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RESOLUTION NO. S2-201

Incorporating Health Policy Education Into Medical Schools and Residency Programs

Introduced by: Laura Doan, MD, Los Angeles, CA
Jeremy Mosher, Vallejo, CA
Megan Chock, San Diego, CA
Redmond Finney, Baltimore, MD
Abeer Mousa, Tucson, AZ

WHEREAS, Evidence shows that medical students have significant gaps in knowledge concerning the U.S. health-care system, and

WHEREAS, evidence shows that most medical students perceive that these deficiencies are not adequately addressed in the medical school curriculum, and

WHEREAS, 96 percent of surveyed medical students felt that knowledge of health policy is important to their career, and

WHEREAS, there have been several recent calls for increased attention to health policy in medical education, both in the undergraduate and post-graduate education of physicians, and

WHEREAS, the Accreditation Council for Graduate Medical Education (ACGME) endorses "systems-based practice," which requires a broader knowledge of the health-care system, as one of the six general competencies expected of all residents, and

WHEREAS, the Society of General Internal Medicine Task Force for Residency Reform recommended increased training to reduce health disparities, which should include curricular focus to address social and cultural issues of care, health policy, and health economics, and

WHEREAS, there is a growing awareness that doctors need more training in the non-clinical parts of health care, and

WHEREAS, there are several excellent and long-standing health policy courses educating residents on health policy topics applicable to daily physician practices, exposing residents to health policy careers through visits with policy makers and analysts, and promoting personal engagement in health policy, now, therefore, be it

RESOLVED That the American Academy of Family Physicians (AAFP) explore a model two-to-four week or longitudinal health policy curriculum that can be modified by chapters based on local policies, and that medical schools and residency training programs can use to teach students and residents, and be it further

RESOLVED, That the American Academy of Family Physicians (AAFP) ask the Liaison Committee on Medical Education (LCME) and American Osteopathic Association (AOA) Commission on Osteopathic College Accreditation (COCA) to consider using the AAFP's model curriculum as part of their accreditation guidelines for medical schools, and be it further

RESOLVED, That the American Academy of Family Physicians (AAFP) ask the Accreditation Council for Graduate Medical Education (ACGME) to consider using the AAFP’s model curriculum as part of their accreditation guidelines for family medicine residency programs.
RESOLUTION NO. S2-202

Policy Recommendations on Men Who Have Had Sex With Men (MSM) Blood Donation

Introduced by: Diana Huang, Philadelphia, PA
Kyle Gleaves, Scranton, PA
Margot Brown, MD, Scranton, PA
Matt Mullane, MD, Denver, CO

WHEREAS, The American Academy of Family Physicians (AAFP) Commission on Health of the Public and Science has previously agreed that the Food and Drug Administration (FDA) lifetime ban on men who have had sex with men (MSM) discriminated against gay men as potential donors, and

WHEREAS, the AAFP has previously written letters to the FDA encouraging it to repeal the lifetime ban on blood donation by MSM, and

WHEREAS, in December 2015, the FDA overturned its previous policy of lifetime ban for MSM and replaced it with a 12-month deferral period, and

WHEREAS, on July 28, 2016, the FDA opened a request for comments on the Federal Register on “scientific evidence such as data from research regarding potential blood donor deferral policy options to reduce the risk of HIV transmission, including the feasibility of moving from the existing time-based deferrals related to risk behaviors to alternate deferral options, such as the use of individual risk assessments, and

WHEREAS, comments are invited regarding the design of potential studies to evaluate the feasibility and effectiveness of such alternative deferral options,” now, therefore, be it

RESOLVED, That the American Academy of Family Physicians develop policy recommendations for blood donation by men who have had sex with other men (MSM) by studying the risks and benefits of changing the Food and Drug Administration’s current 12-month deferral policy on MSM blood donation and consider potential alternative deferral options, such as the use of individual risk assessments, and be it further

RESOLVED, That the American Academy of Family Physicians advocate for the Food and Drug Administration to adopt blood donation policies that protect the safety of blood donation while avoiding discrimination towards presumed risk groups such as men who have had sex with men.
RESOLUTION NO. S2-203

Importance of Oral Health in Medical Practice

Introduced by: Caroline Yang, Norchester, MA
Allen Rodriguez, Los Angeles, CA
Ben Meyernik, Sioux Falls, SD

WHEREAS, Although oral health is part of general health, medical and dental care have long functioned separately, and

WHEREAS, Healthy People 2020 made oral health one of its top nine health indicators, yet in 2012 (the most recent year recorded), only 42.1% of people age two years and older had a dental visit during the past 12 months, and half of the U.S seniors perceive their dental health as poor or very poor, and

WHEREAS, the high cost and poor coverage of dental services is a large barrier to getting proper oral care, particularly for vulnerable populations including children, the elderly, and the socially and economically disadvantaged, and

WHEREAS, approximately 108 million people in the U.S. (nearly 35% of the population) do not have dental insurance – more than three times the number of Americans who lack medical insurance, and

WHEREAS, although Medicaid provides dental benefits for all children, only 15 state Medicaid programs provide a comprehensive dental benefit for adults, and “routine dental care” is explicitly excluded from Medicare by federal statute, and

WHEREAS, periodontal disease affects 743 million people worldwide, making it the sixth-most common chronic condition, and affects about half of all adults in the United States, and

WHEREAS, bacteria normally found in the mouth can migrate throughout the body and affect other systems, having isolated brain abscesses, placenta, and atherosclerotic plaques in coronary arteries, and

WHEREAS, poor oral health can elevate risks for chronic conditions such as diabetes and heart disease, and can lead to lost workdays, reduced employability, and the preventable use of costly acute care, and

WHEREAS, children with poor oral health status have substantially more school absences and significantly poorer academic performance compared to their peers, independent of socioeconomic factors and race, and

WHEREAS, total spending on dental services reached $113.5 billion in 2014 in the United States, with significant spending on restorative care for oral disease that could have been prevented or diagnosed and treated more expediently, and

WHEREAS, in a national survey of pediatricians, one of the most common barriers to participating in oral health-related activities was lack of training, which was endorsed by 35.4% of respondents, and
WHEREAS, delivering oral health preventative care in the primary care setting offers the opportunity to expand access for nearly all patients, particularly high-risk and vulnerable patients who bear the greatest burden of oral disease, and

WHEREAS, Oral Health in America: A Report of the Surgeon General, published in 2000, called for all healthcare providers to participate in oral healthcare, a call to action reaffirmed by the Institute of Medicine in 2010 and the Health Resources and Services Administration (HRSA) in 2014, and

WHEREAS, HRSA developed the Integration of Oral Health and Primary Care Practice (IOHPCP) initiative aimed at expanding oral health clinical competency of primary care clinicians to improve early detection and preventive interventions of oral conditions, ultimately leading to improved oral health, and

WHEREAS, in 2014, the American Academy of Family Physicians, the American Academy of Pediatrics, and the American Academy of Pediatric Dentistry released a report entitled “Interprofessional Study of Oral Health in Primary Care” with the goal of identifying elements that lead to successful promotion of oral health services in primary care offices, and

WHEREAS, with appropriate training, non-dental healthcare professionals, such as physicians, nurses, pharmacists, and physicians assistants, can screen for oral diseases and deliver preventive care services, and

WHEREAS, it is critical for primary care providers to be educated on common oral conditions, risk factors, and health behaviors along with the medical, functional, emotional, and social consequences of poor oral health, now, therefore, be it

RESOLVED, That the American Academy of Family Physicians recognize the importance of managing oral health as part of overall patient care, and be it further

RESOLVED, That the American Academy of Family Physicians support efforts to educate physicians on oral condition screening and management, as well as the consequences of poor oral hygiene on overall health, and be it further

RESOLVED, That the American Academy of Family Physicians encourage closer collaboration of physicians with dental providers to provide comprehensive medical care, and be it further

RESOLVED, That the American Academy of Family Physicians support efforts to increase access to oral health services.
RESOLUTION NO. S2-204

Investigating Supplemental Nutrition Assistance Program Block Grants

Introduced by:  Kandis Samuale-Leutzinger, New Castle, DE
               Paige Ely, Yakima, WA

WHEREAS, Children and adolescents who eat a healthful diet are more likely to reach and maintain a healthy weight, achieve normal growth and development, and have strong immune systems, and

WHEREAS, adults who eat a healthful diet and stay physically active can decrease their risk of a number of adult-onset health conditions and diseases, including heart disease and diabetes, and

WHEREAS, the Supplemental Nutrition Assistance Program (SNAP) is the largest program in the domestic hunger safety net that offers nutrition assistance to millions of eligible, low-income individuals and families, and

WHEREAS, the SNAP program is administered by the state which has considerable discretion to adapt the program, and

WHEREAS, in 2015 SNAP provided $4.23 per person per day, and

WHEREAS, under a block grant, some states facing large budget shortfalls may shift funds from food assistance to other programs including non-food components such as job training and related childcare, now, therefore, be it

RESOLVED, That the American Academy of Family Physicians research the effects of block grants on patient health, and be it further

RESOLVED, That the American Academy of Family Physicians oppose the implementation of the Supplemental Nutrition Assistance Program (SNAP) becoming funded through block grants if it decreases funding to the program.
RESOLUTION NO. S2-205

Increase in Supplemental Nutrition Assistance Program (SNAP) Funding

Introduced by: Paige Ely, Yakima, WA
Kandis Samuels-Leutzinger, New Castle DE

WHEREAS, One in five children in the United States lives in a household that worries where their next meal will come from, and
WHEREAS, the Supplemental Nutrition Assistance Program (SNAP) provides nutrition assistance to low-income families so that children can have proper nutrition to have adequate health and succeed in school, and
WHEREAS, SNAP funding has been cut the last three years, and
WHEREAS, millions of low-income families who are struggling to put food on the table are ineligible for SNAP, and
WHEREAS, of those who receive SNAP, the average amount of nutrition assistance is now only $4.23 per person per day, or $1.41 per person per meal, and
WHEREAS, SNAP funding is projected to continue to decrease in coming years, now, therefore, be it
RESOLVED, That the American Academy of Family Physicians lobby to maintain current Supplemental Nutrition Assistance Program funding, and be it further
RESOLVED, That the American Academy of Family Physicians lobby to increase future Supplemental Nutrition Assistance Program funding.
RESOLUTION NO. S2-206

Climate Change Policy Adjustments

Introduced by: Stewart Decker, MD, Klamath Falls, OR
Redmond Finney, Baltimore, MD

WHEREAS, The 2015 American Academy of Family Physicians (AAFP) Congress of Delegates reaffirmed the 1969 policy, “On Climate Change and Air Pollution,” stating “In recognition of the numerous and serious adverse health consequences resulting from pollution, climate change, and ozone-layer depletion, the AAFP recommends strong action on all public and private levels to limit and correct the pollution of our land, atmosphere and water,” and

WHEREAS, greenhouse gas emissions from human activities are generally recognized as the primary causative factor in modern climate change, and

WHEREAS, it is important for a medical organization such as the AAFP to specifically identify causative factors in order to better focus intervention, and

WHEREAS, the controversy surrounding greenhouse emissions from human activities is political and economic rather than scientific, and

WHEREAS, the AAFP ought to base policy on sound science and resist scientific misinformation that has a direct effect on the health of our population, now, therefore, be it

RESOLVED, That the American Academy of Family Physicians (AAFP) update their climate change and air pollution policy to specifically include language about “greenhouse emissions from human activities,” i.e. “In recognition of the numerous and serious health consequences resulting from pollution, greenhouse emissions from human activities, climate change, and ozone layer depletion, the American Academy of Family Physicians (AAFP) recommends strong action on all public and private levels to limit and correct the pollution of our land, atmosphere and water.”
RESOLUTION NO. S2-207

Physician Suicide Prevention

Introduced by: Joseph Brodine, Washington, DC
Kristina Dakis, MD, Chicago, IL
Mary Warren, Washington, DC
Emily Graber, Chicago, IL

WHEREAS, Physicians are two-three times more likely to commit suicide compared to the general U. S. population, and

WHEREAS, 10 percent of medical students and residents have experienced suicidal ideation in the last year, and

WHEREAS, physicians need to care for themselves in order to be fit to care of patient, now, therefore, be it

RESOLVED, That the American Academy of Family Physicians create an evidence-based online toolkit for medical students, residents, and practicing physicians for suicide prevention.
Resolution NO. S2-208

A Shot in the Dark: The Lack of Gun Violence Research is a Public Health Issue

Introduced by: Meray Ohanassian, Gainsville, FL
               Ashlin Mountjoy, MD, Seattle, WA
               Alexander Langley, MD, Seattle, WA

WHEREAS, Gun violence accounts for 33,000 deaths and 76,000 non-fatal gun injuries each year in the United States, and

WHEREAS, the United States has a homicide rate from gun violence that is 25.2 times greater than other high-income developed countries, and

WHEREAS, there remains a ban on research determining the cause of this disparity, and

WHEREAS, Japan, Germany, Australia, and the United Kingdom have developed stricter gun laws and decreased the homicide rates due to gun violence, and

WHEREAS, the United States has no evidence that previously implemented gun control policies have had a similar effect, and

WHEREAS, public health research into motor vehicle accidents and tobacco use has guided evidence-based interventions and policies to reduce the disease burden from these issues, and

WHEREAS, gun violence continues to be a key political issue with significant uncertainty regarding the best solutions, and

WHEREAS, the American Academy of Family Physicians (AAFP) has policies on the prevention of gun violence, violence as a public health concern, and firearms and safety issues, and

WHEREAS, the AAFP has partnered with other organizations to author a letter to US Representatives and Senators requesting removal of restrictions on gun violence research by the Centers for Disease Control and Prevention, and

WHEREAS, there has still not been action on this issue by the US Congress, now, therefore, be it

RESOLVED, That the American Academy of Family Physicians continue to partner with other health organizations and the Fam Med PAC to actively lobby for the removal of restrictions on gun violence research.
RESOLUTION NO. S2-209

Supporting Common Sense Gun Legislation

Introduced by: Stewart Decker, MD, Klamath Falls, OR
Redmond Finney, Baltimore, MD
Maya Siegel, Baltimore, MD

WHEREAS, There were 33,636 gun deaths in the United States in 2013, which is a representative number over the last decade, and

WHEREAS, 62 percent of these deaths were completed suicides, 36 percent were homicides, and 2 percent were accidental deaths, and

WHEREAS, only 5.6 percent of all suicide attempts are with firearm, but 51-55 percent of completed suicides are with firearm, meaning that suicide attempts by firearm are 85 percent fatal, and

WHEREAS, firearms were used in 69.9 percent of all homicides in 2012, again a representative number, and

WHEREAS, if a person’s preferred suicide method is unavailable, it is unlikely they will switch to a different one, and

WHEREAS, in the first week after the purchase of a handgun, the rate of suicide by means of firearms among purchasers was 57 times higher than the general population, and

WHEREAS, in the 11 states that have “waiting periods” there is a lower overall suicide rate (P=.001), a lower firearms suicide rate (P<.001), and a lower proportion of suicide deaths resulting from firearms, and

WHEREAS, in the year immediately following the repeat of their 48-hour waiting period law, South Dakota saw a 7.6-percent increase in its overall suicide rate compared with 3.3 percent for the United States in general, and

WHEREAS, in the year following implementation of a law that extended the waiting period for acquiring a handgun, Washington, DC, saw a 2.2-percent decrease in their overall suicide rate compared with a 2.1-percent increase in the United States overall, and

WHEREAS, states with laws that required background checks at the point of transfer or before obtaining a permit to purchase a handgun from a private seller exhibited a lower overall suicide rate (P<.001), a lower firearms suicide rate (P<.001), and a lower proportion of suicide deaths resulting from firearms (36.8 percent vs. 58.8 percent, P<.001), and

WHEREAS, when threatening intimate partners, gun owners are 7.8 times more likely to threaten their partners with a gun than non-gun owners, and

WHEREAS, family and intimate partner assaults with firearms are 12 more times likely to result in death than non-firearm assaults, and
WHEREAS, the American Academy of Family Physicians (AAFP) currently “supports increased
research,” “supports strong and robust enforcement of existing federal, state, and local laws and
regulations regarding the manufacture, sale and possession of funds,” “supports legislation
restricting unsupervised access to both firearms and ammunition by children,” and “opposes
private ownership of weapons designed primarily to fire multiple (greater than 10) rounds
quickly,” and
WHEREAS, the AAFP has also stated that the “background-check requirement should be
expanded to include the sale of firearms at gun shows, over the Internet and in classified ads,
and has “call(ed) for ‘an elimination of the ban on federal funding for objective, scientific
research on gun violence,’” and
WHEREAS, the AAFP has been uncharacteristically silent on gun control interventions such as
waiting periods and laws about removing guns from homes with domestic violence claims, now,
therefore, be it
RESOLVED, That the American Academy of Family Physicians (AAFP) support gun laws that
demonstrably decrease morbidity and mortality associated with gun violence in any of its forms,
including but not limited to a receipt of a gun-waiting period and allowance for removal of guns
from houses during domestic violence complaints.
RESOLUTION NO. S2-210

Improving Mental Health Care in the Primary Care Setting

Introduced by: Sway Wu, MD, Detroit, MI
Katie Zurek, MD, Traverse City, MI
Michael Collins, MD, Flint, MI
Max Weston, MD, Seattle, WA

WHEREAS, 43.8 million (about 20%) of adults in the United States experiences mental illness in any given year, and

WHEREAS, only half of the patients with a mental health disorder are diagnosed, and

WHEREAS, only half of diagnosed patients are effectively treated, and

WHEREAS, access to mental health care is of significant national public health concern, now, therefore, be it

RESOLVED, That the American Academy of Family Physicians provide a liaison to the American Psychiatric Association to facilitate cohesion between mental health and family medicine patient care, and be it further

RESOLVED, That the American Academy of Family Physicians website provide links to the American Psychiatric Association for physician use in identifying mental health disorders, and be it further

RESOLVED, That the American Academy of Family Physicians provide continuing medical education at such events as Family Medicine Experience and the National Conference of Family Medicine Residents and Medical Students to improve physician diagnosis of mental health disorders.
RESOLUTION NO. S2-211

No Child “Lead” Behind – Improving Awareness, Detection and Prevention of Lead Contamination

Introduced by: Allen Rodriguez, Los Angeles, CA
               Michael Collins, MD, Grand Blanc, MI
               Ben Meyernik, Sioux Falls, SD

WHEREAS, No safe level of lead for human consumption has ever been determined, and
WHEREAS, lead poisoning has severe adverse health effects for children and adults, including impaired cognitive and behavioral development, hypertension, cardiovascular disease, toxicity to the reproductive organs, miscarriages and birth complications, kidney damage, and cancer, and
WHEREAS, the present value of economic losses associated with early exposure to lead, including increased rates of criminality, drug abuse, incarceration, lower wages, diminished lifetime earning power, and the burden of chronic diseases, is estimated at $43.4 billion annually, and
WHEREAS, the Centers for Disease Control and Prevention (CDC) recognizes that reducing water lead levels is an important step to primary prevention of lead exposure and elevated blood lead levels in children, and
WHEREAS, the 1974 Safe Drinking Water Act authorizes the Environmental Protection Agency (EPA) to establish minimum treatment and testing standards to protect tap water, require all owners or operators of public water systems to comply with health-related standards, and grant primary enforcement responsibility to states to implement safe drinking water standards on behalf of the EPA, and
WHEREAS, public water systems are responsible for collective drinking water samples, sending samples for analysis by laboratories certified by the state or EPA, and reporting water quality parameters, including lead and copper levels, to the state, and
WHEREAS, states and the EPA are jointly responsible for working with public water systems to take steps to prevent or remove contaminants and notify consumers when water-testing results indicate that a contaminant exceeds federal standards under the Safe Drinking Water Act, and
WHEREAS, EPA water testing requirements set by the 2005 Lead and Copper Rule specify lead levels must be tested in one liter of first-draw water taken after the water has been standing in the pipes for at least six hours, and
WHEREAS, public water systems across the Eastern U.S. have adopted methods, including pre-flushing taps before gathering testing samples, in order to lower the amount of lead detected in water contaminant tests, and
WHEREAS, public officials at the state and municipal level have 1) failed to adequately test for lead in water, 2) failed to mitigate lead contamination in water despite knowledge of exposure, and 3) failed to mitigate lead contamination in water to the public (e.g. Flint, MI and Newark, NJ
where health departments were aware of dangerous levels of contamination for months before taking action), and

WHEREAS, an Associated Press analysis of EPA data found that nearly 1,400 water systems serving 3.6 million Americans exceeded the federal lead limit of 15 parts per billion at least once between January 1, 2013 and September 30, 2015, including both public and private water systems in 41 states, and

WHEREAS, a Today analysis of EPA data showed 350 schools and child care facilities exceeded the federal lead limit a total of 470 times from 2012 to 2015, and

WHEREAS, 90,000 public schools and 500,000 child care facilities are not regulated under the Safe Drinking Water Act because they rely on municipal water utilities instead of maintaining their own water supplies and are, therefore, not required to test drinking water quality, and

WHEREAS, lead is the most prevalent toxicant in U.S. school drinking water, and

WHEREAS, children in low-income families tend to reside in older houses, which are more likely to contain lead pipes, and experience a significantly greater burden of lead poisoning than their peers, and

WHEREAS, it is difficult to fully assess the effect of water lead levels on blood lead levels of children and other at-risk populations, as current water sampling protocols were designed to assess water treatment, not the level of human exposure to lead, now, therefore, be it

RESOLVED, That the American Academy of Family Physicians support future research collaborations with other epidemiological and public health organizations regarding water sampling techniques and reporting protocols to better detect and how to reduce human exposure to lead at the point of consumption, and be it further

RESOLVED, That the American Academy of Family Physicians support innovative testing practices for water utilities and at risk populations, such as schools and child care facilities, to accurately measure and reflect lead contamination levels in water, incorporating Environmental Protection Agency testing guidelines, and be it further

RESOLVED, That the American Academy of Family Physicians support improved open public access to testing data on water lead levels by requiring all public water system testing results be posted on a publicly available website in an appropriate and timely fashion, and be it further

RESOLVED, That the American Academy of Family Physicians support federal legislation to reduce, and ultimately, remove lead from the country’s public and private water infrastructure, especially focusing on low-income areas, which have the highest burden of lead poisoning, and be it further

RESOLVED, That the American Academy of Family Physicians support efforts by the Environmental Protection Agency (EPA) to examine compliance with the Safe Drinking Water Act for appropriate water utilities and to exercise the EPA’s oversight and enforcement authority to ensure public protection from lead contamination, and be it further

RESOLVED, That the American Academy of Family Physicians support research and collaboration with the Environmental Protection Agency (EPA) and other public health
stakeholders into the development of a standardized national reporting procedure for blood levels of toxic metals.
RESOLUTION NO. S2-212

Climate Change Advocacy

Introduced by: Stewart Decker, MD, Klamath Falls, OR
               Redmond Finnery, Baltimore, MD
               Maya Siegel, Baltimore, MD

WHEREAS, The health implications of climate change have a profound direct and indirect effect on the health of our patients, and

WHEREAS, the Lancet Commission on Climate Change and Health states that “..tackling climate change could be the greatest global health opportunity of the 21st century” and “(t)he effects of climate change are being felt today, and future projections represent an unacceptably high and potentially catastrophic risk to human health;”, and

WHEREAS, the World Health Organization estimates that between 2030 and 2050 climate change is expected to cause approximately 250,000 additional deaths per year, from malnutrition, malaria, diarrhea, and heat stress, and

WHEREAS, direct damage costs to health is estimated to be between U.S. $2-4 billion/year by 2030, and

WHEREAS, the 2015 United Nations Framework Convention on Climate Change (UNFCCC) Conference of Parties 21 (COP21) resulted in the Paris Agreement, in which government agreed to:

1. “aim to limit [global average temperature] increase(s) to 1.5C, since this would significantly reduce risks and the impacts of climate change;”
2. Peak global emissions as soon as possible,
3. Utilize the best current science utilizing carbon sinks to decrease net emission reduction,
4. Utilize systems of accountability and transparency to assure goals are met,
5. Support climate action in developing countries, and

WHEREAS, the agreement will open for ratification between April 2016-2017 and will only become binding if 55 countries that produce at least 55% of the world’s greenhouse gas emissions ratify the agreement, and

WHEREAS, the United States was the second largest producer of greenhouse gasses in 2010, responsible for 15.6% of global production, and

WHEREAS, the Paris Agreement utilizes Nationally Determined Contributions (NDCs) to quantify and make binding an individual country’s emission reduction targets but does not detail how to do so, and

WHEREAS, the United States’ NDC is to achieve an economy-wide reduction of its greenhouse gas emissions by 26-28% below its 2005 level in 2025, and

WHEREAS, health professionals have an obligation to advocate for efforts to improve the health of our patients, now, therefore, be it
RESOLVED, That the American Academy of Family Physicians endorse U.S. efforts to develop and implement national policies that facilitate U.S. compliance with the 2015 United Nations Framework Convention on Climate Change international agreement reached by over 190 countries in Paris, and be it further.

RESOLVED, That the American Academy of Family Physicians recommend to medical schools, National Board of Medical Examiners (NBME), the Liaison Committee on Medical Education (LCME), the Accreditation Council for Graduate Medical Education (ACGME), and the American Board of Family Medicine that medical education curricula, core competencies and/or milestones should include the effects of climate change on human health, including on the social determinants of health, and be it further.

RESOLVED, That the American Academy of Family Physicians support local and national climate change mitigation and adaptation strategies which seek to realize the United States' Nationally Determined Contribution by (1) endorsing state and federal legislation and regulations to curb greenhouse gas emissions and (2) collaborating with other health professional and environmental organizations to promote ambitious national and international action on climate change, and be it further.

RESOLVED, That the American Academy of Family Physicians provide education to its members on methods for achieving environmental sustainability of medical workplaces (e.g. reducing energy use, increasing energy efficiency, etc.), and be it further.

RESOLVED, That the American Academy of Family Physicians express to appropriate entities in writing its support for the prioritization of epidemiological, translational, clinical and basic science research necessary for evidence-based global climate change policy decisions related to health care and treatment.
RESOLUTION NO. S2-213

Against Public Funding of Crisis Pregnancy Centers

Introduced by: Maya Siegel, Baltimore, MD
               Naomi Gorfinkle, Baltimore, MD
               Redmond Finney, Baltimore, MD
               Stewart Decker, MD, Klamath Falls, OR

WHEREAS, The importance of the patient-physician relationship is integral to patient health, trust of physicians, and the health care system as a whole, and
WHEREAS, “crisis pregnancy centers” often masquerade as women’s health clinics, misleading women in relation to their reproductive health, while often not having a physician or nurse on staff, and
WHEREAS, many of these centers choose names similar to women’s health clinics to confuse patients, and
WHEREAS, these centers often try to frighten patients with misleading films or pictures to influence women seeking abortion care against obtaining an abortion, and
WHEREAS, these centers are known to give incomplete or misleading information about pregnancy options including abortion, adoption, and parenting, and
WHEREAS, many states have introduced legislation that would require women to attend these centers prior to obtaining an abortion, and
WHEREAS, these centers have been known to misinform women of their pregnancy status and dating thereby leading women to think they are earlier along in their pregnancy, and
WHEREAS, these efforts to misinform can divert women from accessing comprehensive and timely care from appropriately trained and licensed medical providers, and
WHEREAS, the American Academy of Family Physicians policy states that “the woman considering an elective abortion should be informed adequately of the potential health risks of both abortion and continued pregnancy”, and
WHEREAS, women who go to one of these centers often feel mislead and may lose trust in medical providers as a whole, and
WHEREAS, 12 states provide public funding to these centers, and
WHEREAS, 20 states refer women to crisis pregnancy centers or compel physicians to provide a list of these centers to patients, and
WHEREAS, the public funding of these centers indicates a public support of these institutions,
now, therefore, be it
RESOLVED, That the American Academy of Family Physicians oppose funding of “crisis pregnancy centers” at the national level and other organizations that mislead patients to further
a political or religious agenda, or to delay them from getting adequate reproductive care, and be
it further
RESOLVED, That the American Academy of Family Physicians oppose legislation that requires
women to attend crisis pregnancy centers prior to obtaining an abortion or requires physicians
to provide information about crisis pregnancy centers.
RESOLUTION NO. S2-214

Ending Direct Consumer Advertising

Introduced by: Stewart Decker, MD, Klamath Falls, OR
Redmond Finny, Baltimore, MD

WHEREAS, The United States (U.S.) and New Zealand are the only two countries in the world that allow direct-to-consumer advertising (DTCA) of prescription drugs, and

WHEREAS, DTCA spending in the U.S. was $4.23 billion in 2014, up from 18% from $3.83 billion in 2013, and

WHEREAS, drug spending increased 86% between 1997 and 2001, up about 18% from $3.83 billion in 2013, and

WHEREAS, increases in DTCA between 1999 and 2000 accounted for 12% of drug sales growth during that period, resulting in an additional $2.6 billion in drug spending in 2000, and

WHEREAS, physicians wrote 34.2% more prescriptions in 1999 than in 1998 for the 25 most DTCA – promoted drugs, and

WHEREAS, physicians wrote only 5.1% more prescriptions for all other prescription drugs, and

WHEREAS, the Food and Drug Administration (FDA) is charged with regulation of the accuracy, honesty, and legality of DTCA but is increasingly unable to do so efficiently due to underfunding despite expansion of responsibilities, resulting in a decreased number of regulatory letters and delay in receipt of them (the FDA sees the ads after they air, when the public does), and

WHEREAS, 78% of physicians believe their patients understand the possible benefits of advertised drugs very well or somewhat well but only 40% believe their patients understand the possible risks, and

WHEREAS, 65% of physicians believe DTC ads confuse patients about the relative risks and benefits of prescription drugs, and

WHEREAS, 75% of physicians believed that DTC ad cause patients to think that the drug works better than it does, and

WHEREAS, 58% of physicians agreed strongly that DTC ads make the drugs seem better than they really are, and

WHEREAS, the success or failure of a pharmaceutical should depend on its safety and efficacy rather than the skill of its marketing team, and

WHEREAS, the American television viewer watches as many as nine drug ads a day, totaling 16 hours per year, which far exceeds the amount of time the average individual spends with a primary care physician, and

WHEREAS, in November 2015 the American Medical Association called for “Ban on Direct to Consumer Advertising of Prescription Drugs and Medical Devices” by convening a physician
task force and launching an advocacy campaign to promote prescription drug affordability
through pushes for greater transparency from drug makers in how they price their medicines,
and
WHEREAS, The American Academy of Family Physicians (AAFP) policy on DTCA currently
states “The AAFP supports efforts by manufacturers of prescription pharmaceuticals,
nonprescription medications, health care devices and health related products and services to
provide general health information to the public. At the same time, the AAFP urges that any
direct-to-consumer advertising of prescription drugs by pharmaceutical companies be based on
disease state only, without mention of a specific drug by name,” and includes a list of conditions
that must be met to maintain acceptability, now, therefore, be it
RESOLVED, The American Academy of Family Physicians change its policy to support a ban
on and/or limitations on direct-to-consumer advertising of prescription drugs and medical
devices, and be it further
RESOLVED, That the American Academy of Family Physicians reach out to the American
Medical Association to coordinate on efforts to advocate in support of a ban on and/or limitation
on direct to consumer advertising.
Resolution NO. S2-215

Improving Medical Care in Immigrant Detention

Introduced by: Sean McClellan, Chicago, IL  
Lauren Williams, MD, Minneapolis, MN

WHEREAS, Resolution No. 410 “Addressing Immigrant Discrimination and Health Disparities” adopted at the 2014 Congress of Delegates resolved “That the American Academy of Family Physicians support policies to reduce health disparities borne by immigrants, refugees or asylees,” and

WHEREAS, the United States has the capacity to hold more than 34,000 non-citizens a night in civil detention, and

WHEREAS, studies by Human Rights Watch and other independent organizations have demonstrated that medical care in immigrant detention centers is substandard, and

WHEREAS, medical neglect has led to at least 7 of 18 deaths reviewed by medical experts between 2013 and 2015, now, therefore, be it

RESOLVED, That the American Academy of Family Physicians advocate through appropriate channels for detained immigrants to receive healthcare to meet or exceed Commission on Correctional Health Care standards for prison and jail healthcare, and be it further

RESOLVED, That the American Academy of Family Physicians advocate through appropriate channels to reduce immigrant detention by releasing people with serious medical and mental health needs, particularly when individuals require higher-level care, and be it further

RESOLVED, That the American Academy of Family Physicians advocate channels to shift current funding for detention to community based alternatives which will allow people to seek medical attention and receive support from family, legal counsel and community, and be it further

RESOLVED, That the American Academy of Family Physicians advocate to remove supervision of medical care in immigrant detention centers from Immigration and Customs Enforcement to maintain clinical independence, and be it further

RESOLVED, That the American Academy of Family Physicians advocate to ensure that inspections of medical care at immigrant detention centers provide meaningful oversight.
RESOLUTION NO. S2-216

Improving Anal Cancer Care

Introduced by: William Guerin, Lebanon, NH
Pie Pichetsurnthorn, Wichita, KS
Jerry Abraham, MD, Los Angeles, CA
Matt Mullane, MD, Denver, CO

WHEREAS, Anal cancer is a preventable, treatable, deadly disease with a rising rate of incidence and mortality, and

WHEREAS, the United States Preventive Services Task Force, American Cancer Society, Centers for Disease Control and Prevention, and the Infectious Society of America make no recommendations regarding screening for anal care, and

WHEREAS, the American Academy of Family Physicians is uniquely positioned to serve the needs of members of high-risk communities like people living with human immunodeficiency virus/acquired immunodeficiency syndrome, men who have sex with men, and people with a history of anoreceptive intercourse, now, therefore, be it

RESOLVED, That the American Academy of Family Physicians educate its members about anal cancer and the risks and benefits of screening, diagnosis, and treatment, and be it further

RESOLVED, That the American Academy of Family Physicians develop clinical practice guidelines for family physicians in the screening, diagnosis, and treatment of anal cancer.
RESOLUTION NO. S2-217

Revisiting the Creation of an Electronic Health Record by the American Academy of Family Physicians

Introduced by:  Daniel E. Edmondson, Reno, NV
          Elizabeth P. Pionk, DO, Bay City, MI
          Travis Walker, MD, Reno, NV

WHEREAS, Electronic health records are intended to enhance quality of patient care by reducing medical costs, and
WHEREAS, the efficacy of electronic health records are limited by the availability of these records across many different healthcare systems nationally, and
WHEREAS, current electronic health record system use has been found to be associated with increased physician stress and burnout, as well as decreased physician satisfaction, and
WHEREAS, the American Academy of Family Physicians has in the past considered creating an electronic health record system, now, therefore, be it

RESOLVED, That the American Academy of Family Physicians create their own electronic health record system, particularly developed for family physicians, and be it further

RESOLVED, That the American Academy of Family Physicians develop and publish person centric guidelines of what should be included in an electronic health record.