

**MEMORIAL RESOLUTIONS  
ADOPTED UNANIMOUSLY**

**Duane M. Cady, MD**  
Introduced by New York

Whereas, It is with deepest regret that we mark the passing of our esteemed colleague, mentor and friend Duane M. Cady, MD, on August 3; and

Whereas, Dr. Duane Cady served in the United States Army as a Captain during a tour of duty in Vietnam, and

Whereas, Dr. Cady served as President of the Onondaga County Medical Society, and President of the Medical Society of the State of New York from 1997-1998, he was on the Board of Trustees of the State Medical Society starting in 1999 and was a member of the New York Delegation to the AMA from 1993 to 1999; and

Whereas, Dr. Cady was elected to the AMA Council on Medical Service in 1996 and to the AMA Board of Trustees in 1999, serving as Chairman of the Board of Trustees of the American Medical Association from 2005 to 2006; and

Whereas, Dr. Cady practiced general surgery in Syracuse, New York, for over 30 years until his retirement in 1998, and

Whereas, Dr. Cady was an advocate for professionalism and a leading figure in medical liability reform, serving on the Executive Committee and Board of the Medical Liability Mutual Insurance Company (MLMIC) for many years; and

Whereas, Dr. Cady was a generous mentor and teacher, making healthcare better for patients and our profession, and

Whereas, Dr. Cady was generous with his time and talents, volunteering for many local organizations, schools and his church; and

Whereas, Dr. Cady was devoted to his wife of 65 years, Joyce, his family of five children, two of whom are also physicians, his 10 grandchildren and 2 great grandchildren; and

Whereas, Dr. Duane Cady will be deeply missed; therefore be it

RESOLVED, That this House of Delegates of the American Medical Association express its sorrow at the passing of our dear friend and esteemed colleague, and that this resolution be made part of the proceedings of the November 2020 Special Meeting of the House of Delegates.

**Alfred C. Cox, MD**  
Introduced by Indiana

Whereas, Dr. Alfred C. Cox passed from this life on June 9, 2020; and

Whereas, Dr. Alfred C. Cox was a devoted husband to his wife Ellaine; and

Whereas, Dr. Alfred C. Cox was a devoted father, grandfather, brother, and uncle to many; and

Whereas, Dr. Alfred C. Cox unselfishly devoted his gifts as a healer to the citizens of St. Joseph County for over fifty years; and

Whereas, Dr. Alfred C. Cox unselfishly devoted a portion of his career championing the causes of his fellow physicians through his involvement in the St. Joseph County Medical Society, the 13th District Medical Society, the Indiana State Medical Association, and the American Medical Association; and

Whereas, Dr. Alfred C. Cox served many leadership roles in the St. Joseph Medical Society and the 13th District Medical Society; and

Whereas, Dr. Alfred C. Cox served many leadership roles in the Indiana State Medical Association and the American Medical Association including, but not limited to ISMA President and AMA Delegate; and

Whereas, Dr. Alfred C. Cox was an inspiration and mentor to many of those who currently serve in leadership of the St. Joseph County Medical Society, the 13th District Medical Society, the Indiana State Medical Association, and the American Medical Association; therefore, be it

RESOLVED, That our American Medical Association recognize the significant contributions of Dr. Alfred C. Cox over the course of his distinguished career; and be it further

RESOLVED, That our AMA extend its sincerest condolences to the family, friends and colleagues of Dr. Alfred C. Cox.

**Marvin S. Kaplan, MD**  
Introduced by California

Whereas, The California Medical Association lost a respected and valued member when Marvin S. Kaplan MD, passed away on June 10, 2020; and

Whereas, Dr. Marvin S. Kaplan served as an active member of the Los Angeles County Medical Association (LACMA) and the California Medical Association (CMA) for 34 years; and

Whereas, Dr. Marvin S. Kaplan was chair of the Los Angeles County Medical Association Delegation in 2016 and 2017; and

Whereas, Dr. Marvin S. Kaplan actively served in the LACMA Delegation to the CMA House of Delegates and the California Delegation to the AMA House of Delegates; and

Whereas, Dr. Marvin S. Kaplan was awarded LACMA's Lifetime Service Award in 2016; and

Whereas, Dr. Marvin S. Kaplan received his medical degree from the University of Illinois College of Medicine; and

Whereas, Dr. Marvin S. Kaplan served as a surgeon in the U.S. Air Force Medical Corps; and

Whereas, Dr. Marvin S. Kaplan continued to serve as a Reserve Flight Surgeon during residency; and

Whereas, Dr. Marvin S. Kaplan has practiced general surgery in LA County since 1965; and

Whereas, Dr. Marvin S. Kaplan held dual appointments at the University of California Irvine's School of Medicine as an academic researcher and at the Veteran's Affairs Long Beach Hospital as a founding member of the surgical staff; and

Whereas, Dr. Marvin S. Kaplan practiced medicine at Doctors Hospital of Lakewood, Long Beach Community Hospital and Long Beach Memorial Hospital; and

Whereas, Dr. Marvin S. Kaplan volunteered at Harbor-UCLA Medical Center where he served as a Chair of the Research and Education Institute (REI); and

Whereas, Dr. Marvin S. Kaplan was an active member of synagogues including Congregation B'nai Israel, Bat Yahm and Temple Sharon; and

Whereas, Dr. Marvin S. Kaplan was dedicated to improving health care outcomes for the patients and communities he served and was a mentor and educator for countless students; therefore be it

RESOLVED, That our American Medical Association House of Delegates recognize with great admiration and appreciation the outstanding contributions made by Marvin S. Kaplan, MD, to the medical profession, his associations, his colleagues, his community, his patients, and extends its sincerest condolences to his friends and family; and be it further

RESOLVED, That our AMA convey this resolution as well as its deepest sympathy to Dr. Marvin S. Kaplan's family.

**David B. L. Meza, III, MD**

Introduced by New York

Whereas, It is with profound sadness that Medical Society of the State of New York reports the passing of David B. L. Meza III, M. D. on April 22, 2020; and

Whereas, Doctor Meza was a member of the Medical Society of the County of Orleans and the Medical Society of the State of New York from 1967 to 2020; and

Whereas, Doctor Meza received his medical degree from the Universite De Geneve Faculte De Medecine in 1960 and completed his Internship at the New York Polyclinic Medical School and Hospital in New York City, and his OBGYN Residency at Maimonides Hospital; and

Whereas, Doctor Meza served on the Board of Directors of the Empire State Medical, Scientific and Educational Foundation for 30 years, most notably as President for the last 20; and

Whereas, He served as Delegate to the American Medical Peer Review Association, served on many committees within the Medical Society of the State of New York, and held many positions of leadership, including as Councilor and the Board of Trustees; and

Whereas, Doctor Meza was a member of the American Medical Association, the Buffalo Academy of Medicine; the Buffalo Gynecologic and Obstetric Society, the American Association of Gynecologic Laparoscopists; the American Fertility Society, the Gynecologic Urology Society, the New York Academy of Sciences, the International Correspondence Society of Obstetricians & Gynecologists, and the Health Systems Agency Western New York Subarea Council; and

Whereas, Doctor David Meza was a member of the New York Delegation to the AMA from 1988 to 2007; and

Whereas, Doctor Meza was a devoted husband to his wife of over five years, Donna Marie; therefore be it

RESOLVED, That our American Medical Association express its sincere sorrow at the passing of David B. L. Meza III, M.D., and that this resolution be made part of the proceedings of this House.

**Michael Neill Moody, MD**

Introduced by Arkansas

Whereas, We lost a cherished member of our medical family with the passing of Michael (Mike) Neill Moody, MD, on December 15, 2019, bringing to a close, 45 years of devotion to his patients and family and a life full of joy and good spirit; and

Whereas, Dr. Moody received his MD degree from the University of Arkansas for Medical Sciences in 1972 and then became one of the first four graduates of the UAMS family practice residency program; and

Whereas, Dr. Moody's love of his profession and dedication to improving the lives of rural Arkansans led him to a lifetime of practice in his childhood home of Salem, Arkansas; and

Whereas, We, the members of the Arkansas Medical Society, have lost one of our most dedicated leaders as evidenced by Dr. Moody having served in numerous positions throughout his career including Secretary and President, as well

as chairing the Legislative Committee, Political Action Committee, Nominating Committee and Annual Session Committee; and

Whereas, Dr. Moody served as an alternate delegate and delegate to the American Medical Association House of Delegates from 1998 to 2019; and

Whereas, Dr. Moody's dedication to family practice led him to become a leader in the Arkansas Academy of Family Physicians, serving as their President in 1991 as well as chair of their Legislative Committee, Rural Health Committee and a Delegate to the American Academy of Family Physicians; and

Whereas, Dr. Moody spent many years being the de facto "doctor on duty" at the Arkansas State Capitol, always willing to help someone in need and always being available to provide insight and counsel to our governmental affairs staff; and

Whereas, Dr. Moody believed strongly that being a physician also meant serving society as a whole and particularly his beloved State of Arkansas. His years of service include serving on the Arkansas Health Services Commission, Governor Bill Clinton's Task Force on Rural Hospitals, Governor Jim Guy Tucker's Task Force on Health Care Reform, and eight years on the Arkansas State Board of Health; and

Whereas, Mike's passing leaves behind shoes that can never be filled, laughter that can no longer be heard, Razorback seats that will sit empty, and family and friends that will miss his presence; therefore be it

RESOLVED, That our American Medical Association House of Delegates join us in saying goodbye to our friend and colleague, Michael Neill Moody, MD, and express its gratitude for a life of service to his patients, the State of Arkansas, and our profession.

**Robert S. Rigolosi, MD**  
Introduced by New Jersey

Whereas, We lost a cherished member of our medical family with the passing of Robert (Bob) S. Rigolosi, MD on March 28, 2020 and he is immensely missed by his family, friends, patients and colleagues; and

Whereas, Most people knew Dr. Robert Rigolosi as a "kidney doctor", his patients knew him as an advocate, healer and guardian; and

Whereas, His colleagues knew Dr. Robert Rigolosi as an innovator who brought dialysis to Northern Bergen County and established criteria for dialysis; and

Whereas, Holy Name Medical Center knew Dr. Robert Rigolosi as an esteemed member of the medical staff for over 50 years, a former President of the Medical Staff, a board member, a member of the Foundation Board of Trustees and a major benefactor; and

Whereas, In 2017, the dialysis unit at Holy Name Medical Center was renamed The Robert S. Rigolosi, MD Dialysis Center, honoring Bob as one of the pioneers of kidney treatment during the 1960s; and

Whereas, Widely published, Dr. Robert Rigolosi was a member of the Editorial Advisory Board of Renal & Urology News, and held office in numerous professional societies; and

Whereas, Recognized in the field of nephrology on both local and national levels, Dr. Robert Rigolosi received numerous awards and accolades throughout his career; and

Whereas, The Medical Society of New Jersey knew him as a leader. Dr. Robert Rigolosi was the 210th President (2002-2003), and while President he organized a march on Trenton with 8,000 physicians objecting the soaring cost of medical liability insurance; and

Whereas, At the AMA Dr. Robert Rigolosi was a well-respected member serving from 1997 until 2015 and as MSNJ Delegation Chair from 2009 – 2015; and

Whereas, As a young man, Dr. Robert Rigolosi started his life as a boxer, he used those fighting skills throughout his life and we were lucky that he fought for his patients, MSNJ, the AMA and the medical profession; therefore be it

RESOLVED, That our American Medical Association House of Delegates join us in saying farewell to our friend and colleague, Robert (Bob) S. Rigolosi, MD, and express gratitude for a life of service to his patients and our profession.

**Grant V. Rodkey, MD**

Introduced by Massachusetts

Whereas, Grant V. Rodkey, MD was born on November 17, 1917 and passed away on January 22, 2020 at 102; and

Whereas, Dr. Rodkey was a World War II Veteran, retiring as a Major in the Army; and

Whereas, Dr. Rodkey graduated from Harvard Medical School on June 1, 1943; and

Whereas, Dr. Rodkey, after a 40-year career at MGH, joined the VA hospital in Jamaica Plain in 1993 as a full-time surgeon; and

Whereas, Dr. Rodkey strongly believed in the VA Health Care System and lobbied tirelessly for the VA; and

Whereas, Dr. Rodkey, following the merger of the Jamaica Plain VA and the West Roxbury VA, was appointed Chief of general surgery for the VA Boston Health Care System in 2002 and held that position until 2004; and

Whereas, Dr. Rodkey joined the Massachusetts Medical Society (MMS) on December 28, 1949, became a delegate in 1961 and served as President of the Society from 1979-1980; and

Whereas, Dr. Rodkey was a member and represented the MMS as a delegate to the AMA for years; and

Whereas, Dr. Rodkey was the first Chair of the AMA/Specialty Society Relative Value Scale Update Committee (RUC); and

Whereas, Dr. Rodkey is honored each year through the MMS' Grant V. Rodkey, MD, Award which recognizes a physician who has made significant contributions to medical students, both in the hospital and in organized medicine; and

Whereas, Dr. Rodkey was a friend and mentor to many, the go to person for advice and consultation in every aspect of medicine and life and his biggest joy was his interaction with people in general and students and residents in particular; and

Whereas, Dr. Rodkey, despite an illustrious career, remained a humble person with a story and a piece of advice tailored to every person and every situation; and

Whereas, Dr. Rodkey will be remembered for his wit, wisdom, optimism, and dedication; therefore be it

RESOLVED, That our American Medical Association note with great sadness the passing of its valued member, friend, and colleague, Grant V. Rodkey, MD, with thankfulness and gratitude for the gift of his life, friendship, and medical contributions.

## RESOLUTIONS

The Resolution Committee reviewed each resolution submitted for the Special Meeting and recommended that a resolution be considered or not considered based on its urgency and priority. The Resolution Committee recommended that the following resolutions not be considered, and the House of Delegates adopted those recommendations: 1, 2, 3, 4, 6, 9, 102, 103, 104, 106, 107, 108, 109, 110, 111, 112, 113, 115, 201, 204, 207, 208, 209, 210, 214, 215, 216, 217, 301, 302, 303, 304, 305, 308, 310, 401, 402, 403, 405, 416, 417, 501, 502, 503, 504, 505, 506, 507, 510, 601, 603, 604, 605, 701, 702, 703, 704, 705, 706, 707, 708, 709, and 711.

Alternate resolutions are considered to have been introduced by the reference committee.

### REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION & BYLAWS

#### 5. RACISM AS A PUBLIC HEALTH THREAT Introduced by Medical Student Section

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

**HOD ACTION: ADOPTED AS FOLLOWS**  
*See Policy H-65.952*

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 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 health equity, and a barrier to appropriate medical care; 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; 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 the causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism; and how to prevent and ameliorate the health effects of racism; and be 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 to prevent or repair them; and be it further

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

#### 7. ACCESS TO CONFIDENTIAL HEALTH CARE SERVICES FOR PHYSICIANS AND TRAINEES

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

**HOD ACTION: FOLLOWING ALTERNATE RESOLUTION ADOPTED**  
*See Policy D-405.978*

RESOLVED, That our American Medical Association advocate that: (1) physicians, medical students and all members of the health care team (a) maintain self-care, and (b) are supported by their institutions in their self-care efforts, and (c) in order to maintain the confidentiality of care have access to affordable health care, including mental and physical health care, outside of their place of work or education; (2) employers support access to mental and physical health

care, including but not limited to providing access to out-of-network in-person and / or via telemedicine, thereby reducing stigma, eliminating discrimination, and removing other barriers to treatment; and be it further

RESOLVED, That our AMA advocate for best practices to ensure physicians, medical students and all members of the health care team have access to appropriate behavioral, mental, primary, and specialty health care and addiction services.

### **8. DELEGATE APPORTIONMENT DURING COVID-19 PANDEMIC CRISIS**

**Introduced by Mississippi, Alabama, Florida, South Carolina, West Virginia, Puerto Rico, Tennessee, New Jersey, Oklahoma, Virginia, Georgia, Louisiana, Kentucky, North Carolina, District of Columbia**

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

**HOD ACTION: ADOPTED**

*See Council on Constitution and Bylaws Report 4*

RESOLVED, That our American Medical Association extend the current grace period from one year to two years for losing a delegate from a state medical or national medical specialty society until the end of 2022

### **10. RACIAL ESSENTIALISM IN MEDICINE**

**Introduced by Minority Affairs Section**

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

**HOD ACTION: ADOPTED AS FOLLOWS**

*See Policy D-350.981*

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

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

RESOLVED, That our AMA collaborate with the AAMC, AACOM, NBME, NBOME, ACGME and other appropriate stakeholders, including minority physician organizations and content experts, to identify and address aspects of medical education and board examinations which may perpetuate teachings, assessments, and practices that reinforce institutional and structural racism; and be it further

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

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

**11. ELIMINATION OF RACE AS A PROXY FOR ANCESTRY, GENETICS, AND BIOLOGY IN  
MEDICAL EDUCATION, RESEARCH, AND CLINICAL PRACTICE  
Introduced by Minnesota**

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

**HOD ACTION:      ADOPTED**  
*See Policy H-65.953*

RESOLVED, That our American Medical Association recognize that race is a social construct and is distinct from ethnicity, genetic ancestry, or biology; and be it further

RESOLVED, That our AMA support ending the practice of using race as a proxy for biology or genetics in medical education, research, and clinical practice; and be it further

RESOLVED, That our AMA encourage undergraduate medical education, graduate medical education, and continuing medical education programs to recognize the harmful effects of presenting race as biology in medical education and that they work to mitigate these effects through curriculum change that: (1) demonstrates how the category “race” can influence health outcomes; (2) that supports race as a social construct and not a biological determinant and (3) presents race within a socio-ecological model of individual, community and society to explain how racism and systemic oppression result in racial health disparities; and be it further

RESOLVED, That our AMA recommend that clinicians and researchers focus on genetics and biology, the experience of racism, and social determinants of health, and not race, when describing risk factors for disease.

**REFERENCE COMMITTEE A**

**101. END OF LIFE CARE PAYMENT  
Introduced by New York**

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

**HOD ACTION:      REFERRED**

RESOLVED, That our American Medical Association petition the Centers for Medicare & Medicaid Services to allow hospice patients to cover the cost of housing (“room and board”) as a patient in a nursing home or assisted living facility; and be it further

RESOLVED, That our AMA advocate that patients be allowed to use their skilled nursing home benefit while receiving hospice services.

**105. ACCESS TO MEDICATION**

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

**HOD ACTION:      FOLLOWING ALTERNATE RESOLUTION ADOPTED**  
*See Policy H-120.920*

RESOLVED, That our American Medical Association advocate against pharmacy practices that interfere with patient access to medications by refusing or discouraging legitimate requests to transfer prescriptions to a new pharmacy, to include transfer of prescriptions from mail-order to local retail pharmacies.



**114. PHYSICIAN PAYMENT ADVOCACY FOR ADDITIONAL WORK AND EXPENSES INVOLVED IN TREATING PATIENTS DURING THE COVID-19 PANDEMIC AND FUTURE PUBLIC HEALTH EMERGENCIES**

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

**HOD ACTION: ADOPTED AS FOLLOWS  
TITLE CHANGED  
See Policy D-390.947**

RESOLVED, That our American Medical Association work with interested national medical specialty societies and state medical associations to advocate for regulatory action on the part of the Centers for Medicare & Medicaid Services to implement a professional services payment enhancement, similar to the HRSA COVID-19 Uninsured Program, to be drawn from additional funds appropriated for the public health emergency to help recognize the additional uncompensated costs associated with COVID-19 incurred by physicians during the COVID-19 Public Health Emergency; and be it further

RESOLVED, That our AMA work with interested national medical specialty societies and state medical associations to continue to advocate that the Centers for Medicare & Medicaid Services and private health plans compensate physicians for the additional work and expenses involved in treating patients during a public health emergency, and that any new payments be exempt from budget neutrality; and be it further

RESOLVED, That our AMA encourage interested parties to work in the CPT Editorial Panel and AMA/Specialty Society RVS Update Committee (RUC) processes to continue to develop coding and payment solutions for the additional work and expenses involved in treating patients during a public health emergency.

**REFERENCE COMMITTEE B**

**202. CARES ACT EQUITY AND LOAN FORGIVENESS IN THE MEDICARE ACCELERATED PAYMENT PROGRAM  
Introduced by New York**

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

**HOD ACTION: ADOPTED AS FOLLOWS  
See Policies D-305.953 and D-385.951**

RESOLVED, That our AMA and the federation of medicine work to improve and expand various federal stimulus programs (e.g., the CARES Act and MAPP) in order to assist physicians in response to the Covid-19 pandemic, including:

Restarting the suspended Medicare Advance payment program, including significantly reducing the re-payment interest rate and lengthening the repayment period;

Expanding the CARES Act health care provider relief pool and working to ensure that a significant share of the funding from this pool is made available to physicians in need regardless of the type of patients treated by those physicians; and

Reforming the Paycheck Protection Program, to ensure greater flexibility in how such funds are spent and lengthening the repayment period; and be it further

RESOLVED, That, in the setting of the COVID-19 pandemic, our AMA advocate for additional financial relief for physicians to reduce medical school educational debt.

### 203. COVID-19 EMERGENCY AND EXPANDED TELEMEDICINE REGULATIONS

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

**HOD ACTION: FOLLOWING ALTERNATE RESOLUTION ADOPTED  
IN LIEU OF RESOLUTION 205  
ADDITIONAL RESOLVE ELEMENTS REFERRED**  
*See Policy D-480.963*

RESOLVED, That our AMA continue to advocate for the widespread adoption of telehealth services in the practice of medicine for physicians and physician-led teams post SARS-COV-2; and be it further

RESOLVED, That our AMA advocate that the Federal government, including the Centers for Medicare & Medicaid Services (CMS) and other agencies, state governments and state agencies, and the health insurance industry, adopt clear and uniform laws, rules, regulations, and policies relating to telehealth services that

1. provide equitable coverage that allows patients to access telehealth services wherever they are located;
2. provide for the use of accessible devices and technologies, with appropriate privacy and security protections, for connecting physicians and patients; and be it further

RESOLVED, That our AMA advocate for equitable access to telehealth services, especially for at-risk and under-resourced patient populations and communities, including but not limited to supporting increased funding and planning for telehealth infrastructure such as broadband and internet-connected devices for both physician practices and patients; and be it further

RESOLVED, that our AMA support the use of telehealth to reduce health disparities and promote access to health care.

The following additional elements were proposed for the second resolve. Paragraphs a and b were referred. Paragraphs c and d were referred for decision.

- a. promote continuity of care by preventing payors from using cost-sharing or other policies to prevent or disincentivize patients from receiving care via telehealth from the physician of the patient's choice;
- b. ensure qualifications of physicians duly licensed in the state where the patient is located to provide such services in a secure environment.
- c. provide equitable payment for telehealth services that are comparable to in-person services;
- d. promote continuity of care by allowing physicians to provide telehealth services, regardless of current location, to established patients with whom the physician has had previous face-to-face professional contact.

### 205. TELEHEALTH POST SARS-COV-2

**Introduced by Virginia, American Association of Clinical Urologists, West Virginia, North Carolina, New Jersey, South Carolina, Mississippi, Louisiana, American Urological Association, Maryland**

**Resolution 205 was considered with Resolution 203. See Resolution 203.**

RESOLVED, That our American Medical Association advocate to facilitate the widespread adoption of telehealth services in the practice of medicine for physicians or physician-led teams post SARS-COV-2 (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage the Centers for Medicare and Medicaid Services, health insurance industry, and Federal/State government agencies to adopt uniform, clear regulations as well as equitable coverage and reimbursement mechanisms that promote physician-led telehealth services (New HOD Policy); and be it further

RESOLVED, That our AMA advocate for equitable access to telehealth services especially for the most at risk and under resourced patient populations and communities.

**206. STRENGTHENING THE ACCOUNTABILITY OF HEALTH CARE REVIEWERS**  
**Introduced by Georgia**

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

**HOD ACTION: ADOPTED AS FOLLOWS**  
*See Policies H-285.915, H-320.968 and D-185.977*

That our American Medical Association continue to advocate that all health plans, including self-insured plans, be subject to state prior authorization reforms that align with AMA policy; and be it further

RESOLVED, That Policies H-285.915 and H-320.968 be reaffirmed.

**211. CREATING A CONGRESSIONALLY MANDATED BIPARTISAN COMMISSION  
 TO EXAMINE THE U.S. PREPARATIONS FOR AND RESPONSE TO THE  
 COVID-19 PANDEMIC TO INFORM FUTURE EFFORTS**  
**Introduced by American Academy of Family Physicians, American College of Obstetricians and  
 Gynecologists, American College of Physicians, Infectious Diseases Society of America, Oregon**

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

**HOD ACTION: ADOPTED AS FOLLOWS**  
*See Policy D-440.923*

RESOLVED, That our American Medical Association advocate for passage of federal legislation to create a congressionally-mandated bipartisan commission composed of scientists, physicians with expertise in pandemic preparedness and response, public health experts, legislators and other stakeholders, which is to examine the U.S. preparations for and response to the COVID 19 pandemic, in order to inform and support future public policy and health systems preparedness; and be it further

RESOLVED, That, in advocating for legislation to create a congressionally-mandated bipartisan commission, our AMA seek to ensure key provisions are included, namely that the delivery of a specific end product (i.e., a report) is required by the commission by a certain period of time, and that adequate funding be provided in order for the commission to complete its deliverables.

**212. COPAY ACCUMULATOR POLICIES**

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

**HOD ACTION: POLICY D-110.986 AMENDED AS FOLLOWS  
 IN LIEU OF RESOLUTION 212**

Our AMA will develop model state legislation regarding Co-Pay Accumulators for all pharmaceuticals, biologics, medical devices, and medical equipment, and support federal and state legislation or regulation that would ban co-pay accumulator policies, including in federally regulated ERISA plans.

**213. PHARMACIES TO INFORM PHYSICIANS WHEN LOWER COST MEDICATION  
OPTIONS ARE ON FORMULARY**

**Introduced by American College of Allergy, Asthma and Immunology**

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

**HOD ACTION: REFERRED**

RESOLVED, That our American Medical Association support legislation or regulatory action to require that in the event a patient cannot afford the medication prescribed, either because it is not on the formulary or it is priced higher than other medications on the formulary, the pharmacist must communicate to the prescriber a medication option in the same class prescribed with the lowest out-of-pocket cost to the patient.

**218. CRISIS PAYMENT REFORM ADVOCACY**

**Introduced by Organized Medical Staff Section**

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

**HOD ACTION: ADOPTED AS FOLLOWS**

*See Policy D-405.979*

RESOLVED, That our American Medical Association continue to promote national awareness of the loss of physician medical practices and patient access to care due to COVID-19 and continue to advocate for reforms that support and sustain physician medical practices.

**REFERENCE COMMITTEE C**

**306. RETIREMENT OF THE NATIONAL BOARD OF MEDICAL EXAMINERS STEP 2 CLINICAL  
SKILLS EXAM FOR US MEDICAL GRADUATES: CALL FOR EXPEDITED  
ACTION BY THE AMERICAN MEDICAL ASSOCIATION**

**Introduced by North Dakota, South Dakota, Iowa**

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

**HOD ACTION: ADOPTED AS FOLLOWS**

*See Policies D-275.950 and D-295.988*

RESOLVED, That our American Medical Association take immediate, expedited action to encourage the National Board of Medical Examiners (NBME), Federation of State Medical Boards (FSMB), and National Board of Osteopathic Medical Examiners (NBOME) to eliminate centralized clinical skills examinations used as a part of state licensure, including the USMLE Step 2 Clinical Skills Exam and the Comprehensive Osteopathic Medical Licensing Examination (COMLEX) Level 2-Performand Evaluation Exam; and be it further

RESOLVED, That our AMA, in collaboration with the Educational Commission for Foreign Medical Graduates (ECFMG) advocate for and equivalent, equitable, and timely pathway for international medical graduates to demonstrate clinical skills; and be it further

RESOLVED, That our AMA strongly encourage all state delegations in the AMA House of Delegates and other interested member organizations of the AMA to engage their respective state medical licensing boards, the Federation of State Medical Boards, their medical schools and other interested credentialing bodies to encourage the elimination of these centralized, costly and low-value exams; and be it further

RESOLVED, That our AMA advocate that any replacement examination mechanisms be instituted immediately in lieu of resuming existing USMLE Step 2-CS and COMLEX Level 2-PE examinations when the COVID-19 restrictions subside; and be it further

RESOLVED, That Policy H-295.988 be reaffirmed.

### **307. USMLE AND COMLEX EXAMINATION FAILURES DURING THE COVID-19 PANDEMIC**

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

**HOD ACTION: FOLLOWING ALTERNATE RESOLUTION ADOPTED**  
*See Policy D-275.951*

RESOLVED, That our AMA advocate to the National Board of Medical Examiners (NBME) and National Board of Osteopathic Medical Examiners (NBOME) that students at allopathic and osteopathic schools of medicine and residents in accredited residency programs in the United States scheduled between March 1, 2020 and May 31, 2021 to sit for any examination step/level in the United States Medical Licensing Examination (USMLE) or the Comprehensive Osteopathic Medical Licensing Examination (COMLEX) sequence be allowed the opportunity to be re-examined, if they failed one of these examinations, one time at no additional charge to the student or resident.

### **309. PRESERVE AND INCREASE GRADUATE MEDICAL EDUCATION FUNDING** **Introduced by Michigan**

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

**HOD ACTION: ADOPTED AS FOLLOWS**  
*See Policy H-310.916*

RESOLVED, That our American Medical Association advocate to appropriate federal agencies and other relevant stakeholders to oppose the diversion of direct and indirect funding away from ACGME-accredited graduate medical education.

### **REFERENCE COMMITTEE D**

#### **404. SUPPORT PUBLIC HEALTH APPROACHES FOR THE PREVENTION AND MANAGEMENT OF CONTAGIOUS DISEASES IN CORRECTIONAL AND DETENTION FACILITIES**

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

**HOD ACTION: FOLLOWING ALTERNATE RESOLUTION ADOPTED**  
**IN LIEU OF RESOLUTION 415**  
*See Policies H-430.979 and H-430.989*

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; and be it further

RESOLVED, That our American Medical Association advocate for adequate access to personal protective equipment and SARS-CoV-2 testing kits, sanitizing and disinfecting equipment for correctional and detention facilities; 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; 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; 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 receiving access to safe, effective COVID-19 vaccine in the initial phases of distribution, and that this policy will be shared with the Advisory Committee on Immunization Practices for consideration in making their final recommendations on COVID-19 vaccine allocation; and be it further

RESOLVED, That Policy H-430.989 be amended by addition and deletion to read as follows:

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

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 other 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.

#### 406. FACE MASKING IN HOSPITALS DURING FLU SEASON

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

**HOD ACTION: FOLLOWING ALTERNATE RESOLUTION ADOPTED**  
*See Policy H-440.811*

RESOLVED, That our American Medical Association: (1) encourage the CDC to study and issue guidance on the most effective infection prevention and control strategies to reduce the spread of influenza in hospital settings, including immunization, source control, and other public health strategies and (2) encourage the National Institute for Occupational Safety and Health and other relevant federal agencies to study the comparative disease-reduction effectiveness of various types of facemasks and respirators to inform future infection control guidance.

#### 407. FULL COMMITMENT BY OUR AMA TO THE BETTERMENT AND STRENGTHENING OF PUBLIC HEALTH SYSTEMS

**Introduced by American College of Preventive Medicine, American College of Occupational and Environmental Medicine, Aerospace Medical Association, American Association of Public Health Physicians, American Society of Addiction Medicine, Academy of Physicians in Clinical Research, Iowa**

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

**HOD ACTION: ADOPTED**  
*See Policy D-440.922*

RESOLVED, That our American Medical Association champion the betterment of public health by enhancing advocacy and support for programs and initiatives that strengthen public health systems, to address pandemic threats, health inequities and social determinants of health outcomes; and be it further

RESOLVED, That our AMA study the most efficacious manner by which our AMA can continue to achieve its mission of the betterment of public health by recommending ways in which to strengthen the health and public health system infrastructure.

**408. AN URGENT INITIATIVE TO SUPPORT COVID-19 VACCINATION PROGRAMS**  
**Introduced by District of Columbia**

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

**HOD ACTION:     ADOPTED AS FOLLOWS**  
**TITLE CHANGED**  
*See Policy D-440.921*

RESOLVED, That our AMA institute a program to promote the integrity of a COVID-19 vaccination program by: (1) educating physicians on speaking with patients about COVID-19 vaccination, bearing in mind the historical context of “experimentation” with vaccines and other medication in communities of color, and providing physicians with culturally appropriate patient education materials; (2) educating the public about the safety and efficacy of COVID-19 vaccines by countering misinformation and building public confidence; (3) forming a coalition of health care and public health organizations, inclusive of those respected in communities of color, committed to developing and implementing a joint public education program promoting the facts about, promoting the need for, and encouraging the acceptance of COVID-19 vaccination; and (4) supporting ongoing monitoring of COVID-19 vaccines to ensure that the evidence continues to support safe and effective use of vaccines among recommended populations.

**409. PROTESTOR PROTECTIONS**  
**Introduced by Medical Student Section**

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

**HOD ACTION:     REFERRED**

RESOLVED, That our American Medical Association 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.

**410. POLICING REFORM**  
**Introduced by Medical Student Section**

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

**HOD ACTION:      FOUR RESOLVES ADOPTED**  
**FOUR RESOLVES REFERRED**  
*See Policy H-65.954*

[Editor's note: The four resolves listed first were 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; 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; 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 legislation and regulations which promote trauma-informed, community-based safety practices.

[Editor's note: The following four resolves were referred.]

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.

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.

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.

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.

**411. SUPPORT FOR EVICTION AND UTILITY SHUT-OFF MORATORIUMS**  
**DURING PUBLIC HEALTH EMERGENCIES**

**Introduced by Medical Student Section**

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

**HOD ACTION:      ADOPTED**  
*See Policy D-440.920*

RESOLVED, That our American Medical Association 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.



**412. AVAILABILITY OF PERSONAL PROTECTIVE EQUIPMENT (PPE)**

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

**HOD ACTION: FOLLOWING ALTERNATE RESOLUTION ADOPTED  
IN LIEU OF RESOLUTION 414**  
*See Policy H-440.810*

RESOLVED, That our AMA affirm that the medical staff of each health care institution should be integrally involved in disaster planning, strategy and tactical management of ongoing crises; and be it further

RESOLVED, That our AMA support evidence-based standards and national guidelines for PPE use, reuse, and appropriate cleaning/decontamination during surge conditions; and be it further

RESOLVED, That our AMA advocate that it is the responsibility of health care facilities to provide sufficient personal protective equipment (PPE) for all employees and staff in the event of a pandemic, natural disaster, or other surge in patient volume or PPE need; and be it further

RESOLVED, That our AMA support physicians and health care professionals in being permitted to use their professional judgement and augment institution-provided PPE with additional, appropriately decontaminated, personally-provided personal protective equipment (PPE) without penalty; and be it further

RESOLVED, That our AMA support a physician's right to participate in public commentary addressing the adequacy of clinical resources and/or health and environmental safety conditions necessary to provide appropriate and safe care of patients and physicians during a pandemic or natural disaster; and be it further

RESOLVED, that our AMA work with the HHS Office of the Assistant Secretary for Preparedness and Response to gain an understanding of the PPE supply chain and ensure the adequacy of the Strategic National Stockpile for public health emergencies.

**413. PROTECTING PHYSICIANS AND OTHER HEALTHCARE WORKERS IN SOCIETY**  
**Introduced by Organized Medical Staff Section**

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

**HOD ACTION: ADOPTED AS FOLLOWS  
TITLE CHANGED**  
*See Policy H-515.950*

RESOLVED, That our American Medical Association acknowledge and act to reduce the incidence of antagonistic actions against physicians as well as other health care workers, including first responders and public health officials, outside as well as within the workplace, including physical violence, intimidating actions of word or deed, and cyber-attacks, particularly those which appear motivated simply by their identification as a health care worker; and be it further

RESOLVED, That our AMA educate the general public on the prevalence of violence and personal harassment against physicians as well as other health care workers, including first responders and public health officials, outside as well as within the workplace; and be it further

RESOLVED, That our AMA work with all interested stakeholders to improve safety of health care workers including first responders and public health officials and prevent violence to health care professionals.

**414. AVAILABILITY OF PERSONAL PROTECTIVE EQUIPMENT (PPE)  
Introduced by Resident and Fellow Section**

**Resolution 414 considered with Resolution 412. See Resolution 412.**

RESOLVED, That our American Medical Association advocate that it is the responsibility of healthcare facilities to provide sufficient personal protective equipment (PPE) for all employees and staff in the event of a pandemic, natural disaster, or other surge in patient volume or PPE need; and be it further

RESOLVED, That our AMA support minimum evidence-based standards and national guidelines for PPE use, reuse, and appropriate cleaning/decontamination during surge conditions; and be it further

RESOLVED, That our AMA advocate that physicians and healthcare professionals must be permitted to use their professional judgement and augment institution-provided PPE with additional, appropriately decontaminated, personally-provided PPE without penalty; and be it further

RESOLVED, That our AMA affirm that the medical staff of each health care institution should be meaningfully involved in disaster planning, strategy and tactical management of ongoing crises; and be it further

RESOLVED, That our AMA work with The Joint Commission, the American Nurses Credentialing Center, the Center for Medicare and Medicaid Services, and other regulatory and certifying bodies to ensure that credentialing processes for healthcare facilities include consideration of adequacy of PPE stores on hand as well as processes for rapid acquisition of additional PPE in the event of a pandemic; and be it further

RESOLVED, That our AMA study a physician's ethical duty to serve in a pandemic including but not limited to the following considerations:

1. The availability and adequacy of institution-supplied PPE and whether inadequate PPE modifies a physician's duty to act;
2. Whether a physician's duty to act is modified by the personal health of the physician and/or those with whom the physician has regular extended contact;
3. Whether a physician's duty to their personal and population safety allows them to speak with local and national media about the safety of their work environment as it relates to the risk it places on themselves, their immediate family and regular social contacts, and the public at large;
4. How medical students, residents, and fellows are affected in the setting of a pandemic in terms of their ethical obligation to care for patients, ramifications to their education, and the protections necessary given their vulnerable status; and
5. The ethical obligation of healthcare institutions and the federal government to protect the physical and emotional wellbeing of physicians and other healthcare workers during and after a pandemic.

**415. SUPPORT PUBLIC HEALTH APPROACHES FOR THE PREVENTION AND MANAGEMENT  
OF CONTAGIOUS DISEASES IN CORRECTIONAL FACILITIES  
Introduced by Medical Student Section**

**Resolution 415 was considered with Resolution 404. See Resolution 404.**

RESOLVED, That our American Medical Association 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:

- (a) Universally available screening, testing, contact tracing, and medical care to staff and individuals that are incarcerated,
- (b) Access to sanitizing equipment including, but not limited to, soap, hand sanitizer, and cleaning supplies,
- (c) Humane and safe quarantine protocol for individuals that test positive for or are exposed to highly contagious respiratory pathogens,
- (d) Adherence to use of personal protective equipment for incarcerated individuals and staff, and

- (e) Expanded data reporting, including testing rates and demographic breakdown of highly contagious infectious disease cases and deaths; and be it further

RESOLVED, That our AMA support efforts to decarcerate 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 amend Policy H-430.989 by insertion as follows:

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

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.

## REFERENCE COMMITTEE E

### 508. HOME INFUSION OF HAZARDOUS DRUGS

Introduced by Association for Clinical Oncology, American College of Rheumatology

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

#### HOD ACTION: ADOPTED AS FOLLOWS

*See Policy H-55.986*

RESOLVED, That our American Medical Association update its existing home infusion policy, H-55.986, “Home Chemotherapy and Antibiotic Infusions,” by addition and deletion to read as follows:

Our AMA (1) endorses the use of home injections and/or infusions of FDA approved drugs and group C drugs (including chemotherapy and/or antibiotic therapy) for appropriate patients under physicians’ recommendation and supervision; and (2) only considers extension of the use of home infusions for biologic agents, immune modulating therapy, and anti-cancer therapy as allowed under the public health emergency when circumstances are present such that the benefits to the patient outweigh the potential risks; (3) encourages CMS and/or other insurers to provide adequate reimbursement and liability protections for such treatment; and (2 4) supports educating legislators and administrators about the risks and benefits of such home infused antibiotics and supportive care treatments in terms of cost saving, increased quality of life and decreased morbidity, and about the need to provide ensure patient and provider safety when considering home infusions for such treatment as biologic, immune modulating, and anti-cancer therapy; and (5) advocates for access to such treatments by appropriate reimbursement policies for home infusions.

RESOLVED, That our AMA oppose any requirement by insurers for home administration of drugs, if in the treating physician’s clinical judgment it is not appropriate, or the precautions necessary to protect medical staff, patients and caregivers from adverse events associated with drug infusion and disposal are not in place; this includes withholding of payment for other settings.

**509. HYDROXYCHLOROQUINE AND COMBINATION THERAPIES – OFF-LABEL USE  
Introduced by Georgia**

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

**HOD ACTION: NOT ADOPTED  
POLICY H-120.988 REAFFIRMED**

RESOLVED, That our American Medical Association rescind its statement calling for physicians to stop prescribing hydroxychloroquine and chloroquine until sufficient evidence becomes available to conclusively illustrate that the harm associated with use outweighs benefit early in the disease course. Implying that such treatment is inappropriate contradicts AMA Policy H 120.988, “Patient Access to Treatments Prescribed by Their Physicians,” that addresses off label prescriptions as appropriate in the judgement of the prescribing physician; and be it further

RESOLVED, That our AMA rescind its joint statement with the American Pharmacists Association and American Society of Health System Pharmacists, and update it with a joint statement notifying patients that further studies are ongoing to clarify any potential benefit of hydroxychloroquine and combination therapies for the treatment of COVID-19; and be it further

RESOLVED, That our AMA reassure the patients whose physicians are prescribing hydroxychloroquine and combination therapies for their early-stage COVID-19 diagnosis by issuing an updated statement clarifying our support for a physician’s ability to prescribe an FDA-approved medication for off label use, if it is in her/his best clinical judgement, with specific reference to the use of hydroxychloroquine and combination therapies for the treatment of the earliest stage of COVID-19; and be it further

RESOLVED, That our AMA take the actions necessary to require local pharmacies to fill valid prescriptions that are issued by physicians and consistent with AMA principles articulated in AMA Policy H-120.988, “Patient Access to Treatments Prescribed by Their Physicians,” including working with the American Pharmacists Association and American Society of Health System Pharmacists.

[Editor’s note: The reference committee recommended that the resolution not be adopted and that Policy H-120.988 be reaffirmed; the House of Delegates adopted those actions.]

**REFERENCE COMMITTEE F**

**602. TOWARDS DIVERSITY AND INCLUSION: A GLOBAL NONDISCRIMINATION POLICY  
STATEMENT AND BENCHMARK FOR OUR AMA  
Introduced by Women Physicians Section**

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

**HOD ACTION: REFERRED FOR REPORT AT THE 2021 ANNUAL MEETING**

RESOLVED, That our American Medical Association adopt an overarching nondiscrimination policy on the basis of sex, color, creed, race, religion, disability, ethnic origin, national origin, sexual orientation, gender identity, age, or for any other reason unrelated to character, competence, ethics, professional status or professional activities that applies to members, employees and patients; and be it further

RESOLVED, That our AMA demonstrate its commitment to complying with laws, rules or regulations against discrimination on the basis of protected characteristics; and be it further

RESOLVED, That our AMA reaffirm Policy H-65.988, “Organizations Which Discriminate,” and Policy G-630.040, “Principles on Corporate Relationships,” in its overarching non-discrimination policy; and be it further

RESOLVED, That our AMA reaffirm Policy G-600.067, “References to Terms and Language in Policies Adopted to Protect Populations from Discrimination and Harassment”; and be it further

RESOLVED, That our AMA study the feasibility and need for a comprehensive business conduct standards policy to be fully integrated with the conflict of interest policy, and report back to the AMA House of Delegates within 18 months; and be it further

RESOLVED, That our AMA provide an update on its comprehensive diversity and inclusion strategy to the AMA House of Delegates within 24 months.

**606. ADOPTING THE USE OF THE MOST RECENT AND UPDATED EDITION OF THE AMA  
GUIDES TO THE EVALUATION OF PERMANENT IMPAIRMENT  
Introduced by International Academy of Independent Medical Evaluators, Maryland,  
American Academy of Physical Medicine and Rehabilitation**

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

**HOD ACTION: REFERRED**

RESOLVED, That our American Medical Association support the adoption of the most current edition of the AMA Guides in all jurisdictions in order to provide fair and consistent impairment evaluations for patients and claimants including injured workers.

**REFERENCE COMMITTEE G**

**710. A RESOLUTION TO AMEND THE AMA'S PHYSICIAN AND MEDICAL STAFF BILL OF RIGHTS  
Introduced by Virginia**

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

**HOD ACTION: REFERRED**

RESOLVED, That our American Medical Association amend Policy H-225.942, "Physician and Medical Staff Member Bill of Rights" by addition to read as follows:

H-225.942, "Physician and Medical Staff Member Bill of Rights"

Our AMA adopts and will distribute the following Medical Staff Rights and Responsibilities:

Preamble

The organized medical staff, hospital governing body and administration are all integral to the provision of quality care, providing a safe environment for patients, staff and visitors, and working continuously to improve patient care and outcomes. They operate in distinct, highly expert fields to fulfill common goals, and are each responsible for carrying out primary responsibilities that cannot be delegated.

The organized medical staff consists of practicing physicians who not only have medical expertise but also possess a specialized knowledge that can be acquired only through daily experiences at the frontline of patient care. These personal interactions between medical staff physicians and their patients lead to an accountability distinct from that of other stakeholders in the hospital. This accountability requires that physicians remain answerable first and foremost to their patients.

Medical staff self-governance is vital in protecting the ability of physicians to act in their patient's best interest. Only within the confines of the principles and processes of self-governance can physicians ultimately ensure that all treatment decisions remain insulated from interference motivated by commercial or other interests that may threaten high-quality patient care.

The AMA recognizes the responsibility to provide for the delivery of high quality and safe patient care, the provision of which relies on mutual accountability and interdependence with the health care organization's governing body, and relies on accountability and inter-dependence with government and public health agencies that regulate and administer to these organizations.

The AMA supports the right to advocate without fear of retaliation by the health care organization's administrative or governing body including the right to refuse work in unsafe situations without retaliation.

The AMA believes physicians should be continuously provided with the resources necessary to continuously improve patient care and outcomes and further be permitted to advocate for planning and delivery of such resources not only with the health agency but with supervising and regulating government agencies.

From this fundamental understanding flow the following Medical Staff Rights and Responsibilities:

I. Our AMA recognizes the following fundamental responsibilities of the medical staff:

- a. The responsibility to provide for the delivery of high-quality and safe patient care, the provision of which relies on mutual accountability and interdependence with the health care organizations governing body.
- b. The responsibility to provide leadership and work collaboratively with the health care organizations administration and governing body to continuously improve patient care and outcomes.
- c. The responsibility to participate in the health care organization's operational and strategic planning to safeguard the interest of patients, the community, the health care organization, and the medical staff and its members.
- d. The responsibility to establish qualifications for membership and fairly evaluate all members and candidates without the use of economic criteria unrelated to quality, and to identify and manage potential conflicts that could result in unfair evaluation.
- e. The responsibility to establish standards and hold members individually and collectively accountable for quality, safety, and professional conduct.
- f. The responsibility to make appropriate recommendations to the health care organization's governing body regarding membership, privileging, patient care, and peer review.

II. Our AMA recognizes that the following fundamental rights of the medical staff are essential to the medical staffs ability to fulfill its responsibilities:

- a. The right to be self-governed, which includes but is not limited to (i) initiating, developing, and approving or disapproving of medical staff bylaws, rules and regulations, (ii) selecting and removing medical staff leaders, (iii) controlling the use of medical staff funds, (iv) being advised by independent legal counsel, and (v) establishing and defining, in accordance with applicable law, medical staff membership categories, including categories for non-physician members.
- b. The right to advocate for its members and their patients without fear of retaliation by the health care organizations administration or governing body.
- c. The right to be provided with the resources necessary to continuously improve patient care and outcomes.
- d. The right to be well informed and share in the decision-making of the health care organization's operational and strategic planning, including involvement in decisions to grant exclusive contracts or close medical staff departments.
- e. The right to be represented and heard, with or without vote, at all meetings of the health care organizations governing body.
- f. The right to engage the health care organizations administration and governing body on professional matters involving their own interests.

III. Our AMA recognizes the following fundamental responsibilities of individual medical staff members, regardless of employment or contractual status:

- a. The responsibility to work collaboratively with other members and with the health care organizations administration to improve quality and safety.
- b. The responsibility to provide patient care that meets the professional standards established by the medical staff.
- c. The responsibility to conduct all professional activities in accordance with the bylaws, rules, and regulations of the medical staff.

- d. The responsibility to advocate for the best interest of patients, even when such interest may conflict with the interests of other members, the medical staff, or the health care organization.
  - e. The responsibility to participate and encourage others to play an active role in the governance and other activities of the medical staff.
  - f. The responsibility to participate in peer review activities, including submitting to review, contributing as a reviewer, and supporting member improvement.
- IV. Our AMA recognizes that the following fundamental rights apply to individual medical staff members, regardless of employment, contractual, or independent status, and are essential to each members ability to fulfill the responsibilities owed to his or her patients, the medical staff, and the health care organization:
- a. The right to exercise fully the prerogatives of medical staff membership afforded by the medical staff bylaws.
  - b. The right to make treatment decisions, including referrals, based on the best interest of the patient, subject to review only by peers.
  - c. The right to exercise personal and professional judgment in voting, speaking, and advocating on any matter regarding patient care or medical staff matters, without fear of retaliation by the medical staff or the health care organizations administration or governing body.
  - d. The right to be evaluated fairly, without the use of economic criteria, by unbiased peers who are actively practicing physicians in the community and in the same specialty.
  - e. The right to full due process before the medical staff or health care organization takes adverse action affecting membership or privileges, including any attempt to abridge membership or privileges through the granting of exclusive contracts or closing of medical staff departments.
  - f. The right to immunity from civil damages, injunctive or equitable relief, criminal liability, and protection from any retaliatory actions, when participating in good faith peer review activities.

**712. PROCESSING PRIOR AUTHORIZATION DECISIONS**  
**Introduced by American Academy of Physical Medicine and Rehabilitation**

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

**HOD ACTION:      ADOPTED AS FOLLOWS**  
**TITLE CHANGED**  
*See Policy D-320.979*

RESOLVED, That our American Medical Association advocate that all insurance companies and benefit managers that require prior authorization have staff available to process approvals 24 hours a day, every day of the year, including holidays and weekends.