

APPENDIX 1**REPORTS OF REFERENCE COMMITTEES****2019 Interim Meeting of the American Medical Association House of Delegates**

Reference committee reports from the House of Delegates meeting are provided for the sake of convenience and because they are part of the record of each meeting.

The Proceedings reflect the official record of the actions taken by the House of Delegates at a given meeting. Discrepancies between the reference committee reports and the actual Proceedings may exist, as the Proceedings are prepared using multiple sources. Policies deriving from House actions are recorded in PolicyFinder, which is updated following each House of Delegates meeting.

Note: Reference committee reports have historically been printed on blue paper; hence the blue background here. Beginning with this meeting, the original language of report recommendations and the original resolve clauses from resolutions are included in the reference committee reports with a light-colored background as in the example below:

The Board of Trustees recommends that the following be adopted in lieu of the resolution and the remainder of this report be filed.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (I-19)

Report of Reference Committee on Amendments to Constitution and Bylaws
David Walsworth, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Board of Trustees Report 17 – Specialty Society Representation in the House of Delegates – Five-Year Review
2. Council on Constitution & Bylaws Report 1 – Parity in our AMA House of Delegates
3. Council on Constitution & Bylaws Report 2 – Bylaw Consistency—Certification Authority for Societies Represented in our AMA House of Delegates and Advance Certification for those Societies
4. Council on Constitution & Bylaws Report 3 – AMA Delegate Apportionment
5. Council on Ethical and Judicial Affairs Report 1 – Competence, Self-Assessment and Self-Awareness
6. Resolution 2 – Endorsing the Creation of a Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) Research IRB Training

RECOMMENDED FOR ADOPTION AS AMENDED

7. Resolution 3 – Accurate Collection of Preferred Language and Disaggregated Race and Ethnicity to Characterize Health Disparities
8. Resolution 4 – Improving Inclusiveness of Transgender Patients Within Electronic Medical Record Systems
9. Resolution 7 – Addressing the Racial Pay Gap in Medicine
10. Resolution 10 – Ban Conversion Therapy of LGBTQ Youth
11. Resolution 11 – End Child Marriage

RECOMMENDED FOR REFERRAL

12. Council on Ethical and Judicial Affairs Report 2 – Amendment to E-1.2.2., “Disruptive Behavior by Patients”
13. Resolution 1 – Support for the Use of Psychiatric Advance Directives
14. Resolution 5 – Removing Sex Designation from the Public Portion of the Birth Certificate
15. Resolution 9 – Data for Specialty Society Five-Year Review

RECOMMENDED FOR NOT ADOPTION

16. Resolution 12 – Study of Forced Organ Harvesting by China

RECOMMENDED FOR ADOPTION

- (1) BOARD OF TRUSTEES REPORT 17 – SPECIALTY SOCIETY REPRESENTATION IN THE HOUSE OF DELEGATES – FIVE-YEAR REVIEW

RECOMMENDATION:

Recommendations in Board of Trustees Report 17 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendations in Board of Trustees Report 17 adopted and the remainder of the Report be filed

The Board of Trustees recommends that the following be adopted, and the remainder of this report be filed:

1. That the American College of Cardiology, American College of Chest Physicians, American College of Emergency Physicians, American College of Gastroenterology, American College of Nuclear Medicine, American Medical Group Association and the National Association of Medical Examiners retain representation in the American Medical Association House of Delegates. (Directive to Take Action)
2. That the American Medical Group Association be reclassified as a Professional Interest Medical Association (PIMA). (Directive to Take Action)

The report was introduced by a member of the Board of Trustees and no further testimony was heard. Your Reference Committee recommends that Board of Trustees Report 17 be adopted.

- (2) COUNCIL ON CONSTITUTION & BYLAWS REPORT 1 – PARITY IN OUR AMA HOUSE OF DELEGATES

RECOMMENDATION:

Recommendations in Council on Constitution and Bylaws Report 1 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendations in Council on Constitution and Bylaws Report 1 adopted and the remainder of the Report be filed

The Council on Constitution and Bylaws recommends: 1) that the following amendments to the AMA Bylaws be adopted; and 2) that the remainder of this report be filed. Adoption requires the affirmative vote of two-thirds of the members of the House of Delegates present and voting.

2.10 Registration and Seating of Delegates.

2.10.5 Constituent Association President. The current president of a constituent association may also be certified as an additional alternate delegate at the discretion of each constituent association.

2.10.6 National Medical Specialty Society or Professional Interest Medical Association President. The current president of a national medical specialty society or a professional interest medical association may also be certified as an additional alternate delegate at the discretion of each national medical specialty society or professional interest medical association.

The report was introduced by the authors, and no further testimony was heard. Your Reference Committee therefore recommends that Council on Constitution and Bylaws Report 1 be adopted.

- (3) COUNCIL ON CONSTITUTION & BYLAWS REPORT 2 – BYLAW CONSISTENCY—CERTIFICATION AUTHORITY FOR SOCIETIES REPRESENTED IN OUR AMA HOUSE OF DELEGATES AND ADVANCE CERTIFICATION FOR THOSE SOCIETIES

RECOMMENDATION:

Recommendations in Council on Constitution and Bylaws Report 2 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendations in Council on Constitution and Bylaws Report 2 adopted and the remainder of the Report be filed

The Council on Constitution and Bylaws recommends: 1) that the following amendments to the AMA Bylaws be adopted; and 2) that the remainder of this report be filed. Adoption requires the affirmative vote of two-thirds of the members of the House of Delegates present and voting.

2.1.4 Certification. The president ~~or secretary~~ of each constituent association, or the president's designee, shall certify to the AMA the delegates and alternate delegates from their respective associations. Certification must occur at least 30 days prior to the Annual or Interim Meeting of the House of Delegates.

2.2.4 Certification. The president ~~or secretary~~ of each specialty society, or the president's designee, shall certify to the AMA the delegates and alternate delegates from their respective societies. Certification must occur at least 30 days prior to the Annual or Interim Meeting of the House of Delegates.

2.3.4 Certification. The Chair of the Medical Student Section Governing Council, or the Chair's designee, shall certify to the AMA the delegates and alternate delegates ~~for~~ from each Medical Student Region. Certification of delegates and alternate delegates must occur at least 30 days prior to the Annual Meeting of the House of Delegates.

2.4.4 Certification. The Chair of the Resident and Fellow Section Governing Council, ~~his or her~~ the Chair's designee, shall certify to the AMA the delegates and alternate delegates for the Resident and Fellow Section. Certification of delegates and alternate delegates must occur at least 30 days prior to the Annual Meeting of the House of Delegates.

2.6 Other Delegates. Each of the following is entitled to a delegate: AMA Sections; the Surgeons General of the United States Army, United States Navy, United States Air Force, and United States Public Health Service; the Chief Medical Director of the Department of Veterans Affairs; the National Medical Association; the American Medical Women's Association; the American Osteopathic Association; and professional interest medical associations granted representation in the House of Delegates.

2.6.1 Certification. The president, ~~secretary~~ or other authorized individual of each entity shall certify to the AMA their respective delegate and alternate delegate. Certification must occur 30 days prior to the Annual or Interim Meeting.

2.10 Registration and Seating of Delegates.

2.10.2 Credentials. ~~A delegate or alternate delegate may only be seated if there is. Before being seated at any meeting of the House of Delegates, each delegate or alternate delegate shall deposit with the Committee on Rules and Credentials a certificate certification on file signed by the president, secretary, or other authorized individual of the delegate's or alternate delegate's organization stating that the delegate or alternate delegate has been properly selected to serve in the House of Delegates.~~

2.10.3 Lack of Credentials. A delegate or alternate delegate may be seated without the certificate defined in Bylaw 2.10.2 provided proper identification as the delegate or alternate delegate selected by the respective ~~organization~~ entity is established, and so certified to the AMA.

2.10.4 Substitute. When a delegate or alternate delegate is unable to attend a meeting of the House of Delegates, the ~~appropriate authorities president, the president's designee or other authorized individual of the organization entity~~ may appoint a substitute delegate or substitute alternate delegate, who ~~on presenting proper credentials~~ shall be eligible to serve as such delegate or alternate delegate in the House of Delegates at that meeting.

2.10.4.1 Temporary Substitute Delegate. A delegate whose credentials have been accepted by the Committee on Rules and Credentials and whose name has been placed on the roll of the House of Delegates shall remain a delegate until final adjournment of that meeting of the House of Delegates. However, if the delegate is not able to remain in attendance, that place of that delegate may be taken during the period of absence by an alternate delegate, or a substitute alternate delegate selected in accordance with Bylaw 2.10.4 if an alternate delegate is not available. The person who takes the place of the delegate must ~~comply with the formal recredentialing procedures established by the Committee on Rules and Credentials for such purpose~~ have certification on file and shall be known as a temporary substitute delegate. Such temporary substitute delegate shall have all of the rights and privileges of a delegate while serving as a temporary substitute delegate, including the right to vote in the House of Delegates and to vote in any election conducted by the House of Delegates. The temporary substitute delegate shall not be eligible for nomination or election as Speaker or Vice Speaker of the House of Delegates.

2.10.67 Representation. No delegate or alternate delegate may be ~~registered~~ credentialled or seated at any meeting to represent more than one organization in the House of Delegates.

Limited testimony was heard requesting a minor amendment to the report in order to ensure the most updated badge credentials are provided. In response to this concern, authors noted that badges and other meeting logistics are and will continue to be executed by appropriate staff, and thus do not affect the Bylaws. No other testimony was heard. Your Reference Committee recommends that Council on Constitution and Bylaws Report 3 be adopted.

- (4) COUNCIL ON CONSTITUTION & BYLAWS REPORT 3 – AMA
DELEGATE APPORTIONMENT

RECOMMENDATION:

Recommendations in Council on Constitution and Bylaws Report 3 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendations in Council on Constitution and Bylaws Report 3 adopted and the remainder of the Report be filed

The Council on Constitution and Bylaws recommends the following:

1. That the following amendment to the AMA Bylaws be adopted. Adoption requires the affirmative vote of two-thirds of the members of the House of Delegates present and voting.

2.1 Constituent Associations. Each recognized constituent association granted representation in the House of Delegates is entitled to delegate representation based on the number of seats allocated to it by apportionment, and such additional delegate seats as may be provided under Bylaw 2.1.1.2. Only one constituent association from each U.S. state, commonwealth, territory, or possession shall be granted representation in the House of Delegates.

2.1.1 Apportionment. The apportionment of delegates from each constituent association is one delegate for each 1,000, or fraction thereof, active constituent and active direct members of the AMA within the jurisdiction of each constituent association, as recorded by the AMA as of December 31 of each year.

2.1.1.1 The December 31 count will include pending members for purposes of apportionment; however, pending members shall not be recounted the following year absent membership renewal. This Bylaw will sunset as of the close of business of the 2022 Interim Meeting unless the House of Delegates acts to retain it.

[Subsequent bylaw provisions shall be renumbered] (Modify Bylaws)

2. That Policy G-600.016(2) be amended by addition to read as follows:

“Pending members” (defined as individuals who at the time they apply for membership are not current in their dues and who pay dues for the following calendar year) will be added to the number of active AMA members in the December 31 count for the purposes of AMA delegate allocations to state medical societies for the following year and this total will be used to determine the number of national medical specialty delegates to maintain parity. (Modify Current HOD Policy)

3. That the remainder of this report be filed.

The only testimony heard regarding this report suggested that if the House of Delegates acts to retain this amendment at the 2022 Interim Meeting, the Council on Constitution and Bylaws could consider adding the definition of the term “pending” to the Bylaws themselves. This term is also included in the glossary. Your Reference Committee recommends that Council on Constitution and Bylaws Report 3 be adopted.

- (5) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS REPORT 1 –
COMPETENCE, SELF-ASSESSMENT AND SELF-AWARENESS

RECOMMENDATION:

Recommendations in Council on Ethical and Judicial Affairs Report 1 be adopted and the remainder of the report be filed.

**HOD ACTION: Recommendations in Council on Ethical and Judicial Affairs
Report 1 adopted and the remainder of the report be filed**

Based on the foregoing analysis, the Council on Ethical and Judicial Affairs recommends that the following be adopted and the remainder of this report be filed:

The expectation that physicians will provide competent care is central to medicine. It undergirds professional autonomy and the privilege of self-regulation granted by society. To this end, medical schools, residency and fellowship programs, specialty boards, and other health care organizations regularly assess physicians’ technical knowledge and skills.

However, as an ethical responsibility competence encompasses more than medical knowledge and skill. It requires physicians to understand that as a practical matter in the care of actual patients, competence is fluid and dependent on context. Each phase of a medical career, from medical school through retirement, carries its own implications for what a physician should know and be able to do to practice safely and to maintain effective relationships with patients and with colleagues. Physicians at all stages of their professional lives need to be able to recognize when they are and when they are not able to provide appropriate care for the patient in front of them or the patients in their practice as a whole.

To fulfill the ethical responsibility of competence, individual physicians and physicians in training should strive to:

- (a) Cultivate continuous self-awareness and self-observation.
- (b) Recognize that different points of transition in professional life can make different demands on competence.

(c) Take advantage of well-designed tools for self-assessment appropriate to their practice settings and patient populations.

(d) Seek feedback from peers and others.

(e) Be attentive to environmental and other factors that may compromise their ability to bring appropriate skills to the care of individual patients and act in the patient's best interest.

(f) Maintain their own health, in collaboration with a personal physician, in keeping with ethics guidance on physician health and wellness.

(g) Intervene in a timely, appropriate, and compassionate manner when a colleague's ability to practice safely is compromised by impairment, in keeping with ethics guidance on physician responsibilities to impaired colleagues.

Medicine as a profession should continue to refine mechanisms for assessing knowledge and skill and should develop meaningful opportunities for physicians and physicians in training to hone their ability to be self-reflective and attentive in the moment.

Testimony was heard that was generally supportive of the changes made to CEJA Report 1 since last submitted, with a number of speakers suggesting that the report should be accepted as written. However, several speakers felt that the recommendations would be stronger if certain explanatory parts of the report body were included. However, your Reference Committee believes that the language referenced (pg. 5, line 39-42: "Physicians who are unable to recognize that they are impaired due to cognitive disability or other illness are not necessarily blameworthy or unethical, unless they decline to address their condition and modify their practice once others have drawn attention to their inability to continue practicing medicine safely.") is appropriately placed in the report as an explanation of the recommendations which become policy. Further, your Reference Committee would like to note that the guidance is offered as something physicians should "strive" to do, as opposed to more stringent Ethics policies which use "must" or "should". Your Reference Committee recommends that Council on Ethical and Judicial Affairs Report 1 be adopted.

(6) RESOLUTION 2 – ENDORSING THE CREATION OF A LESBIAN, GAY, BISEXUAL, TRANSGENDER, AND QUEER (LGBTQ) RESEARCH IRB TRAINING

RECOMMENDATION:

Resolution 2 be adopted.

HOD ACTION: Resolution 2 adopted

RESOLVED, That our American Medical Association work with appropriate stakeholders to support the creation of model training for Institutional Review Boards to use and/or modify for their unique institutional needs as it relates to research collecting data on Lesbian, Gay, Bi-sexual, Transgender and Queer populations. (Directive to Take Action)

Nearly unanimous testimony was heard in support of this resolution. Speakers noted that the resolution is in line with the policies of their own associations and that this training would help to appropriately increase data collection on the populations mentioned in the resolution, which is currently lacking. Speakers also noted that the resolution is in line with other AMA policies recognizing health care disparities and that research should protect and effectively recognize vulnerable populations. Limited testimony in opposition questioned the necessity of the report given how Institutional Review Boards function. Your Reference Committee recommends that Resolution 2 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

- (7) RESOLUTION 3 – ACCURATE COLLECTION OF PREFERRED LANGUAGE AND DISAGGREGATED RACE AND ETHNICITY TO CHARACTERIZE HEALTH DISPARITIES

RECOMMENDATION A:

The first Resolve of Resolution 3 be amended by addition and deletion.

RESOLVED, That our American Medical Association amend Policy H-315.996 by addition to read as follows:

Accuracy in Racial, Ethnic, Lingual, and Religious Designations in Medical Records, H-315.996

The AMA advocates precision without regulatory requirement or mandatory reporting of ~~in~~ racial, ethnic, preferred language, and religious designations in medical records, with information obtained from the patient, always respecting the personal privacy and communication preferences of the patient (Modify Current HOD Policy); and be it further

RECOMMENDATION B:

The second Resolve of Resolution 3 be amended by addition to read as follows:

RESOLVED, That our AMA encourage the Office of the National Coordinator for Health Information Technology (ONC) to expand their data collection requirements, such that electronic health record (EHR) vendors include options for disaggregated coding of race, ~~and~~ ethnicity and preferred language. (Directive to Take Action)

RECOMMENDATION C:

Resolution 3 be adopted as amended.

HOD ACTION: Resolution 3 adopted as amended

RESOLVED, That our American Medical Association amend Policy H-315.996 by addition to read as follows:

Accuracy in Racial, Ethnic, Lingual, and Religious Designations in Medical Records, H-315.996

The AMA advocates precision in racial, ethnic, preferred language, and religious designations in medical records, with information obtained from the patient, always respecting the personal privacy of the patient (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA encourage the Office of the National Coordinator for Health Information Technology (ONC) to expand their data collection requirements, such that electronic health record (EHR) vendors include options for disaggregated coding of race and ethnicity. (Directive to Take Action)

Nearly unanimous testimony was heard in support of the resolution. Speakers testified that inadequate data is a major contributor to disparities in health care, one reason being that data is used to determine the distribution of resources. Limited testimony in opposition noted the possibility of the resolution leading to increased EHR burdens and costs. An amendment was offered with the goal of making the resolution more realistic to implement and a number of subsequent speakers stated their support for that amendment. Your Reference Committee recommends that Resolution 3 be adopted as amended.

(8) RESOLUTION 4 – IMPROVING INCLUSIVENESS OF TRANSGENDER PATIENTS WITHIN ELECTRONIC MEDICAL RECORD SYSTEMS

RECOMMENDATION A:

Resolution 4 be amended by addition and deletion.

Our AMA: (1) supports the voluntary inclusion of a patient’s biological sex, current gender identity, sexual orientation, ~~and preferred gender pronoun(s), preferred name, and an inventory of current anatomy~~ clinically relevant, sex specific anatomy in medical documentation, and related forms, including in electronic health records, in a culturally-sensitive and voluntary manner; ~~and~~ (2) will advocate for collection of patient data in medical documentation and in medical research studies, according to current best practices, that is inclusive of sexual orientation, gender identity, and other sexual and gender minority traits for the purposes of research into patient and population health; (3) will research the problems related to the handling of sex and gender within health information technology (HIT) products and how to best work with vendors so their HIT products treat patients equally and appropriately, regardless of sexual or gender identity; (4) will investigate the use of personal health records to reduce physician burden in maintaining accurate patient information instead of having to query each patient regarding sexual orientation and gender identity at each encounter; and (5) will advocate for the incorporation of recommended best practices into electronic health records and other HIT products at no additional cost to physicians. (Modify Current HOD Policy)

RECOMMENDATION B:

Resolution 4 be adopted as amended.

HOD ACTION: Resolution 4 adopted as amended

RESOLVED, That our AMA amend Policy H-315.967, “Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation,” by addition and deletion to read as follows:

Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation, H-315.967

Our AMA: (1) supports the voluntary inclusion of a patient’s biological sex, current gender identity, sexual orientation, ~~and preferred gender pronoun(s), preferred name, and an inventory of current anatomy~~ in medical documentation and related forms, including in electronic health records, in a culturally-sensitive and voluntary manner and (2) will advocate for collection of patient data in medical documentation and in medical research studies, according to current best practices, that is inclusive of sexual orientation, gender identity, and other sexual and gender minority traits for the purposes of research into patient and population health; (3) will research the problems related to the handling of sex and gender within health information technology (HIT) products and how to best work with vendors so their HIT products treat patients equally and appropriately, regardless of sexual or gender identity; (4) will investigate the use of personal health records to reduce physician burden in maintaining accurate patient information instead of having to query each patient regarding sexual orientation and gender identity at each encounter; and (5) will advocate for the incorporation of recommended best practices into electronic health records and other HIT products at no additional cost to physicians. (Modify Current HOD Policy)

The authors introduced the report with an amendment meant to clarify the intent of the resolution. Unanimous testimony was heard in support of the resolution as amended, with speakers noting that having the information available would be beneficial, and that the resolution would put AMA policy in line with recommendations of advocacy groups. Speakers also noted that the absence of this information is a major barrier to providing quality care. Your Reference Committee recommends that Resolution 4 be adopted as amended.

(9) RESOLUTION 7 – ADDRESSING THE RACIAL PAY GAP IN MEDICINE

RECOMMENDATION A:

The first Resolve of Resolution 7 be amended by addition and deletion.

RESOLVED, That our American Medical Association support measures to eliminate racial disparity in pay of racial pay awareness and the specific challenges that minority physicians face in regards to equal pay financial attainment (New HOD Policy); and be it further

RECOMMENDATION B:

The second Resolve of Resolution 7 be amended by addition and deletion.

RESOLVED, That our AMA work with appropriate stakeholders to study effective and appropriate measures support efforts to increase the transparency and accountability of physician earnings through establishing transparency measures, in which physicians can access information including but not limited to the salaries and race of medical physicians. (New HOD Policy)

RECOMMENDATION C:

Resolution 7 be adopted as amended.

RESOLVED, That our American Medical Association support measures of racial pay awareness and the specific challenges that minority physicians face in regards to equal pay financial attainment (New HOD Policy); and be it further

RESOLVED, That our AMA support efforts to increase the transparency and accountability of physician earnings through establishing transparency measures, in which physicians can access information including but not limited to the salaries and race of medical physicians. (New HOD Policy)

The resolution was introduced by the authors, who recognized that the second Resolve clause may be difficult to implement as written. Testimony was heard in almost unanimous support of the resolution's first Resolve clause, with speakers presenting data that minority physicians are not only paid less but have higher debt, and that this wage gap has not been closing over time. Speakers also noted that the resolution is aligned with the policies of their respective associations/societies. With respect to the second Resolve, there were concerns raised about appropriate data reporting and the need to control for specialty, hours worked, etc. Therefore, your Reference Committee has recommended language to this end. Your Reference Committee recommends that first Resolve in Resolution 7 be adopted and the second Resolve in Resolution 7 be adopted as amended.

(10) RESOLUTION 10 – BAN CONVERSION THERAPY OF LGBTQ YOUTH

RECOMMENDATION A:

Resolution 10 be amended by addition and deletion.

RESOLVED, That our American Medical Association ~~advocate for~~ develop model state federal legislation and advocate for federal legislation to ban ~~oppose~~ “reparative” or “conversion” therapy for sexual orientation or gender identity (Directive to Take Action)

RECOMMENDATION B:

Resolution 10 be adopted as amended.

RECOMMENDATION C:**The title of Resolution 10 be changed to read as follows:****Ban Conversion Therapy of LGBTQ Youth****HOD ACTION: Resolution 10 adopted as amended with change in title**

RESOLVED, That our American Medical Association advocate for federal legislation to ban conversion therapy.
(Directive to Take Action)

Testimony was heard largely in support of Resolution 10. Many speakers noted that this practice must be banned on federal and state levels and that many states have already implemented such a ban. Speakers noted that the practice has been proven to offer no benefit while producing significant harms, and that it is essential that all recommended treatment be evidence-based. An amendment was offered to include state legislation and to define conversion therapy. Another speaker noted that the title of the resolution refers to LGBTQ “youth”, whereas the Resolve clause refers to banning the practice entirely. A substitute resolution was offered suggesting that the AMA create model state legislation on this issue; support was heard for this substitute amendment. Limited opposing testimony expressed concern that the resolution as written could unintentionally disempower parents and legitimate therapies, and that the AMA currently lacks a definition of conversion therapy. However, other speakers noted that the definition of conversion therapy is clear and that adoption of this resolution would still allow for legitimate forms of counseling. Your Reference Committee recommends that Resolution 10 be adopted as amended.

(11) RESOLUTION 11 – END CHILD MARRIAGE**RECOMMENDATION A:****Resolution 11 be amended by addition and deletion.**

RESOLVED, That our American Medical Association oppose the practice of child marriage by advocating for the passage of state and federal legislation to end the practice of child marriage. (Directive to Take Action)
~~(New HOD Policy); and be it further~~

~~RESOLVED, That our AMA advocate for the passage of state and federal legislation to end the practice of child marriage. (Directive to Take Action)~~

RECOMMENDATION B:**Resolution 11 be adopted as amended.****HOD ACTION: Resolution 11 adopted as amended**

RESOLVED, That our American Medical Association oppose the practice of child marriage (New HOD Policy); and be it further

RESOLVED, That our AMA advocate for the passage of state and federal legislation to end the practice of child marriage. (Directive to Take Action)

Testimony was heard largely in support of the resolution. The authors noted that the issue had been raised as to whether a specific age should be specified, but others expressed their belief that the latitude included in the resolution as written is appropriate as state regulations vary. Speakers noted that child marriage is a human rights issue, and that child marriage is a social determinant of health while also being an adverse childhood event. Limited opposing testimony expressed concern that the resolution as written may be too broad, and that the issue may benefit from referral for further study with the goal of developing more clearly defined definitions. Your Reference Committee recommends that Resolution 11 be adopted as amended.

RECOMMENDED FOR REFERRAL

- (12) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS REPORT 2 – AMENDMENT TO E-1.2.2., “DISRUPTIVE BEHAVIOR BY PATIENTS”

RECOMMENDATION:

Recommendations in Council on Ethical and Judicial Affairs Report 2 be referred.

HOD ACTION: Recommendations in Council on Ethical and Judicial Affairs Report 2 referred

In light of the foregoing analysis, the Council on Ethical and Judicial Affairs recommends that Policy D-65.991, “Discrimination against Physicians by Patients,” be rescinded; Opinion 1.2.2, “Disruptive Behavior by Patients,” be amended by addition and deletion as follows; and the remainder of this report be filed:

The relationship between patients and physicians is based on trust and should serve to promote patients’ well-being while respecting ~~their~~ the dignity and rights of both patients and physicians.

Disrespectful, ~~or~~ derogatory, or prejudiced, language or conduct, or prejudiced requests for accommodation of personal preferences on the part of either physicians or patients can undermine trust and compromise the integrity of the patient-physician relationship. It can make members of targeted groups reluctant to seek or provide care, and create an environment that strains relationships among patients, physicians, and the health care team.

Trust can be established and maintained only when there is mutual respect. Therefore, in their interactions with patients, physicians should:

(a) Recognize that disrespectful, derogatory, or prejudiced language or conduct can cause psychological harm to those ~~they target~~ who are targeted.

(b) Always treat patients with compassion and respect.

(c) Explore the reasons for which a patient behaves in disrespectful, derogatory, or prejudiced ways. Physicians should identify, appreciate, and address potentially treatable clinical conditions or personal experiences that influence patient behavior. Regardless of cause, when a patient’s behavior threatens the safety of health care personnel or other patients, steps should be taken to de-escalate or remove the threat.

(d) In general, decline to accommodate patient requests for an alternative physician when the request is solely the product of prejudice against the physician’s personal characteristics.

(e) Consider accommodating a patient’s request for an alternative physician when the request derives from the patient’s adverse personal experience, doing so would promote effective care, and another appropriately qualified physician is available to provide the needed care.

(f) In emergency situations, patients who persist in opposing treatment from the physician assigned may be helped to seek care from other sources. When transfer is not feasible, patients should be informed that care will be provided by appropriately qualified staff independent of the patient’s expressed preference.

(g) ~~Terminate the patient-physician relationship with a patient who uses derogatory language or acts in a prejudiced manner whose volitional behavior is disrespectful, derogatory, or prejudiced~~ only if the patient will not modify the conduct. In such cases, the physician should arrange to transfer the patient’s care when that is feasible.

Physicians, especially those in leadership roles, should encourage the institutions with which they are affiliated to:

(h) Be mindful of the messages the institution conveys within and outside its walls by how it responds to prejudiced behavior by patients.

(i) Promote a safe and respectful working environment and formally set clear expectations for how disrespectful, derogatory, or prejudiced behavior by patients will be managed.

(j) Clearly and openly support physicians, trainees, and facility personnel who experience prejudiced behavior and discrimination by patients.

(k) Collect data regarding incidents of discrimination by patients and their effects on physicians and facility personnel on an ongoing basis and seek to improve how incidents are addressed to better meet the needs of patients, physicians, other facility personnel, and the community.

Mixed testimony was heard on the report. Those opposing the report generally supported its goals, but expressed concern over a number of issues, including the need to address patients' families, continuity of care, deceptive behavior by patients, the consistent use of terminology within the report, the relationship between policy and opinion within the report, and the overall practicality of the report itself. Your Reference Committee recommends that Council on Ethical and Judicial Affairs Report 2 be referred.

(13) RESOLUTION 1 – SUPPORT FOR THE USE OF PSYCHIATRIC
ADVANCE DIRECTIVES

RECOMMENDATION:

Resolution 1 be referred.

HOD ACTION: Resolution 1 referred

RESOLVED, That our American Medical Association support efforts to increase awareness and appropriate utilization of psychiatric advance directives. (New HOD Policy)

Testimony was heard that generally opposed adoption of the resolution as written. Speakers noted that this is a complex issue that should be studied, as it could lead to additional burden for doctors and less than ideal care for patients. Speakers also noted that there are many situations in which psychiatric advance directives can be overridden. Your Reference Committee recommends that Resolution 1 be referred.

(14) RESOLUTION 5 – REMOVING SEX DESIGNATION FROM THE PUBLIC
PORTION OF THE BIRTH CERTIFICATE

RECOMMENDATION:

Resolution 5 be referred.

HOD ACTION: Resolution 5 referred

RESOLVED, That our American Medical Association advocate for the removal of sex as a legal designation on the public portion of the birth certificate and that it be visible for medical and statistical use only. (Directive to Take Action)

Mixed testimony was heard on Resolution 5. Speakers cited precedence for making the changes suggested in the resolution; moving information such as race and ethnicity to the private portion of the birth certificate has already been done so as to attempt to reduce discrimination, and the sex portion of the birth certificate is left blank in cases in which sex cannot be determined at birth. Opposing testimony noted that “data is data”, and that there can be unintended public health consequences from changing methods of data collection. However, other speakers noted that moving information from the public to the private portion of the birth certificate would not interfere with the availability of data for public health needs. Significant testimony supported referral with many speakers noting the complexity of the issue particularly in regards including various state regulations regarding birth certificates. Due to the complexity of the issues raised, your Reference Committee recommends that Resolution 5 be referred.

(15) RESOLUTION 9 – DATA FOR SPECIALTY SOCIETY FIVE-YEAR REVIEW

RECOMMENDATION:

Resolution 9 be referred.

HOD ACTION: Resolution 9 adopted

RESOLVED, That American Medical Association policy G-600.020, “Admission of Specialty Organizations to our AMA House,” item 6, be amended by addition and deletion to read as follows:

The organization must have a voluntary membership and must report as members only those physician members who are current in payment of applicable dues, ~~have full voting privileges~~, and eligible to serve on committees or the governing body ~~hold office~~. (Modify Current HOD Policy)

Mixed testimony was offered on Resolution 9. Multiple speakers suggested amendments with the goal of eliminating unintended consequences, particularly relating to smaller societies and relating to the rule under which 20% of the society must consist of AMA members. Other speakers opposed proposed amendments and spoke in support of the resolution as written, with some noting that other AMA policies exist to address some of the issues raised by speakers suggesting amendments. Referral was also suggested to review the issue of medical students being counted by specialty societies, as they currently are for geographic societies. Other speakers suggested referral, noting that certain elements of the resolution caused confusion and could benefit from further review. Your Reference Committee recommends that Resolution 9 be referred.

RECOMMENDED FOR NOT ADOPTION

- (16) RESOLUTION 12 - STUDY OF FORCED ORGAN HARVESTING BY CHINA

RECOMMENDATION:

Resolution 12 be not adopted.

HOD ACTION: Resolution 12 adopted

RESOLVED, That our American Medical Association gather and study all information available and possible on the issue of forced organ harvesting by China and issue a report to our House of Delegates at the 2020 Annual Meeting. (Directive to Take Action)

Testimony was heard in general support of Resolution 12. Speakers noted that China has reported ending these practices, but there is compelling evidence that organ harvesting still occurs, specifically against those belonging to religious minorities.

While speakers agreed that forced organ harvesting (or forced organ “recovery”) is a crime against humanity, the AMA already has policy to this end. Resolution 210-I-18 was referred to the Board of Trustees for decision, which led to the adoption of D-370.980. D-370.980 reads:

Our AMA: (1) continues to engage the Chinese Medical Association and the transplant community in the People’s Republic of China through support of relevant activities of the World Medical Association; and (2) endorses the goals of the World Health Organization Task Force on Donation and Transplantation of Human Organs and Tissues and other international efforts for oversight of organ procurement and transplantation.

Due to this recently adopted policy, the spirit of Resolution 12 has been met. Therefore, your Reference Committee recommends that Resolution 12 be not adopted.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (I-19)

Report of Reference Committee B
Cyndi Yag-Howard, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Board of Trustees Report 1 – Legalization of the Deferred Action for Legal Childhood Arrival (DALCA)
2. Board of Trustees Report 3 – Restriction on IMG Moonlighting
3. Board of Trustees Report 9 – Opioid Mitigation
4. Board of Trustees Report 15 – Repealing Potential Penalties Associated with MIPS Resolution (206-I-18), Reducing the Regulatory Burden in Health Care (Resolution 231-I-18), Improving the Quality Payment Program and Preserving Patient Access (Resolution 243-A-19)
5. Resolution 203 – Support Expansion of Good Samaritan Laws
6. Resolution 217 – Promoting Salary Transparency Among Veterans Health Administration Employed Physicians
7. Resolution 220 – Oppose Mandatory DNA Collection of Migrants

RECOMMENDED FOR ADOPTION AS AMENDED

8. Resolution 202 – Support for Veterans Courts
9. Resolution 205 – Co-Pay Accumulators
10. Resolution 206 – Improvement of Healthcare Access in Underserved Areas by Retaining and Incentivizing IMG Physicians
11. Resolution 207 – Pharmaceutical Advertising in Electronic Health Record Systems
12. Resolution 212 – Centers for Medicare and Medicaid Services Open Payments Program
13. Resolution 213 – Data Completeness and the House of Medicine
14. Resolution 215 – Board Certification of Physician Assistants
15. Resolution 216 – Legislation to Facilitate Corrections-to-Community Healthcare Continuity via Medicaid
16. Resolution 219 – QPP and the Immediate Availability of Results in CEHRTs
17. Resolution 221 – Safe Supervision of Complex Radiation Oncology Therapeutic Procedures
18. Resolution 222 – State Board Scope of Practice Expansion Beyond Statute
19. Resolution 223 – Appropriate Use of Scientific Studies and Data in the Development of Public Policy

RECOMMENDED FOR ADOPTION IN LIEU OF

20. Resolution 210 – Federal Government Regulation and Promoting Renal Transplantation

RECOMMENDED FOR REFERRAL

21. Board of Trustees Report 2 – Enabling Methadone Treatment of Opioid Use Disorder in Primary Care Settings
22. Resolution 201 – Advocating for the Standardization and Regulation of Outpatient Addiction Rehabilitation Facilities
23. Resolution 208 – Net Neutrality and Public Health
Resolution 211 – Effects of Net Neutrality on Public Health

RECOMMENDED FOR NOT ADOPTION

24. Resolution 214 – AMA Should Provide a Summary of its Advocacy Efforts on Surprise Medical Bill

Resolutions handled via the reaffirmation consent calendar:

- Resolution 204 – AMA Position on Payment Provisions in Health Insurance Policies
- Resolution 209 – Federal Government Regulation and Promoting Patient Access to Kidney Transplantation

RECOMMENDED FOR ADOPTION

- (1) BOARD OF TRUSTEES REPORT 1 – LEGALIZATION OF THE DEFERRED ACTION FOR LEGAL CHILDHOOD ARRIVAL (DALCA)

RECOMMENDATION:

Recommendation in Board of Trustees Report 1 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendation in Board of Trustees Report 1 adopted and the remainder of the Report be filed

The Board recommends that our AMA amend Policy D-255.979, “Permanent Residence Status for Physicians on H1-B Visas,” by addition to read as follows, in lieu of Resolution 205-I-18 and that the remainder of the report be filed:

Our AMA will work with all relevant stakeholders to: 1) clear the backlog for conversion from H1-B visas for physicians to permanent resident status, and 2) allow the children of H-1B visa holders, who have aged out of the H-4 non-immigrant classification, to remain in the U.S. legally while their parents’ green card applications are pending. (Modify Current HOD Policy)

Your Reference Committee heard positive testimony on Board of Trustees Report 1. Your Reference Committee heard testimony that the children of H-1B visa physicians lose their H-4 visa status once they turn 21 and then have limited options to remain in the U.S. Your Reference Committee also heard testimony that it is well known that there is expected to be a physician shortage in the United States; the projected shortage of between 46,900 and 121,900 physicians by 2032 includes both primary care (between 21,100 and 55,200) and specialty care (between 24,800 and 65,800). Your Reference Committee heard testimony that supporting permanent legal status for DALCA children who have finished medical school and residency could assist in reducing the impact of the expected physician shortage and also support the families of H-1B visa physicians. Accordingly, your Reference Committee recommends that Board of Trustees Report 1 be adopted and the remainder of the Report be filed.

- (2) BOARD OF TRUSTEES REPORT 3 – RESTRICTION ON IMG MOONLIGHTING

RECOMMENDATION:

Recommendation in Board of Trustees Report 3 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendation in Board of Trustees Report 3 adopted and the remainder of the Report be filed

The Board recommends that our American Medical Association not adopt Resolution 204-I-18, “Restriction on IMG Moonlighting,” and that the remainder of the report be filed

Your Reference Committee heard mixed testimony on Board of Trustees Report 3. Your Reference Committee heard testimony that our AMA has strong and lengthy policy outlining the rights of residents/fellows and limiting duty hours to ensure patient safety and an optimal learning environment for these physicians. Your Reference Committee heard testimony that allowing J-1s to moonlight would improve access to care for underserved populations in certain areas around the U.S. facing a physician shortage. Your Reference Committee also heard testimony that J-1 physician participants are not currently permitted to engage in any work outside of their approved program of graduate medical education. Further, your Reference Committee heard testimony that if the proposed activity by the J-1 physician falls outside of the normal scope and/or is not a required component of the training program, then it is deemed to be “work outside of the approved training program” and not permitted for J-1 physicians. Your Reference Committee heard testimony that allowing J-1 physicians to moonlight would reduce the inequity between J-1 physicians and U.S. citizens who are allowed to moonlight. Your Reference Committee

acknowledges the inequity caused by not supporting J-1 physicians' ability to moonlight but believes that advocating for a substantial change in moonlighting policy for the J-1 physicians participating in the U.S. Department of State Exchange Visitor Program would increase scrutiny of and potentially jeopardize physician participation in the program. Accordingly, your Reference Committee recommends that Board of Trustees Report 3 be adopted and the remainder of the Report be filed.

(3) BOARD OF TRUSTEES REPORT 9 – OPIOID MITIGATION

RECOMMENDATION:

Recommendation in Board of Trustees Report 9 be adopted and the remainder of the report filed.

HOD ACTION: Recommendation in Board of Trustees Report 9 adopted and the remainder of the report filed

The Board recommends that the following recommendation be adopted in lieu of Resolution 919-I-18, and that the remainder of the report be filed.

1. That our American Medical Association (AMA) encourage relevant federal agencies to evaluate and report on outcomes and best practices related to federal grants awarded for the creation of Quick Response Teams and other innovative local strategies to address the opioid epidemic, and that the AMA share that information with the Federation; (Directive to Take Action)
2. That our AMA update model state legislation regarding needle and syringe exchange to state and specialty medical societies; (Directive to Take Action)
3. That our AMA amend Policy H-100.955, "Support for Drug Courts;"

Our AMA: (1) supports the establishment of drug courts as an effective method of intervention for individuals with addictive disease who are convicted of nonviolent crimes; and (2) encourages legislators to establish drug courts at the state and local level in the United States.; and (3) encourages drug courts to rely upon evidence-based models of care for those who the judge or court determine would benefit from intervention rather than incarceration. (Modify Current HOD Policy)

4. That our AMA urge state and federal policymakers to enforce applicable mental health and substance use disorder parity laws; (Directive to Take Action)
5. That our AMA reaffirm Policy H-95.932, "Increasing Availability of Naloxone;" and (Reaffirm HOD Policy)
6. That our AMA reaffirm Policy D-95.981, "Improving Medical Practice and Patient/Family Education to Reverse the Epidemic of Nonmedical Prescription Drug Use and Addiction." (Reaffirm HOD Policy)

Your Reference Committee heard positive testimony on Board Report 9. Testimony indicated appreciation for the work being done in Huntington, West Virginia and Clark County, Indiana to increase access to evidence-based treatment, as well as harm reduction strategies, such as naloxone access and needle and syringe exchange programs. Your Reference Committee also heard testimony that these approaches are necessary, but not sufficient to end the nation's opioid epidemic. Your Reference Committee heard additional testimony that our AMA policy and the work of our Council on Legislation has helped enact naloxone access laws throughout the nation in partnership with state and specialty societies. Your Reference Committee heard testimony that similarly developed model legislation in support of needle and syringe exchange programs could help reduce transmission of blood-borne disease and be another evidence-based advocacy tool for the Federation. Accordingly, your Reference Committee recommends that Board of Trustees Report 9 be adopted and the remainder of the Report be filed.

- (4) BOARD OF TRUSTEES REPORT 15 – REPEALING POTENTIAL PENALTIES ASSOCIATED WITH MIPS RESOLUTION (206-I-18), REDUCING THE REGULATORY BURDEN IN HEALTH CARE (RESOLUTION 231-I-18), IMPROVING THE QUALITY PAYMENT PROGRAM AND PRESERVING PATIENT ACCESS (RESOLUTION 243-A-19)

RECOMMENDATION:

Recommendation in Board of Trustees Report 15 be adopted and the remainder of the report filed.

HOD ACTION: Recommendation in Board of Trustees Report 15 referred

The Board of Trustees recommends that the following recommendations be adopted in lieu of Resolutions 206-I-18, 231-I-18, and 243-A-19 and that the remainder of the report be filed:

1. That our American Medical Association (AMA) support legislation that replaces or supplements the budget neutrality in MIPS with incentive payments.
2. That our AMA reaffirm Policy D-395.999, “Reducing MIPS Reporting Burden,” Policy D-395.998, “Opposed Replacement of the Merit-Based Incentive Payment System with the Voluntary Value Program,” Policy H-390.838, “MIPS and MACRA Exemption,” Policy D-390.950, “Preserving a Period of Stability in Implementation of the Medicare Access and Children’s Health Insurance Program (CHIP) Reauthorization Act (MACRA),” Policy D-390.949, “Preserving Patient Access to Small Practices Under MACRA,” Policy H-385.913, “Physician-Focused Alternative Payment Models,” Policy H-385.913, “Physician-Focused Alternative Payment Models,” Policy H-450.931, “Moving to Alternative Payment Models,” and Policy H-385.908, “Physician-Focused Alternative Payment Models: Reducing Barriers.”

Your Reference Committee heard positive testimony in support of adopting the recommendations in Board Report 15. Your Reference Committee heard testimony that there is significant frustration among physicians with the MIPS program and that our AMA continues to vigorously advocate that both CMS and Congress make needed changes to improve the program. Your Reference Committee heard testimony that our AMA has convened MIPS and APM workgroups made up of representatives from across the physician community, which have developed creative solutions to improve the QPP. Testimony also indicated that feedback from the MIPS and APM workgroups, as well as other state and specialty medical societies, has led our AMA to focus its efforts to improve the QPP on several key issues, including replacing the upcoming Medicare physician pay freeze with a stable revenue source that allows physicians to sustain their practice; eliminating budget neutrality; extending the Advanced APM payments for an additional six years; simplifying the MIPS scoring system and creating a more meaningful MIPS program; and ensuring small and rural practices have the opportunity to succeed. Your Reference Committee heard testimony that BOT 15 and its recommendations properly supplement existing AMA policy on this issue while also providing our AMA with flexibility as how best to proceed in addressing concerns with budget neutrality.

Testimony indicated that our AMA is joined with many state and specialty medical societies to make it a priority to advocate that Congress provide physicians with positive Medicare payment updates and extend APM payments to provide physicians with additional resources to help transition to APMs. Your Reference Committee heard further testimony that the lack of positive updates from 2020 to 2025 severely threatens physicians’ ability to sustain their practices, especially while at the same time implementing quality improvements. Your Reference Committee also heard testimony that our AMA will work with due purpose to seek positive updates and continue to reduce MIPS burdens.

The Board of Trustees testified that it believes that our AMA should have the ability to support legislation that could shift the budget neutrality dynamic of the current MIPS program. The Board stated that it understood that eliminating the budget neutrality requirements of the MIPS program is a complex issue and that there are many ways to achieve that goal. Your Reference Committee heard further testimony that a recommendation to support replacing or supplementing budget neutrality in a manner that provides flexibility to review and consider legislation without being so narrowly defined that we overlook an opportunity to improve the MIPS program in another way

would be appropriate. Your Reference Committee agrees with Board's recommendations. Accordingly, your Reference Committee recommends that BOT 15 be adopted and the rest of the Report be filed.

(5) RESOLUTION 203 – SUPPORT EXPANSION OF GOOD SAMARITAN LAWS

RECOMMENDATION:

Resolution 203 be adopted.

HOD ACTION: Resolution 203 adopted

RESOLVED, That our AMA amend Policy D-95.977 by addition and deletion to read as follows:

911 Good Samaritan Laws, D-95.977

Our AMA: (1) will support and endorse policies and legislation that provide protections for callers or witnesses seeking medical help for overdose victims; ~~and~~ (2) will promote 911 Good Samaritan policies through legislative or regulatory advocacy at the local, state, and national level; and (3) will work with the relevant organizations and state societies to raise awareness about the existence and scope of Good Samaritan Laws.
(Modify Current HOD Policy)

Your Reference Committee heard overwhelming support for Resolution 203. Your Reference Committee heard testimony that our AMA strongly supports Good Samaritan protections for those who seek medical assistance for a person who is experiencing a medical emergency—whether from a drug overdose, alcohol overdose, or other situation. Your Reference Committee heard further testimony that our AMA has updated model legislation that includes strong Good Samaritan protections for those who seek aid for someone experiencing an overdose. Accordingly, your Reference Committee recommends that Resolution 203 be adopted.

(6) RESOLUTION 217 – PROMOTING SALARY TRANSPARENCY AMONG VETERANS HEALTH ADMINISTRATION EMPLOYED PHYSICIANS

RECOMMENDATION:

Resolution 217 be adopted.

HOD ACTION: Resolution 217 adopted

RESOLVED, That our American Medical Association encourage physician salary transparency within the Veterans Health Administration. (Directive to Take Action)

Your Reference Committee heard positive testimony on Resolution 217. Your Reference Committee heard testimony that the Department of Veterans Affairs (VA) does provide annual pay ranges, which is the sum of the base pay rate and market pay for Veterans Health Administration (VHA) physicians, dentists, and podiatrists as prescribed by the Secretary for department-wide applicability. Your Reference Committee heard testimony that the data is based on specialties; however, there are no published data regarding VHA physician pay differences based on gender or race and further transparency is needed. Your Reference Committee also heard testimony that pay scales should be easily quantifiable metrics and therefore ready targets for intervention to improve equity. Finally, your Reference Committee heard testimony that our AMA's Center for Health Equity is beginning to take shape under the leadership of Dr. Aletha Maybank, and pay equity as it relates to health equity will be one of the areas that the Center will address. Accordingly, your Reference Committee recommends that Resolution 217 be adopted.

(7) RESOLUTION 220 – OPPOSE MANDATORY DNA COLLECTION OF MIGRANTS

RECOMMENDATION:

Resolution 220 be adopted.

HOD ACTION: Resolution 220 adopted

RESOLVED, That our American Medical Association oppose the collection and storage of the DNA of refugees, asylum seekers, and undocumented immigrants for nonviolent immigration-related crimes without non-coercive informed consent. (New HOD Policy)

Your Reference Committee heard positive testimony on Resolution 220. Your Reference Committee heard testimony that the U.S. Department of Justice proposed to amend regulations that would restore the Attorney General's full legal authority to authorize and direct all relevant federal agencies to require DNA sample collection from persons who are detained under the authority of the United States. Testimony indicated that the Department of Homeland Security is expected to submit an additional 748,000 samples annually under the proposal. Your Reference Committee heard testimony Resolution 220 is an extension of existing AMA policy that DNA testing of individuals for information in criminal cases should be conducted only when a warrant has been issued on the basis of a high degree of individualized suspicion, and that maintaining the files of any individual who is no longer a suspect in a particular crime raises serious concerns regarding potential violations of privacy. Accordingly, your Reference Committee recommends that Resolution 220 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED**(8) RESOLUTION 202 – SUPPORT FOR VETERANS COURTS****RECOMMENDATION A:**

Resolution 202 be amended by addition to read as follows:

RESOLVED, That our American Medical Association support the use of Veterans Courts as a method of intervention for veterans who commit ~~non-violent~~ criminal offenses that may be related to a neurological or psychiatric disorder. (New HOD Policy)

RECOMMENDATION B:

Resolution 202 be adopted as amended.

HOD ACTION: Resolution 202 adopted

RESOLVED, That our American Medical Association support the use of Veterans Courts as a method of intervention for veterans who commit criminal offenses that may be related to a neurological or psychiatric disorder. (New HOD Policy)

Your Reference Committee heard positive testimony on Resolution 202. Your Reference Committee heard testimony that existing AMA policy supports the establishment of drug courts for individuals with substance use disorders, so it could logically follow that our AMA could also support the use of Veterans Courts. Your Reference Committee further heard testimony that, generally, a veteran's treatment court judge handles numerous veterans' cases and is supported by a strong, interdisciplinary team that understands the issues that a veteran may be struggling with, such as substance addiction, PTSD, and traumatic brain injury. Your Reference Committee heard additional testimony that Resolution 202 be amended so that the Veteran Court is for non-violent offenders, consistent with existing AMA policy supporting drug courts is also for non-violent offenders. Accordingly, your Reference Committee recommends Resolution 202 be adopted as amended.

(9) RESOLUTION 205 – CO-PAY ACCUMULATORS**RECOMMENDATION A:**

Resolution 205 should be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association develop model state legislation ~~based on the recent law enacted in Virginia~~ regarding Co-Pay Accumulators for all pharmaceuticals, biologics, medical devices, and medical equipment.

RECOMMENDATION B:

Resolution 205 be adopted as amended.

HOD ACTION: Resolution 205 adopted as amended

RESOLVED, That our American Medical Association develop model state legislation based on the recent law enacted in Virginia regarding Co-Pay Accumulators. (Directive to Take Action)

Your Reference Committee heard largely supportive testimony on Resolution 205. Your Reference Committee heard testimony that Resolution 205 highlights the burden that Co-Pay Accumulators place on patients using manufacturers' coupons to lower their out-of-pocket costs. Your Reference Committee further heard testimony that

our AMA should develop model state legislation that addresses Co-Pay Accumulators broadly and not limited to the specific law recently enacted in Virginia. Your Reference Committee also heard testimony that states the importance of protecting patients from out-of-pocket costs when insurers use Co-Pay Accumulators to their own benefit, keeping patients from reaching their deductibles. Testimony also indicated that model legislation on Co-Pay Accumulators should include prescription drugs, biologics, and medical devices to be more comprehensive. Accordingly, your Reference Committee recommends that Resolution 205 be adopted as amended.

- (10) RESOLUTION 206 – IMPROVEMENT OF HEALTHCARE ACCESS IN UNDERSERVED AREAS BY RETAINING AND INCENTIVIZING IMG PHYSICIANS

RECOMMENDATION A:

Resolution 206 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association support efforts to expand opportunities to retain ~~and incentivize~~ international medical graduates after the expiration of allocated periods under current law serving in federally designated health professional shortage areas after the current allocated period.; and be it further

RESOLVED, That our American Medical Association support efforts to increase the recruitment and retention of physicians practicing in federally designated health professional shortage areas (Directive to Take Action).

RECOMMENDATION B:

Resolution 206 be adopted as amended.

RECOMMENDATION C:

The title of Resolution 206 be changed to read as follows.

IMPROVEMENT OF HEALTH CARE ACCESS IN UNDERSERVED AREAS

HOD ACTION: Resolution 206 adopted as amended with change in title

RESOLVED, That our American Medical Association support efforts to retain and incentivize international medical graduates serving in federally designated health professional shortage areas after the current allocated period. (Directive to Take Action).

Your Reference Committee heard mixed testimony on Resolution 206. Your Reference Committee heard testimony that our AMA has a strong history of advocating for the retaining and incentivizing international medical graduates serving in federally designated health professional shortage areas after the current allocated period in the Conrad 30 program. Your Reference Committee further heard testimony that our AMA worked with Congress to ensure the current Conrad 30 bill addresses the current physician green card backlog exacerbated by the statutory per-country cap for employment-based green cards by allowing those physicians who practice in underserved areas for five years then be eligible to receive priority access within the green card system. Your Reference Committee heard testimony that Resolution 206 only applies to International Medical Graduates on a J-1 visa and not U.S. citizens. Your Reference Committee heard testimony that our health care system needs more physicians in underserved areas and our AMA needs to make practicing in rural and underserved a viable and desirable proposition for all physicians. Accordingly, your Reference Committee recommends that Resolution 206 be adopted as amended with a title change.

(11) RESOLUTION 207 – PHARMACEUTICAL ADVERTISING IN ELECTRONIC HEALTH RECORD SYSTEMS

RECOMMENDATION A:

Resolution 207 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association encourage the ~~Centers for Medicare and Medicaid Services~~ federal government to study the effects of direct-to-physician advertising at the point of care, including advertising in Electronic Health Record Systems (EHRs), on physician prescribing, patient safety, health care costs, and EHR access for small practices (Directive to Take Action); and be it further

RESOLVED, That our AMA study the prevalence and ethics of direct-to-physician advertising at the point of care, including advertising in EHRs. (Directive to Take Action)

RECOMMENDATION B:

Resolution 207 be adopted as amended.

HOD ACTION: Resolution 207 adopted as amended

RESOLVED, That our American Medical Association encourage the Centers for Medicare and Medicaid Services to study the effects of direct-to-physician advertising at the point of care, including advertising in Electronic Health Record Systems (EHRs), on physician prescribing, patient safety, health care costs, and EHR access for small practices (Directive to Take Action); and be it further

RESOLVED, That our AMA study the ethics of direct-to-physician advertising at the point of care, including advertising in EHRs. (Directive to Take Action)

Your Reference Committee heard positive testimony on Resolution 207. Your Reference Committee heard testimony that our AMA recognizes that pharmaceutical marketing may benefit patients, but can also inappropriately influence physicians. Your Reference Committee further heard testimony that incorporating advertising information into an EHR can provide important additional information and could potentially provide EHRs to physicians at a lower cost. Testimony also indicated that such advertisement may lead to inappropriate prescribing, and additional study is warranted. Your Reference Committee heard testimony that Resolution 207 should be amended so that our AMA has flexibility to work with Centers for Medicare & Medicaid Services and other federal agencies, such as the Office of the National Coordinator and the Food and Drug Administration. Your Reference Committee heard testimony that our AMA should also study the prevalence of direct-to-physician advertising in EHRs in addition to the ethical concerns. Accordingly, your Reference Committee recommends that Resolution 207 be adopted with amendment.

(12) RESOLUTION 212 – CENTERS FOR MEDICARE AND MEDICAID SERVICES OPEN PAYMENTS PROGRAM

RECOMMENDATION A:

Resolution 220 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association amend current policy H-140.848, “Physician Payments Sunshine Act,” by addition and deletion to read as follows:

Our AMA will:

- (1) continue its efforts to minimize the burden and unauthorized expansion of the Sunshine Act by the Centers for Medicare & Medicaid Services (CMS) and will recommend to the CMS that a physician comment section be included on the "Physician Payments Sunshine Act" public database;**
- (2) lobby Congress to amend the Sunshine Act to limit transfer of value reporting to items with a value of greater than \$100;**
- (3) advocate that: (a)(i) any payment or transfer of value reported as part of the Physician Payments Sunshine Act should include whether the physician acknowledged receipt of said payment or transfer of value, and (ii) each payment or transfer of value on the Open Payments website indicates whether the physician verified the payment or transfer of value; and (b) a contested reported payment or transfer of value should be removed immediately from the Open Payments website until the reporting company validates the compensation with verifiable documentation; ~~and~~**
- (4) support significant modifications to the Sunshine Act, such as substantially increasing the monetary threshold for reporting, that will decrease the regulatory and administrative burden on physicians, protect physician rights to challenge false and misleading reports, change the dispute process so that successfully disputed charges are not included publicly on the Open Payments database, and provide a meaningful, accurate picture of the physician-industry relationship; ~~(5) urge the Centers for Medicare and Medicaid Services to expand support~~**
the expansion of the definition of "covered recipients" to include pharmacists and Pharmacy Benefit Managers; and
- (6) continue to educate physicians about the Sunshine Act and its implications in light of publicly available data on the CMS Open Payments Program website.**

RECOMMENDATION B:

Resolution 212 be adopted as amended.

HOD ACTION: Resolution 212 adopted as amended

RESOLVED, That our American Medical Association amend current policy H-140.848, "Physician Payments Sunshine Act," by addition and deletion to read as follows:

Our AMA will: (1) continue its efforts to minimize the burden and unauthorized expansion of the Sunshine Act by the Centers for Medicare & Medicaid Services (CMS) and will recommend to the CMS that a physician comment section be included on the "Physician Payments Sunshine Act" public database; (2) lobby Congress to amend the Sunshine Act to limit transfer of value reporting to items with a value of greater than \$100; (3) advocate that: (a)(i) any payment or transfer of value reported as part of the Physician Payments Sunshine Act should include whether the physician acknowledged receipt of said payment or transfer of value, and (ii) each payment or transfer of value on the Open Payments website indicates whether the physician verified the payment or transfer of value; and (b) a contested reported payment or transfer of value should be removed immediately from the Open Payments website until the reporting company validates the compensation with verifiable documentation; ~~and~~ (4) support significant modifications to the Sunshine Act, such as substantially increasing the monetary threshold for reporting, that will decrease the regulatory and administrative burden on physicians, protect physician rights to challenge false and misleading reports, change the dispute process so that successfully disputed charges are not included publicly on the Open Payments database, and provide a meaningful, accurate picture of the physician-industry relationship; (5) urge the Centers for Medicare and Medicaid Services to expand the definition of "covered recipients" to include pharmacists and Pharmacy Benefit Managers; and (6) continue to educate physicians about the Sunshine Act and its implications in light of publicly available data on the Centers of Medicare and Medicaid (CMS) Open Payments Program website.
 (Modify Current HOD Policy)

Your Reference Committee heard mixed testimony on Resolution 212. Your Reference Committee heard testimony that physicians are frustrated with the implementation of the Sunshine Act as the Open Payments programs. Your Reference Committee further heard testimony that our AMA advocacy efforts should be focused on making substantial modifications to the Open Payments program to reduce burden, protect physicians, and increase accuracy. Your Reference Committee also heard testimony that actively advocating for application of the Open Payments program to other entities would detract from that message and those efforts. Instead, testimony indicated that our AMA should support those efforts more generally. Accordingly, your Reference Committee recommends that Resolution 212 be adopted as amended.

(13) RESOLUTION 213 – DATA COMPLETENESS AND THE HOUSE OF MEDICINE

RECOMMENDATION A:

The second and third Resolves of Resolution 213 be deleted:

~~RESOLVED, That our AMA direct its advocacy team to work with the National Academy for State Health Policy (NASHP), the All Payer Claims Database Council (APCD Council), the National Association of Health Data Organizations (NAHDO), and other interested organizations to speed promulgation of final rule making as regards Schedule J by the Department of Labor (DOL) in matters related to the Gobeille v. Liberty Mutual Insurance Company decision (Directive to Take Action); and be it further~~

~~RESOLVED, That, in supporting a rule making process by the DOL in matters related to the Gobeille v. Liberty Mutual Insurance Company decision, our AMA support the adoption of a standardized set of health care claims data such as the Common Data Layout, support that any DOL requirement for plans to submit health care claims data must be tied to current rule making processes (such as its proposed Schedule J), and support that the DOL implement a pilot program to collect health care claims data in cooperation with state APCDs. (Directive to Take Action)~~

RECOMMENDATION B:

A new Resolve in Resolution 213 be added:

RESOLVED, That our American Medical Association will work with stakeholder organizations to support efforts to strengthen All Payer Claims Databases, including, but not limited to, supporting reforms to permit states to mandate submission of data from self-insured ERISA plans and supporting the adoption of a standardized set of health care claims data. (Directive to Take Action)

RECOMMENDATION C:

Resolution 213 be adopted as amended.

HOD ACTION: Resolution 213 adopted as amended

RESOLVED, That our American Medical Association amend section 4 of policy D-155.987, “Price Transparency,” by addition to read as follows:

4. Our AMA will work with states and the federal government to support and strengthen the development of all-payer claims databases. (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA work with the National Academy for State Health Policy (NASHP), the All-Payer Claims Database Council (APCD Council), the National Association of Health Data Organizations (NAHDO), and other interested organizations to speed promulgation of final rule making as regards Schedule J by the United States Department of Labor (DOL) in matters related to the *Gobeille v. Liberty Mutual Insurance Company* decision (Directive to Take Action); and be it further

RESOLVED, That, in supporting a rule making process by the DOL in matters related to the *Gobeille v. Liberty Mutual Insurance Company* decision, our AMA support the adoption of a standardized set of health care claims data such as the Common Data Layout, support that any DOL requirement for plans to submit health care claims data must be tied to current rule making processes (such as its proposed Schedule J), and support that the DOL implement a pilot program to collect health care claims data in cooperation with state APCDs. (Directive to Take Action)

Your Reference Committee heard generally positive testimony on Resolution 213. Your Reference Committee heard testimony that our AMA continues to support the development of all claims databases with proper guardrails and input from the health care provider and patient perspective. Your Reference Committee heard testimony focused on the need to refrain from limiting our advocacy on All Payer Claims Databases (APCD) to a set of defined efforts with a set of defined stakeholders. Your Reference Committee further heard testimony from the Council on Legislation encouraging amendment of Resolution 213 to allow for broader advocacy efforts with more flexibility. Your Reference Committee heard testimony that increased attention to promoting completeness and usability of APCDs is warranted. Your Reference Committee agrees with this language and therefore, recommends that Resolution 213 be adopted with amendment.

(14) RESOLUTION 215 – BOARD CERTIFICATION OF PHYSICIAN ASSISTANTS

RECOMMENDATION A:

Resolution 215 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association amend AMA Policy H-35.965, “Regulation of Physician Assistants,” by addition and deletion to read as follows:

Our AMA: (1) will advocate in support of maintaining the authority of medical licensing and regulatory boards to regulate the practice of medicine through oversight of physicians, physician assistants and related medical personnel; ~~and~~ (2) opposes legislative efforts to establish autonomous regulatory boards meant to license, regulate and discipline physician assistants outside of the existing state medical licensing and regulatory bodies' authority and purview; and (3) opposes efforts by ~~independent~~ organizations to board certify physician assistants in a manner that misleads the public to believe such board certification is equivalent to medical specialty board certification. (Modify Current HOD Policy)

RESOLVED, That our American Medical Association amend AMA Policy H-275.926, “Medical Specialty Board Certification Standards,” by addition to read as follows:

Our AMA:

1. Opposes any action, regardless of intent, that appears likely to confuse the public about the unique credentials of American Board of Medical Specialties (ABMS) or American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) board certified physicians in any medical specialty, or take advantage of the prestige of any medical specialty for purposes contrary to the public good and safety.

2. Opposes any action, regardless of intent, by ~~independent organizations~~ providing board certification for non-physicians that appears likely to confuse the public about the unique credentials of medical specialty board certification or take advantage of the prestige of medical specialty board certification for purposes contrary to the public good and safety.

3. Continues to work with other medical organizations to educate the profession and the public about the ABMS and AOA-BOS board certification process. It is AMA policy that when the equivalency of board certification must be determined, accepted standards, such as those adopted by state medical boards or the Essentials for Approval of Examining Boards in Medical Specialties, be utilized for that determination. (Modify Current HOD Policy)

RECOMMENDATION B:

Resolution 215 be adopted as amended.

HOD ACTION: Resolution 215 adopted as amended

RESOLVED, That our American Medical Association amend AMA Policy H-35.965, “Regulation of Physician Assistants,” by addition and deletion to read as follows and be it further

Our AMA: (1) will advocate in support of maintaining the authority of medical licensing and regulatory boards to regulate the practice of medicine through oversight of physicians, physician assistants and related medical personnel; ~~and~~ (2) opposes legislative efforts to establish autonomous regulatory boards meant to license, regulate and discipline physician assistants outside of the existing state medical licensing and regulatory bodies' authority and purview; and (3) opposes efforts by independent organizations to board certify physician assistants in a manner that misleads the public to believe such certification is equivalent to medical specialty board certification. (Modify Current HOD Policy)

RESOLVED, That our American Medical Association amend AMA Policy H-275.926, “Medical Specialty Board Certification Standards,” by addition to read as follows

Our AMA:

1. Opposes any action, regardless of intent, that appears likely to confuse the public about the unique credentials of American Board of Medical Specialties (ABMS) or American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) board certified physicians in any medical specialty, or take advantage of the prestige of any medical specialty for purposes contrary to the public good and safety.

2. Opposes any action, regardless of intent, by independent organizations providing board certification for non-physicians that appears likely to confuse the public about the unique credentials of medical specialty board certification or take advantage of the prestige of medical specialty board certification for purposes contrary to the public good and safety.

3. Continues to work with other medical organizations to educate the profession and the public about the ABMS and AOA-BOS board certification process. It is AMA policy that when the equivalency of board certification must be determined, accepted standards, such as those adopted by state medical boards or the Essentials for Approval of Examining Boards in Medical Specialties, be utilized for that determination. (Modify Current HOD Policy)

Your Reference Committee heard positive testimony on Resolution 215. Your Reference Committee heard testimony that our AMA strongly supports and defends more transparency and clarity in health care delivery. Your Reference Committee heard testimony that our AMA should work to ensure that patients are not misled or confused by terms, such as board certification, which typically applies only to physicians. Your Reference Committee heard testimony from the Council on Legislation that both resolves should be amended to delete “independent” to broaden the scope of the policy. Your Reference Committee also heard testimony that it is necessary to add the term “board” in the first resolve to make it clear the resolution refers to “board certification” of physician assistants, as opposed to “certification” of physician assistants offered through the National Commission on Certification of Physician

Assistants. Your Reference Committee notes that the original authors were in support of the offered amendments. Accordingly, your Reference Committee recommends adopting Resolution 215 as amended.

(15) RESOLUTION 216 – LEGISLATION TO FACILITATE CORRECTIONS-TO-COMMUNITY HEALTHCARE CONTINUITY VIA MEDICAID

RECOMMENDATION A:

Resolution 216 be amended by addition to read as follows:

RESOLVED, That our American Medical Association amend item #6 of HOD Policy H-430.986, “Health Care While Incarcerated,” by addition to read as follows:

6. Our AMA urges Congress, the Centers for Medicare & Medicaid Services (CMS), and state Medicaid agencies to provide Medicaid coverage for health care, care coordination activities and linkages to care delivered to patients up to 30 days before the anticipated release from adult and juvenile correctional facilities in order to help establish coverage effective upon release, assist with transition to care in the community, and help reduce recidivism. (Modify Current HOD Policy)

RECOMMENDATION B:

Resolution 216 be adopted as amended.

HOD ACTION: Resolution 216 adopted as amended

RESOLVED That our American Medical Association amend item #6 of HOD Policy H-430.986, “Health Care While Incarcerated,” by addition of the word “Congress” to read as follows:

6. Our AMA urges Congress, the Centers for Medicare & Medicaid Services (CMS), and state Medicaid agencies to provide Medicaid coverage for health care, care coordination activities and linkages to care delivered to patients up to 30 days before the anticipated release from correctional facilities in order to help establish coverage effective upon release, assist with transition to care in the community, and help reduce recidivism. (Modify Current HOD Policy)

Your Reference Committee heard mostly positive testimony on Resolution 216. Your Reference Committee heard testimony that federal law currently bans Medicaid coverage of individuals while incarcerated, and that legislation would change federal law to allow Medicaid coverage of incarcerated individuals beginning 30 days before the anticipated release of such individuals. Your Reference Committee heard testimony that our AMA supported this legislation in 2017, and sent a letter on October 25, 2019, supporting the legislation introduced in the current session of Congress. Your Reference Committee heard testimony that our AMA should amend existing policy to allow Medicaid coverage for incarcerated individuals beginning 30 days before the anticipated release. Your Reference Committee further heard testimony indicating that our AMA policy should apply to both adults and juveniles. Accordingly, your Reference Committee recommends adoption of Resolution 216 as amended.

(16) RESOLUTION 219 – QPP AND THE IMMEDIATE AVAILABILITY OF RESULTS IN CEHRTS

RECOMMENDATION A:

Resolution 219 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association urge the Centers for Medicare & Medicaid Services, Office of the National Coordinator for Health Information Technology, and other agencies with jurisdiction to

create guardrails around the “immediate” availability of ~~laboratory, pathology, and radiology~~ medical test results, factoring in an allowance for physician judgement and discretion regarding the timing of release of certain results (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage vendors to implement mechanisms that provide physicians the discretion to publish medical test results to a patient portal while ensuring patient access to such information in a reasonable timeframe ~~prompts that give physicians the ability to either approve notes to just the chart or approve and publish them in both the chart and patient portal.~~ (Directive to Take Action)

RECOMMENDATION B:

Resolution 219 be adopted as amended.

RECOMMENDATION C:

The title be changed to read as follows.

QUALITY PAYMENT PROGRAM AND THE IMMEDIATE AVAILABILITY OF RESULTS IN CERTIFIED ELECTRONIC HEALTH RECORD TECHNOLOGIES

HOD ACTION: Resolution 219 adopted as amended with change in title

RESOLVED, That our American Medical Association urge the Centers for Medicare & Medicaid Services to create guardrails around the “immediate” availability of laboratory, pathology, and radiology results, factoring in an allowance for physician judgement and discretion regarding the timing of release of certain results (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage vendors to implement prompts that give physicians the ability to either approve notes to just the chart or approve and publish them in both the chart and patient portal. (Directive to Take Action)

Your Reference Committee heard positive testimony on Resolution 219. Your Reference Committee heard testimony that our AMA strongly supports patients’ access to their entire medical record. Your Reference Committee heard additional testimony that our AMA has long heralded the benefits of Application Programming Interfaces and apps to both patients and physicians. Your Reference Committee heard testimony expressing concerns about providing patients with immediate access to certain medical test results without consulting a physician or without the physician’s knowledge. Testimony indicated that this scenario may lead to unnecessary distress for a variety of reasons, and may harm the patient-physician relationship. Your Reference Committee also heard testimony that Resolution 219 should be broadened to potentially include all medical tests rather than specialty-specific tests. Your Reference Committee also heard testimony recommending that, given the HIPAA right to access, the second resolve should be clarified to strike an appropriate balance between physician discretion and patient access. Your Reference Committee heard testimony that our AMA should also engage with the Office of the National Coordinator on this issue. Accordingly, your Reference Committee recommends that Resolution 219 be adopted as amended.

(17) RESOLUTION 221 – SAFE SUPERVISION OF COMPLEX RADIATION ONCOLOGY THERAPEUTIC PROCEDURES

RECOMMENDATION A:

Resolution 221 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association advocate that radiation therapy services and hyperbaric oxygen services should be exempted from the Hospital Outpatient Prospective Payment System (HOPPS) rule requiring only general supervision of hospital therapeutic services; and be it further

~~**RESOLVED**, That our AMA advocate that direct supervision of radiation therapy services by a physician trained in radiation oncology or radiation therapy services should be required by the Centers for Medicare and Medicaid Services; and~~

RESOLVED, That our AMA advocate that direct supervision of hyperbaric oxygen therapy services by a physician trained in hyperbaric oxygen services should be required by the Centers for Medicare and Medicaid Services.

RECOMMENDATION B:

Resolution 221 by adopted as amended.

RECOMMENDATION C:

The title be changed to read as follows:

SAFE SUPERVISION OF COMPLEX RADIATION ONCOLOGY AND HYPERBARIC OXYGEN THERAPEUTIC PROCEDURES

HOD ACTION: The first and third Resolve of Resolution 221 adopted as amended and the second Resolve of Resolution 221 deleted with change in title

RESOLVED, That our AMA advocate that radiation therapy services should be exempted from the Hospital Outpatient Prospective Payment System (HOPPS) rule requiring only general supervision of hospital therapeutic services; and be it further

RESOLVED, That our AMA advocate that direct supervision of radiation therapy services by a physician trained in radiation oncology should be required by the Centers for Medicare and Medicaid Services.

Your Reference Committee heard mixed testimony on Resolution 221. Your Reference Committee heard testimony that the Centers for Medicare & Medicaid Services (CMS) recently finalized a rule allowing general supervision—instead of direct supervision—for all Medicare therapeutic services under the outpatient prospective payment system. Testimony indicated that, while existing AMA policy largely supports general supervision under these circumstances, physicians are the only health care providers trained in radiation treatment and patient management. Testimony indicated that this change from direct to general supervision would be a patient safety concern and scope of practice issue. Your Reference Committee also heard testimony that the CMS proposal allows physicians the discretion to require a higher level of supervision to ensure a therapeutic outpatient procedure is performed without risking a beneficiary's safety. Your Reference Committee also heard testimony that CMS remains open to identifying individual outpatient therapeutic procedures that may require a higher level of physician supervision. Additional testimony indicated that hyperbaric oxygen patients are also affected by this and a lack of supervision could cause harm patients. Your Reference Committee heard testimony that the second resolve as presented would only allow radiation oncologists to supervise these services. Your Reference Committee further heard testimony that

other specialties also provide and oversee the delivery of radiation treatments. Your Reference Committee also heard testimony that any changes in CMS policy should not eliminate the ability of non-radiation oncologists to deliver treatments that are part of their scope of practice. Your Reference Committee believes that adding radiation therapy services to the second resolve addresses these concerns. Accordingly, your Reference Committee recommends that Resolution 221 be adopted as amended.

(18) RESOLUTION 222 – STATE BOARD SCOPE OF PRACTICE EXPANSION BEYOND STATUTE

RECOMMENDATION A:

Resolve 1 and 2 of Resolution 222 be deleted:

~~RESOLVED, That our American Medical Association consider all available legal, regulatory, and legislative options to correct the State Medical Board of Ohio's erroneous decisions to increase podiatric scope of practice beyond legislative statute with respect to (1) allowing podiatrists in Ohio to harvest bone marrow aspirate from the proximal tibia, and (2) allowing podiatrists in Ohio to perform supramalleolar osteotomies of the tibia and fibula (Directive to Take Action); and be it further~~

~~RESOLVED, That our AMA consider all available legal, regulatory, and legislative options to correct the previous decisions made by the State Medical Board of Ohio to increase podiatric scope of practice beyond legislative statute with respect to defining the foot as including the ankle, allowing split thickness skin grafting from the anterior thigh, and allowing common peroneal nerve decompression at and proximal to the neck of the fibula (Directive to Take Action); and be it further~~

RECOMMENDATION B:

Resolution 222 be adopted as amended.

HOD ACTION: Resolution 222 adopted as amended

RESOLVED, That our American Medical Association consider all available legal, regulatory, and legislative options to correct the State Medical Board of Ohio's erroneous decisions to increase podiatric scope of practice beyond legislative statute with respect to (1) allowing podiatrists in Ohio to harvest bone marrow aspirate from the proximal tibia, and (2) allowing podiatrists in Ohio to perform supramalleolar osteotomies of the tibia and fibula (Directive to Take Action); and be it further

RESOLVED, That our AMA consider all available legal, regulatory, and legislative options to correct the previous decisions made by the State Medical Board of Ohio to increase podiatric scope of practice beyond legislative statute with respect to defining the foot as including the ankle, allowing split thickness skin grafting from the anterior thigh, and allowing common peroneal nerve decompression at and proximal to the neck of the fibula (Directive to Take Action); and be it further

RESOLVED, That our AMA consider all available legal, regulatory, and legislative options to oppose state board decisions that increase non-physician health care provider scope of practice beyond legislative statute or regulation. (Directive to Take Action)

Your Reference Committee heard overwhelming testimony in support of the intent of Resolution 222. Our AMA has extensive policy on scope of practice and created the Scope of Practice Partnership in 2006 to address scope of practice issues in a collaborative, unified manner with national medical associations, state medical associations, and national medical specialty societies. Specific to this resolution, your Reference Committee heard testimony that, since June 2019, our AMA has worked with the Ohio State Medical Association and relevant specialty societies, and has convened conference calls and reviewed legislative and regulatory options with all interested parties. Testimony

also indicated that our AMA wrote a letter to the State Medical Board of Ohio expressing our concern with their decision. Your Reference Committee heard that our AMA will continue to work with American Orthopaedic Foot and Ankle Society, the Ohio State Medical Association, and any interested partners on this issue, as well as any other national medical associations, state medical associations, and national medical specialty societies on issues related to scope of practice. Your Reference Committee also heard testimony about the importance that our AMA only become involved in state legislative or regulatory activity on scope of practice at the request of the state medical association consistent with Policy G-620.021. Your Reference Committee believes that the first and second resolves should be struck because our AMA generally does not have policy that makes specific reference to a state-specific scope issue. Instead, our AMA policy on scope of practice should be nationwide, like the third resolve of Resolution 222, to avoid having specific state scope of practice policy for each state. Therefore, your Reference Committee recommends that Resolution 222 be adopted as amended.

- (19) RESOLUTION 223 – APPROPRIATE USE OF SCIENTIFIC STUDIES AND DATA IN THE DEVELOPMENT OF PUBLIC POLICY

RECOMMENDATION A:

Resolution 223 be amended by addition and deletion to read as follows.

RESOLVED, that our AMA ~~actively oppose policies requiring scientific disclosures of confidential medical records consistent with Policy H-315.983 (Patient Privacy and Confidentiality)~~ proposed changes to 40 CFR Part 30 put forward by the Environmental Protection Agency as reported in draft form on November 11, 2019 and titled “Strengthening Transparency in Regulatory Science” (directive to take action); and be it further

RESOLVED, that our AMA supports the use of all credible scientific data in the development of public policy while ~~recognizing the need to safeguard confidentiality of patient information Protected Health Information.~~ (New HOD policy)

RECOMMENDATION B:

Resolution 223 be adopted as amended.

HOD ACTION: Resolution 223 adopted as amended

RESOLVED, That our American Medical Association actively oppose implementation of proposed changes to 40 CFR Part 30 put forward by the Environmental Protection Agency as reported in draft form on November 11, 2019 and titled “Strengthening Transparency in Regulatory Science” (Directive to Take Action); and be it further

RESOLVED, That our AMA support the use of all credible scientific data in the development of public policy while recognizing the need to safeguard Protected Health Information. (New HOD Policy)

Your Reference Committee heard positive testimony on Resolution 223. Your Reference Committee heard testimony that our AMA policy is aligned with the intent and concerns of this resolution. Your Reference Committee heard testimony that our AMA has existing policy to advocate that environmental health regulations should only be modified or rescinded with scientific justification. Your Reference Committee heard additional testimony that the Code of Medical Ethics supports the ethical conduct of research to yield scientifically valid and significant data and generate useful knowledge while safeguarding confidentiality. Testimony indicated that our AMA policy should not reference a draft proposed rule that was leaked to the press and is already out of date. Your Reference Committee heard testimony that, instead, our AMA policy should reflect opposition to the underlying issue that is the subject of Resolution 223. Your Reference Committee agrees and believes that it would be consistent with the objective of the resolution for our AMA to adopt an amended resolution that would oppose policies that require scientific disclosures of confidential medical records. Your Reference Committee believes that this amended language would be consistent with Policy H-315.983. Thus, our AMA would honor patient privacy in these circumstances “unless waived by the patient in a meaningful way or in rare instances when strong

countervailing interests in public health or safety justify invasions of patient privacy or breaches of confidentiality, and then only when such invasions or breaches are subject to stringent safeguards enforced by appropriate standards of accountability” (Policy H-315.983). Your Reference Committee also heard testimony that our AMA should support safeguarding of all patient information and not be limited to just protected health information. Accordingly, your Reference Committee recommends that Resolution 223 be adopted as amended.

RECOMMENDED FOR ADOPTION IN LIEU OF

- (20) RESOLUTION 210 – FEDERAL GOVERNMENT REGULATION AND PROMOTING RENAL TRANSPLANTATION

RECOMMENDATION:

Alternate Resolution 210 be adopted in lieu of Resolution 210.

RESOLVED, That our AMA support federal legislative and regulatory policies that improve kidney transplantation access by using evidence-based outcome measures which do not impede sound clinical judgment of physicians and surgeons.

HOD ACTION: Alternate Resolution 210 adopted in lieu of Resolution 210

RESOLVED, That our American Medical Association actively advocate for US organ transplant legislative and regulatory policies that would advance kidney transplantation by modifying or eliminating arbitrary transplant center outcomes measures that currently discourage sound clinical judgment by physicians and surgeons to accept and transplant kidneys suitable for many patients. (Directive to Take Action)

Your Reference Committee heard largely positive testimony on Resolution 210. Your Reference Committee heard testimony that our AMA already has strong policy actively opposing any legislative or regulatory effort that would create financial incentives that would curtail the access to kidney transplantation. Your Reference Committee heard testimony that Resolution 210 is specialty-specific and our AMA generally defers to the specific specialty societies to lead those advocacy efforts. Your Reference Committee further heard testimony that an Alternate Resolution 210 should be adopted to have our AMA broadly support efforts to improve kidney transplant legislative and regulatory policies that are evidenced-based. Your Reference Committee also heard testimony that outcome measures should be evidenced based. Your Reference Committee heard further testimony that the science of transplantation has advanced over the last decade and that outcome measures have not kept pace. Accordingly, your Reference Committee recommends that Resolution 210 be adopted as amended.

RECOMMENDED FOR REFERRAL

- (21) BOARD OF TRUSTEES REPORT 2 – ENABLING METHADONE TREATMENT OF OPIOID USE DISORDER IN PRIMARY CARE SETTINGS

RECOMMENDATION A:

Recommendations 1 and 3 in Board of Trustees Report 2 be adopted and the remainder of the report be filed.

RECOMMENDATION B:

Recommendation 2 in Board of Trustees Report 2 be referred.

HOD ACTION:

- **Recommendations 1 and 3 in Board of Trustees Report 2 adopted**
- **Recommendation 2 in Board of Trustees Report 2 referred**
- **The remainder of the report filed**

The Board recommends that the following recommendations be adopted in lieu of Resolution 202-I-18, and that the remainder of the report be filed.

1. That our American Medical Association (AMA) support further research into how primary care practices can implement MAT into their practices and disseminate such research in coordination with primary care specialties; (New HOD Policy)
2. That our AMA support efforts to expand primary care services to patients receiving methadone maintenance therapy (MMT) for patients receiving care in an Opioid Treatment Program or via office-based therapy; (New HOD Policy)
3. That the AMA Opioid Task Force increase its evidence-based educational resources focused on MMT and publicize those resources to the Federation. (Directive to Take Action)

Your Reference Committee heard support for the general intent of Board of Trustees Report 2 and the Reference Committee applauds our Board for a very comprehensive report. Your Reference Committee heard overwhelmingly positive testimony in support of Recommendations 1 and 3 of Board of Trustees Report 2 and at the same time, heard conflicting testimony related to Recommendation 2. Your Reference Committee is sensitive to the perceived complexity of methadone maintenance therapy (MMT). We are confident that our AMA can work with those societies that testified, in addition to our AMA's Opioid Task Force, and to study the issues related to Recommendation 2. Therefore, due to the conflicting testimony, the complexity of the issues raised, and the sensitivity related to MMT, your Reference Committee recommends that Recommendation 2 be referred for further study and that Recommendations 1 and 3 be adopted and the remainder of the report be filed.

- (22) RESOLUTION 201 – ADVOCATING FOR THE STANDARDIZATION AND REGULATION OF OUTPATIENT ADDICTION REHABILITATION FACILITIES

RECOMMENDATION:

Resolution 201 be referred.

HOD ACTION: Resolution 201 referred

RESOLVED, That our American Medical Association advocate for the expansion of federal regulations of outpatient addiction rehabilitation centers in order to provide patient and community protection in line with evidence-based care. (Directive to Take Action)

Your Reference Committee heard a significant amount of testimony related to Resolution 201. Your Reference Committee heard considerable testimony that lauded the authors of Resolution 201 for their effort. Your Reference Committee heard testimony that significant concern was repeatedly raised related to additional federal regulations proffered by Resolution 201. Your Reference Committee also noted a significant number of amendments and substitute language proposals were submitted in an attempt to strengthen the resolution. Your Reference Committee is sympathetic to all the concerns raised and believes that further study is warranted. Therefore, your Reference Committee recommends that Resolution 201 be referred.

(23) RESOLUTION 208 – NET NEUTRALITY AND PUBLIC HEALTH

RESOLUTION 211 – EFFECTS OF NET NEUTRALITY ON PUBLIC HEALTH

RECOMMENDATION:

Resolutions 208 and 211 be referred.

HOD ACTION: Resolutions 208 and 211 referred

Resolution 208

RESOLVED, That our American Medical Association advocate for policies that ensure internet service providers transmit essential healthcare data no slower than any other data on that network (Directive to Take Action); and be it further

RESOLVED, That our AMA collaborate with the appropriate governing bodies to develop guidelines for the classification of essential healthcare data requiring preserved transmission speeds (Directive to Take Action); and be it further

RESOLVED, That our AMA oppose internet data transmission practices that reduce market competition in the health ecosystem. (Directive to Take Action)

Resolution 211

RESOLVED, That our American Medical Association amend current policy H-478.980, “Increasing Access to Broadband Internet to Reduce Health Disparities,” by addition and deletion as follows:

~~Increasing Access to Broadband Internet~~ Access to Reduce Health Disparities

Our AMA: (1) will advocate for net neutrality; and (2) will advocate for the expansion of broadband and wireless connectivity to all rural and underserved areas of the United States while at all times taking care to protecting existing federally licensed radio services from harmful interference that can be caused by broadband and wireless services. (Modify Current HOD Policy)

Your Reference Committee heard mixed testimony on Resolutions 208 and 211. Your Reference Committee heard testimony that the repeal of net neutrality could allow companies to place limits on how, where, and when patients and providers are able to access health care data. Your Reference Committee also heard testimony that repeal of net neutrality allows companies to pursue policies that could lessen both innovation and competition in health care technology, or increase the cost of health care delivery, thus negatively impacting both physicians and patients. Your Reference Committee considered that our AMA policy already supports the expansion of broadband and wireless connectivity to all rural and underserved areas of the United States. Your Reference Committee also heard testimony that defining essential health data needs to be further evaluated because the transmission of certain health data may need to take precedence over other data. Your Reference Committee also heard testimony concerning the use of the term “net neutrality” and its impact on potential AMA advocacy activities. Accordingly, your Reference Committee recommends that Resolutions 208 and 211 be referred.

RECOMMENDED FOR NOT ADOPTION**(24) RESOLUTION 214 – AMA SHOULD PROVIDE A SUMMARY OF ITS
ADVOCACY EFFORTS ON SURPRISE MEDICAL BILL****RECOMMENDATION:****Resolution 214 not be adopted.****HOD ACTION: Resolution 214 not adopted**

RESOLVED, That our American Medical Association Board of Trustees provide a detailed report of its efforts and those of allies and opponents around the issue of surprise medical bills in 2019; this discussion should include the following points comparing the AMA and partners activity vs that of its opponents (the insurance companies):

- 1) What testimony was provided at various committee meetings?
- 2) What letters were written to various legislators?
- 3) What grass roots efforts were performed?
- 4) What other groups supported the efforts?
- 5) What other groups were recruited to support the efforts?
- 6) What media efforts were performed?
- 7) What television ads were run?
- 8) What radio ads were run?
- 9) What print ads were run?
- 10) What op-ed pieces were run, in national journals, Washington journals, and regional publications?
- 11) What meetings occurred with various legislators?
- 12) What meetings occurred with members of the administration?
- 13) How much money was spent on the various efforts?
- 14) What studies were published in insurance journals, medical journals, and other journals on this matter?
- 15) Which senators and representatives and administration members could either side count on as solid supporters?
- 16) What level of collaboration was there with other national, state, and specialty societies and how was this carried out? (Directive to Take Action)

Your Reference Committee heard overwhelming testimony against adoption of Resolution 214. Your Reference Committee heard concerns that this expansive request for the public reporting of lobbying activities by our AMA and partners in the surprise billing debate would undercut coalition advocacy at a critical time in congressional activity. Your Reference Committee heard similar testimony from the Council on Legislation, Council on Medical Service, and delegates from several state and specialty Federation members.

Additionally, your Reference Committee heard testimony that much of the information requested in the resolution has already been compiled and distributed during the Interim 2019 Meeting. This information is widely available through various sources, including over a dozen mentions of surprise billing in AMA Advocacy Update, seven AMA press releases, eight AMA News articles, as well as through regular updates provided by AMA staff to the Federation. For these reasons, your Reference Committee recommends that Resolution 214 not be adopted.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (I-19)

Report of Reference Committee C

Louito C. Edje, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Resolution 301 – Engaging Stakeholders for Establishment of a Two-Interval, or Pass/Fail, Grading System of Non-Clinical Curriculum in U.S. Medical Schools
2. Resolution 303 – Investigation of Existing Application Barriers for Osteopathic Medical Students Applying for Away Rotations
3. Resolution 308 – Study Expediting Entry of Qualified IMG Physicians to US Medical Practice

RECOMMENDED FOR ADOPTION AS AMENDED

4. Council on Medical Education Report 3 – Standardization of Medical Licensing Time Limits Across States (Resolution 305-A-18)
5. Council on Medical Education Report 4 – Board Certification Changes Impact Access to Addiction Medicine Specialists (Resolution 314-A-18)
6. Council on Medical Education Report 6 – Veterans Health Administration Funding of Graduate Medical Education (Resolution 954-I-18)
7. Resolution 302 – Strengthening Standards for LGBTQ Medical Education
8. Resolution 305 – Ensuring Access to Safe and Quality Care for our Veterans
9. Resolution 310 – Protection of Resident and Fellow Training in the Case of Hospital or Training Program Closure

RECOMMENDED FOR ADOPTION IN LIEU OF

10. Council on Medical Education Report 2 – Healthcare Finance in the Medical School Curriculum (Resolution 307-A-18)
Resolution 307 – Implementation of Financial Education Curriculum for Medical Students and Physicians in Training

RECOMMENDED FOR REFERRAL

11. Resolution 304 – Issues with the Match, The National Residency Matching Program (NRMP)
12. Resolution 309 – Follow-up on Abnormal Medical Test Findings

The following resolution was handled via the reaffirmation consent calendar:

Resolution 306 – Financial Burden of USMLE Step 2 CS on Medical Students

RECOMMENDED FOR ADOPTION

- (1) RESOLUTION 301 – ENGAGING STAKEHOLDERS FOR ESTABLISHMENT OF A TWO-INTERVAL, OR PASS/FAIL, GRADING SYSTEM OF NON-CLINICAL CURRICULUM IN U.S. MEDICAL SCHOOLS

RECOMMENDATION:

Resolution 301 be adopted.

HOD ACTION: Resolution 301 adopted

RESOLVED, That our American Medical Association amend Policy H-295.866 by addition and deletion to read as follows:

Supporting Two-Interval Grading Systems for Medical Education, H-295.866
Our AMA will work with stakeholders to encourage the establishment of ~~acknowledges the benefits of a two-~~ interval grading system in medical colleges and universities in the United States for the non-clinical curriculum. (Modify Current HOD Policy)

Your Reference Committee heard mixed testimony that was largely in favor of adoption, due chiefly to the negative emotional and physical health impacts of grades on students. Testimony was provided noting that studies show that students in pass/fail grading systems for preclinical curricula exhibit better mental health and greater satisfaction compared to those in multi-tiered grading systems. Furthermore, the widespread adoption of pass/fail curriculum has not been found to negatively affect student performance on United States Medical Licensing Examination Step 1 and Step 2 examinations. Those providing testimony in opposition to adoption argued for the need for flexibility among the individual needs of a given medical school. As with curricular mandates, the AMA should not propagate a monolithic system of pass/fail grading in all medical schools—which could also make it more difficult for program directors to distinguish the qualifications of one school’s applicants from another. Furthermore, with anticipated changes to the grading and scoring of USMLE Step 1, program directors may very well need this data point to evaluate residency candidates. The AMA should help schools maintain flexibility in appropriate stratification and evaluation of student performance. With these caveats in mind, your Reference Committee nonetheless believes that the weight of the testimony supports adoption. A holistic approach to review of residency program applicants is needed; this resolution helps move the AMA towards this laudable goal. Further, the current policy already acknowledges the benefits of a pass/fail system; the resolution simply moves the ball down the field (versus punting) and helps move the policy from words to action. For these reasons, we urge adoption of Resolution 301 as written.

- (2) RESOLUTION 303 – INVESTIGATION OF EXISTING APPLICATION BARRIERS FOR OSTEOPATHIC MEDICAL STUDENTS APPLYING FOR AWAY ROTATIONS

RECOMMENDATION:

Resolution 303 be adopted.

HOD ACTION: Resolution 303 adopted

RESOLVED, That our American Medical Association work with relevant stakeholders to explore reasons behind application barriers that result in discrimination against osteopathic medical students when applying to elective visiting clinical rotations, and generate a report with the findings by the 2020 Interim Meeting. (Directive to Take Action)

Your Reference Committee heard supportive online and in-person testimony regarding Resolution 303. As noted in testimony, this resolution identifies the significant challenges that osteopathic medical students face when pursuing clinical rotations away from their home educational campus. The resolution’s authors identified potential and real sources of discrimination among MD and DO students, which is averse to AMA policies that call for fairness

balanced with flexibility. Speakers also noted the potential for unequal treatment by some institutions, such that osteopathic medical students bear the brunt of higher rotation fees versus their allopathic colleagues when applying for away rotations through the Visiting Student Application Services program. This is a complex issue with shades of nuance, meriting a full examination and study by our AMA Council on Medical Education, to forestall ongoing adverse consequences for osteopathic medical students. Therefore, your Reference Committee recommends that Resolution 303 be adopted.

(3) RESOLUTION 308 – STUDY EXPEDITING ENTRY OF QUALIFIED IMG PHYSICIANS TO US MEDICAL PRACTICE

RECOMMENDATION:

Resolution 308 be adopted.

HOD ACTION: Resolution 308 adopted

RESOLVED, That our American Medical Association study and make recommendations for the best means for evaluating, credentialing and expediting entry of competently trained international medical graduate (IMG) physicians of all specialties into medical practice in the USA. (Directive to Take Action)

Your Reference Committee received online and in-person testimony in overwhelming support of Resolution 308. Speakers noted that this resolution, which calls for a study, will evaluate how “qualified” foreign-born international medical graduates (IMGs) can be placed into an expeditious pathway of learning the American health care system while fulfilling credentialing, licensure, and certification requirements. Speakers noted the diverse educational and professional experiences that foreign-born IMGs offer and were supportive of expediting the process of entry for those deemed to have the appropriate knowledge and skills required for US medical practice. Speakers also noted that this study is important to prevent the possibility of a tiered level of physician credentialing and to ensure high quality medical care regardless of the patient’s geographic location. Therefore, your Reference Committee recommends that Resolution 308 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

- (4) COUNCIL ON MEDICAL EDUCATION REPORT 3 – STANDARDIZATION OF MEDICAL LICENSING TIME LIMITS ACROSS STATES (RESOLUTION 305-A-18)

RECOMMENDATION A:

Recommendation 1 in Council on Medical Education Report 3 be amended by deletion, to read as follows:

1. That our American Medical Association (AMA) urge the state medical and osteopathic boards that maintain a time limit for completing licensing examination sequences for either USMLE or COMLEX to adopt a time limit of no less than 10 years for completion of the licensing exams to allow sufficient time for individuals who are pursuing combined degrees (e.g., MD/PhD). (New HOD Policy)

RECOMMENDATION B:

Recommendation 3 in Council on Medical Education Report 3 be deleted:

- ~~3. That our AMA encourage uniformity in the time limit for completing the licensing examination sequence across states, allowing for improved inter-state mobility for physicians. (New HOD Policy)~~

RECOMMENDATION C:

Recommendations in Council on Medical Education Report 3 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Education Report 3 adopted as amended and the remainder of the report be filed

The Council on Medical Education recommends that the following recommendations be adopted in lieu of Resolution 305-A-18 and the remainder of the report be filed.

1. That our American Medical Association (AMA) urge the state medical and osteopathic boards that maintain a time limit for completing licensing examination sequences for either USMLE or COMLEX to adopt a time limit of no less than 10 years for completion of the licensing exams to allow sufficient time for individuals who are pursuing combined degrees (e.g., MD/PhD). (New HOD Policy)
2. That our AMA urge that state medical and osteopathic licensing boards with time limits for completing the licensing examination sequence provide for exceptions that may involve personal health/family circumstances. (New HOD Policy)
3. That our AMA encourage uniformity in the time limit for completing the licensing examination sequence across states, allowing for improved inter-state mobility for physicians. (New HOD Policy)

Testimony was offered in unanimous support of the first and second recommendations in Council on Medical Education Report 3. Speakers noted that seven-year limits on licensure eligibility becomes problematic for medical students who need to take leaves of absence or for those pursuing dual degrees in a state that does not grant exception for these students. One speaker offered testimony to amend Recommendation 3 to set a floor on the time limit to avoid states implementing a uniform but lower limit that could negatively impact trainees in a single-degree program. However, the deletion made to the first recommendation extended the time limits for all licensure candidates and eliminated the need for the third recommendation. Therefore, your Reference Committee encourages adoption as amended of the recommendations in Council on Medical Education Report 3.

- (5) COUNCIL ON MEDICAL EDUCATION REPORT 4 – BOARD CERTIFICATION CHANGES IMPACT ACCESS TO ADDICTION MEDICINE SPECIALISTS (RESOLUTION 314-A-18)

RECOMMENDATION A:

Council on Medical Education Report 4 be amended by the addition of a third Recommendation, to read as follows:

That our AMA recognize the American Osteopathic Association Bureau of Osteopathic Specialists for developing and providing a pathway for all qualified physicians to obtain subspecialty certification in addiction medicine, in order to improve access to care for patients with substance use disorder. (Directive to Take Action)

RECOMMENDATION B:

Council on Medical Education Report 4 be amended by the addition of a fourth Recommendation, to read as follows:

That our AMA recognize the American Osteopathic Association (AOA) for developing and providing a pathway for qualified physicians (DOs and MDs) with an active primary AOA board certification in any specialty to obtain subspecialty certification in Addiction Medicine, in order to improve access to care for patients with substance use disorder. (Directive to Take Action)

RECOMMENDATION C:

Recommendations in Council on Medical Education Report 4 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Education Report 4 adopted as amended and the remainder of the report be filed

The Council on Medical Education recommends that the following recommendations be adopted in lieu of Resolution 314-A-18 and the remainder of the report be filed.

1. That our American Medical Association (AMA) recognize the American Board of Preventive Medicine (ABPM) for developing and providing pathways for all qualified physicians to obtain ABMS-approved certification in the new ABPM subspecialty of addiction medicine, in order to improve access to care for patients with substance use disorder. (Directive to Take Action)
2. That our AMA rescind Policy H-300.962 (3) “Recognition of Those Who Practice Addiction Medicine,” since the ABPM certification examination in addiction medicine is now offered. (Rescind HOD Policy)

Your Reference Committee heard mostly supportive testimony favoring adoption of Council on Medical Education Report 4, which calls attention to the urgent need to train physicians in addiction medicine and recognizes the American Board of Preventive Medicine for providing a time-limited pathway for subspecialty certification in addiction medicine for the American Board of Addiction Medicine diplomates. In online and in-person testimony, speakers also noted that the American Osteopathic Association (AOA) and the AOA Bureau of Osteopathic Specialists have both developed and are independently providing a pathway for all qualified physicians to obtain subspecialty certification in addiction medicine. One speaker offered recommendations that asked the AMA to encourage hospitals and health systems to establish departments or sections of addiction medicine and to delineate clinical privileges in addiction medicine. However, a member of the Council on Medical Education testified that these additional recommendations could potentially lead to confusion of credentialing with certification. Therefore, your Reference Committee recommends that Council on Medical Education Report 4 be adopted as amended.

- (6) COUNCIL ON MEDICAL EDUCATION REPORT 6 – VETERANS HEALTH ADMINISTRATION FUNDING OF GRADUATE MEDICAL EDUCATION (RESOLUTION 954-I-18)

RECOMMENDATION A:

Recommendation 1 in Council on Medical Education Report 6 be amended by addition and deletion, to read as follows:

That our AMA support postgraduate medical education service obligations through ~~any programs~~ where the expectation for service, such as military service, is reasonable and explicitly delineated in the contract with the trainee. (New HOD Policy)

RECOMMENDATION B:

Recommendations in Council on Medical Education Report 6 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Education Report 6 adopted as amended and the remainder of the report be filed

The Council on Medical Education recommends that the following recommendations be adopted in lieu of Resolution 954-I-18 and the remainder of the report be filed.

1. That our AMA support postgraduate medical education service obligations through any program where the expectation for service is explicitly delineated in the contract with the trainee. (New HOD Policy)
2. That our American Medical Association (AMA) oppose the blanket imposition of service obligations through any program where physician trainees rotate through the facility as one of many sites for their training. (New HOD Policy)

Testimony was offered online and in-person in unanimous support of Council on Medical Education Report 6. Speakers noted that this report ensures support for postgraduate medical education service obligations, where that expectation is explicitly delineated in a trainee's contract, and opposition to a "blanket imposition" of service obligations on physician trainees who simply rotate through a Veterans Health Administration facility as one of their training sites. Speakers also offered an amendment to clarify that this report focuses on military service, since the Council on Medical Education will address other types of services in an upcoming report on graduate medical education and the corporate practice of medicine planned for the 2020 Annual Meeting. Therefore, your Reference Committee recommends that Council on Medical Education Report 6 be adopted as amended.

- (7) RESOLUTION 302 – STRENGTHENING STANDARDS FOR LGBTQ MEDICAL EDUCATION

RECOMMENDATION A:

Resolution 302 be amended by addition and deletion, to read as follows:

RESOLVED, That our AMA amend policy H-295.878, "Eliminating Health Disparities - Promoting Awareness and Education of Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) Health Issues in Medical Education," by addition and deletion to read as follows:

Our AMA: (1) supports the right of medical students and residents to form groups and meet on-site to further their medical education or enhance patient care without regard to their gender, gender identity, sexual orientation, race, religion, disability, ethnic origin, national origin or age;

(2) supports students and residents who wish to conduct on-site educational seminars and workshops on health issues in Lesbian, Gay, Bisexual, Transgender and Queer communities related to sexual orientation and gender identity; and (3) encourages ~~the Liaison Committee on Medical Education (LCME), the American Osteopathic Association (AOA), and the Accreditation Council for Graduate Medical Education (ACGME)~~ medical education accreditation bodies to both continue to encourage and periodically reassess ~~include Lesbian, Gay, Bisexual, Transgender and Queer education on~~ health issues related to sexual orientation and gender identity in the basic science, clinical care, and cultural competency curriculum ~~curricula for both in~~ undergraduate and graduate medical education; and (4) ~~encourages the Liaison Committee on Medical Education (LCME), American Osteopathic Association (AOA), and Accreditation Council for Graduate Medical Education (ACGME) to~~ periodically reassess the current status of curricula for medical student and residency education addressing the needs of pediatric and adolescent ~~Lesbian, Gay, Bisexual, Transgender and Queer patients.~~

RECOMMENDATION B:

Resolution 302 be adopted as amended.

RECOMMENDATION C:

The title of Policy H-295.878 be changed, to read as follows:

Eliminating Health Disparities - Promoting Awareness and Education of Sexual Orientation and Gender Identity Health Issues in Medical Education

HOD ACTION: Resolution 302 adopted as amended

RESOLVED, That our AMA amend policy H-295.878, “Eliminating Health Disparities - Promoting Awareness and Education of Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) Health Issues in Medical Education,” by addition and deletion to read as follows:

Eliminating Health Disparities – Promoting Awareness and Education of Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) Health Issues, H-295.878

Our AMA: (1) supports the right of medical students and residents to form groups and meet on-site to further their medical education or enhance patient care without regard to their gender, gender identity, sexual orientation, race, religion, disability, ethnic origin, national origin or age; (2) supports students and residents who wish to conduct on-site educational seminars and workshops on health issues in Lesbian, Gay, Bisexual, Transgender and Queer communities; and (3) encourages the Liaison Committee on Medical Education (LCME), the American Osteopathic Association (AOA), and the Accreditation Council for Graduate Medical Education (ACGME) to include Lesbian, Gay, Bisexual, Transgender and Queer health issues in the basic science, clinical care, and cultural competency curriculum ~~curricula for both~~ undergraduate and graduate medical education; and (4) encourages the Liaison Committee on Medical Education (LCME), American Osteopathic Association (AOA), and Accreditation Council for Graduate Medical Education (ACGME) to periodically reassess the current status of curricula for medical student and residency education addressing the needs of ~~pediatric and adolescent~~ Lesbian, Gay, Bisexual, Transgender and Queer patients. (Modify Current HOD Policy)

Your Reference Committee heard unanimous testimony in overwhelming support of this resolution. Additionally, there was testimony that the term “LGBTQ” may not represent individuals who are “non-binary,” a more prevalent term and that leaving the language open to sexual orientation and gender identity may be more inclusive than the current policy’s specificity. The Accreditation Council for Graduate Medical Education provides a model in this regard, referencing education on “sexual orientation.” Your Reference Committee found this language compelling

and clarifying for the purpose of AMA policy enhancement, and therefore has included this verbiage in its proffered revisions to Resolution 302, and urges adoption as amended.

(8) RESOLUTION 305 – ENSURING ACCESS TO SAFE AND QUALITY CARE FOR OUR VETERANS

RECOMMENDATION A:

Resolution 305 be amended by deletion, to read as follows:

RESOLVED, That our American Medical Association amend AMA Policy H-510.986, “Ensuring Access to Care for our Veterans,” by addition to read as follows:

Ensuring Access to Safe and Quality Care for our Veterans H-510.986

- 1. Our AMA encourages all physicians to participate, when needed, in the health care of veterans.**
- 2. Our AMA supports providing full health benefits to eligible United States Veterans to ensure that they can access the Medical care they need outside the Veterans Administration in a timely manner.**
- 3. Our AMA will advocate strongly: a) that the President of the United States take immediate action to provide timely access to health care for eligible veterans utilizing the healthcare sector outside the Veterans Administration until the Veterans Administration can provide health care in a timely fashion; and b) that Congress act rapidly to enact a bipartisan long term solution for timely access to entitled care for eligible veterans.**
- 4. Our AMA recommends that in order to expedite access, state and local medical societies create a registry of doctors offering to see our veterans and that the registry be made available to the veterans in their community and the local Veterans Administration.**
- 5. Our AMA supports access to ~~similar~~ clinical educational resources for all health care professionals involved in the care of veterans such as those provided by the U.S. Department of Veterans Affairs to their employees with the goal of providing better care for all veterans.**
- 6. Our AMA will strongly advocate that the Veterans Health Administration and Congress develop and implement necessary resources, protocols, and accountability to ensure the Veterans Health Administration recruits, hires and retains physicians and other health care professionals to deliver the safe, effective and high-quality care that our veterans have been promised and are owed. (Modify Current HOD Policy)**

RECOMMENDATION B:

Resolution 305 be adopted as amended.

HOD ACTION: Resolution 305 adopted as amended

RESOLVED, That our American Medical Association amend AMA Policy H-510.986, “Ensuring Access to Care for our Veterans,” by addition to read as follows:

Ensuring Access to Safe and Quality Care for our Veterans H-510.986

- 1. Our AMA encourages all physicians to participate, when needed, in the health care of veterans.**
- 2. Our AMA supports providing full health benefits to eligible United States Veterans to ensure that they can access the Medical care they need outside the Veterans Administration in a timely manner.**
- 3. Our AMA will advocate strongly: a) that the President of the United States take immediate action to provide timely access to health care for eligible veterans utilizing the healthcare sector outside the Veterans Administration until the Veterans Administration can provide health care in a timely fashion; and b) that Congress act rapidly to enact a bipartisan long term solution for timely access to entitled care for eligible veterans.**

4. Our AMA recommends that in order to expedite access, state and local medical societies create a registry of doctors offering to see our veterans and that the registry be made available to the veterans in their community and the local Veterans Administration.

5. Our AMA supports access to similar clinical educational resources for all health care professionals involved in the care of veterans as those provided by the U.S. Department of Veterans Affairs to their employees with the goal of providing better care for all veterans.

6. Our AMA will strongly advocate that the Veterans Health Administration and Congress develop and implement necessary resources, protocols, and accountability to ensure the Veterans Health Administration recruits, hires and retains physicians and other health care professionals to deliver the safe, effective and high-quality care that our veterans have been promised and are owed. (Modify Current HOD Policy)

Your Reference Committee heard strong support for the purpose and intent of Resolution 305. Speakers unanimously agreed that physicians should continuously strive to provide optimal care for our nation's veterans. During testimony it was noted that the resolution, as written, may be perceived as placing the onus of developing clinical educational resources on the VA system, which has strict regulations about accessing and completing required compliance and education-related training. An amendment was offered to clarify the goal of developing, and making readily available, these clinical educational resources which could be developed by any entity hopefully in conjunction with the VA. Speakers also noted that communications between VA and non-VA communities should be improved and that further policy changes related to communication merit consideration in the future. Therefore, your Reference Committee recommends that Resolution 305 be adopted as amended.

(9) RESOLUTION 310 – PROTECTION OF RESIDENT AND FELLOW
TRAINING IN THE CASE OF HOSPITAL OR TRAINING PROGRAM
CLOSURE

RECOMMENDATION A:

The first Resolve of Resolution 310 be amended by addition and deletion, to read as follows:

RESOLVED, That our American Medical Association study and provide recommendations on how the process of assisting displaced ~~orphaned~~ residents and fellows could be improved in the case of training hospital or training program closure, including:

- 1) The current processes by which a displaced resident or fellow may seek and secure an alternative training position; and
- 2) How the Centers for Medicare and Medicaid Services (CMS) and other additional or supplemental graduate medical education (GME) funding is re-distributed, including but not limited to:
 - a. The direct or indirect classification of residents and fellows as financial assets and the implications thereof;
 - b. The transfer of training positions between institutions and the subsequent impact on resident and fellow funding lines in the event of closure;
 - c. The transfer of full versus partial funding for new training positions; and
 - d. The transfer of funding for displaced ~~orphaned~~ residents and fellows who switch specialties (Directive to Take Action); and be it further

RECOMMENDATION B:

The second Resolve of Resolution 310 be amended by addition and deletion, to read as follows:

RESOLVED, That our AMA work with the Centers for Medicare and Medicaid Services (CMS) to establish regulations that ~~which~~ protect residents and fellows impacted by program or hospital closure, which may include recommendations for:

- 1) Notice by the training hospital, intending to file for bankruptcy within 30 days, to all residents and fellows primarily associated with the training hospital, as well as those contractually matched at that training institution who may not yet have matriculated, of its intention to close, along with provision of reasonable and appropriate procedures to assist current and matched residents and fellows to find and obtain alternative training positions that ~~which~~ minimize undue financial and professional consequences, including but not limited to maintenance of specialty choice, length of training, initial expected time of graduation, location and reallocation of funding, and coverage of tail medical malpractice insurance that would have been offered had the program or hospital not closed;
- 2) Revision of the current CMS guidelines that may prohibit transfer of funding prior to formal financial closure of a teaching institution;
- 3) Improved provisions regarding transfer of GME funding for displaced residents and fellows for the duration of their training in the event of program closure at a training institution; and
- 4) Protections against the discrimination of displaced ~~orphaned~~ residents and fellows consistent with H-295.969 (Directive to Take Action); and be it further

RECOMMENDATION C:

The third Resolve of Resolution 310 be amended by addition and deletion, to read as follows:

RESOLVED, That our AMA work with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, National Resident Matching Program, Educational Commission for Foreign Medical Graduates, ~~the~~ Centers for Medicare and Medicaid Services, and other relevant stakeholders to identify a process by which displaced ~~orphaned~~ residents and fellows may be directly represented in proceedings surrounding the closure of a training hospital or program (Directive to Take Action); and be it further

RECOMMENDATION D:

The fourth Resolve of Resolution 310 be amended by addition and deletion, to read as follows:

RESOLVED, That our AMA work with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, National Resident Matching Program, Educational Commission for Foreign Medical Graduates, ~~the~~ Centers for Medicare and Medicaid Services, and other relevant stakeholders to:

- 1) Develop a stepwise algorithm for designated institutional officials and program directors to assist residents and fellows with finding and obtaining alternative training positions; ~~and~~
- 2) Create a centralized, regulated process for displaced ~~orphaned~~ residents and fellows to obtain new training positions;

3) Develop pathways that ensure that closing and accepting institutions provide liability insurance coverage to residents, at no cost to residents.
(Directive to Take Action)

RECOMMENDATION E:

Resolution 310 be adopted as amended.

HOD ACTION: Resolution 310 adopted as amended, with the following proposed fifth Resolve referred for decision:

RESOLVED, That our AMA urgently advocate to CMS or other appropriate sources of funding to ensure that liability tail coverage is provided for the 571 residents displaced by the closure of Hahnemann University Hospital, at no cost to the affected residents. (Directive to Take Action)

RESOLVED, That our American Medical Association study and provide recommendations on how the process of assisting orphaned residents and fellows could be improved in the case of training hospital or training program closure, including:

- 1) The current processes by which a displaced resident or fellow may seek and secure an alternative training position; and
- 2) How the Centers for Medicare and Medicaid Services (CMS) and other additional or supplemental GME funding is re-distributed, including but not limited to:
 - a. The direct or indirect classification of residents and fellows as financial assets and the implications thereof;
 - b. The transfer of training positions between institutions and the subsequent impact on resident and fellow funding lines in the event of closure;
 - c. The transfer of full versus partial funding for new training positions; and
 - d. The transfer of funding for orphaned residents and fellows who switch specialties (Directive to Take Action); and be it further

RESOLVED, That our AMA work with the Centers for Medicare and Medicaid Services (CMS) to establish regulations which protect residents and fellows impacted by program or hospital closure which may include recommendations for:

- 1) Notice by the training hospital, intending to file for bankruptcy within 30 days, to all residents and fellows primarily associated with the training hospital, as well as those contractually matched at that training institution who may not yet have matriculated, of its intention to close, along with provision of reasonable and appropriate procedures to assist current and matched residents and fellows to find and obtain alternative training positions which minimize undue financial and professional consequences, including but not limited to maintenance of specialty choice, length of training, initial expected time of graduation, location and reallocation of funding, and coverage of tail medical malpractice insurance that would have been offered had the program or hospital not closed;
- 2) Revision of the current CMS guidelines that may prohibit transfer of funding prior to formal financial closure of a teaching institution;
- 3) Improved provisions regarding transfer of GME funding for displaced residents and fellows for the duration of their training in the event of program closure at a training institution; and
- 4) Protections against the discrimination of orphaned residents and fellows consistent with H-295.969 (Directive to Take Action); and be it further

RESOLVED, That our AMA work with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, National Resident Matching Program, Educational Commission for Foreign Medical Graduates, the Centers for Medicare and Medicaid Services and other relevant stakeholders to identify a process by which orphaned residents and fellows may be directly represented in proceedings surrounding the closure of a training hospital or program (Directive to Take Action); and be it further

RESOLVED, That our AMA work with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, National Resident Matching Program, Educational Commission for Foreign Medical Graduates, the Centers for Medicare and Medicaid Services, and other relevant stakeholders to:

- 1) Develop a stepwise algorithm for designated institutional officials and program directors to assist residents and fellows with finding and obtaining alternative training positions; and
- 2) Create a centralized, regulated process for orphaned residents and fellows to obtain new training positions. (Directive to Take Action)

Your Reference Committee heard strong testimony in support of this resolution, due to the recent events that occurred earlier this year at Hahnemann University Hospital in Philadelphia, and the urgent need for AMA action on this issue for those individuals affected and for future policies to ensure adequate protections going forward. Speakers noted concerns related to the funding for residents inadvertently displaced, as might occur with a natural

disaster (e.g., Hurricane Katrina)—versus those who are removed from a residency program due to issues with clinical performance and/or professionalism. Similarly, the loss of liability coverage when a hospital goes bankrupt was a cogent concern. Speakers also noted the time sensitivity associated with those residents with J-1 Visa contractual obligations. To address the issue of end-to-end liability coverage for residents, additional text was added to the end of Resolve 4 to ensure that neither closing nor accepting institutions capitulate to financial exigencies and eliminate this needed coverage. Therefore, your Reference Committee recommends that Resolution 310 be adopted as amended.

RECOMMENDED FOR ADOPTION IN LIEU OF

- (10) COUNCIL ON MEDICAL EDUCATION REPORT 2 – HEALTHCARE FINANCE IN THE MEDICAL SCHOOL CURRICULUM (RESOLUTION 307-A-18)

RESOLUTION 307 – IMPLEMENTATION OF FINANCIAL EDUCATION CURRICULUM FOR MEDICAL STUDENTS AND PHYSICIANS IN TRAINING

RECOMMENDATION:

Recommendation in Council on Medical Education Report 2 be adopted in lieu of Resolution 307 and the remainder of the report be filed.

HOD ACTION: Recommendation in Council on Medical Education Report 2 adopted in lieu of Resolution 307 and the remainder of the report be filed

The Council on Medical Education recommends that the following recommendation be adopted in lieu of Resolution 307-A-18 and the remainder of the report be filed.

1. That our American Medical Association (AMA) amend Policy H-295.924, “Future Directions for Socioeconomic Education,” by addition and deletion to read as follows:

“The AMA: (1) asks medical schools and residencies to encourage that basic content related to the structure and financing of the current health care system, including the organization of health care delivery, modes of practice, practice settings, cost effective use of diagnostic and treatment services, practice management, risk management, and utilization review/quality assurance, is included in the curriculum; (2) asks medical schools and residencies to ensure that content related to the environment and economics of medical practice in fee-for-service, managed care and other financing systems is presented ~~in didactic sessions and reinforced during clinical experiences, in both inpatient and ambulatory care settings,~~ at educationally appropriate times during undergraduate and graduate medical education; and (3) will encourage ~~representatives to~~ the Liaison Committee on Medical Education (LCME) to ensure that survey teams pay close attention during the accreditation process to the degree to which ‘socioeconomic’ subjects are covered in the medical curriculum.” (Modify Current HOD Policy)

RESOLUTION 307

RESOLVED, That our American Medical Association work with relevant stakeholders to study the development of a curriculum during medical school and residency/fellowship training to educate them about the financial and business aspect of medicine. (Directive to Take Action)

Your Reference Committee heard testimony on Council on Medical Education Report 2 in strong support of the need for adequate and appropriate education for medical students and resident/fellow physicians in curricular content related to financing of the U.S. health care system and personal economics. These issues are increasing in complexity, and importance, and our future physicians need exposure to these issues. Similarly, testimony on Resolution 307, while limited, reflected this need for targeted education on economics-related issues. Curricular content on these topics is currently required by the Liaison Committee on Medical Education and Accreditation Council for Graduate Medical Education in undergraduate and graduate medical education, respectively. With few exceptions, allopathic medical schools report the inclusion of the topics of health care financing, health care costs, medical socioeconomics, and medical economics in their respective curricula. Finally, our AMA provides online educational resources on health systems science (HSS) topics, including the effect of payment models on health outcomes and cost of care, and the AMA-supported Accelerating Change in Medical Education initiative includes medical economics in the focus area of HSS. Accordingly, your Reference Committee recommends that Council on Medical Education Report 2 be adopted in lieu of Resolution 307.

RECOMMENDED FOR REFERRAL

- (11) RESOLUTION 304 – ISSUES WITH THE MATCH, THE NATIONAL RESIDENCY MATCHING PROGRAM (NRMP)

RECOMMENDATION:

Resolution 304 be referred.

HOD ACTION: Resolution 304 referred

RESOLVED, That our American Medical Association redouble its efforts to promote an increase in residency program positions in the U.S. (Directive to Take Action); and be it further

RESOLVED, That our AMA assign an appropriate AMA committee or committees to:

- Study the issue of why residency positions have not kept pace with the changing physician supply and investigate what novel residency programs have been successful across the country in expanding positions both traditionally and nontraditionally.

- Seek to determine what causes a failure to match and better understand what strategies are most effective in increasing the chances of a successful match, especially after a prior failure. The committee(s) would rely upon the BNRMP (Board of the National Residency Matching Program) to provide some of this information through surveys, questionnaires and other means. Valid data would be valuable to medical students who seek to improve their chances of success in The Match.

- Report back to the AMA HOD with findings and recommendations (Directive to Take Action); and be it further

RESOLVED, Because SOAP (Supplemental Offer and Acceptance Program) failed to adequately serve some physicians seeking to match this year, that our AMA support the option to allow individuals participating in one future Match at no cost (Directive to Take Action); and be it further

RESOLVED, That in order to understand the cost of The Match and identify possible savings, our AMA encourage the Board of the National Residency Matching Program to:

1. Conduct an independent and fully transparent audit of SOAP (Supplemental Offer and Acceptance Program) to identify opportunities for savings, with the goal of lowering the financial burden on medical students and new physicians

2. Actively promote success for those participating in The Match by better explaining and identifying those issues that interfere with the successful match and to offer strategies to mitigate those issues. This information can be disseminated through the program website and through services such as its “Help” and “Q&A” links, and also through the AMA. (Directive to Take Action)

Your Reference Committee heard mixed testimony in regard to Resolution 304. Online and in-person testimony suggested that this resolution, which calls for a broad investigation into several different aspects of the resident match, including data on unmatched residents, strategies for a successful match, and last year’s technological failure during the SOAP process, has already been addressed in the recent past by the Council on Medical Education (CME Report 6-A-17, Addressing the Increasing Number of Unmatched Medical Students). Speakers noted that the AMA has extensive policy on expanding graduate medical education (BOT Report, 25-A-19, All Payer Graduate Medical Education Funding). Speakers also noted that the National Resident Matching Program and the Association of American Medical Colleges release yearly authoritative reports on match outcomes with granular data for medical students to aid in their decision making. Testimony also pointed out some factual errors and erroneous statements regarding the Resolves, including the incorrect name for the “National Resident Matching Program,” as well as a lack of awareness of the costs associated and pathways to successful participation with The Match. Speakers also expressed concern that current efforts to address this issue have been insufficient. Your Reference Committee initially considered reaffirmation of existing policy in lieu of Resolves 1 and 2, and deletion of Resolve 3, due to

inconsistencies in terminology, among other issues, but we believe that referral of the entire item is appropriate, so that your Council on Medical Education can fully examine and address these concerns in a future study. Therefore, your Reference Committee recommends that Resolution 304 be referred.

(12) RESOLUTION 309 – FOLLOW-UP ON ABNORMAL MEDICAL TEST FINDINGS

RECOMMENDATION:

Resolution 309 be referred.

HOD ACTION: Resolution 309 referred

RESOLVED, That our American Medical Association advocate for the adoption of evidence-based guidelines on the process for communication and follow-up of abnormal medical test findings to promote better patient outcomes (Directive to Take Action); and be it further

RESOLVED, That our AMA work with appropriate state and specialty medical societies to enhance opportunities for continuing education regarding professional guidelines and other clinical resources to enhance the process for communication and follow-up of abnormal medical test findings to promote better patient outcomes. (Directive to Take Action)

Your Reference Committee heard testimony favoring referral of Resolution 309. Speakers noted that there are many different tests in different settings. Speakers also noted that there is no one accepted uniform guideline for communication of abnormal test results, and federal and state mandated requirements related to imaging studies vary. Speakers also stressed that this item required further study to review all relevant specialties that communicate patient results as well as to determine which published guidelines and recommendations were evidence based. Due to the complexity of this resolution, your Reference Committee recommends that Resolution 309 be referred for further study.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (I-19)

Report of Reference Committee F
Ann R. Stroink, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Board of Trustees Report 8 – Implementing AMA Climate Change Principles Through JAMA Paper Consumption Reduction and Green Healthcare Leadership
2. Council on Long Range Planning and Development Report 1 – Academic Physicians Section Five-Year Review
3. Report of the House of Delegates Committee on the Compensation of the Officers

RECOMMENDED FOR ADOPTION AS AMENDED

4. Board of Trustees Report 6 – Physician Health Policy Opportunity
5. Resolution 602 – Preserving Childcare at AMA Meetings

The following resolution was Recommended Against Consideration:

- Resolution 601 – Amending AMA Policy G-630.140, “Lodging, Meeting Venues, and Social Functions”

RECOMMENDED FOR ADOPTION

- (1) BOARD OF TRUSTEES REPORT 8 - IMPLEMENTING AMA CLIMATE CHANGE PRINCIPLES THROUGH JAMA PAPER CONSUMPTION REDUCTION AND GREEN HEALTHCARE LEADERSHIP (RESOLUTION 615-A-19)

RECOMMENDATION:

Recommendations in Board of Trustees Report 8 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendations in Board of Trustees Report 8 adopted and the remainder of the Report filed.

The Board of Trustees recommends that the following be adopted in lieu of Resolution 615-A-19, and the remainder of this report be filed.

That our American Medical Association continue to explore environmentally sustainable practices for *JAMA* distribution.

Given previously articulated concerns about potential unintended financial consequences, your Reference Committee lauds the JAMA Network's efforts in accelerating the shift to digital printing for journals in the portfolio, as well as moving forward with a pilot program to migrate *JAMA Surgery* to digital printing in 2020 thereby reducing the overall print circulation for that title by over 90 percent.

Your Reference Committee fully supports the recommendation contained in Board of Trustees Report 8, which serves to address the concerns of our Medical Student Section who championed this matter.

- (2) COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT REPORT 1 - ACADEMIC PHYSICIANS SECTION FIVE-YEAR REVIEW

RECOMMENDATION:

Recommendation in Council on Long Range Planning and Development Report 1 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendation in Council on Long Range Planning and Development Report 1 adopted and the remainder of the Report filed.

The Council on Long Range Planning and Development recommends that our American Medical Association renew delineated section status for the Academic Physicians Section through 2024 with the next review no later than the 2024 Interim Meeting. (Directive to Take Action)

On behalf of our House of Delegates, your Reference Committee wishes to extend its appreciation to the members of the Council on Long Range Planning and Development and the leadership of the Academic Physicians Section for their cooperative and collaborative efforts thereby allowing the Council to present a thorough review of the Section's status. Having received no negative testimony, your Reference Committee supports the Council's conclusion.

(3) REPORT OF THE HOUSE OF DELEGATES COMMITTEE ON
COMPENSATION OF THE OFFICERS

RECOMMENDATION:

Recommendations in the Report of the House of Delegates Committee on Compensation of the Officers be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendations in the Report of the House of Delegates Committee on Compensation of the Officers adopted and the remainder of the Report filed.

The Committee on Compensation of the Officers recommends the following recommendations be adopted and the remainder of this report be filed:

1. That there be no change to the current Definitions effective 1 July 1, 2018 as they appear in the Travel and Expenses Standing Rules for AMA Officers for the Governance Honorarium, Per Diem for Representation and Telephonic Per Diem except for the Governance Honorarium and Per Diem amounts as recommended in 2, 3 and 4 below.
 - Definition of Governance Honorarium effective July 1, 2017:
The purpose of this payment is to compensate Officers, excluding Board Chair, Chair-Elect and Presidents, for all Chair-assigned internal AMA work and related travel. This payment is intended to cover all currently scheduled Board meetings, special Board or Board committee, subcommittee and task force meetings, Board orientation, Board development and media training, and Board conference calls, and any associated review or preparatory work, and all travel days related to all such meetings. The Governance Honorarium also covers Internal Representation, such as section and council liaison meetings (and associated travel) or calls, up to eleven (11) Internal Representation days.
 - Definition of Per Diem for Representation effective July 1, 2017:
The purpose of this payment is to compensate for Board Chair-assigned representation day(s) and related travel for Officers, excluding Board Chair, Chair-Elect and Presidents. Representation is either external to the AMA, or for participation in a group or organization with which the AMA has a key role in creating/partnering/facilitating achievement of the respective organization goals such as the AMA Foundation, PCPI, etc., or for Internal Representation days above eleven (11). The Board Chair may also approve a per diem for special circumstances that cannot be anticipated such as weather-related travel delays.
 - Definition of Telephonic Per Diem for Representation effective July 1, 2017:
Officers, excluding the Board Chair, Chair-Elect and Presidents, who are assigned as the AMA representative to outside groups as one of their specific Board assignments or assigned Internal Representation days above eleven (11), receive a per diem rate for teleconference meetings when the total of all teleconference meetings of 30 minutes or longer during a calendar day equal 2 or more hours. Payment for these meetings would require approval of the Chair of the Board.
2. That the Governance Honorarium for all Board members excluding, Board Chair, Board Chair-elect, President, President-elect, and Immediate Past President be increased effective July 1, 2020 to \$67,000. (Directive to Take Action)
3. That the Per Diem for Chair-assigned representation for all Board members excluding the Board Chair, Chair-Elect and Presidents and related travel be increased effective July 1, 2020 to \$1,400 per day. (Directive to Take Action)
4. That the Per Diem for Chair-assigned Telephonic Per Diem for Representation be increased effective July 1, 2020 to \$700 as defined. (Directive to Take Action)

Your Reference Committee received no testimony in opposition to the report. Additionally, your Reference Committee believes that the proposed Honorarium increase for each of the 16 non-leadership Officers of our AMA

Board of Trustees, as well as the Per Diem and Telephonic Per Diem increases, are modest and deserved given the Board of Trustees' increasing representation of our AMA.

RECOMMENDED FOR ADOPTION AS AMENDED

- (4) BOARD OF TRUSTEES REPORT 6 - PHYSICIAN HEALTH POLICY OPPORTUNITY (RESOLUTION 604-I-18)

REQUEST TO AMA FOR TRAINING IN HEALTH POLICY AND HEALTH LAW (RESOLUTION 612-A-19)

RECOMMENDATION A:

Recommendations in Board of Trustees Report 6 be amended by addition and deletion:

1. That our AMA encourage and support efforts to educate interested medical students, residents, fellows, and practicing physicians about health policy and assist them in starting or transitioning to careers that involve health policy. (New HOD Policy)
2. That our AMA recognize, encourage, and support the primary health policy training found in the physician specialties of Public Health / General Preventive Medicine, Occupational and Environmental Medicine, and Aerospace Medicine. (Directive to Take Action)
3. That our AMA significantly increase its collaborative efforts with the National Academy of Medicine (NAM) to make physicians aware of existing health policy ~~fellowship~~ training opportunities and help them to apply for and participate in them. (Directive to Take Action)
4. That our AMA engage with alumni of health policy ~~fellowship~~ training programs and joint degree programs and provide opportunities for them to share their health policy experiences with medical students, residents, fellows, and practicing physicians. (Directive to Take Action)
5. That our AMA include health policy content in its educational resources for members. (Directive to Take Action)
6. That our AMA work with the Office of the U.S. Surgeon General to disseminate information to medical students, residents, fellows, and practicing physicians about opportunities to join the Commissioned Corps of the U.S. Public Health Service. (Directive to Take Action)
7. That our AMA consider options for funding a 1-year educational training program for practicing physicians who wish to transition from clinical practice to employment within the health policy sector. (Directive to Take Action)

RECOMMENDATION B:

Recommendations in Board of Trustees Report 6 be adopted as amended and the remainder of the Report be filed.

HOD ACTION: Recommendations in Board of Trustees Report 6 adopted as amended and the remainder of the Report filed.

The Board of Trustees recommends that the following recommendations be adopted in lieu of Resolutions 604-I-18 and 612-A-19 and the remainder of the report be filed:

1. That our AMA encourage and support efforts to educate interested medical students, residents, fellows, and practicing physicians about health policy and assist them in starting or transitioning to careers that involve health policy. (New HOD Policy)
2. That our AMA significantly increase its collaborative efforts with the National Academy of Medicine (NAM) to make physicians aware of existing health policy fellowship opportunities and help them to apply for and participate in them. (Directive to Take Action)

3. That our AMA engage with alumni of health policy fellowship programs and joint degree programs and provide opportunities for them to share their health policy experiences with medical students, residents, fellows, and practicing physicians. (Directive to Take Action)
4. That our AMA include health policy content in its educational resources for members. (Directive to Take Action)
5. That our AMA work with the Office of the U.S. Surgeon General to disseminate information to medical students, residents, fellows, and practicing physicians about opportunities to join the Commissioned Corps of the U.S. Public Health Service. (Directive to Take Action)

Your Reference Committee received testimony that was overwhelmingly supportive of the recommendations contained in Board of Trustees Report 6 and agree there are external organizations that have educational content and programs to enhance the health policy development skills of physicians; however, much of this content and many of these training programs receive minimal promotion.

Testimony further suggested, and your Reference Committee agrees, that use of the term “fellowship” may be confusing as it implies American Board of Medical Specialties and Accreditation Council for Graduate Medical Education recognition and subspecialty status.

Adding recommendation 7, which calls for our AMA to consider funding its own educational training program, aligns with the requests of the authors of Resolution 604-I-18 and Resolution 612-A-19.

Your Reference Committee believes that the amended language provided in testimony and appended to the recommendations contained in Board of Trustees Report 6 delineates tangible steps to achieve success.

(5) RESOLUTION 602 - PRESERVING CHILDCARE AT AMA MEETINGS

RECOMMENDATION A:

Resolution 602 be amended by addition and deletion:

RESOLVED, That our American Medical Association ~~continue to arrange on-site~~ on-site supervised childcare at no cost to members attending AMA Annual and Interim meetings (New HOD Policy); and be it further

~~RESOLVED, That our American Medical Association offer on-site supervised childcare at no cost to AMA members and staff for Annual and Interim meetings. (New HOD Policy)~~

RESOLVED, That Policy D-600.958, be rescinded. (Rescind HOD Policy)

RECOMMENDATION B:

Resolution 602 be adopted as amended.

HOD ACTION: Resolution 602 adopted as amended.

RESOLVED, That our American Medical Association continue to arrange on-site supervised childcare at AMA Annual and Interim meetings (New HOD Policy); and be it further

RESOLVED, That our American Medical Association offer on-site supervised childcare at no cost to AMA members and staff for Annual and Interim meetings. (New HOD Policy)

Your Reference Committee heard testimony that was overwhelming in support of Resolution 602. At the June 2017 inception of Camp AMA, utilization was low with 4 children from 3 families. Beginning with the 2017 Interim Meeting, an average of 16 children from 12 families have registered for use of the childcare services.

Several delegates noted that the availability of onsite child care services supports professional and personal balance, contributes to the well-being of their children, and facilitates the development of their network. Your Reference Committee believes that providing childcare will lead to an enhanced meeting experience that supports inclusiveness and encourages engagement in AMA House of Delegates meetings. Your Reference Committee also heard testimony that called for the AMA to consider extended hours and expanding activities for the children.

Our AMA Board of Trustees is encouraged to establish parameters to ensure responsible usage and a positive experience for families that participate in the onsite child care arranged by our AMA. Your Reference Committee wishes to note that free childcare for staff would be considered an employee benefit, which is outside the purview of our AMA House of Delegates.

In light of newly proposed policy calling for our AMA to arrange onsite supervised childcare at no cost to members attending Annual and Interim meetings, Policy D-600.958, “Childcare at the AMA Meetings,” which established the pilot program, should be rescinded.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (I-19)

Report of Reference Committee J
Ravi Goel, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Resolution 811 – Require Payers to Share Prior Authorization Cost Burden
2. Resolution 812 – Autopsy Standards as Condition of Participation
3. Resolution 813 – Public Reporting of PBM Rebates

RECOMMENDED FOR ADOPTION WITH CHANGE IN TITLE

4. Resolution 820 – E-Cigarette and Vaping Associated Illness

RECOMMENDED FOR ADOPTION AS AMENDED

5. Council on Medical Service Report 1 – Established Patient Relationships and Telemedicine
6. Council on Medical Service Report 2 – Addressing Financial Incentives to Shop for Lower-Cost Health Care
7. Council on Medical Service Report 3 – Improving Risk Adjustment in Alternative Payment Models
8. Resolution 806 – Support for Housing Modification Policies
9. Resolution 808 – Protecting Patient Access to Seat Elevation and Standing Features in Power Wheelchairs
10. Resolution 810 – Hospital Medical Staff Policy
11. Resolution 815 – Step Therapy
12. Resolution 817 – Transparency of Costs to Patients for Their Prescription Medications Under Medicare Part D and Medicare Advantage Plans

RECOMMENDED FOR ADOPTION IN LIEU OF

13. Council on Medical Service Report 4 – Mechanisms to Address High and Escalating Pharmaceutical Prices in lieu of
Resolution 802 – Ensuring Fair Pricing of Drugs Developed with the United States Government
Resolution 805 – Fair Medication Pricing for Patients in United States: Advocating for a Global Pricing Standard
14. Resolution 801 – Reimbursement for Post-Exposure Protocol for Needlestick Injuries
15. Resolution 807 – Addressing the Need for Low Vision Aid Devices
16. Resolution 816 – Definition of New Patient
17. Resolution 819 – Hospital Website Voluntary Physician Inclusion

RECOMMENDED FOR REFERRAL

18. Resolution 809 – AMA Principles of Medicaid Reform
19. Resolution 814 – PBM Value-Based Framework for Formulary Design
20. Resolution 818 – Medical Center Auto Accept Policies

The following resolutions were handled via the reaffirmation consent calendar:

- Resolution 803 – Encourage Federal Efforts to Expand Access to Scheduled Dialysis for Undocumented People
- Resolution 804 – Protecting Seniors from Medicare Advantage Plans

RECOMMENDED FOR ADOPTION

- (1) RESOLUTION 811 – REQUIRE PAYERS TO SHARE PRIOR AUTHORIZATION COST BURDEN

RECOMMENDATION:

Resolution 811 be adopted.

HOD ACTION: Resolution 811 adopted as amended.

RESOLVED, The AMA petition the Centers for Medicare and Medicaid Services to require the precertification process to include a one-time standard record of identifying information for the patient and insurance company representative to include their name, medical degree and NPI number.

RESOLVED, That our American Medical Association reaffirm policies H-320.939, “Prior Authorization and Utilization Management Reform,” and H-385.951, “Remuneration for Physician Services.” (Reaffirm HOD Policy)

Your Reference Committee heard supportive testimony on Resolution 811. An amendment was offered to petition the Centers for Medicare and Medicaid Services to require a one-time standard record of identifying information for the patient and insurance company representatives. However, your Reference Committee believes that the amendment is outside the scope of Resolution 811. Accordingly, your Reference Committee recommends that Resolution 811 be adopted.

- (2) RESOLUTION 812 – AUTOPSY STANDARDS AS CONDITION OF PARTICIPATION

RECOMMENDATION:

Resolution 812 be adopted.

HOD ACTION: Resolution 812 adopted.

RESOLVED, That our American Medical Association call upon the Centers for Medicare and Medicaid Services to reinstate the Autopsy Standard as a Medicare Condition of Participation. (Directive to Take Action)

Testimony was very supportive of Resolution 812. Speakers testified to the importance of the practice of autopsy and the usefulness of autopsy data. Other testimony spoke to the importance of autopsy as an educational tool. Accordingly, your Reference Committee recommends that Resolution 812 be adopted.

- (3) RESOLUTION 813 – PUBLIC REPORTING OF PBM REBATES

RECOMMENDATION:

Resolution 813 be adopted.

HOD ACTION: Resolution 813 adopted.

RESOLVED, That our American Medical Association advocate for Pharmacy Benefit Managers (PBMs) and state regulatory bodies to make rebate and discount reports and disclosures available to the public (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for the inclusion of required public reporting of rebates and discounts by PBMs in federal and state PBM legislation. (Directive to Take Action)

Your Reference Committee heard supportive testimony on Resolution 813. Your Reference Committee notes that Resolution 813 is consistent with ongoing AMA advocacy efforts on the federal and state levels in support of disclosing PBM rebates and discounts. As such, your Reference Committee recommends that Resolution 813 be adopted.

RECOMMENDED FOR ADOPTION WITH CHANGE IN TITLE

- (4) RESOLUTION 820 – E-CIGARETTE AND VAPING ASSOCIATED ILLNESS

RECOMMENDATION A:

Resolution 820 be adopted.

RECOMMENDATION B:

Title of Resolution 820 be changed to read as follows:

DIAGNOSTIC CODES FOR E-CIGARETTE AND VAPING ASSOCIATED ILLNESS

HOD ACTION: Resolution 820 adopted with change in title.

RESOLVED, That our AMA advocate for diagnostic coding systems including ICD codes to have a mechanism to release emergency codes for emergent diseases; and be it further

RESOLVED, That our AMA advocate for creation and release of ICD codes to include appropriate diagnosis codes for both the use of and toxicity related to e-cigarettes and vaping, including pulmonary toxicity.

Your Reference Committee heard supportive testimony on Resolution 820. Your Reference Committee believes that Resolution 820 builds upon existing AMA policy and advocacy on the issue of e-cigarettes and vaping, and recommends its adoption.

RECOMMENDED FOR ADOPTION AS AMENDED

- (5) COUNCIL ON MEDICAL SERVICE REPORT 1 – ESTABLISHED PATIENT RELATIONSHIPS AND TELEMEDICINE

RECOMMENDATION A:

Council on Medical Service Report 1 be amended by addition of a new Recommendation to read as follows:

4. That our AMA advocate to the Interstate Medical Licensure Compact Commission and Federation of State Medical Boards for reduced application fees and secondary state licensure(s) fees processed through the Interstate Medical Licensure Compact. (Directive to Take Action)

RECOMMENDATION B:

Council on Medical Service Report 1 be amended by addition of a new Recommendation to read as follows:

5. That our AMA work with interested state medical associations to encourage states to pass legislation enhancing patient access to and proper regulation of telemedicine services, in accordance with AMA Policy H-480.946, Coverage of and Payment for Telemedicine. (New HOD Policy)

RECOMMENDATION C:

Recommendations in Council on Medical Service Report 1 be adopted as amended and the remainder of the Report be filed.

HOD ACTION: Recommendations in Council on Medical Service Report 1 adopted as amended and the remainder of the Report filed.

That our AMA reaffirm Policy D-480.969, which supports coverage for telemedicine-provided services comparable to coverage for in-person services.

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 215-A-18, and the remainder of the report be filed:

1. That our American Medical Association (AMA) work with state medical associations to encourage states that are not part of the Interstate Medical Licensure Compact to consider joining the Compact as a means of enhancing patient access to and proper regulation of telemedicine services. (Directive to Take Action)
2. That our AMA reaffirm Policy H-480.946, which delineates standards and safeguards that should be met for the coverage and payment of telemedicine, including that physicians and other health practitioners delivering telemedicine services must be licensed in the state where the patient receives services. (Reaffirm HOD Policy)
3. That our AMA reaffirm Policy H-480.969, which maintains that state medical boards should require a full and unrestricted license in that state for the practice of telemedicine, with no differentiation by specialty, unless there are other appropriate state-based licensing methods, and with exemptions for emergent or urgent circumstances and “curbside consultations.” (Reaffirm HOD Policy)

Your Reference Committee heard supportive testimony on Council on Medical Service Report 1. In introducing the report, a member of the Council on Medical Service testified that the Council found that the Interstate Medical Licensure Compact (the Compact) is the most viable approach to facilitating multistate licensure without undermining state jurisdiction over medical practice, noting that the Compact has been adopted in more than half of

states within two years of its launch. A member of the Council on Legislation testified in support of the report's approach, reiterating that the Compact is the first-line defense against proposals to create a federal telemedicine license.

A representative of the AMA Integrated Physician Practice Section (IPPS) testified to the cost burden of obtaining licenses in multiple states through the Compact and suggested a new recommendation asking the AMA to advocate to the Interstate Medical Licensure Compact Commission and Federation of State Medical Boards for reduced application fees and secondary state licensure(s) fees processed through the Compact. Testimony was supportive of this amendment. An additional amendment was offered asking the AMA to work with state medical associations to encourage state legislation that enhances patient access to and proper regulation of telemedicine services. Your Reference Committee supports this amendment and believes another amendment offered on payment for telemedicine is beyond the scope of this report. Accordingly, your Reference Committee recommends that Council on Medical Service Report 1 be adopted as amended, and the remainder of the report be filed.

(6) COUNCIL ON MEDICAL SERVICE 2 – ADDRESSING FINANCIAL INCENTIVES TO SHOP FOR LOWER-COST HEALTH CARE

RECOMMENDATION A:

Recommendation 2 in Council on Medical Service Report 2 be amended by addition and deletion to read as follows:

2. That our AMA support the following quality and cost principles for any FIP:

- a) Remind patients that they can receive care from the physician or facility of their choice consistent with their health plan benefits.**
- b) Provide publicly available information regarding the metrics used to identify, and quality scores associated with, lower and higher-cost health care items, services, physicians and facilities.**
- c) Provide patients and physicians with the quality scores associated with both lower and higher-cost physicians and facilities, as well as information regarding the methods used to determine quality scores. Differences in cost due to specialty or sub-specialty focus should be explicitly stated and clearly explained if data is made public.**
- d) Respond within a reasonable timeframe to inquiries of whether the physician is among the preferred lower-cost physicians; the physician's quality scores and those of lower-cost physicians; and directions for how to appeal exclusion from lists of preferred lower-cost physicians.**
- e) Provide a process through which patients and physicians can ~~publicly~~ report unsatisfactory care experiences ~~when with~~ referred to lower-cost physicians or facilities. The reporting process should be easily accessible by patients and physicians participating in the program.**
- f) Provide meaningful transparency of prices and vendors.**
- g) Inform patients of the health plan cost-sharing and any financial incentives associated with receiving care from FIP-preferred, other in-network, and out-of-network physicians and facilities.**
- h) Inform patients that pursuing lower-cost and/or incentivized care, including FIP incentives, may require them to undertake some burden, such as traveling to a lower-cost site of service or complying with a more complex dosing regimen for lower-cost prescription drugs.**
- i) Methods of cost attribution to a physician or facility must be transparent, and the assumptions underlying cost attributions must be publicly available if cost is a factor used to stratify physicians or facilities. (New HOD Policy)**

RECOMMENDATION B:

Recommendations in Council on Medical Service Report 2 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Service Report 2 adopted as amended and the remainder of the report filed.

The Council on Medical Service recommends that the following be adopted and that the remainder of the report be filed.

1. That our American Medical Association (AMA) support the following continuity of care principles for any financial incentive program (FIP):
 - a) Collaborate with the physician community in the development and implementation of patient incentives.
 - b) Collaborate with the physician community to identify high-value referral options based on both quality and cost of care.
 - c) Provide treating physicians with access to patients' FIP benefits information in real-time during patient consultations, allowing patients and physicians to work together to select appropriate referral options.
 - d) Inform referring and/or primary care physicians when their patients have selected an FIP service prior to the provision of that service.
 - e) Provide referring and/or primary care physicians with the full record of the service encounter.
 - f) Never interfere with a patient-physician relationship (eg, by proactively suggesting health care items or services that may or may not become part of a future care plan).
 - g) Inform patients that only treating physicians can determine whether a lower-cost care option is medically appropriate in their case and encourage patients to consult with their physicians prior to making changes to established care plans. (New HOD Policy)
2. That our AMA support the following quality and cost principles for any FIP:
 - a) Remind patients that they can receive care from the physician or facility of their choice consistent with their health plan benefits.
 - b) Provide publicly available information regarding the metrics used to identify, and quality scores associated with, lower and higher-cost health care items, services, physicians and facilities.
 - c) Provide patients and physicians with the quality scores associated with both lower and higher-cost physicians and facilities, as well as information regarding the methods used to determine quality scores.
 - d) Respond within a reasonable timeframe to inquiries of whether the physician is among the preferred lower-cost physicians; the physician's quality scores and those of lower-cost physicians; and directions for how to appeal exclusion from lists of preferred lower-cost physicians.
 - e) Provide a process through which patients and physicians can publicly report unsatisfactory care experiences with referred lower-cost physicians or facilities.
 - f) Provide meaningful transparency of prices and vendors.
 - g) Inform patients of the health plan cost-sharing and any financial incentives associated with receiving care from FIP-preferred, other in-network, and out-of-network physicians and facilities.
 - h) Inform patients that pursuing lower-cost and/or incentivized care, including FIP incentives, may require them to undertake some burden, such as traveling to a lower-cost site of service or complying with a more complex dosing regimen for lower-cost prescription drugs. (New HOD Policy)
3. That our AMA support requiring health insurers to indemnify patients for any additional medical expenses resulting from needed services following inadequate FIP-recommended services. (New HOD Policy)
4. That our AMA oppose FIPs that effectively limit patient choice by making alternatives other than the FIP-preferred choice so expensive, onerous and inconvenient that patients effectively must choose the FIP choice. (New HOD Policy)

5. That our AMA encourage state medical associations and national medical specialty societies to apply these principles in seeking opportunities to collaborate in the design and implementation of FIPs, with the goal of empowering physicians and patients to make high-value referral choices. (New HOD Policy)
6. That our AMA encourage objective studies of the impact of FIPs that include data collection on dimensions such as:
 - a) Patient outcomes/the quality of care provided with shopped services;
 - b) Patient utilization of shopped services;
 - c) Patient satisfaction with care for shopped services;
 - d) Patient choice of health care provider;
 - e) Impact on physician administrative burden; and
 - f) Overall/systemic impact on health care costs and care fragmentation. (New HOD Policy)

Testimony on Council on Medical Service Report 2 was supportive. A member of the Council on Medical Service introduced the report stating that the Council's report was intended to address potential consequences with financial incentive programs including patient choice, continuity of care, and the physician-patient relationship. Amendments were offered to improve transparency and remove differences in cost due to specialty and sub-specialty. Your Reference Committee agrees with these amendments and offers language to ensure that transparency is given to patients and physicians.

Further testimony raised concerns with financial incentive programs and their potential to fragment care, and the Council noted that it too shares those concerns. The Council stated that this report is not advocating for the existence of these programs but rather advocating for safeguards within the programs. The Reference Committee agrees and highlights that this report is not an endorsement of any financial incentive program. Therefore, your Reference Committee recommends that Council on Medical Service Report 2 be adopted as amended and the remainder of the report be filed.

- (7) COUNCIL ON MEDICAL SERVICE REPORT 3 – IMPROVING RISK ADJUSTMENT IN ALTERNATIVE PAYMENT MODELS

RECOMMENDATION A:

Council on Medical Service Report 3 be amended by addition of a new Recommendation to read as follows:

8. That our AMA support risk adjustment mechanisms that allow for flexibility to account for changes in science and practice as to not discourage or punish early adopters of effective therapy. (New HOD Policy)

RECOMMENDATION B:

Recommendations in Council on Medical Service Report 3 be adopted as amended and the remainder of the Report be filed.

HOD ACTION: Recommendations in Council on Medical Service Report 3 adopted as amended and the remainder of the Report filed.

The Council on Medical Service recommends that the following be adopted and that the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy H-385.908 stating that the AMA will work with the Centers for Medicare & Medicaid Services and interested organizations to design systems that identify data sources to enable adequate analyses of clinical and non-clinical factors that contribute to a patient's health and success of treatment, such as disease stage and socio-demographic factors; account for differences in patient needs, such as functional limitations, changes in medical conditions, and ability to access health care services; and explore an approach in which the physician managing a patient's care can contribute additional information,

such as disease severity, that may not be available in existing risk adjustment methods to more accurately determine the appropriate risk stratification. (Reaffirm HOD Policy)

2. That our AMA reaffirm Policy D-478.995 advocating for appropriate, effective, and less burdensome documentation requirements in the use of electronic health records so that capturing patient characteristics and risk adjustment measures do not add to physician and practice administrative burden. (Reaffirm HOD Policy)
3. That our AMA support risk stratification systems that use fair and accurate payments based on patient characteristics, including socioeconomic factors, and the treatment that would be expected to result in the need for more services or increase the risk of complications. (New HOD Policy)
4. That our AMA support risk adjustment systems that use fair and accurate outlier payments if spending on an individual patient exceeds a pre-defined threshold or individual stop loss insurance at the insurer's cost. (New HOD Policy)
5. That our AMA support risk adjustment systems that use risk corridors that use fair and accurate payment if spending on all patients exceeds a pre-defined percentage above the payments or support aggregate stop loss insurance at the insurer's cost. (New HOD Policy)
6. That our AMA support risk adjustment systems that use fair and accurate payments for external price changes beyond the physician's control. (New HOD Policy)
7. That our AMA support accountability measures that exclude from risk adjustment methodologies any services that the physician does not deliver, order, or otherwise have the ability to influence. (New HOD Policy)

Testimony on Council on Medical Service Report 3 was unanimously supportive. A member of the Council on Medical Service introduced the report outlining the importance of the Council's recommendations to enable physicians to care for vulnerable populations. An amendment was offered to add a recommendation to ensure the recommendations apply to early adopters of novel therapies. The Council on Medical Service appreciated and agreed with the new recommendation to ensure our AMA is supporting all physicians. Therefore, your Reference Committee agrees with this addition. A concern was raised that the report does not adequately address hierarchical condition category (HCC) coding. The Council on Medical Service subsequently addressed this concern stating that the report is intentionally broad to include not only HCCs but also all risk adjustment methods. Your Reference Committee agrees. Accordingly, your Reference Committee recommends that Council on Medical Service Report 3 be adopted as amended and the remainder of the report be filed.

(8) RESOLUTION 806 – SUPPORT FOR HOUSING MODIFICATION POLICIES

RECOMMENDATION A:

Resolution 806 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association support improved access to legislation for health insurance coverage of housing modification benefits for: (a) the elderly; (b) other populations that require these modifications in order to mitigate preventable health conditions, including but not limited to the elderly, the disabled or soon-to-be disabled, ; and (c) other persons with physical and/or mental disabilities. (New HOD Policy)

RECOMMENDATION B:

Resolution 806 be adopted as amended.

HOD ACTION: Resolution 806 adopted as amended.

RESOLVED, That our American Medical Association support legislation for health insurance coverage of housing modification benefits for: (a) the elderly; (b) other populations that require these modifications in order to mitigate preventable health conditions, including but not limited to the disabled or soon to be disabled; and (c) other persons with physical and/or mental disabilities. (New HOD Policy)

Your Reference Committee heard mixed testimony on Resolution 806. There was unanimous support for the intent of Resolution 806; however, numerous speakers raised concerns that this resolution requests a new, expensive benefit mandate in a budget neutral health insurance environment. A member of the Council on Medical Service commended the authors for bringing forth Resolution 806 and stated that the Council agrees with the intent of the resolution. However, the Council recommended amended language to broaden and simplify the resolution. The Council stated that it does not believe that the legislation called for in Resolution 806 is required to improve access to housing modifications for certain populations nor does it believe that it is necessary to link to Medicare or any insurance to support improved access to housing modifications. Additionally, the Council noted that the Physician-Focused Payment Model Technical Advisory Committee (PTAC) recently reviewed an alternative payment model (APM) proposal for modification services and that a simple policy statement on the issue could be used to support such proposals moving forward. Your Reference Committee believes that the amended language addresses the concerns raised. Therefore, your Reference Committee recommends that Resolution 806 be adopted as amended.

- (9) RESOLUTION 808 – PROTECTING PATIENT ACCESS TO SEAT ELEVATION AND STANDING FEATURES IN POWER WHEELCHAIRS

RECOMMENDATION A:

The second, third, and fourth Resolves of Resolution 808 be deleted.

~~RESOLVED, That our AMA urge CMS to require the DME Medicare Administrative Contractors (MACs) to determine an appropriate coverage policy for Medicare beneficiaries in need of the seat elevation and standing features in their power wheelchairs on an individual basis according to the National Coverage Determination (NCD) for mobility assistance equipment (MAE), activate the existing Healthcare Common Procedure Coding System (HCPCS) codes for seat elevation and standing feature in power wheelchairs, and determine appropriate reimbursement levels for these codes in order to facilitate access to these important benefits for Medicare beneficiaries with mobility impairments (Directive to Take Action); and be it further~~

~~RESOLVED, That if CMS is not able or willing to provide access to seat elevation and standing feature through its administrative authority, our AMA advocate before Congress to support legislation that will clarify the DME benefit to include coverage, coding and reasonable reimbursement of standing feature and seat elevation in power wheelchairs for appropriate Medicare beneficiaries with mobility impairments (Directive to Take Action); and be it further~~

~~RESOLVED, That our AMA encourage all health insurance carriers to cover standing feature and seat elevation in power wheelchairs for appropriate beneficiaries with mobility impairments. (Directive to Take Action)~~

RECOMMENDATION B:

Resolution 808 be adopted as amended.

HOD ACTION: Resolution 808 adopted as amended.

RESOLVED, That our American Medical Association request that the Centers for Medicare and Medicaid Services (CMS) render a benefit category determination (BCD) that establishes that the seat elevation and standing features of power wheelchairs are primarily medical in nature and qualify under the definition of durable medical equipment (DME) when used in a power wheelchair (Directive to Take Action); and be it further

RESOLVED, That our AMA urge CMS to require the DME Medicare Administrative Contractors (MACs) to determine an appropriate coverage policy for Medicare beneficiaries in need of the seat elevation and standing features in their power wheelchairs on an individual basis according to the National Coverage Determination (NCD) for mobility assistance equipment (MAE), activate the existing Healthcare Common Procedure Coding System (HCPCS) codes for seat elevation and standing feature in power wheelchairs, and determine appropriate reimbursement levels for these codes in order to facilitate access to these important benefits for Medicare beneficiaries with mobility impairments (Directive to Take Action); and be it further

RESOLVED, That if CMS is not able or willing to provide access to seat elevation and standing feature through its administrative authority, our AMA advocate before Congress to support legislation that will clarify the DME benefit to include coverage, coding and reasonable reimbursement of standing feature and seat elevation in power wheelchairs for appropriate Medicare beneficiaries with mobility impairments (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage all health insurance carriers to cover standing feature and seat elevation in power wheelchairs for appropriate beneficiaries with mobility impairments. (Directive to Take Action)

Your Reference Committee heard supportive testimony on Resolution 808. A member of the Council on Medical Service stated that, though the Council agrees with the intent of Resolution 808, the Council believes the resolution is overly prescriptive and instead called for adoption of the first resolve and deleting the second, third, and fourth resolve clauses. The Council testified that the specific requests in the resolve clauses are unnecessary and that policy does not need to dictate alternative courses of action to achieve coverage of standing features of power wheelchairs. Finally, the Council testified that Resolution 808 may detract from other advocacy priorities. Subsequent testimony supported this amendment. Moreover, a member of the Council on Legislation echoed the concerns of the Council on Medical Service and joined them in calling for adoption of the first resolve and deleting the remaining resolves. Your Reference Committee agrees and believes that adoption of the first resolve clause satisfies the intent of Resolution 808. Accordingly, your Reference Committee recommends that Resolution 808 be adopted as amended.

(10) RESOLUTION 810 – HOSPITAL MEDICAL STAFF POLICY

RECOMMENDATION A:

The second Resolve of Resolution 810 be deleted.

~~RESOLVED, That our AMA support and advocate that the decisions made by hospital medical staffs focus on quality patient care., medical staff standards and the operation of the hospital, and that those decisions not engage the medical staff in external political matters (e.g., advanced practice clinician scope of practice expansion, etc.) (Directive to Take Action); and be it further~~

RECOMMENDATION B:

The third Resolve of Resolution 810 be deleted.

~~RESOLVED, That AMA Policy H-225.993, “Medical Staff Policy Determination,” be rescinded. (Rescind HOD Policy)~~

RECOMMENDATION C:

Resolution 810 be adopted as amended.

HOD ACTION: Resolution 810 adopted as amended

RESOLVED, That our American Medical Association support and advocate that hospital medical staff leadership should be fully licensed physicians and that if others are included, they should be non-voting or advisory to the hospital medical staff members (Directive to Take Action); and be it further

RESOLVED, That our AMA support and advocate that the decisions made by hospital medical staffs focus on quality patient care, medical staff standards and the operation of the hospital, and that those decisions not engage the medical staff in external political matters (e.g., advanced practice clinician scope of practice expansion, etc.) (Directive to Take Action); and be it further

RESOLVED, That AMA Policy H-225.993, “Medical Staff Policy Determination,” be rescinded. (Rescind HOD Policy)

Testimony on Resolution 810 was mixed. Most speakers asked that the first Resolve clause be adopted and that the second and third Resolve clauses be deleted. Substantial testimony highlighted the scope of practice issues inherent in the second Resolve clause and noted that it is well within the purview of physicians to advocate for their patients and themselves. Speakers were supportive of existing AMA policy on organized medical staffs, including Policy H-225.993 that the third Resolve clause rescinds. Accordingly, your Reference Committee recommends that Resolution 810 be adopted as amended.

(11) RESOLUTION 815 – STEP THERAPY

RECOMMENDATION A:

That the first Resolve of Resolution 815 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association amend Policy D-320.981, “Medicare Advantage Step Therapy,” by addition and deletion to read as follows:

MEDICARE ADVANTAGE STEP THERAPY D-320.981

1. Our AMA believes that step therapy programs create barriers to patient care and encourage health plans to instead focus utilization management protocol on review of statistical outliers.
2. Our AMA will advocate that health plan ~~the Medicare Advantage~~ step therapy protocols, if not repealed, should feature the following patient protections:
 - a. Enable the treating physician, rather than another entity such as the insurance company, to determine if a patient “fails” a treatment;
 - b. Exempt patients from the step therapy protocol when the physician believes the required step therapy treatments would be ineffective, harmful, or otherwise against the patients’ best interests;
 - c. Permit a physician to override the step therapy process when patients are stable on a prescribed medication;
 - d. Permit a physician to override the step therapy if the physician expects the treatment to be ineffective based on the known relevant medical characteristics of the patient and the known characteristics of the drug regimen; if patient comorbidities will cause, or will likely cause, an adverse reaction or physical harm to the patient; or is not in the best interest of the patient, based on medical necessity;
 - e. Include an exemption from step therapy for emergency care;
 - f. Require health insurance plans to process step therapy approval and override request processes electronically;
 - g. Not require a person changing health insurance plans to repeat step therapy that was completed under a prior plan; and

h. Consider a patient with recurrence of the same systematic disease or condition to be considered an established patient and therefore not subject to duplicative step therapy policies for that disease or condition (Modify HOD Policy); and be it further

~~RESOLVED, That our American Medical Association extend its advocacy for the patient protections against step therapy protocols outlined in D-320.981, “Medicare Advantage Step Therapy,” to all health plans (Directive to Take Action); and be it further~~

RECOMMENDATION B:

Resolution 815 be adopted as amended.

HOD ACTION: Resolution 815 adopted as amended.

RESOLVED, That our American Medical Association extend its advocacy for the patient protections against step therapy protocols outlined in D-320.981, “Medicare Advantage Step Therapy,” to all health plans (Directive to Take Action); and be it further

RESOLVED, That our AMA actively support state and federal legislation that would allow timely clinician-initiated exceptions to, and place reasonable limits on, step therapy protocols imposed by health care plans. (Directive to Take Action)

Testimony on Resolution 815 was unanimously supportive. An amendment was offered to ensure that the intent of the first Resolve of Resolution 815 would be included in the content and text of Policy D-320.981, “Medicare Advantage Step Therapy.” Your Reference Committee believes that Resolution 815 is consistent with ongoing AMA advocacy efforts on the state and federal levels, and with commercial plans, focused on step therapy reforms and protections. As such, your Reference Committee recommends that Resolution 815 be adopted as amended.

- (12) **RESOLUTION 817 – TRANSPARENCY OF COSTS TO PATIENTS FOR THEIR PRESCRIPTION MEDICATIONS UNDER MEDICARE PART D AND MEDICARE ADVANTAGE PLANS**

RECOMMENDATION A:

The first Resolve in Resolution 817 be amended by deletion to read as follows:

RESOLVED, That our American Medical Association advocate for transparent patient educational resources on their personal costs for their medications under Medicare ~~Part D~~ and Medicare Advantage plans--both printed and online video--which health care systems could provide to patients and which consumers could access directly (Directive to Take Action); and be it further

RECOMMENDATION B:

The second Resolve in Resolution 817 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA ~~advocate for~~ support increased resources funding for federal and state health insurance assistance programs ~~like Georgia Cares~~ and educate physicians, hospitals, and patients about the availability of these programs. (Directive to Take Action)

RECOMMENDATION C:**Resolution 817 be adopted as amended.****HOD ACTION: Resolution 817 adopted as amended.**

RESOLVED, That our American Medical Association advocate for transparent patient educational resources on their personal costs for their medications under Medicare Part D and Medicare Advantage plans--both printed and online video--which health care systems could provide to patients and which consumers could access directly (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for increased resources for federal and state programs like GeorgiaCares and educate physicians, hospitals, and patients about the availability of these programs. (Directive to Take Action)

Your Reference Committee heard generally supportive testimony on Resolution 817. In response to testimony raising the need for the first Resolve to also include costs to patients under traditional Medicare, your Reference Committee offers an amendment to the first Resolve to enable the AMA to advocate for transparent patient educational resources on their personal costs for their medications under Medicare Parts A, B and D. In addition, your Reference Committee offers an amendment to the second Resolve of Resolution 817 to clarify its intent of supporting increased funding for federal and state health insurance assistance programs, while removing reference to a specific state program. Your Reference Committee recommends that Resolution 817 be adopted as amended.

RECOMMENDED FOR ADOPTION IN LIEU OF

- (13) COUNCIL ON MEDICAL SERVICE REPORT 4 – MECHANISMS TO ADDRESS HIGH AND ESCALATING PHARMACEUTICAL PRICES
RESOLUTION 802 – ENSURING FAIR PRICING OF DRUGS DEVELOPED WITH THE UNITED STATES GOVERNMENT
RESOLUTION 805 – FAIR MEDICATION PRICING FOR PATIENTS IN UNITED STATES: ADVOCATING FOR A GLOBAL PRICING STANDARD

RECOMMENDATION A:

Recommendation 1(e) in Council on Medical Service Report 4 be amended by deletion to read as follows:

e. The arbitration process should include the submission of a value-based price ~~benchmark~~ for the drug in question to inform the arbitrator's decision;

RECOMMENDATION B:

Recommendation 1(f) in Council on Medical Service Report 4 be amended by deletion to read as follows:

f. The arbitrator should be required to choose either the bid of the pharmaceutical manufacturer or the bid of the payer/~~government entity~~;

RECOMMENDATION C:

Recommendation 1 in Council on Medical Service Report 4 be amended by addition of a new standard 1(i) to read as follows:

i. The arbitration process should include a mechanism to revisit the arbitrator's decision due to new evidence or data.

RECOMMENDATION D:

Recommendation 2 in Council on Medical Service Report 4 be amended by addition of a new principle 2(e) to read as follows:

e. Any data used to determine an international price index or average to guide prescription drug pricing should be updated regularly.

RECOMMENDATION E:

Recommendations in Council on Medical Service Report 4 be adopted as amended in lieu of Resolutions 802 and 805 and the remainder of the Report be filed.

HOD ACTION: Recommendations in Council on Medical Service Report 4 adopted as amended in lieu of Resolutions 802 and 805 and the remainder of the Report filed.

Title changed to: ADDITIONAL MECHANISMS TO ADDRESS HIGH AND ESCALATING PHARMACEUTICAL PRICES

CMS Report 4

The Council on Medical Service recommends that the following be adopted and that the remainder of the report be filed:

1. That our American Medical Association (AMA) advocate that the use of arbitration in determining the price of prescription drugs meet the following standards to lower the cost of prescription drugs without stifling innovation:
 - a. The arbitration process should be overseen by objective, independent entities;
 - b. The objective, independent entity overseeing arbitration should have the authority to select neutral arbitrators or an arbitration panel;
 - c. All conflicts of interest of arbitrators must be disclosed and safeguards developed to minimize actual and potential conflicts of interest to ensure that they do not undermine the integrity and legitimacy of the arbitration process;
 - d. The arbitration process should be informed by comparative effectiveness research and cost-effectiveness analysis addressing the drug in question;
 - e. The arbitration process should include the submission of a value-based price benchmark for the drug in question to inform the arbitrator's decision;
 - f. The arbitrator should be required to choose either the bid of the pharmaceutical manufacturer or the bid of the payer/government entity;
 - g. The arbitration process should be used for pharmaceuticals that have insufficient competition; have high list prices; or have experienced unjustifiable price increases; and
 - h. The arbitration process should include a mechanism for either party to appeal the arbitrator's decision. (New HOD Policy)
2. That our AMA advocate that any use of international price indices and averages in determining the price of and payment for drugs should abide by the following principles:
 - a. Any international drug price index or average should exclude countries that have single-payer health systems and use price controls;
 - b. Any international drug price index or average should not be used to determine or set a drug's price, or determine whether a drug's price is excessive, in isolation;
 - c. The use of any international drug price index or average should preserve patient access to necessary medications; and
 - d. The use of any international drug price index or average should limit burdens on physician practices. (New HOD Policy)
3. That our AMA support the use of contingent exclusivity periods for pharmaceuticals, which would tie the length of the exclusivity period of the drug product to its cost-effectiveness at its list price at the time of market introduction. (New HOD Policy)
4. That our AMA reaffirm Policy H-110.983, which advocates that any revised Medicare Part B Competitive Acquisition Program meet certain outlined standards to improve the value of the program by lowering the cost of drugs without undermining quality of care. (Reaffirm HOD Policy)
5. That our AMA reaffirm Policy H-110.986, which outlines principles for value-based pricing programs, initiatives and mechanisms for pharmaceuticals, and supports the inclusion of the cost of alternatives and cost-effectiveness analysis in comparative effectiveness research. (Reaffirm HOD Policy)
6. That our AMA reaffirm Policy H-460.909, which outlines principles for creating a centralized comparative effectiveness research entity. (Reaffirm HOD Policy)
7. That our AMA reaffirm Policy D-330.954, which states that our AMA will work toward eliminating Medicare prohibition on drug price negotiation. (Reaffirm HOD Policy)

Resolution 802

RESOLVED, That our American Medical Association amend Policy H-110.987 by addition to read as follows:

Pharmaceutical Costs, H-110.987

1. Our AMA encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives.
2. Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition.
3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry.
4. Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system.
5. Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies.
6. Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation.
7. Our AMA supports legislation to shorten the exclusivity period for biologics.
8. Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens.
9. Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients.
10. Our AMA supports: (a) drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug (generic, brand, or specialty) by 10% or more each year or per course of treatment and provide justification for the price increase; (b) legislation that authorizes the Attorney General and/or the Federal Trade Commission to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients; and (c) the expedited review of generic drug applications and prioritizing review of such applications when there is a drug shortage, no available comparable generic drug, or a price increase of 10% or more each year or per course of treatment.
11. Our AMA advocates for policies that prohibit price gouging on prescription medications when there are no justifiable factors or data to support the price increase.
12. Our AMA will provide assistance upon request to state medical associations in support of state legislative and regulatory efforts addressing drug price and cost transparency.
13. Our AMA supports legislation to shorten the exclusivity period for FDA pharmaceutical products where manufacturers engage in anti-competitive behaviors or unwarranted price escalations.
14. Our AMA will support trial programs using international reference pricing for pharmaceuticals as an alternative drug reimbursement model for Medicare, Medicaid, and/or any other federally-funded health insurance programs, either as in individual solution or in conjunction with other approaches. (Modify Current HOD Policy)
- 15.

Resolution 805

RESOLVED, That our American Medical Association advocate for legislation to create an International Pricing Index that would track global medication prices for all prescription medications and keep U.S. medication costs aligned with prices paid in other countries to help control costs and reduce unreasonable patient financial barriers to treatment (Directive to Take Action); and be it

RESOLVED, That our AMA advocate for legislation that would ensure that patients are charged fairly for prescription medications based on the International Pricing Index and that additional costs will not be arbitrarily assigned or passed onto patients. (Directive to Take Action)

Your Reference Committee heard predominantly supportive testimony on Council on Medical Service Report 4. In introducing the report, a member of the Council on Medical Service emphasized that lack of competition for some

drugs has weakened the bargaining power of payers. In addition, the Council member underscored that there is often limited recourse following an unjustifiable price hike of a prescription medication, leaving patients wondering whether they will be able to continue to afford their medication. As such, the report recommends policies to promote reasonable pricing behavior in the pharmaceutical marketplace, as an alternative to price controls.

Testimony on Resolutions 802 and 805 was mixed. Your Reference Committee underscores that adopting the resolutions would have unintended consequences, as neither includes any safeguards guiding the use of international price indices in determining prescription drug prices. Concerning Resolution 802, even allowing trial programs using international reference pricing for pharmaceuticals, without safeguards, could have negative consequences to physician practices and patients. Importantly, a member of the Council on Medical Service noted that Council on Medical Service Report 4 addresses the intent of Resolutions 802 and 805, and should be adopted in lieu of the resolutions.

A member of the Council on Legislation testified in strong support of the recommendations of the report, noting that the report is incredibly timely as the U.S. House of Representatives and Senate are moving forward with drug pricing proposals, and the Administration has taken an interest in this issue as well. Pertinent to H.R. 3, the Elijah E. Cummings Lower Drug Costs Now Act of 2019, the member of the Council on Legislation noted that Council on Medical Service Report 4 recommends a key safeguard that ensures that any international drug price index or average exclude countries that have single-payer health systems and use price controls. The Council member highlighted that previously, the Administration has floated the idea of utilizing an international pricing index model for Part B drugs. Finally, the member of the Council on Legislation stated that report recommendations pertaining to the use of arbitration and contingent exclusivity periods to guide pharmaceutical pricing will be welcome policy additions as the Council on Legislation reviews relevant legislation addressing drug pricing in the future.

Amendments were offered to ensure that the advocacy of our AMA pertaining to the use of arbitration in drug pricing is consistent with our advocacy related to surprise billing. In addition, amendments were offered to ensure that prices that are the result of arbitration or the use of international price averages are able to be revisited as new data and evidence are released. A speaker stressed the need for the report to also include the practices of pharmacy benefit managers (PBMs), but a member of the Council on Medical Service highlighted that the Council just presented a report at the 2019 Annual Meeting on PBMs that addresses concerns raised in testimony. In addition, a member of the Council on Medical Service stressed that the second recommendation of Council on Medical Service Report 4 does not endorse the use of international price indices and averages in determining drug prices, but rather establishes broad guiding principles and safeguards to ensure that our AMA has more nuanced policy to respond to relevant legislative and regulatory proposals. Your Reference Committee also heard testimony which highlighted other factors contributing to high drug prices, including off-shoring drug production as well as monopolies in drug production, but notes that these issues are outside of the scope of Council on Medical Service Report 4, and instead fall under the auspices of Reference Committee K.

Your Reference Committee thanks the Council on Medical Service for a comprehensive report. Your Reference Committee believes that Council on Medical Service Report 4 strongly responds to concerns raised at past House of Delegates meetings that more needs to be done to improve the affordability of prescription drugs for our patients. Your Reference Committee underscores that the recommendations of Council on Medical Service Report 4 add to the already large body of AMA policies that address the high cost of prescription medications, which guide AMA advocacy efforts to improve patient access to medication while reducing their costs and balancing the need for appropriate innovation incentives. Pursuant to these policies, the AMA supports: (1) requiring manufacturer and pharmaceutical supply chain transparency; (2) increasing competition and curtailing anti-competitive practices; (3) ensuring prescribers have accurate point-of-care coverage and patient cost-sharing information as part of their workflow including in the electronic health record; and (4) streamlining and modernizing the utilization control methods used by health insurers in response to higher prescription drug costs. As such, your Reference Committee recommends that the recommendations of Council on Medical Service Report 4 be adopted as amended in lieu of Resolutions 802 and 805, and the remainder of the report be filed.

- (14) RESOLUTION 801 – REIMBURSEMENT FOR POST-EXPOSURE PROTOCOL FOR NEEDLESTICK INJURIES

RECOMMENDATION:

Alternate Resolution 801 be adopted in lieu of Resolution 801.

RESOLVED, That our American Medical Association encourage medical schools to have policies in place addressing diagnosis, treatment, and follow-up at no cost to medical students when a medical student is exposed to an infectious or environmental hazard in the course of their medical student duties, including procedures defining financial responsibility that would cover the costs associated with medical student exposures.

HOD ACTION: Alternate Resolution 801 adopted as amended in lieu of Resolution 801.

RESOLVED, That our American Medical Association encourage medical schools to ensure medical students can be reimbursed for the costs associated with post-exposure protocol for blood or body substance exposure sustained during clinical rotations either by their insurance provider or the state's workers' compensation fund, where applicable (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage state societies to work with their respective workers' compensation fund to include medical students as recipients of medical benefits in the event of blood or body substance exposure during clinical rotations. (Directive to Take Action)

Your Reference Committee heard testimony that was supportive of the intent of Resolution 801. A representative of the AMA Medical Student Section highlighted the need to ensure that medical schools have policies addressing needlestick injuries and offer medical students adequate coverage of associated diagnostic testing and therapies. Noting that medical schools have policies in place regarding procedures for care following student exposures per Liaison Committee on Medical Education (LCME) standards, a member of the Council on Medical Service proposed alternate language that meets the sponsor's goal of covering medical students' out-of-pocket expenses associated with post-exposure treatment without trying to change workers' compensation laws and regulations in all 50 states. Additional alternate language was offered that would encourage coverage of testing and indicated medications associated with needlestick injuries for all physicians. There was significant testimony regarding the incidence of exposures and the associated cost burden for students. Your Reference Committee believes that physicians generally have access to disability insurance or workers' compensation programs and that broadening the resolution to physicians is beyond the scope of Resolution 801. Accordingly, your Reference Committee recommends adoption of Alternate Resolution 801 in lieu of Resolution 801.

- (15) RESOLUTION 807 – ADDRESSING THE NEED FOR LOW VISION AID DEVICES

RECOMMENDATION:

Alternate Resolution 807 be adopted in lieu of Resolution 807.

RESOLVED, That our American Medical Association work with interested national medical specialty societies and state medical associations to support insurance coverage for and increased access to low vision aids for patients with visual disabilities. (New HOD Policy)

HOD ACTION: Alternate Resolution 807 adopted as amended in lieu of Resolution 807.

RESOLVED, That our American Medical Association support legislative and regulatory actions promoting insurance coverage and adequate funding for low vision aids for patients with visual disabilities. (Directive to Take Action)

Testimony on Resolution 807 was mixed, with some speakers supportive of insurance coverage of low vision aids, because these devices can positively impact quality of life and independence, and other speakers opposed a new benefit mandate, in accordance with AMA Policies H-185.964 and H-165.856. A member of the Council on Medical Service proposed alternate language that supports patient access to low vision aids without calling for a new benefit mandate. Your Reference Committee believes this alternate language gives the AMA sufficient flexibility to promote patient access to low vision aids. Accordingly, your Reference Committee recommends that Alternate Resolution 807 be adopted in lieu of Resolution 807.

(16) RESOLUTION 816 – DEFINITION OF NEW PATIENT

RECOMMENDATION:

Policies H-70.919 and H-70.921 be reaffirmed in lieu of Resolution 816.

HOD ACTION: Policies H-70.919 and H-70.921 reaffirmed in lieu of Resolution 816.

RESOLVED, That our American Medical Association advocate for the definition of a “new patient” to represent the multitude of factors and time needed to appropriately evaluate a patient’s health condition and in accordance with relevant payer guidelines. (Directive to Take Action)

Substantial testimony supported reaffirmation of existing AMA policy regarding the CPT Editorial Panel process in lieu of Resolution 816. The Chairman of the CPT Editorial Panel spoke to the independent nature of the CPT editorial process and the recent work of the panel on office visits. While limited testimony called for referral for decision, other speakers emphasized that the proper forum for discussing the concerns raised in Resolution 816 is the CPT Editorial Panel. Therefore, your Reference Committee recommends that Policies H-70.919 and H-70.921 be reaffirmed in lieu of Resolution 816.

H-70.919 Use of CPT Editorial Panel Process

Our AMA reinforces that the CPT Editorial Panel is the proper forum for addressing CPT code set maintenance issues and all interested stakeholders should avail themselves of the well-established and documented CPT Editorial Panel process for the development of new and revised CPT codes, descriptors, guidelines, parenthetical statements and modifiers. (BOT Rep. 4, A-06; Reaffirmation A-07; Reaffirmation I-08; Reaffirmation A-09; Reaffirmation A-10; Reaffirmation A-11; Reaffirmation I-14; Reaffirmed: CMS Rep. 4, I-15; Reaffirmation A-16; Reaffirmed in lieu of: Res. 117, A-16; Reaffirmed in lieu of: Res. 121, A-17; Reaffirmation: A-18 Reaffirmation: I-18)

H-70.921 Update on Revision of CPT E&M Codes and Development of Clinical Examples

Our AMA policy is that future efforts to substantially revise Evaluation and Management (E&M) codes should only occur under the auspices of the CPT Editorial Panel and then through a broadly inclusive process that provides for significant and meaningful input from state medical associations, medical specialty societies and public and private payers. (BOT Rep. 26, I-04; Reaffirmed: CMS Rep. 1, A-14)

(17) RESOLUTION 819 – HOSPITAL WEBSITE VOLUNTARY PHYSICIAN INCLUSION

RECOMMENDATION:

Alternate Resolution 819 be adopted in lieu of Resolution 819.

RESOLVED, That our American Medical Association support the inclusion of all credentialed physicians in hospital and other health care facility websites and physician directories. (New HOD Policy)

HOD ACTION: Alternate Resolution 819 and Amendment J9 referred.

RESOLVED, That our American Medical Association advocate for regulation and/or legislation requiring that all credentialed physicians (employed and voluntary) of a hospital and/or other healthcare facility be equally included on the websites and physician search engines, such as Find a Doctor sites (Directive to Take Action); and be it further

RESOLVED, That our American Medical Association study the effect on independent practices of the omission of credentialed physicians from hospital and other healthcare facilities' websites and physician directories. (Directive to Take Action)

RESOLVED, That our American Medical Association advocate for regulation and/or legislation requiring that all credentialed physicians (employed and voluntary) of a hospital and/or other healthcare facility be equally included on the websites and physician search engines, such as Find a Doctor sites (Directive to Take Action); and be it further

RESOLVED, That our American Medical Association study a requirement that all credentialed physicians (employed and voluntary) of a hospital and/or other healthcare facility be equally included on the websites and physician search engines, such as Find a Doctor sites with a report back at the 2020 Annual Meeting. (Directive to Take Action)

Your Reference Committee heard testimony supportive of having all credentialed physicians included in hospital and other health care facility websites. Speakers shared stories of hospitals only advertising employed physicians, and suggested that this practice may be intended to encourage independent physicians to consolidate with these hospitals. Testimony noted that the practice of hospitals and other health care facilities omitting non-employed physicians from their websites is not transparent and can lead patients to be unable to find these physicians. The sponsors testified that the original Resolution 819 was confusing and they were open to alternate language. Your Reference Committee crafted alternate language that is reflective of the testimony, and recommends that Alternate Resolution 819 be adopted in lieu of Resolution 819.

RECOMMENDED FOR REFERRAL**(18) RESOLUTION 809 – AMA PRINCIPLES OF MEDICAID REFORM****RECOMMENDATION:****Resolution 809 be referred.****HOD ACTION: Resolution 809 referred.**

RESOLVED, That our American Medical Association support the following principles of Medicaid reform:

1. Provide appropriate access to care that is the most cost effective and efficient to our citizens.
2. Encourage individuals to be enrolled in private insurance supported by Medicaid funding, if possible.
3. Create the best coverage at the lowest possible cost.
4. Incentivize Medicaid patient behavior to improve lifestyle, health, and compliance with appropriate avenues of care and utilization of services.
5. Establish a set of specialty specific high-quality metrics with appropriate remuneration and incentives for clinicians to provide high quality care.
6. Seek to establish improved access for Medicaid patients to primary care providers and referrals to specialists for appropriate care.
7. Assure appropriate payment and positive incentives to encourage but not require clinician participation in Medicaid for both face-to-face and non-face-to-face encounters, under appropriate establishment of clinician-patient relationship.
8. Include payment incentives to clinicians for after-hours primary care to assist patients with an inability to access care during normal business hours.
9. Avoid tactics and processes that inhibit access to care, delay interventions and prevent ongoing maintenance of health.
10. Eliminate current disincentives (e.g., Medicaid spend-down in order to qualify) to patients improving their lives while on Medicaid, to increase successful transition into the private insurance market.
11. Cease any tax, or attempt to tax, any health care profession for the purpose of supporting the cost of Medicaid.
12. Develop a physician directed clinician oversight board at the state level to insure the proper access, quality and cost of care under the Medicaid program throughout all geographically diverse areas of the states.
13. Allow clinicians to see patients for more than one procedure in a visit so that patients do not have to return for another service at an extra cost to the Medicaid program and extra time and effort to the Medicaid patient (e.g., if patient comes because they are sick, allow them to have a diabetes check-up at the same time).
14. Strategically plan to reduce administrative costs and burdens to clinicians, and of the Medicaid program itself, by reducing at least, but not limited to, burdensome documentation requirements, administrative obstacles, and regulatory impediments. (New HOD Policy) and be it further

RESOLVED, That our AMA pursue action to improve the federal requirements for Medicaid programs based on the AMA's principles of Medicaid reform (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 809. There were multiple calls for referral, as well as for not adoption. The sponsor of the resolution was also open to referral. A member of the Council on Medical Service called for referral, and testified that while some principles outlined in Resolution 809 are consistent with AMA policy, others are not, and would have unintended consequences if adopted. A member of the Council on Legislation also called for referral, stressing that there is no mention in Resolution 809 of foundational AMA policies that have guided our advocacy pertaining to Medicaid on the federal and state levels to date. As such, the member of the Council on Legislation stated that referral would enable a study to be carried out which compares the principles of Medicaid reform outlined in Resolution 809 with existing policy, and advocacy efforts to date, and determines what additional policy on the issue, if any, is needed, to guide AMA advocacy moving forward. Your Reference Committee agrees with the significant concerns regarding Resolution 809 raised in testimony, and recommends that it be referred.

(19) RESOLUTION 814 – PBM VALUE-BASED FRAMEWORK FOR FORMULARY DESIGN

RECOMMENDATION:

Resolution 814 be referred.

HOD ACTION: Resolution 814 referred.

RESOLVED, That our American Medical Association emphasize the importance of physicians' choice of the most appropriate pharmaceutical treatment for their patients in its advocacy; (Directive to Take Action) and be it further

RESOLVED, That our AMA advocate for pharmacy benefit managers (PBMs) and health plans to use a value-based decision-making framework that is transparent and includes applicable specialty clinical oversight when determining which specialty drugs to give preference on their formularies. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 814. A member of the Council on Medical Service testified that the second resolve of Resolution 814 could have severe unintended consequences if adopted. The Council member underscored that more parameters and definitions are needed to guide the use of such value-based decision-making frameworks by PBMs and health plans. Significantly, the member of the Council on Medical Service stressed that adopting such general language pertaining to the use of value-based decision-making frameworks by PBMs in formulary preference decisions could lead the resulting AMA policy to be interpreted in several different ways, some of which may not be the intent of the resolution sponsor and could be problematic for physicians in placing our patients on the most appropriate treatment regimen. The term "value-based" is defined differently by physicians, pharmaceutical companies, health plans and PBMs. Your Reference Committee agrees, and recommends that Resolution 814 be referred.

(20) RESOLUTION 818 – MEDICAL CENTER AUTO ACCEPT POLICIES

RECOMMENDATION:

Resolution 818 be referred.

HOD ACTION: Resolution 818 referred.

RESOLVED, That our American Medical Association study the impact of "auto accept" policies (i.e. unconditional acceptance for the care of a patient) on public health, as well as their compliance with the Emergency Medical Treatment and Labor Act (EMTALA) in order to protect the safety of our patients, with report back at the 2020 Annual Meeting (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate that if a medical center adopts an "auto accept" i.e. unconditional acceptance for the care of a patient) policy, it must have been ratified, as well as overseen and/or crafted, by the independent medical staff (New HOD Policy)

Testimony on Resolution 818 was supportive. However, your Reference Committee notes that simultaneously calling for a study and adoption of policy runs counter to the policymaking process, which is predicated on studying the body of evidence on a particular issue before adopting policy on that issue. Importantly, your Reference Committee highlights that the issue of "auto accept" policies is significantly more nuanced than the resolution implies. The phrase "auto accept" policy is not a policy at hospitals but rather a practice. Moreover, "auto accept" practices may have The Joint Commission or medical staff bylaw implications. Therefore, the accountability may lie in current guidelines instead of the creation of new guidelines. Further, your Reference Committee notes that our AMA has significant policy on patient safety (Ethics Opinion 8.6; Ethics Opinion 9.5.1; Ethics Opinion 9.4.2; Policy H-335.965) and believes that this policy permits AMA advocacy on this issue if needed while the requested study is performed. Accordingly, your Reference Committee recommends that Resolution 818 be referred.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (I-19)

Report of Reference Committee K

Alyn Adrain, MD, Chair

Your reference committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Council on Science and Public Health Report 2 – Real-World Data and Real-World Evidence in Medical Product Decision Making
2. Council on Science and Public Health Report 3 – Patient Use of Non-FDA Approved Cannabis and Cannabinoid Products in Hospitals (Resolution 414-A-19)
3. Resolution 912 – Improving Emergency Response Planning for Infectious Disease Outbreaks

RECOMMENDED FOR ADOPTION AS AMENDED

4. Board of Trustees Report 12 – Distracted Driver Education and Advocacy
5. Council on Science and Public Health Report 1 – Mandatory Reporting of Diseases and Conditions (Resolution 915-I-18)
6. Resolution 902 – Amending H-490.913, Smoke-Free Environments and Workplaces, and H-409.907, Tobacco Smoke Exposure of Children in Multi-Unit Housing, to Include E-Cigarettes
7. Resolution 903 – Encouraging the Development of Multi-Language, Culturally Informed Mobile Health Applications
8. Resolution 904 – Amendment to H-150.949, Healthy Food Options in Hospitals
9. Resolution 905 – Sunscreen Dispensers in Public Spaces as a Public Health Measure
10. Resolution 906 – Ensuring the Best In-School Care for Children with Sickle Cell Disease
11. Resolution 907 – Increasing Access to Gang-Related Laser Tattoo Removal in Prison and Community Settings
12. Resolution 909 – Decreasing the Use of Oximetry Monitors for the Prevention of Sudden Infant Death Syndrome
13. Resolution 914 – Nicotine Replacement Therapy for Minors
14. Resolution 915 – Preventing Death and Disability Due to Particulate Matter Produced by Automobiles
15. Resolution 916 – Sale of Tobacco in Retail Pharmacies
16. Resolution 918 – Banning Flavors, Including Menthol and Mint, in Combustible and Electronic Cigarettes and Other Nicotine Products
17. Resolution 923 – Support Availability of Public Transit System
18. Resolution 934 – Gun Violence and Mental Illness Stigma in the Media

RECOMMENDED FOR ADOPTION IN LIEU OF

19. Resolution 901 – Health Impact of Per- and Polyfluoroalkyl Substances (PFAS) Contamination in Drinking Water
- Resolution 922 – Understanding the Effects of PFAS on Human Health
20. Resolution 910 – Ban on Electronic Nicotine Delivery System (ENDS) Products
- Resolution 925 – Suspending Sales of Vaping Products / Electronic Cigarettes Until FDA Review
- Resolution 935 – AMA Response to a National Vaping Epidemic
21. Resolution 913 – Public Health Impacts and Unintended Consequences of Legalization and Decriminalization of Cannabis for Medicinal and Recreational Use
- Resolution 919 – Raising Awareness of the Health Impact of Cannabis
22. Resolution 930 – Origin of Prescription Medication Production Transparency
- Resolution 932 – Source and Quality of Medications Critical to National Health and Security

RECOMMENDED FOR REFERRAL FOR DECISION

23. Resolution 926 – School Resource Officer Qualifications and Training

RECOMMENDED FOR NOT ADOPTION

24. Resolution 908 – Request for Benzodiazepine-Specific Prescribing Guidelines for Physicians
25. Resolution 917 – Supporting Research into the Therapeutic Potential of Psychedelics
Resolution 933 – Supporting Research into the Therapeutic Potential of Psychedelics
26. Resolution 920 – Maintaining Public Focus on Leading Causes of Nicotine-Related Death
27. Resolution 921 – Vaping in New York State and Nationally
28. Resolution 924 – Update Scheduled Medication Classification
29. Resolution 929 – Regulating Marketing and Distribution of Tobacco Products and Vaping-Related Products

Resolutions handled via the reaffirmation consent calendar:

- Resolution 911 – Basic Courses in Nutrition
- Resolution 927 – Climate Change
- Resolution 928 – CBD Oil and Supplement Use in Treatment
- Resolution 931 – Vaping Ban for Under 21 and Additional Regulations

RECOMMENDED FOR ADOPTION

- (1) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 2 – REAL-WORLD DATA AND REAL-WORLD EVIDENCE IN MEDICAL PRODUCT DECISION MAKING

RECOMMENDATION:

Recommendations in Council on Science and Public Health Report 2 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Science and Public Health Report 2 adopted and the remainder of the report be filed.

The Council on Science and Public Health recommends that the following be adopted and the remainder of the report be filed:

1. Our AMA supports the generation and use of real-world data (RWD) and real-world evidence (RWE) fit for regulatory purpose to: (a) evaluate effectiveness and safety of medical products, while assuring patient privacy and confidentiality; (b) improve regulatory decision-making; (c) decrease medical product costs; (d) increase research efficiency; (e) advance innovative and new models of drug development; and (f) improve clinical care and patient outcomes. (New HOD Policy)
2. Our AMA supports the aim of the U.S. Food and Drug Administration (FDA) to expand and clarify the use RWD and RWE in regulatory decision-making including in:
 - a. understanding the potential of RWE to meet the established standards for adequate and well-controlled clinical investigations;
 - b. pursuing the integration of RWE into medical product development and regulatory review; and
 - c. utilizing RWE to support new indications for approved medical products, and its ability to satisfy post-approval study requirements. (New HOD Policy)
3. Our AMA supports that there be adequate funding of data infrastructure to allow for transparent data management capabilities, improved access to data by clinicians, especially physicians, as well as researchers and other stakeholders, and improved reliability and relevance of data. (New HOD Policy)
4. Our AMA supports cooperation and collaboration of stakeholders to facilitate the collection and use of RWD and RWE that is deemed fit for regulatory purpose. (New HOD Policy)
5. Our AMA will evaluate and develop a response to the educational needs of physicians seeking to understand the use of fit for purpose RWD and RWE in clinical practice. (New HOD Policy)
6. That Policy H-100.992, “FDA,” be amended by addition to read as follows:

H-100.992, “FDA”

 1. Our AMA reaffirms its support for the principles that: (a) an FDA decision to approve a new drug, to withdraw a drug’s approval, or to change the indications for use of a drug must be based on sound scientific and medical evidence derived from controlled trials, real-world data (RWD) fit for regulatory purpose, and/or postmarket incident reports as provided by statute; (b) this evidence should be evaluated by the FDA, in consultation with its Advisory Committees and expert extramural advisory bodies; and (c) any risk/benefit analysis or relative safety or efficacy judgments should not be grounds for limiting access to or indications for use of a drug unless the weight of the evidence from clinical trials, RWD fit for regulatory purpose, and postmarket reports shows that the drug is unsafe and/or ineffective for its labeled indications.
 2. The AMA believes that social and economic concerns and disputes per se should not be permitted to play a significant part in the FDA’s decision-making process in the course of FDA devising either general or product specific drug regulation.
 3. It is the position of our AMA that the Food and Drug Administration should not permit political considerations or conflicts of interest to overrule scientific evidence in making policy decisions; and our AMA urges the current administration and all future administrations to consider our best and brightest

scientists for positions on advisory committees and councils regardless of their political affiliation and voting history. (Modify Current HOD Policy)

7. That Policy D-100.982, “Enhanced Physician Access to Food and Drug Administration Data,” urging the FDA to apply new tools to gather data after drugs are approved for marketing, including a broader use of targeted post-approval studies, institution of active and sentinel event surveillance, and data mining of available drug utilization databases, be reaffirmed. (Reaffirm Current HOD Policy)
8. That Policy H-110.986, “Incorporating Value into Pharmaceutical Pricing” supporting value-based pricing of pharmaceuticals that is evidence-based and the result of valid and reliable inputs and data that incorporate rigorous scientific methods, including clinical trials, clinical data registries, comparative effectiveness research, and robust outcome measures that capture short- and long-term clinical outcomes, be reaffirmed. (Reaffirm Current HOD Policy)
9. That Policy H-406.987, “Medical Information and Its Uses,” identifying three components of a data transparency framework, be reaffirmed. (Reaffirm Current HOD Policy)
10. That Policy H-410.948, “Clinical Pathways,” supporting the development of transparent, collaboratively constructed clinical pathways that are implemented in ways that promote administrative efficiencies for both providers and payers; promote access to evidence-based care for patients; recognize medical variability among patients and individual patient autonomy; promote access to clinical trials; and are continuously updated to reflect the rapid development of new scientific knowledge, be reaffirmed. (Reaffirm Current HOD Policy)
11. That Policy H-450.933, “Clinical Data Registries,” encouraging multi-stakeholder efforts to develop and fund clinical data registries to facilitate quality improvements and research that results in better health care, improved population health, and lower costs be reaffirmed. (Reaffirm Current HOD Policy)
12. That Policy D-460.970, “Access to Clinical Trial Data,” urging the FDA to investigate and develop means by which scientific investigators can access original source safety data from industry-sponsored trials upon request; be reaffirmed. (Reaffirm Current HOD Policy)

Your Reference Committee heard testimony in strong support of the recommendations provided by the Council. Several commenters praised the clarity the report provided on the issues associated with the use of real-world data and evidence. An amendment was offered to ensure that real-world data and evidence not be used to support pseudo-science. Your Reference Committee felt that this was addressed by the language noted in the report, that real-world data be “fit for regulatory purpose.” Therefore, your Reference Committee recommends that Council on Science and Public Health Report 2 be adopted.

- (2) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 3 – PATIENT USE OF NON-FDA APPROVED CANNABIS AND CANNABINOID PRODUCTS IN HOSPITALS (RESOLUTION 414-A-19)

RECOMMENDATION:

Recommendation in Council on Science and Public Health Report 3 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendation in Council on Science and Public Health Report 3 adopted as amended and the remainder of the report filed.

~~The AMA encourages hospitals and health systems to: (1) engage stakeholders, including, but not limited to physicians, nurses, pharmacists, legal counsel, experts in controlled substance diversion prevention, as well as relevant state and federal agencies in developing policies for addressing patient use of non-FDA approved cannabis or cannabis derived products for use within their facilities and (2) communicate their policy on patient use of non-FDA approved cannabis or cannabis derived products~~

~~within their facilities, to ensure clinicians are prepared to treat patients in accordance with policy. (New HOD Policy)~~

AMA encourages hospitals and health systems to (1) not recommend patient use of non-FDA approved cannabis or cannabis derived products within healthcare facilities until such time as federal laws or regulations permit its use and (2) educate medical staffs on cannabis use, effects and cannabis withdrawal syndrome. (New HOD Policy)

The Council recommends that the following recommendation be adopted in lieu of Resolution 414-A-19, and the remainder of the report be filed.

The AMA encourages hospitals and health systems to: (1) engage stakeholders, including, but not limited to physicians, nurses, pharmacists, legal counsel, experts in controlled substance diversion prevention, as well as relevant state and federal agencies in developing policies for addressing patient use of non-FDA approved cannabis or cannabis-derived products for use within their facilities and (2) communicate their policy on patient use of non-FDA approved cannabis or cannabis-derived products within their facilities, to ensure clinicians are prepared to treat patients in accordance with policy. (New HOD Policy)

Your Reference Committee heard mostly supportive testimony on Council on Science and Public Health Report 3. Several who testified believed that the Council on Science and Public Health's recommendations encouraging a broad group of stakeholders to work together to develop hospital facility policies on cannabis, were reasonable. Others noted that they were hoping for more specific guidance on the use of cannabis and cannabinoids by patients in the hospital setting. There were others who spoke against allowing the use of non-FDA approved cannabis products in hospitals. Several amendments were offered, including the addition of the term "cannabinoids." Since cannabis-derived products encompasses cannabinoids, the language as proposed is appropriate. It should be noted that the AMA will be developing a continuing education module on cannabis in 2020 to provide physicians with additional guidance on this topic. Your Reference Committee agrees with the Council on Science and Public Health's approach to addressing this complex issue and recommends adoption of the report's recommendations.

(3) RESOLUTION 912 – IMPROVING EMERGENCY RESPONSE PLANNING FOR INFECTIOUS DISEASE OUTBREAKS

RECOMMENDATION:

Resolution 912 be adopted.

HOD ACTION: Resolution 912 adopted.

RESOLVED, That our American Medical Association encourage hospitals and other entities that collect patient encounter data to report syndromic (i.e., symptoms that appear together and characterize a disease or medical condition) data to public health departments in order to facilitate syndromic surveillance, assess risks of local populations for disease, and develop comprehensive plans with stakeholders to enact actions for mitigation, preparedness, response, and recovery (Directive to Take Action); and be it further

RESOLVED, That our AMA support flexible funding in public health for unexpected infectious disease to improve timely response to emerging outbreaks and build public health infrastructure at the local level with attention to medically underserved areas (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage health departments to develop public health messaging to provide education on unexpected infectious disease. (Directive to Take Action)

Your Reference Committee heard testimony in strong support of this Resolution. Given the potential for the emergence of unexpected infectious disease threats and need for public health surveillance and funding to address these threats, your Reference Committee recommends that Resolution 912 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

- (4) BOARD OF TRUSTEES REPORT 12 – DISTRACTED DRIVER EDUCATION AND ADVOCACY

RECOMMENDATION A

Board of Trustees Report 12 be amended by the addition of a recommendation to read as follows:

Policies H-15.952 and D-15.993 be reaffirmed.

RECOMMENDATION B:

Recommendation in Board of Trustees Report 12 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendation in Board of Trustees Report 12 adopted as amended and the remainder of the report be filed.

That our AMA will escalate the distracted driving campaign to a national level of awareness in coordination with the CDC and the National Education Association to educate elementary up through high school students as well as parents regarding the high-risk behavior of driving while holding cell phones and the opportunity to save lives and avoid injuries, with a review of steps taken and report back to the House at Annual 2020. (New HOD Policy)

Informational Report, no recommendation provided.

Your Reference Committee heard limited, but supportive testimony on the need for AMA action to address distracted driving as directed by the House of Delegates at the A-20 meeting. While we understand that AMA staff have reached out to the Centers for Disease Control and Prevention, Division of Transportation Safety to discuss opportunities for collaboration, we are reaffirming this directive to urge action on this important issue.

H-15.952, “The Dangers of Distraction While Operating Hand-Held Devices”

1. Our American Medical Association encourages physicians to educate their patients regarding the public health risks of text messaging while operating motor vehicles or machinery and will advocate for state legislation prohibiting the use of hand held communication devices to text message while operating motor vehicles or machinery. 2. Our AMA will endorse legislation that would ban the use of hand-held devices while driving. 3. Our AMA: (a) recognizes distracted walking as a preventable hazard and encourages awareness of the hazard by physicians and the public; and (b) encourages research into the severity of distracted walking as a public health hazard as well as ways in which to prevent it. 4. Our AMA supports public education efforts regarding the dangers of distracted driving, particularly activities that take drivers’ eyes off the road, and that the use of earbuds or headphones while driving is dangerous and illegal in some states. 5. Our AMA: (a) supports education on the use of earbuds or headphones in both ears during outdoor activities requiring auditory attention, including but not limited to biking, jogging, rollerblading, skateboarding and walking; and (b) supports the use of warning labels on the packaging of hand-held devices utilized with earbuds or headphones, indicating the dangers of using earbuds or headphones in both ears during outdoor activities requiring auditory attention, including but not limited to biking, jogging, rollerblading, skateboarding and walking. 6. Our AMA will: (a) make it a priority to create a national education and advocacy campaign on distracted driving in collaboration with the Centers for Disease Control and Prevention and other interested stakeholders; and (b) explore developing an advertising campaign on distracted driving with report back to the House of Delegates at the 2019 Interim Meeting. Res. 217, I-08Appended: Res. 905, I-09Appended: BOT Rep. 10, A-13Appended: Res. 416, A-13Modified in lieu of Res. 414, A-15Appended: Res. 425, A-19.

D-15.993, “Distracted Driver Reduction”

1. Our AMA will develop model state legislation to limit cell phone use to hands-free use only while driving. 2. Our AMA will actively lobby for: (a) legislation to decrease distracted driving injuries and fatalities by banning the use of electronic communication such as texting, taking photos or video and posting on social media while operating a motor vehicle; and (b) federal legislation to require automobile manufacturers to integrate hands-free technology into new automobiles. Res. 220, I-16 Appended: Res. 415, A-19.

- (5) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 1 –
MANDATORY REPORTING OF DISEASES AND CONDITIONS
(RESOLUTION 915-I-18)

RECOMMENDATION A:

The recommendation in Council on Science and Public Health Report 1 be amended by addition to read as follows:

Public Health Surveillance

That our AMA: (1) recognizes public health surveillance as a core public health function that is essential to inform decision making, identify underlying causes and etiologies, and respond to acute, chronic, and emerging health threats; (2) recognizes the important role that physicians play in public health surveillance through reporting diseases and conditions to public health authorities; (3) encourages state legislatures to engage relevant state and national medical specialty societies as well as public health agencies when proposing mandatory reporting requirements to ensure they are based on scientific evidence and meet the needs of population health; (4) recognizes the need for increased federal, state, and local funding to modernize our nation’s public health data systems to improve the quality and timeliness of data; (5) supports electronic case reporting, which alleviates the burden of case reporting on physicians through the automatic generation and transmission of case reports from electronic health records to public health agencies for review and action in accordance with applicable health care privacy and public health reporting laws; (6) will share updates with physicians and medical societies on public health surveillance and the progress made toward implementing electronic case reporting. (New HOD Policy)

RECOMMENDATION B:

The recommendation in Council on Science and Public Health Report 1 be adopted as amended and the remainder of the report be filed.

HOD ACTION: The recommendation in Council on Science and Public Health Report 1 adopted as amended and the remainder of the report filed.

The Council recommends that the following recommendation for new policy be adopted in lieu of Resolution 915-I-18, and the remainder of the report be filed.

Public Health Surveillance

That our AMA: (1) recognizes public health surveillance as a core public health function that is essential to inform decision making, identify underlying causes and etiologies, and respond to acute, chronic, and emerging health threats; (2) recognizes the important role that physicians play in public health surveillance through reporting diseases and conditions to public health authorities; (3) encourages state legislatures to engage relevant state and national medical specialty societies as well as public health agencies when proposing mandatory reporting requirements to ensure they are based on scientific evidence and meet the needs of population health; (4) recognizes

the need for increased federal funding to modernize our nation's public health data systems to improve the quality and timeliness of data; (5) supports electronic case reporting, which alleviates the burden of case reporting on physicians through the automatic generation and transmission of case reports from electronic health records to public health agencies for review and action in accordance with applicable health care privacy and public health reporting laws; (6) will share updates with physicians and medical societies on public health surveillance and the progress made toward implementing electronic case reporting. (New HOD Policy)

The Council was commended for its report on mandatory reporting of diseases and conditions. There was strong support for the report's recommendations, which address the importance of public health surveillance as well as the progress being made through electronic case reporting to alleviate the burden that reporting can place on physicians. The recommendations note that state legislatures, when considering reporting requirements, should consult with relevant medical societies and public health agencies. This allows the opportunity for relevant stakeholders to provide input and address concerns. While an amendment was proffered to add federal to this clause, mandatory reporting requirements are made at the state level. Therefore, your Reference Committee did not feel that this amendment was appropriate. Your Reference Committee supported the addition of language to address the need for state and local funding. Therefore, your Reference Committee recommends that Council on Science and Public Health Report 1 be adopted as amended.

- (6) RESOLUTION 902 – AMENDING H-490.913, SMOKE-FREE ENVIRONMENTS AND WORKPLACES, AND H-409.907, TOBACCO SMOKE EXPOSURE OF CHILDREN IN MULTI-UNIT HOUSING, TO INCLUDE E-CIGARETTES

RECOMMENDATION A:

The first Resolve of Resolution 902 be amended by addition and deletion to read as follows:

H-490.913, “Smoke-Free and Vape-Free Environments and Workplaces”

On the issue of the health effects of environmental tobacco smoke (ETS), and passive smoke, and vape aerosol exposure in the workplace and other public facilities, our AMA: (1)(a) supports classification of ETS as a known human carcinogen; (b) concludes that passive smoke exposure is associated with increased risk of sudden infant death syndrome and of cardiovascular disease; (c) encourages physicians and medical societies to take a leadership role in defending the health of the public from ETS risks and from political assaults by the tobacco industry; and (d) encourages the concept of establishing smoke-free and vape-free campuses for business, labor, education, and government; (2) (a) honors companies and governmental workplaces that go smoke-free and vape-free; (b) will petition the Occupational Safety and Health Administration (OSHA) to adopt regulations prohibiting smoking and vaping in the workplace, and will use active political means to encourage the Secretary of Labor to swiftly promulgate an OSHA standard to protect American workers from the toxic effects of ETS in the workplace, preferably by banning smoking and vaping in the workplace; (c) encourages state medical societies (in collaboration with other anti-tobacco organizations) to support the introduction of local and state legislation that prohibits smoking and vaping around the public entrances to buildings and in all indoor public places, restaurants, bars, and workplaces; and (d) will update draft model state legislation to prohibit smoking and vaping in public places and businesses, which would include language that would prohibit preemption of stronger local laws. (3) (a) encourages state medical societies to: (i) support legislation for states and counties mandating smoke-free and vape-free schools and eliminating smoking

and vaping in public places and businesses and on any public transportation; (ii) enlist the aid of county medical societies in local anti-smoking and anti-vaping campaigns; and (iii) through an advisory to state, county, and local medical societies, urge county medical societies to join or to increase their commitment to local and state anti-smoking and anti-vaping coalitions and to reach out to local chapters of national voluntary health agencies to participate in the promotion of anti-smoking and anti-vaping control measures; (b) urges all restaurants, particularly fast food restaurants, and convenience stores to immediately create a smoke-free and vape-free environment; (c) strongly encourages the owners of family-oriented theme parks to make their parks smoke-free and vape-free for the greater enjoyment of all guests and to further promote their commitment to a happy, healthy life style for children; (d) encourages state or local legislation or regulations that prohibit smoking and vaping in stadia and encourages other ball clubs to follow the example of banning smoking in the interest of the health and comfort of baseball fans as implemented by the owner and management of the Oakland Athletics and others; (e) urges eliminating cigarette, pipe, and cigar, ~~and e-cigarette~~ smoking and vaping in any indoor area where children live or play, or where another person's health could be adversely affected through passive smoking inhalation; (f) urges state and county medical societies and local health professionals to be especially prepared to alert communities to the possible role of the tobacco industry whenever a petition to suspend a nonsmoking or non-vaping ordinance is introduced and to become directly involved in community tobacco control activities; and (g) will report annually to its membership about significant anti-smoking and anti-vaping efforts in the prohibition of smoking and vaping in open and closed stadia; (4) calls on corporate headquarters of fast-food franchisers to require that one of the standards of operation of such franchises be a no smoking and no vaping policy for such restaurants, and endorses the passage of laws, ordinances and regulations that prohibit smoking and vaping in fast-food restaurants and other entertainment and food outlets that target children in their marketing efforts; (5) advocates that all American hospitals ban tobacco and supports working toward legislation and policies to promote a ban on smoking, vaping, and use of tobacco products in, or on the campuses of, hospitals, health care institutions, retail health clinics, and educational institutions, including medical schools; (6) will work with the Department of Defense to explore ways to encourage a smoke-free and vape-free environment in the military through the use of mechanisms such as health education, smoking and vaping cessation programs, and the elimination of discounted prices for tobacco products in military resale facilities; and (7) encourages and supports local and state medical societies and tobacco control coalitions to work with (a) Native American casino and tribal leadership to voluntarily prohibit smoking and vaping in their casinos; and (b) legislators and the gaming industry to support the prohibition of smoking and vaping in all casinos and gaming venues.

RECOMMENDATION B:

The second Resolve of Resolution 902 be amended by addition to read as follows:

H-490.907, "Tobacco Smoke and Vaping Aerosol Exposure Of Children In Multi-Unit Housing"

Our AMA: (1) encourages federal, state and local housing authorities and governments to adopt policies that protect children and non-smoking or non-vaping adults from tobacco smoke and vaping aerosol exposure by prohibiting smoking and vaping in multi-unit housing; and (2) encourages state and local medical societies, chapters, and other health organizations to support and advocate for changes in existing state and local laws and policies that protect children and non-smoking or non-vaping adults from tobacco smoke and vaping aerosol exposure by prohibiting smoking and vaping in multi-unit housing. (Modify Current HOD Policy)

RECOMMENDATION C:

Resolution 902 be adopted as amended.

HOD ACTION: Resolution 902 adopted as amended.

RESOLVED, That our American Medical Association (AMA) amend policy H-490.913, “Smoke-Free Environments and Workplaces,” by addition and deletion to read as follows:

H-490.913, “Smoke-Free and Vape-Free Environments and Workplaces”

On the issue of the health effects of environmental tobacco smoke (ETS), and passive smoke, and vape exposure in the workplace and other public facilities, our AMA: (1)(a) supports classification of ETS as a known human carcinogen; (b) concludes that passive smoke exposure is associated with increased risk of sudden infant death syndrome and of cardiovascular disease; (c) encourages physicians and medical societies to take a leadership role in defending the health of the public from ETS risks and from political assaults by the tobacco industry; and (d) encourages the concept of establishing smoke-free and vape-free campuses for business, labor, education, and government; (2) (a) honors companies and governmental workplaces that go smoke-free and vape-free; (b) will petition the Occupational Safety and Health Administration (OSHA) to adopt regulations prohibiting smoking and vaping in the workplace, and will use active political means to encourage the Secretary of Labor to swiftly promulgate an OSHA standard to protect American workers from the toxic effects of ETS in the workplace, preferably by banning smoking and vaping in the workplace; (c) encourages state medical societies (in collaboration with other anti-tobacco organizations) to support the introduction of local and state legislation that prohibits smoking and vaping around the public entrances to buildings and in all indoor public places, restaurants, bars, and workplaces; and (d) will update draft model state legislation to prohibit smoking and vaping in public places and businesses, which would include language that would prohibit preemption of stronger local laws. (3) (a) encourages state medical societies to: (i) support legislation for states and counties mandating smoke-free and vape-free schools and eliminating smoking and vaping in public places and businesses and on any public transportation; (ii) enlist the aid of county medical societies in local anti-smoking and anti-vaping campaigns; and (iii) through an advisory to state, county, and local medical societies, urge county medical societies to join or to increase their commitment to local and state anti-smoking and anti-vaping coalitions and to reach out to local chapters of national voluntary health agencies to participate in the promotion of anti-smoking and anti-vaping control measures; (b) urges all restaurants, particularly fast food restaurants, and convenience stores to immediately create a smoke-free and vape-free environment; (c) strongly encourages the owners of family-oriented theme parks to make their parks smoke-free and vape-free for the greater enjoyment of all guests and to further promote their commitment to a happy, healthy life style for children; (d) encourages state or local legislation or regulations that prohibit smoking and vaping in stadia and encourages other ball clubs to follow the example of banning smoking in the interest of the health and comfort of baseball fans as implemented by the owner and management of the Oakland Athletics and others; (e) urges eliminating cigarette, pipe, cigar, and e-cigarette smoking in any indoor area where children live or play, or where another person’s health could be adversely affected through passive smoking inhalation; (f) urges state and county medical societies and local health professionals to be especially prepared to alert communities to the possible role of the tobacco industry whenever a petition to suspend a nonsmoking or non-vaping ordinance is introduced and to become directly involved in community tobacco control activities; and (g) will report annually to its membership about significant anti-smoking and anti-vaping efforts in the prohibition of smoking and vaping in open and closed stadia; (4)

calls on corporate headquarters of fast-food franchisers to require that one of the standards of operation of such franchises be a no smoking and no vaping policy for such restaurants, and endorses the passage of laws, ordinances and regulations that prohibit smoking and vaping in fast-food restaurants and other entertainment and food outlets that target children in their marketing efforts; (5) advocates that all American hospitals ban tobacco and supports working toward legislation and policies to promote a ban on smoking, vaping, and use of tobacco products in, or on the campuses of, hospitals, health care institutions, retail health clinics, and educational institutions, including medical schools; (6) will work with the Department of Defense to explore ways to encourage a smoke-free and vape-free environment in the military through the use of mechanisms such as health education, smoking and vaping cessation programs, and the elimination of discounted prices for tobacco products in military resale facilities; and (7) encourages and supports local and state medical societies and tobacco control coalitions to work with (a) Native American casino and tribal leadership to voluntarily prohibit smoking and vaping in their casinos; and (b) legislators and the gaming industry to support the prohibition of smoking and vaping in all casinos and gaming venues.

RESOLVED, That our AMA amend Policy H-490.907, “Tobacco Smoke Exposure of Children in Multi-Unit Housing, to include e-cigarettes and vaping by addition to read as follows:

H-490.907, “Tobacco Smoke and Vaping Exposure Of Children In Multi-Unit Housing”

Our AMA: (1) encourages federal, state and local housing authorities and governments to adopt policies that protect children and non-smoking or non-vaping adults from tobacco smoke and vaping exposure by prohibiting smoking and vaping in multi-unit housing; and (2) encourages state and local medical societies, chapters, and other health organizations to support and advocate for changes in existing state and local laws and policies that protect children and non-smoking or non-vaping adults from tobacco smoke and vaping exposure by prohibiting smoking and vaping in multi-unit housing. (Modify Current HOD Policy)

Your Reference Committee heard testimony in strong support of this Resolution. Your Reference Committee made minor amendments to the language to clarify the appropriate terminology regarding exposure to vaping is “vaping aerosol exposure” not “vape exposure.” Therefore, your Reference Committee recommends that Resolution 902 be adopted as amended.

- (7) RESOLUTION 903 – ENCOURAGING THE DEVELOPMENT OF MULTI-LANGUAGE, CULTURALLY INFORMED MOBILE HEALTH APPLICATIONS

RECOMMENDATION A:

Resolution 903 be amended by addition and deletion to read as follows:

8. Our AMA encourages the development of mobile health applications that employ linguistically appropriate and culturally informed health content ~~entered~~ tailored to linguistically and/or culturally diverse backgrounds, with emphasis on underserved and low-income populations. (Modify Current HOD Policy)

RECOMMENDATION B:

Resolution 903 be adopted as amended.

HOD ACTION: Resolution 903 adopted as amended.

RESOLVED, That American Medical Association policy D-480.972 be amended by insertion as follows:

D-480.972, “Guidelines for Mobile Medical Applications and Devices”

1. Our AMA will monitor market developments in mobile health (mHealth), including the development and uptake of mHealth apps, in order to identify developing consensus that provides opportunities for AMA involvement.

2. Our AMA will continue to engage with stakeholders to identify relevant guiding principles to promote a vibrant, useful and trustworthy mHealth market.
3. Our AMA will make an effort to educate physicians on mHealth apps that can be used to facilitate patient communication, advice, and clinical decision support, as well as resources that can assist physicians in becoming familiar with mHealth apps that are clinically useful and evidence-based.
4. Our AMA will develop and publicly disseminate a list of best practices guiding the development and use of mobile medical applications.
5. Our AMA encourages further research integrating mobile devices into clinical care, particularly to address challenges of reducing work burden while maintaining clinical autonomy for residents and fellows.
6. Our AMA will collaborate with the Liaison Committee on Medical Education and Accreditation Council for Graduate Medical Education to develop germane policies, especially with consideration of potential financial burden and personal privacy of trainees, to ensure more uniform regulation for use of mobile devices in medical education and clinical training.
7. Our AMA encourages medical schools and residency programs to educate all trainees on proper hygiene and professional guidelines for using personal mobile devices in clinical environments.
8. Our AMA encourages the development of mobile health applications that employ linguistically appropriate and culturally informed content catered to underserved and low-income populations. (Modify Current HOD Policy)

Your Reference Committee heard supportive testimony, including from your Council on Science and Public Health, related to this Resolution. Testimony noted that the importance of ensuring health equity as innovations via mobile health are introduced. Linguistically and culturally informed versions of mobile health applications were strongly supported as one mechanism to help ensure that these tools do not introduce further health inequities. Additional testimony noted the importance of considering linguistic and diverse backgrounds as well as underserved and low-income populations and your Reference Committee agrees. Therefore, your Reference Committee recommends that Resolution 903 be adopted as amended.

- (8) RESOLUTION 904 – AMENDMENT TO H-150.949, HEALTHY FOOD OPTIONS IN HOSPITALS

RECOMMENDATION A:

Resolution 904 be amended by addition and deletion to read as follows.

RESOLVED, That our American Medical Association encourage the availability of healthy, plant-based options at Medical Care Facilities by amending H-150.949, Healthy Food Options in Hospitals to read as follows:

Healthy~~ful~~ Food Options in Hospitals ~~Medical-Health~~ Care Facilities,
H-150.949

1. Our AMA encourages healthy~~ful~~ food options be available, at reasonable prices and easily accessible, on ~~hospital~~ the premises of ~~Medical-Health~~ Care Facilities.
2. Our AMA hereby calls on ~~US hospitals~~ all ~~Medical-Health~~ Care Facilities and Correctional Facilities to improve the health of patients, staff, and visitors by: (a) providing a variety of healthy food, including plant-based meals, and meals that are low in saturated and trans fat, sodium, and added sugars; (b) eliminating processed meats from menus; and (c) providing and promoting healthy beverages.
3. Our AMA hereby calls for ~~hospital~~ ~~Medical-Health~~ Care Facility cafeterias and inpatient meal menus to publish nutrition information. (Modify Current HOD Policy)

RECOMMENDATION B:

Resolution 904 be adopted as amended.

RECOMMENDATION C:

Policy D-430.995, “Dietary Intake of Incarcerated Populations,” be reaffirmed.

HOD ACTION: Resolution 904 adopted as amended and Policy D-430.995, “Dietary Intake of Incarcerated Populations” reaffirmed.

RESOLVED, That our American Medical Association encourage the availability of healthy, plant-based options at Medical Care Facilities by amending H-150.949, Healthy Food Options in Hospitals to read as follows:

Healthy Food Options in ~~Hospitals~~ Medical Care Facilities, H-150.949

1. Our AMA encourages healthy food options be available, at reasonable prices and easily accessible, on ~~hospital~~ the premises of Medical Care Facilities.
2. Our AMA hereby calls on ~~US hospitals~~ all Medical Care Facilities and Correctional Facilities to improve the health of patients, staff, and visitors by: (a) providing a variety of healthy food, including plant-based meals, and meals that are low in fat, sodium, and added sugars; (b) eliminating processed meats from menus; and (c) providing and promoting healthy beverages.
3. Our AMA hereby calls for ~~hospital~~ Medical Care Facility cafeterias and inpatient meal menus to publish nutrition information. (Modify Current HOD Policy)

Your Reference Committee heard testimony largely in favor of this amendment to existing policy. Minor amendments were offered and supported by your Reference Committee. These amendments included use of the term “health care facilities” rather than “medical care facilities” and specifying that “low in fat” that should be clarified to address saturated and trans fats. It was also noted in testimony that existing policy addresses healthy food in correctional facilities. Your Reference Committee agrees that correctional facilities are outside of the scope of this policy. Therefore, your Reference Committee recommends that Resolution 904 be adopted as amended and Policy D-430.995 be reaffirmed.

D-430.995, “Dietary Intake of Incarcerated Populations”

Our AMA: 1) urges the National Commission on Correctional Health Care, the American Correctional Association, and individual states to mandate adherence to the current Dietary Reference Intakes and Dietary Guidelines for Americans (with adjustments, as needed, for special populations) as a criterion for accreditation and/or standards compliance, until national dietary guidelines specific for adolescent and adult incarcerated populations becomes available; and 2) urges the Food and Nutrition Board of the Institute of Medicine to examine the nutrient status and dietary requirements of incarcerated populations and issue guidelines on menu planning for adolescent and adult incarcerated populations. CSAPH Rep. 4, A-11.

- (9) RESOLUTION 905 – SUNSCREEN DISPENSERS IN PUBLIC SPACES AS A PUBLIC HEALTH MEASURE

RECOMMENDATION A:

Resolution 905 be amended by addition to read as follows:

RESOLVED, That our American Medical Association, as part of a successful skin cancer prevention strategy, supports free public sunscreen programs that: (1) provide sunscreen that is SPF 15 or higher and broad spectrum; (2) supply the sunscreen in public spaces where the population would have a high risk of sun exposure; and (3) protect the product from excessive heat and direct sun. (New HOD Policy)

RECOMMENDATION B:**Resolution 905 be adopted as amended.****RECOMMENDATION C:****Policy H-440.839 be reaffirmed.****HOD ACTION: Resolution 905 adopted as amended and Policy H-440.839 reaffirmed.**

RESOLVED, That our American Medical Association support free public sunscreen programs in public spaces where the population would have a high risk of sun exposure. (New HOD Policy)

Your Reference Committee heard generally supportive testimony on Resolution 905. Commenters pointed to the beneficial public health impact that established free public sunscreen programs have demonstrated. It was noted that these programs enable access to sunscreen in high-traffic public areas where there is a higher risk of sun exposure. Testimony referenced the established evidence of sunscreen as a protectant from cancer causing UVA and UVB radiation from the sun. Amendments related to the SPF level and broad spectrum to strengthen the policy were suggested. Several commenters noted that improved education is necessary for the public. The AMA already has policy related to education on sun protective behavior, therefore your Reference Committee recommends reaffirmation of this policy and the adoption of Resolution 905 as amended.

H-440.839, “Protecting the Public from Dangers of Ultraviolet Radiation”

1. Our AMA encourages physicians to counsel their patients on sun-protective behavior. Tanning Parlors: Our AMA supports: (1) educational campaigns on the hazards of tanning parlors, as well as the development of local tanning parlor ordinances to protect our patients and the general public from improper and dangerous exposure to ultraviolet radiation; (2) legislation to strengthen state laws to make the consumer as informed and safe as possible; (3) dissemination of information to physicians and the public about the dangers of ultraviolet light from sun exposure and the possible harmful effects of the ultraviolet light used in commercial tanning centers; (4) collaboration between medical societies and schools to achieve the inclusion of information in the health curricula on the hazards of exposure to tanning rays; (5) the enactment of federal legislation to: (a) prohibit access to the use of indoor tanning equipment (as defined in 21 CFR 1040.20 [a][9]) by anyone under the age of 18; and (b) require a United States Surgeon General warning be prominently posted, detailing the positive correlation between ultraviolet radiation, the use of indoor tanning equipment, and the incidence of skin cancer; (6) warning the public of the risks of ultraviolet A radiation (UVA) exposure by skin tanning units, particularly the FDA’s findings warning Americans that the use of UVA tanning booths and sun beds pose potentially significant health risks to users and should be discouraged; (7) working with the FDA to ensure that state and local authorities implement legislation, rules, and regulations regarding UVA exposure, including posted warnings in commercial tanning salons and spas; (8) an educational campaign in conjunction with various concerned national specialty societies to secure appropriate state regulatory and oversight activities for tanning parlor facilities, to reduce improper and dangerous exposure to ultraviolet light by patients and general public consumers; and (9) intensified efforts to enforce current regulations. Sunscreens. Our AMA supports: (1) the development of sunscreens that will protect the skin from a broad spectrum of ultraviolet radiation, including both UVA and UVB; and (2) the labeling of sunscreen products with a standardized ultraviolet (UV) logo, inclusive of ratings for UVA and UVB, so that consumers will know whether these products protect against both types of UV radiation. Terms such as low, medium, high and very high protection should be defined depending on standardized sun protection factor level. 2. Our AMA supports sun shade structures (such as trees, awnings, gazebos and other structures providing shade) in the planning of public and private spaces, as well as in zoning matters and variances in recognition of the critical important of sun protection as a public health measure. Citation: CCB/CLRPD Rep. 3, A-14; Appended: Res. 403, A-14; Appended: Res. 404, A-19.

- (10) RESOLUTION 906 – ENSURING THE BEST IN-SCHOOL CARE FOR CHILDREN WITH SICKLE CELL DISEASE

RECOMMENDATION A:

Resolution 906 be amended by the addition of a new resolve to read as follows:

RESOLVED, That our AMA encourage the development of model school policy for best in-school care for children with sickle cell disease. (New HOD Policy);

RECOMMENDATION B:

Resolution 906 be adopted as amended.

HOD ACTION: Resolution 906 adopted as amended.

RESOLVED, That our American Medical Association support the development of an individualized sickle cell emergency care plan by physicians for in-school use, especially during sickle cell crises (New HOD Policy); and be it further

RESOLVED, That our AMA support the education of teachers and school officials on policies and protocols, encouraging best practices for children with sickle cell disease, such as adequate access to the restroom and water, physical education modifications, seat accommodations during extreme temperature conditions, access to medications, and policies to support continuity of education during prolonged absences from school, in order to ensure that they receive the best in-school care, and are not discriminated against, based on current federal and state protections. (New HOD Policy)

Your Reference Committee heard testimony largely in favor of this resolution. Testimony emphasized the importance of recognizing the health-risks for students with sickle cell disease and preventing pain crises. However, several commenters suggested that the language should encourage the development of model policy to simplify adoption by school districts and states. Therefore, your Reference Committee recommends that Resolution 906 be adopted as amended.

- (11) RESOLUTION 907 – INCREASING ACCESS TO GANG-RELATED LASER TATTOO REMOVAL IN PRISON AND COMMUNITY SETTINGS

RECOMMENDATION A:

Resolution 907 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association support increased access to removal of gang-related and human trafficking-related tattoos removal in prisons correctional facilities and community settings. (New HOD Policy)

RECOMMENDATION B:

Resolution 907 be adopted as amended.

RECOMMENDATION C:

The title of Resolution 907 be changed.

**INCREASED ACCESS TO REMOVAL OF GANG-RELATED AND
HUMAN TRAFFICKING-RELATED TATTOOS IN
CORRECTIONAL AND COMMUNITY SETTINGS**

HOD ACTION: Resolution 907 adopted as amended with change in title.

RESOLVED, That our American Medical Association support increased access to gang-related tattoo removal in prison and community settings. (New HOD Policy)

Your Reference Committee heard testimony supportive of this Resolution. It was noted that evidence shows that gang affiliation and activity are associated with poor health outcomes and recidivism. An amendment was offered to broaden the scope of this resolution to include human-trafficking-related tattoos as well as correctional facilities beyond prisons. Your Reference Committee agrees with these recommendations and also offers amendments to clarify the language. Resolution 907 should be adopted as amended with a change in title to reflect the amendments.

- (12) RESOLUTION 909 – DECREASING THE USE OF OXIMETRY
MONITORS FOR THE PREVENTION OF SUDDEN INFANT DEATH
SYNDROME

RECOMMENDATION A:

Resolution 909 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association oppose the sale and use of non-prescription oximetry monitors, to prevent sudden unexplained infant death ~~syndrome~~. (New HOD Policy)

RECOMMENDATION B:

Resolution 909 be adopted as amended.

RECOMMENDATION C:

The title of Resolution 909 be changed.

**DECREASING THE USE OF NON-PRESCRIPTION OXIMETRY
MONITORS FOR THE PREVENTION OF SUDDEN
UNEXPLAINED INFANT DEATH**

HOD ACTION: Resolution 909 adopted as amended with change in title.

RESOLVED, That our American Medical Association oppose the sale and use of oximetry monitors to prevent sudden infant death syndrome. (New HOD Policy)

Your Reference Committee heard testimony largely supportive of this resolution. It was noted that consumer pulse oximetry monitors are inconsistent and unreliable and there is no evidence that they prevent sudden unexplained infant death. Reliance on these devices may encourage parents to forgo safe sleep practices. Amendments to clarify that this policy is addressing non-prescription oximetry monitors use were presented. Your Reference Committee agrees with these amendments and recommends that Resolution 909 be adopted as amended.

(13) RESOLUTION 914 – NICOTINE REPLACEMENT THERAPY FOR MINORS

RECOMMENDATION A:

The first Resolve of Resolution 914 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association ~~seek~~ support immediate and thorough study of the use of ~~all forms of nicotine delivery as well as~~ pharmacologic and non-pharmacologic treatment strategies for tobacco use disorder and nicotine dependence resulting from the use of non-combustible and combustible tobacco products, treating nicotine addiction treatment options in populations under the age of 18 (Directive to Take Action); and be it further

RECOMMENDATION B:

The second Resolve of Resolution 914 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA support federal regulation that encourages manufacturers of ~~pharmacologic nicotine addiction treatment~~ therapy for treatment of tobacco use disorder and nicotine dependence approved for adults to examine their products' effects in populations under age 18. (Directive to Take Action)

RECOMMENDATION C:

Resolution 914 be adopted as amended.

RECOMMENDATION D:

The title of Resolution 914 be changed.

STRATEGIES FOR THE TREATMENT OF TOBACCO USE DISORDER AND NICOTINE DEPENDENCE IN POPULATIONS UNDER THE AGE OF 18

HOD ACTION: Resolution 914 adopted as amended with change in title.

RESOLVED, That our American Medical Association seek immediate and thorough study of the use of all forms of nicotine delivery, as well as all nicotine addiction treatment options in populations under the age of 18 (Directive to Take Action); and be it further

RESOLVED, That our AMA support federal regulation that encourages manufacturers of nicotine addiction treatment therapy approved for adults to examine their products' effects in populations under age 18. (Directive to Take Action)

Your Reference Committee heard testimony in strong support for prioritizing research on effective pharmacological and non-pharmacologic treatment therapies for all forms of tobacco use disorder and nicotine dependence as current products have not been studied as a method for vaping cessation and have not been approved by the FDA in populations under the age of 18. Therefore, your Reference Committee recommends that Resolution 914 be adopted as amended.

- (14) RESOLUTION 915 – PREVENTING DEATH AND DISABILITY DUE TO PARTICULATE MATTER PRODUCED BY AUTOMOBILES

RECOMMENDATION A:

Resolution 915 be amended by addition to read as follows:

RESOLVED, That our American Medical Association: (1) promote policies at all levels of society and government that educate and encourage policy makers to limit or eliminate disease causing contamination of the environment by gasoline and diesel combustion-powered automobiles, advocating for the development of alternative means for automobile propulsion and public transportation; and (2) consider submitting or joining an amicus brief in support of the individual states' of California's legal efforts to retain authority to set vehicle tailpipe emission standards that are more stringent than federal standards. (New HOD Policy)

RECOMMENDATION B:

Resolution 915 be adopted as amended.

RECOMMENDATION C:

Policy D-135.978 be reaffirmed.

HOD ACTION: Resolution 915 adopted as amended and Policy D-135.987 reaffirmed.

RESOLVED, That our American Medical Association promote policies at all levels of society and government that educate and encourage policy makers to limit or eliminate disease causing contamination of the environment by gasoline and diesel combustion-powered automobiles, advocating for the development of alternative means for automobile propulsion and public transportation. (New HOD Policy)

Your Reference Committee heard testimony that was largely in support of encouraging policy makers to limit the proven negative health impacts of particulate matter created by gasoline and diesel combustion-powered automobiles. Since this issue is actively being debated, testimony was offered requesting an amendment to empower the AMA to be a part of the ongoing efforts and potential judicial advocacy. It was noted that the AMA has existing policy on standards for particulate matter. Therefore, your Reference Committee recommends that Resolution 915 be adopted as amended and Policy D-135.978 be reaffirmed.

D-135.978, “Protective NAAQS Standard for Particulate Matter (PM 2.5 & PM 10)”

At such time as a new EPA Proposed Rule on National Ambient Air Quality Standards for Particulate Matter is published, our AMA will review the proposal and be prepared to offer its support for comments developed by the American Thoracic Society and its sister organizations. BOT action in response to referred for decision Res. 926, I-10

- (15) RESOLUTION 916 – SALE OF TOBACCO IN RETAIL PHARMACIES

RECOMMENDATION A:

Resolution 916 be amended by deletion to read as follows:

RESOLVED, That our American Medical Association ~~widely publicize opposition to pharmacies selling tobacco products, especially to minors,~~ and seek active collaboration with other healthcare professionals through their professional organizations, especially pharmacists, but

including all healthcare team members, to persuade all retailers of prescription pharmaceuticals to immediately cease selling tobacco products, with a report back at the 2020 Annual Meeting. (Directive to Take Action)

RECOMMENDATION B:

Resolution 916 be adopted as amended.

RECOMMENDATION C:

Policy D-495.994 be reaffirmed.

HOD ACTION: Resolution 916 adopted as amended and Policy D-495.994 reaffirmed.

RESOLVED, That our American Medical Association widely publicize opposition to pharmacies selling tobacco products, especially to minors, and seek active collaboration with other healthcare professionals through their professional organizations, especially pharmacists, but including all healthcare team members, to persuade all retailers of prescription pharmaceuticals to immediately cease selling tobacco products, with a report back at the 2020 Annual Meeting. (Directive to Take Action)

Your Reference Committee heard testimony that was in favor of prohibition of the sale of tobacco in retail pharmacies. The AMA currently has multiple policies, including a directive to take action, opposing the sale of tobacco products in pharmacies. This policy encourages more active collaboration with stakeholders not included in the existing policy and these actions can be captured in the AMA's annual Tobacco Report being presented to the House of Delegates in 2020. Your Reference Committee therefore recommends adopting Resolution 916 as amended.

D-495.994, "Oppose Sale of Tobacco Products in Pharmacies"

Our AMA: (1) specifically and publicly opposes the sale and marketing of tobacco products, including cigarettes, in pharmacies; (2) will communicate with appropriate federal agencies, including the Bureau of Alcohol, Tobacco, Firearms and Explosives, many public health groups, various pharmacy trade groups, and media outlets, in seeking their help in removing tobacco products, including cigarettes, from pharmacy shelves; (3) will work to pass legislation at the local, state and federal levels to accomplish the goal of banning tobacco sales in pharmacies nationwide; (4) will work with Federation members and national organizations concerned about tobacco use to develop a recognition program for pharmacies that voluntarily agree to eliminate the sale of tobacco; (5) will work with state and local medical societies to disseminate information on these recognized pharmacies to their membership; and 6) will work through its Advocacy Resource Center to provide that list to organizations interested in preventive healthcare. Sub. Res. 419, A-09; Reaffirmed in lieu of Res. 422, A-10; Reaffirmed in lieu of Res. 426, A-10; Modified in lieu of Res. 405, A-12 and Res. 420, A-12; Reaffirmation I-13

- (16) RESOLUTION 918 – BANNING FLAVORS, INCLUDING MENTHOL AND MINT, IN COMBUSTIBLE AND ELECTRONIC CIGARETTES AND OTHER NICOTINE PRODUCTS

RECOMMENDATION A:

The second Resolve in Resolution 918 be deleted.

RESOLVED, That our AMA amend Policy H-495.976, "~~Opposition to Exempting the Addition of Menthol to Cigarettes,~~" by addition and deletion as follows:

Our AMA: (1) ~~will continue to support a ban on the use and marketing of menthol in cigarettes~~ all tobacco products as a harmful additive; and

~~(2) encourages and will assist its members to seek state bans on the sale of menthol cigarettes, electronic nicotine delivery devices and other tobacco products. (Modify Current HOD Policy)~~

RECOMMENDATION B:

Resolution 918 be adopted as amended.

HOD ACTION: Resolution 918 adopted as amended.

RESOLVED, That our American Medical Association amend Policy H-495.971, “Opposition to Addition of Flavors to Tobacco Products,” by addition as follows:

Our AMA: (1) supports state and local legislation to prohibit the sale or distribution of all flavored tobacco products, including menthol, mint and wintergreen flavors; (2) urges local and state medical societies and federation members to support state and local legislation to prohibit the sale or distribution of all flavored tobacco products; and (3) encourages the FDA to prohibit the use of all flavoring agents in tobacco products, which includes electronic nicotine delivery systems as well as combustible cigarettes, cigars and smokeless tobacco (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA amend Policy H-495.976, “Opposition to Exempting the Addition of Menthol to Cigarettes,” by addition and deletion as follows:

Our AMA: (1) will continue to support a ban on the use and marketing of menthol in ~~cigarettes~~ all tobacco products as a harmful additive; and (2) encourages and will assist its members to seek state bans on the sale of menthol cigarettes, electronic nicotine delivery devices and other tobacco products. (Modify Current HOD Policy)

Your Reference Committee heard testimony that was supportive of this resolution. It was noted that this is already the position of the AMA and that the AMA has been advocating in support of banning all flavored tobacco products, including mint and menthol. Since Policy H-495.971 broadly addresses banning flavors in all tobacco products, your Reference believes that Policy H-495.976 should remained focused on combustible cigarettes. The policy on combustible cigarettes was enacted in 2008 prior to the enactment of the 2009 Family Smoking Prevention and Tobacco Control Act, which banned flavored cigarettes, but exempted menthol. While the FDA expressed its intent to ban menthol in cigarettes in 2018, no further action has occurred, and this remains an important public health issue. Therefore, your Reference Committee recommends that Resolution 918 be adopted as amended.

(17) **RESOLUTION 923 – SUPPORT AVAILABILITY OF PUBLIC TRANSIT SYSTEMS**

RECOMMENDATION A:

The first Resolve of Resolution 923 be amended by addition to read as follows:

RESOLVED, That our American Medical Association amend current policy H-135.939, “Green Initiatives and the Health Care Community,” by addition and deletion as follows:

Our AMA supports: (1) responsible waste management and clean energy production policies that minimize health risks, including the promotion of appropriate recycling and waste reduction; (2) the use of ecologically sustainable products, foods, and materials when possible; (3) the development of products that are non-toxic, sustainable, and ecologically sound; (4) building practices that help reduce resource utilization and contribute to a healthy environment; ~~and~~ (5) the establishment, expansion, and continued maintenance of affordable, accessible, barrier-free, reliable, and clean-energy public

transportation; and (6) community-wide adoption of ‘green’ initiatives and activities by organizations, businesses, homes, schools, and government and health care entities; and be it further (Modify Current HOD Policy)

RECOMMENDATION B:

The second Resolve of Resolution 923 be amended by addition to read as follows:

RESOLVED, That our American Medical Association amend current policy H-425.993, “Health Promotion and Disease Prevention,” by addition and deletion as follows:

The AMA (1) reaffirms its current policy pertaining to the health hazards of tobacco, alcohol, accidental injuries, unhealthy lifestyles, and all forms of preventable illness; (2) advocates intensified leadership to promote better health through prevention; (3) believes that preventable illness is a major deterrent to good health and accounts for a major portion of our country’s total health care expenditures; (4) actively supports appropriate scientific, educational and legislative activities that have as their goals: (a) prevention of smoking and its associated health hazards; (b) avoidance of alcohol abuse, particularly that which leads to accidental injury and death; (c) reduction of death and injury from vehicular and other accidents; and (d) encouragement of healthful lifestyles and personal living habits; ~~and~~ **(5) advocates that health be considered one of the goals in transportation planning and policy development including but not limited to the establishment, expansion, and continued maintenance of affordable, accessible, barrier-free, reliable, and preferably clean-energy public transportation; and (6) strongly emphasizes the important opportunity for savings in health care expenditures through prevention. (Modify Current HOD Policy)**

RECOMMENDATION C:

Resolution 923 be adopted as amended.

HOD ACTION: Resolution 923 adopted as amended.

RESOLVED, That our American Medical Association amend current policy H-135.939, “Green Initiatives and the Health Care Community,” by addition and deletion as follows:

Our AMA supports: (1) responsible waste management and clean energy production policies that minimize health risks, including the promotion of appropriate recycling and waste reduction; (2) the use of ecologically sustainable products, foods, and materials when possible; (3) the development of products that are non-toxic, sustainable, and ecologically sound; (4) building practices that help reduce resource utilization and contribute to a healthy environment; ~~and~~ **(5) the establishment, expansion, and continued maintenance of affordable, reliable public transportation; and (6) community-wide adoption of ‘green’ initiatives and activities by organizations, businesses, homes, schools, and government and health care entities; and be it further (Modify Current HOD Policy)**

RESOLVED, That our American Medical Association amend current policy H-425.993, “Health Promotion and Disease Prevention,” by addition and deletion as follows:

The AMA (1) reaffirms its current policy pertaining to the health hazards of tobacco, alcohol, accidental injuries, unhealthy lifestyles, and all forms of preventable illness; (2) advocates intensified leadership to

promote better health through prevention; (3) believes that preventable illness is a major deterrent to good health and accounts for a major portion of our country's total health care expenditures; (4) actively supports appropriate scientific, educational and legislative activities that have as their goals: (a) prevention of smoking and its associated health hazards; (b) avoidance of alcohol abuse, particularly that which leads to accidental injury and death; (c) reduction of death and injury from vehicular and other accidents; and (d) encouragement of healthful lifestyles and personal living habits; ~~and (5) advocates that health be considered one of the goals in transportation planning and policy development including but not limited to the establishment, expansion, and continued maintenance of affordable, reliable public transportation; and (6) strongly emphasizes the important opportunity for savings in health care expenditures through prevention.~~ (Modify Current HOD Policy)

Your Reference Committee heard unanimous testimony in support of this resolution to add public transportation to existing policy on green initiatives and health promotion. Testimony noted the need for more to be done to highlight transportation barriers and help vulnerable populations. Minor amendments were made to align the changes with existing AMA policy on climate change and note the need for transportation systems to be accessible to those with disabilities. Therefore, your Reference Committee recommends that Resolution 923 be adopted as amended.

(18) RESOLUTION 934 – GUN VIOLENCE AND MENTAL ILLNESS
STIGMA IN THE MEDIA

RECOMMENDATION A:

Resolution 934 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association amend Policy H-145.971, “Development and Implementation of Recommendations for Responsible Media Coverage of Mass Shootings,” by addition as follows:

Our AMA encourages the Centers for Disease Control and Prevention, in collaboration with other public and private organizations, to develop recommendations and/or best practices for media coverage of mass shootings, including for accurate and sensitive discussion of the purported relationship between mental illness and gun violence, including informed discussion of the limited data on the relationship between mental illness and gun violence, recognizing the potential for exacerbating stigma against individuals with mental illness. (Modify Current HOD Policy)

RECOMMENDATION B:

Resolution 934 be adopted as amended.

HOD ACTION: Resolution 934 adopted as amended.

RESOLVED, That our American Medical Association amend Policy H-145.971, “Development and Implementation of Recommendations for Responsible Media Coverage of Mass Shootings,” by addition as follows:

Our AMA encourages the Centers for Disease Control and Prevention, in collaboration with other public and private organizations, to develop recommendations or best practices for media coverage of mass shootings, including for accurate and sensitive discussion of the purported relationship between mental illness and gun violence. (Modify Current HOD Policy)

Your Reference Committee heard testimony in strong support of the spirit of this resolution and the importance that this issue be addressed. Suicide is a leading cause of preventable death in the United States and firearms are among the most lethal suicide attempt methods. The need for improved mental health services and decreased stigma related to mental health was noted. The conflation of the issues of mass shooting incidents and mental illness, and the resulting propagation of stigma was also discussed. Multiple amendments were offered to more clearly state the

intent of the resolution. Your Reference Committee agrees with the amendment to clarify the language and, therefore, recommends that Resolution 934 be adopted as amended.

RECOMMENDED FOR ADOPTION IN LIEU OF

- (19) RESOLUTION 901 – HEALTH IMPACT OF PER- AND POLYFLUOROALKYL SUBSTANCES (PFAS) CONTAMINATION IN DRINKING WATER

RESOLUTION 922 – UNDERSTANDING THE EFFECTS OF PFAS ON HUMAN HEALTH

RECOMMENDATION:

Alternate resolution 901 be adopted in lieu of Resolutions 901 and 922.

Per- and Polyfluoroalkyl Substances (PFAS) and Human Health
RESOLVED, That our American Medical Association: (1) support continued research on the impact of perfluoroalkyl and polyfluoroalkyl chemicals on human health; (2) support legislation and regulation seeking to address contamination, exposure, classification, and clean-up of PFAS substances; and (3) advocate for states, at minimum, to follow guidelines presented in the Environmental Protection Agency's Drinking Water Health Advisories for perfluorooctanoic acid (PFOA) and perfluorooctane sulfonic acid (PFOS), with consideration of the appropriate use of Minimal Risk Levels (MRLs) presented in the CDC/ATSDR Toxicological Profile for PFAS. (New HOD Policy)

HOD ACTION: Alternate resolution 901 adopted in lieu of Resolutions 901 and 922.

Resolution 901

RESOLVED, That our American Medical Association support legislation and regulation seeking to address contamination, exposure, classification, and clean-up of Per- and Polyfluoroalkyl substances. (New HOD Policy)

Resolution 922

RESOLVED, That our American Medical Association advocate for continued research on the impact of perfluoroalkyl and polyfluoroalkyl chemicals on human health (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for states to minimally follow guidelines regarding levels of perfluoroalkyl and polyfluoroalkyl chemicals recommended by the Centers for Disease Control and Prevention and the Environmental Protection Agency. (Directive to Take Action)

Your Reference Committee heard testimony in strong support of both Resolution 901 and 922. The need for continued research on the human health effects of newer “replacement” PFAS was noted. There was strong support for the language of Resolution 901, which covers legislation and regulation of PFAS, without reference to research or guidelines that may not be inclusive of newer PFAS currently in use. Additional testimony pointed out that given the long half-lives of PFAS, and their ability to spread in the environment, any current and ongoing contamination may already be difficult to clean up. Therefore, your Reference Committee recommends that an alternate resolution, which is a combination of Resolutions 901 and 922 and inclusive of proposed clarifying amendments, be adopted in lieu of Resolutions 901 and 922.

- (20) RESOLUTION 910 – BAN ON ELECTRONIC NICOTINE DELIVERY SYSTEM (ENDS) PRODUCTS

RESOLUTION 925 – SUSPENDING SALES OF VAPING PRODUCTS / ELECTRONIC CIGARETTES UNTIL FDA REVIEW

RESOLUTION 935 – AMA RESPONSE TO NATIONAL VAPING EPIDEMIC

RECOMMENDATION A:

Alternate Resolution 910 be adopted in lieu of Resolutions 910, 925, and 935.

Ban on Electronic Cigarettes and Vaping Products Not Approved by the FDA as Tobacco Cessation Products

RESOLVED, That our American Medical Association (1) urgently advocate for regulatory, legislative, and/or legal action at the federal and/or state levels to ban the sale and distribution of all e-cigarette and vaping products, with the exception of those which may be approved by the FDA for tobacco cessation purposes and made available by prescription only and (2) advocate for research funding to sufficiently study the safety and effectiveness of e-cigarette and vaping products for tobacco cessation purposes. (Directive to Take Action)

HOD ACTION: Alternate Resolution 910 adopted in lieu of Resolutions 910, 925, and 935.

Resolution 910

RESOLVED, That our American Medical Association advocate for regulatory, and/or legislative, and/or legal action at the federal and/or state levels to ban all Electronic Nicotine Delivery Systems (ENDS) products. (Directive to Take Action)

Resolution 925

RESOLVED, That our American Medical Association support regulations that would prohibit the sale of any e-cigarette or other vaping product that has not undergone U.S. Food and Drug Administration (FDA) pre-market review until the FDA completes its review and allows the products to be sold. (New HOD Policy)

Resolution 935

RESOLVED, That our American Medical Association adopt an immediate AMA declaration that the vaping epidemic has escalated, leading to life-threatening illnesses and if unchecked will become an epidemic of epic proportions, labeling it now as a National Public Health Emergency Crisis (Directive to Take Action); and be it further

RESOLVED, That our AMA, having declared vaping a Public Health Emergency Crisis, advocate for an immediate legislative ban on vaping at the national level, with a minimal duration of one year and which emulates shorter bans already in place in several states (Directive to Take Action); and be it further

RESOLVED, That during any ban on vaping, our AMA advocate for emergency government research funding, under the direction of the Centers for Disease Control and Prevention, at a level sufficient to study and combat both the nicotine addiction and the direct pulmonary toxicity from the use of electronic nicotine delivery systems (Directive to Take Action); and be it further

RESOLVED, That our AMA direct the Public Education Programs of the AMA to disseminate its own teaching materials (or those of sister organizations) to warn of the dangers of vaping. Such materials would be tailored for

specific age group blocks, beginning with the late primary school age group (Directive to Take Action); and be it further

RESOLVED, That our AMA adopt an immediate declaration and advocate for legislative action that requires the vaping industry to follow the same restrictions as the tobacco industry in direct-to-consumer advertising/marketing of their products (Directive to Take Action)

Your Reference Committee heard testimony in strong support of banning e-cigarettes and vaping products. Some supported taking the products off the market until the FDA has completed their review and approval of products through the pre-market tobacco application process. Others noted that the AMA declared the use of e-cigarettes and vaping a public health epidemic a year ago and has repeatedly urged the FDA to act. However, little has been done and we cannot keep waiting on FDA to exercise their authority.

Your Reference Committee believes that the dramatic rise in the youth use of e-cigarettes threatens to put another generation at risk of nicotine dependence. Others cautioned that banning e-cigarettes and vaping products may lead to a rise in the use of combustible tobacco products. Your Reference Committee believes that if e-cigarettes are effective at helping people quit smoking, manufacturers should pursue FDA approval as a tobacco cessation product available by prescription. Otherwise, their risks outweigh the potential benefits.

Your Reference Committee appreciates the urgency of this issue as articulated in Resolution 935, but believes that declaring this epidemic a “national public health emergency crisis” is inappropriate. Therefore, your Reference Committee recommends that alternative Resolution 910 be adopted in lieu of Resolutions 925 and 935.

(21) **RESOLUTION 913 – PUBLIC HEALTH IMPACTS AND UNINTENDED CONSEQUENCES OF LEGALIZATION AND DECRIMINALIZATION OF CANNABIS FOR MEDICINAL AND RECREATIONAL USE**

RESOLUTION 919 – RAISING AWARENESS OF THE HEALTH IMPACT OF CANNABIS

RECOMMENDATION:

Alternate Resolution 913 be adopted in lieu of Resolutions 913 and 919.

Raising Awareness of the Public Health Impact of Cannabis

RESOLVED, That our AMA encourage research on the impact of legalization and decriminalization of cannabis in an effort to promote public health and public safety (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage dissemination of information on the public health impact of legalization and decriminalization of cannabis (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for stronger public health messaging on the health effects of cannabis and cannabinoid inhalation and ingestion (Directive to Take Action); and be it further

RESOLVED, That our American Medical Association coordinate with other health organizations to develop resources on the impact of cannabis on human health and on methods for counseling and educating patients on the use cannabis and cannabinoids (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for urgent regulatory and legislative changes necessary to fund and perform research related to cannabis and cannabinoids (Directive to Take Action).

RESOLVED, That our AMA create a Cannabis Task Force to evaluate and disseminate relevant scientific evidence to health care providers and the public.

HOD ACTION: Alternate Resolution 913 adopted as amended in lieu of Resolutions 913 and 919 and new Resolved below referred.

RESOLVED, That our AMA amend policy H-95.924, “Cannabis Legalization for Recreational Use,” by addition and deletion to read as follows:

Cannabis Legalization of Cannabis Use for Medical or Any Other Purposes ~~or Recreational Use~~ H-95.924

Our AMA: (1) ~~believes~~ warns that use of cannabis and cannabinoids can be a threat to health when inhaled or ingested; (2) advocates that cannabis and cannabinoids use are ~~is a dangerous drug and as such is~~ a serious public health concern; (23) ~~believes that~~ warns against the legalized use and sale of cannabis and cannabinoids ~~for recreational use should not be legalized purposes,~~ due to their potential negative impact on human health; (34) ~~discourages~~ warns against cannabis and cannabinoid use ~~for recreational purposes, especially by persons vulnerable to the drug’s effects and in high-risk populations such as youth, children, adolescents and young adults,~~ pregnant women, and women who are breastfeeding; (45) ~~believes~~ strongly advocates that states that have already legalized cannabis use ~~(for medical purposes or any other purposes recreational use or both)~~ should be required to take steps to regulate ~~the product~~ cannabis and cannabinoids effectively in order to protect public health and safety and that laws and regulations related to legalized cannabis use should consistently be evaluated to determine their effectiveness; (56) strongly encourages local, state, and federal public health agencies to improve surveillance efforts to ensure data is available on the short- and long-term health effects of cannabis and cannabinoid use; and (67) supports decriminalization and public health based strategies, rather than incarceration, in the handling of individuals possessing cannabis or cannabinoids for personal use. (Modify Current HOD Policy)

Resolution 913

RESOLVED, That our American Medical Association work with interested organizations to collate existing worldwide data on the public health impacts, societal impacts, and unintended consequences of legalization and/or decriminalization of cannabis for recreational and medicinal use, with a report back at the 2020 Interim Meeting (Directive to Take Action); and be it further

RESOLVED, That our AMA continue to encourage research on the unintended consequences of legalization and decriminalization of cannabis for recreational and medicinal use in an effort to promote public health and public safety (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage dissemination of information on the public health impacts of legalization and decriminalization of cannabis for recreational and medicinal use, with consideration of making links to that information available on the AMA website (Directive to Take Action); and be it further

RESOLVED, That our AMA work with interested organizations to lobby Congress to allow more sites to conduct research on the risks and benefits of cannabinoid products. (Directive to Take Action)

Resolution 919

RESOLVED, That our American Medical Association coordinate with other health organizations to develop medical resources on the known and anticipated impact of cannabis on human health and on methods for counseling and educating patients who use cannabis and cannabinoids (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for stronger public health messaging on the negative effects of cannabis and cannabinoid inhalation and ingestion (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for urgent regulatory changes necessary to fund and perform research related to cannabis and cannabinoids (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for minimum purchasing age for cannabis products of at least 21 years old (Directive to Take Action); and be it further

RESOLVED, That our AMA continue to use the term “cannabis” in our policies when referencing cannabis plants, and “cannabis derivatives” or “cannabinoids” when referencing their natural chemical derivatives, but will include the term “marijuana” in physician and public education messaging and materials to improve health literacy (Directive to Take Action); and be it further

RESOLVED, That our AMA amend policy H-95.924, “Cannabis Legalization for Recreational Use,” by addition and deletion to read as follows:

Cannabis Legalization for Recreational Use H-95.924

Our AMA: (1) ~~believes warns~~ that cannabis and cannabinoids can be a threat to health when inhaled or ingested; (2) advocates that cannabis and cannabinoids are ~~is a dangerous drug and as such is~~ a serious public health concern; (23) ~~believes that warns against the~~ legalized use and sale of cannabis and cannabinoids for recreational use ~~should not be legalized~~ purposes, due to their negative impact on human health; (34) ~~discourages warns against~~ cannabis and cannabinoid use for recreational purposes, especially by persons vulnerable to the drug’s effects and in high-risk populations such as youth, children and young adults, pregnant women, and women who are breastfeeding; (45) ~~believes strongly advocates that~~ states that have already legalized cannabis (for medical or recreational use or both) should be required to take steps to regulate the product cannabis and cannabinoids effectively in order to protect public health and safety and that laws and regulations related to legalized cannabis use should consistently be evaluated to determine their effectiveness; (56) ~~strongly~~ encourages local, state, and federal public health agencies to improve surveillance efforts to ensure data is available on the short- and long-term health effects of cannabis and cannabinoid use; and (67) supports public health based strategies, rather than incarceration, in the handling of individuals possessing cannabis or cannabinoids for personal use. (Modify Current HOD Policy)

Your Reference Committee heard testimony that was supportive of these resolutions and encourage action on these issues now due to the rapidly changing legal landscape across the country and the need for guidance. The Council on Science and Public Health testified that they are currently working on an updated report on cannabis for the presentation to the HOD at the A-20 meeting. Given this pending report, your Reference Committee believes that an additional report at I-20 is unnecessary. The Council supported referral of these resolutions for inclusion in their report. Your Reference Committee agreed that referral was appropriate, but wanted to provide policy for advocacy purposes in the meantime. Your Reference Committee recommends that this alternate resolution be adopted in lieu of Resolutions 913 and 919.

(22) RESOLUTION 930 – ORIGIN OF PRESCRIPTION MEDICATION
PRODUCTION TRANSPARENCY

RESOLUTION 932 – SOURCE AND QUALITY OF MEDICATIONS
CRITICAL TO NATIONAL HEALTH AND SECURITY

RECOMMENDATION:

Resolution 932 be adopted in lieu of Resolution 930.

HOD ACTION: Resolution 932 adopted in lieu of Resolution 930.

Resolution 930

RESOLVED, that our American Medical Association advocate to Congress to support national legislation to make it a requirement that the identity of the manufacturer(s) and the country (countries) of origin of the components of prescription medications be included on the label of the container dispensed to a patient, including generic medications. (New HOD Policy)

Resolution 932

RESOLVED, that our American Medical Association (AMA) support studies that identify the extent to which the United States is dependent on foreign supplied pharmaceuticals and chemical substrates (New HOD Policy); and be it further

RESOLVED, that our AMA support legislative and regulatory initiatives that help to ensure proper domestic capacity, production and quality of pharmaceutical and chemical substrates as a matter of public well-being and national security (New HOD Policy); and be it further

RESOLVED, that our AMA encourage the development and enforcement of standards that make the sources of pharmaceuticals and their chemical substrates used in the United States of America transparent to prescribers and the general public. (New HOD Policy)

Your Reference Committee heard testimony largely in support of the intent of these Resolutions. Significant testimony also noted frustration with transparency related to the drug supply chain. Many commenters noted their support for the language of Resolution 932 and noted the urgency associated with this problem. It was also stated that legislation is currently being deliberated related to the issues in Resolution 932 and the adoption of this policy should empower the AMA to be engaged in the deliberations. Your Reference Committee therefore recommends that Resolution 932 be adopted in lieu of Resolution 930.

RECOMMENDED FOR REFERRAL FOR DECISION**(23) RESOLUTION 926 – SCHOOL RESOURCE OFFICER
QUALIFICATIONS AND TRAINING****RECOMMENDATION A:**

The first Resolve of Resolution 926 be adopted.

RECOMMENDATION B:

The second Resolve of Resolution 926 be adopted.

RECOMMENDATION C:

The third Resolve of Resolution 926 be referred for decision.

HOD ACTION:

- **The first Resolve of Resolution 926 adopted**
- **The second Resolve of Resolution 926 adopted**
- **The third Resolve of Resolution 926 referred for decision**

RESOLVED, That our American Medical Association (AMA) encourage an evaluation of existing national standards (and legislation, if necessary) to have qualifications by virtue of training and certification that includes child psychology and development, restorative justice, conflict resolution, crime awareness, implicit/explicit biases, diversity inclusion, cultural humility, and individual and institutional safety and others deemed necessary for school resource officers (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage the development of policies that foster the best environment for learning through protecting the health and safety of those in school, including students, teachers, staff and visitors (New HOD Policy); and be it further

RESOLVED, That our AMA encourage mandatory reporting of de-escalation procedures by school resource officers and tracking of student demographics of those reprimanded to identify areas of implicit bias. (Directive to Take Action)

Testimony was supportive of the concepts noted in this resolution and the need for training of school resource officers. There was confusion regarding the intent of the third Resolve, asking for mandatory reporting of de-escalation procedures by school resource officers. It is unclear who is required to report and to whom. Therefore, your Reference Committee recommends that Resolves one and two be adopted and Resolve three be referred for decision.

RECOMMENDED FOR NOT ADOPTION

- (24) RESOLUTION 908 – REQUEST FOR BENZODIAZEPINE-SPECIFIC PRESCRIBING GUIDELINES FOR PHYSICIANS

RECOMMENDATION:

Resolution 908 be not be adopted.

HOD ACTION: Resolution 908 not adopted.

RESOLVED, That our American Medical Association support the creation of national benzodiazepine-specific prescribing guidelines for physicians. (New HOD Policy)

Your Reference Committee heard mixed and passionate testimony on this resolution. Those in support noted the importance of the issue and the lack of guidance for physicians and other health care providers. Those opposed noted the possibility of unintended consequences that could arise from national guidelines similar to those that have emerged after the release of national opioid prescribing guidelines. Additional testimony noted the need for educational resources for physicians related to safe and effective prescribing of benzodiazepines. The nuance of prescribing these medications for a large variety of reasons was passionately discussed; many noted that prescribing benzodiazepines is very patient-specific, the patient-physician relationship is of paramount importance, and any national guideline could not adequately outline the details necessary for every medical specialty. Some testimony called for referral for the AMA to develop guidelines. The Council on Science and Public Health noted that writing of guidelines is outside of their scope and the scope of the AMA. The Council also commented that referral will not accomplish the intended goal of the resolution because national guidelines are not feasible or practical. For all of these reasons, your Reference Committee recommends that Resolution 908 not be adopted.

- (25) RESOLUTION 917 – SUPPORTING RESEARCH INTO THE THERAPEUTIC POTENTIAL OF PSYCHEDELICS

RESOLUTION 933 – SUPPORTING RESEARCH INTO THE THERAPEUTIC POTENTIAL OF PSYCHEDELICS

RECOMMENDATION:

Resolutions 917 and 933 not be adopted.

HOD ACTION: Resolutions 917 and 933 not adopted.

Resolution 917

RESOLVED, That our American Medical Association call for the status of psychedelics as Schedule I substances be reclassified into a lower schedule class with the goal of facilitating clinical research and developing psychedelic-based medicines (Directive to Take Action); and be it further

RESOLVED, That our AMA explicitly support and promote research into the therapeutic potential of psychedelics to help make a more conducive environment for research, given the high regulatory and cultural barriers (Directive to Take Action); and be it further

RESOLVED, That our AMA support and promote research to determine the benefits and adverse effects of long-term psychedelic use. (Directive to Take Action)

Resolution 933

RESOLVED, That our American Medical Association work to establish a waiver process for psychedelics as Schedule 1 substances with the goal of facilitating clinical research. (Directive to Take Action)

Your Reference Committee largely heard testimony opposing the rescheduling of psychedelic drugs. Testimony noted that a drug must have an accepted medical use in the United States to be placed into a schedule other than Schedule I. To change the schedule of these drugs before medical use is established is premature and dangerous.

Testimony in support of this resolve emphasized the need for research on the therapeutic potential of psychedelics. The Council on Science and Public Health noted in testimony that research can, in fact, be conducted on Schedule I drugs and psychedelic compounds has been, and continues to be, an active and robust area of pharmaceutical research. As of December 2017, more than 590 researchers were registered with DEA to study Schedule I substances. Every researcher who has submitted a valid research proposal has been approved. Additionally, several commenters noted that the category of “psychedelics” is too vague and is not a category specifically mentioned in the Controlled Substances Act. Given that research on psychedelics is already enabled with Schedule I classification, your Reference committee therefore recommends that Resolutions 917 and 933 not be adopted.

(26) RESOLUTION 920 – MAINTAINING PUBLIC FOCUS ON LEADING CAUSES OF NICOTINE-RELATED DEATH

RECOMMENDATION:

Resolution 920 not be adopted.

HOD ACTION: Resolution 920 not adopted.

RESOLVED, That in public statements on nicotine issues, and in discussions with government officials, our AMA seek every reasonable opportunity to remind the American public about (1) the massive ongoing death toll from combustible cigarettes; (2) the large and solidly demonstrated death toll from environmental tobacco smoke; and (3) the ongoing need for every smoker to find the best possible way to achieve and maintain abstinence from combustible cigarettes. (Directive to Take Action)

Your Reference Committee heard testimony that was mostly in opposition to this resolution. While smoking is the leading cause of preventable death, adopting a policy calling on the AMA to reference combustible products in any public statements or government meetings on nicotine products is unnecessary and could limit the AMA’s ability to effectively advocate and communicate on e-cigarettes, vaping, or other nicotine products. Both the Council on Science and Public Health and the Council on Legislation testified in opposition to this resolution. In addition, the AMA has existing policy addressing smoking as a major health hazard. Your Reference Committee recommends that Resolution 920 not be adopted.

H-490.917, “Physician Responsibilities for Tobacco Cessation”

Cigarette smoking is a major health hazard and a preventable factor in physicians’ actions to maintain the health of the public and reduce the high cost of health care. Our AMA takes a strong stand against smoking and favors aggressively pursuing all avenues of educating the general public on the hazards of using tobacco products and the continuing high costs of this serious but preventable problem. Additionally, our AMA supports and advocates for appropriate surveillance approaches to measure changes in tobacco consumption, changes in tobacco-related morbidity and mortality, youth uptake of tobacco use, and use of alternative nicotine delivery systems. In view of the continuing and urgent need to assist individuals in smoking cessation, physicians, through their professional associations, should assume a leadership role in establishing national policy on this topic and assume the primary task of educating the public and their patients about the danger of tobacco use (especially cigarette smoking). Accordingly, our AMA: (1) encourages physicians to refrain from engaging directly in the commercial production or sale of tobacco products; (2) supports (a) development of an anti-smoking package program for medical societies; (b) making patient educational and motivational materials and programs on smoking cessation available to physicians; and (c) development and promotion of a consumer health-awareness smoking cessation kit for all segments of society, but especially for youth; (3) encourages physicians to use practice guidelines for the treatment of patients with nicotine dependence and will cooperate with the Agency for Health Research and Quality (AHRQ) in disseminating and implementing evidence-based clinical practice guidelines on smoking cessation, and on other matters related to tobacco and health; (4) (a) encourages physicians to use smoking cessation activities in their practices including (i) quitting smoking and urging their colleagues to quit; (ii) inquiring of all patients at every visit about their smoking habits (and their use of smokeless tobacco as well); (iii) at every visit, counseling those who smoke to quit smoking and eliminate the use of tobacco in all forms; (iv) prohibiting all smoking in the office by patients, physicians, and office staff; and discouraging smoking in hospitals where they work (v) providing smoking cessation pamphlets in the waiting room; (vi) becoming aware of smoking cessation programs in the community and of their success

rates and, where possible, referring patients to those programs; (b) supports the concept of smoking cessation programs for hospital inpatients conducted by appropriately trained personnel under the supervision of a physician; (5) (a) supports efforts to identify gaps, if any, in existing materials and programs designed to train physicians and medical students in the behavior modification skills necessary to successfully counsel patients to stop smoking; (b) supports the production of materials and programs which would fill gaps, if any, in materials and programs to train physicians and medical students in the behavior modification skills necessary to successfully counsel patients to stop smoking; (c) supports national, state, and local efforts to help physicians and medical students develop skills necessary to counsel patients to quit smoking; (d) encourages state and county medical societies to sponsor, support, and promote efforts that will help physicians and medical students more effectively counsel patients to stop smoking; (e) encourages physicians to participate in education programs to enhance their ability to help patients quit smoking; (f) encourages physicians to speak to community groups about tobacco use and its consequences; and (g) supports providing assistance in the promulgation of information on the effectiveness of smoking cessation programs; (6) (a) supports the concept that physician offices, clinics, hospitals, health departments, health plans, and voluntary health associations should become primary sites for education of the public about the harmful effects of tobacco and encourages physicians and other health care workers to introduce and support healthy lifestyle practices as the core of preventive programs in these sites; and (b) encourages the development of smoking cessation programs implemented jointly by the local medical society, health department, and pharmacists; and (7) (a) believes that collaborative approaches to tobacco treatment across all points of contact within the medical system will maximize opportunities to address tobacco use among all of our patients, and the likelihood for successful intervention; and (b) supports efforts by any appropriately licensed health care professional to identify and treat tobacco dependence in any individual, in the various clinical contexts in which they are encountered, recognizing that care provided in one context needs to take into account other potential sources of treatment for tobacco use and dependence. CSA Rep. 3, A-04Appended: Res. 444, A-05Reaffirmed: BOT Rep. 8, A-08Reaffirmed in lieu of Res. 912, I-12Reaffirmed: CSAPH Rep. 05, A-18.

(27) RESOLUTION 921 – VAPING IN NEW YORK STATE AND NATIONALLY

RECOMMENDATION:

Resolution 921 not be adopted.

HOD ACTION: Resolution 921 not adopted.

RESOLVED, That our American Medical Association cooperate with the Medical Society of the State of New York (MSSNY) to express our gratitude to New York Governor Andrew Cuomo and Commissioner of the Department of Health Howard Zucker, MD for their prompt action to protect patients by banning the sale of flavored e cigarettes; and be it further

RESOLVED, That our AMA cooperate with MSSNY to express our gratitude to Governor Cuomo and Health Commissioner Zucker for their advice to consumers to avoid vaporization of medical marijuana available under the New York State medical marijuana program; and be it further

RESOLVED, That our AMA cooperate with MSSNY to recommend to Governor Cuomo, Commissioner Zucker, and New York State Legislators, and in conjunction with other State Medical Societies other State Executives, Health Commissioners and Legislatures to take further action to protect consumers from exposure to vaporized products with a moratorium on dispensing of vaporized products to new certificate holders for medical marijuana until data on the long term safety

RESOLVED, That our AMA cooperate with MSSNY to recommend that state and federal representatives work to reschedule marijuana and its' component substances to Schedule II controlled substance to reduce barriers to further study on the efficacy and harms of various marijuana products. (Directive to Take Action)

Your Reference Committee heard limited testimony on this resolution. It was noted that the AMA has already taken action to address several of the asks included in this resolution. For example, the AMA sent a letter to the Governor of New York, as well as other Governors, applauding their efforts to ban flavored e-cigarettes. In terms of the asks

addressing cannabis, it should be noted that the Council on Science and Public Health is working on a report on this issue due back to the House of Delegates at A-20. Amended language from the authors that significantly departed from the proposed resolution was offered with minimal opportunity for review. Your Reference Committee recommends that if the authors feel strongly about the substitute language they should resubmit a resolution at Annual 2020. Therefore, your Reference Committee recommends that Resolution 921 not be adopted.

(28) RESOLUTION 924 – UPDATE SCHEDULED MEDICATION CLASSIFICATION

RECOMMENDATION:

Resolution 924 not be adopted.

HOD ACTION: Resolution 924 not adopted.

RESOLVED, That our American Medical Association amend current policy D-120.979, “DEA Regulations and the Ability of Physicians to Prescribe Controlled Medication Rationally, Safely, and Without Undue Threat of Prosecution,” by addition as follows:

Our AMA supports ongoing constructive dialogue between the DEA and clinicians, including physicians, regarding: (1) a proper balance between the needs of patients for treatment and the needs of the government to provide oversight and regulation to minimize risks to public health and safety and (2) potential changes to the controlled substances schedules to make it easier to differentiate opioid containing controlled substances from non-opioid controlled substances within each schedule. (Modify Current HOD Policy)

Your Reference Committee heard very limited testimony on this resolution, and most of it was in opposition. The Council on Science and Public Health noted that two drug schedules currently distinguish narcotics (opioids) from non-narcotic drugs, Schedule II/IIN and Schedule III/IIIN. The “N” designation indicates a non-narcotic drug. Since the ask of this resolution is already a part of the Controlled Substances Act and DEA drug classification, your Reference Committee recommends that Resolution 924 not be adopted.

(29) RESOLUTION 929 – REGULATING MARKETING AND DISTRIBUTION OF TOBACCO PRODUCTS AND VAPING-RELATED PRODUCTS

RECOMMENDATION:

Resolution 929 not be adopted.

HOD ACTION: Resolution 929 not adopted.

RESOLVED, That our American Medical Association (AMA) support strict marketing standards to prevent all nicotine-related products from being marketed to, or attractive to, children, adolescents, and young adults, including but not limited to the following measures:

- Banning print advertising except in adult-only publications or media (adults are >85% of audience).
- Banning advertising and/or sponsorship at stadiums, concerts, sporting or other public events that are not primarily targeted to adults.
- Banning offers of any school or college scholarships by any company selling tobacco products.
- Banning television advertising of any tobacco products, including any vapor products.
- Banning advertising, marketing and sale of tobacco products that:
 - Uses the terms “candy” or “candies” or variants in spelling, such as “kandy” or “kandeez,” “bubble gum,” “cotton candy,” and “gummi bear”, and “milkshake.”
 - Uses the terms “cake” or “cakes” or variants such as “cupcake.
 - Uses packaging, trade dress or trademarks that imitate those of food or other products primarily targeted to minors such as candy, cookies, juice boxes or soft drinks.
 - Uses packaging that contains images of food products primarily targeted to minors such as juice boxes, soft drinks, soda pop, cereal, candy, or desserts.

- Imitates a consumer product designed or intended primarily for minors
- Uses cartoons or cartoon characters.
- Uses images or references to superheroes.
- Uses any likeness to images, characters, or phrases that are known to appeal primarily to minors, such as “unicorn”.
- Uses a video game, movie, video, or animated television show known to appeal primarily to minors.
- Banning advertising and marketing of tobacco products, including vapor products, that:
 - Does not accurately represent the ingredients contained in the products.
 - Uses contracted spokespersons or individuals that do not appear to be at least 25 years of age.
- Banning advertising on outdoor billboards near schools and playgrounds.
- Requiring labels to include warnings protecting youth such as “Sales to Minors Prohibited” or “Underage Sales Prohibited” and/or “Keep Out of Reach of Children”.
- Requiring all advertising to be accurate and not misleading (New HOD Policy); and be it further

RESOLVED, That our AMA support the use of the most up-to-date and effective technology for verifying the age of would-be purchasers of tobacco products and vaping-related products, both online and in bricks-and-mortar retail outlets (New HOD Policy); and be it further

RESOLVED, That our AMA oppose sales of tobacco products or vaping-related products on any third-party marketplace such as Alibaba, Amazon, eBay, et al, where the third-party marketplace does not take full responsibility for verifying age; blocking unregulated cannabis and THC products; identifying and prohibiting all counterfeit products; and forbidding packaging and other materials that allow illicit sales of any tobacco product (New HOD Policy); and be it further

RESOLVED, That our AMA support licensing and frequent inspections of all retail outlets selling any tobacco products or vaping-related products, with loss of license for repeated violations (e.g., three violations in a three year period) (New HOD Policy); and be it further

RESOLVED, That our AMA support limitations on the concentration, chemical form, and vehicle chemistry of all nicotine-related products, with special attention to the European product standards which seem to lead to much lower addictiveness than many of the ENDS products sold in the USA (New HOD Policy); and be it further

RESOLVED, That our AMA support a ban on all self-service displays of tobacco products, which would require all tobacco products and vaping-related products to be behind a counter or in a locked display and accessible only to a store employee (New HOD Policy); and be it further

RESOLVED, That our AMA support a ban on sales of all tobacco products and vaping-related products except in stores that display signage indicating that (a) “Unaccompanied Minors Are Not Allowed on Premises” or (b) “Products are Not for Sale to Minors” or (c) “Underage Sale Prohibited”, and that enforce these rules consistently (New HOD Policy); and be it further

RESOLVED, That our AMA support a ban on “straw man” sellers, which would make it illegal for any person who is not a licensed tobacco product dealer or vaping-related product dealer to sell, barter for, or exchange any tobacco product or vaping-related products (New HOD Policy); and be it further

RESOLVED, That our AMA support legislation that would discourage “straw man” distribution by prohibiting the retail sale of quantities likely intended for more than one consumer, such as the retail sale to one customer of (a) more than two electronic-cigarette or vape devices; (b) more than five standard packages of e-liquids; (c) more than 20 packs of cigarettes; or (d) similarly determined quantities of other tobacco products and/or vaping-related products. (New HOD Policy)

Testimony noted that the AMA already has existing policy addressing both the advertising and marketing of e-cigarette products as well as their sale and distribution. Both the Council on Science and Public Health and the Council on Legislation testified in opposition to this resolution as it would limit the AMA’s advocacy efforts and, in some instances, would weaken our existing policies (i.e., internet sales and nicotine standards). A substitute was offered that dramatically altered the original resolution. Given the limited opportunity to review and discuss the

newly proposed language, your Reference Committee believes the most appropriate course of action is to not adopt Resolution 929.

H-495.984, “Tobacco Advertising and Media”

Our AMA: (1) in keeping with its long-standing objective of protecting the health of the public, strongly supports a statutory ban on all advertising and promotion of tobacco products; (2) as an interim step toward a complete ban on tobacco advertising, supports the restriction of tobacco advertising to a “generic” style, which allows only black-and-white advertisements in a standard typeface without cartoons, logos, illustrations, photographs, graphics or other colors; (3) (a) recognizes and condemns the targeting of advertisements for cigarettes and other tobacco products toward children, minorities, and women as representing a serious health hazard; (b) calls for the curtailment of such marketing tactics; and (c) advocates comprehensive legislation to prevent tobacco companies or other companies promoting look-alike products designed to appeal to children from targeting the youth of America with their strategic marketing programs; (4) supports the concept of free advertising space for anti-tobacco public service advertisements and the use of counter-advertising approved by the health community on government-owned property where tobacco ads are posted; (5) (a) supports petitioning appropriate government agencies to exercise their regulatory authority to prohibit advertising that falsely promotes the alleged benefits and pleasures of smoking as well worth the risks to health and life; and (b) supports restrictions on the format and content of tobacco advertising substantially comparable to those that apply by law to prescription drug advertising; (6) publicly commends those publications that have refused to accept cigarette advertisements and supports publishing annually, via JAMA and other appropriate publications, a list of those magazines that have voluntarily chosen to decline tobacco ads, and circulation of a list of those publications to every AMA member; (7) urges physicians to mark the covers of magazines in the waiting area that contain tobacco advertising with a disclaimer saying that the physician does not support the use of any tobacco products and encourages physicians to substitute magazines without tobacco ads for those with tobacco ads in their office reception areas; (8) urges state, county, and specialty societies to discontinue selling or providing mailing lists of their members to magazine subscription companies that offer magazines containing tobacco advertising; (9) encourages state and county medical societies to recognize and express appreciation to any broadcasting company in their area that voluntarily declines to accept tobacco advertising of any kind; (10) urges the 100 most widely circulating newspapers and the 100 most widely circulating magazines in the country that have not already done so to refuse to accept tobacco product advertisements, and continues to support efforts by physicians and the public, including the use of written correspondence, to persuade those media that accept tobacco product advertising to refuse such advertising; (11) (a) supports efforts to ensure that sports promoters stop accepting tobacco companies as sponsors; (b) opposes the practice of using athletes to endorse tobacco products and encourages voluntary cessation of this practice; and (c) opposes the practice of tobacco companies using the names and distinctive hallmarks of well-known organizations and celebrities, such as fashion designers, in marketing their products; (12) will communicate to the organizations that represent professional and amateur sports figures that the use of all tobacco products while performing or coaching in a public athletic event is unacceptable. Tobacco use by role models sabotages the work of physicians, educators, and public health experts who have striven to control the epidemic of tobacco-related disease; (13) (a) encourages the entertainment industry, including movies, videos, and professional sporting events, to stop portraying the use of tobacco products as glamorous and sophisticated and to continue to de-emphasize the role of smoking on television and in the movies; (b) will aggressively lobby appropriate entertainment, sports, and fashion industry executives, the media and related trade associations to cease the use of tobacco products, trademarks and logos in their activities, productions, advertisements, and media accessible to minors; and (c) advocates comprehensive legislation to prevent tobacco companies from targeting the youth of America with their strategic marketing programs; and (14) encourages the motion picture industry to apply an “R” rating to all new films depicting cigarette smoking and other tobacco use. CSA Rep. 3, A-04; Appended: Res. 427, A-04; Reaffirmation A-05; Reaffirmation A-14

H-495.986, “Sales and Distribution of Tobacco Products and Electronic Nicotine Delivery Systems (ENDS) and E-cigarettes”

Our AMA: (1) recognizes the use of e-cigarettes and vaping as an urgent public health epidemic and will actively work with the Food and Drug Administration and other relevant stakeholders to counteract the marketing and use of addictive e-cigarette and vaping devices, including but not limited to bans and strict restrictions on marketing to minors under the age of 21; (2) encourages the passage of laws, ordinances and

regulations that would set the minimum age for purchasing tobacco products, including electronic nicotine delivery systems (ENDS) and e-cigarettes, at 21 years, and urges strict enforcement of laws prohibiting the sale of tobacco products to minors; (3) supports the development of model legislation regarding enforcement of laws restricting children's access to tobacco, including but not limited to attention to the following issues: (a) provision for licensure to sell tobacco and for the revocation thereof; (b) appropriate civil or criminal penalties (e.g., fines, prison terms, license revocation) to deter violation of laws restricting children's access to and possession of tobacco; (c) requirements for merchants to post notices warning minors against attempting to purchase tobacco and to obtain proof of age for would-be purchasers; (d) measures to facilitate enforcement; (e) banning out-of-package cigarette sales ("loosies"); and (f) requiring tobacco purchasers and vendors to be of legal smoking age; (4) requests that states adequately fund the enforcement of the laws related to tobacco sales to minors; (5) opposes the use of vending machines to distribute tobacco products and supports ordinances and legislation to ban the use of vending machines for distribution of tobacco products; (6) seeks a ban on the production, distribution, and sale of candy products that depict or resemble tobacco products; (7) opposes the distribution of free tobacco products by any means and supports the enactment of legislation prohibiting the disbursement of samples of tobacco and tobacco products by mail; (8) (a) publicly commends (and so urges local medical societies) pharmacies and pharmacy owners who have chosen not to sell tobacco products, and asks its members to encourage patients to seek out and patronize pharmacies that do not sell tobacco products; (b) encourages other pharmacists and pharmacy owners individually and through their professional associations to remove such products from their stores; (c) urges the American Pharmacists Association, the National Association of Retail Druggists, and other pharmaceutical associations to adopt a position calling for their members to remove tobacco products from their stores; and (d) encourages state medical associations to develop lists of pharmacies that have voluntarily banned the sale of tobacco for distribution to their members; and (9) opposes the sale of tobacco at any facility where health services are provided; and (10) supports that the sale of tobacco products be restricted to tobacco specialty stores. CSA Rep. 3, A-04; Appended: Res. 413, A-04; Reaffirmation A-07; Amended: Res. 817, I-07; Reaffirmation A-08; Reaffirmation I-08; Reaffirmation A-09; Reaffirmation I-13; Reaffirmation A-14; Reaffirmation I-14; Reaffirmation A-15; Modified in lieu of Res. 421, A-15; Modified in lieu of Res. 424, A-15; Reaffirmation I-16; Appended: Res. 926, I-18

H-495.988, "FDA Regulation of Tobacco Products"

1. Our AMA: (A) acknowledges that all tobacco products (including but not limited to, cigarettes, smokeless tobacco, chewing tobacco, and hookah/water pipe tobacco) are harmful to health, and that there is no such thing as a safe cigarette; (B) recognizes that currently available evidence from short-term studies points to electronic cigarettes as containing fewer toxicants than combustible cigarettes, but the use of electronic cigarettes is not harmless and increases youth risk of using combustible tobacco cigarettes; (C) encourages long-term studies of vaping (the use of electronic nicotine delivery systems) and recognizes that complete cessation of the use of tobacco and nicotine-related products is the goal; (D) asserts that tobacco is a raw form of the drug nicotine and that tobacco products are delivery devices for an addictive substance; (E) reaffirms its position that the Food and Drug Administration (FDA) does, and should continue to have, authority to regulate tobacco products, including their manufacture, sale, distribution, and marketing; (F) strongly supports the substance of the August 1996 FDA regulations intended to reduce use of tobacco by children and adolescents as sound public health policy and opposes any federal legislative proposal that would weaken the proposed FDA regulations; (G) urges Congress to pass legislation to phase in the production of reduced nicotine content tobacco products and to authorize the FDA have broad-based powers to regulate tobacco products; (H) encourages the FDA and other appropriate agencies to conduct or fund research on how tobacco products might be modified to facilitate cessation of use, including elimination of nicotine and elimination of additives (e.g., ammonia) that enhance addictiveness; and (I) strongly opposes legislation which would undermine the FDA's authority to regulate tobacco products and encourages state medical associations to contact their state delegations to oppose legislation which would undermine the FDA's authority to regulate tobacco products. 2. Our AMA: (A) supports the US Food and Drug Administration (FDA) as it takes an important first step in establishing basic regulations of all tobacco products; (B) strongly opposes any FDA rule that exempts any tobacco or nicotine-containing product, including all cigars, from FDA regulation; and (C) will join with physician and public health organizations in submitting comments on FDA proposed rule to regulate all tobacco products. 3. Our AMA: (A) will continue to monitor the FDA's progress towards establishing a low nicotine product standard for tobacco products and will submit comments on the proposed rule that are in line with the

current scientific evidence and (B) recognizes that rigorous and comprehensive post-market surveillance and product testing to monitor for unintended tobacco use patterns will be critical to the success of a nicotine reduction policy. CSA Rep. 3, A-04; Reaffirmed: BOT Rep. 8, A-08; Appended: Res. 234, A-12; Reaffirmation A-13; Modified: Res. 402, A-13; Modified: Speakers Rep., A-14; Appended: Res. 420, A-14; Reaffirmation A-15; Modified: CSAPH Rep. 05, A-18; Reaffirmed in lieu of: Res. 412, A-19; Modified: CSAPH Rep. 03, A-19