it can comply with all of the current guidelines for representation in the House of Delegates.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 309  
(November 2020)

Introduced by: Michigan

Subject: Preserve and Increase Graduate Medical Education Funding

Referred to: Reference Committee C

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1 Whereas, The U.S. General Accountability Office (GAO) recently announced their fiscal year  
2 budget; and  
3  
4 Whereas, Their announcement included information about potential changes in graduate  
5 medical education (GME) funding; and  
6  
7 Whereas, The GAO released a report in December 2019, entitled, "Views on Expanding  
8 Medicare Graduate Medical Education Funding to Nurse Practitioners and Physician  
9 Assistants"; and  
10  
11 Whereas, This report contains potential errors that may adversely influence legislative  
12 decisions; and  
13  
14 Whereas, GME funding, direct and indirect funding, has been earmarked for resident physicians  
15 to support their education and training in teaching hospitals; and  
16  
17 Whereas, Advanced practice professionals, such as nurse practitioners or physician assistants,  
18 have a shorter training period with an associated lower overall cost for the trainee and no  
19 requirement for a residency; and  
20  
21 Whereas, The number of residency slots has not been increased for most residency programs  
22 since 1997 due to the restrictions imposed by the Balanced Budget Act; and  
23  
24 Whereas, Teaching hospitals rely on GME funding to offset the increased cost of providing care  
25 that may occur in a teaching hospital setting due to the presence of additional health care  
26 personnel who are trainees; and  
27  
28 Whereas, An increase in GME funding has been an ongoing request to our legislators for the  
29 past few years due to concerns about the rising expenses of providing education coupled with  
30 the stagnation of GME funding; and  
31  
32 Whereas, The United States is facing a significant and severe physician shortage based on  
33 current predictors and estimates; and  
34  
35 Whereas, The diversion of GME funding to non-physicians will only make this situation worse  
36 with potential serious consequences for the health of our nation due to lack of physician access;  
37 therefore be it

- 1 RESOLVED, That our American Medical Association work with the Liaison Committee on
- 2 Medical Education, the Accreditation Council for Graduate Medical Education, and other
- 3 interested stakeholders to encourage the U.S. Government Accountability Office to oppose and
- 4 refrain from further consideration of the diversion of direct and indirect graduate medical
- 5 education funding to non-physicians. (Directive to Take Action)

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

Received: 10/27/20

Sources:

1. U.S. Government Accountability Office Report to Congressional Committees December 2019 HEALTH CARE WORKFORCE "Views on Expanding Medicare Graduate Medical Education Funding to Nurse Practitioners and Physician Assistants"
2. "Residency: The Bottleneck in Physician Training" Physicians for Patient Protection/PPP Response to GAO Report, on-line resource, accessed February 10, 2020.

## RELEVANT AMA POLICY

### **Funding to Support Training of the Health Care Workforce H-310.916**

1. Our American Medical Association will insist that any new GME funding to support graduate medical education positions be available only to Accreditation Council for Graduate Medical Education (ACGME) and/or American Osteopathic Association (AOA) accredited residency programs, and believes that funding made available to support the training of health care providers not be made at the expense of ACGME and/or AOA accredited residency programs.
  2. Our AMA strongly advocates that: (A) there be no decreases in the current funding of MD and DO graduate medical education while there is a concurrent increase in funding of graduate medical education (GME) in other professions; and (B) there be at least proportional increases in the current funding of MD and DO graduate medical education similar to increases in funding of GME in other professions.
- Citation: (Sub. Res. 913, I-09; Appended: Res. 917, I-15)

### **Securing Funding for Graduate Medical Education H-310.917**

Our American Medical Association: (1) continues to be vigilant while monitoring pending legislation that may change the financing of medical services (health system reform) and advocate for expanded and broad-based funding for graduate medical education (from federal, state, and commercial entities); (2) continues to advocate for graduate medical education funding that reflects the physician workforce needs of the nation; (3) encourages all funders of GME to adhere to the Accreditation Council for Graduate Medical Education's requirements on restrictive covenants and its principles guiding the relationship between GME, industry and other funding sources, as well as the AMA's Opinion 8.061, and other AMA policy that protects residents and fellows from exploitation, including physicians training in non-ACGME-accredited programs; and (4) encourages entities planning to expand or start GME programs to develop a clear statement of the benefits of their GME activities to facilitate potential funding from appropriate sources given the goals of their programs.

Citation: (CME Rep. 3, I-09; Modified: CME Rep. 15, A-10; Reaffirmed in lieu of Res. 324, A-12; Reaffirmed: CME Rep. 5, A-13; Appended: CME Rep. 1, I-15)

### **The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education D-305.967**

1. Our AMA will actively collaborate with appropriate stakeholder organizations, (including Association of American Medical Colleges, American Hospital Association, state medical societies, medical specialty societies/associations) to advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions from all existing sources (e.g. Medicare, Medicaid, Veterans Administration, CDC and others).
2. Our AMA will actively advocate for the stable provision of matching federal funds for state Medicaid programs that fund GME positions.
3. Our AMA will actively seek congressional action to remove the caps on Medicare funding of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 (BBA-1997).
4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation.
5. Our AMA will oppose efforts to move federal funding of GME positions to the annual appropriations process that is subject to instability and uncertainty.

6. Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.).
7. Our AMA will actively explore additional sources of GME funding and their potential impact on the quality of residency training and on patient care.
8. Our AMA will vigorously advocate for the continued and expanded contribution by all payers for health care (including the federal government, the states, and local and private sources) to fund both the direct and indirect costs of GME.
9. Our AMA will work, in collaboration with other stakeholders, to improve the awareness of the general public that GME is a public good that provides essential services as part of the training process and serves as a necessary component of physician preparation to provide patient care that is safe, effective and of high quality.
10. Our AMA staff and governance will continuously monitor federal, state and private proposals for health care reform for their potential impact on the preservation, stability and expansion of full funding for the direct and indirect costs of GME.
11. Our AMA: (a) recognizes that funding for and distribution of positions for GME are in crisis in the United States and that meaningful and comprehensive reform is urgently needed; (b) will immediately work with Congress to expand medical residencies in a balanced fashion based on expected specialty needs throughout our nation to produce a geographically distributed and appropriately sized physician workforce; and to make increasing support and funding for GME programs and residencies a top priority of the AMA in its national political agenda; and (c) will continue to work closely with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, American Osteopathic Association, and other key stakeholders to raise awareness among policymakers and the public about the importance of expanded GME funding to meet the nation's current and anticipated medical workforce needs.
12. Our AMA will collaborate with other organizations to explore evidence-based approaches to quality and accountability in residency education to support enhanced funding of GME.
13. Our AMA will continue to strongly advocate that Congress fund additional graduate medical education (GME) positions for the most critical workforce needs, especially considering the current and worsening maldistribution of physicians.
14. Our AMA will advocate that the Centers for Medicare and Medicaid Services allow for rural and other underserved rotations in Accreditation Council for Graduate Medical Education (ACGME)-accredited residency programs, in disciplines of particular local/regional need, to occur in the offices of physicians who meet the qualifications for adjunct faculty of the residency program's sponsoring institution.
15. Our AMA encourages the ACGME to reduce barriers to rural and other underserved community experiences for graduate medical education programs that choose to provide such training, by adjusting as needed its program requirements, such as continuity requirements or limitations on time spent away from the primary residency site.
16. Our AMA encourages the ACGME and the American Osteopathic Association (AOA) to continue to develop and disseminate innovative methods of training physicians efficiently that foster the skills and inclinations to practice in a health care system that rewards team-based care and social accountability.
17. Our AMA will work with interested state and national medical specialty societies and other appropriate stakeholders to share and support legislation to increase GME funding, enabling a state to accomplish one or more of the following: (a) train more physicians to meet state and regional workforce needs; (b) train physicians who will practice in physician shortage/underserved areas; or (c) train physicians in undersupplied specialties and subspecialties in the state/region.
18. Our AMA supports the ongoing efforts by states to identify and address changing physician workforce needs within the GME landscape and continue to broadly advocate for innovative pilot programs that will increase the number of positions and create enhanced accountability of GME programs for quality outcomes.
19. Our AMA will continue to work with stakeholders such as Association of American Medical Colleges (AAMC), ACGME, AOA, American Academy of Family Physicians, American College of Physicians, and other specialty organizations to analyze the changing landscape of future physician workforce needs as well as the number and variety of GME positions necessary to provide that workforce.
20. Our AMA will explore innovative funding models for incremental increases in funded residency positions related to quality of resident education and provision of patient care as evaluated by appropriate medical education organizations such as the Accreditation Council for Graduate Medical Education.
21. Our AMA will utilize its resources to share its content expertise with policymakers and the public to ensure greater awareness of the significant societal value of graduate medical education (GME) in terms of patient care, particularly for underserved and at-risk populations, as well as global health, research and education.
22. Our AMA will advocate for the appropriation of Congressional funding in support of the National Healthcare Workforce Commission, established under section 5101 of the Affordable Care Act, to provide data and healthcare workforce policy and advice to the nation and provide data that support the value of GME to the nation.

23. Our AMA supports recommendations to increase the accountability for and transparency of GME funding and continue to monitor data and peer-reviewed studies that contribute to further assess the value of GME.
  24. Our AMA will explore various models of all-payer funding for GME, especially as the Institute of Medicine (now a program unit of the National Academy of Medicine) did not examine those options in its 2014 report on GME governance and financing.
  25. Our AMA encourages organizations with successful existing models to publicize and share strategies, outcomes and costs.
  26. Our AMA encourages insurance payers and foundations to enter into partnerships with state and local agencies as well as academic medical centers and community hospitals seeking to expand GME.
  27. Our AMA will develop, along with other interested stakeholders, a national campaign to educate the public on the definition and importance of graduate medical education, student debt and the state of the medical profession today and in the future.
  28. Our AMA will collaborate with other stakeholder organizations to evaluate and work to establish consensus regarding the appropriate economic value of resident and fellow services.
  29. Our AMA will monitor ongoing pilots and demonstration projects, and explore the feasibility of broader implementation of proposals that show promise as alternative means for funding physician education and training while providing appropriate compensation for residents and fellows.
  30. Our AMA will monitor the status of the House Energy and Commerce Committee's response to public comments solicited regarding the 2014 IOM report, Graduate Medical Education That Meets the Nation's Health Needs, as well as results of ongoing studies, including that requested of the GAO, in order to formulate new advocacy strategy for GME funding, and will report back to the House of Delegates regularly on important changes in the landscape of GME funding.
  31. Our AMA will advocate to the Centers for Medicare & Medicaid Services to adopt the concept of "Cap-Flexibility" and allow new and current Graduate Medical Education teaching institutions to extend their cap-building window for up to an additional five years beyond the current window (for a total of up to ten years), giving priority to new residency programs in underserved areas and/or economically depressed areas.
  32. Our AMA will: (a) encourage all existing and planned allopathic and osteopathic medical schools to thoroughly research match statistics and other career placement metrics when developing career guidance plans; (b) strongly advocate for and work with legislators, private sector partnerships, and existing and planned osteopathic and allopathic medical schools to create and fund graduate medical education (GME) programs that can accommodate the equivalent number of additional medical school graduates consistent with the workforce needs of our nation; and (c) encourage the Liaison Committee on Medical Education (LCME), the Commission on Osteopathic College Accreditation (COCA), and other accrediting bodies, as part of accreditation of allopathic and osteopathic medical schools, to prospectively and retrospectively monitor medical school graduates' rates of placement into GME as well as GME completion.
  33. Our AMA encourages the Secretary of the U.S. Department of Health and Human Services to coordinate with federal agencies that fund GME training to identify and collect information needed to effectively evaluate how hospitals, health systems, and health centers with residency programs are utilizing these financial resources to meet the nation's health care workforce needs. This includes information on payment amounts by the type of training programs supported, resident training costs and revenue generation, output or outcomes related to health workforce planning (i.e., percentage of primary care residents that went on to practice in rural or medically underserved areas), and measures related to resident competency and educational quality offered by GME training programs.
- Citation: Sub. Res. 314, A-07; Reaffirmation I-07; Reaffirmed: CME Rep. 4, I-08; Reaffirmed: Sub. Res. 314, A-09; Reaffirmed: CME Rep. 3, I-09; Reaffirmation A-11; Appended: Res. 910, I-11; Reaffirmed in lieu of Res. 303, A-12; Reaffirmed in lieu of Res. 324, A-12; Reaffirmation: I-12; Reaffirmation A-13; Appended: Res. 320, A-13; Appended: CME Rep. 5, A-13; Appended: CME Rep. 7, A-14; Appended: Res. 304, A-14; Modified: CME Rep. 9, A-15; Appended: CME Rep. 1, I-15; Appended: Res. 902, I-15; Reaffirmed: CME Rep. 3, A-16; Appended: Res. 320, A-16; Appended: CME Rep. 04, A-16; Appended: CME Rep. 05, A-16; Reaffirmation A-16; Appended: Res. 323, A-17; Appended: CME Rep. 03, A-18; Appended: Res. 319, A-18; Reaffirmed in lieu of: Res. 960, I-18; Modified: Res. 233, A-19; Modified: BOT Rep. 25, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 407  
(November 2020)

Introduced by: American College of Preventive Medicine, American College of Occupational and Environmental Medicine, Aerospace Medical Association, American Association of Public Health Physicians, American Society of Addiction Medicine, Academy of Physicians in Clinical Research, Iowa

Subject: Full Commitment by our AMA to the Betterment and Strengthening of Public Health Systems

Referred to: Reference Committee D

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- 1 Whereas, The mission of our AMA is to promote the art and science of medicine and the  
2 betterment of public health; and  
3  
4 Whereas, The current AMA strategic focus areas include accelerating medical education,  
5 improving health outcomes, and enhancing professional satisfaction and practice sustainability;  
6 and  
7  
8 Whereas, All physicians have a responsibility to the health, safety and well-being of all citizens  
9 and their patients; and  
10  
11 Whereas, The COVID-19 pandemic has exposed many deficits in the infrastructure and funding  
12 of the US public health systems; and  
13  
14 Whereas, The current public health infrastructure was not prepared for the severity of this  
15 pandemic; and  
16  
17 Whereas, The public health infrastructure should provide all health care workers every  
18 protection to practice in a safe, healthy and effective manner; therefore be it  
19  
20 RESOLVED, That our American Medical Association champion the betterment of public health  
21 by enhancing advocacy and support for programs and initiatives that strengthen public health  
22 systems, to address pandemic threats, health inequities and social determinants of health  
23 outcomes. (Directive to Take Action)

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

Received: 10/14/20

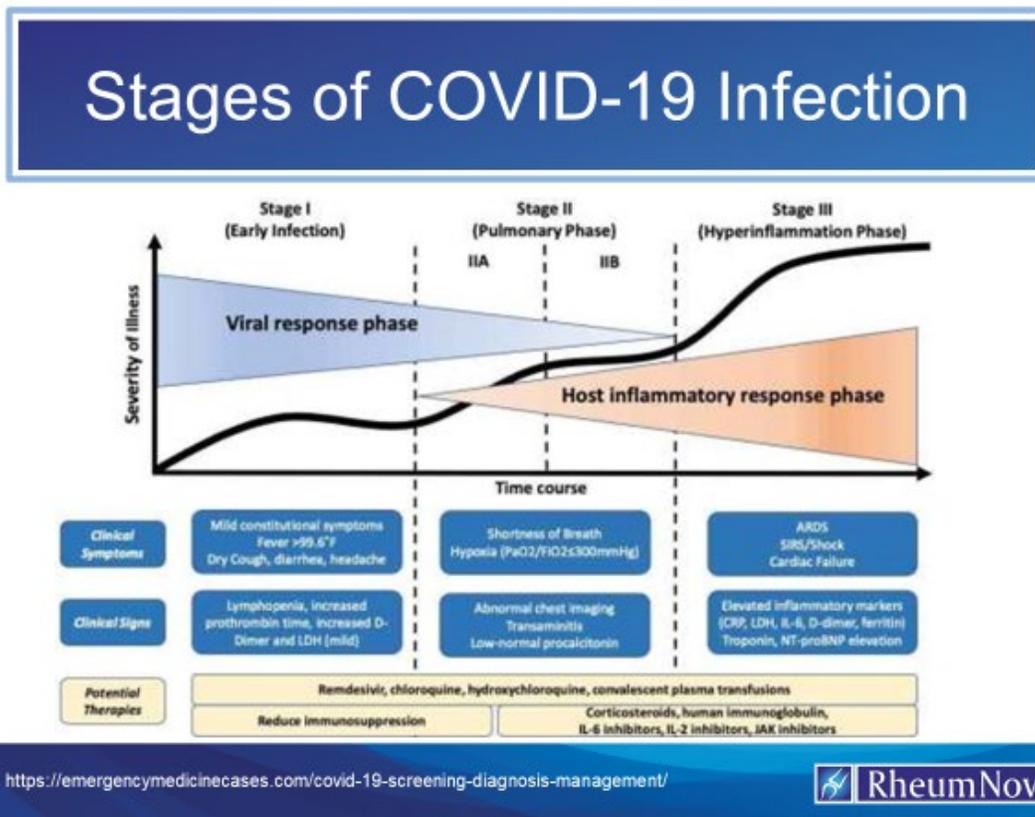
Introduced by: Georgia

Subject: Hydroxychloroquine and Combination Therapies – Off-Label Use

Referred to: Reference Committee E

Whereas, SARS-CoV-2 is the novel coronavirus that causes COVID-19; and

Whereas, Three distinct stages of COVID-19 infection have been observed in some people who test positive for the disease and have variable degrees of symptoms as noted (1); and



Whereas, During the early infection phase (Stage 1), the virus multiplies inside the body and is likely to cause mild symptoms that may be confused with a common cold or flu; and

Whereas, The second phase is the pulmonary phase (Stage 2), when the Immune System becomes strongly affected by infection and leads to primarily respiratory symptoms such as persistent cough, shortness of breath and low oxygen levels. Problems with blood clotting--especially with the formation of blood clots--may be predominant in Stage 2; and

1 Whereas, The third hyperinflammatory phase (Stage 3), occurs when a hyperactivated immune  
2 system may cause injury to the heart, kidneys, and other organs. A "cytokine storm"--where the  
3 body attacks its own tissues--may occur in this phase; and  
4

5 Whereas, There is no current Federal Drug Administration (FDA) indication for the treatment of  
6 Early Coronavirus infection, but early emergency use authorization (EUA) originally approved  
7 the use of hydroxychloroquine and then rescinded it (2); and  
8

9 Whereas, The FDA limited use of convalescence plasma but now has rescinded that  
10 limitation (3); and  
11

12 Whereas, Hydroxychloroquine and Chloroquine are FDA approved medications for over  
13 50 years, and these medications are safely prescribed long-term for other indications (2); and  
14

15 Whereas, AMA President, Patrice A. Harris, MD, issued the following statement: "The AMA  
16 is calling for a stop to any inappropriate prescribing and ordering of medications, including  
17 chloroquine or hydroxychloroquine, and appealing to physicians and all health care  
18 professionals to follow the highest standards of professionalism and ethics" (4); and  
19

20 Whereas, The AMA, American Pharmacists Association, and American Society of Health  
21 System Pharmacists issued a joint statement on March 25, 2020 on inappropriate ordering,  
22 prescribing, or dispensing of medications to treat COVID-19 (4); and  
23

24 Whereas, Some states, pharmacy boards and institutions have forbidden the use of these  
25 medications for COVID-19 infection (4, 5); and  
26

27 Whereas, A proposed regimen to treat COVID-19 for Stage 1, includes 10 days of  
28 hydroxychloroquine, Azithromycin, zinc, and on occasion Vitamin D (6); and  
29

30 Whereas, This regimen is not being advocated for Stage 2 and Stage 3 COVID therapy; and  
31

32 Whereas, The original studies published in *The Lancet* and *The New England Journal of*  
33 *Medicine* (NEJM) initially citing harm due to hydroxychloroquine and chloroquine use were  
34 retracted by said journals due to dubious research methodology and incorrect conclusions  
35 (7, 8, 9); and  
36

37 Whereas, AMA policy H-120.988, "Patient Access to Treatments Prescribed by Their  
38 Physicians," supports a physician's autonomy to prescribe medications the physician believes to  
39 be in the patient's best interest, where the benefits outweigh risk and the patient consents; and  
40

41 Whereas, Physicians have used off label medications for years and this use is supported by  
42 existing policy; and  
43

44 Whereas, Data regarding harm have been limited due to poorly designed studies or studies  
45 usually in Stage 2 or later, or stopped without harm but no effect in phase 2 and hypothesis  
46 (7, 8, 9, 10, 11, 12); and  
47

48 Whereas, There are many studies that indicate that the use of Hydroxychloroquine,  
49 Azithromycin is effective and front-line physicians are using the therapy where permissible  
50 (13, 14, 15); and

1 Whereas, The COVID-19 pandemic is a serious medical issue, people are dying, and  
2 physicians must be able to perform as sagacious prescribers; therefore be it

3  
4 RESOLVED, That our American Medical Association rescind its statement calling for physicians  
5 to stop prescribing hydroxychloroquine and chloroquine until sufficient evidence becomes  
6 available to conclusively illustrate that the harm associated with use outweighs benefit early in  
7 the disease course. Implying that such treatment is inappropriate contradicts AMA Policy  
8 H-120.988, "Patient Access to Treatments Prescribed by Their Physicians," that addresses off  
9 label prescriptions as appropriate in the judgement of the prescribing physician (Directive to  
10 Take Action); and be it further

11  
12 RESOLVED, That our AMA rescind its joint statement with the American Pharmacists  
13 Association and American Society of Health System Pharmacists, and update it with a joint  
14 statement notifying patients that further studies are ongoing to clarify any potential benefit of  
15 hydroxychloroquine and combination therapies for the treatment of COVID-19 (Directive to Take  
16 Action); and be it further

17  
18 RESOLVED, That our AMA reassure the patients whose physicians are prescribing  
19 hydroxychloroquine and combination therapies for their early-stage COVID-19 diagnosis by  
20 issuing an updated statement clarifying our support for a physician's ability to prescribe an FDA-  
21 approved medication for off label use, if it is in her/his best clinical judgement, with specific  
22 reference to the use of hydroxychloroquine and combination therapies for the treatment of the  
23 earliest stage of COVID-19 (Directive to Take Action); and be it further

24  
25 RESOLVED, That our AMA take the actions necessary to require local pharmacies to fill valid  
26 prescriptions that are issued by physicians and consistent with AMA principles articulated in  
27 AMA Policy H-120.988, "Patient Access to Treatments Prescribed by Their Physicians,"  
28 including working with the American Pharmacists Association and American Society of Health  
29 System Pharmacists. (Directive to Take Action)

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

Received: 10/23/20

References:

1. Stages of COVID-19. <https://emergencymedicinecases.com/covid-19-screening-diagnosis-management/>
2. Coronavirus (COVID-19) Update: FDA Revokes Emergency Use Authorization for Chloroquine and Hydroxychloroquine. <https://www.fda.gov/news-events/press-announcements/coronavirus-covid-19-update-fda-revokes-emergency-use-authorization-chloroquine-and>
3. Recommendations for Investigational COVID-19 Convalescent Plasma. <https://www.fda.gov/vaccines-blood-biologics/investigational-new-drug-ind-or-device-exemption-ide-process-cber/recommendations-investigational-covid-19-convalescent-plasma>
4. "The A.M.A. is calling for a stop to any inappropriate prescribing and ordering of medications, including chloroquine or hydroxychloroquine, and appealing to physicians and all health care professionals to follow the highest standards of professionalism and ethics," said AMA President Patrice A. Harris, MD. The American Medical Association, American Pharmacists Association, and American Society of Health System Pharmacists issued a joint statement on March 25, 2020 on inappropriate ordering, prescribing or dispensing of medications to treat COVID-19. <https://www.ama-assn.org/system/files/2020-04/board-of-pharmacy-covid-19-prescribing.pdf>
5. Pharmacy Practice News. Rosenthal M. Hydroxychloroquine: Where Pharmacy, Medicine and Politics Intersect, Pharmacy Practice News August 8, 2020
6. Risch H. Opinion: Early Outpatient Treatment of Symptomatic, High-Risk Covid-19 Patients that Should be Ramped-Up Immediately as Key to the Pandemic Crisis Am J Epidemiol. 2020 May 27;kwaa093. doi: 10.1093/aje/kwaa093. Online ahead of print.
7. Pillar C, Servick k. Two elite medical journals retract coronavirus papers over data integrity questions. <https://www.sciencemag.org/news/2020/06/two-elite-medical-journals-retract-coronavirus-papers-over-data-integrity-questions#> June 4, 2020
8. Lancet retraction website <https://www.thelancet.com/action/showPdf?pii=S0140-6736%2820%2931180-6>
9. NEJM Retraction: Cardiovascular Disease, Drug Therapy, and Mortality in Covid-19. N Engl J Med. DOI: 10.1056/NEJMoa2007621.
11. NIH halts clinical trial of hydroxychloroquine <https://www.nih.gov/news-events/news-releases/nih-halts-clinical-trial-hydroxychloroquine>

12. Filippo Albani F, Fusina F, Giovannini A et al. Impact of Azithromycin and/or Hydroxychloroquine on Hospital Mortality in COVID-19. *J. Clin. Med.* 2020, 9, 2800; doi:10.3390/jcm9092800
13. Schwartz RA, Suskind RH DTH-9999-e13785 Azithromycin and COVID-19 Prompt Early Use at First Signs of this Infection in Adults and Children an Approach Worthy of Consideration. *DTH-999-e13785* doi 10.1111/dth.13785
14. Meo SA, Klonoff DC, Akram J. Efficacy of chloroquine and hydroxychloroquine in the treatment of COVID-19 *European Review for Medical and Pharmacological Sciences* 2020; 24: 4539-4547
15. US 'frontline' doctors' website exposes 'criminal' campaign by tech giants, govt agencies to block COVID med  
file:///C:/Users/JGoldman/Documents/Corona%20Virus/critique%20of%20HCQ/US%20%E2%80%98frontline%E2%80%99%20doctors%E2%80%99%20website%20exposes%20%E2%80%98criminal%E2%80%99%20campaign%20by%20tech%20giants,%20govt%20agencies%20to%20block%20COVID%20med%20\_%20Blogs%20\_%20Lifesitenews.html

## RELEVANT AMA POLICY

### Patient Access to Treatments Prescribed by Their Physicians H-120.988

1. Our AMA confirms its strong support for the autonomous clinical decision-making authority of a physician and that a physician may lawfully use an FDA approved drug product or medical device for an off-label indication when such use is based upon sound scientific evidence or sound medical opinion; and affirms the position that, when the prescription of a drug or use of a device represents safe and effective therapy, third party payers, including Medicare, should consider the intervention as clinically appropriate medical care, irrespective of labeling, should fulfill their obligation to their beneficiaries by covering such therapy, and be required to cover appropriate 'off-label' uses of drugs on their formulary.
  2. Our AMA strongly supports the important need for physicians to have access to accurate and unbiased information about off-label uses of drugs and devices, while ensuring that manufacturer-sponsored promotions remain under FDA regulation.
  3. Our AMA supports the dissemination of generally available information about off-label uses by manufacturers to physicians. Such information should be independently derived, peer reviewed, scientifically sound, and truthful and not misleading. The information should be provided in its entirety, not be edited or altered by the manufacturer, and be clearly distinguished and not appended to manufacturer-sponsored materials. Such information may comprise journal articles, books, book chapters, or clinical practice guidelines. Books or book chapters should not focus on any particular drug. Dissemination of information by manufacturers to physicians about off-label uses should be accompanied by the approved product labeling and disclosures regarding the lack of FDA approval for such uses, and disclosure of the source of any financial support or author financial conflicts.
  4. Physicians have the responsibility to interpret and put into context information received from any source, including pharmaceutical manufacturers, before making clinical decisions (e.g., prescribing a drug for an off-label use).
  5. Our AMA strongly supports the addition to FDA-approved labeling those uses of drugs for which safety and efficacy have been demonstrated.
  6. Our AMA supports the continued authorization, implementation, and coordination of the Best Pharmaceuticals for Children Act and the Pediatric Research Equity Act.
- Citation: (Res. 30, A-88; Reaffirmed: BOT Rep. 53, A-94; Reaffirmed and Modified by CSA Rep. 3, A-97; Reaffirmed and Modified by Res. 528, A-99; Reaffirmed: CMS Rep. 8, A-02; Reaffirmed: CMS Rep. 6, A-03; Modified: Res. 517, A-04; Reaffirmation I-07; Reaffirmed: Res. 819, I-07; Reaffirmation A-09; Reaffirmation I-10; Modified: BOT Rep. 5, I-14; Reaffirmed: Res. 505, A-15)

### Long-Term Care Prescribing of Atypical Antipsychotic Medications H-25.989

Our AMA: (1) will collaborate with appropriate national medical specialty societies to create educational tools and programs to promote the broad and appropriate implementation of non-pharmacological techniques to manage behavioral and psychological symptoms of dementia in nursing home residents and the cautious use of medications; (2) supports efforts to provide additional research on other medications and non-drug alternatives to address behavioral problems and other issues with patients with dementia; and (3) opposes the proposed requirement that physicians who prescribe medications with "black box warnings on an off-label basis certify in writing that the drug meets the minimum criteria for coverage and reimbursement by virtue of being listed in at least one of the authorized drug compendia used by Medicare."

Citation: (Res. 819, I-11)

**Food and Drug Administration H-100.980**

(1) AMA policy states that a strong and adequately funded FDA is essential to ensuring that safe and effective medical products are made available to the American public as efficiently as possible. (2) Our AMA: (a) continue to monitor and respond appropriately to legislation that affects the FDA and to regulations proposed by the FDA; (b) continue to work with the FDA on controversial issues concerning food, drugs, biologics, radioactive tracers and pharmaceuticals, and devices to try to resolve concerns of physicians and to support FDA initiatives of potential benefit to patients and physicians; and (c) continue to affirm its support of an adequate budget for the FDA so as to favor the agency's ability to function efficiently and effectively. (3) Our AMA will continue to monitor and evaluate proposed changes in the FDA and will respond as appropriate.

Citation: Sub. Res. 548, A-92; BOT Rep. 32, A-95; BOT Rep. 18, A-96; Reaffirmed: BOT Rep. 7, I-01; Reaffirmation I-07; Reaffirmed: Sub. Res. 504, A-10; Reaffirmation A-15; Reaffirmed: CMS Rep. 06, I-16; Reaffirmed: CMS Rep. 07, A-18;

**FDA H-100.992**

1. Our AMA reaffirms its support for the principles that: (a) an FDA decision to approve a new drug, to withdraw a drug's approval, or to change the indications for use of a drug must be based on sound scientific and medical evidence derived from controlled trials, real-world data (RWD) fit for regulatory purpose, and/or postmarket incident reports as provided by statute; (b) this evidence should be evaluated by the FDA, in consultation with its Advisory Committees and expert extramural advisory bodies; and (c) any risk/benefit analysis or relative safety or efficacy judgments should not be grounds for limiting access to or indications for use of a drug unless the weight of the evidence from clinical trials, RWD fit for regulatory purpose, and postmarket reports shows that the drug is unsafe and/or ineffective for its labeled indications.

2. The AMA believes that social and economic concerns and disputes per se should not be permitted to play a significant part in the FDA's decision-making process in the course of FDA devising either general or product specific drug regulation.

3. It is the position of our AMA that the Food and Drug Administration should not permit political considerations or conflicts of interest to overrule scientific evidence in making policy decisions; and our AMA urges the current administration and all future administrations to consider our best and brightest scientists for positions on advisory committees and councils regardless of their political affiliation and voting history.

Citation: Res. 119, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmation A-06; Appended: Sub. Res. 509, A-06; Reaffirmation I-07; Reaffirmation I-09; Reaffirmation I-10; Modified: CSAPH Rep. 02, I-18; Modified: CSAPH Rep. 02, I-19;

**FDA Intrusion into the Practice of Medicine H-270.977**

The AMA strongly opposes the FDA's intrusion into the practice of medicine by making decisions for individual care and mandated informed consent documents written without the input of specialists in the related field of medicine.

Citation: (Res. 544, A-92; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: CMS Rep. 4, A-13)

**Code of Medical Ethics 7.3.10 Expanded Access to Investigational Therapies**

Physicians who care for patients with serious, life-threatening illness for whom standard therapies have failed, are unlikely to be effective, or do not exist should determine whether questions about access to investigational therapy through the U.S. Food and Drug Administrations expanded access program are likely to arise in their clinical practice. If so, physicians should familiarize themselves with the program to be better able to engage in shared decision making with patients.

When a patient requests expanded access to an investigational therapy, physicians should:

(a) Assess the patients individual clinical situation to determine whether an investigational therapy would be appropriate, including:

(i) whether there is a satisfactory alternative therapy available to diagnose, monitor, or treat the patients disease or condition;

(ii) the nature of potential risks of the investigational therapy and whether those risks are not unreasonable in the context of the patients disease or condition;

(iii) whether the potential benefit to the patient justifies the risks of the investigational therapy;  
(iv) whether the patient meets inclusion criteria for an existing clinical trial of the investigational therapy.

(b) As part of the informed consent process, advise the patient (or parent/guardian if the patient is a minor) that the investigational therapy has not yet been demonstrated to be effective in treating the patient's condition and may pose as yet unknown risks. Physicians should explain the importance of clinical trials, encourage patients who meet inclusion criteria to participate in an existing trial rather than seek access to investigational therapy through the FDA expanded access program, and direct patients who wish to participate in research to appropriate resources.

(c) Decline to support an application for expanded access to an investigational therapy when:

(i) the physician judges the treatment with the investigational therapy not to be in the patient's best interest, and explain why; or

(ii) the physician does not have appropriate resources and ability to safely supervise the patient's care under expanded access.

In such cases, physicians should refer the patient to another physician with whom to discuss possible application for expanded access.

(d) Discuss the implications of expanded access for the patient and family and help them form realistic expectations about what it will mean to be treated with the investigational therapy outside a clinical trial. Physicians should alert patients:

(i) to the possibility of financial or other responsibilities associated with receiving an investigational therapy through expanded access;

(ii) to the lack of infrastructure to systematically monitor and evaluate the effects of the investigational therapy outside a clinical trial;

(iii) that they need information about how to contact the manufacturer for guidance if they seek emergency care from a health care professional who is not affiliated with a clinical trial of the investigational therapy;

(iv) that the physician has a responsibility to collect and share clinical information about the patient's course of treatment with the investigational therapy, as well as to report any adverse events that may occur over the course of treatment;

(v) to the conditions under which the physician would recommend stopping treatment with the investigational therapy.

[AMA Principles of Medical Ethics: V,VI](#)

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 510  
(November 2020)

Introduced by: Michigan

Subject: Access to Opioid Agonist Treatment for Incarcerated Persons

Referred to: Reference Committee E

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- 1 Whereas, An estimated 65 percent of the United States prison population has an active  
2 substance use disorder (SUD), and between 24 to 36 percent of persons with opioid use  
3 disorder (OUD) pass through U.S. prisons and jails each year; however, only five percent of  
4 people with OUD in jail and prison settings receive appropriate medication treatment; and  
5
- 6 Whereas, The Centers for Disease Control and Prevention and World Health Organization  
7 guidelines recommend any opioid agonist treatment (OAT) during incarceration and upon  
8 release from prison; however, only approximately half of all U.S. prisons/jails provide treatment  
9 options to incarcerated individuals; and  
10
- 11 Whereas, Most correctional institutions mandate withdrawal of any OAT upon entry into the  
12 criminal justice system, often preventing individuals from engaging in OAT outside of prison in  
13 fear of the abrupt cessation of their treatments; and  
14
- 15 Whereas, Within one year of leaving prison, up to 10 percent of those who were formerly  
16 incarcerated die, and 15 percent of deaths of former inmates are due to opioid-related  
17 overdoses; and  
18
- 19 Whereas, A 2013 study in Washington State determined that overdose was the leading cause of  
20 death of persons who were formerly incarcerated; and  
21
- 22 Whereas, OAT, which includes the full agonist methadone and the partial agonist  
23 buprenorphine, is an evidence-based, effective treatment for OUD that lessens the harmful  
24 health and societal effects of such substance use disorders; and  
25
- 26 Whereas, OAT has been studied within correctional facilities in numerous settings in the U.S.  
27 and worldwide and has been shown to decrease re-incarceration rates by 20 percent and  
28 reduce the hazard of death by 75 percent following release; and  
29
- 30 Whereas, One study found that those in a prison who started OAT were less likely to report  
31 using heroin and sharing syringes during their incarceration than those on the waiting list for  
32 OAT; and  
33
- 34 Whereas, Those who start OAT during incarceration have higher rates of successful re-entry  
35 into the community, reduced heroin use, and declining recidivism compared to those who do  
36 not; and

1 Whereas, The American Psychiatric Association (APA) policy states that “Jails and prisons  
2 should make available quality treatment for substance use disorders to all inmates who qualify  
3 for such treatment” and that whenever possible patients who are treated with medication  
4 (buprenorphine or methadone) for their OUD should be continued; and  
5

6 Whereas, The 2017 Presidential Commission on “Combating Drug Addiction and the Opioid  
7 Crisis” recommended increased usage of OAT in corrections settings due to preliminary data  
8 suggesting OAT treatment reduces risk of overdose and improves outcomes for those with  
9 OUD; and  
10

11 Whereas, The American Society of Addiction Medicine recommends pharmacotherapy (either  
12 methadone or buprenorphine) and psychosocial treatment for those with OUD in the criminal  
13 justice system and the initiation of pharmacotherapy a minimum of 30 days before release from  
14 prison; and  
15

16 Whereas, Our AMA has endorsed the use of medication for OUD in prisons, encouraged public  
17 funding for such programs, and supported the establishment of post-incarceration programs to  
18 continue OUD; therefore be it  
19

20 RESOLVED, That our American Medical Association amend policy H-430.987, “Opiate  
21 Replacement Therapy Programs in Correctional Facilities,” by addition to read as follows:  
22

23 H-430.987 Opiate Replacement Therapy Programs in Correctional Facilities

- 24 1. Our AMA endorses: (a) the medical treatment model of employing opiate replacement  
25 therapy (ORT) as an effective therapy in treating opiate-addicted persons who are  
26 incarcerated; and (b) ORT for opiate-addicted persons who are incarcerated, in  
27 collaboration with the National Commission on Correctional Health Care and the American  
28 Society of Addiction Medicine.
- 29 2. Our AMA advocates for legislation, standards, policies and funding that encourage  
30 correctional facilities to increase access to evidence-based treatment of opioid use disorder,  
31 including initiation and continuation of opioid replacement therapy in conjunction with  
32 counseling, in correctional facilities within the United States and that this apply to all  
33 incarcerated individuals including pregnant women.
- 34 3. Our AMA supports legislation, standards, policies, and funding that encourage correctional  
35 facilities within the United States to work in ongoing collaboration with addiction treatment  
36 physician-led teams, case managers, social workers, and pharmacies in the communities  
37 where patients, including pregnant women, are released to offer post-incarceration  
38 treatment plans for opioid use disorder, including education, medication for addiction  
39 treatment and counseling, and medication for preventing overdose deaths and help ensure  
40 post-incarceration medical coverage and accessibility to medication assisted therapy.
- 41 4. Our AMA encourages all correctional facilities to use a validated screening tool to identify  
42 withdrawal and determine potential need for treatment for opioid use disorder for all  
43 incarcerated persons upon entry. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than \$1,000

Received: 10/27/20

**Sources:**

1. National Institute on Drug Abuse (NIDA), "DrugFacts: Criminal Justice," 2019. [Online]. Available: <https://www.drugabuse.gov/publications/drugfacts/criminal-justice>. [Accessed: 05-Jan-2020].
2. M. S. Gordon, T. W. Kinlock, R. P. Schwartz, and K. E. O'Grady, "A randomized clinical trial of methadone maintenance for prisoners: Findings at 6 months post-release," *Addiction*, vol. 103, no. 8, pp. 1333-1342, Aug. 2008, doi: 10.1111/j.1360-0443.2008.002238.x.
3. L. Brinkley-Rubinstein et al., "Criminal justice continuum for opioid users at risk of overdose," 2018, doi: 10.1016/j.addbeh.2018.02.024.
4. National Academy of Sciences, Engineering, "Medications for Opioid Use Disorder Save Lives," 2019. [Online]. Available: <http://www.nationalacademies.org/hmd/Reports/2019/medications-for-opioid-use-disorder-save-lives.aspx>. [Accessed: 05-Jan-2020].
5. Nunn, N. Zaller, S. Dickman, C. Trimbur, A. Nijhawan, and J. D. Rich, "Methadone and buprenorphine prescribing and referral practices in US prison systems: Results from a Nationwide Survey," *Drug Alcohol Depend.*, vol. 105, no. 1-2, pp. 83-88, Nov. 2009, doi: 10.1016/j.drugalcdep.2009.06.015.
6. J. D. Rich et al., "Methadone continuation versus forced withdrawal on incarceration in a combined US prison and jail: A randomised, open-label trial," *Lancet*, vol. 386, no. 9991, pp. 350-359, Jul. 2015, doi: 10.1016/S0140-6736(14)62338-2.
7. J. Hagan and H. Foster, "Imprisonment, opioids and health care reform: The failure to reach a high-risk population," *Prev. Med. (Baltim.)*, p. 105897, 2019, doi: 10.1016/j.ypmed.2019.105897.
8. D. Fox, J. Maradiaga, L. Weiss, J. Sanchez, J. L. Starrels, and C. O. Cunningham, "Release from incarceration, relapse to opioid use and the potential for buprenorphine maintenance treatment: a qualitative study of the perceptions of former inmates with opioid use disorder," 2012, doi: 10.1186/s13722-014-0023-0.
9. W. Dick et al., "Growth In Buprenorphine Waivers For Physicians Increased Potential Access To Opioid Agonist Treatment, 2002-11," *Health Aff.*, vol. 34, no. 6, pp. 1028-1034, Jun. 2015, doi: 10.1377/hlthaff.2014.1205.
10. L. Stotts, C. L. Dodrill, and T. R. Kosten, "Opioid dependence treatment: Options in pharmacotherapy," *Expert Opinion on Pharmacotherapy*, vol. 10, no. 11, pp. 1727-1740, Aug-2009, doi: 10.1517/14656560903037168.
11. S. Larney, B. Toson, L. Burns, and K. Dolan, "Effect of prison-based opioid substitution treatment and post-release retention in treatment on risk of re-incarceration," *Addiction*, vol. 107, no. 2, pp. 372-380, Feb. 2012, doi: 10.1111/j.1360-0443.2011.03618.x.
12. L. Degenhardt et al., "The impact of opioid substitution therapy on mortality post-release from prison: Retrospective data linkage study," *Addiction*, vol. 109, no. 8, pp. 1306-1317, 2014, doi: 10.1111/add.12536.
13. S. E. Wakeman and J. D. Rich, "Addiction Treatment Within U.S. Correctional Facilities: Bridging the Gap between Current Practice and Evidence-Based Care," *J. Addict. Dis.*, vol. 34, no. 2-3, pp. 220-225, Jul. 2015, doi: 10.1080/10550887.2015.1059217.
14. K. A. Dolan, J. Shearer, M. MacDonald, R. P. Mattick, W. Hall, and A. D. Wodak, "A randomised controlled trial of methadone maintenance treatment versus wait list control in an Australian prison system.," *Drug Alcohol Depend.*, vol. 72, no. 1, pp. 59-65, Oct. 2003, doi: 10.1016/s0376-8716(03)00187-x.
15. Sharma, K. E. O'Grady, S. M. Kelly, J. Gryczynski, S. G. Mitchell, and R. P. Schwartz, "Pharmacotherapy for opioid dependence in jails and prisons: research review update and future directions.," *Subst. Abuse Rehabil.*, vol. 7, pp. 27-40, 2016, doi: 10.2147/SAR.S81602.
16. M. and K. D. on behalf of the A. C. on A. P. Elie Aoun, MD; John Renner, "Position Statement on Treatment of Substance Use Disorders in the Criminal Justice System," 2016.
17. American Correctional Association, "Joint Public Correctional Policy On The Treatment Of Opioid Use Disorders For Justice Involved Individuals 2018-2," 2018.
18. S. Comer et al., "The ASAM National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use ASAM National Practice Guideline for the Use of Medi-cations in the Treatment of Addiction Involving Opioid Use Guideline," 2015.

**RELEVANT AMA POLICY**

**Opiate Replacement Therapy Programs in Correctional Facilities H-430.987**

1. Our AMA endorses: (a) the medical treatment model of employing opiate replacement therapy (ORT) as an effective therapy in treating opiate-addicted persons who are incarcerated; and (b) ORT for opiate-addicted persons who are incarcerated, in collaboration with the National Commission on Correctional Health Care and the American Society of Addiction Medicine.
2. Our AMA advocates for legislation, standards, policies and funding that encourage correctional facilities to increase access to evidence-based treatment of opioid use disorder, including initiation and continuation of opioid replacement therapy in conjunction with counseling, in correctional facilities within the United States and that this apply to all incarcerated individuals including pregnant women.
3. Our AMA supports legislation, standards, policies, and funding that encourage correctional facilities within the United States to work in ongoing collaboration with addiction treatment physician-led teams, case managers, social workers, and pharmacies in the communities where patients, including pregnant women, are released to offer post-incarceration treatment plans for opioid use disorder, including education, medication for addiction treatment and counseling, and medication for preventing overdose deaths and help ensure post-incarceration medical coverage and accessibility to medication assisted therapy.

Citation: Res. 443, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Appended: Res. 223, I-17