

**MEMORIAL RESOLUTIONS  
ADOPTED UNANIMOUSLY**

**Richard D. Baltz, MD  
Introduced by Pennsylvania**

Whereas, Richard D. Baltz, MD passed away on Sunday, December 11, 2016 at the age of 83; and

Whereas, Dr. Baltz faithfully served his fellow physician colleagues as President of the Dauphin County Pennsylvania Medical Society for two terms in 1985 and again in 1991, and was the only physician in the history of the Society to do this; and

Whereas, Dr. Baltz was a member of the Pennsylvania Medical Society for 48 years, and also served on its Board of Trustees from October 16, 2005 until October 28, 2012, and participated numerous times as a delegate from the Dauphin County Medical Society to the Pennsylvania Medical Society House of Delegates and as a Delegate to the American Medical Association, helping to shape health policy at both the state and national levels; and

Whereas, Dr. Baltz was also a longstanding member of the American Academy of Pediatrics as well as its Pennsylvania Chapter; and

Whereas, Dr. Baltz's contributions to the health of his community were legion, including service as President of the Harrisburg Hospital Medical Staff, Director of Pediatrics at Polyclinic Hospital, Medical Director of Utilization Review for Harrisburg Hospital, Co-Chair of the Pennsylvania Bar Association/Pennsylvania Medical Society Task Force on Child Abuse and Neglect, consultant to the West Shore School District Nurse Practitioner Program, collaborator in the creation of a Central Pennsylvania clinic dedicated to treatment of persons afflicted with sickle cell disease, member of the Healthy Mothers Healthy Babies Fluoridation Coalition, consultant to the Pennsylvania Department of Public Welfare Bureau of Quality Review, Review Consultant for KePRO, member of the Pennsylvania Chapter American Academy of Pediatrics School Health Committee, and member of the American Academy of Pediatrics Committee on Quality Improvement; and

Whereas, Dr. Baltz honorably served his country as a Captain in the United States Air Force; and

Whereas, Dr. Baltz advanced the science of medicine with peer-reviewed publications by the American Cancer Society and the Journal of Nuclear Medicine; and

Whereas, Dr. Baltz shared his extensive medical wisdom with medical students and residents as Clinical Associate Professor of Pediatrics at Hershey Medical Center; and

Whereas, Dr. Baltz completed his internship and residency in the specialty of pediatrics at Harrisburg Hospital, completed a Fellowship at the Children's Hospital of Philadelphia, and went on to serve countless families in pediatric practice at Baltz and Fromme Pediatric Associates and then Pinnacle Health Children's Health Clinic; and

Whereas, Dr. Baltz is survived by his wife of more than 58 years, Alice (Turner) Baltz; a son, Richard E. Baltz and wife Janice of Burke, VA; a daughter, Karen B. Anderson and husband Dean of Camp Hill; five grandchildren: Matthew R. Baltz, Timothy M. Baltz, Allison M. Baltz, Erik R. Anderson, and Grant R. Anderson; and several nieces and nephews; and

Whereas, Dr. Baltz will long be remembered as a role model by his colleagues for his professional excellence, multiple medical accomplishments, superb teaching skills, extensive community service, and remarkable bonhomie; be it therefore

RESOLVED, That our American Medical Association (AMA) House of Delegates observe a moment of silence, recognizing our appreciation for Dr. Baltz's many years of service to the medical community, his patients, and our county and state societies; and be it further

RESOLVED, That Dr. Baltz's memorial resolution be recorded in the minutes of the 2017 Interim Meeting of the AMA House of Delegates and a copy sent to his family, the Pennsylvania Medical Society and the Dauphin County Pennsylvania Medical Society.

**Donald C. Jones**  
**Introduced by the American Association of Clinical Endocrinologists**

Whereas, Donald Chapman Jones passed away peacefully on July 22, 2017, following a brief illness; and

Whereas, Mr. Jones dedicated more than 47 years of his professional career to managing organized medical associations, including the last 20 years as CEO of the American Association of Clinical Endocrinologists (AACE) until his retirement on May 7; and

Whereas, Mr. Jones previously served as Executive Director and CEO of the Florida Medical Association where he spent the first 29 years of his career, as well as on the Advisory Committee to the Executive Vice President of the American Medical Association (AMA) from 1983 to 1990, and as President of the American Association of Medical Society Executives (AAMSE) in 1989; and

Whereas, His leadership and commitment to ethical standards of management earned him the AMA Executive Achievement Award in 2001, as well as the immeasurable respect of his colleagues; and

Whereas, Mr. Jones demonstrated utmost pride and dedication in all facets of his work, family, and interests, including his love of American history, his commitment to tradition, and his tireless zeal as a self-described "workaholic," and

Whereas, On January 15, 2009, Mr. Jones became a member of the fraternity of survivors when he was one of 155 people aboard the US Airways Flight 1549 that landed in the Hudson River in New York, known as the "Miracle on the Hudson," and

Whereas, Mr. Jones will be greatly missed by his family, his colleagues at AACE, and the medical community; therefore be it

RESOLVED, That our American Medical Association House of Delegates recognize the contributions made by Mr. Donald C. Jones to organized medicine and his dedication to the many medical professionals and colleagues with whom he worked, and be it further

RESOLVED, That our AMA extend its most heartfelt condolences to Mr. Jones' family, and present them with a copy of this resolution.

**William W. Lander, MD**  
**Introduced by Pennsylvania**

Whereas, William W. Lander MD, a well-known, respected and admired family physician who was dedicated to the human spirit and taking care of his patients, passed away on Friday, January 6; and

Whereas, Dr. Lander, an internist, served his patients, the community, and his profession with honor and diligence for more than 60 years; the medical community lost a pioneer in family medicine and a mainstay at Bryn Mawr Hospital (Montgomery County, PA); and

Whereas, Dr. Lander was an experienced and revered member of the organized medicine community, serving in a number of leadership roles that spanned several decades within Bryn Mawr Hospital, Montgomery County Medical Society (MCMS), Pennsylvania Medical Society (PAMED) and our American Medical Association (AMA); and

Whereas, Dr. Lander received his medical degree from the University of Pennsylvania in 1949 and served as a lieutenant in the U.S. Navy while stationed in the First Marine Division on the front line at the Chosin Reservoir during the Korean Conflict from 1950-1951; and

Whereas, Dr. Lander, following his internal medicine residency at Bryn Mawr Hospital, was a solo practitioner who maintained his office in Bryn Mawr, Pennsylvania from 1953 until his death; and

Whereas, Dr. Lander served as president of Bryn Mawr Hospital medical staff from 1979-1981 and served as head of Bryn Mawr Hospital's Family Medicine Service for 25 years; and

Whereas, Dr. Lander served in many roles within MCMS, PAMED and our AMA, including president of MCMS in 1990 and PAMED in 2005 and hospital representative to the AMA; and

Whereas, In June 2017, Dr. Lander was honored by his county medical society for his legacy by renaming its medical student scholarship award after him and created the William "Bill" Lander Excellence in Primary Care Award that recognizes a worthy Montgomery County primary care physician who embodied the legacy of Dr. William Lander; and

Whereas, Dr. Lander's primary love for compassionate treatment of his patients resulted in long hours in the office, frequent house calls and friendly greetings during hospital rounds at night; and

Whereas, Dr. Lander was an active and faithful member of the Church of the Good Shepherd in Rosemont, PA, where his father was a rector for 29 years; and

Whereas, Dr. Lander loved gardening, growing beautiful roses and hearty vegetables and listening to jazz; and

Whereas, Dr. Lander is survived by his three sons, Bill, David and John; 13 grandchildren and five great-grandchildren; and

Whereas, Dr. Lander's dedication to his profession, patients and many friends will be greatly missed; therefore be it

RESOLVED, That our American Medical Association (AMA) House of Delegates observe a moment of silence, recognizing our appreciation for Dr. Lander's many years of service to the medical community, his patients, and our county and state societies; and be it further

RESOLVED, That Dr. Lander's memorial resolution be recorded in the minutes of the 2017 Interim Meeting of the AMA House of Delegates and a copy sent to his family, the Pennsylvania Medical Society and the Montgomery County Pennsylvania Medical Society.

**Rajendra N. Seth, MD, FACC, FACP**  
**Introduced by Pennsylvania**

Whereas, Rajendra N. Seth, MD, FACC, FACP, passed away on Saturday, June 24, 2017 at his residence in Elkins Park, Philadelphia, PA, at the age of 78; and

Whereas, Dr. Seth was born and educated in India, receiving his MD from King George Medical College; a degree of Doctor of Medicine in Pathology and Bacteriology from the University of Lucknow, India; completed a Fellowship in Pathology at Philadelphia General Hospital; Residency in Internal Medicine at Episcopal Hospital, Philadelphia; and was Senior Fellow in Cardiology at Philadelphia General Hospital; Diplomate of the American Board of Internal Medicine; Board Certified in Cardiology and Vascular Diseases; and a Fellow of the American College of Physicians; and

Whereas, Dr. Seth was a dedicated member of the Philadelphia County Medical Society (PCMS), Pennsylvania Medical Society (PAMED), and American Medical Association (AMA); member of the PCMS Board of Directors; Delegate to PAMED and the AMA; and Chair of the PCMS and PAMED International Medical Graduates Sections, where he led the fight for the rights of all IMGs to practice medicine in the United States; and

Whereas, Dr. Seth played an integral role on the PCMS and PAMED Membership and Public Health Committees, where he raised awareness regarding the benefits of membership in organized medicine for medical students, resident/fellows, and physicians, recruiting hundreds of health care professionals to join PCMS, PAMED, and the AMA; and

Whereas, Dr. Seth was a proven leader in coordinating continuing medical education programs and lectured and served on numerous committees and councils around the world, including most recently the 11th World Congress on Clinical Preventive Cardiology and Imaging in Rajasthan, India and the 20th Asian Pacific Society of Cardiology Congress in Abu Dhabi; therefore, be it

RESOLVED, That our American Medical Association (AMA) House of Delegates observe a moment of silence, recognizing our appreciation for Dr. Seth's many years of service to the medical community, his patients, and our county and state societies; and be it further

RESOLVED, That Dr. Seth's memorial resolution be recorded in the minutes of the 2017 Interim Meeting of the AMA House of Delegates and a copy sent to his family, the International Medical Graduate's Section of the AMA, the Pennsylvania Medical Society and the Philadelphia County Pennsylvania Medical Society.

## RESOLUTIONS

Note: Testimony on each item is summarized in the reference committee reports. Items considered on the reaffirmation calendar do not appear in the reference committee reports and were handled as part of the Committee on Rules and Credentials Supplementary Report on Sunday, November 12. The following resolutions were handled on the reaffirmation calendar: 210, 219, 221, 228, 804, 807, 815 and 821.

### 1. DISAGGREGATION OF DATA CONCERNING THE STATUS OF ASIAN-AMERICANS Introduced by Medical Student Section

*Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.*

#### HOUSE ACTION: **ADOPTED AS FOLLOWS**

*See Policy H-350.954*

RESOLVED, That our American Medical Association support the disaggregation of demographic data regarding Asian-Americans and Pacific Islanders in order to reveal the within-group disparities that exist in health outcomes and representation in medicine; and be it further

RESOLVED, That our AMA support the disaggregation of demographic data regarding ethnic groups in order to reveal the within-group disparities that exist in health outcomes and representation in medicine.

### 2. INTIMATE PARTNER VIOLENCE POLICY AND IMMIGRATION Introduced by Women Physicians Section

*Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.*

#### HOUSE ACTION: **ADOPTED**

*See Policy D-515.979*

RESOLVED, That our American Medical Association encourage appropriate stakeholders to study the impact of mandated reporting of domestic violence policies on individuals with undocumented immigrant status and identify potential barriers for survivors seeking care; and be it further

RESOLVED, That our AMA work with community based organizations and related stakeholders to clarify circumstances that would trigger mandated reporting of intimate partner violence and provide education on the implications of mandatory reporting on individuals with undocumented immigrant status.

### 3. REVISION OF AMA POLICY REGARDING INDIVIDUALS WHO EXCHANGE SEX FOR MONEY OR GOODS Introduced by GLMA

*Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.*

#### HOUSE ACTION: **ADOPTED AS FOLLOWS WITH CHANGE IN TITLE**

*See Policies H-20.898, H-20.922 and H-515.958*

RESOLVED, That our American Medical Association amend the text of HOD Policy H-20.898, "Global HIV/AIDS Prevention," by addition and deletion to read as follows:

H-20.898, Global HIV/AIDS Prevention

Our AMA supports continued funding efforts to address the global AIDS epidemic and disease prevention worldwide, without mandates determining what proportion of funding must be designated to treatment of

HIV/AIDS, abstinence or be-faithful funding directives or grantee pledges of opposition to ~~prostitution the exchange of sex for money or goods~~; and be it further

RESOLVED, That our AMA amend the text of HOD Policy H-20.922, "HIV/AIDS as a Global Public Health Priority," by addition and deletion to read as follows:

H-20.922, HIV/AIDS as a Global Public Health Priority

In view of the urgent need to curtail the transmission of HIV infection in every segment of the population, our AMA:

- (1) Strongly urges, as a public health priority, that federal agencies (in cooperation with medical and public health associations and state governments) develop and implement effective programs and strategies for the prevention and control of the HIV/AIDS epidemic;
- (2) Supports adequate public and private funding for all aspects of the HIV/AIDS epidemic, including research, education, and patient care for the full spectrum of the disease. Public and private sector prevention and care efforts should be proportionate to the best available statistics on HIV incidence and prevalence rates;
- (3) Will join national and international campaigns for the prevention of HIV disease and care of persons with this disease;
- (4) Encourages cooperative efforts between state and local health agencies, with involvement of state and local medical societies, in the planning and delivery of state and community efforts directed at HIV testing, counseling, prevention, and care;
- (5) Encourages community-centered HIV/AIDS prevention planning and programs as essential complements to less targeted media communication efforts;
- (6) In coordination with appropriate medical specialty societies, supports addressing the special issues of heterosexual HIV infection, the role of intravenous drugs and HIV infection in women, and initiatives to prevent the spread of HIV infection through ~~prostitutes the exchange sex for money or goods~~;
- (7) Supports working with concerned groups to establish appropriate and uniform policies for neonates, school children, and pregnant adolescents with HIV/AIDS and AIDS-related conditions; and
- (8) Supports increased availability of anti-retroviral drugs and drugs to prevent active tuberculosis infection to countries where HIV/AIDS is pandemic.
- (9) Supports programs raising physician awareness of the benefits of early treatment of HIV and of "treatment as prevention," and the need for linkage of newly HIV-positive persons to clinical care and partner services; and be it further

RESOLVED, That our AMA amend the title and text of HOD Policy H-515.958, "Promoting Safe Exit from Prostitution," by addition and deletion to read as follows:

H-515.958, Promoting ~~Safe Exit from Prostitution~~ Compassionate Care and Alternatives for Individuals Who Exchange Sex for Money or Goods

Our American Medical Association supports efforts to offer ~~individuals opportunities for~~ individuals opportunities for a safe exit from ~~prostitution the exchange of sex for money or goods if individuals choose to do so, and supports access to in~~ prostitution the exchange of sex for money or goods if individuals choose to do so, and supports access to in ~~pursuit of~~ pursuit of compassionate care and "best practices." ~~Our American Medical Association also and~~ Our American Medical Association also and supports legislation for programs that ~~prevent~~ provide alternatives and resources for individuals who exchange sex for money or goods and offer alternatives for those arrested on related charges ~~divert prostitution~~ rather than penalize ~~them~~ them ~~through~~ through criminal conviction and incarceration.

#### **4. TISSUE HANDLING Introduced by Michigan**

*Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.*

#### **HOUSE ACTION: ADOPTED**

*See Policy H-410.947*

RESOLVED, That our American Medical Association adopt policy stating that fetal tissue obtained during the termination of a pregnancy should be handled no differently than other tissues obtained during a medical procedure; and be it further

RESOLVED, That our AMA strongly oppose any proposed laws or regulations that would require the handling of fetal tissue obtained during the termination of a pregnancy differently than other tissues obtained during a medical procedure.

**5. PROTECTION OF PHYSICIAN FREEDOM OF SPEECH**  
**Introduced by American Academy of Pain Medicine**

*Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.*

**HOUSE ACTION: REFERRED**

RESOLVED, That our American Medical Association strongly oppose litigation challenging the exercise of a physician's First Amendment right to express good faith opinions regarding medical issues; and be it further

RESOLVED, That our AMA's House of Delegates encourage the AMA Litigation Center to provide such support to a constituent or component medical society whose members have been sued for expressing good faith opinions regarding medical issues as the Litigation Center deems appropriate in any specific case.

**6. PHYSICIANS' FREEDOM OF SPEECH**  
**Introduced by Minority Affairs Section**

*Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.*

**HOUSE ACTION: REFERRED**

RESOLVED, That our American Medical Association encourage the Council on Ethical and Judicial Affairs to amend Ethical Opinion 1.2.10, "Political Action by Physicians," by addition to read as follows:

E-1.2.10, Political Action by Physicians

Like all Americans, physicians enjoy the right to advocate for change in law and policy, in the public arena, and within their institutions. Indeed, physicians have an ethical responsibility to seek change when they believe the requirements of law or policy are contrary to the best interests of patients and community health. However, they have a responsibility to do so in ways that are not disruptive to patient care.

Physicians who participate in advocacy activities should:

- (a) Ensure that the health of patients is not jeopardized and that patient care is not compromised.
- (b) Avoid using disruptive means to press for reform. Strikes and other collection actions may reduce access to care, eliminate or delay needed care, and interfere with continuity of care and should not be used as a bargaining tactic. In rare circumstances, briefly limiting personal availability may be appropriate as a means of calling attention to the need for changes in patient care. Physicians should be aware that some actions may put them or their organizations at risk of violating antitrust laws or laws pertaining to medical licensure or malpractice.
- (c) Avoid forming workplace alliances, such as unions, with workers who do not share physicians' primary and overriding commitment to patients.
- (d) Refrain from using undue influence or pressure colleagues to participate in advocacy activities and should not punish colleagues, overtly or covertly, for deciding not to participate.

Furthermore, physicians:

- (e) Should indicate they are expressing their personal opinions, which are guaranteed under the First Amendment of the U.S. Constitution, and should refrain from implying or stating that they are speaking on behalf of their employers;
- (f) Should be allowed to express their personal opinions publicly without being subjected to disciplinary actions or termination.

## 7. POLITICAL INTERFERENCE IN THE PATIENT-PHYSICIAN RELATIONSHIP

*Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.*

### HOUSE ACTION: ALTERNATIVE RESOLUTION 7 ADOPTED

*See Policy H-140.835*

RESOLVED, that our AMA oppose 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.

## 201. IMPROVING FDA EXPEDITED APPROVAL PATHWAYS Introduced by Resident and Fellow Section

*Reference committee hearing: see report of Reference Committee B.*

### HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association work with U.S. Food and Drug Administration (FDA) and other interested stakeholders to design and implement via legislative action (including ensuring appropriate FDA staffing) a process by which drugs which obtain FDA approval via the Fast Track, Accelerated Approval, or Breakthrough Therapy pathways be granted FDA approval on a temporary basis not to exceed 5 years, pending further evidence of safety and efficacy that is at the level set for the standard drug approval process; and be it further

RESOLVED, That our AMA work with the FDA and other interested stakeholders in improving the process by which drugs are selected for the expedited pathway to improve the prevalence of these drugs that are classified as “specialty drugs.”

## 202. SEXUAL ASSAULT SURVIVORS’ RIGHTS Introduced by Medical Student Section

*Reference committee hearing: see report of Reference Committee B.*

### HOUSE ACTION: ADOPTED AS FOLLOWS

*See Policies H-80.998 and H-80.999*

RESOLVED, That our American Medical Association advocate for the legal protection of sexual assault survivors’ rights and work with state medical societies to ensure that each state implements these rights, which include but are not limited to, the right to: (1) receive a medical forensic examination free of charge, which includes but is not limited to HIV/STD testing and treatment, pregnancy testing, treatment of injuries, and collection of forensic evidence; (2) preservation of a sexual assault evidence collection kit for at least the maximum applicable statute of limitation; (3) notification of any intended disposal of a sexual assault evidence kit with the opportunity to be granted further preservation; (4) be informed of these rights and the policies governing the sexual assault evidence kit; and (5) access to emergency contraception information and treatment for pregnancy prevention; and be it further

RESOLVED, That our AMA collaborate with relevant stakeholders to develop recommendations for implementing best practices in the treatment of sexual assault survivors, including through engagement with the joint working group established for this purpose under the Survivor’s Bill of Rights Act of 2016; and be it further

RESOLVED, That Policy H-80.998 be amended by addition and deletion to read as follows:

H-80.998, Sexual Assault Survivor ~~Rape Victim~~ Services

The AMA supports the function and efficacy of ~~rape victim~~ sexual assault survivor services, supports state adoption of the sexual assault survivor rights established in the Survivors’ Bill of Rights Act of 2016, encourages ~~rape~~ sexual assault crisis centers to continue working with local police to help ~~rape victims~~ sexual

assault survivors, and encourages physicians to support the option of having a ~~rape victim~~ counselor present while the ~~victim~~ sexual assault survivor is receiving medical care.

RESOLVED, That Policy H-80.999 be amended by addition and deletion to read as follows:

H-80.999, Sexual Assault Survivors ~~Rape Victims~~

Our AMA supports the preparation and dissemination of information, and best practices intended to maintain and improve the skills needed by all practicing physicians involved in providing care to ~~rape victims~~ sexual assault survivors.

**203. BIDIRECTIONAL COMMUNICATION FOR EHR SOFTWARE AND PHARMACIES**  
**Introduced by Virginia, Kentucky, North Carolina, American Urological Association,**  
**American Association of Clinical Urologists**

*Reference committee hearing: see report of Reference Committee B.*

**HOUSE ACTION: REFERRED FOR REPORT AT 2018 ANNUAL MEETING**

RESOLVED, That our American Medical Association engage the American Pharmacy Association, and any other relevant stakeholders, to encourage both Electronic Health Record (EHR) and pharmacy software vendors to have bidirectional communication for an accurate and current medication list in the patient's EHR.

**204. EHR VENDORS RESPONSIBLE FOR HEALTH INFORMATION TECHNOLOGY**  
**Introduced by Virginia, North Carolina, American Urological Association,**  
**American Association of Clinical Urologists**

*Reference committee hearing: see report of Reference Committee B.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**

*See Policy D-478.996*

RESOLVED, That our American Medical Association advocate that physicians are offered flexibility related to the adoption and use of new certified Electronic Health Records (EHRs) versions or editions when there is not a sufficient choice of EHR products that meet the specified certification standards; and be it further

RESOLVED, That our AMA advocate that physicians not be financially penalized for certified EHR technology not meeting current standards.

**205. HEALTH PLAN, PHARMACY, ELECTRONIC HEALTH RECORDS INTEGRATION**  
**Introduced by Virginia, Kentucky, American Urological Association,**  
**American Association of Clinical Urologists**

*Reference committee hearing: see report of Reference Committee B.*

**HOUSE ACTION: REFERRED FOR REPORT AT 2018 ANNUAL MEETING**

RESOLVED, That our American Medical Association advocate that health plans, pharmacies, and EHR vendors integrate their technology programs so that physicians have current and real time access to covered medications for patients within a specific health plan; and be it further

RESOLVED, That our AMA advocate that health plans make patient cost information readily available via this technology so that physicians and their patients may work together to choose the most cost-effective medically appropriate medication for patient care.

**206. DEFENDING FEDERAL CHILD NUTRITION PROGRAMS**  
**Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee B.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**  
*See Policy H-150.962*

RESOLVED, That our American Medical Association oppose legislation and regulatory initiatives that reduce or eliminate access to federal child nutrition programs; and be it further

RESOLVED, That our AMA reaffirm Policy H-150.962, “Quality of School Lunch Program.”

**207. REDISTRIBUTION OF UNUSED PRESCRIPTION DRUGS TO PHARMACEUTICAL  
DONATION AND REUSE PROGRAMS**  
**Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee B.*

**HOUSE ACTION: REFERRED FOR REPORT AT 2018 ANNUAL MEETING**

RESOLVED, That our American Medical Association work with appropriate stakeholders to draft and promote model legislation aimed at developing better funding for drug donation programs on the state level provided these programs follow the quality assurance guidelines set by existing AMA Policy H-280.959.

**208. INCREASED USE OF BODY-WORN CAMERAS BY LAW ENFORCEMENT OFFICERS**  
**Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee B.*

**HOUSE ACTION: REFERRED**

RESOLVED, That our American Medical Association advocate for legislative, administrative, or regulatory measures to expand funding for (1) the purchase of body-worn cameras and (2) training and technical assistance required to implement body-worn camera programs.

**209. GOVERNMENT MANDATED SEQUESTER**  
**Introduced by Indiana**

*Reference committee hearing: see report of Reference Committee B.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**  
*See Policy H-165.827*

RESOLVED, That our American Medical Association advocate to remove the sequester provision for Medicare reimbursement.

**210. MERIT-BASED INCENTIVE PAYMENT SYSTEM AND SMALL PRACTICES  
Introduced by Indiana**

*Considered on reaffirmation calendar.*

**HOUSE ACTION: POLICIES H-390.838 AND D-390.949  
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association advocate for a policy that exempts self-employed small practices, defined as solo practitioners up to five physician providers, from the burdensome regulation of the merit-based incentive payment system (MIPS).

**211. EXCLUSIVE STATE CONTROL OF METHADONE CLINICS  
Introduced by Indiana**

*Reference committee hearing: see report of Reference Committee B.*

**HOUSE ACTION: REFERRED**

RESOLVED, That our American Medical Association support complete state control of all aspects of methadone clinic approval and operations; and, if deemed necessary, this control could be granted on a state by state basis.

**Resolution 212 was not considered.**

**213. BARRIERS TO PRICE TRANSPARENCY  
Introduced by American Academy of Dermatology, American Society for Dermatologic Surgery Association,  
American College of Mohs Surgery, American Society of Dermatopathology, Society for Investigative  
Dermatology, Florida**

*Reference committee hearing: see report of Reference Committee B.*

**HOUSE ACTION: POLICY D-155.987 REAFFIRMED IN LIEU OF FIRST RESOLVE  
POLICIES H-155.958 AND H-380.994 REAFFIRMED  
IN LIEU OF SECOND RESOLVE  
THIRD RESOLVE REFERRED**

EXISTING POLICY REAFFIRMED IN LIEU OF FOLLOWING RESOLVES:

RESOLVED, That our American Medical Association work with states and state medical societies to reduce health insurance contract provisions or gag clauses that restrict disclosure of pricing information to patients; and be it further

RESOLVED, That our AMA work with states and state medical societies to ensure that health insurance contracts do not prohibit the application of discounts to uninsured or under-insured patients if such discounts are compliant with federal anti-kickback statutes; and be it further

FOLLOWING RESOLVE REFERRED:

RESOLVED, That our AMA support access to real-time prescription drug pricing and cost transparency at the point of prescribing.

#### 214. APRN COMPACT

**Introduced by American Society of Anesthesiologists, Mississippi, American Clinical Neurophysiology Society, American Society for Radiation Oncology, Georgia, Ohio, American Academy of Cosmetic Surgery, Louisiana, Kentucky, South Carolina, New Jersey, American College of Legal Medicine, American College of Radiology, Illinois, American College of Emergency Physicians, American Academy of Orthopaedic Surgeons, Texas, North Carolina, Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont**

*Reference committee hearing: see report of Reference Committee B.*

#### **HOUSE ACTION: ADOPTED AS FOLLOWS**

*See Policy H-35.988*

RESOLVED, That our American Medical Association convene an in-person meeting of relevant physician stakeholders to initiate creation of a consistent national strategy (consensus principles of agreement/solutions, model legislation, national and state public relations campaigns) purposed to: (1) Effectively oppose the continual, nationwide efforts to grant independent practice (e.g., APRN Consensus Model, APRN Compact) to non-physician practitioners; (2) Effectively educate the public, legislators, regulators, and healthcare administrators; and (3) Effectively oppose state and national level legislative efforts aimed at inappropriate scope of practice expansion of non-physician healthcare practitioners; with report back at the 2018 Annual Meeting; and be it further

RESOLVED, That Policy H-35.988 be amended by addition and deletion to read as follows:

H-35.988, Independent Practice of Medicine by Advanced Practice Registered Nurses “Nurse Practitioners”  
~~The Our~~ AMA, in the public interest, opposes enactment of legislation to authorize the independent practice of medicine by any individual who has not completed the state’s requirements for licensure to engage in the practice of medicine and surgery in all of its branches. Our AMA opposes enactment of the Advanced Practice Registered Nurse (APRN) Multistate Compact, due to the potential of the APRN Compact to supersede state laws that require APRNs to practice under physician supervision, collaboration or oversight.

#### 215. RELIEVE BURDEN FOR LIVING ORGAN DONORS

**Introduced by Michigan**

*Reference committee hearing: see report of Reference Committee B.*

#### **HOUSE ACTION: ADOPTED**

*See Policy H-370.965*

RESOLVED, That our American Medical Association amend Policy, H-370.965, “Removing Financial Barriers to Living Organ Donation,” by addition and deletion as follows:

Our AMA supports federal and state laws that remove financial barriers to living organ donation, such as: (1) provisions for expenses involved in the donation incurred by the organ donor, (2) providing access to health care coverage for any medical expense related to the donation, (3) prohibiting employment discrimination on the basis of living donor status, ~~and~~ (4) prohibiting the use of living donor status as the sole basis for denying health and life insurance coverage, and (5) provisions to encourage paid leave for organ donation; and be it further

RESOLVED, That our AMA support legislation expanding paid leave for organ donation.

**216. RELATIONSHIP WITH US DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Introduced by Michigan**

*Reference committee hearing: see report of Reference Committee B.*

**HOUSE ACTION: ADOPTED**

*See Policy H-270.952*

RESOLVED, That our American Medical Association continue to consider and implement the most strategic and sustainable approaches to collaborate and engage with the US Department of Health and Human Services to: (1) advance and advocate for policies of importance to physicians and patients; (2) promote physician leadership in emerging health care organizational and reimbursement structures; and (3) enhance the opportunity for physician input.

**217. REGULATIONS REGARDING MEDICAL TOOL AND INSTRUMENT REPAIR  
Introduced by Michigan**

*Reference committee hearing: see report of Reference Committee B.*

**HOUSE ACTION: ADOPTED**

*See Policy H-480.959*

RESOLVED, That our American Medical Association strongly oppose any rules or regulations regarding the repair or refurbishment of medical tools, equipment, and instruments that are not based on objective scientific data.

**218. HEALTH INFORMATION TECHNOLOGY PRINCIPLES  
Introduced by Organized Medical Staff Section**

*Reference committee hearing: see report of Reference Committee B.*

**HOUSE ACTION: REFERRED**

RESOLVED, That our American Medical Association adopt and promote the development of effective electronic health records in accordance with the following health information technology principles:

1. Whenever possible, physicians should have direct control over choice and management of the information technology used in their practices.
2. Information technology available to physicians must be safe (e.g., electronically secure, and in the case of distributed devices, physically so), effective and efficient.
3. Information technology available to physicians should support the physician's obligation to put the interests of patients first.
4. Information technology available to physicians should support the integrity and autonomy of physicians.
5. Information technology should support the patient's autonomy by providing access to that individual's data.
6. There should be no institutional or administrative barriers between physicians and their patients' health data.
7. Information technology should promote the elimination of health care disparities.
8. The cost of installing, maintaining and upgrading information technology should be specifically acknowledged and addressed in reimbursement schedules on an ongoing basis; payments should ensure sustainability of such systems in practice.

**219. CERTIFIED EMR COMPANIES' PRACTICE OF CHARGING FEES  
FOR REGULATORY COMPLIANCE  
Introduced by Maryland**

*Considered on reaffirmation calendar.*

**HOUSE ACTION: POLICIES D-478.975 AND D-478.996 REAFFIRMED  
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association advocate for policy requiring EMR vendors to absorb the cost of software updates required for compliance and participation in government and third-party programs, instead of passing on these expenses to physicians.

**220. PRESERVING PROTECTIONS OF THE AMERICANS WITH DISABILITIES ACT OF 1990  
Introduced by American Academy of Physical Medicine and Rehabilitation**

*Reference committee hearing: see report of Reference Committee B.*

**HOUSE ACTION: ADOPTED AS FOLLOWS  
See Policy D-90.992**

RESOLVED, That our American Medical Association support legislative changes to the Americans with Disabilities Act of 1990, to educate state and local government officials and property owners on strategies for promoting access to persons with a disability; and be it further

RESOLVED, That our AMA oppose legislation amending the Americans with Disabilities Act of 1990, that would increase barriers for disabled persons attempting to file suit to challenge a violation of their civil rights; and be it further

RESOLVED, That our AMA develop educational tools and strategies to help physicians make their offices more accessible to persons with disabilities, consistent with the Americans With Disabilities Act (ADA) as well as any applicable state laws.

**221. HOUSE OF REPRESENTATIVE BILL HR 2077, RESTORING THE  
PATIENT'S VOICE ACT OF 2017  
Introduced by American Society for Gastrointestinal Endoscopy,  
American Gastroenterological Association, American College of Gastroenterology**

*Considered on reaffirmation calendar.*

**HOUSE ACTION: POLICIES H-320.948, H-320.952, H-320.958 AND H-320.968 REAFFIRMED  
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association support HR 2077, a bill to amend the Employee Retirement Income Security Act of 1974 to require a group health plan (or health insurance coverage offered in connection with such a plan) to provide an exceptions process for any medication step therapy protocol, and for other purposes; and be it further

RESOLVED, That our AMA further support, as part of this legislation, that such a request shall be granted as quickly as the disease or condition of the participant or beneficiary requires, but no later than three days after the day of receipt of the request. For circumstances in which the applicable medication step therapy protocol may seriously jeopardize the life, health, or ability to regain maximum function of the participant or beneficiary, such a request shall be granted on an expedited basis, and no later than 24 hours after receipt of such request.

**222. APPROPRIATE USE OF OBJECTIVE TESTS FOR OBSTRUCTIVE SLEEP APNEA  
Introduced by American Academy of Sleep Medicine**

*Reference committee hearing: see report of Reference Committee B.*

**HOUSE ACTION: ADOPTED**

*See Policy H-35.963*

RESOLVED, That it be policy of our American Medical Association that (1) ordering and interpreting objective tests aiming to establish the diagnosis of obstructive sleep apnea (OSA) or primary snoring constitutes the practice of medicine; (2) the need for, and appropriateness of, objective tests for purposes of diagnosing OSA or primary snoring or evaluating treatment efficacy must be based on the patient's medical history and examination by a licensed physician; and (3) objective tests for diagnosing OSA and primary snoring are medical assessments that must be ordered and interpreted by a licensed physician.

**223. TREATING OPIOID USE DISORDER IN CORRECTIONAL FACILITIES  
Introduced by American Association of Public Health Physicians, Washington**

*Reference committee hearing: see report of Reference Committee B.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**

*See Policy H-430.987*

RESOLVED, That our American Medical Association advocate for legislation, standards, policies and funding that encourage correctional facilities to increase access to evidence-based treatment of opioid use disorder, including initiation and continuation of opioid replacement therapy in conjunction with counseling, in correctional facilities within the United States and that this apply to all incarcerated individuals, including pregnant women; and be it further

RESOLVED, That our AMA support legislation, standards, policies and funding that encourage correctional facilities within the United States to work in ongoing collaboration with addiction treatment physician-led teams, case managers, social workers, and pharmacies in the communities where patients, including pregnant women, are released to offer post-incarceration treatment plans for opioid use disorder, including education, medication for addiction treatment and counseling, and medication for preventing overdose deaths and help ensure post-incarceration medical coverage and accessibility to medication assisted therapy.

**224. MODERNIZING PRIVACY REGULATIONS FOR ADDICTION TREATMENT RECORDS  
Introduced by American Society of Addiction Medicine, American Psychiatric Association,  
American Academy of Psychiatry and the Law, American Association for Geriatric Psychiatry, GLMA**

*Reference committee hearing: see report of Reference Committee B.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**

*See Policy H-315.965*

RESOLVED, That our American Medical Association support regulatory and legislative changes that better balance patients' privacy protections against the need for health professionals to be able to offer appropriate medical services to patients with substance use disorders; and be it further

RESOLVED, That our AMA support regulatory and legislative changes that enable physicians to fully collaborate with all clinicians involved in providing health care services to patients with substance use disorders; and be it further

RESOLVED, That our AMA support continued protections against the unauthorized disclosure of substance use disorder treatment records outside the healthcare system.

**225. OPPOSE INCLUSION OF MEDICARE PART B DRUGS IN QPP/MIPS PAYMENT ADJUSTMENT**  
**Introduced by American Society of Clinical Oncology, American College of Rheumatology**

*Reference committee hearing: see report of Reference Committee B.*

**HOUSE ACTION: ADOPTED**  
*See Policy H-385.911*

RESOLVED, That our American Medical Association continue work with impacted specialties to actively lobby the federal government to exclude Medicare Part B drug reimbursement from the Merit-Based Incentive Payment System (MIPS) payment adjustment as part of the Quality Payment Program (QPP).

**226. PRESCRIPTION DRUG IMPORTATION FOR PERSONAL USE**  
**Introduced by Minnesota**

*Reference committee hearing: see report of Reference Committee B.*

**HOUSE ACTION: REFERRED**

RESOLVED, That our American Medical Association support legislation that would allow for the personal purchase and importation of prescription drugs obtained directly from a licensed Canadian pharmacy, provided such drugs are for personal use and of a limited quantity.

**227. COMMUNICATION AND RESOLUTION PROGRAM**  
**Introduced by Georgia**

*Reference committee hearing: see report of Reference Committee B.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**  
*See Policy H-435.941*

RESOLVED, That our American Medical Association support early Communication and Resolution Programs as a viable option to settle disputes, prior to litigation.

**228. DRUG DISCOUNT CARDS**  
**Introduced by Georgia**

*Considered on reaffirmation calendar.*

**HOUSE ACTION: POLICY H-125.977 REAFFIRMED**  
**IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association advocate to the Centers for Medicare & Medicaid Services to have Congress eliminate the “doughnut hole” in Medicare Part D plans, as part of the ongoing Congressional debate on evolving the health care system.

**229. OPPOSITION TO LICENSING FOR INDIVIDUALS HOLDING THE  
DEGREE OF DOCTOR OF MEDICAL SCIENCE  
Introduced by Georgia**

*Reference committee hearing: see report of Reference Committee B.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**

*See Policy H-35.962*

RESOLVED, That our American Medical Association oppose the holders of the degree of Doctor of Medical Science from being recognized as a new category of health care practitioners licensed for the independent practice of medicine and work with interested state medical associations and national medical specialty societies to oppose legislation to create a Doctor of Medical Science license.

**230. OPPOSE PHYSICIAN ASSISTANT INDEPENDENT PRACTICE**

**Introduced by Pennsylvania, American Academy of Dermatology, American Association of Neurological Surgeons, American College of Mohs Surgery, American College of Radiology, American Society for Dermatologic Surgery Association, American Society of Anesthesiologists, American Society of Dermatopathology, Arizona, Arkansas, Congress of Neurological Surgeons, Florida, Kentucky, Maryland, Georgia, Alabama, New Jersey, District of Columbia, New York, Virginia, Michigan, Mississippi, Society for Investigative Dermatology, South Carolina, Tennessee, Wisconsin, American College of Emergency Physicians, American College of Surgeons**

*Reference committee hearing: see report of Reference Committee B.*

**HOUSE ACTION: ADOPTED**

*See Policy H-35.989*

RESOLVED, That our American Medical Association adopt policy to oppose legislation or regulation that allows physician assistant independent practice.

**231. ELECTRONIC PRESCRIPTION CANCELLATION  
Introduced by Oregon**

*Reference committee hearing: see report of Reference Committee B.*

**HOUSE ACTION: ADOPTED**

*See Policy H-478.983*

RESOLVED, That our American Medical Association support the creation, standardization, and implementation of electronic prescription cancellation from all electronic medical record vendors and that these orders be accepted by pharmacies and pharmacy benefit managers.

**232. PRESENCE AND ENFORCEMENT ACTIONS OF IMMIGRATION AND CUSTOMS  
ENFORCEMENT (ICE) IN HEALTHCARE  
Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee B.*

**HOUSE ACTION: ADOPTED**

*See Policy D-160.921*

RESOLVED, That our American Medical Association advocate for and support legislative efforts to designate healthcare facilities as sensitive locations by law; and be it further

RESOLVED, That our AMA work with appropriate stakeholders to educate medical providers on the rights of undocumented patients while receiving medical care, and the designation of healthcare facilities as sensitive locations where U.S. Immigration and Customs Enforcement (ICE) enforcement actions should not occur; and be it further

RESOLVED, That our AMA encourage healthcare facilities to clearly demonstrate and promote their status as sensitive locations; and be it further

RESOLVED, That our AMA oppose the presence of ICE enforcement at healthcare facilities.

**233. EVALUATING ACTIONS BY PHARMACY BENEFIT MANAGER AND  
PAYER POLICIES ON PATIENT CARE  
Introduced by Organized Medical Staff Section**

*Reference committee hearing: see report of Reference Committee B.*

**HOUSE ACTION: ADOPTED AS FOLLOWS  
WITH CHANGE IN TITLE**

*See Policies D-120.934, H-120.947 and D-35.981*

RESOLVED, That Policies H-120.947 and D-35.981 be reaffirmed; and be it further

RESOLVED, That our American Medical Association work with pharmacy benefit managers, payers, relevant pharmacy associations, and stakeholders to a) identify the impact on patients of policies that restrict prescriptions to ensure access to care and urge that these policies receive the same notice and public comment as any other significant policy affecting the practice of pharmacy and medicine; and b) prohibit pharmacy actions that are unilateral medical decisions; and be it further

RESOLVED, That our AMA report back at the 2018 Annual Meeting on actions taken to preserve the purview of physicians in prescription origination.

**234. HEALTH INSURANCE COMPANY PURCHASE BY PHARMACY CHAINS  
Introduced by New York**

*Reference committee hearing: see report of Reference Committee B.*

**HOUSE ACTION: REFERRED FOR DECISION**

RESOLVED, That our American Medical Association object to any purchase of a health insurance plan by any drug store or pharmacy chain and that our AMA work with other stakeholders, including the American Osteopathic Association and specialty colleges, to advocate for protection against such a purchase.

**235. AMA ADVOCACY EFFORTS FOR EMERGENCY MEDICAID FUNDING  
AND ASSISTANCE - PUERTO RICO AND THE U.S. VIRGIN ISLANDS  
Introduced by American College of Gastroenterology**

*Reference committee hearing: see report of Reference Committee B.*

**HOUSE ACTION: ADOPTED AS FOLLOWS  
WITH CHANGE IN TITLE**

*See Policy D-290.975*

RESOLVED, That our American Medical Association urge and advocate the U.S. Congress to quickly pass legislation to adequately fund Puerto Rico's and the U.S. Virgin Island's Medicaid Programs; and be it further

RESOLVED, That our AMA urge and advocate for the Centers for Medicare and Medicaid Services to implement temporary emergency regulatory Medicare and Medicaid funding waivers to help restore access to health care services in Puerto Rico and the U.S. Virgin Islands.

**236. PRESERVING TAX DEDUCTIBILITY OF STUDENT LOAN INTEREST PAYMENTS AND HIGH MEDICAL EXPENSES**

**Introduced by American Academy of Family Physicians, American Academy of Pediatrics, American Congress of Obstetricians and Gynecologists, American College of Physicians**

*Reference committee hearing: see report of Reference Committee B.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**

*See Policy D-270.987*

RESOLVED, That our American Medical Association immediately and strongly urge Congress to preserve the tax deductibility of student loan interest payments in any tax reform legislation; and be it further

RESOLVED, That our AMA immediately and strongly urge Congress to preserve the tax deductibility of high medical expenses in any tax reform legislation; and be it further

RESOLVED, That our AMA immediately and strongly urge Congress to maintain the tax-exempt status of tuition waivers and relevant scholarships in any tax reform legislation.

**237. IMPLEMENTATION OF SCORE ASSESSMENT FOR COST UNDER MACRA MIPS**

**Introduced by American Academy of Neurology, American College of Cardiology, American College of Rheumatology, American Society of Echocardiography, American Society of Clinical Oncology, The Heart Rhythm Society, Society of Cardiovascular Angiography and Intervention**

*Reference committee hearing: see report of Reference Committee B.*

**HOUSE ACTION: REFERRED FOR DECISION**

RESOLVED, That our American Medical Association work with the Centers for Medicare and Medicaid Services to ensure sound methodologies for risk adjustment for physicians with patient populations at risk for high resource use; and be it further

RESOLVED, That our AMA urgently lobby the Congress and the federal government to expedite development of an equitable, validated patient-specific risk adjustment mechanism and not include a cost score in the Merit Based Incentive Payment System (MIPS) until such time as it can be developed.

**601. PHYSICIAN BURNOUT AND WELLNESS CHALLENGES**

**Introduced by International Medical Graduates Section, American Association of Physicians of Indian Origin**

*Reference committee hearing: see report of Reference Committee F.*

**HOUSE ACTION: REFERRED FOR REPORT AT 2018 ANNUAL MEETING**

RESOLVED, That our American Medical Association advocate for health care organizations to develop a wellness plan to prevent and combat physician burnout and improve physician wellness; and be it further

RESOLVED, That our AMA advocate for state and county medical societies to implement wellness programs to prevent and combat physician burnout and improve physician wellness.

**Resolution 602 was not considered.**

**Resolution 603 was not considered.**

**604. PHYSICIAN AND PHYSICIAN ASSISTANT SAFETY NET  
Introduced by Oregon**

*Reference committee hearing: see report of Reference Committee F.*

**HOUSE ACTION: REFERRED FOR REPORT AT 2018 ANNUAL MEETING**

RESOLVED, That our American Medical Association study a safety net, such as a national hotline, that all United States physicians and physician assistants can call when in a suicidal crisis. Such safety net services would be provided by doctorate level mental health clinicians experienced in treating physicians; and be it further

RESOLVED, That our AMA advocate that funding for such safety net program be sought from such entities as foundations, hospital systems, medical clinics, and donations from physicians and physician assistants.

**605. IDENTIFICATION AND REDUCTION OF PHYSICIAN DEMORALIZATION  
Introduced by Organized Medical Staff Section**

*Reference committee hearing: see report of Reference Committee F.*

**HOUSE ACTION: REFERRED FOR REPORT AT 2018 ANNUAL MEETING**

RESOLVED, That our American Medical Association recognize that physician demoralization, defined as a consequence of externally imposed occupational stresses, including but not limited to EHR-related and administrative burdens imposed by health systems or by regulatory agencies, is a problem among medical staffs; and be it further

RESOLVED, That our AMA advocate that hospitals be required by accrediting organizations to confidentially survey physicians to identify factors that may lead to physician demoralization; and be it further

RESOLVED, That our AMA develop guidance to help hospitals and medical staffs implement organizational strategies that will help reduce the sources of physician demoralization and promote overall medical staff wellness.

**801. CHRONIC CARE MANAGEMENT PAYMENT FOR PATIENTS ALSO ON HOME HEALTH  
Introduced by Idaho, Montana, Nevada, New Mexico, North Dakota, Wyoming, Utah**

*Reference committee hearing: see report of Reference Committee J.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**

*See Policy D-390.923*

RESOLVED, That our American Medical Association advocate for the authorization of Chronic Care Management (CCM) reimbursement for all physicians, including those practicing in Rural Health Clinics and Federally Qualified Health Centers, for patients in a home health episode.

**802. OPPOSITION TO MEDICAID WORK REQUIREMENTS  
Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee J.*

**HOUSE ACTION: ADOPTED**  
*See Policy H-290.961*

RESOLVED, That our American Medical Association oppose work requirements as a criterion for Medicaid eligibility.

**803. AIR AMBULANCE REGULATIONS AND REIMBURSEMENTS  
Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee J.*

**HOUSE ACTION: ADOPTED**  
*See Policy D-130.964*

RESOLVED, That our American Medical Association and appropriate stakeholders study the role, clinical efficacy, and cost-effectiveness of air ambulance services, including barriers to adequate competition, reimbursement, and quality improvement.

**804. PRIOR AUTHORIZATION  
Introduced by Indiana**

*Considered on reaffirmation calendar.*

**HOUSE ACTION: POLICIES H-185.942, H-320.939, H-320.945, H-320.950, H-320.968, H-320.982,  
D-190.974 AND D-320.993 REAFFIRMED  
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association promote the appropriate use of prior authorization primarily for initial requests and services that fall outside the standard of care; and be it further

RESOLVED, That our AMA implement and promote policy that minimizes the need for prior authorization annually or on any other schedule when the request is for continuity of care and the prior authorization is for regimens that are working well to control a patient's condition; and be it further

RESOLVED, That our AMA create a policy that prior authorizations need to be completed within three working days by the health plan or pharmacy if approved, or if the prior authorization is denied, the denial must include an explanation, unique and specific to the individual patient, and, if no answer is obtained within three days, the prior authorization is deemed approved and patient care may proceed; and be it further

RESOLVED, That our AMA create a policy for the prior authorization process that, unless a health plan, pharmacy vendor or other payer source can document that medical care or a specific service or pharmaceutical is NOT appropriate or medically-indicated based on nationally recognized evidence-based guidelines, the health plan, pharmacy vendor or other payer source shall approve the request of the attending physician; and be it further

RESOLVED, That our AMA schedule quarterly meetings with insurance companies to discuss any prior authorization issues, as well as any other matters pertinent to physicians and patients; and be it further

RESOLVED, That our AMA support any effort to allow the physician to bill the insurance company directly for prior authorization time, and that the cost not be a pass-through charge to the patient; and be it further

RESOLVED, That our AMA work, both by administrative and/or legislative means, to address the problem of excessive burden from prior authorizations and meaningful use regulations by regulatory and/or legislative means; and be it further

RESOLVED, That our AMA work with Medicare Advantage plans to follow Medicare guidelines if the plan chooses to follow their own guidelines. The plan must be transparent on the criteria for approval or denial.

**805. A DUAL SYSTEM FOR UNIVERSAL HEALTH CARE IN THE UNITED STATES**  
**Introduced by Montana**

*Reference committee hearing: see report of Reference Committee J.*

**HOUSE ACTION: POLICIES H-165.838 AND H-165.920 REAFFIRMED**  
**IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association vigorously advocate for compromise health care reform legislation which restructures all existing government health care programs into a single universal government system which provides health care to all United States citizens and legal residents at a level which is sustainable and affordable; and be it further

RESOLVED, That our AMA simultaneously, with equal vigor, advocate for a far reaching deregulation of privately purchased health care, while maintaining the emphasis on improving quality and safety; and be it further

RESOLVED, That our AMA resist all legislation which attempts to coerce or infringe upon the freedom of the people of the United States to choose the terms of their health care; and be it further

RESOLVED, That our AMA advocate for both public and private health care reforms as an inseparable package.

**806. PRESCRIPTION DRUG PRICE AND COST TRANSPARENCY**

*Reference committee hearing: see report of Reference Committee J.*

**HOUSE ACTION: FOLLOWING ALTERNATIVE RESOLUTION 806 ADOPTED**  
**IN LIEU OF RESOLUTIONS 806, 810 AND 823**

*See Policies H-110.987, H-110.991, H-125.979 and H-125.986 and D-110.988*

RESOLVED, That our AMA reaffirm Policy H-110.987, which encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers (PBMs) and health insurance companies; and supports drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug by 10% or more each year or per course of treatment and provide justification for the price increase, and legislation that authorizes the Attorney General and/or the Federal Trade Commission (FTC) to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients; and be it further

RESOLVED, That our AMA reaffirm Policy H-125.986, which encourages the FTC and the Food and Drug Administration to continue monitoring the relationships between pharmaceutical manufacturers and PBMs, especially with regard to manufacturers' influences on PBM drug formularies and drug product switching programs, and to take enforcement actions as appropriate; and states that certain actions/activities by pharmacy benefit managers and others constitute the practice of medicine without a license and interfere with appropriate medical care to our patients; and be it further

RESOLVED, That our AMA reaffirm Policy H-125.979 containing provisions to improve private health insurance formulary transparency; and be it further

RESOLVED, That our AMA oppose provisions in pharmacies' contracts with pharmacy benefit managers that prohibit pharmacists from disclosing that a patient's co-pay is higher than the drug's cash price; and be it further

RESOLVED, That our AMA continue its efforts with the National Association of Insurance Commissioners addressing the development and management of pharmacy benefits; and be it further

RESOLVED, That our AMA develop model state legislation on the development and management of pharmacy benefits; and be it further

RESOLVED, That our AMA advocate for policies that prohibit price gouging on prescription medications when there are no justifiable factors or data to support the price increase; and be it further

RESOLVED, That our AMA continue implementation of its TruthinRx grassroots campaign to expand drug pricing transparency among pharmaceutical manufacturers, pharmacy benefit managers and health plans, and to communicate the impact of each of these segments on drug prices and access to affordable treatment; and be it further

RESOLVED, That our AMA report back to the House of Delegates at the 2018 Interim Meeting on the progress and impact of the TruthinRx grassroots campaign.

**807. STRUCTURAL BARRIERS TO ACHIEVING BETTER HEALTH CARE EFFICIENCY  
AND OUTCOMES: ACOs AND PHYSICIAN EMPLOYMENT BY HOSPITALS  
Introduced by Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont**

*Considered on reaffirmation calendar.*

**HOUSE ACTION: POLICIES H-160.915, H-285.954, H-330.925, H-450.938, D-160.923, D-240.994 AND  
D-330.997 REAFFIRMED  
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association study and report back on health system-led Accountable Care Organization related barriers to utilizing the site of service determined by the physician to be in the best interest of the patient.

**808. OPPOSITION TO REDUCED PAYMENT FOR THE 25 MODIFIER**

*Reference committee hearing: see report of Reference Committee J.*

**HOUSE ACTION: FOLLOWING ALTERNATIVE RESOLUTION ADOPTED  
IN LIEU OF RESOLUTION  
See Policy D-385.956**

RESOLVED, That our American Medical Association aggressively and immediately advocate through any legal means possible, including direct payer negotiations, regulation, legislation or litigation, to ensure when an evaluation and management (E&M) code is appropriately reported with a modifier 25, that both the procedure and E&M codes are paid at the non-reduced, allowable payment rate.

### **809. EXPANSION OF NETWORK ADEQUACY POLICY**

**Introduced by American Academy of Dermatology, American Society for Dermatologic Surgery Association, American College of Mohs Surgery, American Society of Dermatopathology, Society for Investigative Dermatology, Florida**

*Reference committee hearing: see report of Reference Committee J.*

#### **HOUSE ACTION: ADOPTED AS FOLLOWS**

*See Policy H-285.908*

RESOLVED, That our American Medical Association amend Policy H-285.908 by addition to read as follows:

H-285.908, Network Adequacy

12. Our AMA supports requiring that health insurers that terminate in-network providers:

a) Notify providers of pending termination at least 90 days prior to removal from network;

b) Give to providers, at least 60 days prior to distribution, a copy of the health insurer's letter notifying patients of the provider's change in network status; and

c) Allow the provider 30 days to respond to and contest if necessary the letter prior to its distribution.

### **810. PHARMACY BENEFIT MANAGERS AND PRESCRIPTION DRUG AFFORDABILITY**

**Introduced by American College of Rheumatology, American Academy of Dermatology, American Academy of Neurology, American Association of Clinical Endocrinologists, American Association of Clinical Urologists, American College of Gastroenterology, American Society of Clinical Oncology, Infectious Diseases Society of America**

**Resolution 810 was considered with resolutions 806 and 823. See Resolution [806](#).**

RESOLVED, That our American Medical Association expand the Truth in Rx advocacy campaign to include and explicitly address through educational outreach the effects of pharmacy benefit manager (PBM) practices on drug prices and access to affordable treatment; and be it further

RESOLVED, That our AMA engage in efforts to educate federal lawmakers about the role of PBM practices in drug pricing and urge Congressional action to increase transparency of PBM practices; and be it further

RESOLVED, That our AMA work at the federal and state level to increase transparency for PBMs by: eliminating increases in patient cost-sharing obligations for prescription drugs if such drugs are chosen for profit to the PBM; restricting PBM use of non-medical switching and other utilization management techniques related to PBM formulary development that disrupt the patient treatment plan; and further regulating PBM practices in order to ensure patients have access to effective and affordable medication therapies; and be it further

RESOLVED, That our AMA develop model guidelines for effective and meaningful transparency in the rebate system, to include PBM and health plan disclosure to physicians of the contracted cost of medications including discounts and rebates from manufacturers paid back to health plans and PBMs, and urge PBMs to take active steps to implement those guidelines.

### **811. UPDATE OBRA NURSING FACILITY PREADMISSION SCREENING REQUIREMENTS**

**Introduced by Michigan**

*Reference committee hearing: see report of Reference Committee J.*

#### **HOUSE ACTION: ADOPTED**

*See Policy D-280.986*

RESOLVED, That our American Medical Association work with the US Department of Health and Human Services and Congress to amend applicable statutes and regulations to revise the Preadmission Screening and Resident

Review requirement for nursing facility placement to provide more consistent enactment among states and to allow more reasonable and cost-effective approaches to this mandatory screening process.

**812. MEDICARE COVERAGE OF SERVICES PROVIDED BY PROCTORED MEDICAL STUDENTS**  
**Introduced by Michigan**

*Reference committee hearing: see report of Reference Committee J.*

**HOUSE ACTION: REFERRED FOR REPORT AT 2018 ANNUAL MEETING**

RESOLVED, That our American Medical Association amend Policy, H-390.999, “Payments to Physicians in Teaching Setting by Medicare Fiscal Intermediaries,” by addition as follows:

When a physician assumes responsibility for the services rendered to a patient by a medical student, a resident, or an intern, the physician may ethically bill the patient for services which were performed under the physician’s personal observation, direction, and supervision; and be it further

RESOLVED, That our AMA work with the Centers for Medicare and Medicaid Services to require coverage of medical services performed by medical students while under the physician’s personal observation, direction, and supervision.

**813. SUSTAIN PATIENT-CENTERED MEDICAL HOME PRACTICES**  
**Introduced by Michigan**

*Reference committee hearing: see report of Reference Committee J.*

**HOUSE ACTION: REFERRED**

RESOLVED, That our American Medical Association amend Policy H-160.918, “The Patient-Centered Medical Home,” by addition as follows:

Our AMA:

1. will urge the Centers for Medicare and Medicaid Services (CMS) to work with our AMA and national medical specialty societies to design incentives to enhance care coordination among providers who provide medical care for patients outside the medical home;
2. will urge CMS to assist physician practices seeking to qualify for and sustain medical home status with financial and other resources;
3. will advocate that Medicare incentive payments associated with the medical home model be paid for through system-wide savings--such as reductions in hospital admissions and readmissions (Part A), more effective use of pharmacologic therapies (Part D), and elimination of government subsidies for Medicare Advantage plans (Part C)—and not be subject to a budget neutrality offset in the Medicare physician payment schedule; and
4. will advocate that all health plans and CMS use a single standard to determine whether a physician practice qualifies to be a patient-centered medical home; and be it further

RESOLVED, That our AMA work with and encourage the Centers for Medicare and Medicaid Services to subsidize the cost of sustaining Patient-Centered Medical Home designated practices for practicing physicians.

**814. APPROPRIATE REIMBURSEMENT FOR EVALUATION AND MANAGEMENT SERVICES  
FOR PATIENTS WITH SEVERE MOBILITY-RELATED IMPAIRMENTS  
Introduced by American Academy of Physical Medicine and Rehabilitation**

*Reference committee hearing: see report of Reference Committee J.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**

*See Policy H-390.835*

RESOLVED, That our American Medical Association support additional reimbursement for evaluation and management services for patients who require additional time and specialized equipment during medical visits due to severe mobility-related impairments; and be it further

RESOLVED, That our AMA support that no additional cost-sharing for the additional reimbursement will be passed on to patients with mobility disabilities, consistent with Federal Law; and be it further

RESOLVED, That our AMA support that primary and specialty medical providers be educated regarding the care of patients with severely impaired mobility to improve access to care; and be it further

RESOLVED, That our AMA support additional funding for payment for services provided to patients with mobility-related impairments that is not through a budget neutral adjustment to the physician fee schedule.

**815. PEDIATRIC REPRESENTATION FOR E/M DOCUMENTATION GUIDELINE REVISION  
Introduced by American Academy of Pediatrics**

*Considered on reaffirmation calendar.*

**HOUSE ACTION: POLICY H-70.973 REAFFIRMED  
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That, in the process of collaborating with the Centers for Medicare and Medicaid Services for the future revision of Evaluation and Management Documentation Guidelines, our American Medical Association rely on the American Academy of Pediatrics in addressing the needs of pediatricians and their patients.

**816. SOCIAL DETERMINANTS OF HEALTH IN PAYMENT MODELS  
Introduced by American College of Preventive Medicine**

*Reference committee hearing: see report of Reference Committee J.*

**HOUSE ACTION: REFERRED**

RESOLVED, That our American Medical Association support payment reform policy proposals that incentivize screening for social determinants of health, as defined by Healthy People 2020, and referral to community support systems.

**817. ADDRESSING THE SITE OF SERVICE DIFFERENTIAL  
Introduced by New Mexico**

*Reference committee hearing: see report of Reference Committee J.*

**HOUSE ACTION: REFERRED FOR REPORT AT 2018 ANNUAL MEETING**

RESOLVED, That our American Medical Association study the Site of Service Differential with a report back no later than the 2018 Interim Meeting, including:

- a) The rising gap between independent practice expenses and Medicare reimbursement, taking into account the costs of the regulatory requirements;
- b) The increased cost of medical personnel and equipment, including electronic health record (EHR/EMR) purchase, software requirements, and ongoing support and maintenance;
- c) The expense of maintaining hospital based facilities not common to independent practices, such as burn units and emergency departments, and determine what payment should be provided to cover those explicit costs;
- d) The methodology by which hospitals report their uncompensated care, and the extent to which this is based on actual costs, not charges; and be it further

RESOLVED, That our AMA advocate for a combined Health Care Payment System for patients who receive care that is paid for by the Centers for Medicare and Medicaid Services (CMS), that:

- a) Follows the recommendation of MedPAC to pay “Site-Neutral” reimbursement that sufficiently covers practice expenses without regard to whether services are performed under the Hospital Outpatient Prospective Payment System (HOPPS) or the Physician Fee Schedule (PFS);
- b) Pays appropriate facility fees for both hospital owned facilities and independently owned non-hospital facilities, computed using the real costs of a facility based on its fair market value; and
- c) Provides independent practices with the same opportunity to receive reimbursement for uncompensated care as is provided to hospital owned practices.

### **818. ON-CALL AND EMERGENCY SERVICES PAY** **Introduced by Utah**

*Reference committee hearing: see report of Reference Committee J.*

#### **HOUSE ACTION: ADOPTED**

*See Policies H-130.948 and D-130.963*

RESOLVED, That our American Medical Association amend Policy H-130.948, “On-Call Physicians,” by addition to read as follows:

#### H-130.948 On-Call Physicians

Our AMA:

- (1) strongly encourages physicians and hospitals to work collaboratively to develop solutions based on adequate compensation or other appropriate incentives as the preferred method of ensuring on-call coverage and will monitor and oppose any state legislative or regulatory efforts mandating emergency room on-call coverage as a requirement for medical staff privileges and state licensure that are not supported by the state medical association;
- (2) advocates that physician on-call coverage for emergency departments be guided by the following principles:
  - (a) The hospital and physicians should jointly share the responsibility for the provision of care of emergency department patients.
  - (b) Every hospital that provides emergency services should maintain policies to ensure appropriate on-call coverage of the emergency department by medical staff specialists that are available for consultation and treatment of patients.
  - (c) The organization and function of on-call services should be determined through hospital policy and medical staff by-laws, and include methods for monitoring and assuring appropriate on-call performance.
  - (d) Physicians should be provided adequate compensation for being available and providing on-call and emergency services.
  - ~~(e)~~ (e) Hospital medical staff by-laws and emergency department policies regarding on-call physicians’ responsibilities must be consistent with Emergency Medical Treatment and Active Labor Act (EMTALA) requirements.
  - ~~(f)~~ (f) Medical staffs should determine and adopt protocols for appropriate, fair, and responsible medical staff on-call coverage.
  - ~~(g)~~ (g) Hospitals with specialized emergency care capabilities need to have a means to ensure medical staff responsibility for patient transfer acceptance and care.
  - ~~(h)~~ (h) Hospitals that lack the staff to provide on-call coverage for a particular specialty should have a plan that specifies how such care will be obtained.

- (~~h~~) (i) The decision to operate or close an emergency department should be made jointly by the hospital and medical staff;
- (3) supports the enforcement of existing laws and regulations that require physicians under contract with health plans to be adequately compensated for emergency services provided to the health plans' enrollees; and
- (4) supports the enactment of legislation that would require health plans to adequately compensate out-of-plan physicians for emergency services provided to the health plans' enrollees or be subject to significant fines similar to the civil monetary penalties that can be imposed on hospitals and physicians for violation of EMTALA; and be it further

RESOLVED, That our AMA develop and make available policy guidance for physicians to negotiate with hospital medical staffs to support physician compensation for on call and emergency services.

### **819. CONSULTATION CODES AND PRIVATE PAYERS**

**Introduced by American College of Rheumatology, American Academy of Allergy, Asthma & Immunology, Infectious Diseases Society of America, Georgia, District of Columbia, New Jersey**

*Reference committee hearing: see report of Reference Committee J.*

#### **HOUSE ACTION: ADOPTED**

*See Policy D-385.955*

RESOLVED, That our American Medical Association proactively engage and advocate with any commercial insurance company that discontinues payment for consultation codes or that is proposing to or considering eliminating payment for such codes, requesting that the company reconsider the policy change; and be it further

RESOLVED, Where a reason given by an insurance company for policy change to discontinue payment of consultation codes includes purported coding errors or abuses, that our AMA request the company carry out coding education and outreach to physicians on consultation codes rather than discontinue payment for the codes, and call for release of de-identified data from the company related to purported coding issues in order to help facilitate potential education by physician societies

### **820. ELIMINATION OF THE LABORATORY 14-DAY RULE UNDER MEDICARE**

**Introduced by American Society of Clinical Oncology, College of American Pathologists**

*Reference committee hearing: see report of Reference Committee J.*

#### **HOUSE ACTION: ADOPTED**

*See Policy D-330.903*

RESOLVED, That our American Medical Association actively lobby the federal government to change laboratory Date of Service rules under Medicare such that complex diagnostic laboratory services performed on pathologic specimens collected from a hospital procedure be paid separately from inpatient and outpatient bundled payments.

### **821. HORMONAL CONTRACEPTION AS A PREVENTIVE SERVICE**

**Introduced by Endocrine Society, American Association of Clinical Endocrinologists, American Society for Reproductive Medicine**

*Considered on reaffirmation calendar.*

#### **HOUSE ACTION: POLICIES H-180.958 AND H-425.969 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association advocate to rescind the 2017 Rule "Moral Exemptions and Accommodations for Coverage of Certain Preventive Services under the Affordable Care Act," to ensure that all women have access to no-cost hormonal contraception.

**822. ELIMINATION OF ALL COST-SHARING FOR SCREENING COLONOSCOPIES**  
**Introduced by Georgia**

*Reference committee hearing: see report of Reference Committee J.*

**HOUSE ACTION: REFERRED FOR REPORT AT 2018 ANNUAL MEETING**

RESOLVED, That the American Medical Association develop model national policy that supports the voluntarily removal of all cost-sharing associated with screening colonoscopies in all commercial and Medicare Advantage product lines and advocates for the adoption of these policies nationwide.

**823. UNCONSCIONABLE GENERIC DRUG PRICING**  
**Introduced by Georgia**

**Resolution 823 was considered with resolutions 806 and 810. See Resolution [806](#).**

RESOLVED, That our American Medical Association advocate for national legislation that will prohibit price gouging on off-patent medications where there are fewer than three manufacturers and where there have been no external factors to justify the price increase; and be it further

RESOLVED, That our AMA report back at the 2018 Annual Meeting on the results of the AMA *Truth in Rx Campaign* designed to bring attention to the rising prices of prescription drugs and the status of any proposed legislation on drug pricing transparency, price gouging, and expedited review of generic drug applications as called for in AMA Policy H-110.987.

**824. PAYMENT FOR DEMENTIA TREATMENT IN HOSPITALS AND OTHER  
 PSYCHIATRIC FACILITIES**  
**Introduced by Georgia**

*Reference committee hearing: see report of Reference Committee J.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**

*See Policy D-345.985*

RESOLVED, That our American Medical Association work with relevant specialty societies to promote appropriate payment for treatment for all types of dementias when patients are treated in an accredited facility, whether free-standing or part of a general medical facility, even when dementia is the primary diagnosis for admission.

**825. SUPPORT FOR VA HEALTH SERVICES FOR WOMEN VETERANS**  
**Introduced by Pennsylvania**

*Reference committee hearing: see report of Reference Committee J.*

**HOUSE ACTION: ADOPTED**

*See Policy H-510.981*

RESOLVED, That the American Medical Association recognize the disparity in access to care for women veterans; and be it further

RESOLVED, That our AMA encourage research to address this population's specific needs to improve patient outcomes.

**826. IMPROVING AFFORDABILITY OF INSULIN**  
**Introduced by American Association of Clinical Endocrinologists, The Endocrine Society**

*Reference committee hearing: see report of Reference Committee J.*

**HOUSE ACTION: REFERRED FOR REPORT AT 2018 ANNUAL MEETING**

RESOLVED, That our American Medical Association work with relevant medical specialty societies to convene a summit with participation by patients, clinicians, manufacturers, PBMs, insurers and the appropriate federal representatives to highlight the dramatic increase in insulin costs and identify potential solutions; and be it further

RESOLVED, That our AMA pursue solutions to reduce patient cost-sharing for insulin and ensure patients benefit from rebates at the point of sale; and be it further

RESOLVED, That our AMA work with health insurance companies and federal agencies to stabilize drug formularies and reduce non-medical switching by encouraging plans to cover insulin products at the same cost listed on a drug formulary throughout the entire plan year; and be it further

RESOLVED, That our AMA encourage insulin price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies; and be it further

RESOLVED, That our AMA work with electronic medical record vendors and insurance companies to integrate current formularies and price information into all systems so physicians and patients can make informed decisions on insulin products to reduce cost burdens on patients.

**827. HOSPITAL ACCREDITATION PROGRAMS AND MEDICAL STAFFS**  
**Introduced by Organized Medical Staff Section**

*Reference committee hearing: see report of Reference Committee J.*

**HOUSE ACTION: ADOPTED**  
*See Policy D-220.969*

RESOLVED, That our American Medical Association engage accrediting organizations to ensure that their hospital accreditation standards acknowledge the medical staff's essential role in the provision of high quality care, and otherwise appropriately position the medical staff to fulfill its responsibility to provide leadership and work collaboratively with the health care organization's administration and governing body to continuously improve patient care and outcomes.

**901. HARMFUL EFFECTS OF SCREEN TIME IN CHILDREN**

*Reference committee hearing: see report of Reference Committee K.*

**HOUSE ACTION: FOLLOWING ALTERNATIVE RESOLUTION ADOPTED  
 IN LIEU OF RESOLUTION**  
*See Policy H-60.911*

RESOLVED, That our American Medical Association encourage primary and secondary schools to incorporate into health class curricula the topic of balancing screen time with physical activity and sleep; and be it further

RESOLVED, That our AMA encourage primary care physicians to assess pediatric patients and educate parents about amount of screen time, physical activity and sleep habits.

**902. EXPANDING EXPEDITED PARTNER THERAPY TO TREAT TRICHOMONIASIS  
Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee K.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**

*See Policy H-440.868*

RESOLVED, That our American Medical Association amend Policy H-440.868 by addition and deletion to read as follows:

H-440.868, Expedited Partner Therapy

Our AMA supports state legislation that permits physicians to provide expedited partner therapy to patients diagnosed with gonorrhea, ~~and/or~~ chlamydia infection, and other sexually transmitted infections, as supported by scientific evidence and identified by the CDC.

**903. IMPROVING SCREENING AND TREATMENT GUIDELINES FOR DOMESTIC  
VIOLENCE AGAINST LESBIAN, GAY, BISEXUAL, TRANSGENDER,  
QUEER/QUESTIONING, AND OTHER INDIVIDUALS  
Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee K.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**

*See Policies H-65.976, H-160.991 and D-515.980*

RESOLVED, That our American Medical Association study recent domestic violence data and the unique issues faced by the LGBTQ population; and be it further

RESOLVED, That our AMA promote crisis resources for LGBTQ patients that cater to the specific needs of LGBTQ victims of domestic violence; and be it further

RESOLVED, That our AMA amend AMA Policy H-65.976 by addition to read as follows:

H-65.976, Nondiscriminatory Policy for the Health Care Needs of LGBTQ Populations

Our AMA encourages physician practices, medical schools, hospitals, and clinics to broaden any nondiscriminatory statement made to patients, healthcare workers, or employees to include “sexual orientation, sex, or gender identity” in any nondiscrimination statement;

RESOLVED, That our AMA amend AMA Policy H-160.991 by addition and deletion to read as follows:

H-160.991, Health Care Needs of Lesbian Gay Bisexual and Transgender Populations

1. Our AMA: (a) believes that the physician’s nonjudgmental recognition of patients’ sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, ~~and~~ transgender, queer/questioning, and other (LGBTQ) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBTQ patients; (iii) encouraging the development of educational programs in LGBTQ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBTQ people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBTQ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ patients; and (c) opposes, the use of “reparative” or “conversion” therapy for sexual orientation or gender identity.

2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for women who have sex with women to undergo regular cancer and sexually transmitted infection screenings due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; ~~and~~ (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; ~~and~~ (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors.
3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBTQ health issues.
4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBTQ people.

**904. EDUCATING PHYSICIANS ABOUT THE IMPORTANCE OF CERVICAL CANCER  
SCREENING FOR FEMALE-TO-MALE TRANSGENDER PATIENTS  
Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee K.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**

*See Policy H-160.991*

RESOLVED, That our American Medical Association amend Policy H-160.991[2] by addition to read as follows:

H-160.991, Health Care Needs of Lesbian Gay Bisexual and Transgender Populations

2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for sexual and gender minority individuals ~~women who have sex with women~~ to undergo regular cancer and sexually transmitted infection screenings based on anatomy due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; and (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases.

**905. ADDRESSING SOCIAL MEDIA USAGE AND ITS NEGATIVE IMPACTS ON MENTAL HEALTH  
Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee K.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**

*See Policy D-478.965*

RESOLVED, That our American Medical Association collaborate with relevant professional organizations to (a) support the development of continuing education programs to enhance physicians' knowledge of the health impacts of social media usage, and (b) support the development of effective clinical tools and protocols for the identification, treatment, and referral of children, adolescents, and adults at risk for and experiencing mental health sequelae of social media usage; and be it further

RESOLVED, That our AMA advocate for schools to provide safe and effective educational programs by which students can learn to identify and mitigate the onset of health sequelae of social media usage

**906. BREASTFEEDING IN MOTHERS WHO USE OPIOIDS  
Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee K.*

**HOUSE ACTION: ADOPTED AS FOLLOWS  
WITH CHANGE IN TITLE**  
*See Policies H-245.982 and H-420.962*

RESOLVED, That our American Medical Association’s Opioid Task Force promote educational resources for mothers who are breastfeeding on the benefits and risks of using opioids or medication-assisted therapy for opioid use disorder, based on the most recent guidelines; and be it further

RESOLVED, That our AMA amend by addition existing AMA Policy H-420.962, “Perinatal Addiction - Issues in Care and Prevention,” to read as follows:

H-420.962, Perinatal Addiction - Issues in Care and Prevention

Our AMA: (1) adopts the following statement: Transplacental drug transfer should not be subject to criminal sanctions or civil liability; (2) encourages the federal government to expand the proportion of funds allocated to drug treatment, prevention, and education. In particular, support is crucial for establishing and making broadly available specialized treatment programs for drug-addicted pregnant and breastfeeding women wherever possible; (3) urges the federal government to fund additional research to further knowledge about and effective treatment programs for drug-addicted pregnant and breastfeeding women, encourages also the support of research that provides long-term follow-up data on the developmental consequences of perinatal drug exposure, and identifies appropriate methodologies for early intervention with perinatally exposed children; (4) reaffirms the following statement: Pregnant and breastfeeding patients with substance use disorders should be provided with physician-led, team-based care that is evidence-based and offers the ancillary and supportive services that are necessary to support rehabilitation; and (5) through its communication vehicles, encourages all physicians to increase their knowledge regarding the effects of drug and alcohol use during pregnancy and breastfeeding and to routinely inquire about alcohol and drug use in the course of providing prenatal care.

**907. ADDRESSING HEALTHCARE NEEDS OF CHILDREN IN FOSTER CARE  
Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee K.*

**HOUSE ACTION: ADOPTED AS FOLLOWS  
WITH CHANGE IN TITLE**  
*See Policy H-60.910*

RESOLVED, That our American Medical Association advocate for comprehensive and evidence-based care that addresses the specific health care needs of children in foster care.

**908. UPDATING ENERGY POLICY AND EXTRACTION REGULATIONS TO  
PROMOTE PUBLIC HEALTH AND SUSTAINABILITY  
Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee K.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**  
*See Policies H-135.931 and H-135.949*

RESOLVED, That our American Medical Association amend Policy H-135.949 by addition and deletion to read as follows:

H-135.949, Support of Clean Air and Reduction in Power Plant Emissions

Our AMA supports (1) federal legislation and regulations that meaningfully reduce the following four major power plant emissions: mercury, carbon dioxide, sulfur dioxide and nitrogen oxide; and (2) efforts to limit carbon dioxide emissions through the reduction of the burning of coal in the nation's power generating plants, efforts to improve the efficiency of power plants, ~~substitution of natural gas in lieu of other carbon-based fossil fuels,~~ and continued development, promotion, and widespread implementation of alternative renewable energy sources in lieu of carbon-based fossil fuels.

RESOLVED, That our AMA support research on the implementation of buffer zones or well set-backs between oil and gas development sites and residences, schools, hospitals, and religious institutions, to determine the distance necessary to ensure public health and safety.

**909. EXPANDING NALOXONE PROGRAMS  
Introduced by Indiana**

*Reference committee hearing: see report of Reference Committee K.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**

*See Policy H-95.932*

RESOLVED, That our American Medical Association urge the Food and Drug Administration to study the practicality and utility of Naloxone rescue stations (public availability of Naloxone through wall-mounted display/storage units that also include instructions).

**910. IMPROVING TREATMENT AND DIAGNOSIS OF MATERNAL DEPRESSION  
THROUGH SCREENING AND STATE-BASED CARE COORDINATION  
Introduced by Women Physicians Section**

*Reference committee hearing: see report of Reference Committee K.*

**HOUSE ACTION: ADOPTED**

*See Policy D-420.991*

RESOLVED, That our American Medical Association work with stakeholders to encourage the implementation of a routine protocol for depression screening in pregnant and postpartum women presenting alone or with their child during prenatal, postnatal, pediatric, or emergency room visits; and be it further

RESOLVED, That our AMA encourage the development of training materials related to maternal depression to advise providers on appropriate treatment and referral pathways; and be it further

RESOLVED, That our AMA encourage the development of state-based care coordination programs (e.g., staffing a psychiatrist and care coordinator) to assure appropriate referral, treatment and access to follow-up maternal mental health care.

**911. STATE MATERNAL MORTALITY REVIEW COMMITTEES  
Introduced by American Congress of Obstetricians and Gynecologists**

*Reference committee hearing: see report of Reference Committee K.*

**HOUSE ACTION: ADOPTED**

*See Policy H-60.909*

RESOLVED, That our American Medical Association support the important work of maternal mortality review committees; and be it further

RESOLVED, That our AMA support work with state and specialty medical societies to advocate for state and federal legislation establishing Maternal Mortality Review Committees; and be it further

RESOLVED, That our AMA support work with state and specialty medical societies to secure funding from state and federal governments that fully supports the start-up and ongoing work of state Maternal Mortality Review Committees.

**912. CORRECTIVE STATEMENTS ORDERED TO BE PUBLISHED BY TOBACCO COMPANIES FOR THE VIOLATION OF THE RACKETEER INFLUENCED AND CORRUPT ORGANIZATIONS ACT  
Introduced by American College of Chest Physicians (CHEST), Oklahoma, American Thoracic Society**

*Reference committee hearing: see report of Reference Committee K.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**

*See Policy D-490.974*

RESOLVED, That our American Medical Association collaborate with state and medical specialty societies and other interested public health organizations to help educate the public and policymakers about the tobacco companies' organized conspiracy to commit fraud leading to the federal court verdict finding them in violation of the Racketeer Influenced and Corrupt Organization Act (RICO) and resulting in the corrective statements as ordered by the U.S. Court of Appeals in United States vs. Philip Morris; and be it further

RESOLVED, That our AMA encourage state and medical specialty societies to work with appropriate public health organizations in their states to help identify public policies that may have been directly or indirectly influenced by tobacco companies or their lobbyists and encourage lawmakers to remediate all such influences, to reject any potential tobacco industry influences in the future, and to formally censure the tobacco companies for their fraudulent and harmful behavior.

**913. INCREASED DEATH RATE AND DECREASED LIFE EXPECTANCY IN THE UNITED STATES  
Introduced by American College of Preventive Medicine**

*Reference committee hearing: see report of Reference Committee K.*

**HOUSE ACTION: ADOPTED**

*See Policy D-85.993*

RESOLVED, That our American Medical Association raise awareness of the recent reversals in the improvement of overall death rates and life expectancy with the message that these new problems in the United States are different from all other developed countries and that these trends need to be reversed promptly; and be it further

RESOLVED, That our AMA call on the legislative and executive branches of the Federal Government to fund and carry out investigations into the causes of these very unusual decreases in life expectancy and increases in death rates in order to design multi-disciplinary interventions to reverse these troubling changes; and be it further

RESOLVED, That our AMA encourage state and local medical societies to raise awareness of the new problems of decreasing life expectancy and increasing population death rates as indicators of major public health problems and advocate for local investigation of the causes and remedies for these disturbing problems

**914. SUPPORT OF TRAINING, ONGOING EDUCATION, AND CONSULTATION IN ORDER TO  
REDUCE THE HEALTH IMPACT OF PEDIATRIC ENVIRONMENTAL CHEMICAL EXPOSURES**  
Introduced by American Academy of Pediatrics

*Reference committee hearing: see report of Reference Committee K.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**

*See Policy H-135.922*

RESOLVED, That our American Medical Association support the mission of and ongoing funding of academically-based regional Pediatric Environmental Health Specialty Units (PEHSU) by the Agency for Toxic Substances and Disease Registry of the Centers for Disease Control and Prevention (ATSDR/CDC) and the Environmental Protection Agency (EPA); and be it further

RESOLVED, That our AMA support educational and consultative activities of the PEHSU program with local pediatricians, medical toxicologists, obstetricians, and others providing care to pregnant patients.

**915. EASING BARRIERS TO MEDICAL RESEARCH ON MARIJUANA DERIVATIVES**  
Introduced by Georgia

**Resolution 915 was considered with Council on Science and Public Health Report 5.  
See Council on Science and Public Health [Report 5](#).**

RESOLVED, That our American Medical Association work with the National Institutes of Health to advocate for easing the barriers to medical research regarding chemical components of marijuana such as cannabidiol that show great promise.

**916. HOSPITAL DISASTER PLANS AND MEDICAL STAFFS**  
Introduced by Organized Medical Staff Section

*Reference committee hearing: see report of Reference Committee K.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**

*See Policy H-225.941*

RESOLVED, That our American Medical Association: (1) encourage appropriate stakeholders to examine the barriers and facilitators that medical staffs encounter following a natural or other disaster; and (2) encourage hospitals to incorporate, within their hospital disaster plans, workplace and personal preparedness efforts that reduce barriers to staff response during a natural or other disaster, both within their institutions and across the community

<b>NO RESOLUTIONS WERE NUMBERED FROM 917 THROUGH 950.</b>
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**Resolution 951 was not considered.**

**952. IMPLICIT BIAS, DIVERSITY AND INCLUSION IN MEDICAL EDUCATION  
AND RESIDENCY TRAINING  
Introduced by Resident and Fellow Section**

*Reference committee hearing: see report of Reference Committee K.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**

*See Policy H-350.974*

RESOLVED, That our American Medical Association: (1) actively support the development and implementation of training regarding implicit bias, diversity and inclusion in all medical schools and residency programs; (2) identify and publicize effective strategies for educating residents in all specialties about disparities in their fields related to race, ethnicity, and all populations at increased risk, with particular regard to access to care and health outcomes, as well as effective strategies for educating residents about managing the implicit biases of patients and their caregivers; and (3) support research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations.

**953. FEES FOR TAKING MAINTENANCE OF CERTIFICATION EXAMINATION  
Introduced by Virginia**

*Reference committee hearing: see report of Reference Committee K.*

**HOUSE ACTION: POLICY H-275.924 AMENDED BY ADDITION AND DELETION  
TO READ AS FOLLOWS  
IN LIEU OF RESOLUTION 953**

H-275.924, Maintenance of Certification  
AMA Principles on Maintenance of Certification (MOC)

1. Changes in specialty-board certification requirements for MOC programs should be longitudinally stable in structure, although flexible in content.
2. Implementation of changes in MOC must be reasonable and take into consideration the time needed to develop the proper MOC structures as well as to educate physician diplomates about the requirements for participation.
3. Any changes to the MOC process for a given medical specialty board should occur no more frequently than the intervals used by that specialty board for MOC.
4. Any changes in the MOC process should not result in significantly increased cost or burden to physician participants (such as systems that mandate continuous documentation or require annual milestones).
5. MOC requirements should not reduce the capacity of the overall physician workforce. It is important to retain a structure of MOC programs that permits physicians to complete modules with temporal flexibility, compatible with their practice responsibilities.
6. Patient satisfaction programs such as The Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient survey are neither appropriate nor effective survey tools to assess physician competence in many specialties.
7. Careful consideration should be given to the importance of retaining flexibility in pathways for MOC for physicians with careers that combine clinical patient care with significant leadership, administrative, research and teaching responsibilities.
8. Legal ramifications must be examined, and conflicts resolved, prior to data collection and/or displaying any information collected in the process of MOC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with MOC participation.
9. Our AMA affirms the current language regarding continuing medical education (CME): "Each Member Board will document that diplomates are meeting the CME and Self-Assessment requirements for MOC Part II. The content of CME and self-assessment programs receiving credit for MOC will be relevant to advances within the diplomate's scope of practice, and free of commercial bias and direct support from pharmaceutical

and device industries. Each diplomate will be required to complete CME credits (AMA PRA Category 1 Credit™, American Academy of Family Physicians Prescribed, American College of Obstetricians and Gynecologists, and/or American Osteopathic Association Category 1A).”

10. In relation to MOC Part II, our AMA continues to support and promote the AMA Physician’s Recognition Award (PRA) Credit system as one of the three major credit systems that comprise the foundation for continuing medical education in the U.S., including the Performance Improvement CME (PICME) format; and continues to develop relationships and agreements that may lead to standards accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies and other entities requiring evidence of physician CME.

11. MOC is but one component to promote patient safety and quality. Health care is a team effort, and changes to MOC should not create an unrealistic expectation that lapses in patient safety are primarily failures of individual physicians.

12. MOC should be based on evidence and designed to identify performance gaps and unmet needs, providing direction and guidance for improvement in physician performance and delivery of care.

13. The MOC process should be evaluated periodically to measure physician satisfaction, knowledge uptake and intent to maintain or change practice.

14. MOC should be used as a tool for continuous improvement.

15. The MOC program should not be a mandated requirement for licensure, credentialing, recredentialing, privileging, reimbursement, network participation, employment, or insurance panel participation.

16. Actively practicing physicians should be well-represented on specialty boards developing MOC.

17. Our AMA will include early career physicians when nominating individuals to the Boards of Directors for ABMS member boards.

18. MOC activities and measurement should be relevant to clinical practice.

19. The MOC process should be reflective of and consistent with the cost of development and administration of the MOC components, ensure a fair fee structure, and not be cost prohibitive or present a barriers to patient care.

20. Any assessment should be used to guide physicians’ self-directed study.

21. Specific content-based feedback after any assessment tests should be provided to physicians in a timely manner.

22. There should be multiple options for how an assessment could be structured to accommodate different learning styles.

23. Physicians with lifetime board certification should not be required to seek recertification.

24. No qualifiers or restrictions should be placed on diplomates with lifetime board certification recognized by the ABMS related to their participation in MOC.

25. Members of our House of Delegates are encouraged to increase their awareness of and participation in the proposed changes to physician self-regulation through their specialty organizations and other professional membership groups.

26. The initial certification status of time-limited diplomates shall be listed and publicly available on all American Board of Medical Specialties (ABMS) and ABMS Member Boards’ websites and physician certification databases. The names and initial certification status of time-limited diplomates shall not be removed from ABMS and ABMS Member Boards’ websites or physician certification databases even if the diplomate chooses not to participate in MOC.

27. That our AMA continue to work with the national medical specialty societies to advocate for the physicians of America to receive value in the services they purchase for Maintenance of Certification from their specialty boards. Value in MOC should include cost effectiveness with full financial transparency, respect for physicians’ time and their patient care commitments, alignment of MOC requirements with other regulator and payer requirements, and adherence to an evidence basis for both MOC content and processes.

**954. DEVELOPING PHYSICIAN LED PUBLIC HEALTH/POPULATION HEALTH  
CAPACITY IN RURAL COMMUNITIES  
Introduced by West Virginia**

*Reference committee hearing: see report of Reference Committee K.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**

*See Policy D-295.311*

RESOLVED, That our American Medical Association, with the participation of the appropriate educational and certifying entities, study innovative approaches that could be developed and/or implemented to support interested physicians as they seek qualifications and credentials in preventive medicine/public health to strengthen public health leadership, especially in rural communities.

**955. MINIMIZATION OF BIAS IN THE ELECTRONIC RESIDENCY  
APPLICATION SERVICE RESIDENCY APPLICATION  
Introduced by International Medical Graduates Section**

*Reference committee hearing: see report of Reference Committee K.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**

*See Policy H-310.919*

RESOLVED, That our American Medical Association encourage the Association of American Medical Colleges (AAMC) and its Electronic Residency Application Service (ERAS) Advisory Committee to develop steps to minimize bias in the ERAS and the residency training selection process; and be it further

RESOLVED, That our AMA advocate that modifications in the ERAS Residency Application to minimize bias consider the effects these changes may have on efforts to increase diversity in residency programs.

**956. HOUSE PHYSICIANS CATEGORY  
Introduced by International Medical Graduates Section**

*Reference committee hearing: see report of Reference Committee K.*

**HOUSE ACTION: NOT ADOPTED**

RESOLVED, That our American Medical Association work with state legislators and other regulatory organizations to develop the category of "House Physicians" to help address the anticipated physician need and shortfall of available practitioners in underserved areas of the United States.

**957. STANDARDIZATION OF FAMILY PLANNING TRAINING OPPORTUNITIES  
IN OB-GYN RESIDENCIES  
Introduced by Michigan**

*Reference committee hearing: see report of Reference Committee K.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**

*See Policy H-295.923*

RESOLVED, That our American Medical Association encourage the Accreditation Council for Graduate Medical Education to better enforce compliance with the standardization of abortion training opportunities as per requirements set forth by the Review Committee for Obstetrics and Gynecology and the American Congress of Obstetricians and Gynecologists' recommendations.

**958. SEX AND GENDER BASED MEDICINE IN CLINICAL MEDICAL EDUCATION**  
**Introduced by Michigan**

*Reference committee hearing: see report of Reference Committee K.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**

*See Policy D-295.310*

RESOLVED, That our American Medical Association collaborate with the Accreditation Council for Graduate Medical Education, Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, Association of American Medical Colleges, and Accreditation Council for Continuing Medical Education to disseminate the work produced by medical schools participating in the Accelerating Change in Medical Education consortium and distribute pertinent information and a comprehensive bibliography about the influence that sex and gender have upon clinical medicine.

**959. LIFESTYLE MEDICINE EDUCATION IN MEDICAL SCHOOL TRAINING AND PRACTICE**  
**Introduced by American College of Preventive Medicine**

*Reference committee hearing: see report of Reference Committee K.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**

*See Policy H-425.972*

RESOLVED, That our American Medical Association support policies and mechanisms that incentivize and/or provide funding for the inclusion of lifestyle medicine education and social determinants of health in undergraduate, graduate and continuing medical education.

**960. MEDICAL STUDENT INVOLVEMENT AND VALIDATION OF THE  
 STANDARDIZED VIDEO INTERVIEW IMPLEMENTATION**  
**Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee K.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**

*See Policy D-310.949*

RESOLVED, That our American Medical Association work with the Association of American Medical Colleges and its partners to advocate for medical students and residents to be recognized as equal stakeholders in any changes to the residency application process, including any future working groups related to the residency application process; and be it further

RESOLVED, That our AMA advocate for delaying expansion of the Standardized Video Interview until data demonstrates the Association of American Medical Colleges' stated goal of predicting resident performance, and make timely recommendations regarding the efficacy and implications of the Standardized Video Interview as a mandatory residency application requirement; and be it further

RESOLVED, That our AMA, in collaboration with the Association of American Medical Colleges, study the potential implications and repercussions of expanding the Standardized Video Interview to all residency applicants.