2024-1

RESOLUTION

Subject: Physician Workforce Shortage

Submitted by: KMA Board of Trustees

Referred to: Reference Committee

WHEREAS, physician shortages persist across the country; and

WHEREAS, state-based data shows that Kentucky is not immune from physician shortages as a recent report by the Kentucky Office of Rural Health finds that the number of physicians in Kentucky decreased by 590 between 2019 and 2022; and

WHEREAS, the shortage of physicians creates patient access issues for Kentucky citizens, especially for populations in historically underserved areas; and

WHEREAS, the physician shortage also impacts the economies of local communities and the state as a whole; and

WHEREAS, state policymakers increasingly aim to enhance patient access and alleviate workforce shortages by revising licensure requirements for physicians with international training or practice experience; and

WHEREAS, certain state-based proposals seek to circumvent specific requirements, such as U.S. or Canadian-based postgraduate training, which are intended to guarantee physicians possess the essential knowledge, skills, abilities, and attitudes essential for safe and competent patient care; and

WHEREAS, while some state-based proposals share similarities, distinctions exist that could result in different outcomes among states, potentially causing confusion among physicians, regulators, and patients; and

WHEREAS, medical boards and regulators' operationalization of proposed licensure requirement changes remain uncertain as best-practices for implementation and enforcement of such changes are unclear; now, therefore, be it

RESOLVED, the Kentucky Medical Association request the Kentucky Board of Medical Licensure to study whether allowing physicians who have completed training and/or practiced outside of the United States to forego completing a U.S. or Canadian-based accredited residency training program can help alleviate the state’s physician workforce shortages without compromising patient safety and physician readiness for practice in the American health care system.

RESOLUTION

Subject: Draft Resolutions

Submitted by: Michael Kuduk, MD (KMA President)

Referred to: Reference Committee

WHEREAS, the current system of reviewing draft resolutions, including commission review, Board review and reference committee review, results in a thorough and efficient assessment of resolution content by all interested parties in the Association; and

WHEREAS, the final authority on establishing official Kentucky Medical Association policy is the House of Delegates; and

WHEREAS, prior to House of Delegates approval, draft resolutions do not represent official Association policy; and

WHEREAS, both draft resolutions and official policy are publicly available on the Kentucky Medical association website; and

WHEREAS, members of the media have previously misrepresented draft resolutions which were not approved by the House of Delegates as official Association policy; now, therefore, be it

RESOLVED, that KMA restrict access to draft resolutions to delegates, staff, and members of the Association; and be it further

RESOLVED, that KMA continue to make policies approved by the House of Delegates publicly available.

RESOLUTION

Subject: Proposal for the Kentucky Medical Association to Cover Medical Students' Membership Fees and Medical Student AMA Membership

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, the University of Louisville (UofL) has a class size of 160 students, the University of Kentucky (UK) has 205 across all of its campuses and the Kentucky College of Osteopathic Medicine (KYCOM) has 145 students for a total of 510 students; and

WHEREAS, the cost of a four-year membership into the AMA is a one-time payment of $68; and

WHEREAS, the cost for 510 students will initially cost $34,680 annually; and

WHEREAS, the local AMA chapters propose returning the 35% AMA kickback to the KMA while keeping $1,000 for each chapter for a total of returning $9,138 back to the KMA; and

WHEREAS, the total annual cost to the KMA will be $24,542 to fund this engagement experiment; and

WHEREAS, the KMA invests in developing the next generation of leaders who will shape the landscape of medicine in our state by engaging students early in their careers; and

WHEREAS, by increasing students' benefits and ties to the Kentucky medical community, more Kentucky-trained doctors will be retained in Kentucky to directly address Kentucky's shortage of doctors ; and

WHEREAS, the KMA ensures that all medical students have equal access to the professional development and networking benefits, regardless of their financial circumstances ; and

WHEREAS, the KMA advocates for policies that promote the interests of healthcare professionals and patients and strengthens its advocacy efforts with the inclusion of medical students; and

WHEREAS, the 2023-2024 KMA Policy Manual states:

> "MEDICAL STUDENTS 1) Engagement in Organized Medicine: KMA works with the University of Louisville Medical School, the University of Kentucky College of Medicine, and the University of Pikeville Kentucky College of Osteopathic Medicine to develop more on-campus KMA Medical Student Section (MSS) activities, including regularly scheduled organizational meetings, and the mentoring of medical students by KMA members of the Commission on Young Physicians and Physicians in Training and the

> Resident & Fellow Section. KMA provides funding for one medical student from each of the University of Louisville Medical School, the University of Kentucky College of Medicine, and the College of Osteopathic Medicine in Pikeville to attend the Annual and Interim meetings of the AMA Medical School Section, if said funding is matched one-to-one by the Medical Schools. (Res 2014-07, 2014 HOD, p 330)"; and

WHEREAS, 9 ULSOM students expressed interest in attending the 2024 AMA Medical Advocacy Conference, but 5 students could not attend due to the cost of travel and lodging; and

WHEREAS, participation in the University of Louisville AMA/KMA chapter has increased since the pandemic, where 15 students attended 2024 KMA Physician's Day at the Capitol compared to 7 students the previous year; 4 students attended 2024 AMA Medical Advocacy Conference compared to 2 students the previous year; and 3 students attended the 2023 AMA MSS Annual meeting compared to 1 student the previous year; and

WHEREAS, this effort would potentially increase the involvement of the campuses in the KMA House of Delegates and policy writing; and

WHEREAS, this effort would potentially increase the involvement of the campuses in local, state, and national healthcare policies; and

WHEREAS, this effort would definitely provide medical students with access to an included Journal of the American Medical Association (JAMA) to be more educated about the latest news and breakthroughs in medicine; and

WHEREAS, this would elevate Kentucky's medical student involvement on the national stage through AMA conferences and Region 5 Medical Student Section (MSS) engagement; and

WHEREAS, the KMA emphasizes early engagement of medical students in organized medicine in order to develop the next generation of physician leaders; now, therefore, be it

RESOLVED, that the KMA bylaws be amended as follows: "Chapter 1, Section 2(f): "Student Members. Any medical student in an accredited allopathic or osteopathic medical school in Kentucky shall be eligible for a subsidized four-year membership through the Kentucky Medical Association."; and be it further

RESOLVED, that KMA will fund Kentucky medical students' memberships for four years, beginning with the most recent incoming M1 medical student class and will annually evaluate the impact of this initiative on medical students' engagement and professional development. Feedback will be solicited from participating local AMA Chapters and Executive Boards to identify areas for improvement and ensure that the program continues to boost medical student engagement and development effectively. This proposal will be reviewed and reassessed after four years to determine whether to continue sponsoring the local AMA chapters' members.

2024-4

RESOLUTION

Subject: Medicare Physician Payment Reform

Submitted by: Lexington Medical Society

Referred to: Reference Committee

WHEREAS, Medicare physician payment has declined 29% from 2001 to 2024 when adjusted for inflation; and

WHEREAS, physicians are one of the few Medicare providers without payment adjusted for inflation rates; and

WHEREAS, declining reimbursements and rising practice and staff costs are crippling the sustainability of physician practices, thereby threatening patient access to high quality of medical care and negatively impacting current and future physician shortage; and

WHEREAS, the performance and reporting programs in Medicare's Merit-Based Incentive Payment System (MIPS) are built on outdated legacy systems, and their four components operate largely independently and lack cohesion; and

WHEREAS, Medicare physician pay cuts threaten health care access for seniors as well as patients in rural and underserved areas; and

WHEREAS, Congress is considering comprehensive, long-term solutions to the systematic problems with the current Medicare physician payment system; now, therefore, be it

RESOLVED, that KMA support Medicare physician payment system reform by advocating for federal legislation that ties annual Medicare physician payment updates to the Medicare Economic Index of practice cost inflation, revises budget neutrality policies to lessen inappropriate payment schedule conversion factor cuts and minimize revenue instability, and develops ways to reduce the administrative and financial burden of Merit-Based Incentive Payment System (MIPS) participation; and be it further

RESOLVED, that KMA encourages its members to join efforts aimed at raising awareness among fellow physicians, the public, and Kentucky's Congressional Delegation about the necessity of Medicare physician payment reform.

RESOLUTION

Subject: Investing in Primary Care

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, Dr. Barbara Starfield's published research has long held that the areas with higher ratios of primary care physicians to population have lower total healthcare costs, due in part to better preventive care and lower hospitalization rates (Starfield, 2005)[1]; and

WHEREAS, primary care provided by non-physician providers has shown to increase healthcare costs rather than reducing it (MSMA Journal)[2]; and

WHEREAS, 109 of Kentucky's 120 counties have a primary care shortage (RHI Hub)[3]; and

WHEREAS, 1 in 3 Kentuckians are enrolled in Medicaid (DMS, 2024)[4]; and

WHEREAS, the Kaiser Family Foundation found that for all Medicaid services, Kentucky pays 76% of the Medicare rate, and specifically for primary care services, Kentucky pays 65% of the Medicare rate (KFF)5; and

WHEREAS, in cross comparing the 2024 fee schedule with the 2013 fee schedule, looking specifically at some of the more highly utilized primary care codes (99213 & 99214) there hasn't been a rate change for these codes for at least the last 11 years; now, therefore, be it

RESOLVED, that KMA advocate to the General Assembly for an increase in the reimbursement rates for the most frequently utilized primary care codes on the Medicaid Physician Fee Schedule.

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RESOLUTION

Subject: mRNA Vaccines

Submitted by: Michael Kuduk (KMA President) and Parisa Shamaei Zadeh (Medical Student Section)

Referred to: Reference Committee

WHEREAS, messenger RNA (mRNA) vaccines represent a new and potent means of preventing or treating a wide variety of illnesses, including certain types of cancer; and

WHEREAS, the short-term safety and efficacy of the COVID-19 vaccines in preventing serious complications of COVID-19 is well-established; and

WHEREAS, due to their short production times, mRNA vaccines offer the best hope of containing future pandemics; and

WHEREAS, due to their flexibility, mRNA vaccines may play a role in the treatment and/or prevention of many different diseases, including autoimmune diseases and cancers; and

WHEREAS, mRNA vaccines are quickly degraded in the human body by the RNAse enzyme and do not at any point enter the cell's nucleus or DNA; now, therefore, be it

RESOLVED, that KMA oppose any efforts which prohibit development, distribution, and/or administration of evidence-based, scientifically proven to be efficacious, mRNA vaccines; and be it further

RESOLVED, that KMA educate providers and the public regarding the safety and efficacy of mRNA vaccine technology.

RESOLUTION

Subject: Inclusion of HPV Vaccine on the State Mandated Immunization Schedule

Submitted by: Resident Fellows Section

Referred to: Reference Committee

WHEREAS, Human Papillomavirus (HPV) is a large group of viruses responsible for nearly all cervical cancers, anal cancers, and most oropharyngeal, penile, vaginal, and vulvar cancers[1]; and

WHEREAS, the current 9-valent HPV vaccine protects against 9 different HPV strains, including type 16 and 18 which cause most HPV-related cancers[2,3]; and

WHEREAS, the current 9-valent vaccine and prior HPV vaccines have been shown to be extremely safe with minimal side effects[4,5]; and

WHEREAS, the CDC currently recommends routine HPV vaccination at 11-12 years, however it can be given earlier or later[2]; and

WHEREAS, the vaccines have the potential to prevent more than 90% of HPV-related cancers and there has already been a significant drop in HPV infections, genital warts, and precancerous cervical lesions in young women[2]; and

WHEREAS, Kentucky trails the national average in HPV vaccinations by 10%, has a higher incidence of HPV cancers, and is in the top 3 states nationally for cervical cancer incidence[6], and

WHEREAS, in Kentucky there are 7 vaccinations (DTaP, polio, HepA, HepB, MMR, Varicella, Meningococcal) on the mandated immunization schedule required for attending schools, however HPV is not among them[7]; and

WHEREAS, school-required HPV vaccination has been shown to increase rates of vaccination in other states that have mandated it[8,9]; now, therefore, be it

RESOLVED, that KMA support inclusion of the HPV vaccine on the state mandated immunization schedule.

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RESOLUTION

Subject: Proposal for the Kentucky Medical Association to Reaffirm Support for the HPV Vaccination

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, the KMA has supported the Human Papillomavirus (HPV) vaccine coverage as a standard policy benefit in 2006; and

WHEREAS, the KMA has supported adding the HPV vaccine to the current list of school-based required vaccinations for the recommended age groups in 2012; and

WHEREAS, HPV is the most common viral sexually transmitted infection in the United States[1]; and

WHEREAS, the HPV vaccine is safe, effective, and recommended for ages 9 to 45 years old by leading health organizations including the Centers for Disease Control and Prevention (CDC), the American Cancer Society (ACS), and the American Academy of Pediatrics (AAP)[2]; and

WHEREAS, HPV is the cause of 91% of cervical cancers as well as other types of cancers such as vaginal (75%), oropharyngeal (70%), penile cancers (60%)[3]; and

WHEREAS, these cancers are preventable with HPV vaccination, so increasing HPV vaccination rates can significantly reduce the burden of HPV-related diseases and cancers, thereby saving lives and reducing long-term healthcare costs; and

WHEREAS, in Kentucky, only 57% of adolescents between the ages of 13 and 17 have received the HPV vaccine, reflecting one of the lowest vaccination rates in the country[3]; and

WHEREAS, Kentucky has one of the highest rates of new cases of cervical cancer at 9.6 cases per 100,000 women annually[3]; and

WHEREAS, Kentucky had the highest incidence of cervical cancer of all U.S. states from 2015 to 2019[4]; and

WHEREAS, the death rate from cervical cancer in Appalachian Kentucky is twice that of the national rate in 2023[4]; and

WHEREAS, the HPV vaccine is 97% effective in preventing cervical cancer and almost 100% effective in preventing external genital warts[2]; and

WHEREAS, in 2024, the National Cancer Institute published findings from a Scottish study showing no cases of invasive cervical cancer recorded in women immunized in 2008 at 12 or 13 years of age irrespective of the number of HPV vaccine doses given[5]; and

WHEREAS, in a recent Lancet study, Australia is set to be the first country to eliminate cervical

cancer as a public health problem, as early as 2028[6]; and

WHEREAS, the KMA is committed to promoting public health initiatives that prevent disease and protect the well-being of the citizens of Kentucky; now, therefore, be it

RESOLVED, that the KMA fully endorses and supports the promotion of HPV vaccination as a critical public health measure; and be it further

RESOLVED, that KMA encourages healthcare providers across Kentucky to strongly recommend and offer the HPV vaccine to all eligible patients, including adolescents and young adults; and be it further

RESOLVED, that KMA will actively collaborate with public health agencies, educational institutions, community organizations, and other stakeholders to implement strategies aimed at increasing HPV vaccination rates, such as education campaigns, provider training, and access to vaccination services; and be it further

RESOLVED, that KMA will continue to monitor HPV vaccination rates and outcomes in Kentucky and take further action as needed to ensure that all individuals have access to this life-saving vaccine; and be it further

RESOLVED, that KMA will continue to encourage state lawmakers to change the HPV vaccine status from recommended to required on the current school-based list of vaccinations.

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2024-9

RESOLUTION

Subject: Expanding Insurance Coverage for Cranial Prosthesis in Patients with Alopecia Areata

Submitted by: Gabriella Beharry (Medical Student Section)

Referred to: Reference Committee

WHEREAS, alopecia areata is an autoimmune disorder in which the body attacks its hair follicles, has no cure, and more than 6.8 million people in the United States[1]; and

WHEREAS, alopecia areata creates a significant psychological impact on individuals, negatively influencing one's self-image while also causing financial distress for those diagnosed with this condition[1,2]; and

WHEREAS, on September 30, 2021, Representative James McGovern of the Commonwealth of Massachusetts proposed an amendment to title XVIII of the Social Security Act to provide coverage for cranial prosthesis as durable medical equipment under the Medicare program[4]; and

WHEREAS, cranial prosthesis, such as wigs, were shown to improve the self-esteem and quality of life for individuals, but the total cost was limited with 23% of individuals receiving insurance coverage $645,597[2]; and

WHEREAS, in the state of Massachusetts, cranial prosthesis is covered at a $350 annual maximum for cancer patients having undergone chemotherapy, but hair loss due to alopecia areata is covered only on a case-by-case basis[3,4]; and

WHEREAS, all insurance companies in the state of Minnesota are required to provide coverage for cranial prosthesis at a $350 annual maximum for hair loss specifically due to alopecia areata; and

WHEREAS, Kentucky Medicaid does not provide coverage for wigs, including those used for cranial prosthesis, because they are considered a cosmetic service and not medically necessary[4,5]; and

WHEREAS, most private insurance companies do not pay for cranial prosthetics for alopecia areata patients but will reimburse for cranial prosthetics for other disease-related hair loss, such as those caused by chemotherapy[1]; now, therefore, be it

RESOLVED, that KMA support the Commonwealth of Kentucky to provide coverage for cranial prosthesis as durable medical equipment under the Medicare program; and be it further

RESOLVED, that Medicare and private insurance companies expand coverage for cranial prosthesis at a $350 annual maximum for hair loss due to alopecia areata.

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2024-10

RESOLUTION

Subject: Coronary Calcium Scoring Coverage by Insurance Companies

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, coronary artery disease is the number one cause of death in the Commonwealth of Kentucky; and

WHEREAS, Kentucky is the 6th highest state with atheromatous heart disease in the nation; and

WHEREAS, compared to the national average of 9.1%, 12.4% of adults in the Commonwealth have a diagnosis of coronary heart disease, myocardial infarction (heart attack), or stroke; and

WHEREAS, Kentucky has some of the highest risk factors that lead to heart disease in the country – 24.6% are smokers, 37% are obese; and

WHEREAS, heart disease mortality in the Appalachian region was 45% higher than the national rate and 32% more than non-Appalachians; and

WHEREAS, screening for prevention of disease is a public health measure. Coronary Calcium Scoring (CACS) has the potential to identify individuals at higher risk of coronary artery disease; and

WHEREAS, the American College of Cardiology/American Heart Association (AHA) guidelines on prevention recommend the use of CACS to better understand the risk of future cardiovascular events; and

WHEREAS, the Heart Disease & Stroke Prevention Task Force of Kentucky, in partnership with the Kentucky Department of Public Health's Heart Disease and Stroke Prevention program, recommends preventive screening of lipids (cholesterol) and CACS for earlier identification of at-risk individuals; and

WHEREAS, the AHA forecasts annual health care costs for cardiovascular disease to quadruple, from $393 billion to $1490 billion, and productivity losses to increase by 54%; and

WHEREAS, Coronary Calcium Scoring is not yet required to be covered by insurance companies as part of the Patient Protection and Affordable Care Act of 2010; now, therefore, be it

RESOLVED, that KMA encourages and supports legislation that requires coverage for Coronary Calcium Scoring CT testing.

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2024-11

RESOLUTION

Subject: Review of 201 KAR 9:270 (Kentucky's Buprenorphine Regulation)

Submitted by: James Patrick Murphy, MD, MMM

Referred to: Reference Committee

WHEREAS, according to the 2023 Kentucky Drug Overdose Fatality Report, 1,984 Kentuckians lost their lives last year to a drug overdose[1], which is more than a 50% increase from 2019; and

WHEREAS, recent CDC data[2] lists Kentucky as having the seventh highest overdose death rate in the country; and

WHEREAS, recent CDC data[3] indicates approximately 70% of overdose deaths are caused by opioids; and

WHEREAS, buprenorphine treatment[4] has been associated with more than a 60% reduction in the risk of opioid-involved overdose death; and

WHEREAS, new research out of Kentucky, recently published in the Journal of Addiction Medicine[5], suggests that higher doses of buprenorphine are associated with reduced opioid-involved overdose deaths and death from other causes; and

WHEREAS, 201 KAR 9:270 is a recognized barrier[6,7] to patients accessing treatment with buprenorphine; and

WHEREAS, American Society of Addiction Medicine (ASAM) policy[8] states it is vital that unnecessary and over-burdensome barriers to buprenorphine treatment be avoided so patients can have timely access to care; and

WHEREAS, ASAM policy[8] further recommends any state regulation regarding buprenorphine be evidence-based so as not to dissuade clinicians from offering buprenorphine treatment, nor create environments unattractive to patients because of unnecessary and unhelpful regulatory burdens; and

WHEREAS, 201 KAR 9:270 is seriously outdated[9,10] and long overdue for a review and update; and

WHEREAS, on or about June 4, 2024, KBML informed stakeholders[11] of an updated draft of proposed changes[12] to 201 KAR 9:270; and

WHEREAS, the Kentucky Society of Addiction Medicine and other field experts, have reviewed the KBML's proposed changes to 201 KAR 9:270 and have concluded that the proposed changes will create environments unattractive to patients because of unnecessary and unhelpful regulatory burdens and will not bring the regulation in accord with evidence-based practice[13,14,15,16,17] but will instead create

new treatment barriers and may even worsen Kentucky's overdose crisis; now, therefore, be it

RESOLVED, that KMA call upon the Kentucky Board of Medical Licensure (KBML) to stop KBML's process of finalizing proposed changes to 201 KAR 9:270 and promptly convene a diverse workgroup, comprised of experts in the field, tasked with recommending regulatory changes that will ensure competent, evidence-based, and patient-centered treatment of opioid use disorder with buprenorphine.

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8. ASAM Public Policy Statement on the Regulation of Office-Based Opioid Treatment https://www.asam.org/docs/default-source/public-policy-statements/statement-on-regulation-of-obot.pdf
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17. KYSAM website: SUPPORT OUR PETITION https://www.kysam.org

RESOLUTION

Subject: Review of 201 KAR 9:270 (Kentucky's Buprenorphine Regulation)

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, according to the 2023 Kentucky Drug Overdose Fatality Report, 1,984 Kentuckians lost their lives last year to a drug overdose[1], which is more than a 50% increase from 2019; and

WHEREAS, recent CDC data[2] lists Kentucky as having the seventh highest overdose death rate in the country; and

WHEREAS, recent CDC data[3] indicates approximately 70% of overdose deaths are caused by opioids; and

WHEREAS, buprenorphine treatment[4] has been associated with more than a 60% reduction in the risk of opioid-involved overdose death; and

WHEREAS, new research out of Kentucky, recently published in the Journal of Addiction Medicine[5], suggests that higher doses of buprenorphine are associated with reduced opioid-involved overdose deaths and death from other causes; and

WHEREAS, 201 KAR 9:270 is a recognized barrier[6,7] to patients accessing treatment with buprenorphine; and

WHEREAS, American Society of Addiction Medicine (ASAM) policy[8] states it is vital that unnecessary and over-burdensome barriers to buprenorphine treatment be avoided so patients can have timely access to care; and

WHEREAS, ASAM policy[8] further recommends any state regulation regarding buprenorphine be evidence-based so as not to dissuade clinicians from offering buprenorphine treatment, nor create environments unattractive to patients because of unnecessary and unhelpful regulatory burdens; and

WHEREAS, 201 KAR 9:270 is seriously outdated[9,10] and long overdue for a review and update; and

WHEREAS, on or about June 4, 2024, KBML informed stakeholders[11] of an updated draft of proposed changes[12] to 201 KAR 9:270; and

WHEREAS, the Kentucky Society of Addiction Medicine and other field experts, have reviewed the KBML's proposed changes to 201 KAR 9:270 and have concluded that the proposed changes will create environments unattractive to patients because of unnecessary and unhelpful regulatory burdens and will not bring the regulation in accord with evidence-based practice[13,14,15,16,17] but will instead create

new treatment barriers and may even worsen Kentucky's overdose crisis; now, therefore, be it

RESOLVED, that KMA call upon the Kentucky Board of Medical Licensure (KBML) to stop KBML's process of finalizing proposed changes to 201 KAR 9:270 and promptly convene a diverse workgroup, comprised of experts in the field, tasked with recommending regulatory changes that will ensure competent, evidence-based, and patient-centered treatment of opioid use disorder with buprenorphine.

Reference

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17. KYSAM website: SUPPORT OUR PETITION https://www.kysam.org

2024-13

RESOLUTION

Subject: KBML Autonomy

Submitted by: Michael Kuduk, MD (KMA President)

Referred to: Reference Committee

WHEREAS, the Kentucky Board of Medical Licensure is entrusted by the Commonwealth to ensure the safe practice of medicine in Kentucky; and

WHEREAS, the Kentucky Board of Medical Licensure is responsible for supervision and maintenance of the medical professional licensure process in the Commonwealth; and

WHEREAS, the Kentucky Board of Medical Licensure plays an important role in providing due process protection to physicians who are accused of violating provisions of the Medical Practice Act by conducting impartial hearings and by making decisions which both protect the public and the physician; and

WHEREAS, recently introduced legislation has restricted the Kentucky Board of Medical Licensure's ability to conduct these impartial hearings by mandating penalties and/or licensure removal for performing certain acts, without affording the accused practitioner any element of due process; and

WHEREAS, 2023 Senate Bill 150, which was passed and enacted, mandates licensure removal for violation of the accompanying statute, without mention of due process for the accused provider; now, therefore, be it

RESOLVED, that KMA supports preserving the Kentucky Board of Medical Licensure's independent decision-making authority in regulating physicians; and be it further

RESOLVED, that KMA advocate against legislation that removes or erodes the Kentucky Board of Medical Licensure's ability to independently regulate the practice of medicine through autonomous decision-making that upholds professional standards and protects patient safety.

2024-14

RESOLUTION

Subject: Formal Work Group to Study Actions by the KBML When Physicians Receive Patient Complaints, and for Analysis of Specific Higher Medical Legal Risk For Controlled Medication Prescribing

Submitted by: Northern Kentucky Medical Society

Referred to: Reference Committee

WHEREAS, the burdens associated with all aspects of medical care physicians continue to increase, but those doctors whom undergo action by the Kentucky Board of Medical Licensure (KBML) and / or Criminal Cases face tremendous stigma, increased requirements, and risk; and

WHEREAS, when a well-intentioned functional physician gives up their practice, their stable patients can experience disruptions in care and even destabilization; and

WHEREAS, only physicians and other prescribers with an active DEA license can prescribe controlled medications; and

WHEREAS, a large percentage of patients are currently stable and may benefit from these medications; and

WHEREAS, a greater percentage of prescribing physicians feel these medicines should be used sparingly if at all; and

WHEREAS, many physicians feel the benefit outweighs the risk if patients understand the risk, but fear punishment and therefore do not prescribe these medications; and

WHEREAS, a small and smaller group of doctors shoulder this burden out of devotion to the population they serve; now, therefore, be it

RESOLVED, the Northern Kentucky Medical Society recommends that each medical society forms a work group and coordinate efforts with each other and the state Kentucky Medical society to study actions by the KBML and situations where doctors are placed at higher medical legal risk secondary to prescribing controlled medications, with focus on both the physicians and patients.

RESOLUTION

Subject: Protecting Access to IVF Treatment

Submitted by: Albert L. Hsu, MD

Referred to: Reference Committee

WHEREAS, on Fri 2/16/24, the Alabama Supreme Court[1] ruled that

(a) "an embryo created through in vitro fertilization (IVF) is a child protected by Alabama's wrongful death act and the Alabama Constitution;" and that

(b) "a human frozen embryo is a 'child' which is an unborn or recently born [child];" and that

(c) "the Constitution … commands the judge to … upholding the sanctity of unborn life, including unborn life that exists outside the womb;" and that

(d) "the Court would not create an exception in the statute for these IVF embryo children just because they were located outside the womb;" and

WHEREAS, in current IVF practice in the United States, over half of embryo transfers will *not* result in live birth, as many embryos after transfer will either (a) not result in a pregnancy, or (b) result in a miscarriage, or (c) result in a non-viable ectopic or molar pregnancy; and

WHEREAS, cryopreserved embryos also do *not* have a 100% thaw-survival rate, and a small percentage of embryos will not survive freeze-thaw; such that if embryos in the IVF lab have the same legal status as children, then an embryology laboratory that fails to have a 100% thaw-survival rate may also have some potential liability; and

WHEREAS, not all IVF patients (a) can afford the long-term storage fees to cryopreserve embryos for future use or (b) wish to donate those embryos; and

WHEREAS, defining all embryos as "children" promotes the dangerous notion that all embryos should somehow be transferred in an IVF cycle (instead of cryopreserving extra embryos of adequate quality), which could potentially increase the rate of dangerous higher-order multiple gestation pregnancies (triplets, quadruplets, etc); and

WHEREAS, defining all embryos as "children" may promote the dangerous and misguided notion that an ectopic pregnancy could somehow be safely implanted into the uterus (as is erroneously reported on various "Personhood" websites[9]); and

WHEREAS, the American Society for Reproductive Medicine (ASRM) Position Statement on Personhood Measures states that

- “The ASRM is strongly opposed to measures granting constitutional rights or protections and “personhood” status to fertilized reproductive tissues.
- In a growing number of states, vaguely worded and often misleading measures are… defining when life begins and granting legal “personhood” status to embryos at varying stages of development.
- …, these broadly worded measures will have significant effects on a number of medical treatments available to women of reproductive age.
    - Personhood measures would make illegal some commonly used birth control methods.
    - Personhood measures would make illegal a physician's ability to provide medically appropriate care to women experiencing life-threatening complications due to a tubal pregnancy.
    - Personhood measures would consign infertility patients to less effective, less safe treatments for their disease.
    - Personhood measures would unduly restrict infertile patients’ right to make decisions about their own medical treatments, including determining the fate of any embryos created as part of the IVF process.
- ASRM will oppose any personhood measure;”; and

WHEREAS, partly to respond to a movement to allow establishment of college savings accounts for undelivered pregnancies; the American Medical Association (AMA) established policy H-140.835 (“Political Interference in the Patient-Physician Relationship”) which states that:

> "our AMA opposes any policies that interfere with the patient-physician relationship by giving probate, inheritance, a social security number, or other legal rights to an undelivered pregnancy, or imposing legislative barriers to medical decision-making by changes in tax codes or in definitions of beneficiaries;” and

WHEREAS, the AMA also passed a resolution in June 2024 (Resolutions 217/226 on “Protecting Access to IVF Treatment”), which stated that:

- "RESOLVED, that our American Medical Association oppose any legislation or ballot measures that could criminalize in-vitro fertilization (New HOD Policy); and be it further
- RESOLVED, that our AMA work with other interested organizations to oppose any civil or criminal legislation or ballot measures or court rulings that (a) would equate gametes (oocytes and sperm) or embryos with children and/or (b) would otherwise restrict or interfere with evidence-based care for Assisted Reproductive Technology (ART) (New HOD Policy); and be it further

- RESOLVED, that our AMA, through the AMA Task Force to Preserve the Patient-Physician Relationship, report back at I-24 on the status of, and AMA's activities surrounding, proposed ballot measures or legislation and pending court rulings that (a) would equate gametes or embryos with children and/or (b) would otherwise restrict or interfere with evidence-based care for Assisted Reproductive Technology (ART). (Directive to Take Action)"; now, therefore, be it

RESOLVED, that KMA oppose any legislation or ballot measures that could criminalize in-vitro fertilization; and be it further

RESOLVED, that KMA work with other interested organizations to oppose any civil or criminal legislation or ballot measures or court rulings that (a) would equate gametes (oocytes and sperm) or embryos with children and/or (b) would otherwise restrict or interfere with evidence-based care for Assisted Reproductive Technology (ART).

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RELEVANT AMA POLICY

D-5.999 "Preserving Access to Reproductive Health Services"
Our AMA: (1) recognizes that healthcare, including reproductive health services like contraception and abortion, is a human right; (2) opposes limitations on access to evidence-based reproductive health services, including fertility treatments, contraception, and abortion; (3) 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) supports shared decision-making between patients and their physicians regarding reproductive healthcare; (5) 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) 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) 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; Reaffirmation: A-23, Appended: Res 711, A-23)

G-605.009 "Establishing a Task Force to Preserve the Patient-Physician Relationship when Evidence-Based Appropriate Care is Banned or Restricted"
1. Our AMA will convene a task force of appropriate AMA councils and interested state and medical specialty societies, in conjunction with the AMA Center for Health Equity, and in consultation with relevant organizations, practices, government bodies, and impacted communities for the purpose of preserving the patient-physician relationship.
2. This task force, which will serve at the direction of our AMA Board of Trustees, will inform the Board to help guide organized medicine's response to bans and restrictions on abortion, prepare for widespread criminalization of other evidence-based care, implement relevant AMA policies, and identify and create implementation-focused practice and advocacy resources on issues including but not limited to:
a. Health equity impact, including monitoring and evaluating the consequences of abortion bans and restrictions for public health and the physician workforce and including making actionable recommendations to mitigate harm, with a focus on the disproportionate impact on under-resourced, marginalized, and minoritized communities;
b. Practice management, including developing recommendations and educational materials for addressing reimbursement, uncompensated care, interstate licensure, and provision of care, including telehealth and care provided across state lines;
c. Training, including collaborating with interested medical schools, residency and fellowship programs, academic centers, and clinicians to mitigate radically diminished training opportunities;
d. Privacy protections, including best practice support for maintaining medical records privacy and confidentiality, including under HIPAA, for strengthening physician, patient, and clinic security measures, and countering law enforcement reporting requirements;
e. Patient triage and care coordination, including identifying and publicizing resources for physicians and patients to connect with referrals, practical support, and legal assistance;
f. Coordinating implementation of pertinent AMA policies, including any actions to protect against civil, criminal, and professional liability and retaliation, including criminalizing and penalizing physicians for referring patients to the care they need; and
g. Anticipation and preparation, including assessing information and resource gaps and creating a blueprint for preventing or mitigating bans on other appropriate health care, such as gender affirming care, contraceptive care, sterilization, infertility care, and management of ectopic pregnancy and spontaneous pregnancy loss and pregnancy complications.
3. Our American Medical Association will appoint an ad hoc committee or task force, composed of physicians from specialties who routinely provide gender-affirming care, payers, community advocates, and state Medicaid directors and/or insurance commissioners, to identify issues with physician payment and reimbursement for gender-affirming care and recommend solutions to address these barriers to care.
(Res 621, A-22; Appended: Res 816, I-23)

H-160.954 Criminalization of Medical Judgment
(1) Our AMA continues to take all reasonable and necessary steps to insure that medical decision-making exercised in good faith, does not become a violation of criminal law. (2) Henceforth our AMA opposes any future legislation which gives the federal government the responsibility to define appropriate medical practice and regulate such practice through the use of criminal penalties.
(Sub. Res. 223, I-93; Reaffirmed: Res. 227, I-98; Reaffirmed: Res. 237, A-99; Reaffirmed and Appended: Sub. Res. 215, I-99; Reaffirmation A-09; Reaffirmed: CEJA Rep. 8, A-09)

H-160.946 The Criminalization of Health Care Decision-making
The AMA opposes the attempted criminalization of health care decision-making especially as represented by the current trend toward criminalization of malpractice; it interferes with appropriate decision making and is a disservice to the American public; and will develop model state legislation properly defining criminal conduct and prohibiting the criminalization of health care decision-making, including cases involving allegations of medical malpractice, and implement an appropriate action plan for all components of the Federation to educate opinion leaders, elected officials and the media regarding the detrimental effects on health care resulting from the criminalization of health care decision-making.
(Sub. Res. 202, A-95; Reaffirmed: Res. 227, I-98; Reaffirmed: BOT Rep. 2, A-07; Reaffirmation A-09)

D-160.999 Opposition to Criminalizing Health Care Decisions
Our AMA will educate physicians regarding the continuing threat posed by the criminalization of healthcare decision-making and the existence of our model legislation "An Act to Prohibit the Criminalization of Healthcare Decision-Making."
(Res. 228, I-98; Reaffirmed: BOT Rep. 5, A-08)

H-140.835 Political Interference in the Patient-Physician Relationship
Our AMA opposes any policies that interfere with the patient-physician relationship by giving probate, inheritance, a social security number, or other legal rights to an undelivered pregnancy, or imposing legislative barriers to medical decision-making by changes in tax codes or in definitions of beneficiaries.
(Alt Res 007, I-17)

RESOLUTION

Subject: Frozen Embryos Should Not be Considered Children in Order to Preserve Patient Access to Infertility Treatment

Submitted by: Lexington Medical Society

Referred to: Reference Committee

WHEREAS, infertility can affect individuals with medical problems like previous cancer treatment, obesity, erectile disfunction, age (over 40 for men, 35 for women), diabetes and other medical issues[1]; and

WHEREAS, infertility affects 10-15% of couples with IVF being a common procedure to allow these couples to conceive a child[2]; and

WHEREAS, in vitro fertilization (IVF) is a series of procedures, some of which are invasive with patient risk, that ultimately lead to an egg being combined with sperm outside of the body in a laboratory. The fertilized egg (zygote) undergoes embryo culture and becomes an embryo that can be placed in a woman's uterus or frozen[3]; and

WHEREAS, during IVF procedures, multiple embryos are prepared at a time to decrease patient risk with approximately 40% of IVF procedures performed with the intent to freeze the embryo and use it later[4]; and

WHEREAS, miscarriage is a naturally occurring event and, therefore, embryonic loss is a part of nature; and

WHEREAS, increasing liability and cost for both patients and physicians (i.e. embryo storage) by considering embryos children will lead to fewer infertility options for Kentuckians; now, therefore, be it

RESOLVED, the KMA, in keeping with the AMA (D-5.999), supports access to infertility treatment; and, therefore, opposes embryos being considered children.

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2. Choe J, Shanks AL. In Vitro Fertilization. [Updated 2023 Sep 4]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2024 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK562266/
3. https://medlineplus.gov/ency/article/007279.htm MedlinePlus brings together authoritative health information from the National Library of Medicine (NLM), the National Institutes of Health (NIH), and other government agencies and health-related organizations.
4. https://www.cdc.gov/art/reports/2020/summary.html 2020 National ART (artificial reproductive technology) Summary; Last Reviewed: February 21, 2023.

KMA House of Delegates
August 2024

RESOLUTION

Subject: Life-Limiting Anomaly Inductions

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, certain genetic errors cause malformations that do not allow for life outside of the uterus, now known as life-limiting; and

WHEREAS, serious congenital malformations account for roughly 3% of all pregnancies with a life-limiting rate of roughly 0.3%[1-2]; and

WHEREAS, genetic testing can be done as early as 10 weeks through maternal blood samples that can show some of these life-limiting conditions; and

WHEREAS, confirmation of genetic results can be obtained within weeks of genetic results; and

WHEREAS, knowledge of severe fetal anomalies or a life-limiting pregnancy can increase the risk of severe maternal anxiety and depression; and

WHEREAS, a study reporting a survey of nearly 900 maternal fetal medicine specialists notes that 76% of respondents felt strongly or very strongly that termination of pregnancy should be allowed for life-limiting anomalies[2]; and

WHEREAS, a large U.S. single-institution study of women with life-limiting anomalies before 24 weeks gestation, showed 77% elected for termination[2]; and

WHEREAS, a study involving 44,750 deliveries had 163 cases of life-limiting anomalies and 65% of those life-limiting experienced death in utero. Of those 35% that progressed to delivery, all cases resulted in death with only 1 surviving to 5 weeks[1]; and

WHEREAS, the CDC reported the number of infant deaths at 315,392 (of 49,126,572 live births) between 2003 and 2014 (with the ICD-10 code of termination of pregnancy). Of those 315,392 deaths, only 6 lived one day or more after birth[3]; and

WHEREAS, delivery of a pre-term fetus brings fewer complications and cesarean sections compared to full-term infants; and

WHEREAS, 27% of Kentucky medical school students plan on choosing Obstetrics and Gynecology residencies and 63% strongly agree that they will go outside of Kentucky because of restrictive women's rights laws[4]; and

WHEREAS, 83% of those surveyed strongly agree that abortion bans will exacerbate healthcare disparities in Kentucky[4]; and

WHEREAS, 85% of survey respondents report they strongly agree that abortion bans affect women's access to comprehensive care in Kentucky[4]; now, therefore, be it

RESOLVED, that KMA proposes/supports legislation to allow delivery inductions at any age for lethal anomalies after confirmation by a provider. This will help reduce patient anguish and risk, NICU costs and resources, mitigate the barriers to recruitment of needed obstetrical providers, and improve healthcare disparities.

References

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2. R. Jacobs, Gillian Dean, Erika J. Wasenda, Lauren M. Porsch, Erin L. Moshier, David A. Luthy, Maureen E. Paul. Late termination of pregnancy for lethal fetal anomalies: a national survey of maternal–fetal medicine specialists. Contraception. January 2015, (91), Issue 1, 12-18. https://www.sciencedirect.com/science/article/abs/pii/S0010782414006994
3. Mortality Records with Mention of International Classification of Diseases-10 code P96.4 (Termination of Pregnancy): United States, 2003-2014. Health Policy Data Requests - Mortality Records with Mention of Termination of Pregnancy (cdc.gov). Health Policy Data Requests - Mortality Records with Mention of Termination of Pregnancy
4. Dodwani, Shriya. Impact of Abortion Restrictions on Medical Students of Kentucky Survey dates: March 22, 2024 – May 29, 2024 (no official publication yet).

2024-18

RESOLUTION

Subject: Ensuring Adequate Physician Workforce in Kentucky

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, having an adequate number of physicians is critical for the health and well-being of Kentuckians; and

WHEREAS, laws that limit reproductive autonomy are harmful to the safety of pregnant persons; and

WHEREAS, laws that limit physicians' ability to practice within their scope create untenable ethical dilemmas for obstetricians, making it difficult for them to practice according to their training; and

WHEREAS, for these reasons and others, the laws restricting reproductive autonomy passed by the Kentucky state legislature are negatively impacting the state's ability to attract and retain medical students and residents as evidenced by a recent American Association of Medical Colleges (AAMC) study[1] that found a 4.2% decrease between 2023 and 2024 in the number of applicants to residency programs in states with almost complete abortion bans compared to a 0.6% decrease in states where pregnancy termination remains legal; and

WHEREAS, this same study found steady increases in the number of applicants between 2019-2022, followed by a 15% drop in applicants to Kentucky residency programs from 2023-2024 (Dobbs decision[2] occurred in June 2022, allowing Kentucky's trigger ban to go into effect); and

WHEREAS, a University of Louisville (UofL) study of University of Kentucky and UofL medical students {private communication} found that overall only 53% were planning to stay in Kentucky for residency, 22% were planning to leave the state, and 25% were undecided; and

WHEREAS, the lack of medical students choosing to stay in or come to Kentucky will certainly have a long-term impact on quality of and access to care in the Commonwealth; now, therefore, be it

RESOLVED, that KMA advocate for comprehensive reproductive autonomy for persons capable of conceiving and allowing medical decisions to be made between the patient and their provider.

References

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2. https://www.supremecourt.gov/opinions/21pdf/19-1392_6j37.pdf

KMA House of Delegates
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RESOLUTION

Subject: Prevention of Indoor Tanning in Minors

Submitted by: Maggie Stull and Parisa Shamaei Zadeh (Medical Student Section)

Referred to: Reference Committee

WHEREAS, tanning, a darkening of skin pigmentation caused by melanocyte activation[1], is caused by exposure to ultraviolet (UV) radiation from the sun or tanning beds[2], a common method of indoor tanning; and

WHEREAS, studies have shown that using a tanning device such as a tanning bed, causes an increased risk for malignant melanoma, a dangerous, most common form of cancer diagnosed in the United States[3], as well as basal and squamous cell carcinoma[1]; and

WHEREAS, melanoma rates have been increasing over the past 30 years, with a 31.5% increase between 2011 and 2019[4]; and

WHEREAS, it is estimated that over 200,000 new cases will be diagnosed in the year 2024 in the United States[4]; and

WHEREAS, Kentucky has a higher melanoma skin cancer rate than Texas, California, Arizonia, or Florida, with a rate of 28.2 cases per 100,000 people diagnosed annually[5]; and

WHEREAS, the association between indoor tanning and skin cancer is robust among those who first used a tanning facility in early adulthood[3]; and

WHEREAS, teens under age 18 may feel a tremendous amount of pressure to appear attractive and use tanning beds without being aware of the increased risk for skin cancer associated with tanning[6]; and

WHEREAS, in the state of Kentucky, a person ages 14-17 can use a tanning device with parental consent[7]; and

WHEREAS, the American Academy of Dermatology Association (AADA) supports the World Health Organization (WHO) recommendation that minors should not use indoor tanning equipment because indoor tanning devices emit UVA and UVB radiation, and because overexposure to UV radiation can lead to the development of skin cancer[8]; and

WHEREAS, the American Medical Association (AMA) policy D-440.960, titled “Prohibiting the Sale of Tanning Parlor Ultraviolet Rays to Those Under 18 Years of Age” encourages the development of state legislation prohibiting the sale of tanning parlor ultraviolet rays to those under 18 years of age

except as prescribed by a physician[9]; and

WHEREAS, KMA policy encourages avoiding the use of tanning devices, but does not specify protection from tanning devices for minors[10]; now, therefore, be it

RESOLVED, that KMA advocate for passage of legislation prohibiting tanning bed use in all individuals under the age of 18 by removing the option of providing parental consent for those aged 14-17 desiring to use tanning beds.

References:

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2. Skin Cancer Foundation. (n.d.). Tanning & Your Skin. Retrieved July 1, 2024, from https://www.skincancer.org/risk-factors/tanning/
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4. American Academy of Dermatology Association. (n.d.). Skin Cancer Incidence Rates. Retrieved July 1, 2024, from https://www.aad.org/media/stats-skin-cancer
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9. American Medical Association. (n.d.). Indoor tanning restrictions for minors. Retrieved July 1, 2024, from https://www.ama-assn.org/delivering-care/public-health/indoor-tanning-restrictions-minors
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2024-20

RESOLUTION

Subject: Encourage Expansion of Labeling Requirements for Products Containing Delta-8 and Delta-9 Tetrahydrocannabinol

Submitted by: Juliana Cobb, MS (Medical Student Section) and Monalisa Tailor, MD

Referred to: Reference Committee

WHEREAS, KRS 260.850(5) and 7 U.S.C. recognizes Delta-8 tetrahydrocannabinol and Delta-9 tetrahydrocannabinol, derivatives of cannabidiol, as legal forms of hemp in the state of Kentucky"[1]; and

WHEREAS, tetrahydrocannabinol is known to have broad drug interactions and can enhance the adverse effects of some other medications [1]; and

WHEREAS, Delta-9-tetrahydrocannabinol (Delta-9-THC) is the main psychoactive ingredient of cannabis [2]; and

WHEREAS, the number of reports involving delta-8 tetrahydrocannabinol, delta-10 tetrahydrocannabinol, and tetrahydrocannabinol-O acetate to United States poison control centers between January 2021 and December 2022 totaled 5,022[3]; and

WHEREAS, 30.1 percent of cases of delta-8 tetrahydrocannabinol, delta-10 tetrahydrocannabinol, and tetrahydrocannabinol-O acetate exposure reported to United States poison control centers involved children less than 6 years old[3]; and

WHEREAS, of children exposed to delta-8 tetrahydrocannabinol, delta-10 tetrahydrocannabinol, and tetrahydrocannabinol-O acetate as reported to United States poison control centers between January 2021 and December 2022, 95.1 percent were via ingestion[3]; and

WHEREAS, elderly adults may also experiment with these unregulated products to relieve anxiety, insomnia, or arthritis with higher risk of side effects seen with drowsiness, decreased appetite, light-headedness and impact on liver function tests[4] without a clear understanding of what these products contain; and

WHEREAS, Kentucky Revised Statues require labeling of hemp-derived cannabinoid products to include potency in milligrams per serving for total tetrahydrocannabinol and the warning "(a) "This product is intended for use by adults 21 years and older. Keep out of reach of children." (b) "There may be health risks associated with the consumption of this product." (c) "There may be additional health risks associated with the consumption of this product for those who are pregnant, nursing, or plan to become pregnant." (d) "The intoxicating effects of this product may be delayed by two or more hours." (e) " May cause drowsiness or impairment. Do not drive a motor vehicle or operate machinery while using this

product." (f) "Use of this product may result in a positive drug screen"," but does not outline where on the packaging or how evident these warnings must be; now, therefore, be it

RESOLVED, that KMA encourages that (1) regulations be introduced that require the packaging of products containing Delta-8 tetrahydrocannabinol and Delta-9 tetrahydrocannabinol be clearly and obviously labeled on the front of said packaging.

References:

1. Brown JD. Potential Adverse Drug Events with Tetrahydrocannabinol (THC) Due to Drug-Drug Interactions. J Clin Med. 2020 Mar 27;9(4):919. doi: 10.3390/jcm9040919. PMID: 32230864; PMCID: PMC7231229.
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2024-21

RESOLUTION

Subject: Change in EPA National Ambient Air Quality Standards for Particulate Matter (PM NAAQS) for $PM_{2.5}$

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, fine particulate matter 2.5 microns or smaller in size ($PM_{2.5}$) is a mixture of solid particles and liquid droplets; and

WHEREAS, $PM_{2.5}$ is associated with several illnesses including heart disease, stroke, asthma, low birth weight, and especially lung cancer; and

WHEREAS, the current Environmental Protection Agency (EPA) National Ambient Air Quality Standards for Particulate Matter (PM NAAQS) for $PM_{2.5}$ is 12.0 $\mu g/m^3$; and

WHEREAS, the EPA, based on an evaluation of needs for public health protection consistent with the available health science and an assessment of the costly health impacts of the current $PM_{2.5}$ standard, has revised the primary (health-based) annual $PM_{2.5}$ standard to 9.0 $\mu g/m^3$; and

WHEREAS, Russell Coleman, Attorney General for the Commonwealth of Kentucky, along with 23 other State Attorneys Generals, has sought to block implementation of the revision of $PM_{2.5}$ standard from the current 12.0 $\mu g/m^3$ to 9.0 $\mu g/m^3$; now, therefore, be it

RESOLVED, that KMA opposes the action of the Attorney General, as it is not in the best interest of the health of the people of Kentucky and has the potential to negatively impact the direct and indirect health care cost borne by the citizens of Kentucky; and be it further

RESOLVED, that KMA supports the change in EPA National Ambient Air Quality Standards for Particulate Matter for $PM_{2.5}$ to 9.0 $\mu g/m^3$.

2024-22

RESOLUTION

Subject: Supporting Free School Lunches for all Kentucky Public School Students

Submitted by: Sarah Taheri, MS and Onajia Stubblefield, MS (Medical Student Section)

Referred to: Reference Committee

WHEREAS, 1 in 5 children in Kentucky face hunger [1]; and

WHEREAS, the National School Lunch Program ("NSLP) reimburses states for the provision of free and low-cost nutritionally balanced meals to qualifying students such that students whose families have incomes at or below 130 percent of the federal poverty level qualify for free lunch[2]; and

WHEREAS, the eligibility guidelines result in students, whose parents make more than 130 percent of the federal poverty level but not enough to consistently afford full or reduced-price meals, incurring lunch debt[3]; and

WHEREAS, policies at some schools are such that until the debt is paid off, children receive "cold and less nutritious meal[s], like a cheese or peanut butter sandwich"[4]; and

WHEREAS, the practice of giving alternative meals, physically marking students as different from their peers may enhance stigma, and lead to students feeling shame or embarrassment thereby negatively affecting their social and emotional wellbeing[5]; and

WHEREAS, proper nutrition is essential for the healthy growth and development of children and malnutrition and undernutrition can lead to serious health issues in children including stunting, weakened immune systems, and poor mental development[6,7]; and

WHEREAS, the Community Eligibility Provision (CEP) expanded free meals to all students in schools that have at least 25% of students meeting eligibility criteria for the NLSP, but many schools do not qualify or choose not to participate because the federal government may not cover the entirety of the cost of the expanded program[8]; and

WHEREAS, studies examining universal free school meals that included free lunch found positive associations with diet quality, food security, and academic performance[9]; and

WHEREAS, eight states currently provide free school meals to all students regardless of income, and many more are drafting or have introduced free school meal legislation including the neighboring states of Illinois, Ohio, and Tennessee[10]; now, therefore, be it

RESOLVED, that KMA supports universal free school lunch for all public school students in Kentucky.

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References:

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2. *National School Lunch Program*. USDA ERS - National School Lunch Program. (2023, September 7). https://www.ers.usda.gov/topics/food-nutrition-assistance/child-nutrition-programs/national-school-lunch-program/
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4. *Universal School Meals Policy Brief*, First Focus Campaign for Child. (2023), https://campaignforchildren.org/wp-content/uploads/sites/2/2023/10/FFCFC-Universal-School-Meals-Policy-Brief.pdf.
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2024-23

RESOLUTION

Subject: Prohibit Stigmatizing Language in Credentialing

Submitted by: Shawn C. Jones, MD

Referred to: Reference Committee

WHEREAS, physicians are dedicated to the well-being of their patients and are bound by ethical standards to provide competent and professional care; and

WHEREAS, mental, emotional, and physical health conditions may affect individuals across all professions, including medicine, and should not be stigmatized or discriminated against; and

WHEREAS, the American Medical Association (AMA) and the Federation of State Medical Boards (FSMB) have recognized the importance of refraining from stigmatizing language in credentialing questions related to physicians' health conditions; and

WHEREAS, the FSMB has recommended a standardized question that encompasses all mental and physical health conditions without further categorization or explanation, aiming to assess impairment of judgment or ability to practice medicine competently, ethically, and professionally; and

WHEREAS, stigmatizing language in credentialing questions can discourage physicians from seeking necessary treatment and support, thereby potentially compromising patient care and physician well-being; and

WHEREAS, the use of stigmatizing language may perpetuate misconceptions about mental and physical health conditions among medical professionals and the broader community; and

WHEREAS, creating a supportive and inclusive environment for physicians to disclose health conditions encourages transparency and enhances overall patient safety and care quality; now, therefore, be it

RESOLVED, that KMA supports statutory and regulatory changes that eliminate existing and prohibit future use of stigmatizing language in healthcare credentialing processes and application forms that ask physicians or other providers questions regarding their “prior” mental, emotional, and/or physical health; and be it further

RESOLVED, that KMA urges all healthcare credentialing entities to align their credentialing practices by adopting processes and application forms that utilize personal health questions which, as recommended by the Federation of State Medical Boards, focuses on “current” untreated conditions that impair judgment or that would otherwise adversely affect the ability to practice medicine in a competent, ethical, and professional manner; and be it further

RESOLVED that KMA supports education initiatives among medical professionals and healthcare credentialing entities that raise awareness and promote understanding and destigmatization of mental, emotional, and physical health conditions in the practice of medicine.

2024-24

RESOLUTION

Subject: Support for the Crisis Aversion and Rights Retention (CARR) Legislation

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, the Crisis Aversion and Rights Retention (CARR) legislation aims to prevent gun violence through bipartisan measures and has garnered support from both Republican and Democrat legislators; and

WHEREAS, the Whitney/Strong Organization, dedicated to achieving meaningful gun reform through bipartisan legislation, has strongly endorsed the CARR bill; and

WHEREAS, recent data from the Centers for Disease Control and Prevention (CDC) indicates a significant increase in gun violence, with firearm-related deaths reaching a record high in 2023, posing a serious public health crisis; and

WHEREAS, the American Medical Association (AMA) has identified gun violence as a major public health issue and advocates for evidence-based strategies to prevent firearm injuries and deaths; now, therefore, be it

RESOLVED, that KMA publicly supports the Crisis Aversion and Rights Retention (CARR) legislation and urges the Kentucky General Assembly to pass this vital bill to enhance public safety and protect the rights of individuals; and be it further

RESOLVED, that KMA collaborates with the Whitney/Strong Organization and other stakeholders to promote awareness and understanding of the benefits of the CARR legislation among health care professionals and the broader community.

2024-25

RESOLUTION

Subject: Cost of Medication

Submitted by: Rick Rowe, MD

Referred to: Reference Committee

WHEREAS, the cost of many medications are so high that many patients cannot afford them and often have to choose between purchasing medications or food for themselves and their children; and

WHEREAS, this may disproportionately affect the patients who need medications the most (low income households, many rural patients, minorities, and those who have other barriers to obtaining medical care); and

WHEREAS, even if a patient has “access” to expert healthcare professionals, if they can not afford the medication the expert or their primary care physician prescribes, the “access” was of little or no benefit; now, therefore, be it

RESOLVED, that KMA appoint a committee, workgroup, task force, or other body to evaluate and bring to the attention of KMA members, legislators, and other stake holders the adverse health effects of unaffordable medications; and be it further

RESOLVED, that KMA actively advocate (instead of merely supporting) for the organization (KMA) working with legislators, the AMA, and other groups to find ways, legislative and other, to reduce medication costs and therefore improve the health of Kentuckians.

2024-26

RESOLUTION

Subject: Tax Relief and Support for Employers of Organ Donors and Bone Marrow Donors

Submitted by: Lexington Medical Society

Referred to: Reference Committee

WHEREAS, there are 114,000 patients nationally listed and waiting for organ transplantation, 1,000 of whom are in Kentucky; and

WHEREAS, transplantation provides a significant survival benefit as well as quality of life benefit; and

WHEREAS, transplant waiting lists continue to increase in numbers resulting in longer waiting time for deceased donor organs and subsequently more deaths while awaiting organ transplantation; and

WHEREAS, organ donation from altruistic live donors significantly shortens waiting time for transplant, is less costly than maintenance therapy and provided better transplant function over a longer period of time; and

WHEREAS, employers of organ or bone marrow donors often incur costs during medical leave; and

WHEREAS, the KMA supports providing organ donors with full access to the protections of the Family Medical Leave act, and supports removing financial barriers to organ donation including paid leave and tax credits[1]; and

WHEREAS, eight states (AK, CO, GA, IL, LA, NJ, PA and VA) and the District of Columbia offer employer tax credits offsetting costs incurred from employee/donor leave[2,3]; now, therefore, be it

RESOLVED, that KMA create a commission, if necessary, to examine the feasibility of granting above credits and how best to present it to selected state representatives.

References:

1. KMA Policy Manual page 9. #7, Living donor organ and Bone Marrow protection
2. List of States and DC providing employers or organ donors tax credits to offset costs incurred during medical leave. National Kidney Foundation.
3. Senator Albers (GA) tax credits (for medical leave after donation) were estimated to be $1.7 million and would save the state $62 million by reducing the cost of care for those waiting for transplantation. Fox 5, Atlanta.com February 1, 2022.

2024-27

RESOLUTION

Subject: Promote Independent Medical Practices

Submitted by: Lexington Medical Society

Referred to: Reference Committee

WHEREAS, independent medical practices provide personalized and community-focused care which is highly valued by patients and communities; and

WHEREAS, the number of independent medical practices has been declining significantly, with a nationwide drop from 60.1% in 2012 to 46.7% in 2022 with evidence to suggest that fewer young physicians are choosing private practice in favor of larger institutional employment[1]; and

WHEREAS, the consolidation of medical practices into larger health systems has been shown to increase healthcare costs significantly, with procedures costing up to three times more in hospital settings compared to outpatient or physician office settings[2,3]; and

WHEREAS, independent practices face increasing financial, regulatory, and administrative burdens that threaten their sustainability especially as markets further consolidate into larger institutions and private equity with defined referral sources; and

WHEREAS, maintaining a robust presence of independent practices is critical for ensuring healthcare access, affordability, and quality in Kentucky; now, therefore, be it

RESOLVED, that KMA affirms the indispensable value of independent medical practices to Kentucky since they offer advantages like personalized care, lower costs, and opportunities for greater efficiency; and be it further

RESOLVED, that KMA will facilitate a forum for private practice physicians to meet virtually and discuss obstacles, opportunities, and collaborative endeavors to enhance growth and viability of private practices in Kentucky; and be it further

RESOLVED, that KMA will work with the Kentucky Hospital Association to bolster referrals to independent practices by creating mechanisms for independent practices to be a referral resource within institutional electronic health records systems, ensuring that patients have access to a broad spectrum of care options.

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KMA House of Delegates
August 2024

2024-28

RESOLUTION

Subject: Protecting Medical Research and Improving Access to Care Amendment to HIPAA

Submitted by: William Richardson, MD, Julie Lee, MD, Frank Burns, MD, Ben Mackey, MD, Ben Proctor, MD, Ryan Smith, MD, and Jeremy Clark, MD

Referred to: Reference Committee

WHEREAS, the ACA and subsequent MACRA/MIPS (quality initiatives) created an enormous compliance burden on doctors, including EMR costs, IT support, charting time, registry connection/paperwork, and time away from patients. For example, the AMA states MIPS compliance costs $12,800 per provider, per year. Physicians spend 53 hours per year on compliance and pay for hundreds of administrative hours. As a result, achieving the incentive becomes more difficult each year. In fact, less than half of practices will see small bonuses from MIPS in 2024, and the penalties can reach 9% for non-compliance. It is much more difficult for small, rural practices to comply; and

WHEREAS, physicians are providing structured and unstructured data to the various specialty and medical device Registries that spawned to assist in MIPS compliance. Registries help physicians submit their MIPS quality data by running software in the EMR that uploads all patient information then curates a set for Medicare compliance. Not surprisingly, this data has become extremely valuable to the pharma industries for medical research, much more than the Medicare data set alone; and

WHEREAS, MIPS has now created multi-million-dollar Registries that enjoy "free" data, as HIPAA prevents physicians from sharing in the Fair Market Data Value. Registries enjoy the fact that MIPS penalties keep EMR data flowing. Most physicians do not realize that their Registry contracts allow this; and

WHEREAS, medical research for pharma, etc. has evolved leaps and bounds because of these Registries. However, medical research can be VASTLY improved by including imaging and other diagnostic data that is not captured by the existing Registries. Physicians currently have zero incentive to participate in anything more than what it takes to avoid MIPS penalties; and

WHEREAS, Medicare and Medicaid patients are desperate for physicians, and physicians are opting out or retiring at higher rates since COVID. Physician burnout is greater than 50%, and an entire medical school class is lost every year to suicide. 40% of physicians report that they will be doing “something else” in the next 2 years. Medicare reimbursement has dropped 26% (inflation adjusted) in the last 20 years. Inflation and labor costs are escalating; practice costs are up 47%. (AMA, KMA sources) This is a crisis; and

WHEREAS, a recent polling of Medicare beneficiaries reveals that scheduling to see a physician is very challenging. For example, Kentucky lost 6% of its physician workforce after COVID and the AMA is predicting a 38,000-120,000 physician shortage in 10 years. The physicians in the system are at the breaking point; and

WHEREAS, using the 340B logic that saved rural hospitals (critical access hospitals), it is reasonable to promote similar lawmaking. Allowing physicians to share in the profit from their EMR investment and daily work product will help physicians remain in Medicare and assist with recruitment; and

WHEREAS, if MIPS is eliminated, as some in the US Doctor's Caucus hope, then allowing a profit-sharing system will preserve sharing of data for research, especially images and other structured diagnostic data, and it may be the only course of action that can save the current research (Registry) model if wholesale reform occurs; and

WHEREAS, this initiative will cost taxpayers nothing, it does not include a mandate, and has similar precedent in Congress to save Rural Hospitals; and

WHEREAS, this proposal is not predicted to be a windfall in terms of individual physician revenue, because data for any given research project comes from such a wide array of practices, but it represents something positive in an otherwise bleak Medicare future, it encourages Physician participation, and it is fair; now, therefore, be it

RESOLVED, that KMA use its resources to lobby and promote this proposed solution as set forth below to our US representatives: as an amendment to HIPAA.

42 US Code Section 17935:

> (B) The purpose of the exchange is for research (as described in sections 164.501 and 164.512(i) of title 45, Code of Federal Regulations) or an exchange to a data registry where it will be de-identified and available for research purposes and the price charged reflects the costs of preparation and transmittal of the data for such purpose and, in order to encourage participation in such activities, compensation for professional services, not to exceed thirty percent (30%) of the commercial fair market value of the data and imagery. Compensation for professional services will be limited to entities participating in Medicare and Medicaid. *(Changes are highlighted)*

2024-29

RESOLUTION

Subject: National Tort Reform

Submitted by: Lexington Medical Society

Referred to: Reference Committee

WHEREAS, the shortage of physicians in the United States can be related to the expenses of medical education and medical practice; and

WHEREAS, Kentucky and most other states have physicians with major expenses related to medical liability; and

WHEREAS, Kentucky continues to lose physicians to states which have malpractice damage caps; and

WHEREAS, 30 states have some form of malpractice damage caps, such as caps on pain and suffering, noneconomic damages, and absolute caps; and

WHEREAS, major changes in tort reform in Kentucky will require a change in the state constitution and a referendum by the people; and

WHEREAS, a national approach to limiting medical liability expenses would be fairer and more consistent to physicians in all states; and

WHEREAS, the state and national political climate would likely support a more consistent approach to medical liability expenses; now, therefore, be it

RESOLVED, that KMA formally advocate for a national cap on non-economic damages stemming from medical liability claims and solicit congressional support for such improvement in the medical practice environment.

RESOLUTION

Subject: Support for Expanded Access to Dental Care for the Comprehensive Health of Kentuckians

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, oral health problems and/or periodontal disease are strongly associated with medical health problems that cause severe disease burden in Kentucky, including multiple cancers (oral,[1] esophageal,[2] lung,[3] pancreatic,[4] colorectal[5,6]), cardiovascular disease,[7,8] pneumonia,[9] and pregnancy/birth complications; and

WHEREAS, the American Medical Association (AMA) acknowledged the importance of oral health care for overall patient care and opened the door to collaboration with dental organizations such as the American Dental Association (ADA) in policy D-160.925 from 2023; and

WHEREAS, 27% of Kentucky adults ages 18-64 have lost 6 or more teeth because of tooth decay, infection, or gum disease; furthermore, there has been no improvement from 2016 to 2020[10]; and

WHEREAS, almost half of Kentucky adults in 2020 (43%) had not had a dental visit in the past year, which is drastically higher than the national average of 35%[10]; and

WHEREAS, in 2022, half of Kentuckians with incomes below $50,000 who do not qualify for Medicaid have not had a dental visit in the past year, compared to 25% of Kentuckians with incomes above $75,000[11] – suggesting that affordability is a barrier to accessing dental care in our state; and

WHEREAS, the U.S. Department of Health and Human Services (HHS) Benefit and Payment Parameters Notice for 2025 newly allows the states to choose to classify routine adult dental health coverage as an essential health benefit (EHB) in small group and individual marketplace plans[12]; and

WHEREAS, 75,000 Kentuckians currently receive coverage from small group and individual marketplace plans[13] and could benefit medically from Kentucky's expansion of EHBs to include routine adult dental health coverage; now, therefore, be it

RESOLVED, that KMA advocates for the adoption of policies that improve the accessibility of dental health care for Kentuckians; and be it further

RESOLVED, that KMA joins the Kentucky Oral Health Coalition in pursuing its mission of improving the oral health of all Kentuckians.

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2024-31

RESOLUTION

Subject: Supporting Recruitment and Engagement of Underrepresented Groups Within Medical Specialty Societies

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, Kentucky ranks in the bottom half of all states for primary care doctor availability and for overall physicians,[1] and female,[2,3,4] rural[3,4] and minority medical students[5] are more likely to pursue primary care specialties; and

WHEREAS, as of 2020, only 32.2% of the active physicians in Kentucky were female, and in surgical specialties, females made up less than 13% of orthopedic surgeons and neurological surgeons, 15% of thoracic surgeons and 10% of urologists[1]; and

WHEREAS, from a study in 2019, there was a national 15-year decline in the number of rural medical students, culminating in rural students representing less than 5% of all incoming medical students in 2017[6]; and

WHEREAS, 40.6% of Kentucky's population lives in rural populations[7] but only 25.2% of Kentucky physicians practice in rural counties[8]; and

WHEREAS, Hispanic and Black or African American people make up 2.7% and 3.2% of active physicians in Kentucky,[1] but comprised 3.9% and 7.2% of the Kentucky population,[9] respectively; and

WHEREAS, an inclusive representation of all groups across all medical specialties is needed to address health disparities and minority physicians are more likely to practice in underserved areas and treat patients from minority communities[10]; and

WHEREAS, a physician workforce that mirrors the diversity of the patient population it serves is linked to enhanced healthcare outcomes and fosters health equity[11,12,13,14,15,16]; and

WHEREAS, societies such as the American Medical Association,[17,18] Student National Medical Association,[19] and American Academy of Family Physicians[20] implement various programs, scholarships, mentorship opportunities, and advocacy efforts locally, regionally and nationally aimed at increasing and retaining underrepresented groups within the medical profession; now, therefore, be it

RESOLVED, that KMA supports initiatives in medical professional societies that comply with legal standards and aim to create a more inclusive and representative medical workforce by recruiting and engaging underrepresented groups.

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2024-32

RESOLUTION

Subject: Reduction of Medical Education Debt

Submitted by: Lewis Rowe, MD and Ellen Cowley, MD

Referred to: Reference Committee

WHEREAS, there is a physician shortage in the state of Kentucky; and

WHEREAS, the shortage is going to persist and worsen since 2 of 5 current physicians will be 65 years or older and in retirement age; now, therefore, be it

RESOLVED, that KMA work to find an income stream to reduce debt for all medical students, physicians in training, and early caregivers.

RESOLUTION

Subject: Fostering Respect and Acceptance for Natural Hair and Cultural Headwear in Medicine and Medical Professionalism

Submitted by: Onajia Stubblefield, MS and Sarah Taheri, MS (Medical Student Section)

Referred to: Reference Committee

WHEREAS, Governor Andy Beshear signed an executive order prohibiting discrimination in the workplace based on natural hairstyles associated with race in Kentucky; and

WHEREAS, discrimination against natural hair and hairstyles is prevalent in various professional settings and has been linked to racial and ethnic bias[1,2,3,4,5,6,7,8]; and

WHEREAS, cultural headwear, such as hijabs and turbans, are often targets of religious discrimination in the workplace[9,10]; and

WHEREAS, opposing discrimination helps to create a more equitable and supportive environment for both healthcare workers and patients[11]; and

WHEREAS, promoting acceptance and diversity in healthcare is associated with improved patient outcomes and staff satisfaction[12,13]; now, therefore, be it

RESOLVED, that KMA recognizes that discrimination against natural hair/hairstyles and cultural headwear is a form of racial, ethnic and/or religious discrimination; and be it further

RESOLVED, that KMA opposes discrimination against individuals based on their hair or cultural headwear in health care settings.

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2024-34

RESOLUTION

Subject: Addressing Pulse Oximeter Differences in People of Color

Submitted by: Julia D'Orazio and Maggie Stull (Medical Student Section)

Referred to: Reference Committee

WHEREAS, a pulse oximeter measures oxygen saturation, or SpO2, via spectrophotometry to indirectly calculate the arterial hemoglobin saturation by determining the proportion of oxyhemoglobin in peripheral arterial blood[1]; and

WHEREAS, oxygen saturation is often considered the "5th vital sign"[2] due to its cost effectiveness, lack of invasiveness, continuous monitoring availability, and various points of accessibility[3]; and

WHEREAS, pulse oximetry has a sensitivity of 92% and a specificity of 90% when detecting hypoxia at a threshold of 92% oxygen saturation[2], but the accuracy is reduced as saturations decrease to less than 90%[1]; and

WHEREAS, factors such as increased skin pigmentation, nail polish, anemia, and extreme (both hot and cold) skin temperatures can decrease the accuracy of the pulse oximeter[4]; and

WHEREAS, hypoxia is defined as SpO2 less than 90%, and occult hypoxia is defined as an overestimation of oxygen saturation that is more likely to occur in People of Color compared to White individuals[5]; and

WHEREAS, the American Medical Association (AMA) recognizes that pulse oximeters may not accurately measure oxygen saturation in all skin tones[6]; and

WHEREAS, multiple studies have shown that SpO2 is inaccurate (as it is often overestimated) in People of Color compared to their White counterparts, a phenomenon deemed "skin color related error" (SCRE)[3, 5, 7]; and

WHEREAS, this may lead to inequities in care, such as a delay in the administration of supplemental oxygen, leading to cases of "hidden hypoxia"[1]; and

WHEREAS, "hidden hypoxemia" is associated with higher mortality rates[3, 5]; and

WHEREAS, the largest degree of "hidden hypoxia" is seen in Black populations[5]; now, therefore, be it

RESOLVED, that KMA will encourage education in healthcare providers as well as the general public regarding the use of pulse oximetry and its associated inaccuracy in People of Color, which may lead to inequities in patient care.

KMA House of Delegates
August 2024

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2024-35

RESOLUTION

Subject: Mental Health Support for Individuals with Skin-Related Disorders and Disabilities

Submitted by: Onajia Stubblefield, MS and Sarah Taheri, MS (Medical Student Section)

Referred to: Reference Committee

WHEREAS, individuals with dermatologic disorders frequently experience psychiatric comorbidities such as depression and anxiety, which can exacerbate their overall health burden[1,2,3,4,5]; and

WHEREAS, the chronic and refractory nature of many dermatologic conditions can lead to persistent stress and reduced quality of life[6,7,8]; and

WHEREAS, mental health screenings are essential for early identification and management of psychiatric comorbidities in patients with dermatologic conditions, improving overall patient outcomes[9,10,11,12,13,14]; now, therefore, be it

RESOLVED, that KMA recognizes the unique burdens of dermatologic disorders due to the visibility of skin lesions, psychiatric and psychological comorbidities, and chronic, refractory disease course; and be it further

RESOLVED, that KMA supports offering mental health screenings during dermatological appointments to detect and address mental health concerns of patients with skin-related disorders and disabilities.

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2024-36

RESOLUTION

Subject: Safety Stations

Submitted by: Alexander Thebert, MD (Resident Fellows Section)

Referred to: Reference Committee

WHEREAS, there is a new federal initiative for federal public buildings and the Veterans Health Administration facilities to create safety stations consisting of an automatic emergency defibrillator (AED), opioid reversal agent, and a hemorrhagic control device such as the Stop the Bleed kit[1]; and

WHEREAS, over 1800 Kentuckians die from out-of-hospital cardiac yearly[2]; and

WHEREAS, nearly 2000 Kentuckians died from drug overdose in 2023 and most deaths can be attributed to opioids such as fentanyl[3]; and

WHEREAS, it is estimated that 95% of trauma deaths occur outside the hospital, and hemorrhage accounts for a large portion of those deaths[4]; and

WHEREAS, Kentucky has “Good Samaritan” laws protecting those who use AEDs in good faith and those who seek assistance for drug overdoses[5]; and

WHEREAS, in 2023, Kentucky passed HB 331 which mandated AEDs in schools and the budget set aside $2.5 million for their acquisition by public schools[6]; and

WHEREAS, the Kentucky Opioid Abatement Advisory Commission rewards funds from the Kentucky opioid abatement trust fund to projects to mitigate the opioid epidemic[7]; and

WHEREAS, the Stop the Bleed campaign offers grants to fund kit acquisition[8]; and

WHEREAS, current KMA policy supports increased availability of AEDs, naloxone, and hemorrhagic control devices such as “Stop the Bleed” kits; now, therefore, be it

RESOLVED, that KMA support safety stations in public facilities for emergency treatment of cardiopulmonary arrest, opioid overdose, and hemorrhagic bleed.

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1. U.S Department of Health and Human Services. Safety Station Fact Sheet for Federal Government Employees and Contractors. Published December 8, 2023. https://www.hhs.gov/about/agencies/asa/psc/physical-security-emergency-management/safety-stations/index.html
2. Kentucky HeartSafe Communities - Cabinet for Health and Family Services. https://www.chfs.ky.gov/agencies/dph/dpqi/cdpb/Pages/heartsafe.aspx
3. Kentucky Justice and Public Safety Cabinet. 2023 Drug Overdose Fatality Report. https://odcp.ky.gov/Documents/2023_ODCP_Annual%20Drug%20Overdose%20Report.pdf
4. Kentucky State Trauma System. Kentucky Trauma Data Bank 2022 Annual Report. https://kiprc.uky.edu/sites/default/files/2024-01/trauma%20registry%20annual%20report%202023%20FINAL.pdf
5. Kentucky Cabinet for Health and Family Services. Good Samaritan Law. https://www.chfs.ky.gov/agencies/dph/dpqi/cdpb/Documents/KYGoodSamLaw.pdf
6. 23RS HB 331. https://apps.legislature.ky.gov/record/23rs/hb331.html
7. Opioid Settlement - Kentucky Attorney General. https://www.ag.ky.gov/Priorities/Tackling-the-Drug-Epidemic/Pages/Opioid-Settlement.aspx
8. STOP THE BLEED® Grant Program – Stop the Bleed Project. https://stopthebleedproject.org/stop-the-bleed-grant-program/

2024-37

RESOLUTION

Subject: Raising Awareness of High-Dose Biotin Interference with Lab Results

Submitted by: Onajia Stubblefield, MS and Sarah Taheri, MS (Medical Student Section)

Referred to: Reference Committee

WHEREAS, the use of over-the-counter biotin supplements for hair and nail growth has increased immensely in recent years[1]; and

WHEREAS, the Food and Nutrition Board of the Institute of Medicine has recommended 30 micrograms per day of biotin and current ranges of the some of the most popular brands have dosages ranging from 2500 micrograms to 10000 micrograms[1]; and

WHEREAS, several studies have demonstrated that biotin can interfere with several routine laboratory tests, including thyroid panels and troponins, leading to misdiagnosis and even death[2-14]; and

WHEREAS, the American Medical Association has adopted policy to raise awareness among patients and physicians of potential lab test interference resulting from biotin megadoses[13]; now, therefore, be it

RESOLVED, that KMA advises physicians to educate patients who use biotin supplements about the potential for lab test interferences and recommend practical strategies to reduce biotin intake to recommended levels, such as dividing the tablets; and be it further

RESOLVED, that KMA advises physicians to recommend patients abstain from biotin supplements prior to a planned blood test that could be affected by biotin when possible.

References:

1. John, Jason J., and Shari R. Lipner. "Consumer perception of biotin supplementation." *Journal of cutaneous medicine and surgery* 23.6 (2019): 613-616.
2. Elston, Marianne S., et al. "Factitious Graves' disease due to biotin immunoassay interference—a case and review of the literature." *The Journal of Clinical Endocrinology & Metabolism* 101.9 (2016): 3251-3255.
3. Piketty, Marie-Liesse, et al. "High-dose biotin therapy leading to false biochemical endocrine profiles: validation of a simple method to overcome biotin interference." *Clinical Chemistry and Laboratory Medicine (CCLM)* 55.6 (2017): 817-825.
4. Barbesino, Giuseppe. "Misdiagnosis of Graves' disease with apparent severe hyperthyroidism in a patient taking biotin megadoses." *Thyroid* 26.6 (2016): 860-863.
5. Wijeratne, Nilika G., James CG Doery, and Zhong X. Lu. "Positive and negative interference in immunoassays following biotin ingestion: a pharmacokinetic study." *Pathology-Journal of the RCPA* 44.7 (2012): 674-675.
6. Li, Danni, et al. "Association of biotin ingestion with performance of hormone and nonhormone assays in healthy adults." *Jama* 318.12 (2017): 1150-1160.
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9. Henry, J. G., S. Sobki, and N. Arafat. "Interference by biotin therapy on measurement of TSH and FT4 by enzymeimmunoassay on Boehringer Mannheim ES700 analyser." *Annals of clinical biochemistry* 33.2 (1996): 162-163.
10. Trambas, Christina, et al. "Characterization of the scope and magnitude of biotin interference in susceptible Roche Elecsys competitive and sandwich immunoassays." *Annals of clinical biochemistry* 55.2 (2018): 205-215.
11. Willeman, Théo, et al. "Evaluation of biotin interference on immunoassays: new data for troponin I, digoxin, NT-Pro-BNP, and progesterone." *Clinical Chemistry and Laboratory Medicine (CCLM)* 55.10 (2017): e226-e229.
12. Katzman, Brooke M., et al. "Prevalence of biotin supplement usage in outpatients and plasma biotin concentrations in patients presenting to the emergency department." *Clinical biochemistry* 60 (2018): 11-16.
13. Holmes, Earle W., et al. "Biotin interference in clinical immunoassays: a cause for concern." *Archives of pathology & laboratory medicine* 141.11 (2017): 1459-1460.
14. Ziegler, Rolf, Diane L. Engler, and Norman T. Davis. "Biotin-containing proteins of the insect nervous system, a potential source of interference with immunocytochemical localization procedures." *Insect biochemistry and molecular biology* 25.5 (1995): 569-574.
15. "AMA Adopts New Public Health Policies to Improve Health of Nation." *American Medical Association*, 12 June 2024, www.ama-assn.org/press-center/press-releases/ama-adopts-new-public-health-policies-improve-health-nation-7#:~:text=To%20help%20raise%20awareness%20among,possibility%20of%20lab%20test%20interference.

2024-38

RESOLUTION

Subject: Patient Education of Skin-Applied Insect Repellent and Permethrin Treated Clothing for Prevention of Insect Bites and Vector-Borne Diseases

Submitted by: Sarah Taheri, MS and Onajia Stubblefield, MS (Medical Student Section)

Referred to: Reference Committee

WHEREAS, there are several dangerous tick-borne diseases present in the state of Kentucky including Alpha-Gal Syndrome, Anaplasmosis, Ehrlichiosis, Lyme Disease, and Rocky Mountain Spotted Fever[1]; and

WHEREAS, there are over 50 species of mosquito in Kentucky including species that are capable of transmitting West Nile virus, dengue, yellow fever, La Crosse encephalitis, eastern equine encephalitis, and Zika virus to humans[2]; and

WHEREAS, vector-borne diseases (VBDs) increasingly threaten the health and well-being of people in the United States, with reported cases doubling over the last two decades[3]; and

WHEREAS, the following are active ingredients found in EPA registered skin-applied insect repellents that have been evaluated and approved for safety and effectiveness: DEET, picaridin, IR3535, oil of lemon eucalyptus (OLE), catnip oil, oil of citronella, para-menthane-diol (PMD), or 2-undecanone[4, 5]; and

WHEREAS, the EPA has determined Permethrin factory-treated clothing to be safe and effective in repelling target pests including mosquitoes and ticks[6]; and

WHEREAS, when used consistently and correctly, personal protective measures, like using EPA-registered insect repellents, are effective for preventing mosquito and tick bites. However, most people do not take these precautions[7]; now, therefore, be it

RESOLVED, that KMA encourages physicians to recommend patients apply EPA registered insect repellent to their skin or wear Permethrin treated clothing during outdoor activities at their annual health or preventative care visits.

References:

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2. https://www.uky.edu/Ag/Entomology/PSEP/cat8mosquito.html
3. The U.S. Department of Health and Human Services and the U.S. Centers for Disease Control and Prevention. The National Public Health Strategy to Prevent and Control Vector-Borne Diseases in People. U.S. DHHS, CDC; 2024
4. https://www.epa.gov/insect-repellents/skin-applied-repellent-ingredients
5. https://www.epa.gov/insect-repellents/regulation-skin-applied-repellents
6. https://www.epa.gov/insect-repellents/repellent-treated-clothing
7. Gibney KB, Colborn J, Baty S, Bunko Patterson AM, Sylvester T, Briggs G, Stewart T, Levy C, Komatsu K, MacMillan K, Delorey MJ, Mutebi JP, Fischer M, Staples JE. Modifiable risk factors for West Nile virus infection during an outbreak--Arizona, 2010. Am J Trop Med Hyg. 2012 May;86(5):895-901. doi: 10.4269/ajtmh.2012.11-0502. PMID: 22556093; PMCID: PMC3335699.

RESOLUTION

Subject: The Classification of Arab and Middle Eastern North African Patients as White and its Impact on Health Disparities

Submitted by: Mary Wasef (Medical Student Section)

Referred to: Reference Committee

WHEREAS, Arabs in the United States Census are classified as White, health disparities go undocumented in this population[1]; and

WHEREAS, prejudice and discrimination against the Arab community have impacted health outcomes and susceptibility to violence[2]; and

WHEREAS, evidence has linked racism to health disparities in diverse populations[2]; and

WHEREAS, categorizing Arabs, a minority population, as white leads to undocumented health disparities and invisibility in research[1]; and

WHEREAS, Arabs in the United States are typically perceived and treated as though they are non-White due to ethnicity, culture, religion, and immigration status[1]; and

WHEREAS, nearly a quarter of Arabs in the United States live in poverty[1]; and

WHEREAS, 61% of Arabs in the United States speak a language other than English at home[1]; and

WHEREAS, 60% of Arabs reported discrimination at work following the incidence of the 9/11 attack[1]; and

WHEREAS, 40% of Americans reported personal prejudice toward Arabs or Muslims[1]; and

WHEREAS, disease prevalence and barriers to care are unknown in this population due to lack of classification in research[1]; and

WHEREAS, anti-Arab sentiment was correlated to depression and unhappiness, outlining the still unknowns of potential disparities in mental health outcomes[1]; and

WHEREAS, the lack of disaggregation of data between Arabs and Whites creates issues concerning external validity of research data[3]; now, therefore, be it

RESOLVED, that KMA encourages health care providers to create a demographic for Arabs and those of Middle Eastern and North African origin to have their own classification in categorizing race and ethnicity; and be it further

RESOLVED, that KMA recognize Arab and Middle Eastern North African communities as minority populations; and be it further

RESOLVED, that KMA encourage research efforts that consider all minority populations including the Arab community; and be it further

RESOLVED, that the medical community should broaden research efforts to include unknown communities facing similar concerns.

References:

1. Abboud S, Chebli P, Rabelais E. The Contested Whiteness of Arab Identity in the United States: Implications for Health Disparities Research. Am J Public Health. 2019 Nov;109(11):1580-1583. doi: 10.2105/AJPH.2019.305285. Epub 2019 Sep 19. PMID: 31536397; PMCID: PMC6775909.
2. Awad GH, Abuelezam NN, Ajrouch KJ, Stiffler MJ. Lack of Arab or Middle Eastern and North African Health Data Undermines Assessment of Health Disparities. Am J Public Health. 2022 Feb;112(2):209-212. doi: 10.2105/AJPH.2021.306590. PMID: 35080949; PMCID: PMC8802571.
3. Ford CL, Sharif MZ. Arabs, Whiteness, and Health Disparities: The Need for Critical Race Theory and Data. Am J Public Health. 2020 Aug;110(8):e2-e3. doi: 10.2105/AJPH.2020.305749. PMID: 32639902; PMCID: PMC7349458.

2024-40

RESOLUTION

Subject: GLP-1 Agonist Use and Eating Disorders Screening

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, statistics show the highest mortality related to eating disorders in the United States. There are 10,200 deaths annually as a direct result from an eating disorder, which is almost one death every 52 minutes.[1,2] These numbers reflect the seriousness of these disorders; and

WHEREAS, recently there have been increased discussions about glucagon-like peptide-1 receptor agonists (GLP-1As) being used as approved or as off-label treatments for weight loss; and

WHEREAS, at the same time, there are increased concerns about the potential for GLP-1As to impact eating disorder symptomatology; and

WHEREAS, GLP-1 medications are helpful in the treatment of Type 2 diabetes with reduction of cardiovascular mortality. These medications can cause harm for the individuals with eating disorders, disordered eating behaviors, or people with undiagnosed eating disorders when not used for their intended purpose, when they are not adequately monitored or monitored by clinicians without eating disorder expertise, or when used for weight loss motivated by weight stigma in people with eating disorders; and

WHEREAS, even with current limited evidence, it is very possible that the use or discontinuation of GLP-1A could exacerbate or contribute to the development of disordered eating behaviors in the individual with no previous eating disorder history and can negatively impact their treatment; and

WHEREAS, there is limited research about GLP-1's impact on individuals with eating disorders or disordered eating, so it is critical for patients to be informed about and consider some of the unique risks these drugs can pose before making the decision to take them; and

WHEREAS, there is a high risk of misuse of the drug among those with eating disorders and disordered eating, particularly restrictive eating disorders like Anorexia Nervosa, Atypical Anorexia, or those that involve purging like Bulimia. Rapid weight loss and malnourishment can increase the risk of developing refeeding syndrome; and

WHEREAS, GLP-1As use and mindset about quick weight loss will definitely intensify the thin idealization, weight stigma and fat phobia along with disproportionate negative impact on people living in larger bodies[1]; now, therefore, be it

RESOLVED, that KMA will continue to support the education of health care professionals and the public regarding the eating disorders and its stigma; and be it further

RESOLVED, that KMA support the importance of screening with validated tools for eating disorders history, active eating disorders, and/or vulnerability for an eating disorder when prescribing GLP-1As or other weight loss medications; and be it further

RESOLVED, that KMA support the importance of discussing with patients, baseline screening, goals for treatment and to have regular follow-up appointments for medical monitoring and to communicate any changes in eating disorder symptoms.

References

1. www.nationaleatingdisorders.org
2. www.hsph.harvard.edu
3. ANAD.org

2024-41

RESOLUTION

Subject: Breast Cancer Screening and Education to Reduce Male Mortality

Submitted by: Shriya Dodwani, B.A., Colton Connor, B.S., and Quinton Carr, B.A. (Medical Student Section)

Referred to: Reference Committee

WHEREAS, breast cancer occurs in both males and females; and

WHEREAS, breast cancer is a rare, yet more deadly diagnosis in men due to late stage identification[1]; and

WHEREAS, male breast cancer (MBC) has approximately 60% excess mortality rate in comparison to female breast cancer (FBC)[2]; and

WHEREAS, MBC accounts for 1% of all breast cancers worldwide and 1% of cancers found in men[3]; and

WHEREAS, MBC screening and management research is limited due to lack of awareness about symptoms, late stage diagnoses, and poor patient enrollment in randomized studies[2]; and

WHEREAS, Klinefelter syndrome, gynecomastia, family history of breast cancer, older age, elevated levels of estradiol, and BRCA1 or BRCA2 gene mutations are prominent risk factors for MBC[4]; and

WHEREAS, MBC is understudied in the state of Kentucky and not included in the National Cancer Institute's evaluation of state cancer profiles[5], now, therefore, be it

RESOLVED, that KMA supports educating physicians and the public about the prevalence of breast cancer, risks, signs, and symptoms in assigned male at birth (AMAB) patients; and be it further

RESOLVED, that KMA joins the AMA in support of removing barriers to MBC screening by supporting further research on MBC incidence in AMAB patients.

References:

1. Fox S, Speirs V, Shaaban AM. Male breast cancer: an update. *Virchows Arch*. 2022;480(1):85-93. doi:10.1007/s00428-021-03190-7
2. AlFehaid M. Male Breast Cancer (MBC) - A Review. *Pol Przegl Chir*. 2023;95(6):24-30.
3. Gucalp A, Traina TA, Eisner JR, et al. Male breast cancer: a disease distinct from female breast cancer. *Breast Cancer Res Treat*. 2019;173(1):37-48. doi:10.1007/s10549-018-4921-9
4. Khan NAJ, Tirona M. An updated review of epidemiology, risk factors, and management of male breast cancer. *Med Oncol*. 2021;38(4):39. Published 2021 Mar 15. doi:10.1007/s12032-021-01486-x
5. National Cancer Institute. State Cancer Profiles. statecancerprofiles.cancer.gov. https://statecancerprofiles.cancer.gov/quick-profiles/index.php?statename=kentucky

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2024-42

RESOLUTION

Subject: Child Abuse and Neglect as a Public Health Emergency

Submitted by: Michael Kuduk, MD (KMA President) and Maggie Stull (MSS)

Referred to: Reference Committee

WHEREAS, the definition of child abuse and neglect in the state of Kentucky encompasses physical abuse, neglect, sexual abuse/exploitation, emotional abuse, and abandonment[3]; and

WHEREAS, in Kentucky, domestic violence, substance abuse, and inadequate housing were the leading risk factors in cases of child abuse and neglect[5]; and

WHEREAS, the Child Maltreatment report, which is released by the U.S. Department of Health & Human Services Children's Bureau, found Kentucky's rate of child abuse victims was 12.3 per 1,000 children, which is higher than the United States' rate of 7.7 per 1,000 children in 2022[4]; and

WHEREAS, the Child Maltreatment report finds that Kentucky has more than doubled the time it takes for officials to contact a family or child once a report of child abuse is made since 2018, with Kentucky taking 221 hours to respond, compared to the national average of 93 hours[4]; and

WHEREAS, the largest age group of victims of child abuse and neglect were under the age of 1 year old[6]; and

WHEREAS, child abuse and neglect are important components of adverse childhood experiences, which are known to affect adult physical and mental health adversely in a dose-response fashion, including an increased risk for depression, anxiety, and substance use disorder[7];now, therefore, be it

RESOLVED, that KMA recognize child abuse and neglect as a public health emergency in the Commonwealth; and be it further

RESOLVED, that KMA engage in educating providers and the public regarding the long-term negative effects of child abuse and neglect on its victims; and be it further

RESOLVED, that KMA advocate for ways to reduce the burden of child abuse and neglect in the Commonwealth.

References

1. https://nortonchildrens.com/news/kentucky-child-abuse-statistics/
2. Kentucky's child abuse victim rate was about twice as high as the U.S. rate of 8.1 victims and slightly more than Indiana's rate of 13.6 victims (2021). Most child abuse victims in Kentucky, Indiana and the U.S. were younger than age 1.
3. Only five states reported higher child abuse victim rates than Kentucky in 2021: West Virginia Maine, Massachusetts, Iowa and Alaska.
4. https://policysearch.ama-assn.org/policyfinder/detail/child%20abuse%20?uri=%2FAMADoc%2FHOD.xml-0-4659.xml
5. Our American Medical Association recognizes that suspected **child abuse** is being underreported by physicians.
6. https://www.childwelfare.gov/resources/definitions-child-abuse-and-neglect-kentucky/
7. https://nortonchildrens.com/news/kentuckys-rate-of-child-abuse-continues-to-outpace-the-national-average/#:~:text=Kentucky's%20rate%20of%20child%20abuse%20decreased%20in%202022%2C%20but%20the,still%20surpasses%20the%20national%20average.&text=The%20Child%20Maltreatment%202022%20report,was%2012.3%20per%201%2C000%20children.
8. https://kyyouth.org/the-latest-child-maltreatment-report-shows-improvements-but-still-too-many-victims-in-kentucky/
9. https://www.acf.hhs.gov/cb/data-research/child-maltreatment
10. https://link.springer.com/article/10.1007/s10896-012-9474-9

2024-43

RESOLUTION

Subject: KMA Endorsement of Public Cord Blood Banking Options for Kentucky Residents

Submitted by: Lexington Medical Society

Referred to: Reference Committee

WHEREAS, umbilical cord blood contains hematopoietic stem cells which are valuable in the treatment of various life-threatening diseases including leukemia, lymphoma, and certain inherited metabolic and immune system disorders [1,2]; and

WHEREAS, umbilical cord blood is a valuable resource, without public infrastructure for donation it is otherwise disposed of as medical waste after a delivery; and

WHEREAS, public cord blood banks provide a critical resource for patients in need of stem cell transplants, and the establishment of such a bank can significantly increase the availability of matching stem cell donors[3,4]; and

WHEREAS, individuals who need a hematopoetic stem cell transplant would benefit from a public bank since non-autologous, matched donations lack the same genetic phenotypes that rendered the individual vulnerable to the blood born disease requiring a transplant; and

WHEREAS, the Health Resources and Services Administration (HRSA) and other federal agencies offer grants and funding opportunities to support the development and maintenance of public cord blood banks, providing financial assistance to mitigate the costs associated with collection, processing, and storage[1,2]; and

WHEREAS, there are public cord blood banks exist across the country[5], Kentucky currently lacks an infrastructure to donate into these systems, and

WHEREAS, the establishment of a public cord blood bank process in Kentucky would enhance the state's healthcare infrastructure, provide new treatment options for patients, and align with national efforts to expand the inventory of publicly available cord blood units[1,2]; and

WHEREAS, there are private banks, there is currently no public cord blood bank in Kentucky, thereby limiting the state's contribution to the national cord blood inventory and the availability of these life-saving treatments to residents of Kentucky and the broader region[6,7]; and

WHEREAS, public cord blood banking is endorsed by the American Academy of Pediatrics (AAP) and American Medical Association (AMA) and more information can be obtained at https://parentsguidecordblood.org/en/public-banking/united-states; now, therefore, be it

RESOLVED, that KMA endorses the use of public cord blood bank and encourage the Kentucky Hospital Association to develop options for parents who wish to donate cord blood to a public bank.

References

1. https://www.fda.gov/vaccines-blood-biologics/consumers-biologics/cord-blood-banking-information-consumers
2. https://bloodstemcell.hrsa.gov/donor-information/donate-cord-blood/options-umbilical-cord-blood-banking-donation/donating-umbilical-cord-blood-public-bank
3. https://bethematch.org/support-the-cause/donate-cord-blood/cord-blood-faqs/
4. https://www.cordbloodbank.com/the-cord-blood-timeline-tracing-the-history-of-cord-blood-banking/
5. https://www.fda.gov/vaccines-blood-biologics/biologics-establishment-registration/find-blood-establishment
6. https://kidshealth.org/AetnaBetterHealthKentucky/en/parents/cord-blood.html
7. https://nortonhealthcare.com/services-and-conditions/obstetrics-and-gynecology/services/pregnancy/labor-and-delivery/cord-blood-storage/

2024-44

RESOLUTION

Subject: Standardizing Attire in Procedural Clerkship Training to Promote Cultural and Religious Inclusivity for Medical School Students

Submitted by: Nashwa Saleem, Noor Ali, Skyler Palmer, Lindsay Bryant, and Parisa A. Shamaei Zadeh (Medical Student Section)

Referred to: Reference Committee

WHEREAS, medical students with headwear and attire obligations often are unprepared for procedural-based clerkships due to a lack of standardized scrubbing and personal protective equipment (PPE) training with educators that maintains their cultural or religious practices[1]; and

WHEREAS, the current literature shows that head coverings that extend and are pinned to the V-neck region of scrub tops and are covered by orthopedic hoods without their plastic shield can be worn without sacrificing sterility, the safety of the patients, or the safety of providers with proper education[1,3]; and

WHEREAS, Kentucky medical students are from diverse backgrounds and represent the many ethnicities, religions, and cultures of the people of Kentucky[6]; and

WHEREAS, current evidence shows that lack of access to proper headwear and training discourages medical students from pursuing surgical specialties and contributes to structural discrimination in medicine[4,5]; and

WHEREAS, the First Amendment, Civil Rights Act of 1964, and KMA policy support employer accommodations for the practice of religion through headwear and attire to ensure practice settings are inclusive of all physicians and trainees; and

WHEREAS, the American Medical Association has acknowledged that failing to provide policies supporting students with natural hairstyles and cultural headwear is a form of racial, ethnic, or religious discrimination[2]; now, therefore, be it

RESOLVED, that KMA advocate all medical educational institutes in Kentucky to provide adequate personal protective equipment for medical students and residents during clinical rotations; and be it further

RESOLVED, that KMA advocate all medical educational institutions in Kentucky to provide disposable head coverings that comply with religious and cultural practices and sterility.

References:

1. Abdelwahab, R., Aden, A., Bearden, B., Sada, A., & Bostwick, J. M. (2021). Surgical Scrubbing and Attire in the Operating Room and ICU: A Multicultural Guide. *Journal of the American College of Surgeons*, *233*(2), 321–327. https://doi.org/10.1016/j.jamcollsurg.2021.05.005
2. American Medical Association. (2022). Combating Natural Hair and Cultural Headwear Discrimination in Medicine and Medical Professionalism H-65.949. *American Medical Association.* https://policysearch.ama-assn.org/policyfinder/detail/cultural%20headwear?uri=%2FAMADoc%2FHOD.xml-H-65.949.xml
3. Cowperthwaite, L. and Holm, R.L. (2015), Guideline Implementation: Surgical Attire. AORN Journal, 101: 188-197. https://doi.org/10.1016/j.aorn.2014.12.003
4. Khatun, R., Saleh, Z., Adnan, S., Boukerche, F., &Cooper, A. Covered, but Not Sterile: Reflections on Being a Hijabi in Medicine and Surgery. *Annals of Surgery, 273*(3):p e83-e84, March 2021. | DOI: 10.1097/SLA.0000000000004655
5. Malik, A., Qureshi, H., Abdul-Razakq, H., Yaqoob, Z., Javaid, F. Z., Esmail, F., Wiley, E., & Latif, A. (2019). '*I decided not to go into surgery due to dress code*': a cross-sectional study within the UK investigating experiences of female Muslim medical health professionals on bare below the elbows (BBE) policy and wearing headscarves (hijabs) in theatre. *BMJ open*, *9*(3), e019954. https://doi.org/10.1136/bmjopen-2017-019954
6. University of Kentucky College of Medicine. (2024). Diversity Demographics. *University of Kentucky College of Medicine.* https://medicine.uky.edu/sites/diversity/demographics

RELEVANT AMA, AMA-MSS AND POLICY

H-65.944 Providing Culturally and Religiously Sensitive Attire Options at Hospitals for Patients and Employees
Our American Medical Association supports the provision of safe, culturally, and religiously sensitive operating room scrubs and hospital attire options for both patients and employees. [Res. 005, A-23]

H-65.949 Combating Natural Hair and Cultural Headwear Discrimination in Medicine and Medical Professionalism
Our AMA: (1) recognizes that discrimination against natural hair/hairstyles and cultural headwear is a form of racial, ethnic and/or religious discrimination; (2) opposes discrimination against individuals based on their hair or cultural headwear in health care settings; (3) acknowledges the acceptance of natural hair/hairstyles and cultural headwear as crucial to professionalism in the standards for the health care workplace; (4) encourages medical schools, residency and fellowship programs, and medical employers to create policies to oppose discrimination based on hairstyle and cultural headwear in the interview process, medical education, and the workplace; and (5) encourages healthcare institutions to provide adequate protective equipment in accordance with appropriate patient safety for healthcare workers with natural hair/hairstyles or cultural headwear. [Res. 006, A-22]

2024-45

RESOLUTION

Subject: Increase Inclusion Criteria for Colorectal Cancer Screening

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, in 2002 Kentucky had the highest incidence and mortality rates for colorectal cancer (CRC), and at 43.9/100,000 had the 2nd lowest CRC screening rate in the U.S.; and

WHEREAS, in 2002 the Colon Cancer Prevention Project was founded, and in 2008 KRS 214.540-544[1] established The Kentucky Colon Cancer Screening and Prevention Program which combined resulted in an increase in CRC cancer screening to 70.1/100,000 (17th in the U.S.) and a significant decrease in incidence and mortality rate from CRC; and

WHEREAS, as impressive as these gains have been, there has remained a significant number of people who have not been screened because of intermittent incidental complaints, causing a change in coding from screening (no out-of-pocket costs) to diagnostic (out-of-pocket costs); and

WHEREAS, these, out-of-pocket costs are often a sufficient deterrent that someone who otherwise would be a candidate for CRC screening would not proceed with the test; and

WHEREAS, the cost of treatment for CRC can exceed $84,000. These costs can be significantly minimized by interrupting the progression of precancerous conditions to cancer and the detection of early cancers; now, therefore, be it

RESOLVED, that an incidental finding of blood, stool change, or abdominal pain should not result in coding an otherwise screening procedure to a diagnostic procedure; and be it further

RESOLVED, that KMA supports a policy of when incidental colorectal findings are noted, it is appropriate to apply CRC screening codes, and not use the diagnostic code.

Reference

1. KRS 214.540-544 https://apps.legislature.ky.gov/law/statutes/chapter.aspx?id=38211

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