AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION
(November 2020)

Report of the Medical Student Section Reference Committee

Sarah Mae Smith, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Resolution 018 – Gender-Neutral Language in AMA Policy
2. Resolution 023 – Decreasing Youth Access to E-Cigarettes
3. Resolution 031 – Supporting the Availability of Closed Caption in Medical Education
4. Resolution 033 – Addressing Informal Milk Sharing
5. Resolution 039 – Supporting HIPAA Coverage of Patient's Mobile Health Data
6. Resolution 040 – Support for the Establishment of Medical-Legal Partnerships
7. Resolution 042 – Expanding the Definition of Iatrogenic Infertility to Include Gender Affirming Interventions
8. Resolution 048 – Support for Vote-by-Mail
9. Resolution 055 – Reducing Complexity in the Public Service Loan Forgiveness Program
10. Resolution 067 – Research the Ability of Two-Interval Grading of Clinical Clerkships to Minimize Racial Bias in Medical Education
11. Resolution 082 – Amendment to Food Environments and Challenges Accessing Healthy Food, H-150.925
12. Resolution 083 – Improving Labeling of Over-the-Counter Medications by Including Carbohydrate Content
13. Resolution 095 – Equal Access to Adoption for the LGBTQ Community
14. Resolution 099 – Television Broadcast and Online Streaming of LGBTQ+ Inclusive Sexual Encounters and Public Health Awareness on Social Media Platforms
15. Resolution 106 – Providing Widespread Access to Feminine Hygiene/Menstrual Products
16. Resolution 121 – Encouraging Collaboration between Physicians and Industry in AI (Augmented Intelligence) Development
17. Resolution 124 – Incorporating the Evidence-Based Concepts of the Choosing Wisely Program into Undergraduate and Graduate Medical Education
18. Resolution 134 – Study a Need-Based Scholarship to Encourage Medical Student Participation in the AMA
19. CBH Report A – Development and Implementation of Recommendations for Responsible Media Coverage of Drug Overdoses
20. CEQM Report A – Promoting Early Access to Diabetes Care to Reduce ESRD
21. CGPH CBH Report A – Support for Assisted Outpatient Treatment
22. CGPH MIC Report A – Reimbursement of School-Based Health Centers
23. CGPH WIM Report A – Enhancing Transparency and Regulation in the Personal Care Product Industry
24. CHIT Report A – Incorporation of Machine Learning Technologies into Electronic Health Records

25. CME CHIT Report A – Utilization of Third-Party Educational Resources in Undergraduate Medical Education
26. CME Report A – Studying an Application Cap for the National Residency Match Program
27. COLA Report A – Mandatory Reporting of Sexual Misconduct Allegations to Law Enforcement
28. COLRP CME Report B – Teaching and Assessing Osteopathic Manipulative Treatment and Osteopathic Principles and Practice to Resident Physicians in the Context of ACGME Single System of Accreditation
29. CSI CHIT Report A – Improving Research Standards, Approval Processes, and Post-Market Surveillance Standards for Medical Devices

RECOMMENDED FOR ADOPTION AS AMENDED

30. Resolution 003 – Advocating for Alternatives to Immigrant Detention Centers that Respect Human Dignity
31. Resolution 004 – Amending D-440.847, to call for National Government and States to Maintain Personal Protective Equipment and Medical Supply Stockpiles
32. Resolution 005 – Support Public Health Approaches for the Prevention and Management of COVID-19 in Correctional Facilities
33. Resolution 007 – Representation of Dermatological Pathologies in Varying Skin Tones
34. Resolution 008 – Protestor Protections
35. Resolution 009 – Call for Increased Funding and Research for Post-Viral Syndromes
36. Resolution 011 – Caps on Insulin Co-Payments for Patients with Insurance
37. Resolution 012 – Policing Reform
38. Resolution 014 – Medicaid and Children's Health Insurance Program (CHIP) Coverage of Continuous Glucose Monitoring Devices for Patients with Insulin-Dependent Diabetes
39. Resolution 015 – Amending H-150.962, Quality of School Lunch Program, to Advocate for Expansion and Sustainability of Nutritional Assistance Programs during COVID-19
40. Resolution 019 – Support for Mental Health Courts
41. Resolution 020 – Expanding Medicaid Transportation to include Healthy Grocery Destinations
42. Resolution 022 – Ensuring Consent during Educational Physical Exams on Unconscious Patients
43. Resolution 026 – Non-Cervical HPV Associated Cancer Prevention
44. Resolution 027 – Opposition to the Criminalization and Undue Restrictions of Evidence-Based Gender-Affirming Care for Transgender and Gender-Diverse Individuals
45. Resolution 028 – Anti-Harassment Training
46. Resolution 029 – Against Immunity Passports to Relieve COVID-19 Restrictions
47. Resolution 030 – Mental Health First Aid Training
48. Resolution 041 – Opposition to Medical Bonding in Jail
49. Resolution 043 – Protections for Incarcerated Mothers to Breastfeed and/or Breast Pump
50. Resolution 047 – Supporting Measures to Ensure Safe Indoor Home Temperatures
51. Resolution 051 – Employment of Patients with Psychiatric Illness

52. Resolution 052 – Expansion on Comprehensive Sexual Health Education
53. Resolution 053 – Addressing Adverse Effects of Active Shooter Drills on Children's Health
54. Resolution 054 – Supporting the Study of Reparations as a Means to Reduce Racial Inequalities
55. Resolution 056 – Increasing Regulation of Natural Cosmetic Products
56. Resolution 057 – Educate Residency, Fellowship, and Academic Programs on the United States- Puerto Rico Relationship Status
57. Resolution 061 – Protection of Antibiotic Efficacy through Water System Regulation
58. Resolution 064 – Opposition to Alcohol Industry Marketing Self-Regulation
59. Resolution 070 – Ethical Guidance for Short-Term Medical Service Trips
60. Resolution 072 – Supporting Sun Safety Education in K-12 Schools
61. Resolution 076 – Federal Health Insurance Funding for People Experiencing Incarceration
62. Resolution 078 – Banning LGBTQ+ "Panic" Defenses
63. Resolution 080 – Education in Communicating with and Providing Services to Individuals with Communication Disorders
64. Resolution 085 – Call for Improved Personal Protective Equipment (PPE) Design and Fitting
65. Resolution 087 – Expungement and Sealing of Drug Records
66. Resolution 089 – Providing Reduced Parking for Patients
67. Resolution 091 – Encouraging Residency Program Collaboration to Allow Medical Students Fair and Equitable Application Processes
68. Resolution 094 – Denouncing the Use of Solitary Confinement in Correctional Facilities and Detention Centers
69. Resolution 097 – Addressing Healthcare Accessibility for Current and Aged-Out Youth in the Foster Care System
70. Resolution 104 – Sexual Harassment Accreditation Standards for Medical Training Programs
71. Resolution 107 – Updating AMA-MSS Policies Concerning International Medical Graduates and their Participation in the Physician Profession
72. Resolution 108 – Use of Social Media for Product Promotion and Compensation
73. Resolution 110 – Support Distribution of Free Hearing Protection in Relevant Public Venues
74. Resolution 112 – Guaranteed Time Off on National Election Days at Medical Schools
75. Resolution 114 – Support for Administration of STEP Examinations by Home Institutions
76. Resolution 118 – Evaluating Scientific Journal Articles for Racial and Ethnic Bias
77. Resolution 122 – Respecting Religious Diversity in Medical Education
78. Resolution 125 – Transparency on Restrictions of Care
79. Resolution 128 – Hospital Bans on Trial of Labor after Cesarean
80. CEQM Report C – Researching Policy Recommendations to Address the Shortfalls of Employer-Sponsored Health Insurance
81. CHIT CEQM Report A – Advocating for the Reimbursement of Remote Patient Monitoring for the Management of Chronic Conditions

RECOMMENDED FOR ADOPTION IN LIEU OF

82. Resolution 001 – Support for Institutional Policies for Personal Days for Undergraduate Medical Students
COLRP CME Report A – Support for Mental Health Absences for Students and Residents
83. Resolution 016 – Denouncing Racial Essentialism in Medicine
Resolution 032 – Dissociating Race from Biology in Healthcare Education
84. Resolution 025 – Banning the Practice of Virginity Testing
85. Resolution 037 – Amending D-350.986, Evaluation of DACA-Eligible Medical Students, Residents and Physicians in Addressing Physician Shortages, to Identify and Decreases Barriers these Students Face in Applying to Medical School
86. Resolution 038 – Health Coverage during States of Emergency
87. Resolution 058 – Prohibiting Evictions during Public Health Emergencies Caused by Infectious Pathogens
Resolution 073 – Support for Utility Shut-Off Moratoriums for the Duration of the COVID-19 Pandemic
88. 062 – Environmental Sustainability of AMA National Meetings
Resolution 075 – Net Zero Greenhouse Gas Emissions in the AMA and Healthcare Sector
89. Resolution 069 – Opposition to the Criminalization of Perinatal Demise
90. Resolution 123 – Improving the Use of Medical Interpreter Services by Health Care Providers through CME
CME MIC A – Support for Standardized Interpreter Training for Medical Schools
91. Resolution 129 – Guidelines on Chaperones for Sensitive Exams
92. Resolution 130 – Protections from Risks of Indoor Tanning

RECOMMENDED FOR REFERRAL

93. Resolution 044 – Advocate for the Legalization of Recreational Cannabis to End Mass Incarceration
94. Resolution 045 – Supporting Medical Student Physician Shadowing in a Remote Capacity during the Current Crisis
95. Resolution 049 – Coverage of Pregnancy-Associated Healthcare for 12 Months Postpartum for Uninsured Patients Ineligible for Medicaid
96. Resolution 063 – Exclusion of Race and Ethnicity in the First Sentence of Case Report
97. Resolution 065 – Investigation of Naturopathic Vaccine Exemptions
98. Resolution 074 – Support for Evidence-Based Policy
99. Resolution 093 – Amending Policy H-50.973, to Support the Implementation of Health Care Referrals in Blood Donation Centers for Donors at Risk for HIV
100. Resolution 102 – Opposing the Marketing of Pharmaceuticals to Parties Responsible for Captive Populations
101. Resolution 119 – Amend H-150.927 and H-150.933, to Include Food Products with Added Sugar
102. Resolution 126 – Implementation of a Single Licensing Exam for Medical Students
103. Resolution 135 – Regulation of Phthalates in Adult Personal Sexual Products
104. CEQM MIC Report A – Laying the First Steps towards a Transition to a Financial and citizenship Need-Blind Model for Organ Procurement and Transplantation

105. CEQM Report B – Support of Research on Vision Screenings and Visual Aids for Adults Covered by Medicaid
106. CSI Report A – Supporting Daylight Saving Time as the New, Permanent Standard Time
107. GC Report A – Policy Sunset Report for AMA-MSS Policies

RECOMMENDED FOR REFERRAL FOR DECISION

108. Resolution 006 – Supporting Medical Student Guidelines during Healthcare Crises

RECOMMENDED FOR NOT ADOPTION

109. Resolution 013 – Status of Immigration Laws, Rules, and Legislation during National Crises
110. Resolution 017 – Decriminalization of Physicians who Provide abortion Procedures
111. Resolution 021 – Reconsideration of the Dead Donor Rule to Exempt Maastricht Class III Donors
112. Resolution 034 – Improving Interracial Relationships and Inequity in Academic Medicine
113. Resolution 050 – Advocating for Legal Permanent Resident Status, a Pathway to Citizenship, and Current Protections for Individuals with Deferred Action for Childhood Arrival (DACA) Status
114. Resolution 068 – Authorize Competitive Licensing when Medicare Negotiation Fails
115. Resolution 071 – Consent Reform as a Protective Method for Victims of Human Trafficking
116. Resolution 079 – Advocating for Mental Health and Wellbeing Clinical Protocols at the State and Federal Levels for Patients in Long-Term Care Facilities
117. Resolution 113 – Implications of the Dismissal of Vaccine Non-Compliant Patients
118. Resolution 117 – Impact of Matching Social Interests on Undergraduate Medical Education on Clinical Evaluation
119. Resolution 131 – Advocating Against Medical Students as a Source of Profit for Medical Licensure Examinations
120. Resolution 133 – Study of Health Disparities Accreditation Criteria in Undergraduate Medical Education

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

121. Resolution 002 – Encourage Transparency of Federal Funding Contracts for COVID-19 Diagnostics, Therapeutics, and Vaccines
122. Resolution 010 – Learning History of Experimentation on Black Bodies in Medicine to Understand Medical Mistrust
123. Resolution 024 – Amending Policy D-350.983, to Include Board-Certification and Community Physician Oversight
124. Resolution 035 – Studying Population-Based Reimbursement Disparities
125. Resolution 036 – Provision of Influenza Vaccinations, Treatment, and Screenings to Immigrants Held in Customs and Border Protection Facilities
126. Resolution 046 – Didactic Pre-Clinical Education on De-Escalation, Violence, and Abuse Prevention in the Healthcare Workplace

127. Resolution 059 – Increasing Medication Delivery and Curbside Pick-Up during Pandemics
128. Resolution 060 – Encouragement of Manufacturing Necessary Supplies withing the United States
129. Resolution 066 – Standardization of Intimate Partner Violence Screening within Clinical Settings
130. Resolution 077 – Increased Utilization of Point-of-Care Medical Tools in Undergraduate Medical Education
131. Resolution 081 – Ensuring Access to Child Mental Health Services and Child Abuse Reporting during Increased Stress and Risk
132. Resolution 084 – Ensuring the Best In-School Care for Children with Epilepsy
133. Resolution 086 – Medically Unnecessary Procedures on Intersex Patients
134. Resolution 088 – Increased Attention to Hygiene Facilities
135. Resolution 090 – Naming of New Infectious Pathogens and Diseases
136. Resolution 092 – Supporting the Practice of and Appropriate Reimbursement for Group Prenatal Care
137. Resolution 096 – Amending H-185.947, Insurance Underwriting Reform, to Include Protections for those who have Obtained Opioid Antagonist Medication via Prescription or Standing Order
138. Resolution 098 – Supporting the Clear Labeling of Sunscreens
139. Resolution 100 – Recognizing Misinformation as a Public Health Issue
140. Resolution 101 – Proactive Defense of Cybersecurity Threats
141. Resolution 103 – Improving the Quality of School Provided Meals through Local Produce Supplementation
142. Resolution 105 – Incorporating Human Trafficking Education into the Medical School Curriculum
143. Resolution 109 – Transgender and Intersex Care Training for School Health Professionals
144. Resolution 111 – Amending H-345.984, Awareness, Diagnosis and Treatment of Depression and Other Mental Illnesses to Increase Utilization and Expand Use of Alternative Funding for Collaborative Care
145. Resolution 115 – Support for Endometriosis
146. Resolution 116 – Standardizing Counseling for Pediatric Victims of Gun Violence
147. Resolution 120 – Supporting Buprenorphine Waiver Training in Undergraduate and Graduate Medical Education
148. Resolution 127 – Supporting Improved Public Understanding of Plastic Surgery Board Certification
149. Resolution 132 – Advocacy for “Breast Implant Illness” Patients
150. Resolution 136 – Increasing Surgical Specialty Providers and Anesthesiologists within Rural Areas

RECOMMENDED FOR ADOPTION

(1) RESOLUTION 018 – GENDER-NEUTRAL LANGUAGE IN AMA POLICY

RECOMMENDATION:

Resolution 018 be <u>adopted</u>.

RESOLVED, That our AMA (1) revise all relevant policies to utilize gender-neutral pronouns and other non-gendered language in place of gendered language where such text inappropriately appears; (2) utilize gender-neutral pronouns and other non-gendered language in future policies where gendered language does not specifically need to be used.

Testimony heard on Resolution 018 was overwhelmingly supportive and explicitly endorsed the inclusive nature of the resolution and highlighted precedent for the AMA taking similar actions in the past. This resolution is novel and provides a much-needed update to existing AMA policy. Your Reference Committee recommends Resolution 018 be adopted.

(2) RESOLUTION 023 – DECREASING YOUTH ACCESS TO E-CIGARETTES

RECOMMENDATION A:

Policies H-495.973 and H-495.988 be <u>reaffirmed in lieu</u> of the first Resolve of Resolution 023.

RECOMMENDATION B:

The third Resolve of Resolution 023 be <u>referred for study</u>.

RECOMMENDATION C:

The remainder of Resolution 023 be <u>adopted</u>.

RESOLVED, That our AMA support the inclusion of disposable and tank-based e-cigarettes in the language and implementation of any restrictions that are applied by the Food and Drug Administration or other bodies to cartridge-based e-cigarettes; and be it further

RESOLVED, That AMA policy H-495.986 be amended by insertion as follows:

Tobacco Product Sales and Distribution, H-495.986

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.
(11) supports measures that prevent retailers from opening new tobacco specialty stores in proximity to elementary schools, middle schools, and high schools; and
(12) supports measures that decrease the overall density of tobacco specialty stores, including but not limited to, preventing retailers from opening new tobacco specialty stores in proximity to existing tobacco specialty stores.

; and be it further

RESOLVED, That our AMA-MSS establish formal support for AMA policies H-490.914, H-495.971, H-495.972, H-495.973, H-495.984, and H-495.989.

The MSS House Coordination Committee (HCC) recommended that policies H-495.973 and H-495.988 be reaffirmed in lieu of the first Resolve of Resolution 023. Your Reference Committee understands this recommendation; however, we acknowledge that this ask could be considered novel if the Resolve was made internal.

There was mixed testimony on the VRC with how to handle Resolution 023 and there were several amendments proposed. After review, your Reference Committee recommends that the second Resolve of Resolution 023 be adopted as written and the third Resolve be referred for study. There is concern with formal MSS support for policies that are so expansive. Such an action may inadvertently obligate the MSS to support aspects of these policies that do not accurately reflect the priorities of the Section. For this reason, we believe it would be most beneficial for the MSS to refer this for study and encourage the appropriate MSS Standing Committee(s) to review these and other existing policies and craft original language that captures the MSS views on this topic. We believe this will have a stronger and more lasting impact on section policy-making.

FDA TO EXTEND REGULATORY JURISDICTION OVER ALL NON-PHARMACEUTICAL NICOTINE AND TOBACCO PRODUCTS – H-495.973
Our AMA: (1) supports the U.S. Food and Drug Administration's (FDA) proposed rule that would implement its deeming authority allowing the agency to extend FDA regulation of tobacco products to pipes, cigars, hookahs, e-cigarettes and all other non-pharmaceutical tobacco/nicotine products not currently covered by the Federal Food, Drug, and Cosmetic Act, as amended by the Family Smoking Prevention and Tobacco Control Act; (2) supports legislation and/or regulation of electronic cigarettes and all other non-pharmaceutical tobacco/nicotine products that: (a) establishes a minimum legal purchasing age of 21; (b) prohibits use in all places that tobacco cigarette use is prohibited, including in hospitals and other places in which health care is delivered; (c) applies the same marketing and sales restrictions that are applied to tobacco cigarettes, including prohibitions on television advertising,

product placement in television and films, and the use of celebrity spokespeople; (d) prohibits product claims of reduced risk or effectiveness as tobacco cessation tools, until such time that credible evidence is available, evaluated, and supported by the FDA; (e) requires the use of secure, child- and tamper-proof packaging and design, and safety labeling on containers of replacement fluids (e-liquids) used in e-cigarettes; (f) establishes manufacturing and product (including e-liquids) standards for identity, strength, purity, packaging, and labeling with instructions and contraindications for use; (g) requires transparency and disclosure concerning product design, contents, and emissions; and (h) prohibits the use of characterizing flavors that may enhance the appeal of such products to youth; and (3) urges federal officials, including but not limited to the U.S. Food and Drug Administration to: (a) prohibit the sale of any e-cigarette cartridges and e-liquid refills that do not include a complete list of ingredients on its packaging, in the order of prevalence (similar to food labeling); and (b) require that an accurate nicotine content of e-cigarettes, e-cigarette cartridges, and e-liquid refills be prominently displayed on the product alongside a warning of the addictive quality of nicotine.

FDA REGULATION OF TOBACCO PRODUCTS – H-495.988

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.

(3) RESOLUTION 031 – SUPPORTING THE AVAILABILITY OF CLOSED CAPTION IN MEDICAL EDUCATION

RECOMMENDATION:

Resolution 031 be <u>adopted</u>.

RESOLVED, That our AMA collaborates with the AAMC, AACOM, and other relevant stakeholders to encourage the incorporation of closed captioning to all relevant medical school communications, including but not limited to lecture recordings, videos, webinars, and audio recordings, that may prohibit any students from accessing information.

VRC testimony was largely in support of Resolution 031, with support from the Massachusetts delegation, Region 1, and Region 4. The Academic Physician Section (APS) expressed some concern about the feasibility of implementing closed captioning at individual medical schools. Your Reference Committee believes the authors did a great job incorporating evidence that there are low cost options available and further notes that this policy encourages, but does not mandate, closed captioning. Therefore we do not believe the concerns from the APS outweigh the potential benefits of this resolution, and recommend Resolution 031 be adopted as written.

(4) RESOLUTION 033 – ADDRESSING INFORMAL MILK SHARING

RECOMMENDATION:

Resolution 033 be <u>adopted</u>.

RESOLVED, That our AMA discourage the practice of informal milk sharing when said practice does not rise to health and safety standards comparable to those of milk banks, including but not limited to screening of donors and/or milk pasteurization; and be it further

RESOLVED, That our AMA encourage breast milk donation to regulated human milk banks instead of via informal means; and be it further

RESOLVED, That our AMA support further research into the status of milk donation in the U.S. and how rates of donation for regulated human milk banks may be improved.

There was widespread support for Resolution 033 on the VRC. Your MSS Section Delegates recommended making this resolution internal and supporting it if the American Academy of Pediatrics were to bring a similar resolution forward in the future, but your Reference Committee did not find this compelling in the absence of an identified pending resolution on this subject. We find this resolution to be timely, impactful, and well-researched, and recommend Resolution 033 be adopted as written.

(5) RESOLUTION 039 – SUPPORTING HIPAA COVERAGE OF PATIENT'S MOBILE HEALTH DATA

RECOMMENDATION:

Resolution 039 be <u>adopted</u>.

RESOLVED, That our AMA-MSS support HIPAA or HIPAA-like requirements for all mobile health applications and wearable health technology such that data collected by these applications and devices is afforded the same privacy protections as standard medical records.

Resolution 039 was well-supported by Region 1, Region 3, and the MSS Committee on Health Information and Technology (CHIT) in VRC testimony. We disagree with the recommendation for reaffirmation proposed during testimony, as personal mobile health data is not currently afforded the same privacy protections as protected health information under HIPAA. We find Resolution 039 addresses a current gap in policy and recommend adoption as written.

(6) RESOLUTION 040 – SUPPORT FOR THE ESTABLISHMENT OF MEDICAL-LEGAL PARTNERSHIPS

RECOMMENDATION:

Resolution 040 be <u>adopted</u>.

RESOLVED, That our AMA-MSS support the expansion and development of medical-legal partnerships to better address social determinants of health.

VRC testimony on Resolution 040 was mixed, but your Reference Committee did not find the arguments for reaffirmation in lieu of this resolution to be compelling, recognizing forthcoming efforts to develop AMA policy around the issue. Therefore, we recommended Resolution 040 be adopted as written.

(7) RESOLUTION 042 – EXPANDING THE DEFINITION OF IATROGENIC INFERTILITY TO INCLUDE GENDER AFFIRMING INTERVENTIONS

RECOMMENDATION:

Resolution 042 be <u>adopted</u>.

RESOLVED, That our AMA amend policy H-185.990 by insertion as follows:

Infertility and Fertility Preservation Insurance Coverage H-185.990

It is the policy of the AMA that (1) Our AMA encourages third party payer health insurance carriers to make available insurance benefits for the diagnosis and treatment of recognized male and female infertility; (2) Our AMA supports payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician, and will lobby for appropriate federal legislation requiring payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician; <u>and (3) Our AMA encourages the inclusion of impaired fertility as a consequence of gender-affirming hormone therapy and gender-affirming surgery within legislative definitions of iatrogenic infertility.</u>

RESOLVED, That our AMA amend policy H-185.950 by insertion as follows:

Removing Financial Barriers to Care for Transgender Patients H-185.950
Our AMA supports public and private health insurance coverage for <u>medically necessary</u> treatment of gender dysphoria as recommended by the patient's physician<u>, including gender-affirming hormone therapy and gender-affirming surgery.</u>

Testimony on the VRC was largely in support of Resolution 042. Your Reference Committee deliberated on the importance of the inclusion of the second Resolve clause in the context of iatrogenic infertility but ultimately chose to maintain its inclusion, as it is important to recognize

these specific treatments as medically necessary to avoid efforts by insurers to withhold coverage for these medical services. We recommend Resolution 042 be adopted as written.

(8) RESOLUTION 048 – SUPPORT FOR VOTE-BY-MAIL

RECOMMENDATION:

Resolution 048 be <u>adopted</u>.

RESOLVED, That our AMA support measures to reduce crowding at polling locations and facilitate equitable access to voting for all voters, including:
(a) extending polling hours;
(b) increasing the number of polling locations;
(c) extending early voting periods;
(d) mail-in ballot postage that is free or prepaid by the government; and
(e) adequate resourcing of the United States Postal Service and election operational procedures; and be it further

RESOLVED, That our AMA oppose requirements for voters to stipulate a reason in order to receive a ballot by mail and other constraints for eligible voters to vote-by-mail; and be it further

RESOLVED, That this resolution be immediately forwarded to the November 2020 Special Meeting of the House of Delegates.

VRC testimony was overwhelmingly supportive of Resolution 048. The MSS Committee on Legislation and Advocacy (COLA), the Minority Affairs Section (MAS), the Health Professional Advancing LGBTQ Equality (GLMA), Region 1, the MSS Committee on LGBTQ+ Issues, and your MSS Section Delegates all spoke in support of this resolution as written. Your Reference Committee found Resolution 048 to be extremely well-written and well-argued. We support the inclusion of the immediate forward clause here in the case of run-off elections, as well as state and local elections that may occur before the next AMA National meeting. We commend the authors on eloquently arguing how public health is critically impacted by mail-in ballots and recommend adoption of Resolution 048.

(9) RESOLUTION 055 – REDUCING COMPLEXITY IN THE PUBLIC SERVICE LOAN FORGIVENESS PROGRAM

RECOMMENDATION:

Resolution 055 be <u>adopted</u>.

RESOLVED, That our AMA amend H-305.925 by insertion and deletion as follows:

H-305.925 Principles of and Actions to Address Medical Education Costs and Student Debt

The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in

a given specialty. To help address this issue, our American Medical Association (AMA) will:

1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.
2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs--such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector--to promote practice in underserved areas, the military, and academic medicine or clinical research.
3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.
5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.
6. Work to reinstate the economic hardship deferment qualification criterion known as the “20/220 pathway,” and support alternate mechanisms that better address the financial needs of trainees with educational debt.
7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.
8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.
9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).
10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on medical school programs that cap medical

education debt, including the types of debt management education that are provided.

11. Work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment.

12. Encourage medical schools to (a) Study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, and combined baccalaureate/MD or DO programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education; (b) Engage in fundraising activities to increase the availability of scholarship support, with the support of the Federation, medical schools, and state and specialty medical societies, and develop or enhance financial aid opportunities for medical students, such as self-managed, low-interest loan programs; (c) Cooperate with postsecondary institutions to establish collaborative debt counseling for entering first-year medical students; (d) Allow for flexible scheduling for medical students who encounter financial difficulties that can be remedied only by employment, and consider creating opportunities for paid employment for medical students; (e) Counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation; (f) Inform students of all government loan opportunities and disclose the reasons that preferred lenders were chosen; (g) Ensure that all medical student fees are earmarked for specific and well-defined purposes, and avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees; (h) Use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies; (i) Work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.

13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.

14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals: (a) Eliminating the single holder rule; (b) Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training; (c) Retaining the option of

loan forbearance for residents ineligible for loan deferment; (d) Including, explicitly, dependent care expenses in the definition of the "cost of attendance"; (e) Including room and board expenses in the definition of tax-exempt scholarship income; (f) Continuing the federal Direct Loan Consolidation program, including the ability to "lock in" a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs; (g) Adding the ability to refinance Federal Consolidation Loans; (h) Eliminating the cap on the student loan interest deduction; (i) Increasing the income limits for taking the interest deduction; (j) Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001; (k) Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating; (l) Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.

15. Continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases.

16. Continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students, and monitor the short-and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.

17. Collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.

18. Continue to monitor the availability of and encourage medical schools and residency/fellowship programs to (a) provide financial aid opportunities and financial planning/debt management counseling to medical students and resident/fellow physicians; (b) work with key stakeholders to develop and disseminate standardized information on these topics for use by medical students, resident/fellow physicians, and young physicians; and (c) share innovative approaches with the medical education community.

19. Seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt. The AMA believes that it is improper for physicians not to repay their educational loans, but assistance should be available to those physicians who are experiencing hardship in meeting their obligations.

20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician benefits the program, and will: (a) Advocate that all

resident/fellow physicians have access to PSLF during their training years; (b) Work with the United States Department of Education to ensure that applicants of the PSLF and its supplemental extensions, such as Temporary Expanded Public Service Loan Forgiveness (TEPSLF), are provided with the necessary information to successfully complete the program(s) in a timely manner; (c) Work with the United States Department of Education to ensure individuals who would otherwise qualify for PSLF and its supplemental extensions, such as TEPSLF, are not disqualified from the program(s) due to bureaucratic complexities; (~~b~~d) Advocate against a monetary cap on PSLF and other federal loan forgiveness programs; (~~c~~e) Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed; (~~d~~f) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note; (~~e~~g) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the PSLF program qualifying status of the employer; (~~f~~h) Advocate that the profit status of a physicians training institution not be a factor for PSLF eligibility; (~~g~~i) Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed; (~~h~~j) Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas; (~~i~~k) Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes.

21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student load burden.

22. Formulate a task force to look at undergraduate medical education training as it relates to career choice, and develop new polices and novel approaches to prevent debt from influencing specialty and subspecialty choice.

Your Reference Committee heard unanimous support for Resolution 55. We find that it is aligned with current policy and addresses a gap to move forward in advocating for improved maternal mortality statistics. This resolution highlights the inconsistent reporting that is present even with all of the focus that has been put on reducing maternal mortality in the United States. Our proposed amendment would be to remove the reference to the CDC specifically to allow for work with other stakeholders who may also be collecting this vitally important data.

Testimony on the VRC was very supportive of Resolution 055, including support from the MSS Committee on Economics and Quality in Medicine (CEQM) and your AMA Section Delegates. Your Reference Committee believes this is an important issue and should be adopted as written.

(10) RESOLUTION 067 – RESEARCH THE ABILITY OF TWO-INTERVAL GRADING OF CLINICAL CLERKSHIPS TO MINIMIZE RACIAL BIAS IN MEDICAL EDUCATION

RECOMMENDATION:

Resolution 067 be <u>adopted</u>.

RESOLVED, That our AMA-MSS research the ability of two-interval grading of clinical clerkships to minimize racial bias in medical education.

There was mixed testimony on the VRC for Resolution 067. The MSS Committee on Medical Education (CME) and the Massachusetts delegation spoke in opposition. The MSS Committee on LGBTQ+ issues spoke in favor of the resolution, noting the paucity of knowledge about the effectiveness of two-interval grading to reduce the disparities described in the resolution. Your Reference Committee finds the specific potential impact on bias in medical education compelling, and thus recommends this issue be studied further by the appropriate MSS Standing Committee(s) which can be achieved by adoption of Resolution 067 as written.

(11) RESOLUTION 082 - AMENDMENT TO FOOD ENVIRONMENTS AND CHALLENGES ACCESSING HEALTHY FOOD, H-150.925

RECOMMENDATION:

Resolution 082 be <u>adopted</u>.

RESOLVED, That our AMA amend policy H-150.925, Food Environments and Challenges Accessing Healthy Food by insertion and deletion as follows,

Food Environments and Challenges Accessing Healthy Food H-150.925
Our AMA <u>(1)</u> encourages the U.S. Department of Agriculture and appropriate stakeholders to study the national prevalence, impact, and solutions to ~~the problems of food mirages, food swamps, and food oases as food environments distinct from food deserts~~ <u>challenges accessing healthy affordable food, including, but not limited to, food environments like food mirages, food swamps, and food deserts; and (2) recognizes that food access inequalities are a major contributor to health inequities, disproportionately affecting marginalized communities and people of color; and (3) supports policy promoting community-based initiatives that empower resident</u>

businesses, create economic opportunities, and support sustainable local food supply chains to increase access to affordable healthy food.

Testimony heard on Resolution 082 was overwhelmingly supportive. The MSS Section Delegates suggested combining Resolution 082 with Resolution 020, but we found that these asks are distinct enough to stand alone. We believe this resolution strengthens current policy and recommend Resolution 082 be adopted.

(12) RESOLUTION 083 - IMPROVING LABELING OF OVER-THE-COUNTER MEDICATIONS BY INCLUDING CARBOHYDRATE CONTENT

RECOMMENDATION:

Resolution 083 be adopted.

RESOLVED, Our AMA encourages the Food and Drug Administration to require the inclusion of carbohydrate content, in grams or micrograms, on labels for orally ingested over-the-counter drugs.

VRC testimony was supportive of Resolution 083. While this may only impact a small number of patients, we believe the Resolve clause was well-researched and well-supported by the Whereas clauses and we hope that this will have a significant impact on the health experience of these individuals. Your Reference Committee recommends Resolution 083 be adopted as written.

(13) RESOLUTION 095 - EQUAL ACCESS TO ADOPTION FOR THE LGBTQ COMMUNITY

RECOMMENDATION:

Resolution 095 be adopted.

RESOLVED, That our AMA advocate for equal access to adoption services for LGBTQ individuals who meet federal criteria for adoption regardless of gender identity or sexual orientation; and be it further

RESOLVED, That our AMA encourage allocation of government funding to licensed child welfare agencies that offer adoption services to all individuals or couples including those with LGBTQ identity.

Resolution 095 enjoyed widespread support on the VRC. We find this to be a well-researched and well-written resolution. Your Reference Committee recommends Resolution 095 be adopted as written.

(14) RESOLUTION 099 - TELEVISION BROADCAST AND ONLINE STREAMING OF LGBTQ+ INCLUSIVE SEXUAL ENCOUNTERS AND PUBLIC HEALTH AWARENESS ON SOCIAL MEDIA PLATFORMS

RECOMMENDATION:

Resolution 099 be <u>adopted</u>.

RESOLVED, That our AMA amend policy H-485.994, "Television Broadcast of Sexual Encounters and Public Health Awareness" by addition and deletion, to read as follows:

Television Broadcast <u>and Online Streaming</u> of Sexual Encounters and Public Health Awareness <u>on Social Media Platforms</u>, H-485.994
The AMA urges television broadcasters <u>and online streaming services</u>, producers, ~~and~~ sponsors, <u>and any associated social media outlets</u> to encourage education about <u>heterosexual and LGBTQ+ inclusive</u> safe sexual practices, including but not limited to condom use and abstinence, in television <u>or online</u> programming of sexual encounters, and to accurately represent the consequences of unsafe sex.

Resolution 099 had unanimous support on the VRC. Your Reference Committee finds this resolution to be a timely and appropriate update to existing policy and recommends adoption.

(15) RESOLUTION 106 - PROVIDING WIDESPREAD ACCESS TO FEMININE HYGIENE/MENSTRUAL PRODUCTS

RECOMMENDATION:

Resolution 106 be <u>adopted</u>.

RESOLVED, That our AMA encourage public and private institutions as well as places of work to provide free, readily available menstrual care products to workers and patrons; and be it further

RESOLVED, That our AMA amend H-525.974, "Considering Feminine Hygiene Products as Medical Necessities", as follows:

Considering Feminine Hygiene Products as Medical Necessities, H-525.974
Our AMA will: (1) encourage the Internal Revenue Service to classify feminine hygiene products as medical necessities; and (2) work with federal, state, and specialty medical societies to advocate for the removal of barriers to feminine hygiene products in state and local prisons and correctional institutions to ensure incarcerated women be provided free of charge, the appropriate type and quantity of feminine hygiene products

including tampons for their needs. (3) encourage the American National Standards Institute, the Occupational Safety and Health Administration, and other relevant stakeholders to establish and enforce a standard of practice for providing free, readily available menstrual care products to meet the needs of workers.

VRC testimony was supportive of Resolution 106. Your Reference Committee believes this is a novel resolution that would meaningfully add to existing policy. We commend the authors for addressing this critical issue and recommend adoption.

(16) RESOLUTION 121 - ENCOURAGING COLLABORATION BETWEEN PHYSICIANS AND INDUSTRY IN AI (AUGMENTED INTELLIGENCE) DEVELOPMENT

RECOMMENDATION A:

Resolution 121 be adopted.

RESOLVED, That our AMA augment the existing Physician Innovation Network (PIN) through the creation of advisors to specifically link physician members of AMA and its associated specialty societies with companies or individuals working on augmented intelligence (AI) research and development, focusing on:

(1) Expanding recruitment among AMA physician members,
(2) Advising AMA physician members who are interested in healthcare innovation/AI without knowledge of proper channels to pursue their ideas,
(3) Increasing outreach from AMA to industry leaders and companies to both further promote the PIN and to understand the needs of specific companies,
(4) Facilitating communication between companies and physicians with similar interests,
(5) Matching physicians to projects early in their design and testing stages,
(6) Decreasing the time and workload spent by individual physicians on finding projects themselves,
(7) Above all, boosting physician-centered innovation in the field of AI research and development; and be it further

RESOLVED, That our AMA support selection of PIN advisors through an application process where candidates are screened by PIN leadership for interpersonal skills, problem solving, networking abilities, objective decision making, and familiarity with industry.

Your Reference Committee heard testimony that was limited, but overwhelmingly supportive of Resolution 121 from Region 1 and the American College of Radiology. We note that in the second Resolve that “PIN” should be spelled out to read “Physician Innovation Network (PIN)” but consider this a minor editorial change that can be made in the final version of this resolution. Thus, we recommend for adoption as written.

(17) RESOLUTION 124 - INCORPORATING THE EVIDENCE-BASED CONCEPTS OF THE CHOOSING WISELY PROGRAM INTO UNDERGRADUATE AND GRADUATE MEDICAL EDUCATION

RECOMMENDATION:

Resolution 124 be <u>adopted</u>.

RESOLVED, That our American Medical Association amend D-155.988, Support for the concepts of the "Choosing Wisely" Program by insertion as follows:

Support for the Concepts of the "Choosing Wisely" Program, D-155.988

<u>1.</u> Our AMA supports the concepts of the American Board of Internal Medicine Foundation's Choosing Wisely program.

<u>2. Our AMA supports the inclusion of the evidence-based concepts of the American Board of Internal Medicine Foundation's Choosing Wisely program in undergraduate and graduate medical education.</u>

VRC testimony on Resolution 124 was limited. Your Reference Committee believes this resolution is well-conceptualized and fits neatly into the ethos of training and education of the AMA. We recommend Resolution 124 be adopted as written.

(18) RESOLUTION 134 - STUDY A NEED-BASED SCHOLARSHIP TO ENCOURAGE MEDICAL STUDENT PARTICIPATION IN THE AMA

RECOMMENDATION:

Resolution 134 be <u>adopted</u>.

RESOLVED, That our AMA-MSS study the feasibility and efficacy of an AMA-administered need-based scholarship program to defray the costs of medical student attendance at AMA national meetings and report its findings to the AMA-MSS at the next AMA-MSS national meeting.

VRC testimony was supportive of Resolution 134. The Massachusetts delegation and Region 1 testified in support. Your Reference Committee also supports this resolution and highlights that this resolution backs ongoing action by the MSS Governing Council to achieve these asks, while establishing a strong mandate to pursue such a program and adding an element of accountability with the requirement to report back to the MSS Assembly. We recommend Resolution 134 be adopted as written.

(19) CBH REPORT A - DEVELOPMENT AND IMPLEMENTATION OF RECOMMENDATIONS FOR RESPONSIBLE MEDIA COVERAGE OF DRUG OVERDOSES

RECOMMENDATION:

Recommendation in CBH Report A be <u>adopted</u> and the remainder of the report be <u>filed</u>.

Your Committee on Bioethics and Humanities recommends that the following recommendation be adopted and the remainder of this report be filed:

TITLE: Development and Implementation of Recommendations for Responsible Media Coverage of Opioid Drug Overdoses

RESOLVED, That 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 and portrayal of Opioid Drug overdoses.

Testimony on the VRC was limited for CBH Report A, with only the authors of the original resolution speaking in opposition to the report recommendations. Your Reference Committee believes the Committee on Bioethics and Humanities (CBH) provided excellent research and reasoning supporting their decision for changing the scope of the report to address opioids specifically. We recommend the recommendation in CBH Report A be adopted as written and the remainder of the report be filed.

(20) CEQM REPORT A - PROMOTING EARLY ACCESS TO DIABETES CARE TO REDUCE ESRD

RECOMMENDATION:

Recommendation in CEQM Report A be <u>adopted</u> and the remainder of this report be <u>filed</u>.

Your Committee on Economics and Quality in Medicine recommends that Resolution 12 not be adopted.

CEQM Report A was well-written and well-researched. Your Reference Committee thanks the authors for a thoughtful report and recommend the recommendation in CEQM Report A be adopted and the remainder of the report be filed.

(21) CGPH CBH REPORT A – SUPPORT FOR ASSISTED OUTPATIENT TREATMENT

RECOMMENDATION:

Recommendation in CGPH CBH Report A be adopted and the remainder of the report be filed.

Your Committee on Global and Public Health and Committee on Bioethics and Humanities recommend that the following resolve clauses be adopted in lieu of the original resolution and the remainder of the report be filed:

RESOLVED, That our AMA-MSS recognizes that involuntary outpatient commitment, if systematically implemented and resourced, can be a useful tool to promote recovery through a program of intensive outpatient services designed to improve treatment adherence, reduce relapse and re-hospitalization, and decrease the likelihood of dangerous behavior or severe deterioration among a sub-population of patients with severe mental illness when all other voluntary means of and barriers to treatment have been explored; and be it further

RESOLVED, That our AMA-MSS supports the monitoring of the effectiveness of local and state involuntary outpatient commitment programs in conjunction with study of barriers to success of voluntary outpatient mental healthcare treatment for individuals who are chronically non-adherent for further research and understanding of evidence-based practices.

Additionally, we recommend the title of this resolution be changed to “Use of Involuntary Outpatient Commitment.”

The only VRC testimony on CGPH CBH Report A came from the Psychiatry Student Interest Group Network (PsychSIGN) who spoke in favor of the report. Your Reference Committee found this report to be thoughtful and thorough and note that it overlaps with the Board of Trustees Report 7, which is being considered at the upcoming November 2020 Special Meeting of the House of Delegates. We believe the spirit of this report is consistent with that of the upcoming BOT report but note that the two reports are framed differently and certain nuances may need to be considered. We recommend the recommendations in CGPH CBH Report A be adopted and the remainder of the report be filed.

(22) CGPH MIC REPORT A – REIMBURSEMENT OF SCHOOL-BASED HEALTH CENTERS

RECOMMENDATION:

Recommendation in CGPH MIC Report A be adopted and the remainder of the report be filed.

Your Committee on Global and Public Health and Minority Issues Committee recommend that the following resolution be amended by addition and deletion and the remainder of the report be filed:

RESOLVED, That the AMA promotes the implementation, use, and maintenance of SBHCs by amending H-60.921 School-Based and School-Linked Health Centers as follows:

School-Based and School-Linked Health Centers, H-60.921
1. Our AMA supports ~~the concept of adequately equipped and staffed~~ the implementation, maintenance, and equitable expansion of school-based or school-linked health centers (SBHCs) for the comprehensive management of conditions of childhood and adolescence.
2. Our AMA recognizes that school-based health centers increase access to care in underserved child and adolescent populations.
3. Our AMA supports identifying SBHCs in claims data from Medicaid and other payers for research and quality improvement purposes.
4. Our AMA supports efforts to extend Medicaid reimbursement to school-based health centers at the state and federal level, including, but not limited to the recognition of school-based health centers as a provider under Medicaid.

Your Reference Committee found CGPH MIC Report A to be extremely well-written and well-supported. The recommendations provided clear, actionable amendments to current policy. We thank the authors for their time and recommend the recommendation in this report be adopted and the remainder of the report be filed.

(23) CGPH WIM REPORT A – ENHANCING TRANSPARENCY AND REGULATION IN THE PERSONAL CARE PRODUCT INDUSTRY

RECOMMENDATION:

Recommendation in CGPH WIM Report A be adopted and the remainder of this report be filed.

Your Women in Medicine Committee and Committee on Global and Public Health recommend that MSS Resolution 36 not be adopted.

The authors of the original resolution testified on the VRC against the recommendations made in CGPH WIM Report A. Your Reference Committee believes the reasoning presented in the report for not adopting Resolution 36 is sound and that the ask of the original resolution would not significantly change AMA action on this topic. Our largest concern remains the lack of still no formal definition for “personal care products,” and concerns that creating such a definition would not change AMA advocacy efforts. We recommend the recommendation in CGPH WIM Report A be adopted and the report be filed.

(24) CHIT REPORT A - INCORPORATION OF MACHINE LEARNING TECHNOLOGIES INTO ELECTRONIC HEALTH RECORDS

RECOMMENDATION:

CHIT Report A be <u>adopted</u> and <u>filed</u>.

Your Committee on Health Information Technology recognizes the importance of this research on incorporation of machine learning technologies into EHRs and recommends that the remainder of this report be filed.

Your Reference Committee commends the authors of CHIT Report A for their excellent work on this informational report. We recommend CHIT Report A be adopted and filed.

(25) CME CHIT REPORT A - UTILIZATION OF THIRD-PARTY EDUCATIONAL RESOURCES IN UNDERGRADUATE MEDICAL EDUCATION

RECOMMENDATION:

CME CHIT Report A be <u>adopted</u> and <u>filed</u>.

Your Committee on Medical Education and Committee on Health Information Technology recognizes this research on Third-Party resources and recommends that the remainder of this report be filed.

Your Reference Committee thanks the authors of CME CHIT Report A for their hard work on this informational report. We recommend CME CHIT Report A be adopted and filed.

(26) CME REPORT A - STUDYING AN APPLICATION CAP FOR THE NATIONAL RESIDENCY MATCH PROGRAM

RECOMMENDATION:

CME Report A be <u>adopted</u> and <u>filed</u>.

Your Committee on Medical Education presents this informational report for use by the Medical Student Section and recommends this report be filed.

Your Reference Committee commends the authors of CME Report A on a comprehensive and thorough informational report. We recommend CME Report A be adopted filed.

(27) COLA REPORT A - MANDATORY REPORTING OF SEXUAL MISCONDUCT ALLEGATIONS TO LAW ENFORCEMENT

RECOMMENDATION:

Recommendation in COLA Report A be <u>adopted</u> and the remainder of the report be <u>filed</u>.

Your Medical Student Section Committee on Legislation & Advocacy recommends that the following recommendation is adopted and the remainder of the report is filed:

RESOLVED, That our AMA-MSS strongly encourages universal mandatory reporting of sexual assault claims when the alleged perpetrator is a health care professional to the appropriate law enforcement agencies.

Your Reference Committee thanks the authors of COLA Report A on a well-written and thoughtful report with a well-crafted recommendation. We recommend the recommendation in COLA Report A be adopted and the remainder of the report be filed.

(28) COLRP CME REPORT B - TEACHING AND ASSESSING OSTEOPATHIC MANIPULATIVE TREATMENT AND OSTEOPATHIC PRINCIPLES AND PRACTICE TO RESIDENT PHYSICIANS IN THE CONTEXT OF ACGME SINGLE SYSTEM OF ACCREDITATION

RECOMMENDATION:

Recommendations in COLRP CME Report B be <u>adopted</u> and the remainder of the report be <u>filed</u>.

Your MSS Committees on Long Range Planning and MSS Committee on Medical Education recommend that the following recommendations be adopted and the remainder of the report be filed:

1) That the first resolve clause of MSS Resolution 53 be adopted as amended as follows:

That our AMA collaborate with the Accreditation Council on Graduate Medical Education (ACGME), the American Osteopathic Association (AOA), and any other relevant stakeholders to investigate the need for graduate medical education faculty development in the supervision of Osteopathic Manipulative Treatment across ACGME accredited residency programs.

2) That the second resolved clause of MSS Resolution 53 not be adopted.

There was no VRC testimony on COLRP CME Report B. Your Reference Committee felt the report addressed the original concerns of the Assembly, specifically the issue with task force creation and standardizing education received through different programs. We commend the

authors on a well-constructed report and recommend the recommendations in COLRP CME Report B be adopted and the remainder of the report be filed.

(29) CSI CHIT REPORT A - IMPROVING RESEARCH STANDARDS, APPROVAL PROCESSES, AND POST-MARKET SURVEILLANCE STANDARDS FOR MEDICAL DEVICES

RECOMMENDATION:

Recommendations in CSI CHIT Report A be <u>adopted</u> and the remainder of the report be <u>filed</u>.

Your Committee on Scientific Issues and Committee on Health Information Technology recommends that the following recommendations are adopted, and the remainder of the report is filed:

1) That AMA policy H-100.992 be amended by addition and deletion to read as follows:

FDA, H-100.992
(a) an FDA decision to approve a new drug <u>or medical device</u>, to withdraw a drug <u>or medical device's</u> approval, or to change the indications for use of a drug <u>or medical device</u> must be based on sound scientific and medical evidence derived from controlled trials, real-world data (RWD) fit for regulatory purpose, and/or post market 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 or medical device unless the weight of the evidence from clinical trials, RWD fit for regulatory purpose, and post market reports shows that the drug <u>or medical device</u> is unsafe and/or ineffective for its labeled indications.

2) That the first resolved clause of MSS Resolution 22 be amended by addition and deletion as follows:

RESOLVED, That our AMA support the principles that:
~~(a) an FDA decision to approve a new medical device, to withdraw a medical device's approval, or to change the indications for use of a medical device must be based on sound scientific and medical evidence derived from controlled trials and/or post-market incident reports;~~
~~(b) the evidence for medical devices should be evaluated by the FDA, in consultation with its Advisory Committees and expert extramural advisory bodies, as appropriate;~~

~~(c) expedited programs for medical devices serve the public interest as long as sponsors for medical devices that are approved based on surrogate endpoints or limited evidence conduct confirmatory trials in a timely fashion to establish the expected clinical benefit and predicted risk-benefit profile;~~
~~(d) confirmatory trials for medical devices approved under accelerated approval should be planned at the time of expedited approval;~~
~~(e) the FDA should pursue having in place a systematic process to ensure that sponsors adhere to their obligations for conducting confirmatory trials;~~
~~(f) any risk-benefit analysis or relative safety or efficacy judgments should not be grounds for limiting access to or indications for use of a medical device unless the weight of the evidence from clinical trials and/or post-market incident reports prove that the medical device is unsafe and/or ineffective for its labeled indications; and~~

(a) confirmatory trials should be conducted in a timely fashion following accelerated approval of medical devices that are approved based on surrogate endpoints or limited evidence;
(b) ~~(g)~~ the FDA should make the annual summary of medical devices approved under expedited programs more readily available to the public and consider adding information on confirmatory clinical trials and all reported adverse events for such medical devices.

VRC testimony on CSI CHIT Report A was limited. We did not find the proposed amendment offered by the Government Relations and Advocacy Fellow (GRAF) to be a necessary addition to the recommendations in this report, and thus recommend the recommendations in CSI CHIT Report A be adopted as written and the remainder of the report filed. We thank the authors for their hard work on this report.

RECOMMENDED FOR ADOPTION AS AMENDED

(30) RESOLUTION 003 – ADVOCATING FOR ALTERNATIVES TO IMMIGRANT DETENTION CENTERS THAT RESPECT HUMAN DIGNITY

RECOMMENDATION A:

The first Resolve of Resolution 003 be amended by addition to read as follows:

RESOLVED, That our AMA advocates for the preferential use of community-based, non-custodial Alternatives to Detention programs within the United States that respect the human dignity of immigrants, migrants, and asylum seekers who are in the custody of federal agencies; and be it further

RECOMMENDATION B:

Resolution 003 be adopted as amended.

RESOLVED, That our AMA advocates for the preferential use of Alternatives to Detention programs that respect the human dignity of immigrants, migrants, and asylum seekers who are in the custody of federal agencies; and be it further

RESOLVED, That this resolution be immediately forwarded to the House of Delegates at the November 2020 Special Meeting of the House of Delegates.

VRC testimony was largely supportive of the spirit of Resolution 003. The MSS Community Service Committee and Section Delegates proposed removing the immediate forward clause, but we disagree. Your Reference Committee believes this issue is timely and important, especially with the potential for a spike in COVID-19 cases this winter. Because of this potential, it is important for the AMA to advocate specifically for alternatives to detention programs for the health and safety of immigrants, migrants, and asylum seekers. We offer clarifying amendments to the first Resolve to remove potential ambiguity and recommend Resolution 003 be adopted as amended.

(31) RESOLUTION 004 – AMENDING D-440.847, TO CALL FOR NATIONAL GOVERNMENT AND STATES TO MAINTAIN PERSONAL PROTECTIVE EQUIPMENT AND MEDICAL SUPPLY STOCKPILES

RECOMMENDATION A:

The first Resolve of Resolution 004 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA amend policy D-440.847 by addition and deletion as follows:

PANDEMIC PREPAREDNESS ~~FOR INFLUENZA~~ D-440.847
In order to prepare for a ~~potential influenza~~ pandemic, our AMA:
(1) urges the Department of Health and Human Services Emergency Care Coordination Center, in collaboration with the leadership of the Centers for Disease Control and Prevention (CDC), state and local health departments, and the national organizations representing them, to urgently assess the shortfall in funding, staffing, supplies, vaccine, drug, and data management capacity to prepare for and respond to ~~an influenza~~ a pandemic or other serious public health emergency;
(2) urges Congress and the Administration to work to ensure adequate funding and other resources: (a) for the CDC, the National Institutes of Health (NIH), the Strategic National Stockpile, and other appropriate federal agencies, to support the maintenance of and the implementation of an expanded capacity to produce the necessary vaccines, ~~and~~ anti-~~viral~~ microbial drugs, medical supplies, and personal protective equipment, and to continue development of the nation's capacity to rapidly manufacture the necessary supplies needed to protect, treat, test and vaccinate the entire population and care for large numbers of seriously ill people; and (b) to bolster the infrastructure and capacity of state and local health departments to effectively prepare for and respond to, ~~and protect the population from illness and death in an influenza~~ a pandemic or other serious public health emergency;
(3) encourages states ~~and tribal communities~~ to maintain medical and personal protective equipment stockpiles sufficient for effective preparedness and to respond to a pandemic or other major public health emergency;

(4) urges the federal government to meet treaty and trust obligations by adequately sourcing medical and personal protective equipment directly to tribal communities and the Indian Health Service for effective preparedness and to respond to a pandemic or other major public emergency;

(~~3~~5) urges the CDC to develop and disseminate electronic instructional resources on procedures to follow in an ~~influenza~~ epidemic, pandemic, or other serious public health emergency, which are tailored to the needs of physicians and medical office staff in ambulatory care settings;

(~~4~~6) supports the position that: (a) relevant national and state agencies (such as the CDC, NIH, and the state departments of health) take immediate action to assure that physicians, nurses, other health care professionals, and first responders having direct patient contact, receive any appropriate vaccination in a timely and efficient manner, in order to reassure them that they will have first priority in the event of such a pandemic; and (b) such agencies should publicize now, in advance of any such pandemic, what the plan will be to provide immunization to health care providers;

(~~5~~7) will monitor progress in developing a contingency plan that addresses future ~~influenza~~ vaccine production or distribution problems and in developing a plan to equitably respond to ~~an influenza~~ pandemic in the United States.

RECOMMENDATION B:

The second resolve of Resolution 004 be deleted.

~~**RESOLVED, That our AMA-MSS immediately forward this resolution to the AMA House of Delegates.**~~

RECOMMENDATION C:

Resolution 004 be adopted as amended.

RESOLVED, That our AMA amend policy D-440.847 by addition and deletion as follows:

Pandemic Preparedness ~~for Influenza~~ D-440.847

In order to prepare for a ~~potential influenza~~ pandemic, our AMA:

(1) urges the Department of Health and Human Services Emergency Care Coordination Center, in collaboration with the leadership of the Centers for Disease Control and Prevention (CDC), state and local health departments, and the national organizations representing them, to urgently assess the

shortfall in funding, staffing, supplies, vaccine, drug, and data management capacity to prepare for and respond to a~~n influenza~~ pandemic or other serious public health emergency;

(2) urges Congress and the Administration to work to ensure adequate funding and other resources: (a) for the CDC, the National Institutes of Health (NIH), the Strategic National Stockpile and other appropriate federal agencies, to support the maintenance of and the implementation of an expanded capacity to produce the necessary vaccines, ~~and~~ anti-~~viral~~ microbial drugs, medical supplies, and personal protective equipment, and to continue development of the nation's capacity to rapidly manufacture the necessary supplies needed to protect, treat, test and vaccinate the entire population and care for large numbers of seriously ill people; and (b) to bolster the infrastructure and capacity of state and local health departments to effectively prepare for and respond to~~, and protect the population from illness and death in an influenza~~ a pandemic or other serious public health emergency;

(3) encourages states and tribal communities to maintain medical and personal protective equipment stockpiles sufficient for effective preparedness and to respond to a pandemic or other major public health emergency;

(~~3~~4) urges the CDC to develop and disseminate electronic instructional resources on procedures to follow in an ~~influenza~~ epidemic, pandemic, or other serious public health emergency, which are tailored to the needs of physicians and medical office staff in ambulatory care settings;

(~~4~~5) supports the position that: (a) relevant national and state agencies (such as the CDC, NIH, and the state departments of health) take immediate action to assure that physicians, nurses, other health care professionals, and first responders having direct patient contact, receive any appropriate vaccination in a timely and efficient manner, in order to reassure them that they will have first priority in the event of such a pandemic; and (b) such agencies should publicize now, in advance of any such pandemic, what the plan will be to provide immunization to health care providers;

(6) will monitor progress in developing a contingency plan that addresses future ~~influenza~~ vaccine production or distribution problems and in developing a plan to respond to a~~n influenza~~ pandemic in the United States.

; and be it further

RESOLVED, That our AMA-MSS immediately forward this resolution to the AMA House of Delegates.

Your Reference Committee heard testimony in support of Resolution 004. The MSS Committee on Global and Public Health (CGPH) offered a friendly amendment to the proposed changes to D-440.847, to ensure tribal communities and the Indian Health Service have adequate resources amidst public health emergencies, which is reflected in the Reference Committee's recommendation. The delegation from Massachusetts, as well as your MSS Section Delegates, recommended that the immediate forward clause be removed from Resolution 004. While this is an important topic, the proposed changes will not significantly change current advocacy efforts in the near future. Your Reference Committee found this reasoning to be compelling and agrees that the immediate forward clause should be deleted and Resolution 004 be adopted as amended.

(32) RESOLUTION 005 – SUPPORT PUBLIC HEALTH APPROACHES FOR THE PREVENTION AND MANAGEMENT OF COVID-19 IN CORRECTIONAL FACILITIES

RECOMMENDATION A:

The first Resolve clause of Resolution 005 be <u>amended by addition and deletion</u> as follows:

RESOLVED, That our AMA collaborate with state medical societies to advocate for evidence-based public health measures to curb the spread of highly contagious ~~respiratory~~ pathogens in the setting of prisons and jails, including, but not limited to: 1) Universally available screening, testing, contact tracing, and medical care to staff and individuals that are incarcerated<u>,</u> 2) Access to sanitizing equipment including, but not limited to, soap, hand sanitizer, and cleaning supplies<u>,</u> 3) Humane and safe quarantine protocol for individuals that test positive for or are exposed to highly contagious respiratory pathogens<u>,</u> 4) Adherence to use of personal protective equipment for incarcerated individuals and staff<u>, and</u> 5) Expanded data reporting, including testing rates and demographic breakdown of highly contagious infectious disease cases and deaths; and be it further

RECOMMENDATION B:

The second Resolve clause of Resolution 005 be <u>amended by deletion</u> as follows:

RESOLVED, That our AMA support efforts to de-carcerate non-violent elderly and medically vulnerable individuals to mitigate the spread of highly contagious ~~respiratory~~ pathogens within correctional facilities and communities; and be it further

RECOMMENDATION C:

Resolution 005 be <u>amended by addition of a new Resolve</u> as follows:

<u>RESOLVED, That our AMA support prioritizing COVID vaccine access for justice-involved populations; and be it further</u>

RECOMMENDATION D:

Resolution 005 be <u>amended with a title change</u>:

"Support Public Health Approaches for the Prevention and Management of ~~COVID-19~~ <u>Contagious Diseases</u> in Correctional Facilities"

RECOMMENDATION E:

Resolution 005 be <u>adopted as amended</u>.

RESOLVED, That our AMA collaborate with state medical societies to advocate for evidence-based public health measures to curb the spread of highly contagious respiratory pathogens in the setting of prisons and jails, including, but not limited to:
(a) Universally available screening, testing, contact tracing, and medical care to staff and individuals that are incarcerated
(b) Access to sanitizing equipment including, but not limited to, soap, hand sanitizer, and cleaning supplies
(c) Humane and safe quarantine protocol for individuals that test positive for or are exposed to highly contagious respiratory pathogens
(d) Adherence to use of personal protective equipment for incarcerated individuals and staff
(e) Expanded data reporting, including testing rates and demographic breakdown of highly contagious infectious disease cases and deaths; and be it further

RESOLVED, That our AMA will support efforts to decarcerate non-violent elderly and medically vulnerable individuals to mitigate the spread of highly contagious respiratory pathogens within correctional facilities and communities; and be it further

RESOLVED, That our AMA will amend policy H-430.989 by insertion as follows:

Disease Prevention and Health Promotion in Correctional Institutions, H-430.989

Our AMA urges state and local health departments to develop plans that would foster closer working relations between the criminal justice, medical, and public health systems toward the prevention and control of HIV/AIDS, substance abuse, tuberculosis, ~~and~~ hepatitis<u>, and highly</u>

contagious infectious diseases. Some of these plans should have as their objectives: (a) an increase in collaborative efforts between parole officers and drug treatment center staff in case management aimed at helping patients to continue in treatment and to remain drug free; (b) an increase in direct referral by correctional systems of parolees with a recent, active history of intravenous drug use to drug treatment centers; and (c) consideration by judicial authorities of assigning individuals to drug treatment programs as a sentence or in connection with sentencing

; and be it further

RESOLVED, That this resolution be forwarded immediately to the House of Delegates at the November 2020 Special Meeting.

Your Reference Committee heard widespread support of Resolution 005 on the VRC, including support from Region 1, Region 3, Region 4, your MSS Committees on Legislation and Advocacy (COLA) and Global and Public Health (CGPH), and the delegation from Massachusetts. Testimony supported keeping the immediate forward clause included in Resolution 005 and your Reference Committee agrees that this issue is timely enough to warrant immediate transmission if passed by the MSS Assembly.

Resolution 005 will dovetail nicely with BOT Report 10 that is also being considered at the November 2020 Special Meeting of the AMA House of Delegates. The proposed amendments in Resolve 1 and Resolve 2 are supported by the authors and we hope are considered friendly. The addition of a new Resolve clause to address vaccine access was proposed on the VRC by Neil Rens and supported by the authors. Your Reference Committee also recommends a title change for Resolution 005 that more closely aligns with the final language of the Resolve clauses.

(33) RESOLUTION 007 – REPRESENTATION OF DERMATOLOGICAL PATHOLOGIES IN VARYING SKIN TONES

RECOMMENDATION A:

The first Resolve clause of Resolution 007 be amended by addition and deletion as follows:

RESOLVED, That our AMA encourages the inclusion of ~~medical schools to include~~ a diverse range of skin tones in preclinical and clinical dermatologic medical education materials and evaluations; and be it further

RECOMMENDATION B:

The second Resolve clause of Resolution 007 be amended by addition and deletion as follows:

RESOLVED, That our AMA encourage the development of ~~works with relevant stakeholders to develop~~ educational materials for medical students and physicians that contribute to the equitable representation of diverse skin tones, ~~including support of the overrepresentation of darker skin tones in such materials.~~

RECOMMENDATION C:

Resolution 007 be amended by addition of a new Resolve clause as follows:

RESOLVED, That our AMA support the overrepresentation of darker skin tones in dermatologic medical education materials.

RECOMMENDATION D:

Resolution 007 be adopted as amended.

RESOLVED, That our AMA encourages medical schools to include a diverse range of skin tones in preclinical and clinical dermatologic medical education materials and evaluations; and be it further

RESOLVED, That our AMA works with relevant stakeholders to develop educational materials for medical students and physicians that contribute to the equitable representation of diverse skin tones, including support of the overrepresentation of darker skin tones in such materials.

Your Reference Committee heard widespread support for Resolution 007 on the VRC. We have proposed amendments to the first and second Resolve clauses to clarify the language and the asks, including breaking out the last clause of the second Resolve clause into a third Resolve clause to specifically support overrepresentation of darker skin tones in the creation of educational materials. Overall, we found this resolution to be well-written and commend the authors on a well-constructed proposal.

(34) RESOLUTION 008 – PROTESTOR PROTECTIONS

RECOMMENDATION A:

The second Resolve of Resolution 008 be <u>deleted</u>:

~~**RESOLVED, That our AMA discourage the use of crowd-control weapons that have not been thoroughly researched; and be it further**~~

RECOMMENDATION B:

The third Resolve of Resolution 008 be <u>amended by addition and deletion</u> to read as follows:

RESOLVED, That our AMA encourage relevant stakeholders including but not limited to manufacturers and government agencies to develop, test, and use crowd-control ~~weapons and~~ techniques which ~~minimize~~ <u>pose no risk of</u> physical harm; and be it further

RECOMMENDATION C:

Resolution 008 be <u>adopted as amended</u>.

RESOLVED, That our AMA advocate to ban the use of chemical irritants and kinetic impact projectiles for crowd-control in the United States; and be it further

RESOLVED, That our AMA discourage the use of crowd-control weapons that have not been thoroughly researched; and be it further

RESOLVED, That our AMA encourage relevant stakeholders including but not limited to manufacturers and government agencies to develop, test, and use crowd-control weapons and techniques which minimize physical harm; and be it further

RESOLVED, That our AMA-MSS immediately forward this resolution to the AMA House of Delegates.

Your Reference Committee commends the authors for bringing forward a resolution on such an important and timely topic. The amendments we propose to the third Resolve clause clarify that, in passing this resolution, we do not endorse any form of violence and/or physical harm as allowable by crowd-control techniques. There was ambiguity in the original language that potentially could have been interpreted as limiting physical harm, not eliminating it altogether. We think it is important to strengthen this language and solidify our stance that we do not support physical harm and/or violence of any kind in these circumstances. There was concern that advocating for this issue could be accompanied by a large fiscal note, but we believe that this issue is important enough to not only include “advocate” as the call to action, but also immediately forward this resolution to the House of Delegates should it be passed by the MSS Assembly. There

was widespread and significant support for Resolution 008 on the VRC, including support for immediate forwarding.

(35) RESOLUTION 009 – CALL FOR INCREASED FUNDING AND RESEARCH FOR POST VIRAL SYNDROMES

RECOMMENDATION A:

The first Resolve of Resolution 009 be amended by addition and deletion as follows:

RESOLVED, That our AMA ~~will encourage Congress to enact~~ advocate for legislation to provide funding for research, prevention, control, and treatment of post viral syndromes and long-term sequalae associated with COVID-19, including those experienced by long haulers;~~, but not limited to Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS);~~ and be it further

RECOMMENDATION B:

The second Resolve of Resolution 009 be amended by addition and deletion as follows:

RESOLVED, That our AMA ~~will support~~ provide physicians and medical students with ~~in providing~~ accurate and current information on post-viral syndromes and long-term sequelae associated with COVID-19, including those experienced by long haulers. ~~but not limited to Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS); and be it further~~

RECOMMENDATION C:

The third Resolve of Resolution 009 be deleted:

~~RESOLVED, That our AMA will collaborate with other medical and educational entities to promote education of post-viral syndromes, including but not limited to Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS), to minimize the harm and disability current and future patients face.~~

RECOMMENDATION D:

Resolution 009 be adopted as amended.

RESOLVED, That our AMA will encourage Congress to enact legislation to provide funding for research, prevention, control, and treatment of post viral syndromes associated with COVID-19, including, but not limited to Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS); and be it further

RESOLVED, That our AMA will support physicians in providing accurate and current information on post-viral syndromes, including but not limited to Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS); and be it further

RESOLVED, That our AMA will collaborate with other medical and educational entities to promote education of post-viral syndromes, including but not limited to Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS), to minimize the harm and disability current and future patients face.

VRC testimony was universally supportive of the spirit of Resolution 009. There were concerns about specifically listing Myalgic Encephalomyelitis and Chronic Fatigue Syndrome (ME/CFS), as this might narrow advocacy related to other post-viral syndromes, including those which affect COVID-19 "long haulers." Your Reference Committee's proposed amendments aim to streamline the resolution and remove the specific references to ME/CFS. Your Reference Committee noted possible ambiguity in the term "long hauler" and that other terms exist for this new syndrome (long COVID, post-COVID syndrome, chronic COVID syndrome, among others) and concerns that the term commonly used may have changed by June 2021. However, we believe it is appropriate to use the term "long hauler" as this is currently included in the vernacular around the disease. We found the third Resolve to be redundant and added a reference to medical students to the second Resolve in order to combine the asks of the second and third Resolves and further consolidate the language of this resolution. Your Reference Committee recommends that Resolution 009 be adopted as amended.

(36) RESOLUTION 011 – CAPS ON INSULIN CO-PAYMENTS FOR PATIENTS WITH INSURANCE

RECOMMENDATION A:

Resolution 011 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA amend existing AMA policy H-110.984 Insulin Affordability by addition and deletion to read: ~~supports states limiting the copayments insured patients pay per month for prescribed insulin and amend current policy as shown below:~~

Insulin Affordability H-110.984
Our AMA will: (1) encourage the Federal Trade Commission (FTC) and the Department of Justice to monitor insulin pricing and market competition and take enforcement actions as appropriate; ~~and~~ (2) support initiatives, including those by national medical

specialty societies, that provide physician education regarding the cost-effectiveness of insulin therapies.; and (3) support state and national efforts to limit the copayments insured patients pay per month for prescribed insulin.; and (4) support limits on the copayments insured patients pay per month for prescribed insulin at a national policy level.

RECOMMENDATION C:

Resolution 011 be adopted as amended.

RESOLVED, That our AMA supports states limiting the copayments insured patients pay per month for prescribed insulin and amend current policy as shown below:

Insulin Affordability H-110.984
Our AMA will: (1) encourage the Federal Trade Commission (FTC) and the Department of Justice to monitor insulin pricing and market competition and take enforcement actions as appropriate; and (2) support initiatives, including those by national medical specialty societies, that provide physician education regarding the cost-effectiveness of insulin therapies.; (3) support state and national efforts to limit the copayments insured patients pay per month for prescribed insulin; and (4) support limits on the copayments insured patients pay per month for prescribed insulin at a national policy level.

VRC testimony nearly unanimously favored striking the proposed clause 4 to H-110.984 because it is redundant, but supported the underlying thrust of this resolution in limiting copayments for insulin prescriptions. Your Reference Committee agrees that the proposed asks in clause 4 are contained within the proposed language to clause 3. For this reason we recommend striking the proposed fourth clause. We have removed the explication prior to introducing the proposed amendments to H-110.984. We recommend Resolution 011 be adopted as amended.

(37) RESOLUTION 012 – POLICING REFORM

RECOMMENDATION A:

Policy H-515.955 be reaffirmed in lieu of the second Resolve of Resolution 012.

RECOMMENDATION B:

The third Resolve of Resolution 012 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA advocate for the elimination or reform of qualified immunity, barriers to civilian oversight, and other measures that ~~which~~ shields~~s~~ law enforcement officers from consequences for misconduct~~ and perpetuates a system which leaves the public vulnerable to unpunishable violence~~; and be it further

RECOMMENDATION C:

The fourth Resolve of Resolution 012 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA support efforts to demilitarize law enforcement agencies, including ~~abolition~~ elimination of the controlled category of the United States Department of Defense 1033 Program and cessation of federal and state funding for civil law enforcement acquisition of military-grade weapons; and be it further

RECOMMENDATION D:

The fifth Resolve clause of Resolution 012 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA-MSS supports advocate~~e~~ing for the prohibition of issuance and execution of no-knock warrants; and be it further

RECOMMENDATION E:

The sixth Resolve of Resolution 012 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA advocate ~~for the prohibition of~~ against the utilization of racial and discriminatory profiling by law enforcement through appropriate anti-bias training, individual monitoring, and other measures; and be it further

RECOMMENDATION F:

The seventh Resolve clause of Resolution 012 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA advocate for the prohibition of the use of sedative/hypnotic agents, such as ketamine, ~~ketamine and other sedative/hypnotic agents~~ by first responders for non-medically indicated, law enforcement purposes; and be it further

RECOMMENDATION G:

The ninth Resolve clause of Resolution 012 be amended by addition to read as follows:

RESOLVED, That our AMA support the creation of independent, third party community-based oversight committees with disciplinary power whose mission will be to oversee and decrease police-on-public violence; and be it further

RECOMMENDATION H:

Resolution 012 be adopted as amended.

RESOLVED, That our AMA recognize police brutality as a manifestation of structural racism which disproportionately impacts Black, Indigenous, and other people of color; and be it further

RESOLVED, That our AMA recognize policy brutality as a threat to the physical, mental, and economic health of individuals—especially Black, Indigenous, and other people of color—their loved ones, their communities, and the police themselves; and be it further

RESOLVED, That our AMA advocate for the elimination of qualified immunity, which shields law enforcement officers from consequences for misconduct and perpetuates a system which leaves the public vulnerable to unpunishable violence; and be it further

RESOLVED, That our AMA support efforts to demilitarize law enforcement agencies, including abolition of the United States Department of Defense 1033 Program and cessation of federal and state funding for civil law enforcement acquisition of military-grade weapons; and be it further

RESOLVED, That our AMA advocate for the prohibition of issuance and execution of no-knock warrants; and be it further

RESOLVED, That our AMA advocate for the prohibition of utilization of racial and discriminatory profiling by law enforcement; and be it further

RESOLVED, That our AMA advocate for the prohibition of the use of ketamine and other sedative/hypnotic agents by first responders for non-medically indicated, law enforcement purposes; and be it further

RESOLVED, That our AMA advocate for legislation and regulations which promote trauma-informed, community-based safety practices; and be it further

RESOLVED, That our AMA support the creation of community oversight committees with disciplinary power whose mission will be to decrease police-on-public violence; and be it further

RESOLVED, That this resolution be immediately forwarded to the November 2020 Spcial Meeting of the House of Delegates.

VRC testimony was overwhelmingly supportive of Resolution 012. GLMA, the Minority Affairs Section (MAS), Region 1, Region 4, the MSS Minority Issues Committee (MIC), MSS Committee on LGBTQ+ Issues, the Psychiatry Student Interest Group Network (PsychSIGN) and three individuals supported Resolution 012. The Massachusetts delegation, MSS Committee on Global and Public Health (CGPH) and the MSS Section Delegates supported Resolution 012 with various amendments. The delegate from the American Academy of Pediatrics (AAP) provided testimony that AAP has policy supporting the spirit of this resolution. The American College of Emergency Physicians (ACEP) provided mixed testimony, citing concern with scope and magnitude, and specific concern with the reference to ketamine. The MSS House Coordination Committee (HCC) recommended that policy H-515.955 be reaffirmed in lieu of the second Resolve clause of Resolution 012.

Your Reference Committee thanks the authors for a thorough, well-researched resolution on such a timely topic. We concur with HCC and believe the asks of the second Resolve are already covered in existing policy. We offer a series of amendments to the third, fourth, fifth, sixth, seventh, and ninth Resolve clauses to incorporate feedback received during VRC testimony. We did not incorporate all changes proposed, just those that were well-supported by the existing Whereas clauses in order to stay in line with author intent.

Your Reference Committee found the Section Delegates' proposed amendment compelling for the third Resolve and have added "or reform." The amendments proposed to the fourth Resolve were also proposed by the Section Delegates and supported by the authors. We recommend making the fifth Resolve internal. We believe this is a very important issue that needs to be re-visited with further resources and evidence. We found the VRC testimony suggesting that more justification was needed on the health impacts of no knock warrants compelling and therefore recommend making the fifth Resolve internal at this time. The sixth Resolve clause was amended for clarity. The amendments to the seventh Resolve clause were made to mollify ACEP concerns about specifically citing ketamine use. Finally, we propose clarifying amendments to the ninth Resolve clause. We recommend Resolution 012 be adopted as amended.

RESEARCH THE EFFECTS OF PHYSICAL OR VERBAL VIOLENCE BETWEEN LAW ENFORCEMENT OFFICERS AND PUBLIC CITIZENS ON PUBLIC HEALTH OUTCOMES, H-515.955

Our AMA:

1. Encourages the National Academies of Sciences, Engineering, and Medicine and other interested parties to

study the public health effects of physical or verbal violence between law enforcement officers and public citizens, particularly within ethnic and racial minority communities.
2. Affirms that physical and verbal violence between law enforcement officers and public citizens, particularly within racial and ethnic minority populations, is a social determinant of health.
3. Encourages the Centers for Disease Control and Prevention as well as state and local public health agencies to research the nature and public health implications of violence involving law enforcement.
4. Encourages states to require the reporting of legal intervention deaths and law enforcement officer homicides to public health agencies.
5. Encourages appropriate stakeholders, including, but not limited to the law enforcement and public health communities, to define "serious injuries" for the purpose of systematically collecting data on law enforcement-related non-fatal injuries among civilians and officers.

(38) RESOLUTION 014 – MEDICAID AND CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) COVERAGE OF CONTINUOUS GLUCOSE MONITORING DEVICES FOR PATIENTS WITH INSULIN-DEPENDENT DIABETES

RECOMMENDATION A:

Resolution 014 be amended by addition and deletion as follows:

RESOLVED, That ~~the~~ our AMA amend ~~Resolution~~ Policy H-330.885, to include the following:

~~Medicare~~ Public Insurance Coverage of Continuous Glucose Monitoring Devices for Patients with Insulin-Dependent Diabetes H-330.885

Our AMA supports efforts to achieve ~~Medicare, Medicaid, and Children's Health Insurance Program (CHIP)~~ coverage of continuous glucose monitoring systems for patients with insulin-dependent diabetes by all public insurance programs.

RECOMMENDATION B:

Resolution 014 be adopted as amended.

RESOLVED, That the AMA amend Resolution H-330.885 to include the following:

Medicare Coverage of Continuous Glucose Monitoring Devices for Patients with Insulin-Dependent Diabetes H-330.885

Our AMA supports efforts to achieve Medicare, Medicaid, and Children's Health Insurance Program (CHIP) coverage of continuous glucose monitoring systems for patients with insulin-dependent diabetes.

Testimony on the VRC supported the spirit of Resolution 014. The Massachusetts proposed amending to include all payors, but the authors reiterated their focus being on disadvantaged populations. Your Reference Committee respects the authors' desire to focus on these populations specifically and hope that our proposed language will strike an appropriate balance in seeking to expand access to coverage while remaining broadly palatable, and help to streamline the ask without changing the intention of Resolution 014. We recommend Resolution 014 be adopted as amended.

(39) RESOLUTION 015 – AMENDING H-150.962, QUALITY OF SCHOOL LUNCH PROGRAM, TO ADVOCATE FOR EXPANSION AND SUSTAINABILITY OF NUTRITIONAL ASSISTANCE PROGRAMS DURING COVID-19

RECOMMENDATION A:

The first Resolve clause of Resolution 015 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA amend policy H-150.962, Quality of School Lunch Program, by addition as follows:

Quality of School Lunch Program H-150.962

1. Our AMA recommends to the National School Lunch Program that school meals be congruent with current U.S. Department of Agriculture/Department of HHS Dietary Guidelines.
2. Our AMA opposes legislation and regulatory initiatives that reduce or eliminate access to federal child nutrition programs.
3. Our AMA support adoption and ~~advocates for increased~~ funding of alternative ~~and governmental assistance for both federal and state level~~ nutrition and meal assistance programs~~, including viable alternatives to these programs,~~ during a ~~national~~ crisi~~e~~s, such as a pandemic.
~~4. Our AMA will work with state medical associations to encourage all states, counties, and school districts to~~

~~**adopt programs that provide meals during national crises, such as a pandemic.**~~

RECOMMENDATION B:

The second Resolve clause of Resolution 015 be deleted:

~~**RESOLVED, That this resolution be immediately forwarded to the House of Delegates at the November Meeting in 2020.**~~

RECOMMENDATION C:

Resolution 015 be adopted as amended.

RESOLVED, That our AMA amend policy H-150.962, Quality of School Lunch Program, by addition as follows:

Quality of School Lunch Program H-150.962

1. Our AMA recommends to the National School Lunch Program that school meals be congruent with current U.S. Department of Agriculture/Department of HHS Dietary Guidelines.
2. Our AMA opposes legislation and regulatory initiatives that reduce or eliminate access to federal child nutrition programs.
3. Our AMA advocates for increased funding and governmental assistance for both federal and state level nutrition and meal assistance programs, including viable alternatives to these programs, during national crises, such as a pandemic.
4. Our AMA will work with state medical associations to encourage all states, counties, and school districts to adopt programs that provide meals during national crises, such as a pandemic.

;and be it further

RESOLVED, That this resolution be immediately forwarded to the House of Delegates at the November Meeting in 2020.

VRC testimony highlighted that this is both a novel and much-needed resolution. There were several suggestions, including one from the authors, to remove the immediate forward clause from Resolution 015, and we agree. We offer amendments to consolidate the language from the proposed third and fourth clauses and recommend Resolution 015 be adopted as amended.

(40) RESOLUTION 019 – SUPPORT FOR MENTAL HEALTH COURTS

RECOMMENDATION A:

Resolution 019 be amended by addition and deletion as follows:

RESOLVED, That ~~to expand existing AMA policy on support for drug courts to the various types of mental health courts that exist and to be consistent with recently passed AMA policy on support for veteran courts,~~ AMA Policy H-100.955, "Support for Drug Courts," be amended by ~~insertion~~ addition and deletion as follows:

SUPPORT FOR MENTAL HEALTH ~~DRUG~~ COURTS, H-100.955
Our AMA: (1) supports the establishment and use of mental health ~~drug~~ courts, including drug courts and sobriety courts, as an effective method of intervention for individuals with mental illness involved in the justice system within a comprehensive system of community-based services and supports ~~addictive disease who are convicted of nonviolent crimes~~; (2) encourages legislators to establish mental health ~~drug~~ courts at the state and local level in the United States; and (3) encourages mental health ~~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.

RECOMMENDATION B:

Resolution 019 be adopted as amended.

RESOLVED, That to expand existing AMA policy on support for drug courts to the various types of mental health courts that exist and to be consistent with recently passed AMA policy on support for veteran courts, AMA Policy H-100.955, "Support for Drug Courts," be amended by insertion and deletion as follows:

Support for Mental Health ~~Drug~~ Courts, H-100.955
Our AMA: (1) supports the establishment and use of mental health ~~drug~~ courts, including drug courts and sobriety courts, as an effective method of intervention for individuals with mental illness involved in the justice system ~~addictive disease who are convicted of nonviolent crimes~~; (2) encourages legislators to establish mental health ~~drug~~ courts at the state and local level in the United States; and

(3) encourages mental health ~~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.

Testimony heard on Resolution 019 was generally in support of the spirit of the resolution, including from the American Academy of Psychiatry and the Law. Your Reference Committee found this resolution to be well-written and have incorporated a friendly amendment from Region 3 to ensure that the mental health courts are used in conjunction with a comprehensive system of community-based services and support for people with mental illness. We recommend Resolution 019 be adopted as amended.

(41) RESOLUTION 020 – EXPANDING MEDICAID TRANSPORTATION TO INCLUDE HEALTHY GROCERY DESINATIONS

RECOMMENDATION A:

Resolution 020 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA (1) support the implementation and expansion of transportation services for accessing healthy grocery options; and (2) ~~advocate for~~ support inclusion of supermarkets, food banks and pantries, and local farmers markets as destinations offered by Medicaid transportation at the federal level; and (3) support efforts to extend Medicaid reimbursement to non-emergent medical transportation for healthy grocery destinations.

RECOMMENDATION B:

Resolution 020 be adopted as amended.

RESOLVED, That our AMA (1) support the implementation and expansion of transportation services for accessing healthy grocery options; and (2) advocate for inclusion of supermarkets, food banks and pantries, and local farmers markets as destinations offered by Medicaid transportation at the federal level; and (3) support efforts to extend Medicaid reimbursement to non-emergent medical transportation for healthy grocery destinations.

There was extensive testimony on the VRC on Resolution 020. The MSS Committees on Legislation and Advocacy (COLA) and Economics and Quality in Medicine (CEQM) proposed an amendment striking the second and third Resolve clauses, citing a potential need for more evidence regarding the logistics of this program, but your Reference Committee did not find these compelling to the specific ask of the resolution; the whereas statements included several references to existing, successful polit programs that demonstrate the feasibility of such initiatives. We offer an amendment in the second

proposed clause to change “advocate for” to “support” to not only mirror the language in the other clauses, but also provide longevity and flexibility to the resolution as a whole. Your Reference Committee recommends resolution 020 be adopted as amended.

(42) RESOLUTION 022 – ENSURING CONSENT DURING EDUCATIONAL PHYSICAL EXAMS ON UNCONSCIOUS PATIENTS

RECOMMENDATION A:

The second Resolve of Resolution 022 be amended by addition and deletion as follows:

RESOLVED, That our AMA-MSS support encouraging ~~encourage~~ institutions to adopt policies that ensure patients are ~~educated on~~ explicitly informed that sensitive physical exams such as breast, pelvic, genitourinary, and rectal exams may occur under anesthesia. ~~that occur under anesthesia.~~

RECOMMENDATION B:

Resolution 022 be adopted as amended.

RESOLVED, That our AMA-MSS oppose performing physical exams on patients under anesthesia or on unconscious patients when these exams are not urgently medically necessary or without prior informed consent to do so; and be it further

RESOLVED, That our AMA-MSS encourage institutions to adopt policies that ensure patients are educated on pelvic, genitourinary, and rectal exams that occur under anesthesia.

VRC testimony supported the spirit of Resolution 022. Your Reference Committee received compelling information concerning the feasibility of the second Resolve clause, as the MSS does not itself work with outside institutions. We propose language to rectify this. We also propose language amending the second Resolve that clarifies the ask and also adds breast exams to the list presented. Your Reference Committee recommends Resolution 022 be adopted as amended.

(43) RESOLUTION 026 – NON-CERVICAL HPV ASSOCIATED CANCER PREVENTION

RECOMMENDATION A:

The first Resolve of Resolution 026 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA amend policy H-440.872 "HPV Vaccine and Cervical Cancer Prevention Worldwide" by ~~insertion~~ addition and deletion as follows:

HPV Vaccine and ~~Cervical~~ Cancer Prevention Worldwide, H-440.872

1. Our AMA (a) urges physicians to educate themselves and their patients about HPV and associated diseases, HPV vaccination, as well as routine ~~cervical~~ cancer screening for those at risk; and (b) encourages the development and funding of programs targeted at HPV vaccine introduction and cervical cancer screening in countries without organized cervical cancer screening programs.

2. Our AMA will intensify efforts to improve awareness and understanding about HPV and associated diseases, in all individuals regardless of sex ~~both sexes~~ such as, but not limited to, cervical cancer, head and neck cancer, anal cancer, and penile cancer, the availability and efficacy of HPV vaccinations, and the need for routine cervical cancer screening in the general public.

3. Our AMA (a) encourages the integration of HPV vaccination and routine cervical cancer screening into all appropriate health care settings and visits ~~for adolescents and young adults~~, (b) supports the availability of the HPV vaccine and routine cervical cancer screening to appropriate patient groups that benefit most from preventive measures, including but not limited to low-income and pre-sexually active populations, (c) recommends HPV vaccination for all groups for whom the federal Advisory Committee on Immunization Practices recommends HPV vaccination.

4. Our AMA encourage appropriate stakeholders to investigate means to increase HPV vaccination rates by: (a) facilitating administration of HPV vaccinations in community-based settings including school settings, and (b) supporting state mandates for HPV vaccination for school attendance; and be it further

RECOMMENDATION B:

Policy D-170.995 be reaffirmed in lieu of the second and third Resolves of Resolution 026.

RECOMMENDATION C:

Resolution 026 be adopted as amended.

RESOLVED, That our AMA amend policy H-440.872 "HPV Vaccine and Cervical Cancer Prevention Worldwide" by insertion and deletion as follows:

HPV Vaccine and ~~Cervical~~ Cancer Prevention Worldwide, H-440.872

1. Our AMA (a) urges physicians to educate themselves and their patients about HPV and associated diseases, HPV vaccination, as well as routine ~~cervical~~ cancer screening for those at risk; and (b) encourages the development and funding of programs targeted at HPV vaccine introduction and cervical cancer screening in countries without organized cervical cancer screening programs.

2. Our AMA will intensify efforts to improve awareness and understanding about HPV and associated diseases, in all both sexes such as, but not limited to, cervical cancer, head and neck cancer, anal cancer, and penile cancer, the availability and efficacy of HPV vaccinations, and the need for routine cervical cancer screening in the general public.

3. Our AMA

(a) encourages the integration of HPV vaccination and routine cervical cancer screening into all appropriate health care settings and visits ~~for adolescents and young adults~~,

(b) supports the availability of the HPV vaccine and routine cervical cancer screening to appropriate patient groups that benefit most from preventive measures, including but not limited to low-income and pre-sexually active populations,

(c) recommends HPV vaccination for all groups for whom the federal Advisory Committee on Immunization Practices recommends HPV vaccination.

4. Our AMA encourage appropriate stakeholders to investigate means to increase HPV vaccination rates by:

(a) facilitating administration of HPV vaccinations in community-based settings including school settings, and

(b) supporting state mandates for HPV vaccination for school attendance

; and be it further

RESOLVED, That our AMA work with appropriate stakeholders to promote educational resources on the relationship between HPV and all associated cancers and conditions, in addition to the HPV vaccination guidelines; and be it further

RESOLVED, That our AMA encourage gender-neutrality when educating and about HPV infection and promoting the HPV vaccine in order to normalize vaccination in all individuals; and be it further

RESOLVED, That our AMA support legislation and funding for research aimed towards discovering screening methodology and early detection methods for other non-cervical HPV associated cancers.

The MSS House Coordination Committee (HCC) recommended policy D-170.995 be reaffirmed in lieu of the second and third Resolve clauses of Resolution 026. Your Reference Committee concurs and only considered the first and fourth Resolve clauses in our deliberations. VRC testimony was supportive of the spirit of this well-written resolution. Testimony on the VRC proposed amendments to the second and third Resolve clauses that could be considered novel. We propose a friendly amendment to the first resolve, changing “both sexes” to “all individuals regardless of sex” to be more inclusive. We support the fourth Resolve as written. Your Reference Committee recommends Resolution 026 be adopted as amended.

> HUMAN PAPILLOMAVIRUS (HPV) INCLUSION IN SCHOOL EDUCATION CURRICULA, D-170.995
> Our AMA will: (1) strongly urge existing school health education programs to emphasize the high prevalence of human papillomavirus in all genders, the causal relationship of HPV to cancer and genital lesions, and the importance of routine pap tests in the early detection of cancer; (2) urge that students and parents be educated about HPV and the availability of the HPV vaccine; and (3) support appropriate stakeholders to increase public awareness of HPV vaccine effectiveness for all genders against HPV-related cancers.

(44) RESOLUTION 027 – OPPOSITION TO THE CRIMINALIZATION AND UNDUE RESTRICTION OF EVIDENCE-BASED GENDER-AFFIRMING CARE FOR TRANSGENDER AND GENDER-DIVERSE INDIVIDUALS

RECOMMENDATION A:

The first Resolve of Resolution 027 be <u>amended by addition and deletion</u> as follows:

RESOLVED, That our AMA amend policy H-185.927, "Clarification of Medical Necessity for Treatment of Gender Dysphoria" by addition and deletion as follows:

CLARIFICATION OF MEDICAL NECESSITY FOR TREATMENT OF GENDER DYSPHORIA H-185.927

Our AMA: (1) recognizes that medical and surgical treatments for gender dysphoria, as determined by shared decision making between the patient and physician, are medically necessary as outlined by generally-accepted standards of medical and surgical practice; ~~and~~ (2) will advocate for federal, state, and local policies to provide medically necessary care for gender dysphoria; and (3) opposes efforts ~~the~~ that criminalize~~ation~~ or otherwise ~~undue~~ restrict~~ion of~~ evidence-based gender-affirming care or place an undue burden on individuals seeking access to this care.

RECOMMENDATION B:

The second Resolve of Resolution 027 be deleted:

~~**RESOLVED, This resolution immediately be forward to the House of Delegates for A-20.**~~

RECOMMENDATION C:

Resolution 027 be adopted as amended.

RESOLVED, That our AMA amend policy H-185.927, "Clarification of Medical Necessity for Treatment of Gender Dysphoria" by addition and deletion as follows:

Clarification of Medical Necessity for Treatment of Gender Dysphoria H-185.927
Our AMA: (1) recognizes that medical and surgical treatments for gender dysphoria, as determined by shared decision making between the patient and physician, are medically necessary as outlined by generally-accepted standards of medical and surgical practice; ~~and~~ (2) will advocate for federal, state, and local policies to provide medically necessary care for gender dysphoria; and (3) opposes the criminalization and otherwise undue restriction of evidence-based gender-affirming care.

RESOLVED, This resolution immediately be forward to the House of Delegates for A-20.

Your Reference Committee heard testimony that was generally supportive of Resolution 027. Our recommendation highlights changes requested by the authors to ensure AMA opposition to any efforts that restrict gender-affirming care including criminalization and legislative barriers that may place undue burden on the individuals seeking care. These amendments are supported by GLMA and the MSS Standing Committee on LGBTQ+ Issues. There was consensus from testimony, and support from the authors, to strike the immediate forward clause from Resolution 027. Your Reference Committee recommends Resolution 027 be adopted as amended.

(45) RESOLUTION 028 – ANTI-HARASSMENT TRAINING

RECOMMENDATION A:

The first Resolve of Resolution 028 be amended by addition and deletion as follows:

RESOLVED, That our AMA require all members ~~in~~ elected and appointed to national and regional AMA leadership positions to complete AMA ~~c~~ Code of ~~c~~ Conduct and anti-harassment training, ~~within one month of being elected~~ with continuous evaluation of the training for effectiveness in reducing harassment within the AMA; and be it further

RECOMMENDATION B:

The second Resolve of Resolution 028 be amended by addition and deletion as follows:

RESOLVED, That our AMA work with the Women Physicians Section, American Medical Women's Association, GLMA: Health Professionals Advancing LGBTQ Equality, and other stakeholders ~~Times Up Healthcare or other relevant parties and outside organizations~~ to identify an appropriate, evidence-based anti-harassment and sexual harassment prevention training to administer to leadership., ~~and~~

RECOMMENDATION C:

The third Resolve of Resolution 028 be deleted:

~~RESOLVED, That our AMA shall distribute surveys and analyze the effectiveness of these trainings regarding both reduction in harassment in the AMA and leadership's confidence in their capabilities to reduce harassment for at least five years following initiation.~~

RECOMMENDATION D:

Resolution 028 be <u>adopted as amended</u>.

RESOLVED, That our AMA require all members in elected and appointed AMA leadership positions to complete AMA code of conduct and anti-harassment training within one month of being elected; and be it further

RESOLVED, That our AMA work with Womens Physician Section, American Medical Womens Association, GLMA: Health Professionals Advancing LGBTQ Equality, Times Up Healthcare or other relevant parties and outside organizations to identify an appropriate, evidence-based anti-harassment and sexual harassment prevention training to administer to leadership, and

RESOLVED, That our AMA shall distribute surveys and analyze the effectiveness of these trainings regarding both reduction in harassment in the AMA and leadership's confidence in their capabilities to reduce harassment for at least five years following initiation.

VRC testimony was supportive of the spirit of Resolution 028 but called for clarity in some of the asks. Your Reference Committee proposes these amendments to address clarification sought by the Section Delegates and others, as well as to make the resolution more concise and feasible. These amendments ensure that each Resolve clause stands on its own and does not make internal references. With these amendments, your Reference Committee recommends adoption of Resolution 028.

(46) RESOLUTION 029 – AGAINST IMMUNITY PASSPORTS TO RELIEVE COVID-19 RESTRICTIONS

RECOMMENDATION A:

Resolution 029 be <u>amended by addition and deletion</u> to read as follows:

RESOLVED, That our AMA <u>oppose the implementation of</u> ~~recognize that~~ immunity passports <u>which give an individual differential privilege on the basis of immune status to a pathogen.</u> ~~have the potential to exacerbate racial, social and health inequities, stigmatization, and discrimination.~~

RECOMMENDATION B:

Resolution 029 be <u>adopted as amended</u>.

RESOLVED, That our AMA recognize that immunity passports have the potential to exacerbate racial, social and health inequities, stigmatization, and discrimination.

VRC testimony supported the spirit of Resolution 029. Our recommendation incorporates compelling clarifying amendments proposed by Bennett Vogt in testimony and makes the

resolution more actionable, which we believe is in line with the intent of the authors. Your Reference Committee recommends Resolution 029 be adopted as amended.

(47) RESOLUTION 030 – MENTAL HEALTH FIRST AID TRAINING

RECOMMENDATION A:

Policies H-345.999, H-345.984, H-345.981 and 345.021MSS be reaffirmed in lieu of the first Resolve of Resolution 030.

RECOMMENDATION B:

The second Resolve of Resolution 030 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA ~~work with~~ encourage appropriate stakeholders including physicians, medical societies, physician specialty organizations, federation of state medical boards, and state medical boards to provide access to evidence-based mental illness rescue training programs~~, such as Mental Health First Aid,~~ as accredited Continuing Medical Education (CME) commensurate with their responsibilities in emergent mental illness crises, both in the clinical setting and community.

RECOMMENDATION C:

Resolution 030 be adopted as amended.

RESOLVED, That our AMA will work with the Association of American Medical Colleges (AAMC), American Osteopathic Association (AOA), and Accreditation Council for Graduate Medical Education (ACGME) to encourage awareness and access to evidence-based mental illness rescue training programs, such as Mental Health First Aid, for medical students and graduate medical education programs in all specialties; and be it further

RESOLVED, That our AMA work with appropriate stakeholders including physicians, medical societies, physician specialty organizations, federation of state medical boards, and state medical boards to provide access to evidence-based mental illness rescue training programs, such as Mental Health First Aid, as accredited Continuing Medical Education (CME) commensurate with their responsibilities in emergent mental illness crises, both in the clinical setting and community.

We would first like to commend the authors for recognizing an important deficiency in policy and practice through this resolution. VRC testimony was overall supportive of Resolution 030. Region 3, the MSS Membership Engagement and Recruitment

Committee (MERC), the MSS Committee on LGBTQ+ Issues, the Massachusetts delegation, and the Psychiatry Student Interest Group Network (PsychSIGN) all testified in support of this resolution. The MSS House Coordination Committee (HCC) placed the first Resolve on the reaffirmation consent calendar, and although your Reference Committee concurs with this decision, we do acknowledge there is the potential for new policy development surrounding training specifically for mental illness crises. Our amendments strengthen the ask and make Resolution 030 more generalizable by striking references to specific curricular programs.

> STATEMENT OF PRINCIPLES ON MENTAL HEALTH, H-345.999
> (1) Tremendous strides have already been made in improving the care and treatment of patients with psychiatric illness, but much remains to be done. The mental health field is vast and includes a network of factors involving the life of the individual, the community, and the nation. Any program designed to combat psychiatric illness and promote mental health must, by the nature of the problems to be solved, be both ambitious and comprehensive.
> (2) The AMA recognizes the important stake every physician, regardless of type of practice, has in improving our mental health knowledge and resources. The physician participates in the mental health field on two levels, as an individual of science and as a citizen. The physician has much to gain from a knowledge of modern psychiatric principles and techniques, and much to contribute to the prevention, handling, and management of emotional disturbances. Furthermore, as a natural community leader, the physician is in an excellent position to work for and guide effective mental health programs.
> (3) The AMA will be more active in encouraging physicians to become leaders in community planning for mental health.
> (4) The AMA has a deep interest in fostering a general attitude within the profession and among the lay public more conducive to solving the many problems existing in the mental health field.
>
> AWARENESS, DIAGNOSIS AND TREATMENT OF DEPRESSION AND OTHER MENTAL ILLNESSES, H-345.984
> 1. Our AMA encourages: (a) medical schools, primary care residencies, and other training programs as appropriate to include the appropriate knowledge and skills to enable graduates to recognize, diagnose, and treat depression and other mental illnesses, either as the chief complaint or with another general medical condition; (b) all physicians providing clinical care to acquire the same knowledge and skills; and (c) additional research into the course and outcomes of patients with depression and other mental

illnesses who are seen in general medical settings and into the development of clinical and systems approaches designed to improve patient outcomes. Furthermore, any approaches designed to manage care by reduction in the demand for services should be based on scientifically sound outcomes research findings.
2. Our AMA will work with the National Institute on Mental Health and appropriate medical specialty and mental health advocacy groups to increase public awareness about depression and other mental illnesses, to reduce the stigma associated with depression and other mental illnesses, and to increase patient access to quality care for depression and other mental illnesses.
3. Our AMA: (a) will advocate for the incorporation of integrated services for general medical care, mental health care, and substance use disorder care into existing psychiatry, addiction medicine and primary care training programs' clinical settings; (b) encourages graduate medical education programs in primary care, psychiatry, and addiction medicine to create and expand opportunities for residents and fellows to obtain clinical experience working in an integrated behavioral health and primary care model, such as the collaborative care model; and (c) will advocate for appropriate reimbursement to support the practice of integrated physical and mental health care in clinical care settings.
4. Our AMA recognizes the impact of violence and social determinants on women’s mental health.

ACCESS TO MENTAL HEALTH SERVICES, H-345.981
Our AMA advocates the following steps to remove barriers that keep Americans from seeking and obtaining treatment for mental illness:
(1) reducing the stigma of mental illness by dispelling myths and providing accurate knowledge to ensure a more informed public;
(2) improving public awareness of effective treatment for mental illness;
(3) ensuring the supply of psychiatrists and other well-trained mental health professionals, especially in rural areas and those serving children and adolescents;
(4) tailoring diagnosis and treatment of mental illness to age, gender, race, culture, and other characteristics that shape a person's identity;
(5) facilitating entry into treatment by first-line contacts recognizing mental illness, and making proper referrals and/or to addressing problems effectively themselves; and
(6) reducing financial barriers to treatment.

345.021MSS – SUPPORT FOR MENTAL HEALTH COURTS
AMA-MSS supports the establishment and use of mental health courts, including drug courts and sober courts, as an effective method of intervention for individuals with mental illness and substance use disorders who are convicted of nonviolent crimes and the state and local level in the United States.

(48) RESOLUTION 041 – OPPOSITION TO MEDICAL BONDING IN JAIL

RECOMMENDATION A:

Resolution 041 be <u>amended by addition and deletion</u> to read as follows:

RESOLVED, That our AMA-MSS <u>support</u> advocate~~e~~<u>ing</u> against <u>prisoners' release on bond when used</u> ~~medical bonding practices being used~~ to abdicate responsibility for ~~captive~~ <u>incarcerated</u> populations' healthcare.

RECOMMENDATION B:

Resolution 041 be <u>adopted as amended</u>.

RESOLVED, That our AMA-MSS advocate against medical bonding practices being used to abdicate responsibility for captive populations' healthcare.

VRC testimony was limited on Resolution 041. The Massachusetts delegation opposed the resolution as written, citing weak evidence and no formal definition of medical bonding. Your MSS Section Delegates recommended combining Resolution 041 with Resolution 076. We disagree with combination given significant differences in scope and offer clarifying amendments to Resolution 041 in line with testimony on the VRC to accurately and unambiguously convey the desired advocacy.

(49) RESOLUTION 043 – PROTECTIONS FOR INCARCERATED MOTHERS TO BREASTFEED AND/OR BREAST PUMP

RECOMMENDATION A:

Resolution 043 be <u>amended by addition and deletion</u> to read as follows:

RESOLVED, That our AMA amend policy H-430.990 by addition to read as follows:

Bonding Programs for Women Prisoners and their Newborn Children H-430.990

Because there are insufficient data at this time to draw conclusions about the long-term effects of prison nursery programs on mothers and their children, the AMA supports and encourages further research on the impact of infant bonding programs on incarcerated women and their children. However, since there are established benefits of breast milk for infants and breast milk expression for mothers, the AMA supports ~~advocates for~~ policy and legislation that extends the right to breastfeed and/or pump and store breast milk to include incarcerated mothers. The AMA recognizes the prevalence of mental health and substance abuse problems among incarcerated women and continues to support access to appropriate services for women in prisons. The AMA recognizes that a large majority of incarcerated females who may not have developed appropriate parenting skills are mothers of children under the age of 18. The AMA encourages correctional facilities to provide parenting skills and breastfeeding/breast pumping training to all female inmates in preparation for their release from prison and return to their children. The AMA supports and encourages further investigation into the long-term effects of prison nurseries on mothers and their children.

RECOMMENDATION B:

Resolution 043 be adopted as amended.

RESOLVED, That our AMA amend policy H-430.990 by addition to read as follows:

Bonding Programs for Women Prisoners and their Newborn Children H-430.990

Because there are insufficient data at this time to draw conclusions about the long-term effects of prison nursery programs on mothers and their children, the AMA supports and encourages further research on the impact of infant bonding programs on incarcerated women and their children. However, since there are established benefits of breast milk for infants and breast milk expression for mothers, the AMA advocates for policy and legislation that extends the right to breastfeed and/or pump and store breast milk to include incarcerated mothers. The AMA recognizes the prevalence of mental health and substance

abuse problems among incarcerated women and continues to support access to appropriate services for women in prisons. The AMA recognizes that a large majority of incarcerated females who may not have developed appropriate parenting skills are mothers of children under the age of 18. The AMA encourages correctional facilities to provide parenting skills and breastfeeding/breast pumping training to all female inmates in preparation for their release from prison and return to their children. The AMA supports and encourages further investigation into the long-term effects of prison nurseries on mothers and their children.

VRC testimony was universally supportive of Resolution 043. The MSS Women in Medicine Committee (WIM), the MSS Committee on Global and Public Health (CGPH), the Massachusetts delegation, and the Carle Illinois College of Medicine all supported the resolution. CGPH proposed pulling out the proposed amendment to stand on its own. Your Reference Committee discussed this proposal at length, but ultimately decided that this amendment to existing policy is strongest as written, and recommends slightly changing the language for consistency and adopting Resolution 043 as amended.

(50) RESOLUTION 047 – SUPPORTING MEASURES TO ENSURE SAFE INDOOR HOME TEMPERATURES

RECOMMENDATION A:

Resolution 047 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA-MSS support environmentally conscious efforts aimed at providing safe indoor temperatures ~~which may~~ includeing but not limited to more efficient weatherization, income-based subsidies, and/or seasonal termination protections to mitigate poor health outcomes among at-risk populations.

RECOMMENDATION B:

Resolution 047 be adopted as amended.

RESOLVED That our AMA support environmentally conscious efforts aimed at providing safe indoor temperatures which may include more efficient weatherization, income-based subsidies, and/or seasonal termination protections to mitigate poor health outcomes among at-risk populations.

VRC testimony on Resolution 047 overall supported the spirit of the resolution. Those expressing concern found the resolution to be too broad and sufficient research was not presented from primary sources regarding weatherization and income-based subsidies in the Whereas statements. Your Reference Committee offers clarifying amendments;

additionally, we recognize the importance of this issue but do not believe it is the best use of MSS political capital at this time to transmit this resolution to the House of Delegates. Therefore, we recommend making this resolution internal. With these amendments, your Reference Committee recommends Resolution 047 be adopted.

(51) RESOLUTION 051 – EMPLOYMENT OF PATIENTS WITH PSYCHIATRIC ILLNESS

RECOMMENDATION A:

The first Resolve of Resolution 051 be <u>amended by addition</u> to read as follows:

RESOLVED, That our AMA-<u>MSS</u> recognize~~s~~ the role that employment has in improving the health and quality of life for patients with psychiatric disorders; and be it further

RECOMMENDATION B:

The second Resolve of Resolution 051 be <u>amended by addition and deletion</u> to read as follows:

RESOLVED, That our AMA-<u>MSS support</u> ~~advocates for~~ the employment of patients with psychiatric illness through measures such as the development of Individual Placement and Support (IPS) programs.

RECOMMENDATION C:

Resolution 051 be <u>adopted as amended</u>.

RESOLVED, That our AMA recognizes the role that employment has in improving the health and quality of life for patients with psychiatric disorders; and be it further

RESOLVED, That our AMA advocates for the employment of patients with psychiatric illness through measures such as the development of Individual Placement and Support (IPS) programs.

VRC testimony was supportive of the spirit of Resolution 051. The MSS Section Delegates recommend making this resolution internal and supporting a similar resolution if brought forward in the future by the American Psychiatric Association (APA). Your Reference Committee found this testimony compelling and has incorporated these changes, as well as a change from “advocate” to “supports” in the second Resolve to make the ask feasible, since the MSS cannot advocate on its own. We recognize the many benefits from this resolution but agree with the Section Delegates that it would be most appropriate coming from the APA. We recommend Resolution 051 be adopted as amended.

(52) RESOLUTION 052 – EXPANSION ON COMPREHENSIVE SEXUAL HEALTH EDUCATION

RECOMMENDATION A:

Resolution 052 be <u>amended by deletion</u> to read as follows:

RESOLVED, That our AMA amend H-170.968 by addition and deletion as follows:

Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools, H-170.968

(1) ~~Recognizes that the primary responsibility for family life education is in the home, and additionally s~~ <u>S</u>upports the concept of a ~~complementary~~ family life and sexuality education program in the schools at all levels, at local option and direction;
(2) Urges schools at all education levels to implement comprehensive, developmentally appropriate sexuality education programs that: (a) are based on rigorous, peer reviewed science; (b) incorporate sexual violence prevention; (c) show promise for delaying the onset of sexual activity and a reduction in sexual behavior that puts adolescents at risk for contracting human immunodeficiency virus (HIV) and other sexually transmitted diseases and for becoming pregnant; (d) include an integrated strategy for making condoms<u>, dental dams, and other barrier protection methods</u> available to students and for providing both factual information and skill-building related to reproductive biology, sexual abstinence, sexual responsibility, contraceptives including condoms, alternatives in birth control, and other issues aimed at prevention of pregnancy and sexual transmission of diseases; (e) utilize classroom teachers and other professionals who have shown an aptitude for working with young people and who have received special training that includes addressing the needs of <u>LGBTQ</u> ~~gay, lesbian, and bisexual~~ youth; (f) appropriately and comprehensively address the sexual behavior of all people, inclusive of sexual and gender minorities; (g) include ample involvement of parents, health professionals, and other concerned members of the community in the development of the program; (h) are part of an overall health education program; and (i) include culturally

competent materials that are language-appropriate for Limited English Proficiency (LEP) pupils;

(3) Continues to monitor future research findings related to emerging initiatives that include abstinence-only, school-based sexuality education, and consent communication to prevent dating violence while promoting healthy relationships, and school-based condom availability programs that address sexually transmitted diseases and pregnancy prevention for young people and report back to the House of Delegates as appropriate;

(4) Will work with the United States Surgeon General to design programs that address communities of color and youth in high risk situations within the context of a comprehensive school health education program;

(5) Opposes the sole use of abstinence-only education, as defined by the 1996 Temporary Assistance to Needy Families Act (P.L. 104-193), within school systems;

(6) Endorses comprehensive family life education in lieu of abstinence-only education, unless research shows abstinence-only education to be superior in preventing negative health outcomes;

(7) Supports federal funding of comprehensive sex education programs that stress the importance of ~~abstinence in~~ preventing unwanted teenage pregnancy and sexually transmitted infections via comprehensive education, ~~and also teach about~~ including contraceptive choices, abstinence, and safer sex, and opposes federal funding of community-based programs that do not show evidence-based benefits; and

(8) Extends its support of comprehensive family-life education to community-based programs promoting abstinence as the best method to prevent teenage pregnancy and sexually transmitted diseases while also discussing the roles of condoms and birth control, as endorsed for school systems in this policy;

(9) Supports the development of sexual education curriculum that integrates dating violence prevention through lessons on healthy relationships, sexual health, and conversations about consent; and

(10) Encourages physicians and all interested parties to ~~conduct research and~~ develop best-practice, evidence-based, guidelines for sexual education curricula that are developmentally appropriate as well as medically, factually, and technically accurate.

RECOMMENDATION B:

Resolution 052 be adopted as amended.

RESOLVED, That our AMA amend H-170.968 by addition and deletion as follows:

Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools, H-170.968

(1) ~~Recognizes that the primary responsibility for family life education is in the home, and additionally s~~ Supports the concept of a ~~complementary~~ family life and sexuality education program in the schools at all levels, at local option and direction;

(2) Urges schools at all education levels to implement comprehensive, developmentally appropriate sexuality education programs that: (a) are based on rigorous, peer reviewed science; (b) incorporate sexual violence prevention; (c) show promise for delaying the onset of sexual activity and a reduction in sexual behavior that puts adolescents at risk for contracting human immunodeficiency virus (HIV) and other sexually transmitted diseases and for becoming pregnant; (d) include an integrated strategy for making condoms, dental dams, and other barrier protection methods available to students and for providing both factual information and skill-building related to reproductive biology, sexual abstinence, sexual responsibility, contraceptives including condoms, alternatives in birth control, and other issues aimed at prevention of pregnancy and sexual transmission of diseases; (e) utilize classroom teachers and other professionals who have shown an aptitude for working with young people and who have received special training that includes addressing the needs of LGBTQ ~~gay, lesbian, and bisexual~~ youth; (f) appropriately and comprehensively address the sexual behavior of all people, inclusive of sexual and gender minorities; (g) include ample involvement of parents, health professionals, and other concerned members of the community in the development of the program; (h) are part of an overall health education program; and (i) include culturally competent materials that are language-appropriate for Limited English Proficiency (LEP) pupils;

(3) Continues to monitor future research findings related to emerging initiatives that include abstinence-only, school-based sexuality education, and consent communication to prevent dating violence while promoting healthy relationships, and school-based condom availability programs that address sexually transmitted diseases and

pregnancy prevention for young people and report back to the House of Delegates as appropriate;
(4) Will work with the United States Surgeon General to design programs that address communities of color and youth in high risk situations within the context of a comprehensive school health education program;
(5) Opposes the sole use of abstinence-only education, as defined by the 1996 Temporary Assistance to Needy Families Act (P.L. 104-193), within school systems;
(6) Endorses comprehensive family life education in lieu of abstinence-only education, unless research shows abstinence-only education to be superior in preventing negative health outcomes;
(7) Supports federal funding of comprehensive sex education programs that stress the importance of ~~abstinence in~~ preventing unwanted teenage pregnancy and sexually transmitted infections via comprehensive education, ~~and also teach about~~ including contraceptive choices abstinence and safer sex, and opposes federal funding of community-based programs that do not show evidence-based benefits; and
(8) Extends its support of comprehensive family-life education to community-based programs promoting abstinence as the best method to prevent teenage pregnancy and sexually transmitted diseases while also discussing the roles of condoms and birth control, as endorsed for school systems in this policy;
(9) Supports the development of sexual education curriculum that integrates dating violence prevention through lessons on healthy relationships, sexual health, and conversations about consent; and
(10) Encourages physicians and all interested parties to conduct research and develop best-practice, evidence-based, guidelines for sexual education curricula that are developmentally appropriate as well as medically, factually, and technically accurate.

This is a well-written resolution with broad support on the VRC, specifically from the MSS Committee on LGBTQ+ Issues, Region 3, and the Massachusetts delegation. While concerns were raised by an individual around the specific implications of removing the recognition of home-based education, your Reference Committee concluded that the proposed amendments did have merit. Your Reference Committee elected not to incorporate the amendment proposed in clause (10), due to imprecision around the intended meaning, the fact that the rationale for this amendment is not well-supported either in the Whereas statements or the associated testimony, and there is potential to detract from the primary focus of the resolution on shifting away from abstinence-based sex education. As such, your Reference Committee recommends Resolution 052 be adopted as amended.

(53) RESOLUTION 053 – ADDRESSING ADVERSE EFFECTS OF ACTIVE SHOOTER DRILLS ON CHILDREN'S HEALTH

RECOMMENDATION A:

The first Resolve of Resolution 053 be amended by addition or deletion to read as follows:

RESOLVED, That our AMA support that all school systems ~~elementary and secondary schools only~~ conduct evidence-based active shooter drills in a trauma-informed manner that a. is cognizant of children's physical and mental wellness, b. considers prior experiences that might affect children's response to a simulation, c. avoids creating additional traumatic experiences for children, and d. provides support for students who may be adversely affected; and be it further

RECOMMENDATION B:

The second Resolve of Resolution 053 be amended by deletion to read as follows:

RESOLVED, That our AMA work with relevant stakeholders~~, such as the American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatrists, the National Association of School Psychologists, and the National Child Traumatic Stress Network~~, to raise awareness of ways to conduct active shooter drills that are safe for children and age-appropriate.~~; and be it further~~

RECOMMENDATION C:

The third Resolve of Resolution 053 be deleted:

~~RESOLVED, That our AMA encourage physicians with appropriate expertise to become involved in their local school systems to guide the use of active shooter drills in firearm injury prevention efforts.~~

RECOMMENDATION D:

Resolution 053 be adopted as amended.

RESOLVED, That our AMA support that elementary and secondary schools only conduct active shooter drills in a trauma-informed manner that

a. is cognizant of children's physical and mental wellness,
b. considers prior experiences that might affect children's response to a simulation,
c. avoids creating additional traumatic experiences for children, and
d. provides support for students who may be adversely affected; and be it further

RESOLVED, That our AMA work with relevant stakeholders, such as the American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatrists, the National Association of School Psychologists, and the National Child Traumatic Stress Network, to raise awareness of ways to conduct active shooter drills that are safe for children and age-appropriate; and be it further

RESOLVED, That our AMA encourage physicians with appropriate expertise to become involved in their local school systems to guide the use of active shooter drills in firearm injury prevention efforts.

VRC testimony was generally supportive of Resolution 053. There was consensus that the third Resolve clause was not actionable as written so your Reference Committee recommends striking. We do acknowledge that the third Resolve could be amended to entail a stronger, more feasible directive, but as written we are unsure if it is appropriate for physicians to be the ones going into school and providing this training. We note that the ambiguity about what kind of appropriate expertise (e.g. expertise in trauma, expertise in active shooter situations, or something else) in the clause made it difficult to discern the intended or likely outcomes of this clause. Your Reference Committee also recommends amendments to the second Resolve clause because we do not want to include reference to the specific groups listed without their agreement to support this resolution, which to our knowledge we do not currently have. Your Reference Committee also offers clarifying amendments to the first Resolve clause and recommends Resolution 053 be adopted as amended.

(54) RESOLUTION 054 – SUPPORTING THE STUDY OF REPARATIONS AS A MEANS TO REDUCE RACIAL INEQUALITIES

RECOMMENDATION A:

The first Resolve of Resolution 054 be <u>amended by addition and deletion</u> to read as follows:

RESOLVED, <u>That</u> ~~O~~<u>o</u>ur AMA ~~will~~ study~~, in partnership with the Center for Health Equity, how~~ potential mechanisms of national economic reparations that <u>could improve</u> ~~may impact~~ health inequities associated with institutionalized, systematic racism <u>and report back to the House of Delegates</u>; and be it further

RECOMMENDATION B:

The second Resolve of Resolution 054 be amended by addition and deletion to read as follows:

RESOLVED, That ~~O~~our AMA ~~will specifically also~~ study~~,~~ ~~in partnership with the Center for Health Inequity, how~~ the potential adoption of a policy of reparations ~~might be adopted~~ by the AMA to support the African American community currently interfacing with, practicing within, and entering the medical field and report back to the House of Delegates; and be it further

RECOMMENDATION C:

The third Resolve of Resolution 054 be deleted:

~~**RESOLVED, Our AMA will report the results of the aforementioned study to the Board of Trustees at I21, or A21, depending on if this will be an immediate forward.**~~

RECOMMENDATION D:

Resolution 054 be amended by addition of a new Resolve clause:

RESOLVED, That our AMA support federal legislation that facilitates the study of reparations.

RECOMMENDATION E:

Resolution 054 be adopted as amended.

RESOLVED, Our AMA will study, in partnership with the Center for Health Equity, how potential mechanisms of national economic reparations may impact health inequities associated with institutionalized, systematic racism; and be it further

RESOLVED, Our AMA will specifically also study, in partnership with the Center for Health Inequity, how a policy of reparations might be adopted by the AMA to support the African American community currently interfacing with, practicing within, and entering the medical field; and be it further

RESOLVED, Our AMA will report the results of the aforementioned study to the Board of Trustees at I21, or A21, depending on if this will be an immediate forward.

Testimony on Resolution 054 was mixed. The MSS Councilor on Legislation supported Resolution 054, while the Massachusetts delegation recommended this resolution be amended to have the MSS undertake the study inherent in the resolution. Your Reference

Committee offers amendments for clarity and to implement conventions of AMA policy-making process (i.e. typically will not dictate how studies are conducted). We do not believe an internal study will be productive, and instead feel the resources of the larger AMA will be necessary to execute the intended action. We therefore recommend Resolution 054 be adopted as amended.

(55) RESOLUTION 056 – INCREASING REGULATION OF NATURAL COSMETIC PRODUCTS

RECOMMENDATION A:

The second Resolve of Resolution 056 be amended by addition and deletion to read as follows:

RESOLVED, That o~~o~~ur AMA amend H-440.855, National Cosmetics Registry and Regulation by addition and deletion as follows to support the expansion of the FDA's regulatory authority to recall misbranded cosmetics:

NATIONAL COSMETICS REGISTRY AND REGULATION - H-440.855
1. Our AMA: (a) supports the creation of a publicly available registry of all cosmetics and their ingredients in a manner which does not substantially affect the manufacturers; proprietary interests and (b) supports providing the Food and Drug Administration with sufficient authority to recall cosmetic products that it dee~~n~~ms to be harmful~~.~~ or misbranded.
2. Our AMA will monitor the progress of HR 759 (Food and Drug Administration Globalization Act of 2009) and respond as appropriate.

RECOMMENDATION B:

Resolution 056 be adopted as amended.

RESOLVED, That our AMA support the creation of a standard definition of “natural’ or “naturally derived” as it pertains to the labeling of cosmetic products; and be it further

RESOLVED, That our AMA support the expansion of the FDA's regulatory authority to recall misbranded cosmetics by amending National Cosmetics Registry and Regulation H-440.855,

National Cosmetics Registry and Regulation - H-440.855

1. Our AMA: (a) supports the creation of a publicly available registry of all cosmetics and their ingredients in a manner which does not substantially affect the manufacturers; proprietary interests and (b) supports providing the Food and Drug Administration with sufficient authority to recall cosmetic products that it deen~~n~~ms to be harmful~~.~~ or misbranded.

~~2. Our AMA will monitor the progress of HR 759 (Food and Drug Administration Globalization Act of 2009) and respond as appropriate.~~

VRC testimony for Resolution 056 was mixed, with support from Region 3, Region 4, the MSS Committees on Economics and Quality in Medicine (CEQM) and Scientific Issues (CSI), and the MSS Women in Medicine Committee (WIM). Concern was expressed by the Section Delegates and the Massachusetts delegation. We note that the topic of CGPH WIM Report A, also being presented at this meeting, is similar to Resolution 056, but agreed it was best to consider these two items separately. We therefore offer editorial amendments and reinstate the second clause of H-440.855, because the resolution did not make it clear in the Whereas statements why it was deleted. If it were because the second clause references legislation from 2009, we believe that would be better addressed by a Sunset Report in the House of Delegates, is not within our purview, and could distract from the focus of the resolution. Therefore, we recommend Resolution 056 be adopted as amended.

(56) RESOLUTION 057 – EDUCATE RESIDENCY, FELLOWSHIP, AND ACADEMIC PROGRAMS ON THE UNITED STATES-PUERTO RICO RELATIONSHIP STATUS

RECOMMENDATION A:

The second Resolve of Resolution 057 be deleted:

~~**RESOLVED, That our AMA will work with appropriate stakeholders to ensure that schools participating in the Visiting Student Learning Opportunities (VSLO/VSAS), Electronic Residency Application Service (ERAS), and the National Resident Matching Program (NRMP) systems understand the accreditation of Puerto Rican medical schools and the citizenship of their medical students; and be it further**~~

RECOMMENDATION B:

The third Resolve of Resolution 057 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA ~~will~~ support policies that ensure equity and parity in the undergraduate and graduate educational and professional opportunities available to medical students and graduates from Puerto Rican medical schools ~~by ensuring they are judged based on their individual qualifications, skills, and character.~~

RECOMMENDATION C:

Resolution 057 be adopted as amended.

RESOLVED, That our AMA will issue an official public statement regarding the academic status of Puerto Rican medical students and schools to inform residency, fellowship, and academic programs in the continental United States that all medical schools from Puerto Rico are Liaison Committee on Medical Education (LCME), American Association of Medical Colleges (AAMC), and Middle States Commission on Higher Education (MSCHE) accredited, and their medical students are not considered international medical graduates; and be it further

RESOLVED, That our AMA will work with appropriate stakeholders to ensure that schools participating in the Visiting Student Learning Opportunities (VSLO/VSAS), Electronic Residency Application Service (ERAS), and the National Resident Matching Program (NRMP) systems understand the accreditation of Puerto Rican medical schools and the citizenship of their medical students; and be it further

RESOLVED, That our AMA will support policies that ensure equity and parity in the educational and professional opportunities available to medical students and graduates from Puerto Rican medical schools by ensuring they are judged based on their individual qualifications, skills, and character.

VRC testimony was mixed on Resolution 057 but there was general support of the spirit of the resolution. Your Reference Committee recommends that the second Resolve be deleted and the third Resolve be amended. We support the first Resolve clause as written. Testimony from the Resident and Fellow Section (RFS) suggested the action proposed in the second Resolve clause is already being done, however, we do believe that there is potential to include individual evaluators in addition to schools in future policymaking. We include amendments to the third Resolve to clarify the asks and increase actionability. With these amendments we recommend Resolution 057 be adopted as amended.

(57) RESOLUTION 061 – PROTECTION OF ANTIBIOTIC EFFICACY THROUGH WATER SYSTEM REGULATION

RECOMMENDATION A:

Resolution 061 be <u>amended by deletion</u> to read as follows:

RESOLVED, That our AMA <u>study and make recommendations on</u> ~~support legislation and~~ practices to address contamination, exposure, classification, and clean-up of antibiotics, ~~their transformant particles (TPs), antibiotic resistant bacteria (ABR), and antibiotic resistant genes (ARGs)~~ from public water supplies.

RECOMMENDATION B:

Resolution 061 be <u>adopted as amended</u>.

RESOLVED, That our AMA support legislation and regulation to address contamination, exposure, classification, and clean-up of antibiotics, their transformant particles (TPs), antibiotic resistant bacteria (ABR), and antibiotic resistant genes (ARGs) from public water supplies.

VRC testimony on Resolution 061 was split. The MSS Section Delegates and MSS Government Relations and Advocacy Fellow (GRAF) recommend this resolution be referred for study to be further refined and clarified. Your Reference Committee considered referring the suggestion for study within an MSS Committee but concluded that an AMA Council or other AMA body would be the most appropriate body to study and recommend policy stances the AMA should take on this issue, since AMA bodies are better resourced and staffed. As originally written, we feel that the resolution is too prescriptive and therefore offer amendments which would be in line with author intent, yet more generalizable. We offer clarifying amendments to simplify the ask and recommend Resolution 061 be adopted as amended.

(58) RESOLUTION 064 – OPPOSITION TO ALCOHOL INDUSTRY MARKETING SELF-REGULATION

RECOMMENDATION:

Resolution 064 be <u>amended by deletion</u> to read as follows:

RESOLVED, That our AMA amend policy H-30.940, Labeling, Advertising, and Promotion of Alcoholic Beverages, by addition and subtraction as follows:

LABELING, ADVERTISING, AND PROMOTION OF ALCOHOLIC BEVERAGES, H-30.940

(1.) (a) Supports accurate and appropriate labeling disclosing the alcohol content of all beverages, including so-called "nonalcoholic" beer and other substances as well, including over-the-counter and prescription medications, with removal of "nonalcoholic" from the label of any substance containing any alcohol; (b) supports efforts to educate the public and consumers about the alcohol content of so-called "nonalcoholic" beverages and other substances, including medications, especially as related to consumption by minors; (c) urges the Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF) and other appropriate federal regulatory agencies to continue to reject proposals by the alcoholic beverage industry for authorization to place beneficial health claims for its products on container labels; and (d) urges the development of federal legislation to require nutritional labels on alcoholic beverages in accordance with the Nutritional Labeling and Education Act.

(2.) (a) Expresses its strong disapproval of any consumption of "nonalcoholic beer" by persons under 21 years of age, which creates an image of drinking alcoholic beverages and thereby may encourage the illegal underaged use of alcohol; (b) recommends that health education labels be used on all alcoholic beverage containers and in all alcoholic beverage advertising (with the messages focusing on the hazards of alcohol consumption by specific population groups especially at risk, such as pregnant women, as well as the dangers of irresponsible use to all sectors of the populace); and (c) recommends that the alcohol beverage industry be encouraged to accurately label all product containers as to ingredients, preservatives, and ethanol content (by percent, rather than by proof).

(3.) Actively supports and will work for a total statutory prohibition of advertising of all alcoholic beverages except for inside retail or wholesale outlets. Pursuant to that goal, our AMA (a) supports federal and/or state oversight for all forms of alcohol advertising ~~in lieu of the alcohol industry's current practice of self-regulated advertising and marketing~~; ~~(a)~~(b) supports continued research, educational, and promotional activities dealing with issues of alcohol advertising and health education to provide more definitive evidence on whether, and in what manner, advertising contributes to alcohol abuse; ~~(b)~~(c) opposes ~~the use of the radio and television~~ any form of advertising which links alcoholic products to agents of socialization in order to promote drinking; ~~(c)~~(d) will work with state and local medical

societies to support the elimination of advertising of alcoholic beverages from all mass transit systems; ~~(d)~~(e) urges college and university authorities to bar alcoholic beverage companies from sponsoring athletic events, music concerts, cultural events, and parties on school campuses, and from advertising their products or their logo in school publications; and ~~(e)~~(f) urges its constituent state associations to support state legislation to bar the promotion of alcoholic beverage consumption on school campuses and in advertising in school publications.

(4.) (a) Urges producers and distributors of alcoholic beverages to discontinue all advertising directed toward youth, including ~~such as~~ promotions on high school and college campuses; (b) urges advertisers and broadcasters to cooperate in eliminating television program content that depicts the irresponsible use of alcohol without showing its adverse consequences (examples of such use include driving after drinking, drinking while pregnant, or drinking to enhance performance or win social acceptance); (e) supports continued warnings against the irresponsible use of alcohol and challenges the liquor, beer, and wine trade groups to include in their advertising specific warnings against driving after drinking; and (f) commends those automobile and alcoholic beverage companies that have advertised against driving while under the influence of alcohol.

RESOLVED, That our AMA amend policy H-30.940, Labeling Advertising, and Promotion of Alcoholic Beverages, by addition and subtraction as follows:

H-30.940, Labeling, Advertising, and Promotion of Alcoholic Beverages

(1.) (a) Supports accurate and appropriate labeling disclosing the alcohol content of all beverages, including so-called "nonalcoholic" beer and other substances as well, including over-the-counter and prescription medications, with removal of "nonalcoholic" from the label of any substance containing any alcohol; (b) supports efforts to educate the public and consumers about the alcohol content of so-called "nonalcoholic" beverages and other substances, including medications, especially as related to consumption by minors; (c) urges the Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF) and other appropriate federal regulatory agencies to continue to reject proposals by the alcoholic beverage industry for authorization to place beneficial health claims for its

products on container labels; and (d) urges the development of federal legislation to require nutritional labels on alcoholic beverages in accordance with the Nutritional Labeling and Education Act.

(2.) (a) Expresses its strong disapproval of any consumption of "nonalcoholic beer" by persons under 21 years of age, which creates an image of drinking alcoholic beverages and thereby may encourage the illegal underaged use of alcohol; (b) recommends that health education labels be used on all alcoholic beverage containers and in all alcoholic beverage advertising (with the messages focusing on the hazards of alcohol consumption by specific population groups especially at risk, such as pregnant women, as well as the dangers of irresponsible use to all sectors of the populace); and (c) recommends that the alcohol beverage industry be encouraged to accurately label all product containers as to ingredients, preservatives, and ethanol content (by percent, rather than by proof).

(3.) Actively supports and will work for a total statutory prohibition of advertising of all alcoholic beverages except for inside retail or wholesale outlets. Pursuant to that goal, our AMA (a) Supports federal and/or state oversight for all forms of alcohol advertising in lieu of the alcohol industry's current practice of self-regulated advertising and marketing; ~~(a)~~(b) supports continued research, educational, and promotional activities dealing with issues of alcohol advertising and health education to provide more definitive evidence on whether, and in what manner, advertising contributes to alcohol abuse; ~~(b)~~(c) opposes ~~the use of the radio and television~~ any form of advertising which links alcoholic products to agents of socialization in order to promote drinking; ~~(c)~~(d) will work with state and local medical societies to support the elimination of advertising of alcoholic beverages from all mass transit systems; ~~(d)~~(e) urges college and university authorities to bar alcoholic beverage companies from sponsoring athletic events, music concerts, cultural events, and parties on school campuses, and from advertising their products or their logo in school publications; and ~~(e)~~(f) urges its constituent state associations to support state legislation to bar the promotion of alcoholic beverage consumption on school campuses and in advertising in school publications.

(4.) (a) Urges producers and distributors of alcoholic beverages to discontinue all advertising directed toward youth, including ~~such as~~ promotions on high school and college campuses; (b) urges advertisers and broadcasters to cooperate in eliminating television program content that depicts the irresponsible use of alcohol without showing its adverse consequences (examples of such use include

driving after drinking, drinking while pregnant, or drinking to enhance performance or win social acceptance); (e) supports continued warnings against the irresponsible use of alcohol and challenges the liquor, beer, and wine trade groups to include in their advertising specific warnings against driving after drinking; and (f) commends those automobile and alcoholic beverage companies that have advertised against driving while under the influence of alcohol.

Your Reference Committee heard widespread support of Resolution 064, including from the Delegate to the American Academy of Pediatrics (AAP) and the Psychiatry Student Interest Group Network (PsychSIGN) and agrees that this resolution is important and represents a meaningful addition to existing AMA policy. We offer a clarifying amendment to clause 3a and recommend Resolution 064 be adopted as amended.

(59) RESOLUTION 070 – ETHICAL GUIDANCE FOR SHORT-TERM MEDICAL SERVICE TRIPS

RECOMMENDATION A:

Resolution 070 be <u>amended by addition and deletion</u> to read as follows:

RESOLVED, That our AMA-MSS supports fundamental ethical standards for short-term medical service trips that include: (1) ensuring that programs have legitimate community partnerships that guide culturally sensitive and sustainable work based on community-identified needs; (2) volunteer cultural ~~competency~~ <u>humility</u> training including specific education on the local community norms and the principles of nonmaleficence and beneficence in the context of the trip objectives; and (3) emphasis on empowerment of local communities in the form of health professional and community education.

RECOMMENDATION B:

Resolution 070 be <u>adopted as amended</u>.

RESOLVED, That our AMA-MSS supports fundamental ethical standards for short-term medical service trips that include: (1) ensuring that programs have legitimate community partnerships that guide culturally sensitive and sustainable work based on community-identified needs; (2) volunteer cultural competency training including specific education on the local community norms and the principles of nonmaleficence and beneficence in the context of the trip objectives; and (3) emphasis on empowerment of local communities in the form of health professional and community education.

We commend the authors for their thoughtful and well-researched resolution. Testimony heard on Resolution 070 from Region 3, Region 4, and the Massachusetts delegation was generally positive. The MSS Committee on Global and Public Health (CGPH) proposed a friendly amendment which your Reference Committee incorporates here to emphasize the process of self-reflection, critique, and personal growth required to deliver high-quality care to patients and communities of varying cultural backrounds. We recommend Resolution 070 be adopted as amended.

(60) RESOLUTION 072 – SUPPORTING SUN SAFETY EDUCATION IN K-12 SCHOOLS

RECOMMENDATION A:

Resolution 072 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA-MSS amend 60.011MSS, "Sun Protection Programs in Elementary Schools," by insertion and deletion:

60.011MSS. Sun Protection Programs and Education in ~~Elementary~~ K-12 Schools
AMA-MSS will ~~ask the AMA to~~ support working with the National Association of State Boards of Education, the Centers for Disease Control and Prevention, and other appropriate entities to encourage ~~elementary~~ schools to incorporate ~~develop~~ sun protection policies and sun safety education curricula.

RECOMMENDATION B:

Resolution 072 be adopted as amended.

RESOLVED, That our AMA-MSS amend 60.011MSS, "Sun Protection Programs in Elementary Schools," by insertion and deletion:

60.011MSS. Sun Protection Programs and Education in ~~Elementary~~ K-12 Schools
AMA-MSS will ask the AMA to work with the National Association of State Boards of Education, the Centers for Disease Control and Prevention, and other appropriate entities to encourage ~~elementary~~ schools to incorporate ~~develop~~ sun protection policies and sun safety education curricula.

VRC testimony on Resolution 072 was mixed. The Massachusetts delegation provided testimony questioning when at what age education for sun protection programs is most appropriate. However, AMA has policy supporting physicians continuing to educate their patients on sun safety and protection at all ages and your Reference Committee sees no

harm in having internal policy supporting a similar stance. We offer an editorial amendment and recommend Resolution 072 be adopted as amended.

(61) RESOLUTION 076 – FEDERAL HEALTH INSURANCE FUNDING FOR PEOPLE EXPERIENCING INCARCERATION

RECOMMENDATION A:

The first Resolve of Resolution 076 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA advocate for the continuation of federal health insurance benefits, ~~such as~~ including Medicaid, Medicare, and the Children's Health Insurance Program, for ~~otherwise~~ enrolled and eligible individuals in pre-trial detention ~~who are detained prior to trial, until they receive a final guilty verdict~~; and be it further

RECOMMENDATION B:

The second Resolve of Resolution 076 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA advocate for the repeal of the Medicaid Inmate Exclusion Policy ~~continuation of federal health insurance benefits such as Medicaid, for otherwise eligible individuals throughout the entire duration of their incarceration~~.

RECOMMENDATION C:

Resolution 076 be adopted as amended.

RESOLVED, That our AMA advocate for the continuation of federal health insurance benefits, such as Medicaid, for otherwise eligible individuals who are detained prior to trial, until they receive a final guilty verdict; and be it further

RESOLVED, That our AMA advocate for the continuation of federal health insurance benefits, such as Medicaid, for otherwise eligible individuals throughout the entire duration of their incarceration.

VRC testimony was largely in support of the spirit of Resolution 076. The MSS Section Delegates recommended combining with Resolution 041. Your Reference Committee disagrees and believes these two items address distinct issues and should be considered separately. We offer amendments to both Resolve clauses for clarity, brevity and to address some of the opposing points raised; we recommend Resolution 076 be adopted as amended.

(62) RESOLUTION 078 – BANNING LGBTQ+ "PANIC" DEFENSES

RECOMMENDATION A:

Resolution 078 be <u>amended by deletion</u> to read as follows:

RESOLVED, That our AMA advocate for legislation that would ban the use of LGBTQ+ "panic" defenses in court ~~in order to protect LGBTQ+ victims of sexual violence~~.

RECOMMENDATION B:

Resolution 078 be <u>adopted as amended</u>.

RESOLVED, That our AMA advocate for legislation that would ban the use of LGBTQ+ "panic" defenses in court in order to protect LGBTQ+ victims of sexual violence.

VRC testimony was supportive of Resolution 078 with amendments. Your Reference Committee found the VRC testimony recommending an amendment to eliminate unnecessary explication that could inadvertently narrow the scope of the resolution to be compelling and chose to incorporate such an amendment into our recommendation. There was some discussion that suggested changing "advocate" to "support," but given that legislation on this topic is being actively debated around the nation, we believe "advocate" is an appropriate action. We recommend Resolution 078 be adopted as amended.

(63) RESOLUTION 080 – EDUCATION IN COMMUNICATING WITH AND PROVIDING SERVICES TO INDIVIDUALS WITH COMMUNICATION DISORDERS

RECOMMENDATION A:

295.186MSS be <u>reaffirmed in lieu of</u> the first Resolve of Resolution 080.

RECOMMENDATION B:

The second Resolve of Resolution 080 be amended by addition and deletion to read as follows:

RESOLVED, That o~~O~~ur AMA-MSS support the development and implementation of ~~promotes and develops~~ medical student education that addresses the role and utility of rehabilitative healthcare providers in the treatment of individuals with communication disorders, including, but not limited to, speech-language pathologists and audiologists.

RECOMMENDATION C:

Resolution 080 be adopted as amended.

RESOLVED, That our AMA-MSS amend Resolution 295.186MSS by insertion of the following:

295.186MSS Addressing Communication Deficits in Medical School Curricula
1. AMA-MSS supports the development and implementation of innovative, integrated technologically current and evidence-based methods to teach and evaluate patient-centered communication.
2. AMA-MSS supports medical student training that emphasizes the unique communication needs of individuals with communication disorders.
;and be it further

RESOLVED, Our AMA-MSS promotes and develops medical student education that addresses the role and utility of rehabilitative healthcare providers in the treatment of individuals with communication disorders, including, but not limited to, speech-language pathologists and audiologists.

The first Resolve of Resolution 080 was placed on the reaffirmation calendar by the MSS House Coordination Committee (HCC). Your Reference Committee concurs with this recommendation, as we do not believe the proposed changes impact 296.186MSS in a meaningful way. Additionally, we propose an amendment to the second Resolve clause to improve on feasibility of the ask. We recommend Resolution 080 be adopted as amended.

295.186MSS – ADDRESSING COMMUNICATION DEFICITS IN MEDICAL SCHOOL CURRICULA
AMA-MSS supports the development and implementation of innovative, integrated technologically current and evidence-based methods to teach and evaluate patient-centered communication.

(64) RESOLUTION 085 - CALL FOR IMPROVED PERSONAL PROTECTIVE EQUIPMENT (PPE) DESIGN AND FITTING

RECOMMENDATION A:

Resolution 085 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA ~~will~~ encourage the diversification of personal protective equipment design to better fit ~~the diversity of~~ all body types among healthcare workers~~., including PPE specifically designed for women's and minorities' bodies.~~

RECOMMENDATION B:

Resolution 085 be adopted as amended.

RESOLVED, That our AMA will encourage the diversification of personal protective equipment design to better fit the diversity of body types among healthcare workers, including PPE specifically designed for women's and minorities' bodies.

VRC testimony was generally supportive of Resolution 085. The Massachusetts delegation expressed concern over dated resources used, but your Reference Committee did not find this testimony compelling. We offer clarifying amendments to broaden the language and recommend Resolution 085 be adopted as amended.

(65) RESOLUTION 087 – EXPUNGEMENT AND SEALING OF DRUG RECORDS

RECOMMENDATION A:

Resolution 087 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA support efforts that allow ~~individuals to~~ for the expungement, destruction, or sealing of ~~public~~ criminal records for legal offenses related to cannabis ~~of past illicit substance~~ use or possession.

RECOMMENDATION B:

Resolution 087 be <u>amended by addition of a new Resolve clause</u> as follows:

<u>RESOLVED, That our AMA-MSS immediately forward Resolution 087 to the November 2020 Special Meeting of the House of Delegates.</u>

RECOMMENDATION C:

Resolution 087 be <u>adopted as amended</u>.

RESOLVED, That our AMA support efforts that allow individuals to expunge or seal public records of past illicit substance use or possession.

Testimony on the VRC was limited but supportive – there was no opposition expressed towards the spirit of Resolution 087. Your Reference Committee thanks the authors for bringing forward such an important topic and offer amendments to improve clarity of the Resolve clause, as well as focus strategically on the AMA Council of Science and Public Health (CSAPH) Report 4 being presented at the upcoming November 2020 Special Meeting of the House of Delegates, which includes some discussion on expungement but no accompanying recommendation.

There was some concern about the ability of the Whereas clauses to support the broad ask of "all past substance use"; however, the references were better served to support an ask specifically pertaining to cannabis. Further, the amended language is more in line with the relevant legislature cited. We believe that amending Resolution 087 to focus specifically on cannabis would bolster the conversation surrounding CSAPH Report 4 and have recommended immediately forwarding of this resolution so it may be discussed in tandem. Your Reference Committee believes that this language will allow Resolution 087 to be included in the important forthcoming discussion at the House of Delegates.

(66) RESOLUTION 089 – PROVIDING REDUCED PARKING FOR PATIENTS

RECOMMENDATION A:

Resolution 089 be <u>amended by addition and deletion</u> to read as follows:

RESOLVED, That our AMA-<u>MSS</u> ~~works with relevant stakeholders, such as the American Hospital Association, the Federation of American Hospitals, and the Children's Hospital Association, to encourage healthcare facilities to~~ recognize parking fees as a burden of care for patients and ~~to implement~~ <u>encourage</u> mechanisms for reducing parking costs.

RECOMMENDATION B:

Resolution 089 be <u>adopted as amended</u>.

RESOLVED, That our AMA works with relevant stakeholders, such as the American Hospital Association, the Federation of American Hospitals, and the Children's Hospital Association, to encourage healthcare facilities to recognize parking fees as a burden of care for patients and to implement mechanisms for reducing parking costs.

VRC testimony supported the spirit of Resolution 089. Region 3 and Region 4 supported Resolution 089 as written and the Massachusetts delegation and the MSS Committee on Economics and Quality in Medicine (CEQM) supported with amendments. The MSS Section Delegates proposed making this resolution internal given that this resolution would not significantly change the efforts of the AMA. We found this suggestion compelling. Your Reference Committee recognizes that parking fees are a barrier to healthcare and we support lessening those burdens for our patients. We propose amendments that make the resolution more generalizable and recommend Resolution 089 be adopted as amended.

(67) RESOLUTION 091 - ENCOURAGING RESIDENCY PROGRAM COLLABORATION TO ALLOW MEDICAL STUDENTS FAIR AND EQUITABLE APPLICATION PROCESSES

RECOMMENDATION A:

The first Resolve of Resolution 091 be <u>deleted</u>:

~~**RESOLVED, That our AMA will encourage residency programs to prioritize applicants whose universities do not have home programs to have a minimum of one opportunity to participate in an in-person or virtual away rotation over students coming from an institution with a residency program in the field they are applying to; and be it further**~~

RECOMMENDATION B:

The second Resolve of Resolution 091 be <u>amended by addition and deletion</u> to read as follows:

RESOLVED, That our AMA ~~will~~ collaborate with the AAMC, AACOM<u>,</u>~~AS, LCME~~, ACGME, and other relevant stakeholders to encourage the creation of equally accessible virtual away-rotation opportunities and networking events for medical students and residents, <u>especially those who do not have home programs in their desired specialty</u>; and be it further

RECOMMENDATION C:

The third Resolve of Resolution 091 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA encourages residency programs to ~~provide more~~ expand and regularly update information provided on their websites, including but not limited to ~~such as~~ residency research achievements, fellowship match information, operative/rotation schedules, and trends in post-residency practice settings. ~~information about where residents who have graduated now work to allow students who cannot participate in rotations to learn about the program; and be it further~~

RECOMMENDATION D:

The fourth Resolve of Resolution 091 be deleted:

~~RESOLVED, That our AMA-MSS will immediately forward this resolution to the AMA house of delegates.~~

RECOMMENDATION E:

Resolution 091 be adopted as amended.

RESOLVED, That our AMA will encourage residency programs to prioritize applicants whose universities do not have home programs to have a minimum of one opportunity to participate in an in-person or virtual away rotation over students coming from an institution with a residency program in the field they are applying to; and be it further

RESOLVED, That our AMA will collaborate with the AAMC AACOMAS LCME ACGME and other relevant stakeholders to encourage the creation of equally accessible virtual away-rotation opportunities and networking events for medical students and residents; and be it further

RESOLVED, That our AMA encourages residency programs to provide more information on their websites such as residency research achievements, fellowship match information, operative/rotation schedules, and information about where residents who have graduated now work to allow students who cannot participate in rotations to learn about the program; and be it further

RESOLVED, That our AMA-MSS will immediately forward this resolution to the AMA House of Delegates.

There was extensive testimony heard on Resolution 091. Your Reference Committee found the testimony from the MSS Committee on Medical Education (CME) compelling and recommends striking the first Resolve clause to avoid potential unintended

consequences of permanently changing residency programs beyond immediate COVID-19-related disruptions. We have amended the second and third Resolves for clarity and to incorporate the intent of the first Resolve in a more actionable context as suggested by CME. Because this resolution would not impact this residency application cycle we do not believe it is timely or urgent enough to warrant immediate forwarding and have recommended striking the fourth Resolve clause.

(68) RESOLUTION 094 - DENOUNCING THE USE OF SOLITARY CONFINEMENT IN CORRECTIONAL FACILITIES AND DETENTION CENTERS

RECOMMENDATION A:

Resolution 094 be amended by addition and deletion to read as follows:

RESOLVED, That AMA policy H-430.983 be amended by addition and deletion as follows:

~~Reducing~~ Opposing the Use of Restrictive Housing ~~in~~ for Prisoners ~~with Mental Illness~~ H-430.983
Our AMA will: (1) ~~support limiting~~ oppose the use of solitary confinement of any length~~, with rare exceptions,~~ for incarcerated persons ~~with mental illness~~, in ~~adult~~ correctional facilities and detention centers, except for medical isolation or to protect individuals who are actively being harmed or will be immediately harmed by a physically violent individual, in which cases confinement may be used for as short a time as possible; ~~and~~ (2) while solitary confinement practices are still in place, support efforts to ensure that the mental and physical health of all individuals placed in solitary confinement are regularly monitored by health professionals~~.~~; and (3) encourage appropriate stakeholders to develop and implement safe, humane, and ethical alternatives to solitary confinement for incarcerated persons in all correctional facilities. ~~; and (3) encourage appropriate stakeholders to develop and implement alternatives to solitary confinement for incarcerated persons in all correctional facilities.~~

RECOMMENDATION B:

Resolution 094 be adopted as amended.

RESOLVED, That AMA policy H-430.983 be amended by addition and deletion as follows:

~~Reducing~~ Opposing the Use of Restrictive Housing in Prisoners ~~with Mental Illness~~ H-430.983

Our AMA will: (1) ~~support limiting~~ oppose the use of solitary confinement of any length~~, with rare exceptions,~~ for incarcerated persons ~~with mental illness~~, in ~~adult~~ correctional facilities and detention centers; and (2) while solitary confinement practices are still in place, support efforts to ensure that the mental and physical health of all individuals placed in solitary confinement are regularly monitored by health professionals.~~; and (3) encourage appropriate stakeholders to develop and implement alternatives to solitary confinement for incarcerated persons in all correctional facilities.~~

Your Reference Committee commends Resolution 094 as a well-researched and well-written resolution that addresses the serious consequences of solitary confinement in correctional facilities. There was extensive testimony heard on this resolution. The authors of the resolution originally proposed striking the third clause of existing policy. However, we believe that there is merit in that clause and recommend adding "safe, humane, and ethical" to further strengthen it. Your Reference Committee proposes clarifying amendments to help allay the concerns of some of the groups opposed to this resolution and reconcile the numerous proposals on the VRC. Specifically, we feel the development and implementation of safe, humane, and ethical alternatives to solitary confinement is a critical component to ensuring the feasibility of the resolution. We recommend Resolution 094 be adopted as amended.

(69) RESOLUTION 097 - ADDRESSING HEALTHCARE ACCESSIBILITY FOR CURRENT AND AGED-OUT YOUTH IN THE FOSTER CARE SYSTEM

RECOMMENDATION A:

Resolution 097 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA amend H-60.910, by addition to read as follows:

Addressing Healthcare Needs of Youth ~~Children~~ in Foster Care

1. **Our AMA advocates for comprehensive and evidence-based care that addresses the specific health care needs of ~~current and aged-out~~ ~~children~~ youth in foster care. ~~until 26 years of age regardless of which state they aged-out in.~~**
2. **Our AMA advocates that all youth currently in foster care remain eligible for Medicaid or other publicly funded health coverage in their state until at least 26 years of age.**

RECOMMENDATION B:

Resolution 097 be <u>adopted as amended</u>.

RESOLVED, That our AMA amend H-60.910, by addition to read as follows:

Addressing Healthcare Needs of Children in Foster Care
Our AMA advocates for comprehensive and evidence-based care that addresses the specific health care needs of <u>current and aged-out</u> children in foster care <u>until 26 years of age regardless of which state they aged-out in.</u>

Your Reference Committee heard significant VRC Testimony overwhelmingly in support of the intent of Resolution 097, including support from Regions 3 and 4, and the Committees on Economics and Quality in Medicine (CEQM), Health Information Technology (CHIT), and LGBTQ+ Issues. Rajadhar Reddy proposed a compelling amendment to clarify and strengthen the authors' ask. We incorporated these changes and recommend this resolution be adopted as amended.

(70) RESOLUTION 104 - SEXUAL HARASSMENT ACCREDITATION STANDARDS FOR MEDICAL TRAINING PROGRAMS

RECOMMENDATION A:

The first Resolve of Resolution 104 be <u>amended by addition and deletion</u> to read as follows:

RESOLVED, That our AMA encourage the LCME and ACGME to create a standard for accreditation ~~that addresses sexual harassment in medical education~~ <u>that includes sexual harassment training, policies, and repercussions for sexual harassment in undergraduate and graduate medical programs</u>; and be it further

RECOMMENDATION B:

The second Resolve of Resolution 104 be <u>amended by addition and deletion</u> to read as follows:

RESOLVED, That our AMA encourage the LCME and ACGME to ~~investigate~~ <u>assess</u> 1) medical trainees' perception of institutional culture regarding sexual harassment and preventative trainings, and 2) sexual harassment prevalence, reporting, investigation of allegations, and Title IX resource utilization in order to recommend best practices.

RECOMMENDATION C:

Resolution 104 be <u>adopted as amended</u>.

RESOLVED, That our AMA encourage the LCME and ACGME to create a standard for accreditation that addresses sexual harassment in medical education; and be it further

RESOLVED, That our AMA encourage the LCME and ACGME to investigate 1) medical trainees' perception of institutional culture regarding sexual harassment and preventative trainings, and 2) sexual harassment prevalence, reporting, investigation of allegations, and Title IX resource utilization in order to recommend best practices.

VRC testimony was supportive of the spirit of Resolution 104. The Women Physicians Section (WPS) offered amendments supported by the authors. Those amendments are included here. Your Reference Committee recommends Resolution 104 be adopted as amended.

(71) RESOLUTION 107 - UPDATING AMA-MSS POLICIES CONCERNING INTERNATIONAL MEDICAL GRADUATES AND THEIR PARTICIPATION IN THE PHYSICIAN PROFESSION

RECOMMENDATION A:

The second Resolve of Resolution 107 be <u>amended by addition and deletion</u> to read as follows:

RESOLVED, That our AMA-MSS amend 255.001MSS, The Status of Foreign Medical School Graduates in the United States, by addition and deletion as follows:

The Status of ~~Foreign~~ <u>International</u> Medical School Graduates in the United States, 255.001MSS
AMA-MSS supports the following principles: ~~(1) The US Government should provide preferential support (e.g., financial aid) to US citizens enrolled in US medical schools, as opposed to alien and US FMG's. (2) There should be guidelines to limit the number of FMG's entering the US for the purpose of graduate medical training as well as to practice medicine modified as appropriate in response to assessment of needs. Public policy toward extending the rights of foreign-trained physicians to practice in the US should be sensitive to the impact of the individual's practice on the health care delivery system. (3~~<u>1</u>) Immigration legislation should allow adequate time to complete training. (~~4~~<u>2</u>~~) Steps should be taken to aid developing countries in providing incentives for their physicians to return to or remain in their own country.~~ ~~(5)~~ Determination of an**

~~**individual's qualifications should include assessment of the individual student or medical school graduate as well as the foreign medical school attended. (632)**~~ **Individuals contemplating a career in medicine should be informed of the requirements necessary to successfully enter the US medical profession.** ~~**as well as residency training programs' preference for graduates of US medical schools.**~~

RECOMMENDATION B:

Resolution 107 be adopted as amended.

RESOLVED, That our AMA-MSS:
1) Recognizes the important contributions of international medical graduates to the United States health care system;
2) Opposes discrimination against medical students, residents, or physicians solely on the basis of national origin and/or the country in which they completed their medical education;
3) Supports equal and fair certification for international medical graduates as established by the Educational Commission for Foreign Medical Graduates (ECFMG);
4) Supports that physicians and medical students should be evaluated for purposes of entry into graduate medical education programs, licensure, and hospital medical staff privileges on the basis of their individual qualifications, skills, and character; and
5) Supports legislation, policies, and rules that allow international medical graduates to obtain the appropriate visas and licenses to enter graduate medical education and practice medicine within the United States; and, be it further

RESOLVED, That our AMA-MSS amend 255.001MSS, The Status of Foreign Medical School Graduates in the United States, by addition and deletion as follows:

The Status of ~~Foreign~~ International Medical School Graduates in the United States, 255.001MSS

AMA-MSS supports the following principles: ~~(1) The US Government should provide preferential support (e.g., financial aid) to US citizens enrolled in US medical schools, as opposed to alien and US FMG's. (2) There should be guidelines to limit the number of FMG's entering the US for the purpose of graduate medical training as well as to practice medicine modified as appropriate in response to assessment of needs. Public policy toward extending the rights of foreign-trained physicians to practice in the US should be sensitive to the impact of the individual's practice on the health care delivery system. (31)~~ Immigration legislation should allow adequate time to complete training. (~~4~~2) Steps should be taken to aid developing countries in providing incentives for their physicians to return to or remain in their own country. ~~(5) Determination of an individual's qualifications should include assessment of the individual student or medical school graduate as well as the~~

~~foreign medical school attended.~~ (~~6~~3) Individuals contemplating a career in medicine should be informed of the requirements necessary to successfully enter the US medical profession. ~~as well as residency training programs' preference for graduates of US medical schools.~~

VRC testimony was generally supportive of Resolution 107. The Asian Pacific American Medical Student Association, Region 1, and two individuals spoke in support. The Massachusetts delegation supported Resolution 107 with an amendment and Rutgers New Jersey Medical School spoke in opposition. Your Reference Committee believes this is an important issue and having a well-informed, up-to-date MSS stance is crucial, especially to act upon relevant resolutions in the House of Delegates should they arise. We recommend striking original clause (4) of the second Resolve clause as it is unclear what action is expected from this clause. During the Reference Committee deliberations several amendments were proposed to update the language of original clause (4) of the second Resolve, but ultimately we were unable to capture the nuances and recommend an appropriate amended ask. We do recognize there is potential to encompass the gestalt of this clause in future policy-making and would ask the MSS Assembly to consider doing so in a future resolution.

(72) RESOLUTION 108 - USE OF SOCIAL MEDIA FOR PRODUCT PROMOTION AND COMPENSATION

RECOMMENDATION A:

The first Resolve of Resolution 108 be deleted:

~~**RESOLVED, That our AMA encourages medical students, residents, fellows, and physicians to separate their personal and professional online profiles so as to avoid undue influence when promoting the sale of non-health related products; and be it further**~~

RECOMMENDATION B:

The second Resolve clause of Resolution 108 be deleted:

~~**RESOLVED, That our AMA release a statement recommending that medical students, residents, fellows, and physicians adhere to the FTC guidelines for disclosing financial, employment, personal, and family relationships with a company on social media posts; and be it further**~~

RECOMMENDATION C:

The third Resolve clause of Resolution 108 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA study the ethical issue of ~~develop ethical guidelines for~~ medical students, residents, fellows, and physicians ~~around~~ endorsing non-health related products through social and mainstream media for personal or financial gain.

RECOMMENDATION D:

Resolution 108 be adopted as amended.

RESOLVED, That our AMA encourages medical students, residents, fellows, and physicians to separate their personal and professional online profiles so as to avoid undue influence when promoting the sale of non-health related products; and be it further

RESOLVED, That our AMA release a statement recommending that medical students, residents, fellows, and physicians adhere to the FTC guidelines for disclosing financial, employment, personal, and family relationships with a company on social media posts; and be it further

RESOLVED, That our AMA develop ethical guidelines for medical students, residents, fellows, and physicians around endorsing non-health related products through social and mainstream media for personal or financial gain.

VRC Testimony on Resolution 108 was mixed. The MSS House Coordination Committee (HCC) placed the first Resolve on the reaffirmation consent calendar to reaffirm Code of Medical Ethics 2.3.2, Professionalism in the Use of Social Media. However, the ethical opinions contained in the Code of Medical Ethics cannot be reaffirmed, so we have recommended the first Resolve clause to be deleted to enact the desired action by HCC, as it is already covered by existing ethical opinion 2.3.2.

Your Reference Committee believes that the third Resolve clause of Resolution 108 is the most actionable and feasible and have made amendments to strengthen this language. We recommend striking the second Resolve clause to avoid conflation of the Federal Trade Commission guidelines and internal AMA ethical guidance during the transmittal of this item to the House of Delegates. We believe the AMA should study this issue as this subject needs to be thoroughly reviewed by the AMA Council on Ethics and Judicial Affairs (CEJA). We recommend Resolution 108 be adopted as amended.

(73) RESOLUTION 110 - SUPPORT DISTRIBUTION OF FREE HEARING PROTECTION IN RELEVANT PUBLIC VENUES

RECOMMENDATION A:

Resolution 110 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA-MSS supports the availability of free hearing protection, such as foam earplugs, in public spaces where noise levels exceed 85dBA, such as bars and live music venues.

RECOMMENDATION B:

Resolution 110 be adopted as amended.

RESOLVED, That our AMA supports the availability of free hearing protection, such as foam earplugs, in public spaces where noise levels exceed 85 dBA, such as bars and live music venues.

VRC testimony was mixed on Resolution 110. The Massachusetts delegation spoke in opposition, stating this resolution was a reaffirmation of existing policy and that many of the venues mentioned are private, which could limit the feasibility of the ask. Region 1 spoke in support of the resolution. Your Reference Committee believes that this resolution would be best introduced in the House of Delegates by an appropriate specialty society and recommends making the resolution internal. This amendment will allow the MSS to aptly support this resolution, or a similar one, should it be introduced in the House of Delegates by another entity. We recommend Resolution 110 be adopted as amended.

(74) RESOLUTION 112 - GUARANTEED TIME OFF ON NATIONAL ELECTION DAYS AT MEDICAL SCHOOLS

RECOMMENDATION:

Resolution 112 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA ~~will~~ work with appropriate stakeholders to guarantee ~~time off~~ a full day off on ~~National~~ Election Days at medical schools.

RECOMMENDATION B:

Resolution 112 be adopted as amended.

RESOLVED, That our AMA will work with appropriate stakeholders to guarantee time off on National Election Days at medical schools.

There was broad support for Resolution 112 on the VRC. The MSS Committee on LGBTQ+ Issues offered an amendment that your Reference Committee found compelling to specify that medical students should have a full day off to vote. Your Reference Committee offers an additional amendment to strike "National" as state and local elections are also important, especially for healthcare-related topics.

(75) RESOLUTION 114 - SUPPORT FOR ADMINISTRATION OF STEP EXAMINATIONS BY HOME INSTITUTIONS

RECOMMENDATION A:

Resolution 114 be <u>amended by addition and deletion</u> to read as follows:

RESOLVED, That our AMA-MSS support the continued exploration of a permanent shift in the administration of ~~written STEP~~ <u>USMLE</u> and COMLEX examinations away from third-party testing sites and toward primary administration of home institutions with the supplementation of third party testing sites to accommodate test takers incapable of testing at home institutions.

RECOMMENDATION B:

Resolution 114 be <u>amended with a title change</u>:

"Support for Administration of ~~Step~~ <u>USMLE and COMLEX</u> Examinations by Home Institutions"

RECOMMENDATION C:

Resolution 114 be <u>adopted as amended</u>.

RESOLVED, That our AMA-MSS support the continued exploration of a permanent shift in the administration of written STEP and COMLEX examinations away from third-party testing sites and toward primary administration of home institutions with the supplementation of third party testing sites to accommodate test takers incapable of testing at home institutions.

VRC testimony was supportive of Resolution 114. The MSS Committee on Medical Education (CME) and Rutgers New Jersey Medical School spoke in support of this resolution. The Massachusetts delegation supported Resolution 114 with amendments. Your Reference Committee offers a minor amendment to the verbiage of this resolution, as well as an amendment to the title to reflect this change, and recommend this resolution be adopted as amended.

(76) RESOLUTION 118 - EVALUATING SCIENTIFIC JOURNAL ARTICLES FOR RACIAL AND ETHNIC BIAS

RECOMMENDATION A:

The first Resolve of Resolution 118 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA~~-MSS send a letter to~~ support major journal publishers ~~to~~ issueing guidelines for interpreting previous research which define race and ethnicity by outdated means ~~that conflict with the AMA definitions~~; and be it further

RECOMMENDATION B:

The second Resolve of Resolution 118 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA~~-MSS affirm policy H-460.924 and pending policy 350.025MSS by asking our AMA-MSS to send a letter to~~ support major journal publishers ~~to~~ implementing a screening method for future research submissions concerning the incorrect use of race and ethnicity.

RECOMMENDATION C:

Resolution 118 be adopted as amended.

RESOLVED, That our AMA-MSS send a letter to major journal publishers to issue guidelines for interpreting previous research which define race and ethnicity by outdated means that conflict with the AMA definitions; and be it further

RESOLVED, That our AMA-MSS affirm policy H-460.924 and pending policy 350.025MSS by asking our AMA-MSS to send a letter to major journal publishers to implement a screening method for future research submissions concerning the incorrect use of race and ethnicity.

VRC testimony was mixed on Resolution 118. There was concern regarding the actionability of this as an internal resolution; as such, your Reference Committee recommends making Resolution 118 external. There were also concerns about feasibility and unintended consequences of the resolution as originally written. We provide amendments that support the spirit of the original resolution but increase actionability and allay concerns of overreach.

(77) RESOLUTION 122 - RESPECTING RELIGIOUS DIVERSITY IN MEDICAL EDUCATION

RECOMMENDATION A:

The first Resolve of Resolution 122 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA-MSS ~~should work with appropriate stakeholders to develop~~ support inclusive accommodation for students who feel restricted in their religious obligations in peer physical examination courses, including ~~which include~~ osteopathic manipulative medicine and clinical skills instruction.~~;~~

RECOMMENDATION B:

The second Resolve of Resolution 122 be deleted:

~~RESOLVED, That our AMA encourage actions by medical schools and work with appropriate stakeholders to provide sufficient accommodations in peer physical examination courses in order to align with student consent and religious obligation.~~

RECOMMENDATION C:

Resolution 122 be adopted as amended.

RESOLVED, That our AMA should work with appropriate stakeholders to develop inclusive accommodation for students who feel restricted in their religious obligations in peer physical examination courses which include osteopathic manipulative medicine and clinical skills instruction; and

RESOLVED, That our AMA encourage actions by medical schools and work with appropriate stakeholders to provide sufficient accommodations in peer physical examination courses in order to align with student consent and religious obligation.

VRC testimony for Resolution 122 was mixed. Region 1, Region 4 and two individuals supported the resolution with amendments. Region 4 recommended amending the resolution to direct the AMA study this issue further. The delegation from Massachusetts spoke in opposition citing the dearth of research, and the MSS Committee on Medical Education (CME) testified with concern about the lack of evidence supporting the ask and the scope of the resolution. Your Reference Committee appreciates this testimony and recommends making the first Resolve clause internal and striking the second Resolve clause altogether. We also offer amendments to the first Resolve for clarity and brevity. Your Reference Committee found the testimony on the paucity of evidence compelling. We recognize this as a very important issue and are troubled by the anecdotal evidence provided by individuals. At this time, however, we are hesitant to bring this resolution

forward to the AMA House of Delegates due to the current lack of recent peer-reviewed evidence included in this resolution. However, we would like to commend the authors on bringing forward a resolution on such an important topic. We recommend Resolution 122 be adopted as amended.

(78) RESOLUTION 125 - TRANSPARENCY ON RESTRICTIONS OF CARE

RECOMMENDATION A:

The first Resolve of Resolution 125 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA-MSS amend policy 5.006MSS, Reproductive Health Care in Religiously-Affiliated Hospitals, as follows:

AMA-MSS 5.066 ~~Reproductive Health Care in Religiously- Affiliated Hospitals~~ Transparency on Restrictions of Care AMA-MSS (1) supports advocate~~s~~ing that all ~~religiously-affiliated~~ medical institutions provide medically accurate information on the full breadth of reproductive health options available for patients, including, but not limited to, all forms of contraception, emergency care during miscarriages, and infertility treatments, regardless of the institution's willingness to perform the aforementioned services; ~~and~~ (2) endorses the timely referral of patients seeking reproductive services from healthcare providers with religious commitments to accessible health care systems offering the aforementioned services, all the while avoiding any undue burden to the patient~~.~~; and (3) supports advocate~~s~~ing that all facilities and hospitals disclose all restrictions in care, including reproductive care and end of life care, to all patients seeking care at their facility, all trainees considering training programs at their facility, and all physicians seeking employment at their facility. ~~; and be it further~~

RECOMMENDATION B:

The second Resolve of Resolution 125 be deleted:

~~**RESOLVED, That our AMA amend the following Code of Ethics Policy 1.1.7,**~~
~~**"(d) Recognize that physicians' primary obligation is to their patients, and promote transparency between hospitals and employed healthcare professionals as to permissible and prohibited services at the facility.**~~
~~**(f) Physicians should refer a patient to another physician or institution to provide treatment the physician or their affiliated group/employed health-system declines to offer. Institutions should not be able to prevent physicians from providing referrals to patients for services not provided at the facility.**~~

RECOMMENDATION C:

The third Resolve of Resolution 125 be deleted:

~~**RESOLVED, That our AMA-MSS forward internal policy 5.006MSS to the AMA House of Delegates as amended, as well as the remainder of this resolution.**~~

RECOMMENDATION D:

Resolution 125 be adopted as amended.

RESOLVED, That our AMA-MSS amend policy AMA-MSS 5.066 Reproductive Health Care in Religiously Affiliated Hospitals as follows:

AMA-MSS 5.066 ~~Reproductive Health Care in Religiously Affiliated Hospitals~~ Transparency on Restrictions of Care

AMA-MSS (1) advocates that all ~~religiously-affiliated~~ medical institutions provide medically accurate information on the full breadth of reproductive health options available for patients, including, but not limited to, all forms of contraception, emergency care during miscarriages, and infertility treatments, regardless of the institution's willingness to perform the aforementioned services; and (2) endorses the timely referral of patients seeking reproductive services from healthcare providers with religious commitments to accessible health care systems offering the aforementioned services, all the while avoiding any undue burden to the patient. (3) advocates that all facilities and hospitals disclose all restrictions in care, including reproductive care and end of life care, to all patients seeking

care at their facility, all trainees considering training programs at their facility, and all physicians seeking employment at their facility.

; and be it further

RESOLVED, That our AMA amend the following Code of Ethics Policy 1.1.7,

"(d) Recognize that physicians' primary obligation is to their patients, and promote transparency between hospitals and employed healthcare professionals as to permissible and prohibited services at the facility.

(f) Physicians should refer a patient to another physician or institution to provide treatment the physician or their affiliated group/employed health-system declines to offer. Institutions should not be able to prevent physicians from providing referrals to patients for services not provided at the facility.

; and be it further

RESOLVED, That our AMA-MSS forward internal policy 5.006MSS to the AMA House of Delegates as amended, as well as the remainder of this resolution.

VRC testimony on Resolution 125 was mixed. Region 4 and the MSS Committee on Economics and Quality in Medicine (CEQM) spoke in support and the authors of the resolution proposed several clarifying amendments. The MSS, and, indeed, the House of Delegates is unable to amend the Code of Medical Ethics directly, so we recommend striking the second Resolve clause. We also believe 5.006MS should remain internal and therefore recommend striking the third resolve clause. While your Reference Committee supports the spirit of this resolution, we ultimately believe that it would be best brought forward by the American College of Obstetrics and Gynecology (ACOG). Amending 5.006MSS and keeping the policy internal will allow for the MSS Caucus to adeptly support a similar resolution should it be brought forward to the House of Delegates. We recommend Resolution 125 be adopted as amended.

(79) RESOLUTION 128 - HOSPITAL BANS ON TRIAL OF LABOR AFTER CESAREAN

RECOMMENDATION A:

The first Resolve of Resolution 128 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA encourage hospitals that can ~~at least~~ provide basic maternal care as defined by American College of Obstetrics and Gynecology not to ~~ban~~ prohibit trial of labor after cesarean (TOLAC) ~~to protect the shared decision-making process between patient and physician~~; and be it further

RECOMMENDATION B:

The second Resolve of Resolution 128 be amended by deletion to read as follows:

RESOLVED, That our AMA encourage hospitals that do not ~~feel they~~ have resources to perform trial of labor after cesarean (TOLAC) to assist in the transfer of care of patients who desire TOLAC ~~trial of labor after cesarean~~ to a hospital that is equipped to perform TOLAC ~~trial of labor after cesarean.; and be it further~~

RECOMMENDATION C:

The third Resolve of Resolution 128 be deleted:

~~RESOLVED, That our AMA encourage hospitals to publish their trial of labor after cesarean policies to allow patients to make informed maternal healthcare decisions.~~

RECOMMENDATION D:

Resolution 128 be adopted as amended.

RESOLVED, That our AMA encourage hospitals that can at least provide basic maternal care as defined by American College of Obstetrics and Gynecology not to ban trial of labor after cesarean to protect the shared decision-making process between patient and physician; and be it further

RESOLVED, That our AMA encourage hospitals that do not feel they have resources to perform TOLAC to assist in the transfer of care of patients who desire trial of labor after cesarean to a hospital that is equipped to perform trial of labor after cesarean; and be it further

RESOLVED, That our AMA encourage hospitals to publish their trial of labor after cesarean policies to allow patients to make informed maternal healthcare decisions.

VRC testimony on Resolution 128 was limited, with Massachusetts in support with an amendment. We offer amendments for clarity and brevity to the first and second Resolve clauses, which the American College of Obstetrics and Gynecology (ACOG) noted were consistent with ACOG policy. ACOG also warned that the third resolve could be considered contentious and inflammatory . We find this testimony compelling and recommend striking the third Resolve clause. Your Reference Committee recommends resolution 128 be adopted as amended.

(80) CEQM REPORT C – RESEARCHING POLICY RECOMMENDATIONS TO ADDRESS THE SHORTFALLS OF EMPLOYER-SPONSORED HEALTH INSURANCE

RECOMMENDATION A:

The Recommendation from CEQM Report C be amended by addition to read as follows:

Your Committee on Economics & Quality in Medicine recommends that the following be adopted and the remainder of this report is filed:

RESOLVED, That our AMA-MSS support transitioning away from a system that relies on employer-sponsored health insurance to facilitate universal access to high quality, affordable healthcare.

RECOMMENDATION B:

Recommendation in CEQM Report C be adopted as amended and the remainder of the report be filed.

Your Committee on Economics & Quality in Medicine recommends that the following be adopted and the remainder of this report is filed:

1. RESOLVED, That our AMA support transitioning away from a system that relies on employer-sponsored health insurance to facilitate universal access to high quality, affordable healthcare.

Your Reference Committee found CEQM Report C to be well-researched and well-written. Testimony on the VRC came from the Section Delegates who recommended adding a second Resolve clause. We did not find this testimony to be compelling. This report critically examines the history and nature of employer-sponsored healthcare in an extremely nuanced way and brings in an immense amount of evidence and expertise for this issue. From a strategic perspective, we believe making this report internal and

proposing an amendment to related items to be considered at the House of Delegates in the near future (e.g. a closely-related resolution from the Resident and Fellow Section) it to bolster future conversations about healthcare reform would be most appropriate. We thank the authors for the time and effort that went into writing CEQM Report C and recommend the recommendation in the report be adopted as amended and the remainder of the report be filed.

(81) CHIT CEQM REPORT A - ADVOCATING FOR THE REIMBURSEMENT OF REMOTE PATIENT MONITORING FOR THE MANAGEMENT OF CHRONIC CONDITIONS

RECOMMENDATION A:

The first Recommendation from CHIT CEQM Report A be deleted:

~~**RESOLVED, That our AMA will develop model legislation at the federal level to expand and standardize remote patient monitoring coverage policies.**~~

RECOMMENDATION B:

The third Recommendation from CHIT CEQM Report A be deleted:

~~**RESOLVED, That our AMA will work with appropriate stakeholders to provide guidance on which remote patient monitoring devices and software services should be reimbursable and under what circumstances.**~~

RECOMMENDATION C:

Recommendations in CHIT CEQM Report A be adopted as amended and the remainder of the report be filed.

Your Committee on Health Information and Technology (CHIT) and Committee on Economics and Quality in Medicine (CEQM) recommend the following resolve clauses be adopted in lieu of the A-19 MSS Resolution 65 – "Advocating for the Reimbursement of Remote Patient Monitoring for the Management of Chronic Conditions," and the remainder of this report be filed.

1. RESOLVED, That our AMA will develop model legislation at the federal level to expand and standardize remote patient monitoring coverage policies.
2. RESOLVED, That our AMA will work with the Federation of State Medical Boards to draft model legislation to ensure remote patient monitoring is defined in each state's medical practice statutes and its regulation falls under the jurisdiction of the state medical board.

3. RESOLVED, That our AMA will work with appropriate stakeholders to provide guidance on which remote patient monitoring devices and software services should be reimbursable and under what circumstances.

Your Reference Committee thanks the MSS Committees on Health Information Technology (CHIT) and Economics and Quality in Medicine (CEQM) for a well-written and thoughtful report. We recommend striking the first Resolve clause, as the AMA does not develop model federal legislation (rather, model state legislation as directed in the second Resolve clause). We also recommend striking the third Resolve clause as this is nebulous and inherently included in AMA activities, and we do not believe this recommendation will significantly change the AMA's efforts in remote patient monitoring. Your Reference Committee recommends the first and third Resolve clauses be deleted from the recommendation and CHIT CEQM Report A be adopted as amended and filed.

RECOMMENDED FOR ADOPTION IN LIEU OF

(82) RESOLUTION 001 – SUPPORT FOR INSTITUTIONAL POLICIES FOR PERSONAL DAYS FOR UNDERGRADUATE MEDICAL STUDENTS
COLRP CME REPORT A – SUPPORT FOR MENTAL HEALTH ABSENCES FOR STUDENTS AND RESIDENTS

RECOMMENDATION:

Substitute Resolution 001 be adopted in lieu of Resolution 001 and COLRP CME Report A.

RESOLVED, That our AMA encourage medical schools to accept flexible uses for excused absences from clinical clerkships; and be it further

RESOLVED, That our AMA support a clearly defined number of easily accessible personal days for medical students per academic year, which should be explained to students at the beginning of each academic year and a subset of which should be granted without requiring an explanation on the part of the students; and be it further

RESOLVED, That our AMA-MSS reaffirm 295.001MSS.

RESOLVED, That our AMA recognizes the importance of personal days as health resources to ensure appropriate self-care and maintenance of a healthy lifestyle through amending Policy H-295.858, "Access to Confidential Health Services" by addition as follows:

Access to Confidential Health Services, H-295.858:
1. Our AMA will ask the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, American Osteopathic Association, and Accreditation Council for Graduate Medical Education to encourage medical schools and residency/fellowship programs, respectively, to:
A. Provide or facilitate the immediate availability of urgent and emergent access to low-cost, confidential health care, including mental health and substance use disorder counseling services, that: (1) include appropriate follow-up; (2) are outside the trainees' grading and evaluation pathways; and (3) are available (based on patient preference and need for assurance of confidentiality) in reasonable proximity to the education/training site, at an

external site, or through telemedicine or other virtual, online means;
B. Ensure that residency/fellowship programs are abiding by all duty hour restrictions, as these regulations exist in part to ensure the mental and physical health of trainees;
C. Encourage and promote routine health screening among medical students and resident/fellow physicians, and consider designating some segment of already-allocated personal time off (if necessary, during scheduled work hours) specifically for routine health screening and preventive services, including physical, mental, and dental care; and
D. Remind trainees and practicing physicians to avail themselves of any needed resources, both within and external to their institution, to provide for their mental and physical health and well-being, as a component of their professional obligation to ensure their own fitness for duty and the need to prioritize patient safety and quality of care by ensuring appropriate self-care, not working when sick, and following generally accepted guidelines for a healthy lifestyle.
E. Support a clearly defined number of personal days for medical students per academic year, a subset of which should be granted without explanation. Personal day policies should be easily accessible and explained to students at the beginning of each academic year.
2. Our AMA will urge state medical boards to refrain from asking applicants about past history of mental health or substance use disorder diagnosis or treatment, and only focus on current impairment by mental illness or addiction, and to accept "safe haven" non-reporting for physicians seeking licensure or re-licensure who are undergoing treatment for mental health or addiction issues, to help ensure confidentiality of such treatment for the individual physician while providing assurance of patient safety.
3. Our AMA encourages medical schools to create mental health and substance abuse awareness and suicide prevention screening programs that would:
A. be available to all medical students on an opt-out basis;
B. ensure anonymity, confidentiality, and protection from administrative action;
C. provide proactive intervention for identified at-risk students by mental health and addiction professionals; and
D. inform students and faculty about personal mental health, substance use and addiction, and other risk factors that may contribute to suicidal ideation.
4. Our AMA: (a) encourages state medical boards to consider physical and mental conditions similarly; (b) encourages state medical boards to recognize that the

presence of a mental health condition does not necessarily equate with an impaired ability to practice medicine; and (c) encourages state medical societies to advocate that state medical boards not sanction physicians based solely on the presence of a psychiatric disease, irrespective of treatment or behavior.

5. Our AMA: (a) encourages study of medical student mental health, including but not limited to rates and risk factors of depression and suicide; (b) encourages medical schools to confidentially gather and release information regarding reporting rates of depression/suicide on an opt-out basis from its students; and (c) will work with other interested parties to encourage research into identifying and addressing modifiable risk factors for burnout, depression and suicide across the continuum of medical education.

6. Our AMA encourages the development of alternative methods for dealing with the problems of student-physician mental health among medical schools, such as: (a) introduction to the concepts of physician impairment at orientation; (b) ongoing support groups, consisting of students and house staff in various stages of their education; (c) journal clubs; (d) fraternities; (e) support of the concepts of physical and mental well-being by heads of departments, as well as other faculty members; and/or (f) the opportunity for interested students and house staff to work with students who are having difficulty. Our AMA supports making these alternatives available to students at the earliest possible point in their medical education.

7. Our AMA will engage with the appropriate organizations to facilitate the development of educational resources and training related to suicide risk of patients, medical students, residents/fellows, practicing physicians, and other health care professionals, using an evidence-based multidisciplinary approach.

Your Reference Committee considered Resolution 001 in conjunction with COLRP CME Report A, as these items are closely related. VRC testimony on Resolution 001 was supportive. The Psychiatry Student Interest Group Network (PsychSIGN), Region 1, and the MSS Committees on Legislation and Advocacy (COLA) and LGBTQ+ Issues supported Resolution 001 as written and the MSS Committee on Medical Education (CME) offered an amendment to include “easily accessible” to describe personal days requested. We found this amendment compelling and incorporated into the final combined language for this item. VRC testimony on COLRP CME Report A was limited, with support from PsychSIGN, however, your Reference Committee found the report to be well-written and thoughtful. We believe these items are stronger together and therefore recommend combining the language of Resolution 001 and COLRP CME Report A and adopting Substitute Resolution 001 in lieu of these individual items. We recommend the remainder of COLRP CME Report A be filed.

(83) RESOLUTION 016 – DENOUNCING RACIAL ESSENTIALISM IN MEDICINE
RESOLUTION 032 – DISSOCIATING RACE FROM BIOLOGY IN HEALTHCARE EDUCATION

RECOMMENDATION:

Substitute Resolution 016 be <u>adopted in lieu of Resolutions 016 and 032</u>.

RESOLVED, That our AMA recognize that the false conflation of race with inherent biological or genetic traits leads to inadequate examination of true underlying disease risk factors, which exacerbates existing health inequities; and be it further

RESOLVED, That our AMA encourage characterizing race as a social construct, rather than an inherent biological trait, and recognize that when race is described as a risk factor, it is more likely to be a proxy for influences including structural racism than a proxy for genetics; and be it further

RESOLVED, That our AMA collaborate with the AAMC, AACOM, NBME, NBOME, other national-level stakeholders across the various domains of health care education and public health and content experts to identify and address aspects of medical and health care education and examinations which may be perpetuating the mistaken belief that race is an inherent biologic risk factor for diseases; and be it further

RESOLVED, That our AMA advocate for the revision of Liaison Committee on Medical Education (LCME) accreditation standards to (1) identify systemic racism as the root cause of health inequities and require that curricula support the knowledge, skills, and core professional attributes needed to eliminate health inequities, and (2) require that medical students attending LCME-accredited institutions pass a school-administered cultural competency assessment and practicum to graduate from medical school; and be it further

RESOLVED, That our AMA encourage the AMA Foundation to create new scholarships, research grants, and awards to support outstanding academic and community efforts related to the impact of systemic racism on health; and be it further

RESOLVED, That our AMA collaborate with appropriate stakeholders and content experts to develop recommendations on how to interpret or improve clinical algorithms that currently include race-based correction factors; and be it further

RESOLVED, That our AMA support research that promotes antiracist strategies to mitigate algorithmic bias in medicine; and be it further

RESOLVED, That our AMA-MSS immediately forward this resolution to the November 2020 Special Meeting of the AMA House of Delegates.

Resolution 016

RESOLVED, Our AMA recognizes that the false conflation of race with inherent biological or genetic traits leads to inadequate examination of true underlying disease risk factors, which exacerbates existing health inequities; and be it further

RESOLVED, Our AMA encourages characterizing race as a social construct, rather than an inherent biological trait, and recognizes that when race is described as a risk factor, it is more likely to be a proxy for influences including structural racism than a proxy for genetics; and be it further

RESOLVED, Our AMA will collaborate with the AAMC, AACOM, NBME, NBOME, other appropriate stakeholder organizations, and content experts to identify and address aspects of medical education and board examinations which may be perpetuating the mistaken belief that race is an inherent biologic risk factor for diseases; and be it further

RESOLVED, Our AMA will collaborate with appropriate stakeholders and content experts to develop recommendations on how to interpret or improve clinical algorithms that currently include race-based correction factors; and be it further

RESOLVED, Our AMA will issue a position statement on the first two Resolved clauses; and be it further

RESOLVED, Our AMA will report back to the House of Delegates at I-21 on the status of the third and fourth Resolved clauses; and be it further

RESOLVED, Given the timely nature of national conversations on this issue, our AMA-MSS will immediately forward this resolution to the AMA House of Delegates.

Resolution 032
RESOLVED, That our AMA encourages the dissociation of race from biology in healthcare curricula, textbooks, and educational materials by promoting the recognition of race as a social construct; and be it further

RESOLVED, That our AMA calls upon the AMA Foundation to repurpose a portion of existing funds on new scholarships, research grants, and awards to support outstanding academic and community efforts related to the impact of systemic racism on health; and be it further

RESOLVED, That our AMA calls upon the Liaison Committee on Medical Education (LCME) to revise its accreditation standards under Section 7.6 “Cultural Competence and Health Care Disparities” to: (1) change the current language from “disparities” to “inequities” and work with the AMA to update language ambiguity regarding the causes of health inequities, (2) identify systemic racism as the root cause of such inequities and require that curricula support the knowledge, skills, and core professional attributes needed to eliminate health inequities, and (3) require that medical students attending LCME-accredited institutions pass a school-administered cultural competency assessment and practicum to graduate from medical school; and be it further

RESOLVED, That our AMA will collaborate with national-level stakeholders across the various domains of healthcare education including (but not limited to): medicine, physician’s assistant, nursing, pharmacy, podiatry, dentistry, optometry, midwifery, technical, and public health on the issue of transitioning to dissociate race and biology in healthcare education and research; and be it further

RESOLVED, That our AMA will create and develop new modules and educational resources about systemic racism and its effects on health, including but not limited to anti-racism training, implicit bias training, advocacy, and interprofessional collaboration to broadly assist the education of healthcare students and faculty; and be it further

RESOLVED, That our AMA encourages the justification for any inclusions of race as a risk factor for disease states in healthcare educational material, and where appropriate, include the systemic injustices (particularly but not limited to racism) that contribute to the development of that disease; and be it further

RESOLVED, That our AMA-MSS will immediately forward this resolution to the AMA House of Delegates; and be it further

RESOLVED, That our AMA will report back to the House of Delegates at I-21 on the status of the resolved clauses above.

Your Reference Committee heard extensive testimony on both Resolution 016 and Resolution 032. After deliberations, we have decided it is best to combine Resolution 016 and Resolution 032 into Substitute Resolution 016. We found that both resolutions have Resolves that merit inclusion and by combining we not only consolidate the asks but have a stronger resolution as a result.

The spirit of both resolutions was well-supported on the VRC, with many testifying to the importance of the issue. The authors of Resolution 016 worked closely with the AMA Minority Affairs Section (MAS) to craft language similar to a resolution that will be brought forward by MAS. Two of the original resolve clauses of Resolution 032 (R5 and R6) were recommended for reaffirmation by HCC. We agree with these recommendations and therefore have incorporated components of the novel clauses for consideration in Substitute Resolution 016. The new fourth Resolve clause (originally from Resolution 032) was modified to advocate for revisions to accreditation standards that will be more palatable than influencing representatives to act in a certain way. In the new fifth Resolve clause we propose changing the language from "calls upon" to "encourage" to more closely reflet the vernacular norms of the House of Delegates.

We believe this resolution is timely and warrants immediate forwarding to the AMA House of Delegates if passed by the MSS Assembly. Thank you to all authors for working on this critically important issue. We recommend that Substitute Resolution 016 be adopted in lieu of Resolution 016 and Resolution 032.

(84) RESOLUTION 025 – BANNING THE PRACTICE OF VIRGINITY TESTING

RECOMMENDATION:

Substitute Resolution 025 be <u>adopted in lieu of Resolution 025</u>.

RESOLVED, That our AMA advocate for the elimination of the practice of virginity testing exams, physical examinations purported to assess virginity; and be it further

REOSLVED, That our AMA support culturally-sensitive counseling by health professionals to educate patients and family members about the negative effects and inaccuracy of virginity testing and where needed, referral for further psychosocial support; and be it further

RESOLVED, That our AMA support efforts to educate medical students and physicians about the continued existence of the practice of virginity testing and its detrimental effects on patients.

RESOLVED, That our AMA:

(1) advocates for banning the practice of virginity testing exams;

(2) supports culturally sensitive counseling by providers to educate patients and family members about the negative effects and inaccuracy of virginity testing and where needed, referral for further psychosocial support;

(3) will work to ensure that medical students, residents, and practicing physicians are made aware of the continued existence of the practice of virginity testing in the United States and abroad and its detrimental effects on patients.

VRC testimony was supportive of Resolution 025 with amendments. Your Reference Committee found the most compelling testimony to be that from the American College of Obstetrics and Gynecology (ACOG). The amendments proposed address their concerns while maintaining the intent of the authors and align with ACOG's policy on this topic. Other proposed amendments are editorial and aim to streamline the proposed language. We have also split this into three separate Resolve clauses which is the most appropriate format for the House of Delegates, as the first Resolve would be considered a new directive to take action and the latter two Resolves are asking for new AMA policy. The Reference Committee also found the phrase "in the United States and abroad" superfluous and opted to delete for this reason.

(85) RESOLUTION 037 – AMENDING D-350.986, EVALUATION OF DACA-ELIGIBLE MEDICAL STUDENTS, RESIDENTS AND PHYSICIANS IN ADDRESSING PHYSICIAN SHORTAGES, TO IDENTIFY AND DECREASE BARRIERS THESE STUDENTS FACE IN APPLYING TO MEDICAL SCHOOL

RECOMMENDATION:

Substitute Resolution 037 be <u>adopted in lieu of Resolution 037</u>.

RESOLVED, That our AMA-MSS work with appropriate stakeholders to identify and decrease barriers, including but not limited to those for undergraduate education and undergraduate medical education, faced by Deferred Action for Childhood Arrivals-eligible individuals who are applying to medical schools in the United States.

RESOLVED, That our AMA amend policy D-350.986, Evaluation of DACA-Eligible Medical Students, Residents and Physicians in Addressing Physician Shortages, by addition as follows:

Evaluation of DACA-Eligible Medical Students, Residents and Physicians in Addressing Physician Shortages, D-350.986

1. Our American Medical Association will study the issue of Deferred Action for Childhood Arrivals-eligible medical students, residents, and physicians and consider the opportunities for their participation in the physician profession and report its findings to the House of Delegates.

2. Our AMA will issue a statement in support of current US healthcare professionals, including those currently training as medical students or residents and fellows, who are Deferred Action for Childhood Arrivals recipients.
3. Our AMA will work with appropriate stakeholders to identify and decrease barriers, including but not limited to those for undergraduate education and undergraduate medical education, faced by Deferred Action for Childhood Arrivals-eligible individuals who are applying to medical schools in the United States.

Your Reference Committee heard extensive testimony and had extensive deliberations on Resolution 037. Ultimately, we recommend making the proposed addition to existing policy internal. The AMA is very active advocating on DACA issues and we do not believe this proposed amendment to existing policy will significantly change AMA efforts. Additionally, the MSS has a transmittal in queue for consideration at the House of Delegates dealing with medical licensure for DACA-eligible individuals. We believe this is a very important topic but feel it is being adequately addressed by the AMA, including a recent Council on Medical Education report presented at the Annual 2017 House of Delegates pursuant to the first directive in the policy to be amended, D-250.986, that delineated many of the barriers to medical education for Deferred Action for Childhood Arrivals-eligible individuals. Further, we found that Resolution 037 needed to lay out a tangible directive more clearly in order to maximize its impact. For these reasons, your Reference Committee recommends Substitute Resolution 037 be adopted.

(86) RESOLUTION 038 – HEALTH COVERAGE DURING STATES OF EMERGENCY

RECOMMENDATION:

Substitute Resolution 038 be adopted in lieu of Resolution 038.

RESOLVED, That our AMA study mechanisms to reduce unexpected losses of insurance coverage during states of emergency; and be it further

RESOLVED, That our AMA-MSS support increases in states' Federal Medical Assistance Percentages or other funding during significant economic downturns to allow state Medicaid programs to continue serving Medicaid patients and cover rising enrollment.

RESOLVED, That our AMA investigate the recent use of Special Enrollment Periods during the COVID-19 pandemic to identify their potential impact in federal emergency response legislation; and be it further

RESOLVED, That our AMA advocate for the immediate expansion of Medicaid eligibility during national states of emergency; and be it further

RESOLVED, That our AMA collaborate with relevant subject matter experts and entities to develop model legislation for Federal Medical Assistant Percentage increases during a national emergency according to appropriate measures including, but not limited to, unemployment rates.

There were several amendments proposed on the VRC regarding Resolution 038. Ultimately, your Reference Committee found that there were challenges in feasibility in the first and third Resolve clauses and confusing language in the second Resolve clause. Proposed amendments by the authors raised similar concerns. Frequent opening of Special Enrollment Periods, including for states of emergency that may not result in coverage losses, could engender confusion for patients and unintentionally encourage some patients not to acquire coverage until such an emergency exists, particularly in the context of a nonfunctional federal individual mandate, undermining the insurance market. It is unclear whether federal law allows states to expand Medicaid solely in the context of a state of emergency, and thus, such a proposal raises questions about when such coverage would terminate, and advocacy in this vein could undermine the AMA's efforts to support the full expansion of Medicaid in states that have yet to do so. However, there may be a role for the AMA to explore other mechanisms to reduce unexpected losses of insurance coverage in the context of states of emergency, like the COVID-19 pandemic. In addition, pertaining to the provisions around the Federal Medicaid Assistance Percentage, AMA Council on Medical Service (CMS) Report 5 will be considered at the November 2020 Special Meeting of the House of Delegates and includes a recommendation addressing this issue, which appears to be in line with the intent of the authors of Resolution 038.

For these reasons we recommend Substitute Resolution 038 be adopted in lieu of Resolution 038 as written. Our amendments clarify and streamline the language of the asks and make the resolution more feasible. As a note, the AMA does not draft model federal legislation, but rather only drafts legislation at the state level.

(87) RESOLUTION 058 – PROHIBITING EVICTIONS DURING PUBLIC HEALTH EMERGENCIES CAUSED BY INFECTIOUS PATHOGENS
RESOLUTION 073 – SUPPORT FOR UTILITY SHUT-OFF MORATORIUMS FOR THE DURATION OF THE COVID-19 PANDEMIC

RECOMMENDATION:

Substitute Resolution 058 be adopted in lieu of Resolution 058 and Resolution 073.

RESOLVED, That our AMA advocate for policies that prohibit evictions during public health emergencies; and be it further

RESOLVED, That our AMA advocate for shut-off moratoria on life-essential utilities during public health emergencies; and be it further

RESOLVED, That our AMA-MSS immediately forward this resolution to the November 2020 Special Meeting of the House of Delegates.

Resolution 058
RESOLVED, Our AMA advocate for federal policies that prohibit evictions during public health emergencies caused by infectious pathogens.

Resolution 073
RESOLVED, That our AMA supports local, state, and/or national shut-off moratoriums on all life-essential utilities for the duration of the national emergency relating to COVID-19; and be it further

RESOLVED, That our AMA encourages local, state, and federal governments to provide financial assistance, such as with forgivable loans, for utility companies that are compliant with government-sanctioned moratoriums during the national emergency relating to COVID-19.

VRC testimony supported Resolution 058 and was mixed on Resolution 073. Your Reference Committee found Resolution 058 and Resolution 073 to address similar themes and therefore considered them in conjunction with each other. The language of these resolutions was combined and harmonized, and an immediate forward clause was added.

We heard compelling testimony to strike the phrase “caused by infectious pathogens” from the original Resolution 058 and chose not to include in the final language presented here. This proposed amendment removes restrictions without impacting advocacy efforts. We also heard compelling testimony from Region 1 on original Resolution 073, which stated that it is not the AMA’s role to protect the financial viability of utility companies, but rather

to protect our patients from losing access to necessities for the maintenance of their health. As such we have proposed removing this language (originally the second Resolve of Resolution 073) from the final proposed Substitute Resolution. Your Reference Committee believes this issue is time-sensitive and urgent and have added an immediate forward clause. We recommend Substitute Resolution 058 be adopted in lieu of Resolution 058 and Resolution 073.

(88) RESOLUTION 062 – ENVIRONMENTAL SUSTAINABILITY OF AMA NATIONAL MEETINGS
RESOLUTION 075 – NET ZERO GREENHOUSE GAS EMISSIONS IN THE AMA AND HEALTHCARE SECTOR

RECOMMENDATION:

Substitute Resolution 062 be <u>adopted in lieu of Resolutions 062 and 075</u>.

RESOLVED, That our AMA commit to reaching net zero emissions for its business operations by 2030, and remain net zero or net negative, as defined by a carbon neutral certifying organization, and report annually on the AMA's progress towards implementation; and be it further

RESOLVED, That our AMA work with appropriate stakeholders to encourage the United States healthcare system, including but not limited to hospitals, clinics, ambulatory care centers, and healthcare professionals, to decrease emissions to half of 2010 levels by 2030 and become net zero by 2050, and remain net zero or negative, as defined by a carbon neutral certifying organization, including by creating educational materials; and be it further

RESOLVED, That our AMA evaluate the feasibility of purchasing carbon offsets for member travel to and from Annual and Interim meetings and report back to the House of Delegates; and be it further

RESOLVED, That our AMA evaluate the feasibility of holding future Annual and Interim meetings at Leadership in Energy and Environmental Design-certified or sustainable conference centers and report back to the House of Delegates.

Resolution 062

RESOLVED, That our AMA will evaluate the feasibility of purchasing carbon offsets for member travel to and from annual and interim meetings and report back to the House of Delegates at the 2022 Interim Meeting; and be it further

RESOLVED, That our AMA will evaluate the feasibility of holding future annual and interim meetings at LEED-certified or sustainable conference centers and report back to the House of Delegates at the 2022 Interim Meeting.

Resolution 075
RESOLVED, That our AMA will commit to reaching net zero emissions for its business operations by 2030, and remain net zero or net negative, as defined by a carbon neutral certifying organization; and be it further

RESOLVED, That our AMA create educational programs for and encourage the United States healthcare system, including but not limited to hospitals, clinics, ambulatory care centers, and healthcare professionals, to decrease emissions to half of 2010 levels by 2030 and become net zero by 2050, and remain net zero or negative, as defined by a carbon neutral certifying organization; and be it further

RESOLVED, That our AMA will report the progress on implementing this resolution at each Annual Meeting hereafter.

Your Reference Committee had extensive deliberation over Resolution 062 and ultimately recommend that this resolution be combined with Resolution 075. Concern was raised about both the cost and downstream effects of purchasing carbon offsets, but we did not find that testimony compelling and believe they could represent a worthwhile expenditure by the AMA. The authors of Resolution 075 previously submitted their ask as a Governing Council Action Item (GCAI) but were directed to submit a resolution that could be considered at the House of Delegates instead. Your Reference Committee believes that these resolutions are stronger together and have combined them, while eliminating self-referential clauses and otherwise clarifying the language. We recommend adoption of Substitute Resolution 062 in lieu of Resolution 062 and Resolution 075.

(89) RESOLUTION 069 – OPPOSITION TO THE CRIMINALIZATION OF PERINATAL DEMISE

RECOMMENDATION:

Substitute Resolution 069 be <u>adopted in lieu of Resolution 069</u>.

RESOLVED, That our AMA-MSS oppose the criminalization of perinatal loss in women who experience known medical conditions, including addiction or other mental health disorders during pregnancy.

RESOLVED, That AMA policy H-420.970 be amended by addition and deletion as follows:

Treatment Versus Criminalization - Physician Role in Drug Addiction and Mental Health Crises During Pregnancy and the Perinatal Period H-420.970

It is the policy of the AMA (1) to reconfirm its position that drug addiction and mental health crises, including but not limited to suicidality, ~~is a~~ are conditions ~~disease~~ amenable to treatment rather than a criminal activity;
(2) to forewarn the U.S. government and the public at large that there are extremely serious implications of drug addiction during pregnancy and there is a pressing need for adequate maternal drug treatment and family supportive child protective services;
(3) to oppose legislation which criminalizes maternal drug addiction and other mental health disorders or requires physicians to function as agents of law enforcement - gathering evidence for prosecution rather than provider of treatment; and
(4) to provide concentrated lobbying efforts to encourage legislature funding for maternal drug addiction treatment rather than prosecution, and to encourage state and specialty medical societies to do the same.
(5) to advocate against the criminalization of perinatal loss in women who experience known medical conditions, including addiction or other mental health disorders during pregnancy.

VRC testimony was supportive of the spirit of Resolution 069. The American College of Obstetrics and Gynecology (ACOG) respectfully requested that they be the organization to bring resolutions forward on contentious topics such as that addressed in this resolution. Your Reference Committee agrees with deferring to ACOG on this important topic and recommends making this resolution internal in order to support a resolution on this issue should it be introduced in the AMA House of Delegates in the future.

(90) RESOLUTION 123 - IMPROVING THE USE OF MEDICAL INTERPRETER SERVICES BY HEALTH CARE PROVIDERS THROUGH CME
CME MIC REPORT A - SUPPORT FOR STANDARDIZED INTERPRETER TRAINING FOR MEDICAL SCHOOLS

RECOMMENDATION:

Substitute Resolution 123 be adopted in lieu of Resolution 123 and CME MIC Report A.

RESOLVED, That our AMA recognize the importance of using medical interpreters as a means of improving quality of care provided to patients with Limited English Proficiency (LEP) including patients with sensory impairments; and be it further

RESOLVED, That our AMA encourage physicians and physicians in training to improve interpreter-use skills and increase education through publicly available resources such as the AAMC "Guidelines for Use of Medical Interpreter Services; and be it further

RESOLVED, That our AMA work with the Commission for Medical Interpreter Education, National Hispanic Medical Association, National Council of Asian Pacific Islander Physicians, National Medical Association, Association of American Indian Physicians, National Association of the Deaf, and other relevant stakeholders to develop educational resources, such as through the AMA Ed Hub, for physicians to effectively and appropriately use interpreter services to ensure optimal patient care.

Resolution 123
RESOLVED, That our AMA work with the Commission for Medical Interpreter Education, National Hispanic Medical Association, National Council of Asian Pacific Islander Physicians, National Medical Association, Association of American Indian Physicians, and other relevant stakeholders to develop a cohesive Continuing Medical Education (CME) module offered through the AMA Ed Hub for physicians to effectively and appropriately use interpreter services to ensure optimal patient care.

CME MIC Report A
Your Committee on Medical Education and Minority Issues Committee recommend that the following recommendations be adopted in lieu of Resolution 48 and the remainder of the report be filed:

1) That our AMA recognize the importance of using medical interpreters as a means of improving quality of care provided to patients with Limited English Proficiency (LEP) including patients with sensory impairments.

2) That our AMA encourage physicians and physicians in training to improve interpreter-use skills and increase education through publicly available resources such as the AAMC "Guidelines for Use of Medical Interpreter Services."

Your Reference Committee considered Resolution 123 in conjunction with CME MIC Report A due to the similarity of their content. We found CME MIC Report A to be extremely well-written and well-researched. The report recognizes the importance of interpreters and encourages physicians and students to improve interpreter skills. Testimony on the VRC was generally supportive of Resolution 123. We believe it is most efficient to combine the asks of these items. We propose those amendments here, along with clarifying language and the addition of the National Association of the Deaf to the list of stakeholders for potential collaboration. We commend all authors on addressing this important issue and recommend Substitute Resolution 123 be adopted in lieu of Resolution 123 and CME MIC Report A. We recommended the remainder to CME MIC Report A be filed.

(91) RESOLUTION 129 - GUIDELINES ON CHAPERONES FOR SENSITIVE EXAMS

RECOMMENDATION:

Substitute Resolution 129 be <u>adopted in lieu of Resolution 129</u>:

RESOLVED, That our AMA ask the Council on Ethical & Judicial Affairs to consider amending E-1.2.4, "Use of Chaperones in Code of Medical Ethics," to ensure that it is most in line with the current best practices and includes the following topics: a) Opt-out chaperones for breast, genital, and rectal exams; b) Documentation surrounding use or not-use of chaperones; c) Use of chaperones for patients without capacity; d) Asking patients' consent regarding the gender of the chaperone and attempting to accommodate that preference as able.

RESOLVED, That our AMA amend policy 1.2.4 Use of Chaperones in Code of Medical Ethics by addition as follows:

Code of Ethics 1.2.4 Use of Chaperones
Efforts to provide a comfortable and considerate atmosphere for the patient and the physician are part of respecting patients' dignity. These efforts may include providing appropriate gowns, private facilities for undressing, sensitive use of draping, and clearly explaining

various components of the physical examination. They also include having chaperones available. Having chaperones present can also help prevent misunderstandings between patient and physician.
Physicians should:
(a) Adopt a policy that patients are free to request a chaperone and ensure that the policy is communicated to patients. Ensure patients are educated about the role of the chaperone and chaperone policy.
(b) Always honor a patient's request to have a chaperone and explicitly offer chaperones for patients of all genders and sexual orientations during sensitive exams.
(c) Have an authorized member of the health care team serve as a chaperone. Physicians should establish clear expectations that chaperones will uphold professional standards of privacy and confidentiality.
(d) In general, use a chaperone even when a patient's trusted companion is present.
(e) Provide opportunity for private conversation with the patient without the chaperone present. Physicians should minimize inquiries or history taking of a sensitive nature during a chaperoned examination.
(f) Aim to document in every patient's chart his or her preference regarding chaperones before such exams are performed.
(g) Aim to document all sensitive encounters involving chaperones in the health record, including names, time, and date. If a patient declines a chaperone, this should also be noted. If a patient with decision-making capacity declines a part of or the whole examination, it should not be done. The refusal should be noted in the chart.
(h) Encourage nurse/desk staff to document patient preference before the patient encounters the physician rather than having the provider ask themselves.
(i) Encourage use of chaperones in cases where a patient declines a chaperone but the physician still feels uncomfortable, allowing the provider to defer the exam to another day or to another physician or chaperone, with reassurance to the patient that this is standard practice.
(j) Encourage formal training for all chaperones including when to report and how to report.
(k) Not allow the process of ensuring that an exam is chaperoned to interfere with appropriate and timely patient care and clinical judgment.
(l) Ensure that a chaperone is present for all vulnerable patients.

VRC testimony was opposed to Resolution 129, with the MSS Committee on Economics and Quality in Medicine (CEQM) and the Massachusetts delegation testifying against

adoption of this resolution as written. Your Reference Committee notes that we are unable to propose amendments to the Code of Medical Ethics and recommend adopting Substitute Resolution 129 in lieu of Resolution 129. We believe the Substitute Resolution summarizes the asks proposed by the original resolution in a format more palatable to the House of Delegates. There was testimony on the VRC asking to add a fourth clause regarding the gender of the chaperone. We found that to be compelling and have incorporated that language into our final recommendation.

(92) RESOLUTION 130 - PROTECTION FROM RISKS OF INDOOR TANNING

RECOMMENDATION:

Substitute Resolution 130 be adopted in lieu of Resolution 130.

RESOLVED, That our AMA-MSS amend 440.004MSS to read as follows:

440.004MSS. ~~Education on t~~The Harmful Effects of UVA and UVB Light: (1) AMA-MSS will ask the AMA to assemble and disseminate 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~~.~~; and (2) AMA-MSS supports a complete ban of minors' utilization of indoor tanning.

RESOLVED, That the AMA-MSS amend current policy and support emphasizing the causal relationship of tanning beds use and the increase in skin cancer rates, and support of the recommendations of the American Academy of Dermatology and public health organizations; and further be it

RESOLVED, That the AMA-MSS support a complete ban of minors' utilization of indoor tanning.

VRC testimony was mixed on Resolution 130. The Massachusetts delegation opposed the resolution as written and Region 1 opposed the resolution unless the first Resolve was amended to be more specific. Your Reference Committee believes the first Resolve clause is already covered in 440.004MSS. Instead of reaffirming 440.004MSS in lieu of the first Resolve and potentially creating a new, separate policy with the second Resolve clause, we propose striking the first Resolve and amending 440.004MSS to incorporate the second Resolve clause of Resolution 130. We recommend adopting Substitute Resolution 130 to amend 440.004MSS in lieu of Resolution 130.

RECOMMENDED FOR REFERRAL

(93) RESOLUTION 044 – ADVOCATE FOR THE LEGALIZATION OF RECREATIONAL CANNABIS TO END MASS INCARCERATION

RECOMMENDATION:

Resolution 044 be referred for study.

RESOLVED, That Our AMA amend current policies H-95.924, H-95.952 and D-95.969 as denoted below:

Cannabis Legalization for Recreational Use H-95.924
Our AMA: (1) believes that cannabis is a dangerous drug and as such is a serious public health concern; (2) ~~believes that the sale of cannabis for recreational use should not be legalized~~; (2) ~~(3)~~ discourages cannabis use, especially by persons vulnerable to the drug's effects and in high-risk populations such as youth, pregnant women, and women who are breastfeeding; (3)~~(4)~~ believes states that have already legalized cannabis (for medical or recreational use or both) should be required to take steps to regulate the product 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; (4)~~(5)~~ 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; (5)~~(6)~~ supports public health based strategies, rather than incarceration, in the handling of individuals possessing cannabis for personal use; (6)~~(7)~~ encourages research on the impact of legalization and decriminalization of cannabis in an effort to promote public health and public safety; (7)~~(8)~~ encourages dissemination of information on the public health impact of legalization and decriminalization of cannabis; (8)~~(9)~~ will advocate for stronger public health messaging on the health effects of cannabis and cannabinoid inhalation and ingestion; and (9)~~(10)~~ will 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.

Cannabis and Cannabinoid Research H-95.952
1. Our AMA calls for further adequate and well-controlled studies of marijuana and related cannabinoids in patients who have serious conditions for which preclinical,

anecdotal, or controlled evidence suggests possible efficacy and the application of such results to the understanding and treatment of disease. 2. Our AMA urges that marijuana's status as a federal schedule I controlled substance be reviewed with the goal of facilitating the conduct of clinical research and development of cannabinoid-based medicines, and alternate delivery methods. ~~This should not be viewed as an endorsement of state-based medical cannabis programs, the legalization of marijuana, or that scientific evidence on the therapeutic use of cannabis meets the current standards for a prescription drug product.~~ 3. Our AMA urges the National Institutes of Health (NIH), the Drug Enforcement Administration (DEA), and the Food and Drug Administration (FDA) to develop a special schedule and implement administrative procedures to facilitate grant applications and the conduct of well-designed clinical research involving cannabis and its potential medical utility. This effort should include: a) disseminating specific information for researchers on the development of safeguards for cannabis clinical research protocols and the development of a model informed consent form for institutional review board evaluation; b) sufficient funding to support such clinical research and access for qualified investigators to adequate supplies of cannabis for clinical research purposes; c) confirming that cannabis of various and consistent strengths and/or placebo will be supplied by the National Institute on Drug Abuse to investigators registered with the DEA who are conducting bona fide clinical research studies that receive FDA approval, regardless of whether or not the NIH is the primary source of grant support. 4. Our AMA supports research to determine the consequences of long-term cannabis use, especially among youth, adolescents, pregnant women, and women who are breastfeeding. ~~5. Our AMA urges legislatures to delay initiating the legalization of cannabis for recreational use until further research is completed on the public health, medical, economic, and social consequences of its use. 6.~~ 5. Our AMA will advocate for urgent regulatory and legislative changes necessary to fund and perform research related to cannabis and cannabinoids. ~~7.~~ 6. Our AMA will create a Cannabis Task Force to evaluate and disseminate relevant scientific evidence to health care providers and the public.

Cannabis Legalization for Medicinal Use D-95.969
Our AMA: (1) believes that scientifically valid and well-controlled clinical trials conducted under federal investigational new drug applications are necessary to assess the safety and effectiveness of all new drugs,

including potential cannabis products for medical use; ~~(2) believes that cannabis for medicinal use should not be legalized through the state legislative, ballot initiative, or referendum process; (3)~~ (2) will develop model legislation requiring the following warning on all cannabis products not approved by the U.S. Food and Drug Administration: "Marijuana has a high potential for abuse. This product Tetrahydrocannabinol, its major active ingredient, has not been approved by the Food and Drug Administration for preventing or treating any only certain disease process."; ~~(4)~~ (3) supports legislation ensuring or providing immunity against federal prosecution for physicians who certify that a patient has an approved medical condition or recommend cannabis in accordance with their state's laws; ~~(5)~~ (4) believes that effective patient care requires the free and unfettered exchange of information on treatment alternatives and that discussion of these alternatives between physicians and patients should not subject either party to criminal sanctions; ~~(6) will, when necessary and prudent, seek clarification from the United States Justice Department (DOJ) about possible federal prosecution of physicians who participate in a state operated marijuana program for medical use and based on that clarification, ask the DOJ to provide federal guidance to physicians; and (7)~~ (5) encourages hospitals and health systems to: (a) 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 (b) educate medical staffs on cannabis use, effects and cannabis withdrawal syndrome.

; and be it further

RESOLVED, That this resolution be immediately forwarded to the AMA House of Delegates.

VRC testimony was mixed on Resolution 044. The authors and one individual spoke in support of the resolution as written, while all other testimony was in opposition. Your Reference Committee thoroughly deliberated the potential merits of Resolution 044 and ultimately decided this resolution would benefit from further study within the MSS. It is important to note that the AMA Council on Science and Public Health (CSAPH) has a report on this topic that will be discussed at the November 2020 Special Meeting of the House of Delegates, and a CSAPH report on similar topics was discussed at I-19.

Your Reference Committee notes that most of the opposition to this resolution was regarding the strategy surrounding the upcoming CSAPH report, not opposition to the stance taken by the authors on legalization of recreational cannabis, and some ambiguity exists within extant MSS policy on this issue. Your Reference Committee believes that the MSS can act appropriately in response to the CSAPH report without passing Resolution

044 as written. Your Reference Committees recommends referral for study so MSS policy can be informed by the forthcoming CSAPH report. For this reason, we believe the appropriate MSS Standing Committee(s) should study and report back on this topic to solidify the MSS stance on this issue. By doing so the MSS Caucus will be prepared for forthcoming discussions at the HOD. Additionally, a study would provide an opportunity to develop a well-researched stance on the issue of legalization of recreational cannabis specifically, which does address a current gap in policy.

(94) RESOLUTION 045 – SUPPORTING MEDICAL STUDENT PHYSICIAN SHADOWING IN A REMOTE CAPACITY DURING THE CURRENT CRISIS

RECOMMENDATION:

Resolution 045 be <u>referred for study</u>.

RESOLVED, That our AMA-MSS support the use of telemedicine technologies for use by pre-medical and medical students for the purpose of physician shadowing.

Testimony on the VRC was mixed, but generally supportive of the spirit of Resolution 045. Region 1 proposed amending to include the definition of a crisis and the MSS Section Delegates asked that this be referred for study. Your Reference Committee did not find that the proposed amendments adequately addressed the concerns raised and agrees that a study on this topic is warranted. We believe there needs to be language added to protect students' right to shadow in person and clarify that virtual shadowing should not be prioritized over in-person shadowing when both are safely feasible. While we acknowledge the timeliness of this ask, we think there are several process measures that need to be further fleshed out to avoid unintended consequences. For these reasons we recommend Resolution 045 be referred for study.

(95) RESOLUTION 049 – COVERAGE OF PREGNANCY-ASSOCIATED HEALTHCARE FOR 12 MONTHS POSTPARTUM FOR UNINSURED PATIENTS INELIGIBLE FOR MEDICAID

RECOMMENDATION:

Resolution 049 be <u>referred for study</u>.

RESOLVED, That, to expand coverage of pregnancy-associated healthcare for more uninsured patients and further reduce pregnancy-associated morbidity and mortality, AMA Policy H-290.974, "Extending Medicaid Coverage for One Year Postpartum," be amended by insertion as follows:

Extending Medicaid Coverage for One Year Postpartum D-290.974

<u>1)</u> Our AMA will work with relevant stakeholders to support extension of Medicaid coverage to 12 months postpartum.

2) Our AMA will work with relevant stakeholders to support coverage of pregnancy-associated healthcare until at least 12 months postpartum for uninsured patients ineligible for Medicaid, including, but not limited to, coverage under their child's health insurance plan through Children's Medicaid, the Children's Health Insurance Program (CHIP), or private insurers.

VRC testimony on Resolution 049 was mixed. Perhaps most compelling were questions raised about the ambiguity of the phrase "uninsured patients ineligible for Medicaid." The AMA is very active in advocating on issues of maternal health and the lack of explicit policy has not hindered these efforts. Examples include letters to the Senate Committee on Finance and Black Maternal Health Caucus Stakeholder Summit and testimony to the House of Representatives Committee on Energy and Commerce Subcommittee on Health, which all reflect the AMA's support for legislation to "ensure Medicaid and CHIP coverage for women for one year postpartum" and "ensuring the full range of comprehensive benefits for pregnant and postpartum women." Testimony provided by the American College of Obstetrics and Gynecology (ACOG) asked for clarification of what this coverage would entail, as programs provided by the Children's Health Insurance Program (CHIP) and Children's Medicaid often are centered on the care of the child, and not postpartum care of the birthing parent. For these reasons, your Reference Committee believes Resolution 049 could benefit from further study and recommend this be referred to the appropriate MSS Standing Committee(s).

(96) RESOLUTION 063 – EXCLUSION OF RACE AND ETHNICITY IN THE FIRST SENTENCE OF CASE REPORT

RECOMMENDATION:

Resolution 063 be referred for study.

RESOLVED, Our AMA encourages curriculum and clinical practice that omits race and/or ethnicity from the first sentence of case reports; and

RESOLVED, Our AMA encourages the maintenance of race and ethnicity in either social or family history of the patient; and

RESOLVED, Our AMA study common cultural processes in clinical practice that advance racism and bias.

VRC testimony was supportive of Resolution 063, with support from Region 1 and the MSS Minority Issues Committee (MIC). The MSS Section Delegates raised concern that the Whereas clauses do not fully support the Resolve clauses. Your Reference Committee found this testimony compelling and believes Resolution 063 could benefit from further evaluation. We therefore recommend Resolution 063 be referred for study by the appropriate MSS Standing Committee(s).

(97) RESOLUTION 065 – INVESTIGATION OF NATUROPATHIC VACCINE EXEMPTIONS

RECOMMENDATION:

Resolution 065 be <u>referred for study</u>.

RESOLVED, Our AMA opposes medical vaccine exemptions by naturopathic physicians; and be it further

RESOLVED, Our AMA advocates for state and national legislation opposing the ability of naturopathic physicians to provide medical vaccine exemptions.

VRC testimony was mixed on Resolution 065 with the MSS Committees on Legislation and Advocacy (COLA), Long-Range Planning (COLRP), and Economics and Quality in Medicine (CEQM) in support of the spirit, but Region 1 and the Massachusetts delegation speaking in opposition. Your Reference Committee believes this resolution would benefit from additional research and evidence around the current conditions surrounding naturopathic practitioners and medical vaccine exemptions. We note the paucity of evidence cited in the Whereas clauses, limited scope (studies cited were only from one state), and potential considerations regarding a broader swath of practitioners potentially issuing medical vaccine exemptions as reasons why we support referral for study.

(98) RESOLUTION 074 – SUPPORT FOR EVIDENCE-BASED POLICY

RECOMMENDATION:

Resolution 074 be <u>referred for study</u>.

RESOLVED, That our AMA-MSS defines evidence-based policy as policy based on rigorous, objective, replicable research, especially randomized control trials; and be it further

RESOLVED, That our AMA-MSS supports policy proposals that are evidence-based and align with our goals as outlined in the MSS Policy Digest; and be it further

RESOLVED, That our AMA-MSS opposes policy proposals that are contradicted by evidence; and be it further

RESOLVED, That our AMA-MSS, in cases where insufficient evidence exists to indicate a proper course of action, supports studies to acquire the necessary data to make an evidence-based decision; and be it further

RESOLVED, That our AMA-MSS will not allow the process of ensuring evidence-based analysis to interfere with policy decision making in exigent circumstances that cannot await further study.

Testimony on Resolution 074 for was mixed – there were many in strong favor of this resolution and many in strong opposition. We do support the spirit of the resolution. Your Reference Committee found pieces of both sides of testimony compelling and believe this resolution would benefit from further study by the appropriate MSS Standing Committee(s). We point out that the MSS already incorporates a vigorous review process for resolution submission and passing this resolution as written could potentially delay or dilute MSS participation in timely advocacy. However, your Reference Committee also strongly agrees that MSS resolutions should be well-researched and based in evidence. We recognize the delicacy and nuance of Resolution 074 and recommend it be referred for further study and refinement.

(99) RESOLUTION 093 - AMENDING POLICY H-50.973 TO SUPPORT THE IMPLEMENTATION OF HEALTH CARE REFERRALS IN BLOOD DONATION CENTERS FOR DONORS AT RISK FOR HIV

RECOMMENDATION:

Resolution 093 be referred for study.

RESOLVED, That our AMA amend policy H-50.973, "Blood Donor Deferral Criteria" by addition and deletion, to read as follows:

Blood Donor Deferral Criteria, H-50.973
Our AMA: (1) supports the use of rational, scientifically-based blood and tissue donation deferral periods that are fairly and consistently applied to donors according to their individual risk; (2) opposes all policies on deferral of blood and tissue donations that are not based on evidence; (3) supports a blood donation deferral period for those determined to be at risk for transmission of HIV that is representative of current HIV testing technology; and (4) supports research into individual risk assessment criteria for blood donation (5) supports referrals for those deemed to be at high risk for HIV transmission to healthcare organizations for testing and treatment.

VRC testimony on Resolution 093 was mixed. The MSS Section Delegates recommended H-20.920 and H-20.922 be reaffirmed in lieu of Resolution 093. We disagree that this is a reaffirmation of existing policy but do believe this topic warrants study from the appropriate MSS Standing Committee(s). The MSS Committee on LGBTQ+ Issues provided testimony stating that the proposed amendment does not address the concern of defining who is a part of the high-risk population using evidence-based, non-stigmatizing criteria. We believe that Resolution 093 would benefit from further study to strengthen the language of the proposed amendment so that it is not harmful but does address the current gap.

(100) RESOLUTION 102 - OPPOSING THE MARKETING OF PHARMACEUTICALS TO PARTIES RESPONSIBLE FOR CAPTIVE POPULATIONS

RECOMMENDATION:

Resolution 102 be referred for study.

RESOLVED, That our AMA will actively oppose the practice of pharmaceutical marketing towards those who make decisions for captive populations, including, but not limited to, doctors working in a correctional capacity, judges, wardens, sheriffs, correctional officers, and other detention administrators; and be it further

RESOLVED, That our AMA will advocate for the inclusion of physicians in the selection and negotiation of which drugs are available to vulnerable populations such as inmates; and be it further

RESOLVED, That our AMA will work with state legislatures and their respective Departments of Corrections to adopt transparency-increasing measures, including, but not limited to, (1) requiring those responsible for medical procurement to report gifts from pharmaceutical companies over a *de minimis* amount, and (2) centralizing formulary choices, to the extent they are not already, in a physician-led office, agency, or commission.

VRC testimony was supportive of the spirit of Resolution 102. Region 4 and the MSS Committee on Economics and Quality in Medicine (CEQM) spoke in favor of the resolution; the Massachusetts delegation spoke in support with amendments. The MSS Section Delegates recommended referral. We find the Section Delegates testimony compelling and agree Resolution 102 could benefit from further refinement, including to potentially extend its reach. There is not a clear definition of the scope of the problem presented nor the implication of what advocating for or against this would have on the bureaucratic process of formulary selection for incarcerated populations. We note that there were not many peer-reviewed sources cited in this resolution and would ask for more supporting evidence from a report. Given the importance of this topic and the vulnerability of incarcerated or detained populations we believe AMA policies should be clearly delineated and based in thorough and extensive evidence from the literature. Your Reference Committee recommends Resolution 102 be referred for study, as we believe that further study will strengthen this ask.

(101) RESOLUTION 119 - AMEND H-150.927 AND H-150.933 TO INCLUDE FOOD PRODUCTS WITH ADDED SUGAR

RECOMMENDATION:

Resolution 119 be referred for study.

RESOLVED, That our AMA amend H-150.927, “Strategies to Reduce the Consumption of Beverages with Added Sweeteners” by addition to read as follows:

Strategies to Reduce the Consumption of Beverages with Added Sweeteners, H-150.927
Our AMA: (1) acknowledges the adverse health impacts of sugar-sweetened beverage (SSB) consumption and food products with added sugars, and support evidence-based strategies to reduce the consumption of SSBs and food products with added sugars, including but not limited to, excise taxes on SSBs and food products with added sugars, removing options to purchase SSBs and food products with added sugars in primary and secondary schools, the use of warning labels to inform consumers about the health consequences of SSB consumption and food products with added sugars, and the use of plain packaging; (2) encourages continued research into strategies that may be effective in limiting SSB consumption and food products with added sugars, such as controlling portion sizes; limiting options to purchase or access SSBs and food products with added sugars in early childcare settings, workplaces, and public venues; restrictions on marketing SSBs and food products with added sugars to children; and changes to the agricultural subsidies system; (3) encourages hospitals and medical facilities to offer healthier beverages, such as water, unflavored milk, coffee, and unsweetened tea, for purchase in place of SSBs and apply calorie counts for beverages in vending machines to be visible next to the price; and (4) encourages physicians to (a) counsel their patients about the health consequences of SSB consumption and food products with added sugars and replacing SSBs and food products with added sugars with healthier beverage and food choices, as recommended by professional society clinical guidelines; and (b) work with local school districts to promote healthy beverage and food choices for students.

; and be it further

RESOLVED, That our AMA amend H-150.933, "Taxes on Beverages with Added Sweeteners" by addition to read as follows:

Strategies to Reduce the Consumption of Beverages with Added Sweeteners, H-150.933
1. Our AMA recognizes the complexity of factors contributing to the obesity epidemic and the need for a multifaceted approach to reduce the prevalence of obesity and improve public health. A key component of such a multifaceted approach is improved consumer education on the adverse health effects of excessive consumption of beverages and food products containing added sweeteners. Taxes on beverages and food products with added

sweeteners are one means by which consumer education campaigns and other obesity-related programs could be financed in a stepwise approach to addressing the obesity epidemic.
2. Where taxes on beverages and food products with added sweeteners are implemented, the revenue should be used primarily for programs to prevent and/or treat obesity and related conditions, such as educational ad campaigns and improved access to potable drinking water, particularly in schools and communities disproportionately affected by obesity and related conditions, as well as on research into population health outcomes that may be affected by such taxes.
3. Our AMA will advocate for continued research into the potentially adverse effects of long-term consumption of non-caloric sweeteners in beverages and food products, particularly in children and adolescents.
4. Our AMA will: (a) encourage state and local medical societies to support the adoption of state and local excise taxes on sugar-sweetened beverages and food products, with the investment of the resulting revenue in public health programs to combat obesity; and (b) assist state and local medical societies in advocating for excise taxes on sugar-sweetened beverages and food products as requested.

VRC testimony was limited on Resolution 119. Your Reference Committee supports the spirit of this resolution but believe it could be strengthened by further study. We are mostly concerned with the ask of the second Resolve clause but recommend studying the resolution in its entirety. Our main concern is that adding taxes to food products containing added sweeteners could hurt people with low socioeconomic status (SES) and/or people living in food desserts who might not have access to non-sugar-added foods. Additionally, this Cochrane Public Health Review was unable to comment on the effectiveness of adding taxes to reduce consumption of foods with added sugar or the impact on obesity. We believe further research on this topic by the appropriate MSS Standing Committee(s) could better elucidate an appropriate ask and strengthen the resolution as a whole.

(102) RESOLUTION 126 - IMPLEMENTATION OF A SINGLE LICENSING EXAM FOR MEDICAL STUDENTS

RECOMMENDATION:

Resolution 126 be referred for study.

RESOLVED, our AMA support allowing osteopathic medical students to take the United States Medical Licensing Exam (USMLE) series and an osteopathic specific subject test, in lieu of the Comprehensive Osteopathic Medical Licensing Examination (COMLEX) series; and be it further

RESOLVED, our AMA will study the impact and plausibility of implementing a single licensing exam series for medical students who attend Commission on Osteopathic College Accreditation (COCA) and Liaison Committee on Medical Education (LCME) accredited schools, where osteopathic medical students are required to take an osteopathic specific subject test instead of a separate licensing exam series.

VRC testimony on Resolution 126 was mixed. Region 1 and an individual supported the spirit of the resolution. The MSS Committee on Legislation and Advocacy (COLA) thought the ask was powerful but could be better supported by the Whereas clauses, especially concerning the match process and credentialing. The authors of this resolution proposed an amendment on the VRC, but your Reference Committee did not find that this amendment ameliorated the concerns conveyed by the others testifying.

The Student Osteopathic Medical Association (SOMA) testified that the first Resolve clause as written was in direct opposition to their stance on the issue, and that even with the authors amendments, it was still unclear if the authors were asking to support one exam (COMLEX vs. USMLE) over another or supporting combining these two exams.

Your Reference Committee recognizes this is a complex issue that involves multiple external stakeholders and multiple revenue streams, in addition to the logistical complexities of potentially merging two examinations and the unpredictable consequences of the impending changes to USMLE Step 1 grading. For these reasons, we believe Resolution 126 would benefit from further study by the appropriate MSS Standing Committee(s).

(103) RESOLUTION 135 - REGULATION OF PHTHALATES IN ADULT PERSONAL SEXUAL PRODUCTS

RECOMMENDATION:

Resolution 135 be <u>referred for study</u>.

RESOLVED, That our AMA (1) advocates for the centralized regulation of phthalates, particularly DEHP, in adult personal sexual products; and (2) encourages the federal government to conduct a risk assessment of adult personal sexual products as a source of phthalates; and (3) supports manufacturer development of safe alternative products that do not contain phthalates.

VRC testimony was mixed on Resolution 135. Your Reference Committee recognizes there are a lot of complexities with this issue and believes Resolution 135 could benefit from further study by the appropriate MSS Standing Committee(s). The American College of Obstetrics and Gynecology (ACOG) also points out that the market for sex toys is not well-regulated, complicating the issue further, but also indicating that policy development on this issue may be prudent. We do believe this is within the scope of the AMA, however, we ask the MSS Standing Committee(s) assigned to this study to clarify the language to maximize impact and actionability.

(104) CEQM MIC REPORT A - LAYING THE FIRST STEPS TOWARDS A TRANSITION TO A FINANCIAL AND CITIZENSHIP NEED-BLIND MODEL FOR ORGAN PROCUREMENT AND TRANSPLANTATION

RECOMMENDATION:

CEQM MIC Report A be referred for study.

Your Minority Issues Committee and Committee on Economics and Quality in Medicine recommend that the following recommendations be adopted and the remainder of the report be filed:

1) That the first resolved clause of MSS Resolution 46 be amended by addition and deletion as follows:

RESOLVED, That our AMA support and advocate for federal ~~laws~~ mechanisms that ~~remove~~ decrease financial barriers to transplant recipients, such as provisions for expenses involved in the transplantation of organs incurred by the uninsured and underinsured regardless of United States Citizenship and Immigration Service (USCIS) status in the country as long as the person ~~can show physical presence~~ lives in the U.S. ~~prior to needing the organ~~; and

2) That the second resolved clause of MSS Resolution 46 be amended by addition and deletion as follows:

RESOLVED, That our AMA ~~promote and advocate~~ support the creation for of a 2020 national taskforce for organ procurement and transplant, that will be renewed every ~~20~~ 10 years to ~~access~~ assess the needs of the generation and account for changes in demographics and technology; and

3) That the third resolved clause of MSS Resolution 46 be amended by addition as follows:

RESOLVED, That our AMA support the research of a fiscal federal strategy to cover annual transplant costs in the U.S. for patients without or are ineligible for insurance distributed among the over 200 transplant centers in the U.S.; and

4) That the fifth resolved clause of MSS Resolution 46 be amended by addition and deletion as follows:

RESOLVED, That our AMA amend H-370.982 ~~to also clarify its stance of not regarding immigration status as long as the person lives in the U.S. thereby keeping the overall equitability of the system for organ donation and receiving parties intact~~ by addition to read as follows:

Ethical Considerations in the Allocation of Organ and Other Scarce Medical Resources Among Patients, H-370.982

Our AMA has adopted the following guidelines as policy: (1) Decisions regarding the allocation of scarce medical resources among patients should consider only ethically appropriate criteria relating to medical need. (a) These criteria include likelihood of benefit, urgency of need, change in quality of life, duration of benefit, and, in some cases, the amount of resources required for successful treatment without regard to a legally defined United States Citizenship and Immigration Service (USCIS).

5) That the fourth resolved be not adopted.

There was no VRC testimony on CEQM MIC Report A. Your Reference Committee found CEQM MIC Report A to be well-researched, however, there are several concerns we feel need to still be addressed. We believe the proposed amendments are helpful, but do not assuage all concerns raised. Your Reference Committee does not believe there is enough evidence in the report to support the recommendation calling for a task force, and we would like to see specific enumeration of the purpose of such a task force and we note that the creation of a task force within the AMA is typically reserved for issues having very broad and far-reaching impacts, such as the AMA Opioid Task Force and the AMA Health Equity Task Force. We would like to see greater consideration and justification of the need for a task force, and we would like to see specific recommendations on who would be included in this task force. Your Reference Committee also believes that the research called for in the third recommendations is fairly specific and as a result may not end up being impactful. We recognize the time and effort put into the creation of this report and thank the members of the Committee on Economics and Quality in Medicine (CEQM) and the Minority Issues Committee (MIC) for their hard work.

(105) CEQM REPORT B - SUPPORT OF RESEARCH ON VISION SCREENINGS AND VISUAL AIDS FOR ADULTS COVERED BY MEDICAID

RECOMMENDATION:

CEQM Report B be referred for study.

Your Committee on Economics and Quality in Medicine recommends that the following recommendations be adopted and the remainder of the report filed:

RESOLVED, That our AMA encourages appropriate scientific and medical research to determine the benefits of routine comprehensive eye exam and benefits of visual aids in adults eligible for Medicaid.

Your Reference Committee thanks the authors of CEQM Report B for their submission of this report. We appreciate the intent of CEQM Report B but ultimately find it needs further refinement. In the research presented, there was compelling evidence to include vision screenings for adults eligible for Medicaid but we found the evidence for including visual aids to be lacking. Additionally, the final recommendation calls for further research into benefits of routine comprehensive eye exams, which seems redundant and is likely to be

minimally impactful as the AMA would not conduct such primary research itself. We appreciate the hard work and effort that went into the creation of CEQM Report B and would ask the Committee to re-visit some of their research to provide more support for including visual aids in addition to vision screenings and hone their recommendation to perhaps be more definitive than calling for additional research.

(106) CSI REPORT A - SUPPORTING DAYLIGHT SAVING TIME AS THE NEW, PERMANENT STANDARD TIME

RECOMMENDATION:

CSI Report A be referred for study.

Your Committee on Scientific Issues recommends that the following recommendations are adopted and the remainder of the report is filed:

RESOLVED, That our AMA support the elimination of biannual time changing; and be it further

RESOLVED, That our AMA support daylight saving time as the permanent standard time.

Your Reference Committee found CSI Report A to be well-researched but recognizes the need for further refinement. Notably, there are no in-text citations included in this report which made it difficult to check citations and read more about each claim made. Additionally, we believe that many of the claims made in this report are based in correlation, more so than in causation, and we are hesitant to accept recommendations that are not evidence-based and supported by peer-reviewed research. We also note that some of the references cited claim that daylight savings time is preferable, while others make the argument for standard time.

Your Reference Committee appreciates the time and effort put into this report by the authors and applaud the Committee on Scientific Issues (CSI) for your work on such a complex issue. We concede it is difficult to do research on this topic but believe further evidence is needed to support the recommendations made. We recommend referring CSI Report A back to the committee for further modification.

(107) GC REPORT A - POLICY SUNSET REPORT FOR AMA-MSS POLICIES

RECOMMENDATION:

GC Report A be referred for study.

Your AMA-MSS Governing Council recommends that the following be adopted and the remainder of the report by filed:

1. That the policies specified for retention in Appendix 1 of this report be retained as official, active policies of the AMA-MSS.

2. That the AMA-MSS Governing Council review the AMA-MSS Digest of Policy Actions every five years for redundant and outdated statements of support.

Your Reference Committee recommends GC Report A be referred for further refinement. There were several policies amended to remove specific references and we were not sure why this was done (60.014MSS, 120.003MSS, 120.007MSS, 140.023MSS, 160.018MSS, 250.002MSS, 310.041MSS, 345.008MSS, 370.015MSS). There is precedent for removing outdated references but not necessarily specific references absent some other imperative to do so.

Your Reference Committee found issues with other proposed amendments as well (160.014MSS, 160.031MSS, 295.132MSS, 460.017MSS, 490.022MSS). More information on our concerns can be shared with the Governing Council to aid in reconciling the Sunset Report.

We also note that there were several policies that were accidentally omitted from the report and need to be included (60.015MSS, 140.030MSS, 170.016MSS, 245.020MSS, 270.028MSS, 480.016MSS, 565.005MSS, 630.060MSS).

Your Reference Committee recommends these edits be made and the report presented at the next meeting of the MSS Assembly.

RECOMMENDED FOR REFERRAL FOR DECISION

(108) RESOLUTION 006 – SUPPORTING MEDICAL STUDENT GUIDELINES DURING HEALTHCARE CRISIS

RECOMMENDATION:

Resolution 006 be referred for decision.

RESOLVED, That our AMA-MSS collaborate with relevant AMA stakeholders in order to develop and continuously revise as necessary recommendations regarding the role medical students are able to safely fill in a healthcare setting during a crisis that results in a significant departure from normal medical education as determined by the MSS governing council.

Testimony heard by your Reference Committee supported Resolution 006. We found this resolution to be well-evidenced but believe it could benefit from further work by the MSS Governing Council to capture the proper language for this ask. Members of your Reference Committee interpreted this resolution differently, so we ask specifically for clarification around which stakeholders the Governing Council should collaborate with and what determination is to be made – and when – by the Governing Council.

RECOMMENDED FOR NOT ADOPTION

(109) RESOLUTION 013 – STATUS OF IMMIGRATION LAWS, RULES, AND LEGISLATION DURING NATIONAL CRISES

RECOMMENDATION:

Resolution 013 not be adopted.

RESOLVED, In order to prioritize the unique health needs of immigrants, asylees, refugees, and migrant workers during national crises, such as a pandemic, our AMA:

(1) opposes the slowing or halting of immigration processing, courts, or decisions that might unnecessarily prolong detention of individuals and families

(2) opposes continual detention when the health of these groups is at risk and supports releasing immigrants on recognizance during national crises that impose a health risk

(3) supports the extension of work authorization regardless of immigration status if a national crisis causes the halting of immigration processing

(4) opposes eligibility restrictions, such as those for enrollment in Medicaid, that would hinder immigrants, refugees, migrant farm workers, and asylum seekers from accessing adequate health care

(5) supports the ability of immigrants, refugees, migrant farm workers, and asylum seekers who utilize Individual Taxpayer Identification Numbers (ITIN) to pay taxes to be able to receive economic assistance the federal government allocates through emergency relief bills designed to alleviate taxpayer financial stress

(6) opposes the federal government utilizing public health concerns as a false threat to national security to deny or significantly hinder eligibility for asylum status to immigrants, refugees, or migrant workers; and be it further

RESOLVED, That this resolution be immediately forwarded to the House of Delegates at the November Meeting in 2020.

Your Reference Committee commends the authors for the spirit of this resolution, which we believe is in line with current advocacy efforts. VRC testimony on Resolution 013 was overall supportive. Region 1, Region 4, the MSS Community Service Committee, and the Massachusetts delegation were supportive; the Section Delegates opposed the immediate forward clause. After extensive deliberation including the consideration of several amendments, your Reference Committee ultimately recommends against adoption of Resolution 013. We find that the only part of Resolution 013 that could meaningfully add to existing AMA Advocacy efforts would be the fourth proposed clause, which is somewhat nebulous but could confer AMA support for enabling undocumented immigrants to seek coverage under emergency Medicaid during a public health emergency such as a pandemic. However, we feel that is a much bigger discussion that is not supported robustly enough in the Whereas statements presented in Resolution 013 as written, though future policy-making endeavors could target this issue.

(110) RESOLUTION 017 – DECRIMINALIZATION OF PHYSICIANS WHO PROVIDE ABORTION PROCEDURES

RECOMMENDATION A:

Policies H-373.995 and H-5.989 be reaffirmed in lieu of the first Resolve of Resolution 017.

RECOMMENDATION B:

The remainder of Resolution 017 not be adopted.

RESOLVED, The AMA opposes local, state, and regional sanctions and interference in the criminalization of or any other legal repercussions for physicians who perform essential reproductive care and family planning services, including, but not limited to, contraceptive care, emergency care for miscarriages, infertility treatments, voluntary sterilization, or the induction of miscarriage; and be it further

RESOLVED, That our AMA amends policy H-5.993, Right to Privacy in Termination of Pregnancy, H-5.995, Abortion, 4.2.7, Abortion, H-160.946, The Criminalization of Health Care Decision Making, H-5.001MSS, Public Funding of Abortion Services and H-160.954, Criminalization of Medical Judgement, to include practices, and local, state, regional, and deletions as follows:

Right to Privacy in Termination of Pregnancy, H-5.993
"The AMA reaffirms existing policy that (1) abortion is a medical procedure and should be performed only by a duly licensed physician in conformance with standards of good medical practice ~~and the laws of the state~~; and (2) no physician or other professional personnel shall be required to perform an act violative of good medical judgment or personally held moral principles";

; and be it further

RESOLVED, That our AMA amends policy H-5.995, Abortion, 4.2.7, Abortion, H-160.946, The Criminalization of Health Care Decision Making, H-5.001MSS, Public Funding of Abortion Services and H-160.954, Criminalization of Medical Judgement, to include practices, and local, state, regional, and deletions as follows:

Abortion, H-5.995
"Our AMA reaffirms that: (1) abortion is a medical procedure and should be performed only by a duly licensed physician and surgeon in conformance with standards of good medical practice ~~and the Medical Practice Act of his state~~; and (2) no physician or other professional personnel shall be required to perform an act violative of good medical judgment. Neither physician, hospital, nor hospital

personnel shall be required to perform any act violative of personally held moral principles";

; and be it further

RESOLVED, That our AMA amends policy 4.2.7, Abortion, H-160.946, The Criminalization of Health Care Decision Making, H-5.001MSS, Public Funding of Abortion Services and H-160.954, Criminalization of Medical Judgement, to include practices, and local, state, regional, and deletions as follows:

Abortion, AMA Principles of Medical Ethics, 4.2.7
"The Principles of Medical Ethics of the AMA do not prohibit a physician from performing an abortion in accordance with good medical practice ~~and under circumstances that do not violate the law.~~"

; and be it further

RESOLVED, That our AMA amends policy H-160.946, The Criminalization of Health Care Decision Making, H-5.001MSS, Public Funding of Abortion Services and H-160.954, Criminalization of Medical Judgement, to include practices, and local, state, regional, and deletions as follows:

The Criminalization of Health Care Decision Making, H-160.946
"The AMA opposes the attempted criminalization of health care decision-making and practice, especially as represented by the current trend toward criminalization of malpractice; it interferes with appropriate decision making and practice and is a disservice to the American public; and will develop model state legislation properly defining criminal conduct and prohibiting the criminalization of health care decision-making and practice, including cases involving allegations of medical malpractice, and implement an appropriate action plan for all components of the Federation to educate opinion leaders, elected officials and the media regarding the detrimental effects on health care resulting from the criminalization of health care decision-making and practice."

; and be it further

RESOLVED, That our AMA amends policy H-5.001MSS, Public Funding of Abortion Services and H-160.954, Criminalization of Medical Judgement, to include practices, and local, state, regional, and deletions as follows:

Public Funding of Abortion Services, H-5.001MSS
"(2) continue to actively support legislation recognizing abortion as a compensable service; and (3) continue

opposition to local, regional, and state legislative measures which interfere with medical decision making or deny full reproductive choice, including abortion, based on a patient's dependence on government funding."

; and be it further

RESOLVED, That our AMA amends policy H-160.954, Criminalization of Medical Judgement, to include practices, and local, state, regional, and deletions as follows:

Criminalization of Medical Judgement, H-160.954
"(2) Henceforth our AMA opposes any future legislation which gives the federal, regional, state, or local government the responsibility to define appropriate medical practice and regulate such practice through the use of criminal penalties."

VRC testimony was mixed on Resolution 017. The MSS House Coordination Committee (HCC) recommended the first Resolve clause be placed on the reaffirmation consent calendar. While we did not discuss the first Resolve clause at length, we do recognize that the amendments from the Section Delegates proposed on the VRC could be novel and may represent the best vehicle within this resolution to develop impactful policy.

Your Reference Committee only considered Resolves 2-7 in our deliberations. There was some support on the VRC and from the American College of Obstetrics and Gynecology (ACOG) for the second and third Resolve clauses but also concern the asks may be redundant or minimally impactful. We note that the fourth Resolve clause proposes amendments to the Code of Medical Ethics, which cannot be amended via resolution by the House of Delegates. We also agree with the Committee on Global and Public Health (CGPH) and HCC that the amendments in Resolves 5 through 7 are not substantive and would not meaningfully affect AMA advocacy in this arena.

Your Reference Committee found that some of the language proposed could be interpreted to encourage physicians to flout the laws around abortion in their states, putting those physicians at personal risk by breaking the law, which could potentially be detrimental. We would also caution that bringing such an extensive slate of amendments forward on AMA abortion policy could potentially result in more restrictive policies being adopted on the floor of the HOD. For these reasons we recommend against adoption of Resolution 017.

GOVERNMENT INTERFERENCE IN PATIENT COUNSELING, H-373.995
1. Our AMA vigorously and actively defends the physician-patient-family relationship and actively opposes state and/or federal efforts to interfere in the content of communication in clinical care delivery between clinicians and patients.
2. Our AMA strongly condemns any interference by government or other third parties that compromise a physician's ability to use his or her medical judgment as to

the information or treatment that is in the best interest of their patients.

3. Our AMA supports litigation that may be necessary to block the implementation of newly enacted state and/or federal laws that restrict the privacy of physician-patient-family relationships and/or that violate the First Amendment rights of physicians in their practice of the art and science of medicine.

4. Our AMA opposes any government regulation or legislative action on the content of the individual clinical encounter between a patient and physician without a compelling and evidence-based benefit to the patient, a substantial public health justification, or both.

5. Our AMA will educate lawmakers and industry experts on the following principles endorsed by the American College of Physicians which should be considered when creating new health care policy that may impact the patient-physician relationship or what occurs during the patient-physician encounter:

A. Is the content and information or care consistent with the best available medical evidence on clinical effectiveness and appropriateness and professional standards of care?

B. Is the proposed law or regulation necessary to achieve public health objectives that directly affect the health of the individual patient, as well as population health, as supported by scientific evidence, and if so, are there no other reasonable ways to achieve the same objectives?

C. Could the presumed basis for a governmental role be better addressed through advisory clinical guidelines developed by professional societies?

D. Does the content and information or care allow for flexibility based on individual patient circumstances and on the most appropriate time, setting and means of delivering such information or care?

E. Is the proposed law or regulation required to achieve a public policy goal - such as protecting public health or encouraging access to needed medical care - without preventing physicians from addressing the healthcare needs of individual patients during specific clinical encounters based on the patient's own circumstances, and with minimal interference to patient-physician relationships?

F. Does the content and information to be provided facilitate shared decision-making between patients and their physicians, based on the best medical evidence, the physician's knowledge and clinical judgment, and patient values (beliefs and preferences), or would it undermine shared decision-making by specifying content that is forced upon patients and physicians without regard to the best

medical evidence, the physician's clinical judgment and the patient's wishes?
G. Is there a process for appeal to accommodate individual patients' circumstances?
6. Our AMA strongly opposes any attempt by local, state, or federal government to interfere with a physician's right to free speech as a means to improve the health and wellness of patients across the United States.

FREEDOM OF COMMUNICATION BETWEEN PHYSICIANS AND PATIENTS, H-5.989
It is the policy of the AMA: (1) to strongly condemn any interference by the government or other third parties that causes a physician to compromise his or her medical judgment as to what information or treatment is in the best interest of the patient;
(2) working with other organizations as appropriate, to vigorously pursue legislative relief from regulations or statutes that prevent physicians from freely discussing with or providing information to patients about medical care and procedures or which interfere with the physician-patient relationship;
(3) to communicate to HHS its continued opposition to any regulation that proposes restrictions on physician-patient communications; and
(4) to inform the American public as to the dangers inherent in regulations or statutes restricting communication between physicians and their patients.

(111) RESOLUTION 021 – RECONSIDERATION OF THE DEAD DONOR RULE TO EXEMPT MAASTRICHT CLASS III DONORS

RECOMMENDATION:

Resolution 021 <u>not be adopted</u>.

RESOLVED, That our AMA supports reconsideration of the Dead Donor Rule specifically in the case of cardiac transplantation for Maastricht Category III donors who would otherwise be precluded from heart donation in order to expand the donor pool in an ethical manner.

VRC testimony on Resolution 021 was mixed. Region 3 was in support, the Massachusetts delegation was opposed, and the Section Delegates proposed a clarifying amendment. We find the testimony from Massachusetts compelling; this is a well-intentioned and very well-written resolution, but not within the expertise of the MSS. The American Society of Transplant Surgeons (ASTS) has previously opposed policy brought by the MSS asking for the study of the implications of the removal of barriers to living organ donation at the time of imminent death, which was compelling opposition

considering the stake transplant surgeons have in this issue. At Interim 2016, the Medical Student Section brought forward a resolution seeking AMA study of the "implications of the removal of barriers to living organ donation at the time of imminent death," which is the same issue at hand here – this resolution engendered strong opposition, including from ASTS, and resulted in reaffirmation of policies more generally related to expanding the organ donor pool. Most of the references in the resolution predate this discussion within the House. Given the contentious discussion in the recent past and without a clear indication of specialty society support moving forward, we recommend against adoption of Resolution 021.

(112) RESOLUTION 034 – IMPROVING INTERRACIAL RELATIONSHIPS AND INEQUITY IN ACADEMIC MEDICINE

RECOMMENDATION A:

Policies D-65.989, H-350.974 and D-295.327 be reaffirmed in lieu of the fifth and sixth Resolve clauses of Resolution 034.

RECOMMENDATION B:

The remainder of Resolution 034 not be adopted.

RESOLVED, That our AMA urge residency programs, irrespective of specialty, to track, report, and make publicly available race and ethnicity data at important aspects of graduate medical education (e.g., application, matriculation, graduation of residency, graduation of medical school, reports of discrimination) in order to improve transparency regarding diversity, cultural-competence and inclusion efforts; and be it further

RESOLVED, That our AMA record data on race and ethnicity in a self-reported, open manner, for example by allowing for specifiers that permit African-Americans to distinguish themselves as Black, Nigerian, or a subset of Afro Caribbean, rather than the current system which only records, "black, white, and Latino"; and be it further

RESOLVED, That our AMA recommend that academic medical programs to retain a Chief Officer for Diversity, Equity, and Inclusion, Executive Associate Dean of Diversity, Equity, and Inclusion, or some other upper-level administrator whose responsibilities include but are not limited to mediating incidents pertaining to discrimination, creating race neutral policies, and advocating on behalf of minorities in medicine; and be it further

RESOLVED, That our AMA encourage the above-mentioned programs to promptly adapt and make changes based on disparities and inequities identified through this reporting; and be it further

RESOLVED, That our AMA advocate for increased support of residency programs and rotations that incorporate longitudinal training on public health, including but not limited to training on healthcare inequities, social determinants of health, and improved cross-

cultural relationships as they pertain to health care teamwork and education; and be it further

RESOLVED, That our AMA encourage institutions to consider the role of implicit bias in the promotion and retention of constituents.

The MSS House Coordination Committee (HCC) recommended that existing policy be reaffirmed in lieu of the fifth and sixth Resolve clauses of Resolution 034. Your Reference Committee agrees and only considered the first through fourth Resolve clauses in our deliberations and recommendations. There was mixed testimony on the VRC regarding Resolution 034, with the most compelling testimony being the need to consult relevant outside stakeholders. We appreciate the spirit of the resolution and encourage the authors to resubmit at a future meeting after further developing their asks in conjunction with appropriate stakeholder groups.

ADVANCING GENDER EQUITY IN MEDICINE, D-65.989

1. Our AMA will: (a) advocate for institutional, departmental and practice policies that promote transparency in defining the criteria for initial and subsequent physician compensation; (b) advocate for pay structures based on objective, gender-neutral criteria; (c) encourage a specified approach, sufficient to identify gender disparity, to oversight of compensation models, metrics, and actual total compensation for all employed physicians; and (d) advocate for training to identify and mitigate implicit bias in compensation determination for those in positions to determine salary and bonuses, with a focus on how subtle differences in the further evaluation of physicians of different genders may impede compensation and career advancement.

2. Our AMA will recommend as immediate actions to reduce gender bias: (a) elimination of the question of prior salary information from job applications for physician recruitment in academic and private practice; (b) create an awareness campaign to inform physicians about their rights under the Lilly Ledbetter Fair Pay Act and Equal Pay Act; (c) establish educational programs to help empower all genders to negotiate equitable compensation; (d) work with relevant stakeholders to host a workshop on the role of medical societies in advancing women in medicine, with co-development and broad dissemination of a report based on workshop findings; and (e) create guidance for medical schools and health care facilities for institutional transparency of compensation, and regular gender-based pay audits.

3. Our AMA will collect and analyze comprehensive demographic data and produce a study on the inclusion of women members including, but not limited to, membership, representation in the House of Delegates, reference

committee makeup, and leadership positions within our AMA, including the Board of Trustees, Councils and Section governance, plenary speaker invitations, recognition awards, and grant funding, and disseminate such findings in regular reports to the House of Delegates and making recommendations to support gender equity.
4. Our AMA will commit to pay equity across the organization by asking our Board of Trustees to undertake routine assessments of salaries within and across the organization, while making the necessary adjustments to ensure equal pay for equal work.

RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE, H-350.974

1. Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in health care an issue of highest priority for the American Medical Association.
2. The AMA emphasizes three approaches that it believes should be given high priority:
A. Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform.
B. Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities.
C. Practice parameters - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decision-making process. The efforts of the specialty societies, with the coordination and assistance of

our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities

3. Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our AMA supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons.

4. Our AMA: (a) actively supports the development and implementation of training regarding implicit bias, diversity and inclusion in all medical schools and residency programs; (b) will identify and publicize effective strategies for educating residents in all specialties about disparities in their fields related to race, ethnicity, and all populations at increased risk, with particular regard to access to care and health outcomes, as well as effective strategies for educating residents about managing the implicit biases of patients and their caregivers; and (c) supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations.

INTEGRATING CONTENT RELATED TO PUBLIC HEALTH AND PREVENTIVE MEDICINE ACROSS THE MEDICAL EDUCATION CONTINUUM, D-295.327

1. Our AMA encourages medical schools, schools of public health, graduate medical education programs, and key stakeholder organizations to develop and implement longitudinal educational experiences in public health for medical students in the pre-clinical and clinical years and to provide both didactic and practice-based experiences in public health for residents in all specialties including public health and preventive medicine.

2. Our AMA encourages the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education to examine their standards to assure that public health-related content and skills are included and integrated as appropriate in the curriculum.

3. Our AMA actively encourages the development of innovative models to integrate public health content across undergraduate, graduate, and continuing medical education.

4. Our AMA, through the Initiative to Transform Medical Education (ITME), will work to share effective models of integrated public health content.

5. Our AMA supports legislative efforts to fund preventive medicine and public health training programs for graduate medical residents.

6. Our AMA will urge the Centers for Medicare and Medicaid Services to include resident education in public health graduate medical education funding in the Medicare Program and encourage other public and private funding for graduate medical education in prevention and public health for all specialties.

(113) RESOLUTION 050 – ADVOCATING FOR LEGAL PERMANENT RESIDENT STATUS, A PATHWAY TO CITIZENSHIP, AND CURRENT PROTECTIONS FOR INDIVIDUALS WITH DEFERRED ACTION FOR CHILDHOOD ARRIVAL (DACA) STATUS

RECOMMENDATION:

Resolution 050 <u>not be adopted</u>.

RESOLVED, That our AMA advocates for the establishment of a pathway to legal permanent resident status and/or citizenship status for those individuals who are currently eligible for or who have Deferred Action for Childhood Arrivals (DACA) status; and be it further

RESOLVED, That our AMA supports legislation, rather than an executive order or other means, to accomplish these actions and opposes extraneous barriers that would cause undue stress as a requirement for these individuals to obtain either legal permanent resident status or citizenship status.

Resolution 050 was considered individually as well as in relation to Resolution 037. VRC testimony on Resolution 050 was mixed. Your Reference Committee believes AMA Advocacy efforts on DACA issues and legislation already encompass the asks of this resolution. The AMA has already been aggressive in advocating for DACA-eligible individuals in every available arena from legislative advocacy to public statements to judicial briefs. In the legislative realm, most recently, the AMA signed a letter to Senate leadership supporting two bills (the American Dream and Promise Act of 2019, H.R. 6, and the Dream Act of 2019, S. 874), that would meet the objectives of this resolution, insofar as the legislation would establish a pathway to legal permanent residency for individuals eligible for DACA. We have some reticence to introducing this item in the House in that it could inadvertently facilitate backsliding, especially on the issue of citizenship. We also share the Section Delegates' concerns about the second Resolve potentially being misinterpreted to imply that the AMA would not be supportive of an executive order protecting DACA, and feel the intent of the second Resolve fundamentally misunderstands the purpose of AMA policy – it is unlikely the AMA will be in a position to choose between supporting an executive order and legislation on DACA, political realities will likely dictate with path forward will prevail. For these reasons, we recommend this resolution not be adopted..

(114) RESOLUTION 068 – AUTHORIZE COMPETITIVE LICENSING WHEN MEDICARE NEGOTIATION FAILS

RECOMMENDATION:

Resolution 068 not be adopted.

RESOLVED, That the AMA will amend D-330-954 as such

Prescription Drug Prices and Medicare, D-330.954

1. Our AMA will support federal legislation which gives the Secretary of the Department of Health and Human Services the authority to ~~negotiate contracts with manufacturers of covered Part D drugs.~~ negotiate prices with drug manufacturers and issue competitive licenses if negotiations fail to reach an agreed-upon price for all Part D covered drugs.
2. Our AMA will work toward eliminating Medicare prohibition on drug price negotiation.
3. Our AMA will prioritize its support for the Centers for Medicare & Medicaid Services to negotiate pharmaceutical pricing and issue necessary competitive licenses to ensure end-user affordability for all applicable medications covered by CMS.

Your Reference Committee thanks the authors for bringing forth Resolution 068. We believe this is a strong resolution but are concerned that it will not be given appropriate consideration in the HOD because of the Council on Medical Service (CMS) report that was adopted at I-19. The CMS report favors an arbitration-based approach to Medicare drug price negotiation. Additionally, competitive licensing is not the only approach to enforcing Medicare drug price negotiations and has not been the preferred approach for the leading legislative proponents on this issue – the specific legislation referenced in these Whereas clauses did not advance out of subcommittee in Congress, while legislation that employs an excise tax to enforce negotiations was adopted by the House of Representatives. Ultimately your Reference Committee believes that adopting this resolution will be strategically restrictive for the AMA and the MSS, which is why we recommend Resolution 068 not be adopted.

(115) RESOLUTION 071 – CONSENT REFORM AS A PROTECTIVE METHOD FOR VICTIMS OF HUMAN TRAFFICKING

RECOMMENDATION:

Resolution 071 not be adopted.

RESOLVED, Policy H-60.912 Commercial Exploitation and Human Trafficking of Minors be amended as follows:

Commercial Exploitation and Human Trafficking of Minors, H-60.912
1. Our AMA supports the development of laws and policies that utilize a public health framework to address the commercial sexual exploitation and sex trafficking of minors by promoting care and services for victims instead of arrest and prosecution.

2. Our AMA collaborate with the state medical societies to support legislation that applies federal definitions and criteria to all cases of human trafficking.

There was mixed testimony on the VRC for Resolution 071. The Massachusetts delegation recommended reaffirmation and the MSS Section Delegates recommended this be referred for study. As written, your Reference Committee does not believe the ask of the resolution is clear. We recognize that this issue was well-researched and the Whereas clauses indicate there is a problem; however, we do not believe the ask is made clear enough, particularly the benchmarking to a federal policy that could be altered in the future and inadvertently exclude support for more comprehensive or favorable policies. We encourage the authors to strengthen and clarify the language in their Resolve and re-submit this resolution at a future meeting.

(116) RESOLUTION 079 – ADVOCATING FOR MENTAL HEALTH AND WELLBEING CLINICAL PROTOCOLS AT THE STATE AND FEDERAL LEVELS FOR PATIENTS IN LONG-TERM CARE FACILITIES

RECOMMENDATION:

Resolution 079 not be adopted.

RESOLVED, That our AMA advocate for expanded mental health and wellbeing programs targeting social isolation and loneliness for the residents of long-term care facilities when in-person interaction is not available or advised; and it be further

RESOLVED, That our AMA supports efforts to increase awareness and education on social isolation and its impact on emotional and physical health, especially in the senior population; and it be further

RESOLVED, That our AMA studies the use of audio-visual services utilized in telemedicine services to combat social isolation and loneliness in patients who cannot be with others in person due to convenience matters or safety concerns.

VRC testimony generally supported Resolution 079. However, your Reference Committee concurs with your Section Delegates, who noted that this ask is very similar to an MSS resolution that has already been passed by the Assembly and is awaiting transmittal. The first and second Resolve clauses of Resolution 079 are already covered by this MSS action (440.082MSS – Recognizing Loneliness as a Public Health Issue) and we do not

believe the third Resolve had enough support from the Whereas clauses to stand on its own. We echo the Section Delegates' call to evaluate the disposition of 440.082MSS once it is transmitted to the House of Delegates before commencing additional policy development in this realm.

(117) RESOLUTION 113 - IMPLICATIONS OF THE DISMISSAL OF VACCINE-NONCOMPLIANT PATIENTS

RECOMMENDATION:

Resolution 113 <u>not be adopted</u>.

RESOLVED, That to better assess the net medical and public health implications of widespread dismissal of vaccine-noncompliant patients from physician practices, our American Medical Association (AMA) support the comparative study of the impact of physician practices engaging in motivational interviewing versus the impact of physician practices dismissing vaccine-noncompliant patients, including the following suggested measures:

1. change in individual vaccine compliance status
2. rates of vaccination within communities
3. rates of infection with vaccine-preventable diseases in the community and in participating physician practices, especially among the immunocompromised
4. number of vaccine-noncompliant patients with a reliable primary care provider (medical home.

VRC testimony was largely opposed to Resolution 113 as written. The Massachusetts delegation and the MSS Committee on Economics and Quality in Medicine (CEQM) testified in opposition; Region 3 spoke in support. Your Reference Committee believes that the highly prescriptive nature of this resolution would be poorly received at the AMA House of Delegates, and ultimately, asking the AMA to support the study of these specific aspects on the issue could potentially have merit; however, this is not the chare of the resolution as presented. Instead, the MSS Section Delegates noted that this resolution could be re-configured for a future meeting to increase its feasibility and impact. Your MSS Reference Committee found this testimony compelling and recommend against adoption of Resolution 113 at this time. We encourage the authors to re-visit their ask and re-submit this resolution at a future meeting.

(118) RESOLUTION 117 - IMPACT OF MATCHING SOCIAL INTERESTS ON UNDERGRADUATE MEDICAL EDUCATION ON CLINICAL EVALUATION

RECOMMENDATION:

Resolution 117 <u>not be adopted</u>.

RESOLVED, That our AMA-MSS extend these standards for evaluating residency program faculty to evaluating undergraduate medical students and discourage the consideration of matching social interests, which can lead to unfair bias, between evaluators and undergraduate medical students in clinical evaluations.

VRC testimony on Resolution 117 was mixed. Ultimately your Reference Committee found this resolution to be vague, especially the term “these standards” as it was unclear what standards were being referenced. The MSS Committee on Medical Education (CME) was opposed to Resolution 117 as written, stating that the ask misrepresents existing AMA policy on trainee evaluation. We do recognize that the authors proposed an amendment, however, your Reference Committee did not find that it rectified the issues identified with the resolution, and thus recommends that Resolution 117 not be adopted.

(119) RESOLUTION 131 - ADVOCATING AGAINST MEDICAL STUDENTS AS A SOURCE OF PROFIT FOR MEDICAL LICENSURE EXAMINATIONS

RECOMMENDATION A:

Policy H-305.925 be <u>reaffirmed in lieu of</u> the third Resolve clause of Resolution 131.

RECOMMENDATION B:

The remainder of Resolution 131 <u>not be adopted</u>.

RESOLVED, That our AMA advocate against the use of current students or graduates of AAMC LCME-accredited medical schools as a source of profit for medical licensure examinations; and be it further

RESOLVED, That our AMA advocate for medical licensure examinations and related study, practice examinations, and examination preparatory materials released by the National Board of Medical Examiners to be available at a cost to American medical students that does not exceed the cost of services to provide the examination with no net profit from the medical student’s examination fees; and be it further

RESOLVED, That our AMA will work to reasonably decrease costs incurred by medical students for their education and training; and be it further

RESOLVED, That this resolution be immediately forwarded to the House of Delegates.

The MSS House Coordination Committee (HCC) placed the third Resolve of Resolution 131 on the reaffirmation consent calendar. Your Reference Committee recognizes this and ultimately recommends that the remainder of Resolution 131 not be adopted. The language presented in this resolution could be interpreted as accusatory towards the noted organizations and the Resolve clauses were not well-supported by the Whereas clauses, which were limited and out-of-date. VRC testimony was largely in opposition to Resolution 131 as written and your Reference Committee believes that this resolution could have potential negative consequences on the AMA’s relationships with the organizations cited. We are strongly in favor of not adoption for Resolution 131.

PRINCIPLES OF AND ACTIONS TO ADDRESS MEDICAL EDUCATION COSTS AND STUDENT DEBT, H-305.925

The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty. To help address this issue, our American Medical Association (AMA) will:

1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.

2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs--such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector--to promote practice in underserved areas, the military, and academic medicine or clinical research.

3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.

4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.

5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.

6. Work to reinstate the economic hardship deferment qualification criterion known as the “20/220 pathway,” and support alternate mechanisms that better address the financial needs of trainees with educational debt.

7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.

8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.

9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations

(such as community- or institution-based loan repayment programs or state medical society loan programs).

10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided.

11. Work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment.

12. Encourage medical schools to (a) Study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, and combined baccalaureate/MD or DO programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education; (b) Engage in fundraising activities to increase the availability of scholarship support, with the support of the Federation, medical schools, and state and specialty medical societies, and develop or enhance financial aid opportunities for medical students, such as self-managed, low-interest loan programs; (c) Cooperate with postsecondary institutions to establish collaborative debt counseling for entering first-year medical students; (d) Allow for flexible scheduling for medical students who encounter financial difficulties that can be remedied only by employment, and consider creating opportunities for paid employment for medical students; (e) Counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation; (f) Inform students of all government loan opportunities and disclose the reasons that preferred lenders were chosen; (g) Ensure that all medical student fees are earmarked for specific and well-defined purposes, and avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees; (h) Use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies; (i) Work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.

13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.

14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals: (a) Eliminating the single holder rule; (b) Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training; (c) Retaining the option of loan forbearance for residents ineligible for loan deferment; (d) Including, explicitly, dependent care expenses in the definition of the "cost of attendance"; (e) Including room and board expenses in the definition of tax-exempt scholarship income; (f) Continuing the federal Direct Loan Consolidation program, including the ability to "lock in" a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs; (g) Adding the ability to refinance Federal Consolidation Loans; (h) Eliminating the cap on the student loan interest deduction; (i) Increasing the income limits for taking the interest deduction; (j) Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001; (k) Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating; (l) Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.

15. Continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases.

16. Continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students, and monitor the short-and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.

17. Collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.

18. Continue to monitor the availability of and encourage medical schools and residency/fellowship programs to (a) provide financial aid opportunities and financial planning/debt management counseling to medical students and resident/fellow physicians; (b) work with key stakeholders to develop and disseminate standardized information on these topics for use by medical students,

resident/fellow physicians, and young physicians; and (c) share innovative approaches with the medical education community.

19. Seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt. The AMA believes that it is improper for physicians not to repay their educational loans, but assistance should be available to those physicians who are experiencing hardship in meeting their obligations.

20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician benefits the program, and will: (a) Advocate that all resident/fellow physicians have access to PSLF during their training years; (b) Advocate against a monetary cap on PSLF and other federal loan forgiveness programs; (c) Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed; (d) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note; (e) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the PSLF program qualifying status of the employer; (f) Advocate that the profit status of a physicians training institution not be a factor for PSLF eligibility; (g) Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed; (h) Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas; (i) Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes.

21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student load burden.

22. Formulate a task force to look at undergraduate medical education training as it relates to career choice, and develop new polices and novel approaches to prevent debt from influencing specialty and subspecialty choice.

(120) RESOLUTION 133 - STUDY OF HEALTH DISPARITIES ACCREDITATION CRITERIA IN UNDERGRADUATE MEDICAL EDUCATION

RECOMMENDATION:

Resolution 133 <u>not be adopted</u>.

RESOLVED, That our AMA work with appropriate stakeholders to study effective means of teaching medical students a variety of possible solutions to health disparities as well as ways of effectively evaluating undergraduate medical curricula on this topic and report its findings to the Association of American Medical Colleges and the Liaison Committee on Medical Education.

VRC testimony was mixed on Resolution 133, with testimony primarily in opposition to the resolution as written. It is unclear how this resolution would add to current AMA policy in a meaningful way. The Accelerating Change in Medical Education consortium is actively working on this issue and your Reference Committee does not believe that Resolution 133 will significantly change current activities. While we support the spirit, we recommend that Resolution 133 not be adopted.

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

(121) RESOLUTION 002 – ENCOURAGE TRANSPARENCY OF FEDERAL FUNDING CONTRACTS FOR COVID-19 DIAGNOSTICS, THERAPEUTICS, AND VACCINES

RECOMMENDATION:

Policies H-460.912, H-460.941, H-110.987, H-100.956, H-440.847, H-440.928 and H-440.860 be reaffirmed in lieu of Resolution 002.

RESOLVED, That our AMA advocates for full transparency of all past, current, and future government contracts that provide tax-payer funds for COVID-19 related diagnostics, therapeutics, and vaccines; and be it further

RESOLVED, That our AMA opposes government contracts from limiting or eliminating existing Bayh-Dole safeguards; and be it further

RESOLVED, That our AMA advocates for the U.S. federal government to use march-in-rights as provided by the Bayh-Dole Act for the purpose of ensuring accessibility and affordability for COVID-19 diagnostics, therapeutics, and vaccines that are developed with significant monetary investment by the public.

Your MSS House Coordination Committee (HCC) recommended reaffirmation of existing policy in lieu of Resolution 002. VRC testimony on Resolution 002 was mixed, with some support for reaffirmation, as well as support for the resolution as written with amendments. It could be argued that some aspects of Resolution 002 are novel, particularly the aspects around the Bayh-Dole Act.

PRINCIPLES FOR CONDUCT AND REPORTING OF CLINICAL TRIALS, H-460.912
Our AMA: (1) endorses the Association of American Medical Colleges' "Principles for Protecting Integrity in the Conduct and Reporting of Clinical Trials"; (2) commends the AAMC, the Centers for Education and Research in Therapeutics and the BlueCross BlueShield Association for the development and dissemination of these principles; (3) supports the timely dissemination of clinical trial data for public accessibility as permitted by research design and/or regulatory protocol; (4) supports the promotion of improved data sharing and the reaffirmation and enforcement of deadlines for submitting results from clinical research studies; (5) encourages the expansion of clinical trial registrants to ClinicalTrials.gov; and (6) will sign the petition titled "All Trials Registered; All Results Reported" at Alltrials.net that supports the registration of all past, present

and future clinical trials and the release of their summary reports.

H-460.941 – SCIENCE AND BIOMEDICAL RESEARCH
Opportunities, Challenges and Health System Reform
Our AMA will:
(1) take every appropriate opportunity during the health system reform debate and implementation stages to educate the public, the Administration, and Congress about the importance of support for science and biomedical research and about the potential problems if these areas are not given sufficient consideration in health system reform;
(2) take steps to become the coordinating point for efforts, both within and outside of the Federation, to promote, enhance, and defend biomedical science;
(3) continue and expand its efforts to advocate for the primacy of science and biomedical research as the basis of quality medical care by working with and influencing both the private sector and the federal government, including the legislative, executive, and judicial branches;
(4) take necessary steps to monitor the scientific enterprise, establish programs and policies as appropriate, and initiate advocacy efforts as needed;
(5) consider and take the necessary steps to anticipate and establish guidelines to assist physicians and others in responding to the ethical issues emerging from the scientific revolution;
(6) increase its educational efforts to the public and to the profession to explain how science is critical to the future of the profession and to the future development of high quality medical care; and
(7) support preregistration in order to mitigate publication bias and improve the reproducibility of biomedical research.

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.

NATIONAL DRUG SHORTAGES, H-100.956

1. Our AMA considers drug shortages to be an urgent public health crisis, and recent shortages have had a dramatic and negative impact on the delivery and safety of appropriate health care to patients.

2. Our AMA supports recommendations that have been developed by multiple stakeholders to improve manufacturing quality systems, identify efficiencies in regulatory review that can mitigate drug shortages, and explore measures designed to drive greater investment in production capacity for products that are in short supply, and will work in a collaborative fashion with these and other stakeholders to implement these recommendations in an urgent fashion.

3. Our AMA supports authorizing the Secretary of the U.S. Department of Health and Human Services (DHHS) to expedite facility inspections and the review of manufacturing changes, drug applications and supplements that would help mitigate or prevent a drug shortage.

4. Our AMA will advocate that the US Food and Drug Administration (FDA) and/or Congress require drug manufacturers to establish a plan for continuity of supply of vital and life-sustaining medications and vaccines to avoid production shortages whenever possible. This plan should include establishing the necessary resiliency and redundancy in manufacturing capability to minimize disruptions of supplies in foreseeable circumstances including the possibility of a disaster affecting a plant.

5. The Council on Science and Public Health shall continue to evaluate the drug shortage issue, including the impact of group purchasing organizations on drug shortages, and report back at least annually to the House of Delegates on progress made in addressing drug shortages.

6. Our AMA urges the development of a comprehensive independent report on the root causes of drug shortages. Such an analysis should consider federal actions, the number of manufacturers, economic factors including federal reimbursement practices, as well as contracting practices by market participants on competition, access to drugs, and pricing. In particular, further transparent analysis of economic drivers is warranted. The federal Centers for Medicare & Medicaid Services (CMS) should review and evaluate its 2003 Medicare reimbursement formula of average sales price plus 6% for unintended consequences including serving as a root cause of drug shortages.

7. Our AMA urges regulatory relief designed to improve the availability of prescription drugs by ensuring that such products are not removed from the market due to

compliance issues unless such removal is clearly required for significant and obvious safety reasons.
8. Our AMA supports the view that wholesalers should routinely institute an allocation system that attempts to fairly distribute drugs in short supply based on remaining inventory and considering the customer's purchase history.
9. Our AMA will collaborate with medical specialty society partners and other stakeholders in identifying and supporting legislative remedies to allow for more reasonable and sustainable payment rates for prescription drugs.
10. Our AMA urges that during the evaluation of potential mergers and acquisitions involving pharmaceutical manufacturers, the Federal Trade Commission consult with the FDA to determine whether such an activity has the potential to worsen drug shortages.
11. Our AMA urges the FDA to require manufacturers to provide greater transparency regarding production locations of drugs and provide more detailed information regarding the causes and anticipated duration of drug shortages.
12. Our AMA encourages electronic health records (EHR) vendors to make changes to their systems to ease the burden of making drug product changes.
13. Our AMA urges the FDA to evaluate and provide current information regarding the quality of outsourcer compounding facilities.
14. Our AMA urges DHHS and the U.S. Department of Homeland Security (DHS) to examine and consider drug shortages as a national security initiative and include vital drug production sites in the critical infrastructure plan.

PANDEMIC PREPAREDNESS FOR INFLUENZA, H-440.987
In order to prepare for a potential influenza pandemic, our AMA: (1) urges the Department of Health and Human Services Emergency Care Coordination Center, in collaboration with the leadership of the Centers for Disease Control and Prevention (CDC), state and local health departments, and the national organizations representing them, to urgently assess the shortfall in funding, staffing, vaccine, drug, and data management capacity to prepare for and respond to an influenza pandemic or other serious public health emergency; (2) urges Congress and the Administration to work to ensure adequate funding and other resources: (a) for the CDC, the National Institutes of Health (NIH) and other appropriate federal agencies, to support implementation of an expanded capacity to produce the necessary vaccines and anti-viral drugs and to continue development of the nation's capacity to rapidly vaccinate the entire population and care for large numbers of seriously ill

people; and (b) to bolster the infrastructure and capacity of state and local health department to effectively prepare for, respond to, and protect the population from illness and death in an influenza pandemic or other serious public health emergency; (3) urges the CDC to develop and disseminate electronic instructional resources on procedures to follow in an influenza epidemic, pandemic, or other serious public health emergency, which are tailored to the needs of physicians and medical office staff in ambulatory care settings; (4) supports the position that: (a) relevant national and state agencies (such as the CDC, NIH, and the state departments of health) take immediate action to assure that physicians, nurses, other health care professionals, and first responders having direct patient contact, receive any appropriate vaccination in a timely and efficient manner, in order to reassure them that they will have first priority in the event of such a pandemic; and (b) such agencies should publicize now, in advance of any such pandemic, what the plan will be to provide immunization to health care providers; (6) will monitor progress in developing a contingency plan that addresses future influenza vaccine production or distribution problems and in developing a plan to respond to an influenza pandemic in the United States.

UPDATE ON IMMUNIZATIONS AND VACCINE PURCHASES, H-440.928
Our AMA: (1) encourages state and local health departments to identify local barriers to immunization and collaborate with state and local medical societies to devise plans to eliminate the barriers.
(2) encourages the Administration and Congress to consider immunization initiatives within the broader context of health system reform and payment for preventive care services, and not only as a separate issue.
(3) will release a public statement and actively advocate for increased federal funding for vaccines, including activities funded through Section 317 of the Public Health Service Act, which supports purchasing vaccines and implementing the national vaccine strategy, and includes monies for education of the American public about the importance of immunization, education and training for health professionals, and for support to state and local governments to remove barriers to effective immunization.
(4) encourages states and other public health entities to make greater use of the option they have through their grantee to use their own appropriated funds to purchase vaccines at the Centers for Disease Control and Prevention contract price and encourages vaccine manufacturers to make the contract vaccine price widely available to such

purchasing agents. This would further increase availability of vaccines at the best available price.
(5) encourages private physicians and groups such as HMOs to work together with vaccine manufacturers to secure a negotiated bulk purchase price for vaccines by guaranteeing a larger volume of purchase and lower administrative costs.
(6) encourages health insurance companies to cover the cost of vaccine purchase and administration for all childhood immunizations since immunization of young children is highly cost effective.
(7) encourages all states to alter their Medicaid program so that childhood vaccines can be purchased at the federal contract price and private physicians can be reimbursed for immunization services and cost of vaccine purchase.

FINANCING FOR ADULT VACCINES:
RECOMMENDATIONS FOR ACTION, H-440.860
1. Our AMA supports the concepts to improve adult immunization as advanced in the Infectious Diseases Society of America's 2007 document "Actions to Strengthen Adult and Adolescent Immunization Coverage in the United States," and support the recommendations as advanced by the National Vaccine Advisory Committee's 2008 white paper on pediatric vaccine financing.
2. Our AMA will advocate for the following actions to address the inadequate financing of adult vaccination in the United States:

Provider-related
a. Develop a data-driven rationale for improved vaccine administration fees.
b. Identify and explore new methods of providing financial relief for adult immunization providers through, for example, vaccine company replacement systems/deferred payment/funding for physician inventories, buyback for unused inventory, and patient assistance programs.
c, Encourage and facilitate adult immunization at all appropriate points of patient contact; e.g., hospitals, visitors to long-term care facilities, etc.
d. Encourage counseling of adults on the importance of immunization by creating a mechanism through which immunization counseling alone can be reimbursed, even when a vaccine is not given.

Federal-related
a. Increase federal resources for adult immunization to: (i) Improve Section 317 funding so that the program can meet its purpose of improving adult immunizations; (ii) Provide

universal coverage for adult vaccines and minimally, uninsured adults should be covered; (iii) Fund an adequate universal reimbursement rate for all federal and state immunization programs.
b. Optimize use of existing federal resources by, for example: (i) Vaccinating eligible adolescents before they turn 19 years of age to capitalize on VFC funding; (ii) Capitalizing on public health preparedness funding.
c. Ease federally imposed immunization burdens by, for example: (i) Providing coverage for Medicare-eligible individuals for all vaccines, including new vaccines, under Medicare Part B; (ii) Creating web-based billing mechanisms for physicians to assess coverage of the patient in real time and handle the claim, eliminating out-of-pocket expenses for the patient; (iii) Simplifying the reimbursement process to eliminate payment-related barriers to immunization.
d. The Centers for Medicare & Medicaid Services should raise vaccine administration fees annually, synchronous with the increasing cost of providing vaccinations.

State-related
a. State Medicaid programs should increase state resources for funding vaccines by, for example: (i) Raising and funding the maximum Medicaid reimbursement rate for vaccine administration fees; (ii) Establishing and requiring payment of a minimum reimbursement rate for administration fees; (iii) Increasing state contributions to vaccination costs; and (iv) Exploring the possibility of mandating immunization coverage by third party payers.
b. Strengthen support for adult vaccination and appropriate budgets accordingly.

Insurance-related
1. Provide assistance to providers in creating efficiencies in vaccine management by: (i) Providing model vaccine coverage contracts for purchasers of health insurance; (ii) Creating simplified rules for eligibility verification, billing, and reimbursement; (iii) Providing vouchers to patients to clarify eligibility and coverage for patients and providers; and (iv) Eliminating provider/public confusion over insurance payment of vaccines by universally covering all Advisory Committee on Immunization Practices (ACIP)-recommended vaccines.
b. Increase resources for funding vaccines by providing first-dollar coverage for immunizations.
c. Improve accountability by adopting performance measurements.
d. Work with businesses that purchase private insurance to

include all ACIP-recommended immunizations as part of the health plan.

e. Provide incentives to encourage providers to begin immunizing by, for example: (i) Including start up costs (freezer, back up alarms/power supply, reminder-recall systems, etc.) in the formula for reimbursing the provision of immunizations; (ii) Simplifying payment to and encouraging immunization by nontraditional providers; (iii) Facilitating coverage of vaccines administered in complementary locations (e.g., relatives visiting a resident of a long-term care facility).

Manufacturer-related

2. Market stability for adult vaccines is essential. Thus: (i) Solutions to the adult vaccine financing problem should not deter research and development of new vaccines; (ii) Solutions should consider the maintenance of vibrant public and private sector adult vaccine markets; (iii) Liability protection for manufacturers should be assured by including Vaccine Injury Compensation Program coverage for all ACIP-recommended adult vaccines; (iv) Educational outreach to both providers and the public is needed to improve acceptance of adult immunization.

3. Our AMA will conduct a survey of small- and middle-sized medical practices, hospitals, and other medical facilities to identify the impact on the adult vaccine supply (including influenza vaccine) that results from the large contracts between vaccine manufacturers/distributors and large non-government purchasers, such as national retail health clinics, other medical practices, and group purchasing programs, with particular attention to patient outcomes for clinical preventive services and chronic disease management.

(122) RESOLUTION 010 – LEARNING HISTORY OF EXPERIMENTATION ON BLACK BODIES IN MEDICINE TO UNDERSTAND MEDICAL MISTRUST

RECOMMENDATION:

350.025MSS be <u>reaffirmed in lieu of</u> Resolution 010.

RESOLVED, That our AMA promotes graduate medical education integration of historical context for medical advancements achieved through forced participation of black people that has contributed to current distrust in medicine.

The MSS House Coordination Committee (HCC) recommended that 350.025MSS be reaffirmed in lieu of Resolution 010. While there was not consensus on reaffirmation during

testimony, your Reference Committee agrees that the asks of Resolution 010 are covered by 350.025MSS, which states that the AMA should "acknowledge that historic and racist medical practices have caused and continue to cause harm to marginalized communities…[and] encourage the development, implementation, and evaluation of undergraduate, graduate and continuing medical education programs and curricula that engender greater understanding of (a) the causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism…" Additionally, 350.025MSS has been transmitted for consideration at the November 2020 Special Meeting of the AMA House of Delegates. We thank the authors for their hard work on this resolution, but ultimately believe this to be reaffirmation of existing policy.

> 350.025MSS – RACISM AS A PUBLIC HEALTH THREAT
> AMA-MSS will ask the AMA to: (1) acknowledge that historic and racist medical practices have caused and continue to cause harm to marginalized communities; (2) recognize racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care; (3) identify a set of current best practices for healthcare institutions, physician practices, and academic medical centers to recognized, address and mitigate the effects of racism on patients, providers, and populations; (4) encourage the development , implementation, and evaluation of undergraduate, graduate and continuing medical education programs and curricula that engender greater understanding of (a) the causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism and (b) how to prevent and ameliorate the health effects of racism; (5) (a) supports the development of policy to combat racism and its effects and (b) encourages governmental agencies and nongovernmental organizations to increase funding of research into the epidemiology of risks and damages related to racism and how to prevent or repair them; and (6) work to prevent and combat the influences of racism and bias in innovative health technologies.

(123) RESOLUTION 024 – AMENDING POLICY D-350.983, TO INCLUDE BOARD-CERTIFICATION AND COMMUNITY PHYSICIAN OVERSIGHT

RECOMMENDATION:

Policies D-65.992, D-350.983, and H-350.957 be <u>reaffirmed in lieu of</u> Resolution 024.

RESOLVED, That our AMA amend policy D-350.983, Improving Medical Care in Immigrant Detention Centers, to support community physicians accessing U.S. Immigrations

and Customs Enforcement and Customs and Border Patrol facilities to provide medical care to individuals detained in these buildings by addition and deletion as follows:

Improving Medical Care in Immigrant Detention Centers, D-350.983

Our AMA will: (1) issue a public statement urging U.S. Immigrations and Customs Enforcement Office of Detention Oversight to (a) revise its medical standards governing the conditions of confinement at detention facilities to meet those set by the National Commission on Correctional Health Care, (b) take necessary steps to achieve full compliance with these standards, and (c) track complaints related to substandard healthcare quality; (2) recommend the U.S. Immigrations and Customs Enforcement refrain from partnerships with private institutions whose facilities do not meet the standards of medical, mental, and dental care as guided by the National Commission on Correctional Health Care; ~~and~~ (3) support requiring physicians providing care within detention facilities to maintain board-certification in the specialty they are practicing and allowing community physicians oversight in U.S. Immigration Enforcement and Customs and Border Protection facilities; and (~~3~~4) advocate for access to health care for individuals in immigration detention.

The MSS House Coordination Committee (HCC) recommended Resolution 024 be added to the reaffirmation consent calendar. Your Reference Committee concurs, although we do recognize that there are amendments proposed on the VRC that could merit discussion by the MSS Assembly.

MEDICAL NEEDS OF UNACCOMPANIED, UNDOCUMENTED IMMIGRANT CHILDREN, D-65.992

1. Our AMA will take immediate action by releasing an official statement that acknowledges that the health of unaccompanied immigrant children without proper documentation is a humanitarian issue.
2. Our AMA urges special consideration of the physical, mental, and psychological health in determination of the legal status of unaccompanied minor children without proper documentation.
3. Our AMA will immediately meet and work with other physician specialty societies to identify the main obstacles to the physical health, mental health, and psychological well-being of unaccompanied children without proper documentation.
4. Our AMA will participate in activities and consider legislation and regulations to address the unmet medical

needs of unaccompanied minor children without proper documentation status, with issues to be discussed to include the identification of: (A) the health needs of this unique population, including standard pediatric care as well as mental health needs; (B) health care professionals to address these needs, to potentially include but not be limited to non-governmental organizations, federal, state, and local governments, the US military and National Guard, and local and community health professionals; (C) the resources required to address these needs, including but not limited to monetary resources, medical care facilities and equipment, and pharmaceuticals; and (D) avenues for continuity of care for these children during the potentially extended multi-year legal process to determine their final disposition.

IMPROVING MEDICAL CARE IN IMMIGRANT DETENTION CETNERS, D-350.983
Our AMA will: (1) issue a public statement urging U.S. Immigrations and Customs Enforcement Office of Detention Oversight to (a) revise its medical standards governing the conditions of confinement at detention facilities to meet those set by the National Commission on Correctional Health Care, (b) take necessary steps to achieve full compliance with these standards, and (c) track complaints related to substandard healthcare quality; (2) recommend the U.S. Immigrations and Customs Enforcement refrain from partnerships with private institutions whose facilities do not meet the standards of medical, mental, and dental care as guided by the National Commission on Correctional Health Care; and (3) advocate for access to health care for individuals in immigration detention.

ADDRESSING IMMIGRANT HEALTH DISPARITIES, H-350.957
1. Our American Medical Association recognizes the unique health needs of refugees, and encourages the exploration of issues related to refugee health and support legislation and policies that address the unique health needs of refugees.
2. Our AMA: (A) urges federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology; (B) advocates for and publicizes medically accurate information to reduce anxiety, fear, and marginalization of specific populations; and (C) advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees.

3. Our AMA will call for asylum seekers to receive all medically appropriate care, including vaccinations in a patient centered, language and culturally appropriate way upon presentation for asylum regardless of country of origin.

(124) RESOLUTION 035 – STUDYING POPULATION-BASED REIMBURSEMENT DISPARITIES

RECOMMENDATION:

Policies H-70.927, H-65.961, D-65.989, and H-385.906 be <u>reaffirmed in lieu of</u> Resolution 035.

RESOLVED, That our AMA study the root causes for reimbursement disparities among physicians who treat distinct patient populations but provide similar services, as well as reimbursement disparities for similar care performed on distinct patient populations.

The MSS House Coordination Committee (HCC) recommended Resolution 035 be placed on the reaffirmation consent calendar. Your Reference Committee agrees. This resolution was well-intentioned, but we believe the spirit is captured in policies H-70.927, H-65.961, D-65.989, and H-385.906. We do also believe the language of Resolution 035 could be strengthened and submitted at a future meeting.

PREVENTION OF MISUSE OF CURRENT PROCEDURAL TERMINOLOGY (CPT), H-70.927
Our AMA: (1) in order to avoid harm to physicians and patients, shall continue to pursue proper use of CPT codes, guidelines and modifiers by software claims editing vendors and their customers; and (2) will explore additional ways to work with state medical associations to provide coding advocacy for members.

PRINCIPLES FOR ADVANCING GENDER EQUITY IN MEDICINE, H-65.961
Principles for Advancing Gender Equity in Medicine:
Our AMA:
1. declares it is opposed to any exploitation and discrimination in the workplace based on personal characteristics (i.e., gender);
2. affirms the concept of equal rights for all physicians and that the concept of equality of rights under the law shall not be denied or abridged by the U.S. Government or by any state on account of gender;
3. endorses the principle of equal opportunity of employment and practice in the medical field;
4. affirms its commitment to the full involvement of women in leadership roles throughout the federation, and encourages all components of the federation to vigorously

continue their efforts to recruit women members into organized medicine;
5. acknowledges that mentorship and sponsorship are integral components of one's career advancement, and encourages physicians to engage in such activities;
6. declares that compensation should be equitable and based on demonstrated competencies/expertise and not based on personal characteristics;
7. recognizes the importance of part-time work options, job sharing, flexible scheduling, re-entry, and contract negotiations as options for physicians to support work-life balance;
8. affirms that transparency in pay scale and promotion criteria is necessary to promote gender equity, and as such academic medical centers, medical schools, hospitals, group practices and other physician employers should conduct periodic reviews of compensation and promotion rates by gender and evaluate protocols for advancement to determine whether the criteria are discriminatory; and
9. affirms that medical schools, institutions, and professional associations should provide training on leadership development, contract and salary negotiations and career advancement strategies that include an analysis of the influence of gender in these skill areas.
Our AMA encourages: (1) state and specialty societies, academic medical centers, medical schools, hospitals, group practices and other physician employers to adopt the AMA Principles for Advancing Gender Equity in Medicine; and (2) academic medical centers, medical schools, hospitals, group practices and other physician employers to: (a) adopt policies that prohibit harassment, discrimination and retaliation; (b) provide anti-harassment training; and (c) prescribe disciplinary and/or corrective action should violation of such policies occur.

ADVANCING GENDER EQUITY IN MEDICINE, D-65.989
1. Our AMA will: (a) advocate for institutional, departmental and practice policies that promote transparency in defining the criteria for initial and subsequent physician compensation; (b) advocate for pay structures based on objective, gender-neutral criteria; (c) encourage a specified approach, sufficient to identify gender disparity, to oversight of compensation models, metrics, and actual total compensation for all employed physicians; and (d) advocate for training to identify and mitigate implicit bias in compensation determination for those in positions to determine salary and bonuses, with a focus on how subtle differences in the further evaluation of physicians of different

genders may impede compensation and career advancement.
2. Our AMA will recommend as immediate actions to reduce gender bias: (a) elimination of the question of prior salary information from job applications for physician recruitment in academic and private practice; (b) create an awareness campaign to inform physicians about their rights under the Lilly Ledbetter Fair Pay Act and Equal Pay Act; (c) establish educational programs to help empower all genders to negotiate equitable compensation; (d) work with relevant stakeholders to host a workshop on the role of medical societies in advancing women in medicine, with co-development and broad dissemination of a report based on workshop findings; and (e) create guidance for medical schools and health care facilities for institutional transparency of compensation, and regular gender-based pay audits.
3. Our AMA will collect and analyze comprehensive demographic data and produce a study on the inclusion of women members including, but not limited to, membership, representation in the House of Delegates, reference committee makeup, and leadership positions within our AMA, including the Board of Trustees, Councils and Section governance, plenary speaker invitations, recognition awards, and grant funding, and disseminate such findings in regular reports to the House of Delegates and making recommendations to support gender equity.
4. Our AMA will commit to pay equity across the organization by asking our Board of Trustees to undertake routine assessments of salaries within and across the organization, while making the necessary adjustments to ensure equal pay for equal work.

ADDRESSING THE RACIAL PAY GAP IN MEDICINE, H-385.906
Our AMA: (1) supports measures to eliminate racial disparity in pay and specific challenges that minority physicians face in regards to equal pay financial attainment; and (2) will work with appropriate stakeholders to study effective and appropriate measures 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.

(125) RESOLUTION 036 – PROVISION OF INFLUENZA VACCINATIONS, TREATMENT, AND SCREENINGS TO IMMIGRANTS HELD IN CUSTOMS AND BORDER PROTECTION FACILITIES

RECOMMENDATION:

Policy D-350.983 be reaffirmed in lieu of Resolution 036.

RESOLVED, That our AMA advocates for the reduction of influenza related illness and mortality in Customs and Border Protection facilities through the following methods: 1) provision of timely influenza vaccinations to all detained immigrants, refugees, and asylum seekers, regardless of length of stay, and Customs and Border Protection personnel, 2) provision of evidence-based treatment for any immigrant, refugee, or asylum seeker with suspected or confirmed influenza, and 3) increased screening for influenza and other respiratory related illnesses in these facilities.

The MSS House Coordination Committee (HCC) recommended existing policy be reaffirmed in lieu of Resolution 036. VRC testimony on Resolution 036 was mixed, with several amendments proposed. Your Reference Committee agrees with HCC's recommendation of reaffirmation, particularly in light of the AMA's active advocacy around this issue, but does acknowledge that amendments proposed on the VRC that specifically focus on vaccination and screening could be merit discussion by the MSS Assembly.

> IMPROVING MEDICAL CARE IN IMMIGRANT DETENTION CENTERS, D-350.983
> Our AMA will: (1) issue a public statement urging U.S. Immigrations and Customs Enforcement Office of Detention Oversight to (a) revise its medical standards governing the conditions of confinement at detention facilities to meet those set by the National Commission on Correctional Health Care, (b) take necessary steps to achieve full compliance with these standards, and (c) track complaints related to substandard healthcare quality; (2) recommend the U.S. Immigrations and Customs Enforcement refrain from partnerships with private institutions whose facilities do not meet the standards of medical, mental, and dental care as guided by the National Commission on Correctional Health Care; and (3) advocate for access to health care for individuals in immigration detention.

(126) RESOLUTION 046 – DIDACTIC PRE-CLINICAL EDUCATION ON DE-ESCALATION, VIOLENCE, AND ABUSE PREVENTION IN THE HEALTHCARE WORKPLACE

RECOMMENDATION:

Policy H-215.978 be reaffirmed in lieu of Resolution 046.

RESOLVED, That our AMA-MSS amend Workplace Violence Prevention H-215.978 to read

H-215.978 – Workplace Violence Prevention
Our AMA: (1) supports the efforts of the International Association for Healthcare Security and Safety, the AHA, and The Joint Commission to develop guidelines or standards regarding hospital security issues and recognizes these groups' collective expertise in this area. As standards are developed, the AMA will ensure that physicians and medical students are advised; and (2) encourages physicians and medical students to: work with their hospital safety committees to address the security issues within particular hospitals; become aware of and familiar with their own institution's policies and procedures; participate in training to prevent and respond to workplace violence threats; report all incidents of workplace violence; and promote a culture of safety within their workplace.

RESOLVED, That our AMA-MSS encourages medical schools to provide didactic pre-clinical education on de-escalation, violence, and abuse prevention in the healthcare workplace.

RESOLVED, That our AMA-MSS encourages the appropriate stakeholders to conduct research on the benefits of de-escalation, violence, and abuse prevention trainings to preclinical medical students.

The MSS House Coordination Committee (HCC) recommended that existing policy H-215.978 be reaffirmed in lieu of the first Resolve of Resolution 046. Your Reference Committee agrees and believes reaffirmation should be extended to the resolution in its entirety. The AMA-MSS cannot directly encourage stakeholders to act in the way these Resolves suggest. Furthermore, the Whereas clauses do not provide compelling evidence that workplace violence is an issue specifically faced by medical students and do not demonstrate that additional trainings would resolve the issue. While not opposed to the intent of this resolution, your Reference Committee believes reaffirmation is the most appropriate way to handle this resolution but would encourage the authors to resubmit Resolution 046 after strengthening the support provided by the Whereas clauses and making the asks more actionable.

WORKPLACE VIOLENCE PREVENTION, H-215.978

Our AMA: (1) supports the efforts of the International Association for Healthcare Security and Safety, the AHA, and The Joint Commission to develop guidelines or standards regarding hospital security issues and recognizes these groups' collective expertise in this area. As standards are developed, the AMA will ensure that physicians are advised; and (2) encourages physicians to: work with their hospital safety committees to address the security issues within particular hospitals; become aware of and familiar with their own institution's policies and procedures; participate in training to prevent and respond to workplace violence threats; report all incidents of workplace violence; and promote a culture of safety within their workplace.

(127) RESOLUTION 059 – INCREASING MEDICATION DELIVERY AND CURBSIDE PICK-UP DURING PANDEMICS

RECOMMENDATION:

Policy D-120.961 be <u>reaffirmed in lieu of</u> Resolution 059.

RESOLVED, That our AMA amend current policy D-120.961 Personal Medication and Medical Supplies in Times of Disaster to address the safety of medication distribution methods by insertion as follows:

Personal Medication and Medical Supplies in Times of Disaster D-120.961
Our AMA urges continued dialogue with appropriate federal agencies, medical societies, health care organizations, and other appropriate stakeholders to: (a) ensure timely distribution of and access to medications for acute and chronic medical conditions in a disaster; (b) issue guidance to health professionals and the public on the appropriate stockpiling <u>and safe distribution</u> of medications for acute and chronic medical conditions in a disaster or other serious emergency; and (c) deliberate the design, feasibility, and utility of a universal mechanism, that provides the essential health and medical supplies and information that can assist emergency medical responders and other health care personnel with the provision of medical care and assistance in a disaster or other serious emergency.

RESOLVED, That our AMA amend current policy 120.007MSS Patient Access to Legal Pharmaceuticals under Pharmacist Conscientious Objector Policy by insertion as follows:

120.007MSS Patient Access to Legal Pharmaceuticals under Pharmacist Conscientious Objector Policy

AMA-MSS: (1) supports the American Pharmaceutical Association in ensuring that pharmacies and pharmacists set up systems which guarantee patient access to legal pharmaceuticals without unnecessary delay or interference; (2) supports legislation which requires pharmacies to fill legally written prescriptions or to provide timely alternative access without interference; and (3) That our AMA encourage pharmacies to adopt curbside pick-up and delivery programs for prescription medications to reduce the risk of transmission of infectious pathogens among patients who require prescriptions during all epidemics and pandemics.

The MSS House Coordination Committee (HCC) recommended the second Resolve clause be added to the reaffirmation consent calendar. Your Reference Committee concurs and recommends that D-120.961 be reaffirmed in lieu of Resolution 059 in its entirety. We do not find the proposed amendments compelling and we do not believe AMA advocacy efforts will be impacted by these changes. The authors may consider submitting a Governing Council Action Item (GCAI) to inquire about specific ongoing and novel advocacy efforts covered in these existing policies.

PERSONAL MEDICATION AND MEDICAL STUPPLIES IN TIMES OF DISASTER, D-120.961
Our AMA urges continued dialogue with appropriate federal agencies, medical societies, health care organizations, and other appropriate stakeholders to: (a) ensure timely distribution of and access to medications for acute and chronic medical conditions in a disaster; (b) issue guidance to health professionals and the public on the appropriate stockpiling of medications for acute and chronic medical conditions in a disaster or other serious emergency; and (c) deliberate the design, feasibility, and utility of a universal mechanism, that provides the essential health and medical supplies and information that can assist emergency medical responders and other health care personnel with the provision of medical care and assistance in a disaster or other serious emergency.

(128) RESOLUTION 060 – ENCOURAGEMENT OF MANUFACTURING NECESSARY SUPPLIES WITHIN THE UNITED STATES

RECOMMENDATION:

Policy H-100.956 be <u>reaffirmed in lieu of</u> Resolution 060.

RESOLVED, That our AMA advocate for the manufacturing and sourcing of necessary supplies and parts used in healthcare facilities, including but not limited to PPE, medications, cleaning supplies, hospital machinery, and personal hygiene products, to be predominantly located within the United States of America in order to prevent supply chain malfunctions in the event of a national emergency; and be it further

RESOLVED, That our AMA advocate against the movement of factories producing manufactured goods used in healthcare and healthcare facilities by companies to production locations outside the United States of America; and be it further

RESOLVED, That our AMA support the locating of manufacturing of goods used in healthcare and healthcare facilities in regions of the United States that have low socioeconomic status and high unemployment rate, especially those regions affected by the prior loss of manufacturing and mining jobs; and be it further

RESOLVED, That this resolution be immediately forwarded to the AMA House of Delegates.

The MSS House Coordination Committee (HCC) recommended that existing policy be reaffirmed in lieu of Resolution 060 and your Reference Committee agrees. The AMA has extensive policy in respect to supply chain disruption and although the clause specifying that this manufacturing be done in the United States could potentially be perceived as novel, we believe it is outside of the scope of the AMA to prescribe specific manufacturing locations and therefore recommend reaffirmation of H-100.956 in lieu of Resolution 060.

NATIONAL DRUG SHORTAGES, H-100.956

1. Our AMA considers drug shortages to be an urgent public health crisis, and recent shortages have had a dramatic and negative impact on the delivery and safety of appropriate health care to patients.
2. Our AMA supports recommendations that have been developed by multiple stakeholders to improve manufacturing quality systems, identify efficiencies in regulatory review that can mitigate drug shortages, and explore measures designed to drive greater investment in production capacity for products that are in short supply, and will work in a collaborative fashion with these and other stakeholders to implement these recommendations in an urgent fashion.

3. Our AMA supports authorizing the Secretary of the U.S. Department of Health and Human Services (DHHS) to expedite facility inspections and the review of manufacturing changes, drug applications and supplements that would help mitigate or prevent a drug shortage.
4. Our AMA will advocate that the US Food and Drug Administration (FDA) and/or Congress require drug manufacturers to establish a plan for continuity of supply of vital and life-sustaining medications and vaccines to avoid production shortages whenever possible. This plan should include establishing the necessary resiliency and redundancy in manufacturing capability to minimize disruptions of supplies in foreseeable circumstances including the possibility of a disaster affecting a plant.
5. The Council on Science and Public Health shall continue to evaluate the drug shortage issue, including the impact of group purchasing organizations on drug shortages, and report back at least annually to the House of Delegates on progress made in addressing drug shortages.
6. Our AMA urges the development of a comprehensive independent report on the root causes of drug shortages. Such an analysis should consider federal actions, the number of manufacturers, economic factors including federal reimbursement practices, as well as contracting practices by market participants on competition, access to drugs, and pricing. In particular, further transparent analysis of economic drivers is warranted. The federal Centers for Medicare & Medicaid Services (CMS) should review and evaluate its 2003 Medicare reimbursement formula of average sales price plus 6% for unintended consequences including serving as a root cause of drug shortages.
7. Our AMA urges regulatory relief designed to improve the availability of prescription drugs by ensuring that such products are not removed from the market due to compliance issues unless such removal is clearly required for significant and obvious safety reasons.
8. Our AMA supports the view that wholesalers should routinely institute an allocation system that attempts to fairly distribute drugs in short supply based on remaining inventory and considering the customer's purchase history.
9. Our AMA will collaborate with medical specialty society partners and other stakeholders in identifying and

supporting legislative remedies to allow for more reasonable and sustainable payment rates for prescription drugs.
10. Our AMA urges that during the evaluation of potential mergers and acquisitions involving pharmaceutical manufacturers, the Federal Trade Commission consult with the FDA to determine whether such an activity has the potential to worsen drug shortages.
11. Our AMA urges the FDA to require manufacturers to provide greater transparency regarding production locations of drugs and provide more detailed information regarding the causes and anticipated duration of drug shortages.
12. Our AMA encourages electronic health records (EHR) vendors to make changes to their systems to ease the burden of making drug product changes.
13. Our AMA urges the FDA to evaluate and provide current information regarding the quality of outsourcer compounding facilities.
14. Our AMA urges DHHS and the U.S. Department of Homeland Security (DHS) to examine and consider drug shortages as a national security initiative and include vital drug production sites in the critical infrastructure plan.

(129) RESOLUTION 066 – STANDARDIZATION OF INTIMATE PARTNER VIOLENCE SCREENING WITHIN CLINICAL SETTINGS

RECOMMENDATION:

Policy H-515.965 be <u>reaffirmed in lieu of</u> Resolution 066.

RESOLVED, That the AMA amend Policy H-515.965, “Family and Intimate Partner Violence”, by addition to read as follows:

Family and Intimate Partner Violence, H-515.965

(1) Our AMA believes that all forms of family and intimate partner violence (IPV) are major public health issues and urges the profession, both individually and collectively, to work with other interested parties to prevent such violence and to address the needs of survivors. Physicians have a major role in lessening the prevalence, scope and severity of child maltreatment, intimate partner violence, and elder abuse, all of which fall under the rubric of family violence. To support physicians in practice, our AMA will continue to campaign against family violence and remains open to

working with all interested parties to address violence in US society.

(2) Our AMA believes that all physicians should be trained in issues of family and intimate partner violence through undergraduate and graduate medical education as well as continuing professional development. The AMA, working with state, county and specialty medical societies as well as academic medical centers and other appropriate groups such as the Association of American Medical Colleges, should develop and disseminate model curricula on violence for incorporation into undergraduate and graduate medical education, and all parties should work for the rapid distribution and adoption of such curricula. These curricula should include coverage of the diagnosis, treatment, and reporting of child maltreatment, intimate partner violence, and elder abuse and provide training on interviewing techniques, risk assessment, safety planning, and procedures for linking with resources to assist survivors. Our AMA supports the inclusion of questions on family violence issues on licensure and certification tests.

(3) The prevalence of family violence is sufficiently high and its ongoing character is such that physicians, particularly physicians providing primary care, will encounter survivors on a regular basis. Persons in clinical settings are more likely to have experienced intimate partner and family violence than non-clinical populations. Thus, to improve clinical services as well as the public health, our AMA encourages physicians to: (a) Routinely inquire about the family violence histories of their patients as this knowledge is essential for effective diagnosis and care; (b) Utilize standardized, evidence-based screening methods which prioritize patient safety and confidentiality in clinical settings; (c) Upon identifying patients currently experiencing abuse or threats from intimates, assess and discuss safety issues with the patient before he or she leaves the office, working with the patient to develop a safety or exit plan for use in an emergency situation and making appropriate referrals to address intervention and safety needs as a matter of course; (d) After diagnosing a violence-related problem, refer patients to appropriate medical or health care professionals and/or community-based trauma-specific resources as soon as possible; (e) Have written lists of resources available for survivors of violence, providing information on such matters as emergency shelter, medical assistance, mental health services, protective services and legal aid; (f) Screen patients for psychiatric sequelae of violence and make appropriate referrals for these conditions upon identifying a history of family or other interpersonal violence; (g) Become aware of local resources and referral

sources that have expertise in dealing with trauma from IPV; (h) Be alert to men presenting with injuries suffered as a result of intimate violence because these men may require intervention as either survivors or abusers themselves; (i) Give due validation to the experience of IPV and of observed symptomatology as possible sequelae; (j) Record a patient's IPV history, observed traumata potentially linked to IPV, and referrals made; (k) Become involved in appropriate local programs designed to prevent violence and its effects at the community level.

(4) Within the larger community, our AMA:

(a) Urges hospitals, community mental health agencies, and other helping professions to develop appropriate interventions for all survivors of intimate violence. Such interventions might include individual and group counseling efforts, support groups, and shelters.

(b) Believes it is critically important that programs be available for survivors and perpetrators of intimate violence.

(c) Believes that state and county medical societies should convene or join state and local health departments, criminal justice and social service agencies, and local school boards to collaborate in the development and support of violence control and prevention activities.

(5) With respect to issues of reporting, our AMA strongly supports mandatory reporting of suspected or actual child maltreatment and urges state societies to support legislation mandating physician reporting of elderly abuse in states where such legislation does not currently exist. At the same time, our AMA oppose the adoption of mandatory reporting laws for physicians treating competent, non-elderly adult survivors of intimate partner violence if the required reports identify survivors. Such laws violate basic tenets of medical ethics. If and where mandatory reporting statutes dealing with competent adults are adopted, the AMA believes the laws must incorporate provisions that: (a) do not require the inclusion of survivors' identities; (b) allow competent adult survivors to opt out of the reporting system if identifiers are required; (c) provide that reports be made to public health agencies for surveillance purposes only; (d) contain a sunset mechanism; and (e) evaluate the efficacy of those laws. State societies are encouraged to ensure that all mandatory reporting laws contain adequate protections for the reporting physician and to educate physicians on the particulars of the laws in their states.

(6) Substance abuse and family violence are clearly connected. For this reason, our AMA believes that:

(a) Given the association between alcohol and family violence, physicians should be alert for the presence of one behavior given a diagnosis of the other. Thus, a physician

with patients with alcohol problems should screen for family violence, while physicians with patients presenting with problems of physical or sexual abuse should screen for alcohol use.
(b) Physicians should avoid the assumption that if they treat the problem of alcohol or substance use and abuse they also will be treating and possibly preventing family violence.
(c) Physicians should be alert to the association, especially among female patients, between current alcohol or drug problems and a history of physical, emotional, or sexual abuse. The association is strong enough to warrant complete screening for past or present physical, emotional, or sexual abuse among patients who present with alcohol or drug problems.
(d) Physicians should be informed about the possible pharmacological link between amphetamine use and human violent behavior. The suggestive evidence about barbiturates and amphetamines and violence should be followed up with more research on the possible causal connection between these drugs and violent behavior.
(e) The notion that alcohol and controlled drugs cause violent behavior is pervasive among physicians and other health care providers. Training programs for physicians should be developed that are based on empirical data and sound theoretical formulations about the relationships among alcohol, drug use, and violence.

The MSS House Coordination Committee (HCC) recommended reaffirmation of H-515.956 in lieu of Resolution 066. Testimony on Resolution 066 was mixed. Your Reference Committee concurs with the decision by HCC and believes existing policy should be reaffirmed.

FAMILY AND INTIMATE PARTNER VIOLENCE, H-515.965
(1) Our AMA believes that all forms of family and intimate partner violence (IPV) are major public health issues and urges the profession, both individually and collectively, to work with other interested parties to prevent such violence and to address the needs of survivors. Physicians have a major role in lessening the prevalence, scope and severity of child maltreatment, intimate partner violence, and elder abuse, all of which fall under the rubric of family violence. To support physicians in practice, our AMA will continue to campaign against family violence and remains open to working with all interested parties to address violence in US society.
(2) Our AMA believes that all physicians should be trained in issues of family and intimate partner violence through undergraduate and graduate medical education as well as

continuing professional development. The AMA, working with state, county and specialty medical societies as well as academic medical centers and other appropriate groups such as the Association of American Medical Colleges, should develop and disseminate model curricula on violence for incorporation into undergraduate and graduate medical education, and all parties should work for the rapid distribution and adoption of such curricula. These curricula should include coverage of the diagnosis, treatment, and reporting of child maltreatment, intimate partner violence, and elder abuse and provide training on interviewing techniques, risk assessment, safety planning, and procedures for linking with resources to assist survivors. Our AMA supports the inclusion of questions on family violence issues on licensure and certification tests.

(3) The prevalence of family violence is sufficiently high and its ongoing character is such that physicians, particularly physicians providing primary care, will encounter survivors on a regular basis. Persons in clinical settings are more likely to have experienced intimate partner and family violence than non-clinical populations. Thus, to improve clinical services as well as the public health, our AMA encourages physicians to: (a) Routinely inquire about the family violence histories of their patients as this knowledge is essential for effective diagnosis and care; (b) Upon identifying patients currently experiencing abuse or threats from intimates, assess and discuss safety issues with the patient before he or she leaves the office, working with the patient to develop a safety or exit plan for use in an emergency situation and making appropriate referrals to address intervention and safety needs as a matter of course; (c) After diagnosing a violence-related problem, refer patients to appropriate medical or health care professionals and/or community-based trauma-specific resources as soon as possible; (d) Have written lists of resources available for survivors of violence, providing information on such matters as emergency shelter, medical assistance, mental health services, protective services and legal aid; (e) Screen patients for psychiatric sequelae of violence and make appropriate referrals for these conditions upon identifying a history of family or other interpersonal violence; (f) Become aware of local resources and referral sources that have expertise in dealing with trauma from IPV; (g) Be alert to men presenting with injuries suffered as a result of intimate violence because these men may require intervention as either survivors or abusers themselves; (h) Give due validation to the experience of IPV and of observed symptomatology as possible sequelae; (i) Record a patient's IPV history, observed traumata potentially linked

to IPV, and referrals made; (j) Become involved in appropriate local programs designed to prevent violence and its effects at the community level.

(4) Within the larger community, our AMA:

(a) Urges hospitals, community mental health agencies, and other helping professions to develop appropriate interventions for all survivors of intimate violence. Such interventions might include individual and group counseling efforts, support groups, and shelters.

(b) Believes it is critically important that programs be available for survivors and perpetrators of intimate violence.

(c) Believes that state and county medical societies should convene or join state and local health departments, criminal justice and social service agencies, and local school boards to collaborate in the development and support of violence control and prevention activities.

(5) With respect to issues of reporting, our AMA strongly supports mandatory reporting of suspected or actual child maltreatment and urges state societies to support legislation mandating physician reporting of elderly abuse in states where such legislation does not currently exist. At the same time, our AMA oppose the adoption of mandatory reporting laws for physicians treating competent, non-elderly adult survivors of intimate partner violence if the required reports identify survivors. Such laws violate basic tenets of medical ethics. If and where mandatory reporting statutes dealing with competent adults are adopted, the AMA believes the laws must incorporate provisions that: (a) do not require the inclusion of survivors' identities; (b) allow competent adult survivors to opt out of the reporting system if identifiers are required; (c) provide that reports be made to public health agencies for surveillance purposes only; (d) contain a sunset mechanism; and (e) evaluate the efficacy of those laws. State societies are encouraged to ensure that all mandatory reporting laws contain adequate protections for the reporting physician and to educate physicians on the particulars of the laws in their states.

(6) Substance abuse and family violence are clearly connected. For this reason, our AMA believes that:

(a) Given the association between alcohol and family violence, physicians should be alert for the presence of one behavior given a diagnosis of the other. Thus, a physician with patients with alcohol problems should screen for family violence, while physicians with patients presenting with problems of physical or sexual abuse should screen for alcohol use.

(b) Physicians should avoid the assumption that if they treat the problem of alcohol or substance use and abuse they also will be treating and possibly preventing family violence.

(c) Physicians should be alert to the association, especially among female patients, between current alcohol or drug problems and a history of physical, emotional, or sexual abuse. The association is strong enough to warrant complete screening for past or present physical, emotional, or sexual abuse among patients who present with alcohol or drug problems.
(d) Physicians should be informed about the possible pharmacological link between amphetamine use and human violent behavior. The suggestive evidence about barbiturates and amphetamines and violence should be followed up with more research on the possible causal connection between these drugs and violent behavior.
(e) The notion that alcohol and controlled drugs cause violent behavior is pervasive among physicians and other health care providers. Training programs for physicians should be developed that are based on empirical data and sound theoretical formulations about the relationships among alcohol, drug use, and violence.

(130) RESOLUTION 077 – INCREASED UTILIZATION OF POINT-OF-CARE MEDICAL TOOLS IN UNDERGRADUATE MEDICAL EDUCATION

RECOMMENDATION:

Policy D-480.972 be <u>reaffirmed in lieu of</u> Resolution 077.

RESOLVED, That our AMA-MSS support education of physicians-in-training on proper utilization of medical POC electronic knowledge resources in clinical practice.

The MSS House Coordination Committee (HCC) recommended Resolution 077 be placed on the reaffirmation consent calendar. Your Reference Committee agrees. While this resolution deals with a more specific aspect of utilization of point-of-care medical tools, we find this ask falls under the umbrella of existing policy and agree with HCC that D-480.972 be reaffirmed in lieu of Resolution 077.

GUIDELINES FOR MOBILE MEDICAL APPLICATIONS AND DEVICES, D-480.972
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 health content tailored to linguistically and/or culturally diverse backgrounds, with emphasis on underserved and low-income populations.

(131) RESOLUTION 081 - ENSURING ACCESS TO CHILD MENTAL HEALTH SERVICES AND CHILD ABUSE REPORTING DURING INCREASED STRESS AND RISK

RECOMMENDATION:

Policy H-515.965 be <u>reaffirmed in lieu of</u> Resolution 081.

RESOLVED, That our AMA will collaborate with state and other relevant medical societies to increase public knowledge and awareness about available virtual child abuse and mental health resources for the pediatric population during times of increased stress and risk, such as a pandemic; and be it further

RESOLVED, That this resolution be immediately forwarded to the House of Delegates at the November 2020 Special Meeting.

The House Coordination Committee (HCC) recommended reaffirmation for Resolution 081. Your Reference Committee agrees with this recommendation, as H-515.965 – clause (4)(c) specifically – encompasses the ask of this resolution.

FAMILY AND INTIMATE PARTNER VIOLENCE, H-515.965

(1) Our AMA believes that all forms of family and intimate partner violence (IPV) are major public health issues and urges the profession, both individually and collectively, to work with other interested parties to prevent such violence and to address the needs of survivors. Physicians have a major role in lessening the prevalence, scope and severity of child maltreatment, intimate partner violence, and elder abuse, all of which fall under the rubric of family violence. To support physicians in practice, our AMA will continue to campaign against family violence and remains open to working with all interested parties to address violence in US society.

(2) Our AMA believes that all physicians should be trained in issues of family and intimate partner violence through undergraduate and graduate medical education as well as continuing professional development. The AMA, working with state, county and specialty medical societies as well as academic medical centers and other appropriate groups such as the Association of American Medical Colleges, should develop and disseminate model curricula on violence for incorporation into undergraduate and graduate medical education, and all parties should work for the rapid distribution and adoption of such curricula. These curricula should include coverage of the diagnosis, treatment, and reporting of child maltreatment, intimate partner violence, and elder abuse and provide training on interviewing techniques, risk assessment, safety planning, and procedures for linking with resources to assist survivors. Our AMA supports the inclusion of questions on family violence issues on licensure and certification tests.

(3) The prevalence of family violence is sufficiently high and its ongoing character is such that physicians, particularly physicians providing primary care, will encounter survivors on a regular basis. Persons in clinical settings are more likely to have experienced intimate partner and family violence than non-clinical populations. Thus, to improve clinical services as well as the public health, our AMA encourages physicians to: (a) Routinely inquire about the family violence histories of their patients as this knowledge is essential for effective diagnosis and care; (b) Upon identifying patients currently experiencing abuse or threats from intimates, assess and discuss safety issues with the patient before he or she leaves the office, working with the patient to develop a safety or exit plan for use in an emergency situation and making appropriate referrals to address intervention and safety needs as a matter of course; (c) After diagnosing a violence-related problem, refer patients to appropriate medical or health care professionals and/or community-based trauma-specific

resources as soon as possible; (d) Have written lists of resources available for survivors of violence, providing information on such matters as emergency shelter, medical assistance, mental health services, protective services and legal aid; (e) Screen patients for psychiatric sequelae of violence and make appropriate referrals for these conditions upon identifying a history of family or other interpersonal violence; (f) Become aware of local resources and referral sources that have expertise in dealing with trauma from IPV; (g) Be alert to men presenting with injuries suffered as a result of intimate violence because these men may require intervention as either survivors or abusers themselves; (h) Give due validation to the experience of IPV and of observed symptomatology as possible sequelae; (i) Record a patient's IPV history, observed traumata potentially linked to IPV, and referrals made; (j) Become involved in appropriate local programs designed to prevent violence and its effects at the community level.

(4) Within the larger community, our AMA:

(a) Urges hospitals, community mental health agencies, and other helping professions to develop appropriate interventions for all survivors of intimate violence. Such interventions might include individual and group counseling efforts, support groups, and shelters.

(b) Believes it is critically important that programs be available for survivors and perpetrators of intimate violence.

(c) Believes that state and county medical societies should convene or join state and local health departments, criminal justice and social service agencies, and local school boards to collaborate in the development and support of violence control and prevention activities.

(5) With respect to issues of reporting, our AMA strongly supports mandatory reporting of suspected or actual child maltreatment and urges state societies to support legislation mandating physician reporting of elderly abuse in states where such legislation does not currently exist. At the same time, our AMA oppose the adoption of mandatory reporting laws for physicians treating competent, non-elderly adult survivors of intimate partner violence if the required reports identify survivors. Such laws violate basic tenets of medical ethics. If and where mandatory reporting statutes dealing with competent adults are adopted, the AMA believes the laws must incorporate provisions that: (a) do not require the inclusion of survivors' identities; (b) allow competent adult survivors to opt out of the reporting system if identifiers are required; (c) provide that reports be made to public health agencies for surveillance purposes only; (d) contain a sunset mechanism; and (e) evaluate the efficacy of those laws. State societies are encouraged to ensure that all

mandatory reporting laws contain adequate protections for the reporting physician and to educate physicians on the particulars of the laws in their states.
(6) Substance abuse and family violence are clearly connected. For this reason, our AMA believes that:
(a) Given the association between alcohol and family violence, physicians should be alert for the presence of one behavior given a diagnosis of the other. Thus, a physician with patients with alcohol problems should screen for family violence, while physicians with patients presenting with problems of physical or sexual abuse should screen for alcohol use.
(b) Physicians should avoid the assumption that if they treat the problem of alcohol or substance use and abuse they also will be treating and possibly preventing family violence.
(c) Physicians should be alert to the association, especially among female patients, between current alcohol or drug problems and a history of physical, emotional, or sexual abuse. The association is strong enough to warrant complete screening for past or present physical, emotional, or sexual abuse among patients who present with alcohol or drug problems.
(d) Physicians should be informed about the possible pharmacological link between amphetamine use and human violent behavior. The suggestive evidence about barbiturates and amphetamines and violence should be followed up with more research on the possible causal connection between these drugs and violent behavior.
(e) The notion that alcohol and controlled drugs cause violent behavior is pervasive among physicians and other health care providers. Training programs for physicians should be developed that are based on empirical data and sound theoretical formulations about the relationships among alcohol, drug use, and violence.

(132) RESOLUTION 084 – ENSURING THE BEST IN-SCHOOL CARE FOR CHILDREN WITH EPILEPSY

RECOMMENDATION:

Policies H-60.974 and D-60.976 be <u>reaffirmed in lieu of</u> Resolution 084.

RESOLVED, That our AMA supports evidence-based initiatives to optimize in-school care for children with epilepsy, including but not limited to (1) seizure recognition and first-aid response training for teachers and school personnel; (2) the inclusion of seizure action plans within school records to be accessed easily by all school personnel; and (3) accessibility to, and storage of, emergency seizure rescue medications in schools.

Your Reference Committee concurs with the MSS House Coordination Committee's (HCC) recommendation that Resolution 084 be placed on the reaffirmation calendar. However, we do acknowledge that amendments proposed on the VRC by the authors in consultation with the American Academy of Pediatrics could merit discussion by the MSS Assembly.

CHILDREN AND YOUTH WITH DISABILITIES, H-60.974
It is the policy of the AMA: (1) to inform physicians of the special health care needs of children and youth with disabilities;
(2) to encourage physicians to pay special attention during the preschool physical examination to identify physical, emotional, or developmental disabilities that have not been previously noted;
(3) to encourage physicians to provide services to children and youth with disabilities that are family-centered, community-based, and coordinated among the various individual providers and programs serving the child;
(4) to encourage physicians to provide schools with medical information to ensure that children and youth with disabilities receive appropriate school health services;
(5) to encourage physicians to establish formal transition programs or activities that help adolescents with disabilities and their families to plan and make the transition to the adult medical care system;
(6) to inform physicians of available educational and other local resources, as well as various manuals that would help prepare them to provide family-centered health care; and
(7) to encourage physicians to make their offices accessible to patients with disabilities, especially when doing office construction and renovations.

CHILDHOOD ANAPHYLACTIC REACTIONS, D-60.976
Our AMA will: (1) urge all schools, from preschool through 12th grade, to: (a) develop Medical Emergency Response Plans (MERP); (b) practice these plans in order to identify potential barriers and strategies for improvement; (c) ensure that school campuses have a direct communication link with an emergency medical system (EMS); (d) identify students at risk for life-threatening emergencies and ensure these children have an individual emergency care plan that is formulated with input by a physician; (e) designate roles and responsibilities among school staff for handling potential life-threatening emergencies, including administering medications, working with EMS and local emergency departments, and contacting families; (f) train school personnel in cardiopulmonary resuscitation; (g) adopt the School Guidelines for Managing Students with Food Allergies distributed by FARE (Food Allergy Research &

Education); and (h) ensure that appropriate emergency equipment to deal with anaphylaxis and acute asthmatic reactions is available and that assigned staff are familiar with using this equipment; (2) work to expand to all states laws permitting students to carry prescribed epinephrine or other medications prescribed by their physician for asthma or anaphylaxis; (3) support increased research to better understand the causes, epidemiology, and effective treatment of anaphylaxis; (4) urge the Centers for Disease Control and Prevention to study the adequacy of school personnel and services to address asthma and anaphylactic emergencies; (5) urge physicians to work with parents and schools to ensure that all their patients with a food allergy have an individualized emergency plan; and (6) work to allow all first responders to carry and administer epinephrine in suspected cases of anaphylaxis.

(133) RESOLUTION 086 – MEDICALLY UNNECESSARY PROCEDURES ON INTERSEX PATIENTS

RECOMMENDATION:

245.020MSS be reaffirmed in lieu of Resolution 086.

RESOLVED, That our AMA recognize intersex infants should not undergo genitoplasty unless the procedure resolves a functional impairment that if left untreated would likely endanger the life of the patient; and be it further

RESOLVED, That our AMA work with relevant stakeholders to research factors impacting genitoplasty outcomes in intersex individuals, such as: the safety and complications of genitoplasty on intersex individuals (especially those under 5 years of age); whether genitoplasty has a meaningful impact on intersex patients' long-term mental and physical health outcomes (e.g. quality of life, sexual function and satisfaction, and gender identity); key factors required to establish standardized indications for genitoplasty on intersex infants; trends in satisfaction with patient counseling and patient involvement in surgical decision-making.

VRC testimony was largely opposed to Resolution 086 as written. Your Reference Committee wants to be clear that we support the spirit of this resolution, but we are recommending reaffirmation of 245.020MSS due to strategic concerns. The LGBTQ+ Advisory Committee, GLMA, and the delegation from Massachusetts spoke in opposition to Resolution 086. These groups were skeptical that this resolution would be an effective vehicle for navigating a sensitive issue at the House of Delegates, as prior resolutions of this issue were met with strong pushback.

Your Reference Committee reiterates again that the decision to reaffirm existing policy in lieu of Resolution 086 is not indicative of receding from the position that medically unnecessary surgeries in individuals born with differences of sex development are unethical and wrong. However, we find opposing testimony compelling, especially from

leaders of groups representing individuals with differences of sex development (i.e. LGBTQ+, GLMA). The Reference Committee noted that, given previous strong opposition, such as by the American Urological Association, in the House of Delegates to such resolutions, passage of such a resolution would first require coalition building and advocacy within states and specialty societies to build toward strong enough support to achieve the eventual denouncing of this practice by the House of Medicine. Without first building such support, we are strongly inclined to believe this resolution would meet the same opposition that similar resolution met previously.

Specific to the Resolve clauses presented here, we note that genitoplasties are not the only medically unnecessary surgeries that infants with differences in sex development are forced to undergo (gonadectomies, clitorectomies, etc.). The second Resolve clause could unintentionally set back the cause by inadvertently playing into a bad-faith argument used by urologists performing these surgeries, who claim research is lacking to demonstrate that surgeries are more harmful than letting these kids develop without performing these procedures.

For all of these reasons, your Reference Committee recommends that 245.020MSS be reaffirmed in lieu of Resolution 086.

245.020MSS – SUPPORTING AUTONOMY FOR PATIENTS WITH DIFFERENCES OF SEX DEVELOPMENT

AMA-MSS will ask that our AMA affirm that medically unnecessary surgeries in individuals born with differences of sex development are unethical and should be avoided until the patient can actively participate in decision-making.

(134) RESOLUTION 088 – INCREASED ATTENTION TO HYGIENE FACILITIES

RECOMMENDATION:

Policy H-160.903 be <u>reaffirmed in lieu of</u> Resolution 088.

RESOLVED, That our AMA amend policy H-160.903 Eradicating Homelessness, by addition and subtraction as follows:

Eradicating Homelessness, H-160.903

Our AMA:

(1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost-effective approaches which recognize the positive impact of stable and affordable housing coupled with social services;

(2) recognizes that stable, affordable housing as a first priority, without mandated therapy or services compliance, is effective in improving housing stability and quality of life among individuals who are chronically homeless;

(3) recognizes adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address this societal problem on a long-term basis;
(4) recognizes the need for an effective, evidence-based national plan to eradicate homelessness;
(5) calls upon relevant social service organizations and governments to increase access to safe and sanitary hygiene facilities, including public showers and restrooms;
(~~5~~ 6) encourages the National Health Care for the Homeless Council to study the funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons;
(~~6~~ 7) will partner with relevant stakeholders to educate physicians about the unique healthcare and social needs of homeless patients and the importance of holistic, cost-effective, evidence-based discharge planning, and physicians' role therein, in addressing these needs;
(~~7~~ 8) encourages the development of holistic, cost-effective, evidence-based discharge plans for homeless patients who present to the emergency department but are not admitted to the hospital;
(~~8~~ 9) encourages the collaborative efforts of communities, physicians, hospitals, health systems, insurers, social service organizations, government, and other stakeholders to develop comprehensive homelessness policies and plans that address the healthcare and social needs of homeless patients;
(~~9~~ 10) (a) supports laws protecting the civil and human rights of individuals experiencing homelessness, and (b) opposes laws and policies that criminalize individuals experiencing homelessness for carrying out life-sustaining activities conducted in public spaces that would otherwise be considered non-criminal activity (i.e., eating, sitting, or sleeping) when there is no alternative private space available; and
(~~10~~ 11) recognizes that stable, affordable housing is essential to the health of individuals, families, and communities, and supports policies that preserve and expand affordable housing across all neighborhoods.

The MSS House Coordination Committee (HCC) recommended Resolution 088 be added to the reaffirmation calendar. As written, your Reference Committee agrees that this resolution is a reaffirmation of H-160.903, in particular given that (8(of H-160.903 encourages all relevant "stakeholders to develop comprehensive homelessness policies and plans that address the healthcare and social needs of homeless patients."

ERADICATING HOMELESSNESS, H-160.903
Our AMA:

(1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost-effective approaches which recognize the positive impact of stable and affordable housing coupled with social services;
(2) recognizes that stable, affordable housing as a first priority, without mandated therapy or services compliance, is effective in improving housing stability and quality of life among individuals who are chronically homeless;
(3) recognizes adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address this societal problem on a long-term basis;
(4) recognizes the need for an effective, evidence-based national plan to eradicate homelessness;
(5) encourages the National Health Care for the Homeless Council to study the funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons;
(6) will partner with relevant stakeholders to educate physicians about the unique healthcare and social needs of homeless patients and the importance of holistic, cost-effective, evidence-based discharge planning, and physicians' role therein, in addressing these needs;
(7) encourages the development of holistic, cost-effective, evidence-based discharge plans for homeless patients who present to the emergency department but are not admitted to the hospital;
(8) encourages the collaborative efforts of communities, physicians, hospitals, health systems, insurers, social service organizations, government, and other stakeholders to develop comprehensive homelessness policies and plans that address the healthcare and social needs of homeless patients;
(9) (a) supports laws protecting the civil and human rights of individuals experiencing homelessness, and (b) opposes laws and policies that criminalize individuals experiencing homelessness for carrying out life-sustaining activities conducted in public spaces that would otherwise be considered non-criminal activity (i.e., eating, sitting, or sleeping) when there is no alternative private space available; and
(10) recognizes that stable, affordable housing is essential to the health of individuals, families, and communities, and supports policies that preserve and expand affordable housing across all neighborhoods.

(135) RESOLUTION 090 – NAMING OF NEW INFECTIOUS PATHOGENS AND DISEASES

RECOMMENDATION:

Policy H-65.965 be reaffirmed in lieu of Resolution 090.

RESOLVED, That our AMA support the naming of new human infectious diseases and pathogens—including colloquial names—that avoid references to geographic location, peoples, and cultures; and be it further

RESOLVED, That our AMA denounce actions that discriminate against any group of individuals who have been related to a new infectious pathogen based on sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin, or age.

VRC testimony on Resolution 090 was limited, with strong support from GLMA. This is a very important issue; however, your Reference Committee believes this ask is already encompassed by H-65.965. This existing policy has allowed for AMA action on this timely issue, and we recommend reaffirming H-65.965 in lieu of Resolution 090.

> SUPPORT OF HUMAN RIGHTS AND FREEDOM, H-65.965
> Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age; (3) opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage of appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States.

(136) RESOLUTION 092 - SUPPORTING THE PRACTICE OF AND APPROPRIATE REIMBURSEMENT FOR GROUP PRENATAL CARE

RECOMMENDATION:

Policy H-160.911 be reaffirmed in lieu of Resolution 092.

RESOLVED, That our AMA supports the principles and use of group prenatal care and recognizes that it is an effective method for providing prenatal care; and be it further

RESOLVED, That our AMA will advocate for equitable reimbursement rates for group prenatal care from all private and public insurances; and be it further

RESOLVED, That our AMA will work with appropriate stakeholders and state medical associations to draft model legislation that can be used to ensure equitable Medicaid reimbursements for group prenatal care in all states.

The MSS House Coordination Committee (HCC) recommended H-160.911 be reaffirmed in lieu of Resolution 092. Your Reference Committee concurs and believes that reaffirmation should be extended to the item in its entirety. We specifically recommend reaffirmation for the second and third Resolves since the American College of Obstetrics and Gynecology (ACOG) does not have a firm stance on the ask of the first Resolve, and the second and third Resolves are dependent on the first. VRC testimony supported the spirit of the resolution, but ultimately we did not find the asks to be novel.

VALUE OF GROUP MEDICAL APPOINTMENTS, H-160.911
Our AMA promotes education about the potential value of group medical appointments for diagnoses that might benefit from such appointments including chronic diseases, pain, and pregnancy.

(137) RESOLUTION 096 - AMENDING H-185.947, INSURANCE UNDERWRITING REFORM, TO INCLUDE PROTECTIONS FOR THOSE WHO HAVE OBTAINED OPIOID ANTAGONIST MEDICATION VIA PRESCRIPTION OR STANDING ORDER

RECOMMENDATION:

100.025MSS be reaffirmed in lieu of Resolution 096.

RESOLVED, That our AMA amend H-185.947, Insurance Underwriting Reform, to include protections for those who have obtained opioid antagonist medication via prescription or standing order by addition and deletion as follows:

Insurance Underwriting Reform, H-185.947

Our AMA: (1) urges insurance companies to recognize that some medical conditions can be resolved or reduced to the extent that they are no longer valid predictors of morbidity and mortality, (2) urges insurance companies to make underwriting decisions based only on the presence of conditions that are valid predictors of morbidity and mortality; ~~and~~ (3) urges any insurance provider to accept appropriately amended medical records when underwriting decisions require medical record review; and (4) urges insurance companies to not issue any underwriting decision that would deny, limit, or increase the charge for coverage in any way based on prior or current attainment of an opioid antagonist via prescription or standing order.

Your Reference Committee recommends 100.025MSS be reaffirmed in lieu of Resolution 096. The AMA is currently very active on this issue including supporting the National Council of Insurance Legislators resolution cited in the Whereas clauses of this resolution and supporting the Colorado Division of Insurance taking action to prohibit the consideration of naloxone prescriptions in the underwriting process. We also recognize that the MSS has a resolution titled "Oppose Tracking of People who Purchase Naloxone" that is in queue for transmittal to the House of Delegates at the next most appropriate meeting. For these reasons, we recommend 100.025MSS be reaffirmed in lieu of Resolution 096.

100.025MSS – OPPOSE TRACKING OF PEOPLE WHO PURCHASE NALOXONE
AMA-MSS will ask the AMA to oppose any policies that require personally identifiable information associated with naloxone prescriptions or purchases to be tracked or monitored by non-healthcare providers.

(138) RESOLUTION 098 - SUPPORTING THE CLEAR LABELING OF SUNSCREENS

RECOMMENDATION:

Policies H-115.988 and H-100.947 be reaffirmed in lieu of Resolution 098.

RESOLVED, That our AMA amend H-440:839, "Protecting the Public from Dangers of Ultraviolet Radiation," by insertion as follows:

Protecting the Public from Dangers of Ultraviolet Radiation, H-440.839
SUNSCREENS. Our AMA supports: (a) the development of sunscreens that will protect the skin from a broad spectrum of ultraviolet radiation, including both UVA and UVB; and (b) 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. (c) the labeling of sunscreen active ingredients which have not been determined to be generally recognized as safe and effective.

The MSS House Coordination Committee (HCC) recommended H-115.988 and H-100.947 be reaffirmed in lieu of Resolution 098. While VRC testimony was generally supportive from Region 1, Region 3, the Massachusetts delegation, and the MSS Committee on Global and Public Health (CGPH), your Reference Committee concurs with the decision for reaffirmation. However, we acknowledge that with the amendments proposed on the VRC, specifically regarding cases in which safety data is nebulous, this resolution could merit discussion by the MSS Assembly.

QUALITATIVE LABELING OF ALL DRUGS, H-115.988
The AMA supports efforts to promote the qualitative labeling of all drugs and dietary supplements, requiring both active and inactive ingredients of over the counter and prescription drugs and dietary supplements to be listed on the manufacturer's label or package insert.

ANIMAL-DERIVED INGREDIENTS, H-100.947
Our AMA: (1) urges manufacturers to include all ingredients and components present in medical products on the product label, including both active and inactive ingredients, and denote any derived from an animal source; and (2) encourages cultural awareness regarding patient preferences associated with medical products containing active or inactive ingredients or components derived from animal sources.

(139) RESOLUTION 100 - RECOGNIZING MISINFORMATION AS A PUBLIC HEALTH ISSUE

RECOMMENDATION:

Policies H-445.995 and H-445.998 be reaffirmed in lieu of Resolution 100.

RESOLVED, That Our AMA define misinformation as, “any publicly disseminated false or inaccurate information that has significant potential to deceive the public and/or cause public harm if propagated or widely believed”; and be it further

RESOLVED, That Our AMA reaffirm policies H-445.995 and H-445.998.

The MSS House Coordination Committee (HCC) recommended the second Resolve of Resolution 100 be placed on the reaffirmation calendar. Your Reference Committee

recommends the entire item be placed on the reaffirmation calendar. The AMA has previously spoken out against misinformation currently is speaking out against misinformation and we do not believe the asks of this resolution would change what is already being accomplished. We therefore recommend reaffirmation of H-445.995 and H-445.998 in lieu of Resolution 100.

> RESPONSES TO NEWS REPORTS AND ARTICLES, H-445.995
> Our AMA encourages the public relations committees of all county, state and national medical societies to initiate positive programs with the media and to make timely responses to misleading and inaccurate media releases giving the general public a more accurate and balanced perspective of the medical profession and medical issues.
>
> PROPRIETY OF PROFESSIONAL PUBLIC COMMUNICATIONS, H-445.998
> Our AMA encourages: (1) the initiative of those physicians who desire to speak out as individuals, on public issues; and (2) all authorized spokesmen for component societies to participate in local, state and national issues as responsible physicians in order that the voice of organized medicine be heard.

(140) RESOLUTION 101 - PROACTIVE DEFENSE OF CYBERSECURITY THREATS

RECOMMENDATION:

315.006MSS be reaffirmed in lieu of Resolution 101.

RESOLVED, That our AMA encourages hospitals to prioritize cybersecurity to improve patient care, quality, and safety, and be it further

RESOLVED, That our AMA encourages hospitals to prioritize cybersecurity to prevent hospitals from experiencing monetary loss and decrease time and resources spent on responding to attacks; and be it further

RESOLVED, That our AMA encourages hospitals to create access management policies, cybersecurity audit processes, and any future cybersecurity defense systems.

VRC testimony was mixed for Resolution 101. The delegation from Massachusetts recommended that existing policy be reaffirmed in lieu of Resolution 101 and your Reference Committee agrees. The AMA is currently very active in the cybersecurity realm and we do not find that Resolution 101 would change AMA action on this topic. See the following articles on: Physician cybersecurity, Cybersecurity 101: What you need to know, Medical cybersecurity: A patient safety issue, and AMA & AHA respond in rise to cyber threats exploiting COVID-19 pandemic.

315.006MSS – IMPROVING CYBERSECURITY IN HEALTHCARE FACILITIES
AMA-MSS supports the development of new cybersecurity resources for providers that go beyond HIPAA compliance in order to adequately protect patient health information against new cybersecurity threats, such as ransomware, as they emerge.

(141) RESOLUTION 103 - IMPROVING THE QUALITY OF SCHOOL PROVIDED MEALS THROUGH LOCAL PRODUCE SUPPLEMENTATION

RECOMMENDATION:

Policies H-150.925, D-440.954, H-150.944, and H-170.961 be <u>reaffirmed in lieu of</u> Resolution 103.

RESOLVED, That our AMA work with state education and agriculture departments to create streamlined and equitable food safety regulations and certification requirements for local farmers to reduce the disproportionate; and it be further

RESOLVED, That our AMA encourages the USDA and state agriculture departments to enhance or add new spaces for food hubs, databases or cooperatives for small farmers and producers to interact with each other and the general public in order to help them become more competitive with corporate or national foodservice companies.

The MSS House Coordination Committee (HCC) recommended existing policies H-150.925, D-440.954, H-150.944, and H-170.961 be reaffirmed in lieu of Resolution 103 and your Reference Committee concurs. We understand this resolution is asking to make policy more specific to the supply chain; however, that is already encompassed by existing AMA policy and Resolution 103 would not significantly change AMA action on this topic. Existing policy more broadly captures this ask and establishes an actionable way to accomplish what the authors are asking to do. The new language presented is more restrictive than current policy, and for this reason your Reference Committee recommends H-150.925, D-440.954, H-150.944, and H-170.961 be reaffirmed in lieu of Resolution 103.

FOOD ENVIRONMENTS AND CHALLENGES ACCESSING HEALTHY FOOD, H-150.925
Our AMA encourages the U.S. Department of Agriculture and appropriate stakeholders to study the national prevalence, impact, and solutions to the problems of food mirages, food swamps, and food oases as food environments distinct from food deserts.

ADDRESSING OBESITY, D-440.954
1. Our AMA will: (a) assume a leadership role in collaborating with other interested organizations, including national medical specialty societies, the American Public Health Association, the Center for Science in the Public

Interest, and the AMA Alliance, to discuss ways to finance a comprehensive national program for the study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations; (b) encourage state medical societies to collaborate with interested state and local organizations to discuss ways to finance a comprehensive program for the study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations; and (c) continue to monitor and support state and national policies and regulations that encourage healthy lifestyles and promote obesity prevention.

2. Our AMA, consistent with H-440.842, Recognition of Obesity as a Disease, will work with national specialty and state medical societies to advocate for patient access to and physician payment for the full continuum of evidence-based obesity treatment modalities (such as behavioral, pharmaceutical, psychosocial, nutritional, and surgical interventions).

3. Our AMA will: (a) work with state and specialty societies to identify states in which physicians are restricted from providing the current standard of care with regards to obesity treatment; and (b) work with interested state medical societies and other stakeholders to remove out-of-date restrictions at the state and federal level prohibiting healthcare providers from providing the current standard of care to patients affected by obesity.

COMBATING OBESITY AND HEALTH DISPARITIES, H-150.944

Our AMA supports efforts to: (1) reduce health disparities by basing food assistance programs on the health needs of their constituents; (2) provide vegetables, fruits, legumes, grains, vegetarian foods, and healthful dairy and nondairy beverages in school lunches and food assistance programs; and (3) ensure that federal subsidies encourage the consumption of foods and beverages low in fat, added sugars, and cholesterol.

PREVENTION OF OBESITY THROUGH INSTRUCTION IN PUBLIC SCHOOLS, H-170.961

Our AMA will urge appropriate agencies to support legislation that would require meaningful yearly instruction in nutrition, including instruction in the causes, consequences, and prevention of obesity, in grades 1 through 12 in public schools and will encourage physicians to volunteer their time to assist with such an effort.

(142) RESOLUTION 105 - INCORPORATING HUMAN TRAFFICKING EDUCATION INTO THE MEDICAL SCHOOL CURRICULUM

RECOMMENDATION:

Policy D-170.992 be <u>reaffirmed in lieu of</u> Resolution 105.

RESOLVED, That our AMA amend policy H-65.966, Physicians Response to Victims of Human Trafficking, to increase medical student competency in identifying human trafficking victims by addition as follows:

Physicians Response to Victims of Human Trafficking H-65.966

1. Our AMA encourages its Member Groups and Sections, as well as the Federation of Medicine, to raise awareness about human trafficking and inform physicians about the resources available to aid them in identifying and serving victims of human trafficking.

Physicians should be aware of the definition of human trafficking and of resources available to help them identify and address the needs of victims.

The US Department of State defines human trafficking as an activity in which someone obtains or holds a person in compelled service. The term covers forced labor and forced child labor, sex trafficking, including child sex trafficking, debt bondage, and child soldiers, among other forms of enslavement. Although it's difficult to know just how extensive the problem of human trafficking is, it's estimated that hundreds of thousands of individuals may be trafficked every year worldwide, the majority of whom are women and/or children.

The Polaris Project -
In addition to offering services directly to victims of trafficking through offices in Washington, DC and New Jersey and advocating for state and federal policy, the Polaris Project:
- Operates a 24-hour National Human Trafficking Hotline
- Maintains the National Human Trafficking Resource Center, which provides
a. An assessment tool for health care professionals
b. Online training in recognizing and responding to human trafficking in a health care context
c. Speakers and materials for in-person training
d. Links to local resources across the country

The Rescue & Restore Campaign -
The Department of Health and Human Services is designated under the Trafficking Victims Protection Act to assist victims of trafficking. Administered through the Office of Refugee Settlement, the Department's Rescue & Restore campaign provides tools for law enforcement personnel, social service organizations, and health care professionals.

2. Our AMA will help encourage the education of physicians about human trafficking and how to report cases of suspected human trafficking to appropriate authorities to provide a conduit to resources to address the victim's medical, legal, and social needs.

3. Our AMA encourage medical schools to include human trafficking awareness within the medical school curriculum, including but not limited to education on screening, intervention, and providing resources for victims.

4. Our AMA will collaborate with subject matter experts to determine best practice recommendations on human trafficking education that will be developed and made available as a prototype curriculum for use in all levels of training.

The MSS House Coordination Committee (HCC) recommended existing AMA policy D-170.992 be reaffirmed in lieu of Resolution 105 and your Reference Committee agrees. VRC testimony on Resolution 105 was unanimously in support of reaffirmation. The proposed amendments do not significantly change the existing policy as medical school education on this topic is covered by the language of D-170.992.

HUMAN TRAFFICKING/SLAVERY AWARENESS, D-170.992
Our AMA will study the awareness and effectiveness of physician education regarding the recognition and reporting of human trafficking and slavery.

(143) RESOLUTION 109 - TRANSGENDER AND INTERSEX CARE TRAINING FOR SCHOOL HEALTH PROFESSIONALS

RECOMMENDATION:

Policy H-160.991 be <u>reaffirmed in lieu of</u> Resolution 109.

RESOLVED, That our AMA recommends school-based health professionals serving children and adolescents receive training in the physical and mental development of youth with gender dysphoria and/or differences in sex development, and that this training be periodically assessed and renewed.

The MSS House Coordination Committee (HCC) found Resolution 109 to be a reaffirmation of existing policy H-160.991. Your Reference Committee concurs. H-160.991 states that the AMA will collaborate with other organizations to provide comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBTQ patients, which we believe encompasses this ask.

> HEALTH CARE NEEDS OF LESBIAN, GAY, BISEXUAL, TRANSGENDER AND QUEER POPULATIONS, H-160.991
> 1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, transgender, queer/questioning, and other (LGBTQ) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBTQ patients; (iii) encouraging the development of educational programs in LGBTQ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBTQ people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBTQ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.
> 2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection screenings based on anatomy due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from

their cisgender, heterosexual peers and may have unique complicating factors.
3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBTQ health issues.
4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBTQ people.

(144) RESOLUTION 111 - AMENDING H-345.984, AWARENESS, DIAGNOSIS AND TREATMENT OF DEPRESSION AND OTHER MENTAL ILLNESSES TO INCREASE UTILIZATION AND EXPAND USE OF ALTERNATIVE FUNDING FOR COLLABORATIVE CARE

RECOMMENDATION:

Policies H-290.966, H-290.982, H-385.915, and H-290.987 be <u>reaffirmed in lieu of</u> Resolution 111.

RESOLVED, That our AMA amend policy H-345.984, Awareness, Diagnosis and Treatment of Depression and other Mental Illnesses, by addition and deletion as follows:

Awareness, Diagnosis and Treatment of Depression and other Mental Illnesses H-345.984
1. Our AMA encourages: (a) medical schools, primary care residencies, and other training programs as appropriate to include the appropriate knowledge and skills to enable graduates to recognize, diagnose, and treat depression and other mental illnesses, either as the chief complaint or with another general medical condition; (b) all physicians providing clinical care to acquire the same knowledge and skills; and (c) additional research into the course and outcomes of patients with depression and other mental illnesses who are seen in general medical settings and into the development of clinical and systems approaches designed to improve patient outcomes. Furthermore, any approaches designed to manage care by reduction in the demand for services should be based on scientifically sound outcomes research findings.
2. Our AMA will work with the National Institute on Mental Health and appropriate medical specialty and mental health advocacy groups to increase public awareness about depression and other mental illnesses, to reduce the stigma associated with depression and other mental illnesses, and

to increase patient access to quality care for depression and other mental illnesses.
3. Our AMA: (a) will advocate for the incorporation of integrated services for general medical care, mental health care, and substance use disorder care into existing psychiatry, addiction medicine and primary care training programs' clinical settings; (b) encourages graduate medical education programs in primary care, psychiatry, and addiction medicine to create and expand opportunities for residents and fellows to obtain clinical experience working in an integrated behavioral health and primary care model, such as the collaborative care model; and (c) will advocate for appropriate reimbursement to support the practice of integrated physical and mental health care in clinical care settings; and (d) will advocate for increased utilization and expansion of alternative funding sources for collaborative care models, including advocating for the use and expansion of section 1115 waivers in states that currently utilize these waivers.
4. Our AMA recognizes the impact of violence and social determinants on women's mental health.

The MSS House Coordination Committee (HCC) recommended H-290.966, H-290.982, H-290.987, and H-385.915 be reaffirmed in lieu of Resolution 111. VRC testimony on this resolution was mixed, with support from the Psychiatry Student Interest Group Network (PsychSIGN) and the MSS Committee on Economics and Quality in Medicine (CEQM). The Massachusetts delegation opposed Resolution 111, stating that it was similar to existing policy and discussed issues that were not applicable across all states. We found this compelling. Your Reference Committee recognizes that this is a very important issue, but we ultimately concur with HCC and recommend existing policy be reaffirmed in lieu of Resolution 111.

MEDICAID EXPANSION OPTIONS AND ALTERNATIVES, H-290.966
1. Our AMA encourages policymakers at all levels to focus their efforts on working together to identify realistic coverage options for adults currently in the coverage gap.
2. Our AMA encourages states that are not participating in the Medicaid expansion to develop waivers that support expansion plans that best meet the needs and priorities of their low-income adult populations.
3. Our AMA encourages the Centers for Medicare & Medicaid Services to review Medicaid expansion waiver requests in a timely manner, and to exercise broad authority in approving such waivers, provided that the waivers are consistent with the goals and spirit of expanding health insurance coverage and eliminating the coverage gap for low-income adults.

4. Our AMA advocates that states be required to develop a transparent process for monitoring and evaluating the effects of their Medicaid expansion plans on health insurance coverage levels and access to care, and to report the results annually on the state Medicaid web site.

TRANSFORMING MEDICAID AND LONG-TERM CARE AND IMPROVING ACCESS TO CARE FOR THE UNINSURED, H-290.982

AMA policy is that our AMA: (1) urges that Medicaid reform not be undertaken in isolation, but rather in conjunction with broader health insurance reform, in order to ensure that the delivery and financing of care results in appropriate access and level of services for low-income patients;

(2) encourages physicians to participate in efforts to enroll children in adequately funded Medicaid and State Children's Health Insurance Programs using the mechanism of "presumptive eligibility," whereby a child presumed to be eligible may be enrolled for coverage of the initial physician visit, whether or not the child is subsequently found to be, in fact, eligible.

(3) encourages states to ensure that within their Medicaid programs there is a pluralistic approach to health care financing delivery including a choice of primary care case management, partial capitation models, fee-for-service, medical savings accounts, benefit payment schedules and other approaches;

(4) calls for states to create mechanisms for traditional Medicaid providers to continue to participate in Medicaid managed care and in State Children's Health Insurance Programs;

(5) calls for states to streamline the enrollment process within their Medicaid programs and State Children's Health Insurance Programs by, for example, allowing mail-in applications, developing shorter application forms, coordinating their Medicaid and welfare (TANF) application processes, and placing eligibility workers in locations where potential beneficiaries work, go to school, attend day care, play, pray, and receive medical care;

(6) urges states to administer their Medicaid and SCHIP programs through a single state agency;

(7) strongly urges states to undertake, and encourages state medical associations, county medical societies, specialty societies, and individual physicians to take part in, educational and outreach activities aimed at Medicaid-eligible and SCHIP-eligible children. Such efforts should be designed to ensure that children do not go without needed and available services for which they are eligible due to

administrative barriers or lack of understanding of the programs;

(8) supports requiring states to reinvest savings achieved in Medicaid programs into expanding coverage for uninsured individuals, particularly children. Mechanisms for expanding coverage may include additional funding for the SCHIP earmarked to enroll children to higher percentages of the poverty level; Medicaid expansions; providing premium subsidies or a buy-in option for individuals in families with income between their state's Medicaid income eligibility level and a specified percentage of the poverty level; providing some form of refundable, advanceable tax credits inversely related to income; providing vouchers for recipients to use to choose their own health plans; using Medicaid funds to purchase private health insurance coverage; or expansion of Maternal and Child Health Programs. Such expansions must be implemented to coordinate with the Medicaid and SCHIP programs in order to achieve a seamless health care delivery system, and be sufficiently funded to provide incentive for families to obtain adequate insurance coverage for their children;

(9) advocates consideration of various funding options for expanding coverage including, but not limited to: increases in sales tax on tobacco products; funds made available through for-profit conversions of health plans and/or facilities; and the application of prospective payment or other cost or utilization management techniques to hospital outpatient services, nursing home services, and home health care services;

(10) supports modest co-pays or income-adjusted premium shares for non-emergent, non-preventive services as a means of expanding access to coverage for currently uninsured individuals;

(11) calls for CMS to develop better measurement, monitoring, and accountability systems and indices within the Medicaid program in order to assess the effectiveness of the program, particularly under managed care, in meeting the needs of patients. Such standards and measures should be linked to health outcomes and access to care;

(12) supports innovative methods of increasing physician participation in the Medicaid program and thereby increasing access, such as plans of deferred compensation for Medicaid providers. Such plans allow individual physicians (with an individual Medicaid number) to tax defer a specified percentage of their Medicaid income;

(13) supports increasing public and private investments in home and community-based care, such as adult day care, assisted living facilities, congregate living facilities, social health maintenance organizations, and respite care;

(14) supports allowing states to use long-term care eligibility criteria which distinguish between persons who can be served in a home or community-based setting and those who can only be served safely and cost-effectively in a nursing facility. Such criteria should include measures of functional impairment which take into account impairments caused by cognitive and mental disorders and measures of medically related long-term care needs;
(15) supports buy-ins for home and community-based care for persons with incomes and assets above Medicaid eligibility limits; and providing grants to states to develop new long-term care infrastructures and to encourage expansion of long-term care financing to middle-income families who need assistance;
(16) supports efforts to assess the needs of individuals with intellectual disabilities and, as appropriate, shift them from institutional care in the direction of community living;
(17) supports case management and disease management approaches to the coordination of care, in the managed care and the fee-for-service environments;
(18) urges CMS to require states to use its simplified four-page combination Medicaid / Children's Health Insurance Program (CHIP) application form for enrollment in these programs, unless states can indicate they have a comparable or simpler form; and
(19) urges CMS to ensure that Medicaid and CHIP outreach efforts are appropriately sensitive to cultural and language diversities in state or localities with large uninsured ethnic populations.

INTEGRATING PHYSICAL AND BEHAVIORAL HEALTH CARE, H-385.915
Our American Medical Association: (1) encourages private health insurers to recognize CPT codes that allow primary care physicians to bill and receive payment for physical and behavioral health care services provided on the same day; (2) encourages all state Medicaid programs to pay for physical and behavioral health care services provided on the same day; (3) encourages state Medicaid programs to amend their state Medicaid plans as needed to include payment for behavioral health care services in school settings; (4) encourages practicing physicians to seek out continuing medical education opportunities on integrated physical and behavioral health care; and (5) promotes the development of sustainable payment models that would be used to fund the necessary services inherent in integrating behavioral health care services into primary care settings.

MEDICAID WAIVERS FOR MANAGED CARE DEMONSTRATION PROJECTS, H-290.987
(1) Our AMA adopts the position that the Secretary of Health and Human Services should determine as a condition for granting waivers for demonstration projects under Section 1115(a) of the Medicaid Act that the proposed project: (i) assist in promoting the Medicaid Act's objective of improving access to quality medical care, (ii) has been preceded by a fair and open process for receiving public comment on the program, (iii) is properly funded, (iv) has sufficient provider reimbursement levels to secure adequate access to providers, (v) does not include provisions designed to coerce physicians and other providers into participation, such as those that link participation in private health plans with participation in Medicaid, and (vi) maintains adequate funding for graduate medical education. (2) Our AMA advocates that CMS establish a procedure which state Medicaid agencies can implement to monitor managed care plans to ensure that (a) they are aware of their responsibilities under EPSDT, (b) they inform patients of entitlement to these services, and (c) they institute internal review mechanisms to ensure that children have access to medically necessary services not specified in the plan's benefit package.

(145) RESOLUTION 115 - SUPPORT FOR ENDOMETRIOSIS

RECOMMENDATION:

Policy H-170.986 be <u>reaffirmed in lieu of</u> Resolution 115.

RESOLVED, That our AMA recognize endometriosis as a chronic illness and a leading cause of infertility in the United States; and be it further

RESOLVED, That our AMA encourage appropriate screening programs to detect endometriosis including early-detection methods to reduce the current burden on our healthcare system and prevalence of infertility among endometriosis patients; and be it further

RESOLVED, That our AMA advocate for increased federal funding from the National Institutes of Health for biomedical research that works towards finding the etiology and optimal management for endometriosis; and be it further.

RESOLVED, That our AMA advocate for physician and patient education and awareness of endometriosis including developing provider training on diagnosis and management.

The MSS House Coordination Committee (HCC) recommended reaffirmation of existing policy in lieu of Resolution 115 and your Reference Committee concurs. The ask of Resolution 115 is further covered in the Code of Medical Ethics opinion 8.11, Health

Promotion and Preventive Care. Ethical opinions cannot be reaffirmed, but we do highlight that the asks of Resolution 115 are contained within 8.11. We do not find that Resolution 115 would substantively impact AMA action on this issue and recommend reaffirmation.

HEALTH INFORMATION AND EDUCATION, H-170.986
(1) Individuals should seek out and act upon information that promotes appropriate use of the health care system and that promotes a healthy lifestyle for themselves, their families, and others for whom they are responsible. Individuals should seek informed opinions from health care professionals regarding health information delivered by the mass media self-help and mutual aid groups are important components of health promotion/disease and injury prevention, and their development and maintenance should be promoted.
(2) Employers should provide and employees should participate in programs on health awareness, safety, and the use of health care benefit packages.
(3) Employers should provide a safe workplace and should contribute to a safe community environment. Further, they should promptly inform employees and the community when they know that hazardous substances are being used or produced at the worksite.
(4) Government, business, and industry should cooperatively develop effective worksite programs for health promotion and disease and injury prevention, with special emphasis on substance abuse.
(5) Federal and state governments should provide funds and allocate resources for health promotion and disease and injury prevention activities.
(6) Public and private agencies should increase their efforts to identify and curtail false and misleading information on health and health care.
(7) Health care professionals and providers should provide information on disease processes, healthy lifestyles, and the use of the health care delivery system to their patients and to the local community.
(8) Information on health and health care should be presented in an accurate and objective manner.
(9) Educational programs for health professionals at all levels should incorporate an appropriate emphasis on health promotion/disease and injury prevention and patient education in their curricula.
(10) Third party payers should provide options in benefit plans that enable employers and individuals to select plans that encourage healthy lifestyles and are most appropriate for their particular needs. They should also continue to develop and disseminate information on the appropriate utilization of health care services for the plans they market.

(11) State and local educational agencies should incorporate comprehensive health education programs into their curricula, with minimum standards for sex education, sexual responsibility, and substance abuse education. Teachers should be qualified and competent to instruct in health education programs.
(12) Private organizations should continue to support health promotion/disease and injury prevention activities by coordinating these activities, adequately funding them, and increasing public awareness of such services.
(13) Basic information is needed about those channels of communication used by the public to gather health information. Studies should be conducted on how well research news is disseminated by the media to the public. Evaluation should be undertaken to determine the effectiveness of health information and education efforts. When available, the results of evaluation studies should guide the selection of health education programs.

(146) RESOLUTION 116 - STANDARDIZING COUNSELING FOR PEDIATRIC VICTIMS OF GUN VIOLENCE

RECOMMENDATION:

Policy H-515.952 be <u>reaffirmed in lieu of</u> Resolution 116.

RESOLVED, That our AMA collaborate with relevant stakeholders such as American Academy of Pediatrics to encourage the development of evidence-based standard counseling protocols for children who are shot or exposed to gun violence, including in the emergency department settings.

VRC testimony on Resolution 116 was limited. The MSS House Coordination Committee (HCC) recommended H-515.952 be reaffirmed in lieu of Resolution 116. We concur with HCC's recommendation. H-515.952 "recognizes trauma-informed care as a practice that recognizes the widespread impact of trauma on patients" and "supports evidence-based trauma-informed care in all medical settings that focuses on the prevention of poor health and life outcomes after Adverse Childhood Experiences (ACEs) or other trauma at any time in life."

We recognize the ask of this resolution is more specific, but believe it falls under the umbrella of existing policy and would not change AMA action on this issue significantly. We encourage the authors to reach out to the MSS Government Relations and Advocacy Fellow (GRAF), MSS Board of Trustees member, or the MSS Governing Council (through a Governing Council Action Item) if they do not believe enough is being done by the AMA on this issue.

ADVERSE CHILDHOOD EXPERIENCES AND TRAUMA-INFORMED CARE, H-515.952

1. Our AMA recognizes trauma-informed care as a practice that recognizes the widespread impact of trauma on patients, identifies the signs and symptoms of trauma, and treats patients by fully integrating knowledge about trauma into policies, procedures, and practices and seeking to avoid re-traumatization.
2. Our AMA supports:
a. evidence-based primary prevention strategies for Adverse Childhood Experiences (ACEs);
b. evidence-based trauma-informed care in all medical settings that focuses on the prevention of poor health and life outcomes after ACEs or other trauma at any time in life occurs;
c. efforts for data collection, research, and evaluation of cost-effective ACEs screening tools without additional burden for physicians;
d. efforts to educate physicians about the facilitators, barriers and best practices for providers implementing ACEs screening and trauma-informed care approaches into a clinical setting; and
e. funding for schools, behavioral and mental health services, professional groups, community, and government agencies to support patients with ACEs or trauma at any time in life.

(147) RESOLUTION 120 - SUPPORTING BUPRENORPHINE WAIVER TRAINING IN UNDERGRADUATE AND GRADUATE MEDICAL EDUCATION

RECOMMENDATION:

295.208MSS be <u>reaffirmed in lieu of</u> Resolution 120.

RESOLVED, That our AMA support the incorporation of buprenorphine waiver training into undergraduate and graduate medical education by amending current policy D-95.972, Expanding Access to Buprenorphine for the Treatment of Opioid Use Disorder, by addition as follows:

Expanding Access to Buprenorphine for the Treatment of Opioid Use Disorder D-95.972
1. Our AMA's Opioid Task Force will publicize existing resources that provide advice on overcoming barriers and implementing solutions for prescribing buprenorphine for treatment of Opioid Use Disorder.
2. Our AMA supports eliminating the requirement for obtaining a waiver to prescribe buprenorphine for the treatment of opioid use disorder.
<u>3. Our AMA supports buprenorphine waiver training incorporation in undergraduate and graduate medical</u>

education while this waiver requirement to prescribe buprenorphine exists.

; and, be it further

RESOLVED, That our AMA-MSS further support this addition to medical education by amending current AMA-MSS policy 295.208MSS, Buprenorphine Training in Medical Schools by addition as follows:

295.208MSS Buprenorphine Training in Medical Schools
AMA-MSS supports the standardized buprenorphine waiver training addition in medical school curricula to reduce the patient-provider gap in prescribing medication assisted treatment to those with substance use disorder.

The MSS House Coordination Committee (HCC) recommended the second Resolve clause of Resolution 120 be placed on the reaffirmation calendar. Your Reference Committee believes reaffirmation should be extended to Resolution 120 in its entirety. We understand that this is a temporary solution as the AMA works towards the goal of eliminating the buprenorphine waiver, outlined in D-95.972, but we are unsure of the need to bring this forward to the AMA House of Delegates.

VRC testimony was mixed on Resolution 120, including feedback from the American Society of Addiction Medicine (ASAM) that was supportive of the spirit, but was unsure this ask met the threshold of needing to be discussed at the AMA House of Delegates given already existing policy calling for elimination of this practice. Ultimately your Reference Committee believes the asks of this resolution are covered by 295.208MSS and recommend reaffirmation in lieu of Resolution 120.

295.208MSS – BUPRENORPHINE TRAINING IN MEDICAL SCHOOLS
AMA-MSS supports the standardized buprenorphine training addition in medical school curricula to reduce the patient-provider gap in prescribing medication assisted treatment to those with substance use disorder.

(148) RESOLUTION 127 - SUPPORTING IMPROVED PUBLIC UNDERSTANDING OF PLASTIC SURGERY BOARD CERTIFICATION

RECOMMENDATION:

Policies H-275.926, H-275.975, and H-405.956 be reaffirmed in lieu of Resolution 127.

RESOLVED, That our AMA affirm its support for efforts to inform patients of the difference in training requirements between ABPS board-certified plastic surgeons and individuals board-certified through self-designated medical boards; and be it further

RESOLVED, That our AMA affirm its advocacy for appropriate scope of practice by discouraging non-ABPS certified individuals from advertising themselves as board-certified plastic surgeons and performing plastic surgery procedures.

The MSS House Coordination Committee (HCC) recommended H-275.926, H-275.975, and H-405.956 be reaffirmed in lieu of Resolution 127. Your Reference Committee agrees with reaffirmation and also notes that the American Society of Plastic Surgeons would be the more appropriate body to bring forward a resolution such as this.

MEDICAL SPECIALTY BOARD CERTIFICATION STANDARDS, H-275.926

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 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.

(4) Opposes discrimination against physicians based solely on lack of ABMS or equivalent AOA-BOS board certification, or where board certification is one of the criteria considered for purposes of measuring quality of care, determining eligibility to contract with managed care entities, eligibility to receive hospital staff or other clinical privileges, ascertaining competence to practice medicine, or for other purposes. Our AMA also opposes discrimination that may occur against physicians involved in the board certification process, including those who are in a clinical practice period for the

specified minimum period of time that must be completed prior to taking the board certifying examination.
(5) Advocates for nomenclature to better distinguish those physicians who are in the board certification pathway from those who are not.
(6) Encourages member boards of the ABMS to adopt measures aimed at mitigating the financial burden on residents related to specialty board fees and fee procedures, including shorter preregistration periods, lower fees, and easier payment terms.

QUALIFICATIONS OF HEALTH PROFESSIONALS, H-275.975
(1) Private certifying organizations should be encouraged to continue certification programs for all health professionals and to communicate to the public the qualifications and standards they require for certification. Decisions concerning recertification should be made by the certifying organizations. (2) Working with state licensing and certifying boards, health care professions should use the results of quality assurance activities to ensure that substandard practitioner behavior is dealt with in a professional and timely manner. Licensure and disciplinary boards, in cooperation with their respective professional and occupational associations, should be encouraged to work to identify "deficient Health care professionals.

TRANSPARENCY OF HEALTH CARE PROVIDER PROILES IN COMMERCIAL AND FEDERAL PHYSICIAN COMPARISON DATABASES, H-405.956
1. Our AMA encourages accurate and transparent listings of professional degree(s), post-graduate specialty education, and naming of the certifying agency with board certification data released to the public for comparison of healthcare providers or other healthcare services, in accordance with existing AMA policy.
2. Our AMA urges commercial entities and federal programs providing healthcare provider ratings, comparisons, referrals, direct appointments, telehealth, or other services to revise the search and reporting methodology used for profiling of all healthcare providers so as to increase transparency requirements, including the description of professional degree(s), post graduate specialty education, and naming of the certifying board(s), in accordance with existing AMA policy.

(149) RESOLUTION 132 - ADVOCACY FOR "BREAST IMPLANT ILLNESS" PATIENTS

RECOMMENDATION:

Policy H-525.984 be <u>reaffirmed in lieu of</u> Resolution 132.

RESOLVED, That our AMA supports research by the appropriate stakeholders to investigate the etiology of the symptoms termed “breast implant illness” in order to definitively establish or discredit “breast implant illness” as a medically diagnosable syndrome; and be it further

RESOLVED, That our AMA encourages physicians to discuss breast implant explantation as a treatment option in cases where patients exhibit symptoms consistent with “breast implant illness”; and be it further

RESOLVED, That our AMA advocates for patients suffering from the systemic symptoms consistent with “breast implant illness” by promoting awareness through the dissemination of relevant scientific information to the public.

The MSS House Coordination Committee (HCC) recommended the third Resolve clause be placed on the reaffirmation calendar. On the VRC, the Massachusetts delegation, MSS Women in Medicine Committee (WIM), and MSS Committee on Scientific Issues (CSI) also supported reaffirming the resolution as a whole. Your Reference Committee concurs with HCC and finds the VRC testimony compelling. We recommend reaffirmation of H-525.984 be extended to Resolution 132 in its entirety.

> BREAST IMPLANTS, H-525.984
> Our AMA: (1) supports that women be fully informed about the risks and benefits associated with breast implants and that once fully informed the patient should have the right to choose; and (2) based on current scientific knowledge, supports the continued practice of breast augmentation or reconstruction with implants when indicated.

(150) RESOLUTION 136 - INCREASING SURGICAL SPECIALTY PROVIDERS AND ANESTHESIOLOGISTS WITHIN RURAL AREAS

RECOMMENDATION:

Policies H-465.994, D-400.989, H-10.984, and H-200.954 be <u>reaffirmed in lieu of</u> Resolution 136.

RESOLVED, That our AMA advocate for support mechanisms and incentives for surgeons and anesthesiologists practicing in rural areas, as well as their families such as assisting in job placement for their partners and compensating moving expenses, in order to retain these needed healthcare services in rural areas; and be it further

RESOLVED, That our AMA advocate for the expansion of the National Health Service Corps to include all medical specialties, including surgery, surgical subspecialties, and anesthesiology; and be it further

RESOLVED, That our AMA support financial incentives, such as increased re-reimbursement rates for both private insurance, Medicare, and Medicaid and financial compensation at competitive rates from the hospital to the providers for procedures done on patients during on-call hours; and be it further

RESOLVED, That the following AMA policy be amended in order to better specify the need for rural surgeons and anesthesiologists in the care of farm-related injuries, Farm-Related Injuries H-10.984:

Farm-Related Injuries, H-10.984
Our AMA:

(1) emphasizes the need for more complete data on farm-related and other types of traumatic and occupational injuries;

(2) reaffirms its support of regional medical facilities and programs having well-trained medical personnel, including trained surgical subspecialists and anesthesiologists capable of providing immediate care for injuries such as limb and digit reattachment, and emergency care facilities such as fully-equipped operating rooms capable of responding effectively to farm-related and other types of injuries. Physicians in rural areas should assume leadership roles in developing these facilities;

(3) advises manufacturers to improve machinery and farm implements so they are less likely to injure operators and others. Safety instructions should accompany each sale of a machine such as a power auger or tractor. Hazard warnings should be part of each power implement;

(4) encourages parents, teachers, physicians, agricultural extension agencies, voluntary farm groups, manufacturers, and other sectors of society to inform children and others about the risks of agricultural injuries and about approaches to their prevention;

(5) endorses the concept of making injury surveillance and prevention programs ongoing activities of state and local departments of public health; and

(6) encourages the inclusion of farm-related injury issues as part of the training program for medical students and residents involved in a rural health experience.

VRC testimony on Resolution 136 was mixed. The MSS House Coordination Committee (HCC) recommended policies H-465.994, D-400.989, H-10.984, and H-200.954 be reaffirmed in lieu of this resolution. Your Reference Committee concurs with HCC's recommendation. The delegation from Massachusetts believed the asks of this resolution were too broad and the MSS Committee on Medical Education (CME) supported reaffirmation. While we support the spirit of this resolution, we do not find these asks to be novel. Additionally, we do not believe Resolution 136 will change AMA action on this issue and therefore, we recommend existing policies be reaffirmed in lieu of Resolution 136.

IMPROVING RURAL HEALTH, H-465.994
1. Our AMA (a) supports continued and intensified efforts to develop and implement proposals for improving rural health care, (b) urges physicians practicing in rural areas to be actively involved in these efforts, and (c) advocates widely publicizing AMA's policies and proposals for improving rural health care to the profession, other concerned groups, and the public.
2. Our AMA will work with other entities and organizations interested in public health to:

- Identify and disseminate concrete examples of administrative leadership and funding structures that support and optimize local, community-based rural public health.
- Develop an actionable advocacy plan to positively impact local, community-based rural public health including but not limited to the development of rural public health networks, training of current and future rural physicians in core public health techniques and novel funding mechanisms to support public health initiatives that are led and managed by local public health authorities.
- Study efforts to optimize rural public health.

EQUAL PAY FOR EQUAL WORK, D-400.989
Our AMA: (1) shall make its first legislative priority to fix the Medicare payment update problem because this is the most immediate means of increasing Medicare payments to physicians in rural states and will have the greatest impact; (2) shall seek enactment of legislation directing the General Accounting Office to develop and recommend to Congress policy options for reducing any unjustified geographic disparities in Medicare physician payment rates and improving physician recruitment and retention in underserved rural areas; and (3) shall advocate strongly to the current administration and Congress that additional funds must be put into the Medicare physician payment system and that continued budget neutrality is not an option.

FARM-RELATED INJURIES, H-10.984
Our AMA (1) emphasizes the need for more complete data on farm-related and other types of traumatic and occupational injuries;
(2) reaffirms its support of regional medical facilities and programs having well-trained medical personnel and emergency care facilities capable of responding effectively to farm-related and other types of injuries. Physicians in rural areas should assume leadership roles in developing these facilities;
(3) advises manufacturers to improve machinery and farm implements so they are less likely to injure operators and others. Safety instructions should accompany each sale of a machine such as a power auger or tractor. Hazard warnings should be part of each power implement;
(4) encourages parents, teachers, physicians, agricultural extension agencies, voluntary farm groups, manufacturers, and other sectors of society to inform children and others about the risks of agricultural injuries and about approaches to their prevention;
(5) endorses the concept of making injury surveillance and prevention programs ongoing activities of state and local departments of public health; and
(6) encourages the inclusion of farm-related injury issues as part of the training program for medical students and residents involved in a rural health experience.

US PHYSICIAN SHORTAGE, H-200.954
Our AMA:
(1) explicitly recognizes the existing shortage of physicians in many specialties and areas of the US;
(2) supports efforts to quantify the geographic maldistribution and physician shortage in many specialties;
(3) supports current programs to alleviate the shortages in many specialties and the maldistribution of physicians in the US;
(4) encourages medical schools and residency programs to consider developing admissions policies and practices and targeted educational efforts aimed at attracting physicians to practice in underserved areas and to provide care to underserved populations;
(5) encourages medical schools and residency programs to continue to provide courses, clerkships, and longitudinal experiences in rural and other underserved areas as a means to support educational program objectives and to influence choice of graduates' practice locations;

(6) encourages medical schools to include criteria and processes in admission of medical students that are predictive of graduates' eventual practice in underserved areas and with underserved populations;
(7) will continue to advocate for funding from public and private payers for educational programs that provide experiences for medical students in rural and other underserved areas;
(8) will continue to advocate for funding from all payers (public and private sector) to increase the number of graduate medical education positions in specialties leading to first certification;
(9) will work with other groups to explore additional innovative strategies for funding graduate medical education positions, including positions tied to geographic or specialty need;
(10) continues to work with the Association of American Medical Colleges (AAMC) and other relevant groups to monitor the outcomes of the National Resident Matching Program; and
(11) continues to work with the AAMC and other relevant groups to develop strategies to address the current and potential shortages in clinical training sites for medical students.
(12) will: (a) promote greater awareness and implementation of the Project ECHO (Extension for Community Healthcare Outcomes) and Child Psychiatry Access Project models among academic health centers and community-based primary care physicians; (b) work with stakeholders to identify and mitigate barriers to broader implementation of these models in the United States; and (c) monitor whether health care payers offer additional payment or incentive payments for physicians who engage in clinical practice improvement activities as a result of their participation in programs such as Project ECHO and the Child Psychiatry Access Project; and if confirmed, promote awareness of these benefits among physicians.