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

MSS ACTION: SUBSTITUTE RESOLUTION 001 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 schools 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

RESOLUTION 002 – ENCOURAGE TRANSPARENCY OF FEDERAL FUNDING CONTRACTS FOR COVID-19 DIAGNOSTICS, THERAPEUTICS, AND VACCINES

MSS ACTION: NOT CONSIDERED

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

MSS ACTION: ADOPT AS AMENDED

RESOLVED, That our AMA advocate 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

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

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

MSS ACTION: ADOPT 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 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), 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 pandemic or other serious public health emergency;
3. encourages states 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;
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;
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;
7. will monitor progress in developing a contingency plan that addresses future influenza vaccine production or distribution
RESOLUTION 005 – SUPPORT PUBLIC HEALTH APPROACHES FOR THE PREVENTION AND MANAGEMENT OF CONTAGIOUS DISEASES IN CORRECTIONAL FACILITIES

MSS ACTION: ADOPT AS AMENDED

RESOLVED, That our AMA collaborate with state medical societies to advocate for evidence-based public health measures to curb the spread of highly contagious 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, 2) Access to sanitizing equipment including, but not limited to, soap, hand sanitizer, and cleaning supplies, 3) Humane and safe quarantine protocol for individuals that test positive for or are exposed to highly contagious respiratory pathogens, 4) Adherence to use of personal protective equipment for incarcerated individuals and staff, and 5) 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 support efforts to de-carcerate non-violent elderly and medically vulnerable individuals to mitigate the spread of highly contagious pathogens within correctional facilities and communities; and be it further

RESOLVED, That our AMA support prioritizing COVID vaccine access for justice-involved populations; 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, and highly 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.

RESOLUTION 006 – SUPPORTING MEDICAL STUDENT GUIDELINES DURING HEALTHCARE CRISIS
MSS ACTION: NOT CONSIDERED

RESOLUTION 007 – REPRESENTATION OF DERMATOLOGICAL PATHOLOGIES IN VARYING SKIN TONES

MSS ACTION: ADOPT AS AMENDED

RESOLVED, That our AMA encourage the inclusion of a diverse range of skin tones in preclinical and clinical dermatologic medical education materials and evaluation; and be it further

RESOLVED, That our AMA encourage the development of educational materials for medical students and physicians that contribute to the equitable representation of diverse skin tones; and be it further

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

RESOLUTION 008 – PROTESTOR PROTECTIONS

MSS ACTION: ADOPT AS AMENDED

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 encourage relevant stakeholders including but not limited to manufacturers and government agencies to develop, test, and use crowd-control techniques which pose no risk of physical harm; and be it further

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

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

MSS ACTION: ADOPT AS AMENDED

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

RESOLVED, That our AMA provide physicians and medical students with accurate and current information on post-viral syndromes and long-term sequelae 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 collaborate with other medical and educational entities to promote education among patients about post viral syndromes and long-term sequelae associated with COVID-19, including but not limited to Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS), to minimize the harm and disability current and future patients face.
RESOLUTION 010 – LEARNING HISTORY OF EXPERIMENTATION ON BLACK BODIES IN MEDICINE TO UNDERSTAND MEDICAL MISTRUST

MSS ACTION: 350.025MSS BE REAFFIRMED IN LIEU OF RESOLUTION 010

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 recognize, 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.
(MSS Res. 30, I-19)

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

MSS ACTION: ADOPT AS AMENDED

RESOLVED, That our AMA amend existing AMA policy H-110.984, Insulin Affordability, by addition and deletion to read:

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.

RESOLUTION 012 – POLICING REFORM

MSS ACTION: ADOPT AS AMENDED AND REAFFIRM H-515.955

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 advocate for the elimination or reform of qualified immunity, barriers to civilian oversight, and other measures that shield law enforcement officers from consequences for misconduct; and be it further

RESOLVED, That our AMA support efforts to demilitarize law enforcement agencies, including 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

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

RESOLVED, That our AMA advocate 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

RESOLVED, That our AMA advocate for the prohibition of the use of sedative/hypnotic agents, such as ketamine, 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 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

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

Reaffirm:

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.

RESOLUTION 013 – STATUS OF IMMIGRATION LAWS, RULES, AND LEGISLATION DURING NATIONAL CRISES

MSS ACTION: ADOPT AS AMENDED

RESOLVED, In order to recognize 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 the release of individuals and families that are currently part of the immigration process; and
   2. opposes continual detention when the health of these groups is at risk and supports releasing immigrants on recognizance, community support, bonding, or a formal monitoring program during national crises that impose a health risk; and
   3. supports the extension or reauthorization of visas that were valid prior to a national crisis if the crisis causes the halting of immigration processing; and
   4. opposes utilizing public health concerns to deny or significantly hinder eligibility for asylum status to immigrants, refugees, or migrant workers without a viable, medically sound alternative solution.

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

MSS ACTION: ADOPT AS AMENDED

RESOLVED, That our AMA amend 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.

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

MSS ACTION: ADOPT 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 support adoption and funding of alternative nutrition and meal assistance programs during a national crisis, such as a pandemic.

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

MSS ACTION: ADOPT AS AMENDED

RESOLVED, That our AMA-MSS 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-MSS 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-MSS 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-MSS amend 350.025MSS Racism as a Public Health Threat by addition and deletion as follows:

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; and (7) 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.

RESOLVED, That our AMA-MSS 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-MSS support research that promotes antiracist strategies to mitigate algorithmic bias in medicine.

RESOLUTION 017 – DECRIMINALIZATION OF PHYSICIANS WHO PROVIDE ABORTION PROCEDURES

MSS ACTION: H-373.995 AND H-5.989 BE REAFFIRMED IN LIEU 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.

RESOLUTION 018 – GENDER-NEUTRAL LANGUAGE IN AMA POLICY
MSS ACTION: ADOPT

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.

RESOLUTION 019 – SUPPORT FOR MENTAL HEALTH COURTS

MSS ACTION: ADOPT AS AMENDED

RESOLVED, That AMA Policy H-100.955, Support for Drug Courts, be amended by 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; (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.

RESOLUTION 020 – EXPANDING MEDICAID TRANSPORTATION TO INCLUDE HEALTHY GROCERY DESTINATIONS

MSS ACTION: ADOPT AS AMENDED

RESOLVED, That our AMA (1) support the implementation and expansion of transportation services for accessing healthy grocery options; and (2) 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.

RESOLUTION 021 – RECONSIDERATION OF THE DEAD DONOR RULE TO EXEMPT MAASTRICHT CLASS III DONORS

MSS ACTION: NOT CONSIDERED

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

MSS ACTION: ADOPT 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 consent to do so; and be it further
RESOLVED, That our AMA-MSS support encouraging institutions to adopt policies that ensure patients are explicitly informed that sensitive physical exams such as breast, pelvic, genitourinary, and rectal exams may occur under anesthesia.

RESOLUTION 023 – DECREASING YOUTH ACCESS TO E-CIGARETTES

MSS ACTION: H-495.973 AND H-495.988 BE REAFFIRMED, REFER THE SECOND RESOLVE, ADOPT AS AMENDED

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. (Adopt as amended)

; 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. (Refer for study)

Reaffirm:

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.

RESOLUTION 024 – AMENDING POLICY D-350.983, TO INCLUDE BOARD-CERTIFICATION AND COMMUNITY PHYSICIAN OVERSIGHT

MSS ACTION: NOT CONSIDERED

RESOLUTION 025 – BANNING THE PRACTICE OF VIRGINITY TESTING

MSS ACTION: SUBSTITUTE RESOLUTION 025 BE ADOPTED IN LIEU OF RESOLUTION 025

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

RESOLVED, 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.

RESOLUTION 026 – NON-CERVICAL HPV ASSOCIATED CANCER PREVENTION

MSS ACTION: ADOPT AS AMENDED, REAFFIRM D-170.995

RESOLVED, That our AMA amend policy H-440.872, HPV Vaccine and Cervical Cancer Prevention Worldwide, by 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, 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, and (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 support legislation and funding for research aimed towards discovering screening methodology and early detection methods for other non-cervical HPV-associated cancers.

Reaffirm:

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.

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

MSS ACTION: ADOPT 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 are for gender dysphoria; and (3)
opposes efforts that criminalize or otherwise restrict evidence-based gender-affirming care or place an undue burden on individuals seeking access to this care.

RESOLUTION 028 – ANTI-HARASSMENT TRAINING

MSS ACTION: ADOPT AS AMENDED

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

RESOLVED, That our AMA work with the Women Physicians Section, American Medical Women’s Association, GLMA: Health Professionals Advancing LGBTQ Equality, and other stakeholders to identify an appropriate, evidence-based anti-harassment and sexual harassment prevention training to administer leadership.

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

MSS ACTION: ADOPT AS AMENDED

RESOLVED, That our AMA oppose the implementation of immunity passports which give an individual differential privilege on the basis of immune status to a pathogen.

RESOLUTION 030 – MENTAL HEALTH FIRST AID TRAINING

MSS ACTION: ADOPT AS AMENDED, REAFFIRM H-345.999, H-345.984, H-345.981, AND 345.021MSS

RESOLVED, That our AMA 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 as accredited Continuing Medical Education (CME) commensurate with their responsibilities in emergent mental illness crises, both in the clinical setting and community.

Reaffirm:

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.

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

MSS ACTION: ADOPT

RESOLVED, That our AMA collaborate with the Association of American Medical Colleges (AAMC), American Association of Colleges of Osteopathic Medicine (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.

RESOLUTION 033 – ADDRESSING INFORMAL MILK SHARING

MSS ACTION: ADOPT

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.

RESOLUTION 034 – IMPROVING INTERRACIAL RELATIONSHIPS AND INEQUITY IN ACADEMIC MEDICINE
MSS ACTION: D-65.989, H-350.974, AND D-295.327 BE REAFFIRMED IN LIEU OF RESOLUTION 034

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.

RESOLUTION 035 – STUDYING POPULATION-BASED REIMBURSEMENT DISPARITIES

MSS ACTION: NOT CONSIDERED

RESOLUTION 036 – PROVISION OF INFLUENZA VACCINATIONS, TREATMENT, AND SCREENINGS TO IMMIGRANTS HELD IN CUSTOMS AND BORDER PROTECTION FACILITIES

MSS ACTION: NOT CONSIDERED

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

MSS ACTION: SUBSTITUTE RESOLUTION 037 BE ADOPTED IN LIEU OF RESOLUTION 037

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.

RESOLUTION 038 – HEALTH COVERAGE DURING STATES OF EMERGENCY

MSS ACTION: ADOPT AS AMENDED
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.

RESOLUTION 039 – SUPPORTING HIPAA COVERAGE OF PATIENT’S MOBILE HEALTH DATA

MSS ACTION: ADOPT

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 040 – SUPPORT FOR THE ESTABLISHMENT OF MEDICAL-LEGAL PARTNERSHIPS

MSS ACTION: ADOPT

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

RESOLUTION 041 – OPPOSITION TO MEDICAL BONDING IN JAIL

MSS ACTION: ADOPT AS AMENDED

RESOLVED, That our AMA-MSS support advocating against prisoners’ release on bond when used to abdicate responsibility for incarcerated populations’ healthcare.

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

MSS ACTION: ADOPT

RESOLVED, That our AMA amend policy H-185.990 by addition 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; 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.
; and be it further

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

REMOVING FINANCIAL BARRIERS TO CARE FOR TRANSGENDER PATIENTS, H-185.950
Our AMA supports public and private health insurance coverage for medically necessary treatment of gender dysphoria as recommended by the patient’s physician, including gender-affirming hormone therapy and gender-affirming surgery.

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

MSS ACTION: ADOPT 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 supports 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 use 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 develop 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.

RESOLUTION 044 – ADVOCATE FOR THE LEGALIZATION OF RECREATIONAL CANNABIS TO END MASS INCARCERATION

MSS ACTION: ADOPT AS AMENDED

RESOLVED, That our AMA-MSS support the legalization of recreational cannabis at the federal level.

RESOLUTION 045 – SUPPORTING MEDICAL STUDENT PHYSICIAN SHADOWING IN A REMOTE CAPACITY DURING THE CURRENT CRISIS
MSS ACTION: ADOPT AS AMENDED

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.

RESOLUTION 046 – DIDACTIC PRE-CLINICAL EDUCATION ON DE-ESCALATION, VIOLENCE, AND ABUSE PREVENTION IN THE HEALTHCARE WORKPLACE

MSS ACTION: H-215.978 BE REAFFIRMED IN LIEU OF RESOLUTION 046

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.

RESOLUTION 047 – SUPPORTING MEASURES TO ENSURE SAFE INDOOR HOME TEMPERATURES

MSS ACTION: ADOPT AS AMENDED

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

RESOLUTION 048 – SUPPORT FOR VOTE-BY-MAIL

MSS ACTION: ADOPT

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.

RESOLUTION 049 – COVERAGE OF PREGNANCY-ASSOCIATED HEALTHCARE FOR 12 MONTHS POSTPARTUM FOR UNINSURED PATIENTS INELIGIBLE FOR MEDICAID

MSS ACTION: REFER FOR STUDY

RESOLVED, That to expand coverage of pregnancy-associated healthcare for more uninsured patients and further reduce pregnancy-associated morbidity and mortality, AMA Policy D-290.974, Extending Medicaid Coverage for One Year Postpartum, be amended by addition as follows:

EXTENDING MEDICAID COVERAGE FOR ONE YEAR POSTPARTUM, D-290.974
1) 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.

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

MSS ACTION: NOT ADOPT

RESOLUTION 051 – EMPLOYMENT OF PATIENTS WITH PSYCHIATRIC ILLNESS

MSS ACTION: ADOPT AS AMENDED

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

RESOLUTION 052 – EXPANSION ON COMPREHENSIVE SEXUAL HEALTH EDUCATION

MSS ACTION: ADOPT 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: 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; (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.

RESOLUTION 053 – ADDRESSING ADVERSE EFFECTS OF ACTIVE SHOOTER DRILLS ON CHILDREN’S HEALTH

MSS ACTION: ADOPT AS AMENDED

RESOLVED, That our AMA support that all school systems 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

RESOLVED, That our AMA work with relevant stakeholders to raise awareness of ways to conduct active shooter drills that are safe for children and age appropriate.

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

MSS ACTION: ADOPT AS AMENDED

RESOLVED, That our AMA study potential mechanisms of national economic reparations that could improve inequities associated with institutionalized, systemic racism and report back to the House of Delegates; and be it further

RESOLVED, That our AMA study the potential adoption of a policy of reparations 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

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

RESOLUTION 055 – REDUCING COMPLEXITY IN THE PUBLIC SERVICE LOAN FORGIVENESS

MSS ACTION: ADOPT

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

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) 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; (d) Advocate against a monetary cap on PSLF and other federal loan
forgiveness programs; (ce) 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; (df) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note; (eg) 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; (fh) Advocate that the profit status of a physicians training institution not be a factor for PSLF eligibility; (gi) Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed; (hj) 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; (ik) 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 loan 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.

RESOLUTION 056 – INCREASING REGULATION OF NATURAL COSMETIC PRODUCTS

MSS ACTION: REFER FOR STUDY

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 to read as follows:

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 deems 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.

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

MSS ACTION: ADOPT 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 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.

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

MSS ACTION: 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 059 – INCREASING MEDICATION DELIVERY AND CURBSIDE PICK-UP DURING PANDEMICS

MSS ACTION: D-120.961 BE REAFFIRMED IN LIEU OF RESOLUTION 059

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 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.

**RESOLUTION 060 – ENCOURAGEMENT OF MANUFACTURING NECESSARY SUPPLIES WITHIN THE UNITED STATES**

**MSS ACTION: H-100.956 BE REAFFIRMED 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.

RESOLUTION 061 – PROTECTION OF ANTIBIOTIC EFFICACY THROUGH WATER SYSTEM REGULATION

MSS ACTION: ADOPT AS AMENDED

RESOLVED, That our AMA-MSS study and make recommendations on practices to address contamination, exposure, classification, and clean-up of antibiotics, from public water supplies.

RESOLUTION 062 – ENVIRONMENTAL SUSTAINABILITY OF AMA NATIONAL MEETINGS
RESOLUTION 075 – NET ZERO GREENHOUSE GAS EMISSION IN THE AMA AND HEALTHCARE SECTOR

MSS ACTION: SUBSTITUTE RESOLUTION 062 BE ADOPTED IN LIEU OF RESOLUTION 062 AND RESOLUTION 074

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 063 – EXCLUSION OF RACE AND ETHNICITY IN THE FIRST SENTENCE OF CASE REPORT

MSS ACTION: REFER 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.

RESOLUTION 064 – OPPOSITION TO ALCOHOLIC INDUSTRY MARKETING SELF-REGULATION

MSS ACTION: ADOPT AS AMENDED

RESOLVED, That our AMA amend policy H-30.940, Labeling, Advertising, and Promotion of Alcoholic Beverages, by addition and deletion 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.

RESOLUTION 065 – INVESTIGATION OF NATUROPATHIC VACCINE EXEMPTIONS

MSS ACTION: REFER FOR STUDY

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.

RESOLUTION 066 – STANDARDIZATION OF INTIMATE PARTNER VIOLENCE SCREENING WITHIN CLINICAL SETTINGS

MSS ACTION: H-515.965 BE REAFFIRMED IN LIEU OF RESOLUTION 066

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.

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

MSS ACTION: ADOPT AS AMENDED

RESOLVED, That our AMA-MSS research various approaches to grading of clinical clerkships, which may minimize racial bias in medical education.
RESOLUTION 068 – AUTHORIZE COMPETITIVE LICENSING WHEN MEDICARE NEGOTIATION FAILS

MSS ACTION: NOT CONSIDERED

RESOLUTION 069 – OPPOSITION TO THE CRIMINALIZATION OF PERINATAL DEMISE

MSS ACTION: SUBSTITUTE RESOLUTION 069 BE ADOPTED IN LIEU OF RESOLUTION 069

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.

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

MSS ACTION: ADOPT AS AMENDED

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 humility 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.

RESOLUTION 071 – CONSENT REFORM AS A PROTECTIVE METHOD FOR VICTIMS OF HUMAN TRAFFICKING

MSS ACTION: NOT ADOPT

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

MSS ACTION: ADOPT AS AMENDED

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

60.011MSS – SUN PROTECTION PROGRAMS AND EDUCATION IN 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.

RESOLUTION 074 - SUPPORT FOR EVIDENCE-BASED POLICY

MSS ACTION: REFER FOR STUDY
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.

RESOLUTION 076 – FEDERAL HEALTH INSURANCE FUNDING FOR PEOPLE EXPERIENCING INCARCERATION

MSS ACTION: ADOPT AS AMENDED

RESOLVED, That our AMA advocate for the continuation of federal funding for health insurance benefits, including Medicaid, Medicare, and the Children’s Health Insurance Program, for otherwise eligible individuals in pre-trial detention; and be it further

RESOLVED, That our AMA amend policy H-430.986 by addition and deletion as follows:

HEALTH CARE WHILE INCARCERATED, H-430.986

1. Our AMA advocates for adequate payment to health care providers, including primary care and mental health, and addiction treatment professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process from intake to re-entry into the community.

2. Our AMA supports partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for juveniles and adults in the correctional system.

3. Our AMA encourages state Medicaid agencies to accept and process Medicaid applications from juveniles and adults who are incarcerated.

4. That our AMA encourage state Medicaid agencies to work with their local departments of corrections, prisons, and jails to assist incarcerated juveniles and adults who may not have been enrolled in Medicaid at the time of their incarceration to apply and receive an eligibility determination for Medicaid.
5. That our AMA advocate for the repeal of the Medicaid Inmate Exclusion Policy.

56. Our AMA encourages states not to suspend rather than terminate Medicaid eligibility of juveniles and adults upon intake into the criminal justice system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community.

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

78. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of incarcerated women and adolescent females, including gynecological care and obstetrics care for pregnant and postpartum women.

89. Our AMA will collaborate with state medical societies and federal regulators to emphasize the importance of hygiene and health literacy information sessions for both inmates and staff in correctional facilities.

910. Our AMA supports: (a) linkage of those incarcerated to community clinics upon release in order to accelerate access to comprehensive health care, including mental health and substance abuse disorder services, and improve health outcomes among this vulnerable patient population, as well as adequate funding; and (b) the collaboration of correctional health workers and community health care providers for those transitioning from a correctional institution to the community.

RESOLUTION 077 – INCREASED UTILIZATION OF POINT-OF-CARE MEDICAL TOOLS IN UNDERGRADUATE MEDICAL EDUCATION

MSS ACTION: 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.

RESOLUTION 078 – BANNING LGBTQ+ “PANIC” DEFENSES

MSS ACTION: ADOPT AS AMENDED

RESOLVED, That our AMA advocate for legislation that would ban the use of LGBTQ+ “panic” defenses in court.

RESOLUTION 079 – ADVOCATING FOR MENTAL HEALTH AND WELLBEING CLINICAL PROTOCOLS AT THE STATE AND FEDERAL LEVELS FOR PATIENTS IN LONG-TERM CARE FACILITIES

MSS ACTION: NOT ADOPT

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

MSS ACTION: ADOPT AS AMENDED, REAFFIRM 295.186MSS

RESOLVED, That our AMA-MSS support the development and implementation of medical student education that address 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.

Reaffirm:
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.

RESOLUTION 081 – ENSURING ACCESS TO CHILD MENTAL HEALTH SERVICES AND CHILD ABUSE REPORTING DURING INCREASED STRESS AND RISK

MSS ACTION: H-515.965 BE REAFFIRMED IN LIEU OF RESOLUTION 081

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.

RESOLUTION 082 – AMENDMENT TO FOOD ENVIRONMENTS AND CHALLENGES ACCESSING HEALTHY FOOD, H-150.925

MSS ACTION: ADOPT

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

FOOD ENVIRONMENTS AND CHALLENGES ACCESSING HEALTHY FOOD H-150.925

Our AMA (1) 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; 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 businesses, create economic opportunities, and support
sustainable local food supply chains to increase access to affordable healthy food.

RESOLUTION 083 – IMPROVING LABELING OF OVER-THE-COUNTER MEDICATIONS BY INCLUDING CARBOHYDRATE CONTENT

MSS ACTION: REFER FOR STUDY

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.

RESOLUTION 084 – ENSURING THE BEST IN-SCHOOL CARE FOR CHILDREN WITH EPILEPSY

MSS ACTION: NOT CONSIDERED

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

MSS ACTION: ADOPT ON AMENDED

RESOLVED, That our AMA encourage the diversification of personal protective equipment design to better fit all body types among healthcare workers.

RESOLUTION 086 – MEDICALLY UNNECESSARY PROCEDURES ON INTERSEX PATIENTS

MSS ACTION: 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.

RESOLUTION 087 – EXPUNGEMENT AND SEALING OF DRUG RECORDS

MSS ACTION: ADOPT AS AMENDED

RESOLVED, That our AMA amend policy H-95.924, Cannabis Legalization for Recreational Use, by addition and deletion as follows:

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; (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; (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; (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; (6) supports public health based strategies, rather than incarceration, in the handling of individuals possessing cannabis for personal use; (7) support efforts that allow for the expungement, destruction, or sealing of criminal records for legal offenses related to cannabis use or possession; (78) encourages research on the impact of legalization and decriminalization of cannabis in an effort to promote public health and public safety; (89) encourages dissemination of information on the public health impact of legalization and decriminalization of cannabis; (910) will advocate for stronger public health messaging on the health effects of cannabis and cannabinoid inhalation and ingestion; and (1011) 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.

; 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 088 - INCREASED ATTENTION TO HYGIENE FACILITIES

MSS ACTION: POLICY H-160.903 BE REAFFIRMED IN LIEU OF RESOLUTION 088

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.

RESOLUTION 089 – PROVIDING REDUCED PARKING FEES FOR PATIENTS

MSS ACTION: ADOPT AS AMENDED

RESOLVED, That our AMA works with relevant stakeholders to recognize parking fees as a burden of care for patients and encourage mechanisms for reducing parking costs.

RESOLUTION 090 – NAMING OF NEW INFECTIOUS PATHOGENS AND DISEASES

MSS ACTION: H-65.965 BE REAFFIRMED 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.

RESOLUTION 091 – ENCOURAGING RESIDENCY PROGRAM COLLABORATION TO ALLOW MEDICAL STUDENTS FAIR AND EQUITABLE APPLICATION PROCESSES

MSS ACTION: ADOPT AS AMENDED

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

RESOLVED, That our AMA encourage residency programs to expand and regularly update information provided on their websites, including but not limited to residency research achievements, fellowship match information, operative/rotation schedules, and trends in post-residency practice settings.

RESOLUTION 092 – SUPPORTING THE PRACTICE OF AND APPROPRIATE REIMBURSEMENT FOR GROUP PRENATAL CARE

MSS ACTION: H-160.911 BE REAFFIRMED IN LIEU OF RESOLUTION 092

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.

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

MSS ACTION: NOT CONSIDERED

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

MSS ACTION: ADOPT 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 FOR PRISONERS WITH MENTAL ILLNESS

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
harm 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, human, 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.

RESOLUTION 095 – EQUAL ACCESS TO ADOPTION FOR THE LGBTQ COMMUNITY

MSS ACTION: ADOPT

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 096 – AMENDING H-185.947, INSURANCE UNDERWRITING REFORM, TO INCLUDE PROTECTIONS FOR THOSE WHO HAVE OBTAINED OPIOID ANTAGONIST MEDICATION VIA PRESCRIPTION OR STANDING ORDER

MSS ACTION: 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.

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

MSS ACTION: ADOPT AS AMENDED

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

ADDRESSING HEALTHCARE NEEDS OF YOUTH CHILDREN IN FOSTER CARE, H-60.910
1. Our AMA advocates for comprehensive and evidence-based care that addresses the specific health care needs of children youth in foster care,
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.

RESOLUTION 098 – SUPPORTING THE CLEAR LABELING OF SUNSCREENS

MSS ACTION: NOT CONSIDERED

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

MSS ACTION: ADOPT

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 AND ONLINE STREAMING OF SEXUAL ENCOUNTERS AND PUBLIC HEALTH AWARENESS ON SOCIAL MEDIA PLATFORMS, H-485.994

The AMA urges television broadcasters and online streaming services, producers, and sponsors, and any associated social media outlets to encourage education about heterosexual and LGBTQ+ inclusive safe sexual practices, including but not limited to condom use and abstinence, in television or online programming of sexual encounters, and to accurately represent the consequences of unsafe sex.

RESOLUTION 100 – RECOGNIZING MISINFORMATION AS A PUBLIC HEALTH ISSUE

MSS ACTION: NOT CONSIDERED

RESOLUTION 101 – PROACTIVE DEFENSE OF CYBERSECURITY THREATS

MSS ACTION: 315.006MSS BE REAFFIRMED IN LIEU OF RESOLUTION 101

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.

RESOLUTION 102 – OPPOSING THE MARKETING OF PHARMACEUTICALS TO PARTIES RESPONSIBLE FOR CAPTIVE POPULATIONS

MSS ACTION: REFER 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.

RESOLUTION 103 – IMPROVING THE QUALITY OF SCHOOL PROVIDED MEALS THROUGH LOCAL PRODUCE SUPPLEMENTATION

MSS ACTION: 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.

RESOLUTION 104 – SEXUAL HARASSMENT ACCREDITATION STANDARDS FOR MEDICAL TRAINING PROGRAMS

MSS ACTION: ADOPT AS AMENDED

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

RESOLVED, That our AMA encourage the LCME and ACGME to assess 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.

RESOLUTION 105 – INCORPORATING HUMAN TRAFFICKING EDUCATION INTO THE MEDICAL SCHOOL CURRICULUM

MSS ACTION: D-170.992 BE REAFFIRMED IN LIEU OF RESOLUTION 105

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.

RESOLUTION 106 – PROVIDING WIDESPREAD ACCESS TO FEMININE HYGIENE/MENSTRUAL PRODUCTS

MSS ACTION: ADOPT
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.

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

MSS ACTION: ADOPT 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:

255.001MSS – THE STATUS OF FOREIGN INTERNATIONAL MEDICAL SCHOOL GRADUATES IN THE UNITED STATES
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. (42) 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. (62) 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.

RESOLUTION 108 – USE OF SOCIAL MEDIA FOR PRODUCT PROMOTION AND COMPENSATION

MSS ACTION: ADOPT AS AMENDED

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

RESOLUTION 109 – TRANSGENDER AND INTERSEX CARE TRAINING FOR SCHOOL HEALTH PROFESSIONALS

MSS ACTION: NOT CONSIDERED

RESOLUTION 110 – SUPPORT DISTRIBUTION OF FREE HEARING PROTECTION IN RELEVANT PUBLIC VENUES

MSS ACTION: ADOPT AS AMENDED

RESOLVED, That our AMA-MSS 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.

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


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.

RESOLUTION 112 – GUARANTEED TIME OFF ON NATIONAL ELECTION DAYS AT MEDICAL SCHOOLS

MSS ACTION: ADOPT AS AMENDED

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

RESOLUTION 113 – IMPLICATIONS OF THE DISMISSAL OF VACCINE NON-COMPLIANT PATIENTS

MSS ACTION: NOT CONSIDERED

RESOLUTION 114 – SUPPORT FOR ADMINISTRATION OF USMLE AND COMLEX EXAMINATIONS BY HOME INSTITUTIONS

MSS ACTION: ADOPT AS AMENDED

RESOLVED, That our AMA-MSS support the continued exploration of a permanent shift in the administration of USMLE 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.

RESOLUTION 115 – SUPPORT FOR ENDOMETRIOSIS

MSS ACTION: NOT CONSIDERED

RESOLUTION 116 – STANDARDIZING COUNSELING FOR PEDIATRIC VICTIMS OF GUN VIOLENCE

MSS ACTION: H-515.952 BE REAFFIRMED IN LIEU OF RESOLUTION 116

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.

RESOLUTION 117 – IMPACT OF MATCHING SOCIAL INTERESTS ON UNDERGRADUATE MEDICAL EDUCATION ON CLINICAL EVALUATION

MSS ACTION: NOT ADOPT

RESOLUTION 118 – EVALUATING SCIENTIFIC JOURNAL ARTICLES FOR RACIAL AND ETHNIC BIAS

MSS ACTION: ADOPT AS AMENDED

RESOLVED, That our AMA support major journal publishers issuing guidelines for interpreting previous research which define race and ethnicity by outdated means; and be it further

RESOLVED, That our AMA support major journal publishers implementing a screening method for future research submissions concerning the incorrect use of race and ethnicity.

RESOLUTION 119 – AMEND H-150.927 AND H-150.933 TO INCLUDE FOOD PRODUCTS WITH ADDED SUGAR

MSS ACTION: REFER 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.

RESOLUTION 120 – SUPPORTING BUPRENORPHINE WAIVER TRAINING IN UNDERGRADUATE AND GRADUATE MEDICAL EDUCATION

MSS ACTION: 295.208MSS BE REAFFIRMED 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.

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

MSS ACTION: ADOPT

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.

RESOLUTION 122 – RESPECTING RELIGIOUS DIVERSITY IN MEDICAL EDUCATION

MSS ACTION: ADOPT AS AMENDED

RESOLVED, That our AMA-MSS support inclusive accommodation for students who feel restricted in their religious obligations in peer physical examination courses, including osteopathic manipulative medicine and clinical skills instruction.

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

MSS ACTION: 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 124 – INCORPORATING THE EVIDENCE-BASED CONCEPTS OF THE CHOOSING WISELY PROGRAM INTO UNDERGRADUATE AND GRADUATE MEDICAL EDUCATION

MSS ACTION: ADOPT

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

RESOLUTION 125 – TRANSPARENCY ON RESTRICTIONS OF CARE

MSS ACTION: ADOPT AS AMENDED

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

5.066MSS – REPRODUCTIVE HEALTH CARE IN RELIGIOUSLY-AFFILIATED HOSPITALS TRANSPARENCY ON RESTRICTIONS OF CARE
AMA-MSS (1) supports advocating 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 the healthcare providers with religious commitments to accessible health care systems offering the aforementioned services, all the while avoiding any undue burden to the patients; and (3) supports advocating 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.

RESOLUTION 126 – IMPLEMENTATION OF A SINGLE LICENSING EXAM FOR MEDICAL STUDENTS

MSS ACTION: NOT CONSIDERED

RESOLUTION 127 – SUPPORTING IMPROVED PUBLIC UNDERSTANDING OF PLASTIC SURGERY BOARD CERTIFICATION


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 PROFILES 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.

RESOLUTION 128 – HOSPITAL BANS ON TRIAL OF LABOR AFTER CESAREAN

MSS ACTION: ADOPT AS AMENDED
RESOLVED, That our AMA encourage hospitals that can provide basic maternal care as defined by American College of Obstetrics and Gynecology not to prohibit trial of labor after cesarean (TOLAC); and be it further

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

RESOLUTION 129 – GUIDELINES ON CHAPERONES FOR SENSITIVE EXAMS

MSS ACTION: ADOPT AS AMENDED

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 is most in line with the current best practices and potentially considers the following topics: a) opt-out chaperones for breast, genital, and rectal exams; b) documentation surrounding the use of 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.

RESOLUTION 130 – PROTECTION FROM RISKS OF INDOOR TANNING

MSS ACTION: ADOPT AS AMENDED

RESOLVED, That our AMA-MSS amend 440.004MSS to read as follows:

440.004MSS – EDUCATION ON 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.

RESOLUTION 131 – ADVOCATING AGAINST MEDICAL STUDENTS AS A SOURCE OF PROFIT FOR MEDICAL LICENSURE EXAMINATIONS

MSS ACTION: NOT ADOPT, REAFFIRM H-305.925

Reaffirm:

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 policies and novel approaches to prevent debt from influencing specialty and subspecialty choice.

RESOLUTION 132 – ADVOCACY FOR “BREAST IMPLANT ILLNESS” PATIENTS

MSS ACTION: H-525.984 BE REAFFIRMED IN LIEU OF RESOLUTION 132

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.

RESOLUTION 133 – STUDY OF HEALTH DISPARITIES ACCREDITATION CRITERIA IN UNDERGRADUATE MEDICAL EDUCATION

MSS ACTION: NOT ADOPT

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

MSS ACTION: ADOPT

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.

RESOLUTION 135 – REGULATION OF PHTHALATES IN ADULT PERSONAL SEXUAL PRODUCTS

MSS ACTION: REFER FOR STUDY

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.

RESOLUTION 136 – INCREASING SURGICAL SPECIALTY PROVIDERS AND ANESTHESIOLOGISTS WITHIN RURAL AREAS

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.

CBH REPORT A – DEVELOPMENT AND IMPLEMENTATION OF RECOMMENDATIONS FOR RESPONSIBLE MEDIA COVERAGE OF DRUG OVERDOSES

MSS ACTION: ADOPT RECOMMENDATIONS AND FILE REPORT

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.

CEQM MIC REPORT A – LAYING THE FIRST STEPS TOWARDS A TRANSITION TO A FINANCIAL AND CITIZENSHIP NEED-BLIND MODEL FOR ORGAN PROCUREMENT AND TRANSPLANTATION

MSS ACTION: NOT CONSIDERED

CEQM REPORT A – PROMOTING EARLY ACCESS TO DIABETES CARE TO REDUCE ESRD

MSS ACTION: ADOPT RECOMMENDATIONS AND FILE REPORT

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

CEQM REPORT B – SUPPORT OF RESEARCH ON VISION SCREENINGS AND VISUAL AIDS FOR ADULTS COVERED BY MEDICAID

MSS ACTION: REFER 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.
CEQM REPORT C – RESEARCHING POLICY RECOMMENDATIONS TO ADDRESS THE SHORTFALLS OF EMPLOYER-SPONSORED HEALTH INSURANCE

MSS ACTION: ADOPT AS AMENDED AND FILE REPORT

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.

CGPH CBH REPORT A – SUPPORT FOR ASSISTED OUTPATIENT TREATMENT

MSS ACTION: ADOPT RECOMMENDATIONS AND FILE REPORT

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.”

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

MSS ACTION: ADOPT RECOMMENDATIONS AND FILE REPORT

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.

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

MSS ACTION: ADOPT RECOMMENDATIONS AND FILE REPORT

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

CHIT CEQM REPORT A – ADVOCATING FOR THE REIMBURSEMENT OF REMOTE PATIENT MONITORING FOR THE MANAGEMENT OF CHRONIC CONDITIONS

MSS ACTION: ADOPT AS AMENDED AND FILE REPORT

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.

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.

CHIT REPORT A – INCORPORATION OF MACHINE LEARNING TECHNOLOGIES INTO ELECTRONIC HEALTH RECORDS

MSS ACTION: ADOPT RECOMMENDATIONS AND FILE REPORT

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.

CME CHIT REPORT A – UTILIZATION OF THIRD-PARTY EDUCATIONAL RESOURCES IN UNDERGRADUATE MEDICAL EDUCATION

MSS ACTION: ADOPT RECOMMENDATIONS AND FILE REPORT

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.
CME REPORT A – STUDYING AN APPLICATION CAP FOR THE NATIONAL RESIDENCY MATCH PROGRAM

MSS ACTION: ADOPT RECOMMENDATIONS AND FILE REPORT

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

COLA REPORT A – MANDATORY REPORTING OF SEXUAL MISCONDUCT ALLEGATIONS TO LAW ENFORCEMENT

MSS ACTION: ADOPT RECOMMENDATIONS AND FILE REPORT

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.

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

MSS ACTION: ADOPT RECOMMENDATIONS AND FILE REPORT

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 follows:

RESOLVED, 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 resolve clause of MSS Resolution 53 not be adopted.

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

MSS ACTION: ADOPT RECOMMENDATIONS AND FILE REPORT

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:
1. Our AMA reaffirms its support for the principles that: (a) an FDA decision to approve a new drug or medical device, to withdraw a drug or medical device’s approval, or to change the indications for use of a drug or medical device 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 or medical device is unsafe and/or ineffective for its labeled indications. 
2. The AMA believes that social and economic concerns and disputes per se should not be permitted to play a significant part in the FDA’s decision-making process in the course of FDA devising either general or product specific drug regulation. 
3. It is the position of our AMA that the Food and Drug Administration should not permit political considerations or conflicts of interest to overrule scientific evidence in making policy decisions; and our AMA urges the current administration and all future administrations to consider our best and brightest scientists for positions on advisory committees and councils regardless of their political affiliation and voting history. 

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.

CSI REPORT A – SUPPORTING NEW DAYLIGHT SAVINGS TIME AS THE NEW, PERMANENT STANDARD TIME

MSS ACTION: REFER 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.

GC REPORT A – POLICY SUNSET REPORT FOR AMA-MSS POLICIES

MSS ACTION: REFER FOR STUDY

Your AMA-MSS Governing Council recommends that the following be adopted and the remainder of the report be 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.

LATE RESOLUTION 001 – SUPPORT FOR UNIVERSAL INTERNET ACCESS

MSS ACTION: ADOPT AS AMENDED

RESOLVED, That our AMA amend policy H-478.980, Increasing Access to Broadband Internet to Reduce Health Disparities, by addition and deletion as follows:

INCREASING ACCESS TO BROADBAND INTERNET TO REDUCE HEALTH DISPARITIES, H-478.980
1. Our AMA recognizes internet access as a social determinant of health and will advocate for universal and affordable access to the expansion of broadband and high-speed wireless internet and voice connectivity, especially in all rural and underserved areas of the United States while at all times taking care to protecting existing federally licensed radio services from harmful interference that can be caused by broadband and wireless services.

2. Our AMA advocate for federal, state and local policies to support infrastructure that reduces the cost of broadband and wireless connectivity and covers multiple devices and streams per household.

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

EMERGENCY RESOLUTION 001 – CREATING AN AMA-MSS ELECTION TASK FORCE

MSS ACTION: ADOPT

RESOLVED, That our AMA-MSS create a Election Task Force, consisting of at least two region-appointed voting members from each region and non-voting MSS Governing Council members, to review election rules and processes pertaining to Governing Council elections and provide recommendations for their equitable application and enforcement, and report back to Assembly at A-21.
RESOLUTION 005 – RACISM AS A PUBLIC HEALTH THREAT

HOD ACTION: ADOPT AS AMENDED

RESOLVED, That our American Medical Association acknowledge that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health care delivery have caused and continue to cause harm to marginalized communities and society as a whole (New HOD Policy); and be it further

RESOLVED, That our AMA recognize racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of the health equity, and a barrier to appropriate to appropriate medical care (New HOD Policy); and be it further

RESOLVED, That our AMA identify a set of current, best practices for healthcare institutions, physician practices, and academic medical centers to recognize, address, and mitigate the effects of racism on patients, providers, international medical graduates, and populations (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of:
1. The causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism; and
2. How to prevent and ameliorate the health effects of racism (New HOD Policy); and it further

RESOLVED, That our AMA: (a) support the development of policy to combat racism and its effects; (b) encourage governmental agencies and nongovernmental organizations to increase funding for research into the epidemiology of risks and damages related to racism and how t prevent or repair them (New HOD Policy); and be it further

RESOLVED, That our AMA work to prevent and combat the influences of racism and bias in innovative health technologies. (Directive to Take Action)

RESOLUTION 215 – ADVOCATING FOR ALTERNATIVES TO IMMIGRANT DETENTION CENTERS THAT RESPECT HUMAN DIGNITY

HOD ACTION: NOT CONSIDERED, WILL TRANSMIT AT A FUTURE MEETING

RESOLUTION 216 – EXPUNGEMENT AND SEALING OF DRUG RECORDS

HOD ACTION: NOT CONSIDERED, WILL TRANSMIT AT A FUTURE MEETING
RESOLUTION 217 – SUPPORT FOR UNIVERSAL INTERNET ACCESS

HOD ACTION: NOT CONSIDERED, WILL TRANSMIT AT A FUTURE MEETING

RESOLUTION 409 – PROTESTOR PROTECTIONS

HOD ACTION: REFER FOR STUDY, REPORT BACK AT NEXT MEETING OF THE HOUSE OF DELEGATES

RESOLUTION 410 – POLICING REFORM

HOD ACTION: ADOPT RESOLVES 1, 2, 5, AND 7, REFER RESOLVES 3, 4, 6, AND 8

Adopted:

RESOLVED, That our American Medical Association recognize police brutality as a manifestation of structural racism which disproportionately impacts Black, Indigenous, and other people of color (New HOD Policy); and be it further

RESOLVED, That our AMA work with interested national, state, and local medical societies in a public health effort to support the elimination of excessive use of force by law enforcement officers (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate against the utilization of racial and discriminatory profiling by law enforcement through appropriate anti-bias training, individual monitoring, and other measures (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for legislation and regulations which promote trauma-informed, community-based safety practices (Directive to Take Action).

Referred for Study:

RESOLVED, That our AMA advocate for the elimination or reform of qualified immunity, barriers to civilian oversight, and other measures that shield law enforcement officers from consequences for misconduct (Directive to Take Action); and be it further

RESOLVED, That our AMA support efforts to demilitarize law enforcement agencies, including 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 (New HOD Policy); and be it further

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

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 (New HOD Policy).

RESOLUTION 411 – SUPPORT FOR EVICTION AND UTILITY SHUT-OFF MORATORIUMS DURING PUBLIC HEALTH EMERGENCIES

HOD ACTION: ADOPT AS AMENDED
RESOLVED, That our American Medical Association advocate for policies that prevent evictions during public health emergencies (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for prevention of termination of life-essential utilities during public health emergencies. (Directive to Take Action)

Adopted with Title Change: Support for the Prevention of Eviction and the Termination of Life-Essential Utility Services during Public Health Emergencies

RESOLUTION 415 – SUPPORT PUBLIC HEALTH APPROACHES FOR THE PREVENTION AND MANAGEMENT OF CONTAGIOUS DISEASES IN CORRECTIONAL FACILITIES

HOD ACTION: SUBSTITUTE RESOLUTION 404 ADOPTED IN LIEU OF RESOLUTION 404 AND RESOLUTION 415

RESOLVED, That our American Medical Association, in collaboration with state and national medical specialty societies and other relevant stakeholders, advocate for the improvement of conditions of incarceration in all correctional and immigrant detention facilities to allow for the implementation of evidence-based COVID-19 infection prevention and control guidance (Directive to Take Action); and be it further

RESOLVED, That our American Medical Association advocate for adequate access personal protective equipment and SARS-CoV-2 testing kits, sanitizing and disinfection equipment for correctional and detention facilities (Directive to Take Action); and be it further

RESOLVED, That our American Medical Association advocate for humane and safe quarantine protocols for individuals who are incarcerated or detained that test positive for or are exposed to SARS-CoV-2, or other contagious respiratory pathogens, (Directive to Take Action); and be it further

RESOLVED, That our American Medical Association support expanded data reporting, to include testing rates and demographic breakdown for SARS-CoV-2 and other contagious infectious disease cases and deaths in correctional and detention facilities (Directive to Take Action); and be it further

RESOLVED, That our American Medical Association recognizes that detention center and correctional workers, incarcerated persons and detained immigrants are at high-risk for COVID-19 infection and therefore should be prioritized in received access to safe, effective COVID-19 vaccine in the initial phases of distribution, and that this policy will be shared with Advisory Committee on Immunization Practices for consideration in making their final recommendations on COVID-19 vaccine allocation. (Directive to Take Action)

RESOLUTION 416 – SUPPORT FOR VOTE-BY-MAIL

HOD ACTION: NOT CONSIDERED, WILL TRANSMIT AT A FUTURE MEETING