Abridged Handbook Document is currently laid out for letter-sized paper; change as desired.

Note: this table includes only the recommendations from reports and the resolve statements from resolutions. The table can be sorted in Word using either the “committee” column or the “item” column (or both). Alternatively, the table can be copied to a spreadsheet and manipulated there. The table includes all items of business contained in the initial Handbook, the Handbook Addendum and the Saturday Tote excepting informational reports. Only the primary sponsor, usually the submitter, is listed for resolutions.

| **Cmte\*** | **Item** | **Sponsor†** | **Title** | **Recommendations or Resolves** |
| --- | --- | --- | --- | --- |
|  | Late 1001 | American Association of Physicians of Indian Origin | COVID-19 Crisis in India | RESOLVED, That our American Medical Association urge the U.S. government to provide all possible assistance including surplus vaccines and vaccines that have not had emergency use authorization to the citizens of India and other countries in a similar situation in this humanitarian crisis (New HOD Policy); and be it further  RESOLVED, That our AMA advocate for all possible assistance through WMA and WHO for government and the citizens of India and other countries in a similar situation (Directive to Take Action); and be it further  RESOLVED, That our AMA recognize the extraordinary efforts of many dedicated physicians and ethnic organizations assisting in this humanitarian crisis. (New HOD Policy) |
|  | Late 1002 | Louisiana | Prohibition of Racist Characterization Based on Personal Attributes | RESOLVED, That it is the policy of our American Medical Association that no person or group of persons shall be considered or characterized as racist based on personal attributes of race, color, religion, sex (including pregnancy, sexual orientation, or gender identity), national origin, age, disability, or genetic information. (New HOD Policy) |
|  | Late 1003 | Louisiana | Free Speech and Civil Discourse in our American Medical Association | RESOLVED, That it is the policy of our American Medical Association that:  Our American Medical Association unequivocally commits to truly open discourse, debate, exchange of ideas, and argument;  Our American Medical Association unequivocally commits to a culture which recognizes the inherent dignity and worth of all its members, which resolves that freedom of expression and civility must coexist, and where those who disagree will do so without enmity;  Our American Medical Association unequivocally commits to the principle that dissenting and unpopular voices must be afforded the opportunity to be heard;  Our American Medical Association unequivocally commits that members of the American Medical Association of different faiths, philosophies, and persuasions may speak their minds and honor their deepest convictions without fear of punishment or retaliation;  Our American Medical Association unequivocally commits that the mere exposure to ideas that some may find offensive is not an act of violence or hatred, nor is the expression of opposition to any such ideas an act of violence or hatred;  Our American Medical Association unequivocally commits that ideological demonization of opponents to block debate and to silence disagreement in the proceedings of the American Medical Association is unprofessional conduct subject to appropriate disciplinary action;  Our American Medical Association unequivocally commits that defamation, obscenity, intimidation, threats, and incitement to violence, have no place in the proceedings of the American Medical Association, and if exhibited are unprofessional conduct subject to appropriate disciplinary action. (New HOD Policy) |
|  | Late 1004 | American Academy of Dermatology | Non-Physician Title Misappropriation | RESOLVED, That our American Medical Association actively oppose the American Academy of Physician Assistants’ (AAPA’s) recent move to change the official title of the profession from “Physician Assistant” to “Physician Associate” (Directive to Take Action); and be it further  RESOLVED, That our AMA actively advocate that the stand-alone title “Physician” be used only to refer to doctors of allopathic medicine (MDs) and doctors of osteopathic medicine (DOs), and not be used in ways that have the potential to mislead patients about the level of training and credentials of non-physician health care workers. (Directive to Take Action) |
| .Con | BOT 17 | n/a | Specialty Society Representation in the House of Delegates -  Five-Year Review | That AMDA – The Society for Post-Acute and Long-Term Care Medicine, American Academy of Child and Adolescent Psychiatry, American Association of Clinical Endocrinology, American Association of Physicians of Indian Origin, American College of Medical Genetics and Genomics, American College of Radiation Oncology, American Institute of Ultrasound in Medicine, American Orthopaedic Foot and Ankle Society, American Society for Clinical Pathology, American Society of Anesthesiologists, American Society of Cataract and Refractive Surgery, American Society of Colon and Rectal Surgeons, American Society of Dermatopathology, American Society of Neuroradiology, Obesity Medicine Association, Renal Physicians Association, Society of Critical Care Medicine, and the Society of Interventional Radiology retain representation in the American Medical Association House of Delegates. (Directive to Take Action) |
| .Con | CC&B 01 | n/a | Bylaw Accuracy: Single Accreditation Entity for Allopathic and Osteopathic Graduate Medical Education Programs | RECOMMENDATIONS  The Council on Constitution and Bylaws recommends that the following amendments to the AMA Bylaws be adopted and that the remainder of this report be filed. Adoption requires the affirmative vote of two-thirds of the members of the House of Delegates present and voting.  **7.1 Resident and Fellow Section.** The Resident and Fellow Section is a fixed Section.  **7.1.1 Membership.** All active resident/fellow physician members of the AMA shall be members of the Resident and Fellow Section.  **7.1.1.1 Definition of a Resident.** For purposes of membership in the Resident and Fellow Section, the term Resident shall be applied to any physicians who meet at least one of the following criteria:  a) Members who are enrolled in a residency approved by the Accreditation Council for Graduate Medical Education ~~or the American Osteopathic Association~~.  b) Members who are active duty military or public health service residents required to provide service after their internship as general medical officers (including underseas medical officers or flight surgeons) before their return to complete a residency.  c) Members who are serving, as their primary occupation, in a structured educational, vocational, or research program of at least one year to broaden competency in a specialized field prior to completion of their residency.  **7.1.1.2** **Definition of a Fellow.** For purposes of membership in the Resident and Fellow Section, the term Fellow shall be applied to any physicians who have completed a residency and meet at least one of the following criteria:  a) Members who are serving in fellowships approved by the Accreditation Council for Graduate Medical Education ~~or the American Osteopathic Association~~.  b) Members who are serving, as their primary occupation, in a structured clinical, educational, vocational, or research training program of at least six months to broaden competency in a specialized field. |
| .Con | CC&B 02 | n/a | AMA Women Physicians Section: Clarification of Bylaw Language | RECOMMENDATIONS  The Council on Constitution and Bylaws recommends: 1) that the following amendments to the AMA Bylaws be adopted; and 2) that the remainder of this report be filed. Adoption requires the affirmative vote of two-thirds of the members of the House of Delegates present and voting.  **7.10** **Women Physicians Section.** The Women Physicians Section is a delineated Section.  **7.10.1** **Membership.** All female physicians and medical students who are active members of the AMA shall be ~~eligible to be~~ members of the Women Physicians Section. **~~7.10.1.1~~** Other active members of the AMA who express an interest in women’s issues shall be eligible to join the section. (Modify Bylaws) |
| .Con | CC&B 03 | n/a | Clarification to Bylaw 7.5.2, Cessation of Eligibility (for the Young Physicians Section) | The Council on Constitution and Bylaws recommends that the following amendments to the AMA Bylaws be adopted and that the remainder of this report be filed. Adoption requires the affirmative vote of two-thirds of the members of the House of Delegates present and voting.  7.5 Young Physicians Section. The Young Physicians Section is a fixed Section.  **7.5.1 Membership.** All active physician members of the AMA who are not resident/fellow physicians, but who are under 40 years of age or are within the first 8 years of professional practice after residency and fellowship training programs, shall be members of the Young Physicians Section.**7.5.2 Cessation of Eligibility of Governing Council Members.** If any ~~officer or~~ Governing Council member ceases to meet the membership requirements of Bylaw 7.5.1 prior to the expiration of the term for which elected, the term of such ~~officer~~ ~~or~~ member shall terminate and the position shall be declared vacant. If any ~~officer’s or~~ member’s term would terminate prior to the conclusion of an Annual Meeting, such ~~officer or~~ member shall be permitted to serve in office until the conclusion of the Annual Meeting in the calendar year in which such ~~officer~~ ~~or~~ member ceases to meet the membership requirements of Bylaw 7.5.1, as long as the ~~officer~~ ~~or~~ member remains an active physician member of the AMA. ~~The preceding provision shall not apply to the Chair-Elect. Notwithstanding the immediately preceding provision of this section, the Immediate Past Chair shall be permitted to complete the term of office even if the Immediate Past Chair is unable to continue to meet all of the membership requirements of Bylaw 7.5.1, as long as the officer remains an active physician member of the AMA.~~  **7.5.2.1** The chair position is a three-year commitment and divided into the roles of chair-elect, chair, and immediate past chair. The young physician must meet the requirements of Bylaws 7.5.1 and 7.5.2 through the end of the chair role, or 2nd year. The immediate past chair shall be permitted to complete the term of office even if unable to continue to meet all of the requirements of Bylaw 7.5.1, as long as the physician remains an active physician member of the AMA.) |
| .Con | CEJA 01 | n/a | CEJA’s Sunset Review of 2011 House Policies | The Council on Ethical and Judicial Affairs recommends that the House of Delegates policies that are listed in the Appendix to this report be acted upon in the manner indicated and the remainder of this report be filed. (Directive to Take Action) |
| .Con | CEJA 02 | n/a | Short-term Medical Service Trips | Short-term medical service trips, which send physicians and physicians in training from wealthier countries to provide care in resource-limited settings for a period of days or weeks, have emerged as a prominent strategy for addressing global health inequities. They also provide training and educational opportunities, thus offering benefit both to the communities that host them and the medical professionals and trainees who volunteer their time and clinical skills.  By definition, short-term medical service trips take place in contexts of scarce resources and vulnerable communities. The realities of scarcity and vulnerability define fundamental ethical responsibilities to enable good health outcomes, promote justice and sustainability, minimize burdens on host communities, and respect persons and local cultures. Responsibly carrying out short-term medical service trips requires diligent preparation on the part of sponsors and participants in collaboration with host communities.  Physicians and trainees who are involved with short-term medical service trips should ensure that the trips with which they are associated:  (a) Focus prominently on promoting justice and sustainability by collaborating with the host community to define mission parameters, including identifying community needs, mission goals, and how the volunteer medical team will integrate with local health care professionals and the local health care system. In collaboration with the host community, short-term medical service trips should identify opportunities for and priority of efforts to support the community in building health care capacity. Trips that also serve secondary goals, such as providing educational opportunities for trainees, should prioritize benefits as defined by the host community over benefits to members of the volunteer medical team.  (b) Seek to proactively identify and minimize burdens the trip may place on the host community, including not only direct, material costs of hosting volunteers, but on possible disruptive effects the presence of volunteers could have for local practice and practitioners as well. Sponsors and participants should ensure that team members bring appropriate skill sets and experience, and that resources are available to support the success of the trip, including arranging for local mentors, translation services, and volunteers’ personal health needs as appropriate.  (c) Seek to become broadly knowledgeable about the communities in which they will work and take advantage of resources to begin to cultivate the “cultural sensitivity” they will need to provide safe, respectful, patient-centered care in the context of the specific host community. Members of the volunteer medical team are expected to uphold the ethics standards of their profession and volunteers should insist that strategies are in place to address ethical dilemmas as they arise. In cases of irreducible conflict with local norms, volunteers may withdraw from care of an individual patient or from the mission after careful consideration of the effect that will have on the patient, the medical team, and the mission overall, in keeping with ethics guidance on the exercise of conscience.  Sponsors of short-term medical service trips should:  (d) Ensure that resources needed to meet the defined goals of the trip will be in place, particularly resources that cannot be assured locally  (e) Proactively define appropriate roles and permissible range of practice for members of the volunteer team, including the training, experience, and oversight of team members required to provide acceptable safe, high quality care in the host setting. Team members should practice only within the limits of their training and skills in keeping with the professional standards of the sponsor’s country.  (f) Put in place a mechanism to collect data on success in meeting collaboratively defined goals for the trip in keeping with recognized standards for the conduct of health services research and quality improvement activities in the sponsor’s country. |
| .Con | CEJA 03 | n/a | Amendment to Opinion E-9.3.2, “Physician Responsibilities to Impaired Colleagues” | The Council on Ethical and Judicial Affairs Recommends that Opinion 9.3.2, “Physician Responsibilities to Impaired Colleagues,” be retitled as “Physician Responsibilities to Colleagues with Illness, Disability or Impairment” and amended by substitution as follows; and the remainder of this report be filed:  Providing safe, high quality care is fundamental to physicians’ fiduciary obligation to promote patient welfare. Yet a variety of physical and mental health conditions—including physical disability, medical illness, and substance use—can undermine physicians’ ability to fulfill that obligation. These conditions in turn can put patients at risk, compromise physicians’ relationships with patients, as well as colleagues, and undermine public trust in the profession.  While some conditions may render it impossible for a physician to provide care safely, with appropriate accommodations or treatment many can responsibly continue to practice, or resume practice once those needs have been met. In carrying out their responsibilities to colleagues, patients, and the public, physicians should strive to employ a process that distinguishes conditions that are permanently incompatible with the safe practice of medicine from those that are not and respond accordingly.  As individuals, physicians should:  (a) Maintain their own physical and mental health, strive for self-awareness, and promote recognition of and resources to address conditions that may cause impairment.  (b) Seek assistance as needed when continuing to practice is unsafe for patients, in keeping with ethics guidance on physician health and competence.  (c) Intervene with respect and compassion when a colleague is not able to practice safely. Such intervention should strive to ensure that the colleague is no longer endangering patients and that the individual receive appropriate evaluation and care to treat any impairing conditions.  (d) Protect the interests of patients by promoting appropriate interventions when a colleague continues to provide unsafe care despite efforts to dissuade them from practice.  (e) Seek assistance when intervening, in keeping with institutional policies, regulatory requirements, or applicable law.  Collectively, physicians should nurture a respectful, supportive professional culture by:  (f) Encouraging the development of practice environments that promote collegial mutual support in the interest of patient safety.  (g) Encouraging development of inclusive training standards that enable individuals with disabilities to enter the profession and have safe, successful careers.  (h) Eliminating stigma within the profession regarding illness and disability.  (i) Advocating for supportive services and accommodations to enable physicians who require assistance to provide safe, effective care.  (j) Advocating for respectful and supportive, evidence-based peer review policies and practices that will ensure patient safety and practice competency. |
| .Con | Res 001 | New York | Discrimination Against Physicians Treated for Medication Opioid Use Disorder (MOUD) | RESOLVED, That our American Medical Association affirm that no physician or medical student should be presumed to be impaired by substance or illness solely because they are diagnosed with a substance use disorder (New HOD Policy); and be it further  RESOLVED, That our AMA affirm that no physician or medical student should be presumed impaired because they and their treating physician have chosen medication for opioid use disorder (MOUD) to address the substance use disorder, including methadone and buprenorphine (New HOD Policy); and be it further  RESOLVED, That our AMA strongly encourage the leadership of physician health and wellness programs, state medical boards, hospital and health system credentialing bodies, and employers to help end stigma and discrimination against physicians and medical students with substance use disorders and allow and encourage the usage of medication for opioid use disorder (MOUD), including methadone or buprenorphine, when clinically appropriate and as determined by the physician or medical student (as patient) and their treating physician, without penalty (such as restriction of privileges, licensure, ability to prescribe medications or other treatments, or other limits on their ability to practice medicine), solely because the physician's or medical student’s treatment plan includes MOUD (Directive to Take Action); and be it further  RESOLVED, That our AMA survey physician health programs and state medical boards and report back about whether they allow participants/licensees to use MOUD without punishment, or exclusion from practicing medicine or having to face other adverse consequences. (Directive to Take Action) |
| .Con | Res 002 | American College of Cardiology | Sharing Covid-19 Resources | Now Resolution 608 |
| .Con | Res 003 | American Academy of Pediatrics | Healthcare Organizational Policies and Cultural Changes to Prevent and Address Racism, Discrimination, Bias and Microaggressions | RESOLVED, That our American Medical Association adopt the following guidelines for healthcare organizations and systems, including academic medical centers, to establish policies and an organizational culture to prevent and address systemic racism, explicit and implicit bias and microaggressions in the practice of medicine:  GUIDELINES TO PREVENT AND ADDRESS SYSTEMIC RACISM, EXPLICIT BIAS AND MICROAGGRESSIONS IN THE PRACTICE OF MEDICINE  Health care organizations and systems, including academic medical centers, should establish policies to prevent and address discrimination including systemic racism, explicit and implicit bias and microaggressions in their workplaces.  An effective healthcare anti-discrimination policy should:   * Clearly define discrimination, systemic racism, explicit and implicit bias and microaggressions in the healthcare setting. * Ensure the policy is prominently displayed and easily accessible. * Describe the management’s commitment to providing a safe and healthy environment that actively seeks to prevent and address systemic racism, explicit and implicit bias and microaggressions. * Establish training requirements for systemic racism, explicit and implicit bias, and microaggressions for all members of the healthcare system. * Prioritize safety in both reporting and corrective actions as they relate to discrimination, systemic racism, explicit and implicit bias and microaggressions. * Create anti-discrimination policies that:   + Specify to whom the policy applies (i.e., medical staff, students, trainees, administration, patients, employees, contractors, vendors, etc.).   + Define expected and prohibited behavior.   + Outline steps for individuals to take when they feel they have experienced discrimination, including racism, explicit and implicit bias and microaggressions.   + Ensure privacy and confidentiality to the reporter.   + Provide a confidential method for documenting and reporting incidents.   + Outline policies and procedures for investigating and addressing complaints and determining necessary interventions or action. * These policies should include:   + Taking every complaint seriously.   + Acting upon every complaint immediately.   + Developing appropriate resources to resolve complaints.   + Creating a procedure to ensure a healthy work environment is maintained for complainants and prohibit and penalize retaliation for reporting.   + Communicating decisions and actions taken by the organization following a complaint to all affected parties.   + Document training requirements to all the members of the healthcare system and establish clear expectations about the training objectives.   In addition to formal policies, organizations should promote a culture in which discrimination, including systemic racism, explicit and implicit bias and microaggressions are mitigated and prevented. Organized medical staff leaders should work with all stakeholders to ensure safe, discrimination-free work environments within their institutions.  Tactics to help create this type of organizational culture include:   * Surveying staff, trainees and medical students, anonymously and confidentially to assess:   + Perceptions of the workplace culture and prevalence of discrimination, systemic racism, explicit and implicit bias and microaggressions.   + Ideas about the impact of this behavior on themselves and patients. * Integrating lessons learned from surveys into programs and policies. * Encouraging safe, open discussions for staff and students to talk freely about problems and/or encounters with behavior that may constitute discrimination, including racism, bias or microaggressions. * Establishing programs for staff, faculty, trainees and students, such as Employee Assistance Programs, Faculty Assistance Programs, and Student Assistance Programs, that provide a place to confidentially address personal experiences of discrimination, systemic racism, explicit or implicit bias or microaggressions. * Providing designated support person to confidentially accompany the person reporting an event through the process. (New HOD Policy) |
| .Con | Res 004 | Resident and Fellow Section | AMA Resident/Fellow Councilor Term Limits | RESOLVED, That our American Medical Association amend the AMA “Constitution and Bylaws” by addition and deletion to read as follows:  **6.5 Council on Ethical and Judicial Affairs.**  **6.5.7 Term.**  **6.5.7.2** Except as provided in Bylaw 6.11, the resident/fellow physician member of the Council shall be elected for a term of 2~~3~~ years provided that if the resident/fellow physician member ceases to be a resident/fellow physician at any time prior to the expiration of the term for which elected, the service of such resident/fellow physician member on the Council shall thereupon terminate, and the position shall be declared vacant.  **6.5.8 Tenure.** Members of the Council may serve only one term, except that the resident/fellow physician member shall be eligible to serve for 3 terms and the medical student member shall be eligible to serve for 2 terms. A member elected to serve an unexpired term shall not be regarded as having served a term unless such member has served at least half of the term.  **6.5.9 Vacancies.**  **6.5.9.2 Resident/Fellow Physician Member.** If the resident/fellow physician member of the Council ceases to complete the term for which elected, the remainder of the term shall be deemed to have expired. The successor shall be elected by the House of Delegates at the next Annual Meeting, on nomination by the President, for a 2~~3~~-year term. (Modify Bylaws) and be it further  RESOLVED, That our AMA amend the AMA “Constitution and Bylaws” by addition and deletion to read as follows:  **6.6 Council on Long Range Planning and Development.**  **6.6.3 Term.**  **6.6.3.2 Resident/Fellow Physician Member.** The resident/fellow physician member of the Council shall be appointed for a term of 2~~3~~ years beginning at the conclusion of the Annual Meeting provided that if the resident/fellow physician member ceases to be a resident/fellow physician at any time prior to the expiration of the term for which appointed except as provided in Bylaw 6.11, the service of such resident/fellow physician member on the Council shall thereupon terminate, and the position shall be declared vacant.  **6.6.5 Vacancies.**  **6.6.5.2 Resident/Fellow Physician Member.** If the resident/fellow physician member of the Council ceases to complete the term for which appointed, the remainder of the term shall be deemed to have expired. The successor shall be appointed by the Speaker of the House of Delegates for a 2~~3~~-year term. (Modify Bylaws) and be it further  RESOLVED, That our AMA amend the AMA “Constitution and Bylaws” by addition and deletion to read as follows:  **6.9 Term and Tenure - Council on Constitution and Bylaws, Council on Medical Education, Council on Medical Service, and Council on Science and Public Health.**  **6.9.1 Term.**  **6.9.1.2 Resident/Fellow Physician Member.** The resident/fellow physician member of these Councils shall be elected for a term of 2~~3~~ years. Except as provided in Bylaw 6.11, if the resident/fellow physician member ceases to be a resident/fellow physician at any time prior to the expiration of the term for which elected, the service of such resident/fellow physician member on the Council shall thereupon terminate, and the position shall be declared vacant.  **6.9.3 Vacancies.**  **6.9.3.2 Resident/Fellow Physician Member.** If the resident/fellow physician member of these Councils ceases to complete the term for which elected, the remainder of the term shall be deemed to have expired. The successor shall be elected by the House of Delegates for a 2~~3~~-year term. (Modify Bylaws) |
| .Con | Res 005 | Resident and Fellow Section | Resident and Fellow Access to Fertility Preservation | RESOLVED, That our American Medical Association support education for residents and fellows regarding the natural course of female fertility in relation to the timing of medical education, and the option of fertility preservation and infertility treatment (Directive to Take Action); and be it further  RESOLVED, That our AMA advocate inclusion of insurance coverage for fertility preservation and infertility treatment within health insurance benefits for residents and fellows offered through graduate medical education programs (Directive to Take Action); and be it further  RESOLVED, That our AMA support the accommodation of residents and fellows who elect to pursue fertility preservation and infertility treatment, including the need to attend medical visits to complete the oocyte preservation process and to administer medications in a time-sensitive fashion. (Directive to Take Action) |
| .Con | Res 006 | Resident and Fellow Section | Ensuring Consent for Educational Physical Exams on Anesthetized and Unconscious Patients | RESOLVED, That our American Medical Association oppose performing physical exams on patients under anesthesia or on unconscious patients that offer the patient no personal benefit and are performed solely for teaching purposes without prior informed consent to do so (Directive to Take Action); and be it further  RESOLVED, That our AMA encourage institutions to align current practices with published guidelines, recommendations, and policies to ensure patients are educated on pelvic, genitourinary, and rectal exams that occur under anesthesia (Directive to Take Action); and be it further  RESOLVED, That our AMA strongly oppose issuing blanket bans on student participation in educational physical exams (Directive to Take Action); and be it further  RESOLVED, That our AMA reaffirm policy H-320.951, “AMA Opposition to "Procedure-Specific" Informed Consent.” (Reaffirm HOD Policy) |
| .Con | Res 007 | Virginia | Nonconsensual Audio/Video  Recording at Medical  Encounters | RESOLVED, That our American Medical Association encourage that any audio or video recording made during a medical encounter should require both physician and patient notification and consent. (New HOD Policy) |
| .Con | Res 008 | Pennsylvania | Organ Transplant Equity for Persons with Disabilities | RESOLVED, That our American Medical Association support equitable inclusion of people with intellectual and developmental disabilities (IDD) in eligibility for transplant surgery (New HOD Policy); and be it further  RESOLVED, That our AMA support individuals with IDD having equal access to organ transplant services and protection from discrimination in rendering these services (New HOD Policy); and be it further  RESOLVED, That our AMA support the goal of the Organ Procurement and Transplantation Network (OPTN) in adding disability status to their nondiscrimination policy under the National Organ Transplant Act of 1984 (New HOD Policy); and be it further  RESOLVED, That our AMA work with relevant stakeholders to distribute antidiscrimination education materials for healthcare providers related to equitable inclusion of people with IDD in eligibility for transplant surgery. (Directive to Take Action) |
| .Con | Res 009 | Illinois | Supporting Women and Underrepresented Minorities in Overcoming Barriers to Positions of Medical Leadership and Competitive Specialties | RESOLVED, That our American Medical Association advocate for increased research on changes in specialty interests throughout medical education, including both undergraduate and graduate medical education, specifically in competitive specialties, with a focus on student demographics; (Directive to Take Action) and be it further  RESOLVED, That our AMA amend the following policy to in order to support increasing representation and the recruitment of students who identify with groups classically not represented in competitive fields:  H-200.951 Strategies for Enhancing Diversity in the Physician Workforce  Our AMA supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, gender, sexual orientation/gender identity, socioeconomic origin and persons with disabilities. Our AMA will both support and take active measures to support medical students who identify with groups underrepresented in competitive specialties, such as women and minority students, in order to take concrete steps to enhance diversity in the physician workforce. (Modify Current HOD Policy); and be it further  RESOLVED, That our AMA maintain allocated yearly funding for AMA-MSS national meeting attendance and maintain concrete and standing mechanisms for increasing participation for medical students within our AMA-MSS from medical schools with classically low national meeting attendance, which will be defined as less than five students per national AMA-MSS meeting over a period of five consecutive years, having one or more of the following characteristics:  1. Identify with group(s) underrepresented and disadvantaged in medicine  2. Are from medically underserved areas  3. Are first generation college graduates  as a mechanism to create more exposure to leadership and networking opportunities for these students. (Directive to Take Action) |
| .Con | Res 010 | Georgia | Updated Medical Record Policy Regarding Physicians with Suspended or Revoked Licenses | RESOLVED, That the Council on Ethical and Judicial Affairs be requested to examine  E-3.3.1, “Management of Medical Records,” with regards to physicians whose license has been suspended or revoked and prepare a report to the 2021 Interim Meeting, including guidance for timely transfer of patient records to the patient or a state medical board-approved custodian. (Directive to Take Action) |
| .Con | Res 011 | Minority Affairs Section | Truth, Reconciliation, and Healing in Medicine and Medical Education | RESOLVED, That our American Medical Association establish a combined external and internal task force to guide organizational transformation within and beyond the AMA toward restorative justice to promote truth, reconciliation, and healing in medicine and medical education. (Directive to Take Action) |
| .Con | Res 012 | Young Physicians Section | Increasing Public Umbilical Cord Blood Donations in Transplant Centers | RESOLVED, That our American Medical Association encourage all hospitals with obstetrics programs to make available to patients and reduce barriers to public (altruistic) umbilical cord blood donation (Directive to Take Action); and be it further  RESOLVED, That our AMA encourage the availability of altruistic cord blood donations in all states. (Directive to Take Action) |
| .Con | Res 013 | Medical Student Section | Combating Natural Hair and Cultural Headwear Discrimination in Medicine and Medical Professionalism | RESOLVED, That our American Medical Association recognize that discrimination against natural hair/hairstyles and cultural headwear is a form of racial, ethnic and/or religious discrimination (New HOD Policy); and be it further  RESOLVED, That our AMA oppose discrimination against individuals based on their hair or cultural headwear in health care settings (New HOD Policy); and be it further  RESOLVED, That our AMA acknowledge the acceptance of natural hair/hairstyles and cultural headwear as crucial to professionalism in the standards for the health care workplace (New HOD Policy); and be it further  RESOLVED, That our AMA encourage medical schools, residency and fellowship programs, and medical employers to create policies to oppose discrimination based on hairstyle and cultural headwear in the interview process, medical education, and the workplace (New HOD Policy) |
| .Con | Res 014 | Medical Student Section | Supporting the Study of Reparations as a Means to Reduce Racial Inequalities | RESOLVED, That our American Medical Association study potential mechanisms of national economic reparations that could improve inequities associated with institutionalized, systemic racism and report back to the House of Delegates (Directive to Take Action); and be it further  RESOLVED, That our AMA study the potential adoption 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 (Directive to Take Action); and be it further  RESOLVED, That our AMA support federal legislation that facilitates the study of reparations. (Directive to Take Action) |
| .Con | Res 015 | Medical Student Section | Opposition to the Criminalization and Undue Restriction of Evidence-Based Gender-Affirming Care for Transgender and Gender-Diverse Individuals | RESOLVED, That our American Medical Association amend policy H-185.927, “Clarification of Medical Necessity for Treatment of Gender Dysphoria,” by addition and deletion to read as follows: Clarification of Medical Necessity for Treatment of Gender Dysphoria H-185.927 Our AMA: (1) recognizes that medical and surgical treatments for gender dysphoria, as determined by shared decision making between the patient and physician, are medically necessary as outlined by generally-accepted standards of medical and surgical practice; ~~and~~ (2) will advocate for federal, state, and local policies to provide medically necessary care for gender dysphoria; and (3) opposes the criminalization and otherwise undue restriction of evidence-based gender-affirming care. (Modify Current HOD Policy) |
| .Con | Res 016 | Medical Student Section | Denouncing the Use of Solitary Confinement in Correctional Facilities and Detention Centers | RESOLVED, That our American Medical Association policy H-430.983 be amended by addition and deletion to read as follows:  **~~Reducing~~ Opposing the Use of Restrictive Housing in Prisoners ~~with Mental Illness~~ H-430.983**  Our AMA will: (1) ~~support limiting~~ oppose the use of solitary confinement of any length~~, with rare exceptions,~~ for incarcerated persons ~~with mental illness~~, in ~~adult~~ correctional facilities and detention centers, except for medical isolation or to protect individuals who are actively being harmed or will be immediately harmed by a physically violent individual, in which cases confinement may be used for a short a time as possible; ~~and~~ (2) while solitary confinement practices are still in place, support efforts to ensure that the mental and physical health of all individuals placed in solitary confinement are regularly monitored by health professionals; and (3) encourage appropriate stakeholders to develop and implement safe, humane, and ethical alternatives to solitary confinement for incarcerated persons in all correctional facilities. ~~and (3) encourage appropriate stakeholders to develop and implement alternatives to solitary confinement for incarcerated persons in all correctional facilities.~~ (Modify Current HOD Policy) |
| .Con | Res 017 | Medical Student Section | Improving the Health and Safety of Sex Workers | RESOLVED, That our American Medical Association recognize the adverse health outcomes of criminalizing consensual sex work (New HOD Policy); and be it further  RESOLVED, That our AMA: 1) support legislation that decriminalizes individuals who offer sex in return for money or goods; 2) oppose legislation that decriminalizes sex buying and brothel keeping; and 3) support the expungement of criminal records of those previously convicted of sex work, including trafficking survivors (New HOD Policy); and be it further  RESOLVED, That our AMA support research on the long-term health, including mental health, impacts of decriminalization of the sex trade. (New HOD Policy) |
| .Con | Res 018 | Medical Student Section | LGBTQ+ Representation in Medicine | RESOLVED, That our American Medical Association advocate for the creation of targeted efforts to recruit sexual and gender minority students in efforts to increase medical student, resident, and provider diversity; and be it further  RESOLVED, That our AMA encourage the inclusion of sexual orientation and gender identity data in all surveys as part of standard demographic variables, including but not limited to governmental, AMA, and the Association of American Medical Colleges surveys, given respondent confidentiality and response security can be ensured (Directive to Take Action); and be it further  RESOLVED, That our AMA work with the Association of American Medical Colleges to disaggregate data of LGBTQ+ individuals in medicine to better understand the representation of the unique experiences within the LGBTQ+ communities and their overlap with other identities. (Directive to Take Action) |
| .Con | Res 019 | Medical Student Section | Evaluating Scientific Journal Articles for Racial and Ethnic Bias | RESOLVED, That our American Medical Association support major journal publishers issuing guidelines for interpreting previous research which define race and ethnicity by outdated means (New HOD Policy); 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. (New HOD Policy) |
| .Con | Res 020 | Medical Student Section | Amendment to Truth and Transparency in Pregnancy Counseling Centers, H‑420.954 | RESOLVED, That our American Medical Association amend policy H-420.954, “Truth and Transparency in Pregnancy Counseling Centers,” by insertion and deletion to read as follows, to further strengthen our AMA policy against the dissemination of purposely incomplete or deceptive information intended to mislead patients and the utilization of state and federal funds for potentially biased services provided by Pregnancy Counseling Centers:  **Truth and Transparency in Pregnancy Counseling Centers H-420.954**  1. Our AMA ~~supports~~ advocates that any entity offering crisis pregnancy services disclose information on site, in its advertising; and before any services are provided concerning medical services, contraception, termination of pregnancy or referral for such services, adoption options or referral for such services that it does and does not provide, as well as fully disclose any financial, political, or religious associations which such entities may have;  2. Our AMA discourages the use of marketing, counseling, or coercion (by physical, emotional, or financial means) by any agency offering crisis pregnancy services that aim to discourage or interfere with a pregnant woman’s pursuit of any medical services for the care of her unplanned pregnancy;  3. Our AMA advocates that any entity providing medical or health services to pregnant women that markets medical or any clinical services abide by licensing requirements and have the appropriate qualified licensed personnel to do so and abide by federal health information privacy laws, and additionally disclose their level of compliance to such requirements and laws to patients receiving services;  4. Our AMA opposes the utilization of state and federal funding to finance such entities offering crisis pregnancy services, which do not provide statistically validated evidence-based medical information and care to pregnant women**.** (Modify Current HOD Policy) |
| .Con | Res 021 | Medical Student Section | Expanding the Definition of Iatrogenic Infertility to Include Gender Affirming Interventions | RESOLVED, That our American Medical Association 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. (Modify Current HOD Policy); and be it further  RESOLVED, That our AMA amend policy H-185.950 by addition to read 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. (Modify Current HOD Policy) |
| .Con | Res 022 | Michigan | Maternal Levels of Care Standards of Practice | RESOLVED: That our American Medical Association amend existing policy D-420.993, “Disparities in Maternal Mortality,” by addition and deletion to read as follows:  Our AMA: (1) will ask the Commission to End Health Care Disparities to evaluate the issue of health disparities in maternal mortality and offer recommendations to address existing disparities in the rates of maternal mortality in the United States; (2) will work with the CDC, HHS, state and county health departments to decrease maternal mortality rates in the US; (3) encourages and promotes to all state and county health departments to develop a maternal mortality surveillance system; ~~and~~ (4) will advocate for the adoption of national standards of practice by birthing centers across the country to help improve maternal health; and (5) will work with stakeholders to encourage research on identifying barriers and developing strategies toward the implementation of evidence-based practices to prevent disease conditions that contribute to poor obstetric outcomes, maternal morbidity and maternal mortality in racial and ethnic minorities. (Modify Current HOD Policy) |
| .Con | Res 023 | Young Physicians Section | Pandemic Ethics and the Duty of Care | RESOLVED, That our Council on Ethical and Judicial Affairs reconsider its guidance on pandemics, disaster response and preparedness in terms of the limits of professional duty of individual physicians, especially in light of the unique dangers posed to physicians, their families and colleagues during the COVID-19 global pandemic. (Directive to Take Action) |
| .Con | Res 024 | Young Physicians Section | AMA Bylaws Language on AMA Young Physicians Section Governing Council Eligibility | RESOLVED, That the American Medical Association amend AMA Bylaw 7.5.1, Membership, to read as follows:  7.5.1 Membership. All active physician members of the AMA who are not resident/fellow physicians, but who are under 40 years of age or are within the first 8 years of professional practice after residency and fellowship training programs, shall be members of the Young Physicians Section until December 31 of the year of their 40th birthday or December 31 of the eighth year following the completion of their graduate medical education.  7.5.1.1 Membership shall be granted to any physician serving as Chair or Chair-Elect of the YPS, so long as they fulfilled the requirements of 7.5.1 when they were elected to Chair-Elect, until their term as Chair has expired. (Modify Bylaws); and be it further  RESOLVED, That the AMA amend AMA Bylaw 7.5.2, Cessation of Eligibility, to read as follows:  7.5.2 If any officer or Governing Council member ceases to meet the membership requirements of Bylaw 7.5.1 prior to the expiration of the term for which elected, they shall be permitted to complete the term of office even if they are ~~the term of such officer or member shall terminate and~~ ~~the position shall be declared vacant. If any officer’s or~~ ~~member’s term would terminate prior to the conclusion of~~ ~~an Annual Meeting, such officer or member shall be~~ ~~permitted to serve in office until the conclusion of the~~ ~~Annual Meeting in the calendar year in which such officer~~ ~~or member ceases to meet the membership requirements~~ ~~of Bylaw 7.5.1, as long as the officer or member remains~~ ~~an active physician member of the AMA. The preceding~~ ~~provision shall not apply to the Chair-Elect. Notwithstanding the immediately preceding provision of~~ ~~this section, the Immediate Past Chair shall be permitted~~ ~~to complete the term of office even if the Immediate Past~~ ~~Chair is~~ unable to continue to meet all of the membership requirements of Bylaw 7.5.1, as long as the office remains an active physician member of the AMA. (Modify Bylaws) |
| .Con | Speakers Report 2 | n/a | Report of the Election Task Force | *Campaign Memorabilia*  **Recommendation 1:** Campaign memorabilia may not be distributed in the Not for Official Business (NFOB) bag. (New HOD Policy)  **Recommendation 2:** Policy G-610.020, Rules for AMA Elections, paragraph 10 be amended by addition and deletion to read as follows:  (10) Campaign expenditures and activities should be limited to reasonable levels necessary for adequate candidate exposure to the delegates. ~~Campaign gifts can be distributed only at the Annual Meeting in the non-official business bag and at one campaign party. Campaign gifts should only be distributed during the Annual Meeting and not mailed to delegates and alternate delegates in advance of the meeting. The Speaker of the House of Delegates shall establish a limit on allowable expenditures for campaign-related gifts. In addition to these giveaway gifts, campaign memorabilia are allowed but are limited to a button, pin, or sticker.~~ ~~No other c~~Campaign memorabilia and giveaways that include a candidate’s name or likeness may not ~~shall~~ be distributed at any time; (Modify Current HOD Policy)  *Stickers, Buttons, and Pins*  **Recommendation 3:** Campaign stickers, pins, buttons and similar campaign materials are disallowed. This rule will not apply for pins for AMPAC, the AMA Foundation, specialty societies, state and regional delegations and health related causes that do not include any candidate identifier. These pins should be small, not worn on the badge and distributed only to members of the designated group. General distribution of any pin, button or sticker is disallowed. (New HOD Policy)  **Recommendation 4:** Policy G-610.020, Rules for AMA Elections, paragraph 8 be amended by deletion to read as follows:  (8) A state, specialty society, caucus, coalition, etc. may contribute to more than one party. However, a candidate may be featured at only one party, which includes: (a) being present in a receiving line, (b) appearing by name or in a picture on a poster or notice in or outside of the party venue~~, or (c) distributing stickers, buttons, etc. with the candidate’s name on them~~. At these events, alcohol may be served only on a cash or no-host bar basis; (Modify Current HOD Policy)  *Campaign Receptions*  **Recommendation 5:** Our AMA will investigate the feasibility of a two- (2) year trial of sponsoring a welcome reception open to all candidates and all meeting attendees. Any candidate may elect to be “featured” at the AMA reception. There will not be a receiving line at the AMA reception. Other receptions sponsored by societies or coalitions, whether featuring a candidate or not, would not be prohibited, but the current rules regarding cash bars only at campaign receptions and limiting each candidate to be featured at a single reception (the AMA reception or another) would remain. The Speakers will report back to the House after the two year trial with a recommendation for possible continuation of the AMA reception. (New HOD Policy)  **Recommendation 6:** Policy G-610.020, Rules for AMA Elections, paragraph 8 be reaffirmed (minus phrase “c” recommended for deletion above):  (8) A state, specialty society, caucus, coalition, etc. may contribute to more than one party. However, a candidate may be featured at only one party, which includes: (a) being present in a receiving line, (b) appearing by name or in a picture on a poster or notice in or outside of the party venue~~, or (c) distributing stickers, buttons, etc. with the candidate’s name on them~~. At these events, alcohol may be served only on a cash or no-host bar basis; (Reaffirm HOD Policy)  *Dinners, Suites and Such*  **Recommendation 7:** Group dinners, if attended by an announced candidate in a currently contested election, must be “Dutch treat” - each participant pays their own share of the expenses, with the exception that societies and delegations may cover the expense for their own members. This rule would not disallow societies from paying for their own members or delegations gathering together with each individual or delegation paying their own expense. Gatherings of 4 or fewer delegates or alternates are exempt from this rule. (New HOD Policy)  **Recommendation 8:** Policy G-610.020, Rules for AMA Elections, paragraph 6 be amended by addition and deletion to read as follows:  (6) At any AMA meeting convened prior to the time period for active campaigning ~~the Interim Meeting~~, campaign-related expenditures and activities shall be discouraged. Large campaign receptions, luncheons, other formal campaign activities and the distribution of campaign literature and gifts are prohibited ~~at the Interim Meeting~~. It is permissible ~~at the Interim Meeting~~ for candidates seeking election to engage in individual outreach~~, such as small group meetings, including informal dinners,~~ meant to familiarize others with a candidate’s opinions and positions on issues; (Modify Current HOD Policy)  *Campaign Literature*  **Recommendation 9:** Campaign materials may not be distributed by postal mail or its equivalent. The AMA Office of House of Delegates Affairs will no longer furnish a file containing the names and mailing addresses of members of the AMA-HOD. Printed campaign materials will not be included in the “Not for Official Business” bag and may not be distributed in the House of Delegates. Candidates are encouraged to eliminate printed campaign materials. (New HOD Policy)  **Recommendation 10:** Policy G-610.020, Rules for AMA Elections, paragraph 9 be amended by addition and deletion to read as follows:  (9) Displays of campaign posters, signs, and literature in public areas of the hotel in which Annual Meetings are held are prohibited because they detract from the dignity of the position being sought and are unsightly. Campaign posters may be displayed at a single campaign reception at which the candidate is featured ~~parties, and campaign literature may be distributed in the non-official business bag for members of the House of Delegates~~. No campaign literature shall be distributed in the House of Delegates and no mass outreach electronic messages shall be transmitted after the opening session of the House of Delegates; (Modify Current HOD Policy)  **Recommendation 11:** The AMA Office of House of Delegates Affairs will provide an opportunity for all announced candidates to submit material to the HOD office which will then be sent electronically by the HOD Office in a single communication to all delegates and alternates. Parameters regarding content and deadlines for submission will be established by the Speaker and communicated to all announced candidates. (New HOD Policy)  **Recommendation 12:** Policy G-610.020, Rules for AMA Elections, paragraph 5 be amended by addition and deletion to read as follows:  (5) A reduction in the volume of telephone calls and electronic communication from candidates~~, and literature and letters by or~~ and on behalf of candidates is encouraged. The Office of House of Delegates Affairs does not provide email addresses for any purpose. The use of electronic messages to contact electors should be minimized, and if used must include a simple mechanism to allow recipients to opt out of receiving future messages; (Modify Current HOD Policy)  **Recommendation 13:** An AMA Candidates’ Page will be created on the AMA website or other appropriate website to allow each candidate the opportunity to post campaign materials. Parameters for the site will be established by the Speaker and communicated to candidates. (New HOD Policy)  **Recommendation 14:** Policy G-610.020, Rules for AMA Elections, paragraph 4 be amended by addition to read as follows:  (4) An Election Manual containing information on all candidates for election shall continue to be developed annually, with distribution limited to publication on our AMA website, typically on the Web pages associated with the meeting at which elections will occur. The Election Manual will provide a link to the AMA Candidates’ Page, but links to personal, professional or campaign related websites will not be allowed. The Election Manual provides an equal opportunity for each candidate to present the material he or she considers important to bring before the members of the House of Delegates and should relieve the need for the additional expenditures incurred in making non-scheduled telephone calls and duplicative mailings. The Election Manual serves as a mechanism to reduce the number of telephone calls, mailings and other messages members of the House of Delegates receive from or on behalf of candidates; (Modify Current HOD Policy)  *Interviews*  **Recommendation 15:** Policy G-610.020, Rules for AMA Elections, paragraph 14 be reaffirmed:  (14) Every state and specialty society delegation is encouraged to participate in a regional caucus, for the purposes of candidate review activities; and (Reaffirm HOD Policy)  **Recommendation 16:** Delegations and caucuses may conduct interviews by virtual means in advance of the Annual Meeting of the House of Delegates during a period of time to be determined by the Speaker in lieu of in-person interviews at the meeting. Delegations and caucuses may choose either method, but not both for a given race. Groups electing to interview candidates for a given position must provide an equal opportunity for all candidates for that position who have announced their intention to be nominated at the time interviews are scheduled, to be interviewed using the same format and platform. An exception being that a group may elect to meet with a candidate who is from their own delegation without interviewing other candidates. Recording of virtual interviews must be disclosed to candidates prior to recording and may only be recorded with candidate consent. Interview recordings may only be shared with members of the interviewing caucus/group. (New HOD Policy)  **Recommendation 17:** The Speakers are encouraged to continue recorded virtual interviews of announced candidates in contested races, to be posted on the AMA website. (New HOD Policy)  *Voting Process and Election Session*  **Recommendation 18:** Voting for all elected positions including runoffs will be conducted electronically during an Election Session to be arranged by the Speaker. (New HOD Policy)  **Recommendation 19:** Policy G-610.030, Election Process be amended by addition and deletion to read as follows:  AMA guidelines on the election process are as follows: (1) AMA elections will be held on Tuesday at each Annual Meeting; (2) ~~Poll hours will not be extended beyond the times posted.~~ All delegates eligible to vote must be seated within the House~~in line to vote~~ at the time appointed to cast their electronic votes~~.for the close of polls~~; and (3) The final vote count of all secret ballots of the House of Delegates shall be made public and part of the official proceedings of the House. (Modify Current HOD Policy)  **Recommendation 20:** The Speaker is encouraged to consider means to reduce the time spent during the HOD meeting on personal points by candidates after election results are announced, including collecting written personal points from candidates to be shared electronically with the House after the meeting or imposing time limits on such comments. (New HOD Policy)  *Announcements and Nomination*  **Recommendation 21:** Policy G-610.020, Rules for AMA Elections, paragraph 2 be amended by addition to read as follows:  (2) Individuals intending to seek election at the next Annual Meeting should make their intentions known to the Speakers, generally by providing the Speaker’s office with an electronic announcement “card” that includes any or all of the following elements and no more: the candidate’s name, photograph, email address, URL, the office sought and a list of endorsing societies. The Speakers will ensure that the information is posted on our AMA website in a timely fashion, generally on the morning of the last day of a House of Delegates meeting or upon adjournment of the meeting. Announcements that include additional information (e.g., a brief resume) will not be posted to the website. Printed announcements may not be distributed in the venue where the House of Delegates meets. Announcements sent by candidates to members of the House are considered campaigning and are specifically prohibited prior to the start of active campaigning. The Speakers may use additional means to make delegates aware of those members intending to seek election; (Modify Current HOD Policy)  **Recommendation 22:** Announcement cards of all known candidates will be projected on the last day of the Annual and Interim Meetings of our House of Delegates and posted on the AMA website as per Policy G-610.020, paragraph 2. Following each meeting, an “Official Candidate Notification” will be sent electronically to the House. It will include a list of all announced candidates and all potential newly opened positions which may open as a result of the election of any announced candidate. Additional notices will also be sent out following the April Board meeting and on “Official Announcement Dates” to be established by the Speaker. (New HOD Policy)  **Recommendation 23:** Candidates may notify the HOD Office of their intention to run for potential newly opened positions, as well as any scheduled open positions on any council or the Board of Trustees, at any time by submitting an announcement card and their conflict of interest statement to the House Office. They will then be included in all subsequent projections of announcements before the House, “Official Candidate Notifications” and in any campaign activity that had not yet been finalized. All previously announced candidates will continue to be included on each Official Announcement Date. Any candidate may independently announce their candidacy after active campaigning is allowed, but no formal announcement from the HOD office will take place other than at the specified times. (New HOD Policy)  **Recommendation 24:** Policy G-610.020, Rules for AMA Elections, paragraph 15 be reaffirmed:  (15) Our AMA (a) requires completion of conflict of interest forms by all candidates for election to our AMA Board of Trustees and councils prior to their election; and (b) will expand accessibility to completed conflict of interest information by posting such information on the “Members Only” section of our AMA website before election by the House of Delegates, with links to the disclosure statements from relevant electronic documents. (Reaffirm HOD Policy)  **Recommendation 25:** Policy G-610.010, Nominations be amended by addition and deletion to read as follows:  Guidelines for nominations for AMA elected offices include the following: (1) every effort should be made to nominate two or more eligible members for each Council vacancy; (2) the Federation (in nominating or sponsoring candidates for leadership positions), the House of Delegates (in electing Council and Board members), and the Board, the Speakers, and the President (in appointing or nominating physicians for service on AMA Councils or in other leadership positions) to consider the need to enhance and promote diversity; (3) the date for submission of ~~nominations to~~ applications for consideration by the Board of Trustees at its April meeting for the Council on Legislation, Council on Constitution and Bylaws, Council on Medical Education, Council on Medical Service, Council on Science and Public Health, Council on Long Range Planning and Development, and Council on Ethical and Judicial Affairs is made uniform to March 15th of each year; (4) the announcement of the Council nominations and the official ballot should list candidates in alphabetical order by name only; (Modify Current HOD Policy)  **Recommendation 26:** Policy G-610.020, Rules for AMA Elections, paragraph 3, be amended by addition and deletion to read as follows:  (3) Active campaigning for AMA elective office may not begin until the Board of Trustees, after its April meeting, announces the ~~nominees~~ candidates for council seats. Active campaigning includes mass outreach activities directed to all or a significant portion of the members of the House of Delegates and communicated by or on behalf of the candidate. If in the judgment of the Speaker of the House of Delegates circumstances warrant an earlier date by which campaigns may formally begin, the Speaker shall communicate the earlier date to all known candidates; (Modify Current HOD Policy)  *Newly Opened Positions*  **Recommendation 27:** The Federation and members of the House of Delegates will be notified of unscheduled potential newly opened positions that may become available as a result of the election of announced candidates. Candidates will be allowed to announce their intention to run for these positions. (New HOD Policy)  **Recommendation 28:** If there are no scheduled open seats on the Board or specified council for which a potential newly opened position is announced and if the potential newly opened position does not open (ie., the individual with the unexpired term is not elected to the office they sought), no election for the position will be held. (New HOD Policy)  **Recommendation 29:** If a potential newly opened position on the Board or a specified council does not open but there are other open positions for the same council or the Board, an election will proceed for the existing open seats. Candidates will be offered the opportunity to withdraw their nomination prior to the vote. (New HOD Policy)  **Recommendation 30:** In the event that a prior election results in a newly opened position without a nominated candidate or more positions are open than nominated candidates, the unfilled position/s would remain unfilled until the next annual meeting. (New HOD Policy)  **Recommendation 31:** Bylaws 3.4.2.2 and 6.8.1.5 be rescinded.  **3.4.2.2 At-Large Trustees to be Elected to Fill Vacancies after a Prior Ballot**. The nomination and election of Trustees to fill a vacancy that did not exist at the time of the prior ballot shall be held after election of other Trustees and shall follow the same procedure. Individuals so elected shall be elected to a complete 4-year term of office. Unsuccessful candidates in any election for Trustee, other than the young physician trustee and the resident/fellow physician trustee, shall automatically be nominated for subsequent elections until all Trustees have been elected. In addition, nominations from the floor shall be accepted.  **6.8.1.5 Council Members to be Elected to Fill Vacancies after a Prior Ballot.** The nomination and election of members of the Council to fill a vacancy that did not exist at the time of the prior ballot shall be held after election of other members of the Council, and shall follow the same procedure. Individuals elected to such vacancy shall be elected to a complete 4-year term. Unsuccessful candidates in the election for members of the Council shall automatically be nominated for subsequent elections to fill any such vacancy until all members of the Council have been elected. In addition, nominations from the floor shall be accepted. (Modify Bylaws)  *Appointing Select Councils*  **Recommendation 32:** Members of the Council on Constitution & Bylaws (CC&B) will be appointed. The appointment process would include consideration by the Board of Trustees of nominated candidates with a slate for each open position presented to the House of Delegates for approval. Terms, tenure and role of the council would remain unchanged. Appropriate bylaws to accomplish this change will be crafted by CC&B. (Modify Bylaws)  *The Role and Influence of Caucuses*  **Recommendation 33:** Policy G-610.021, Guiding Principles for House Elections, principle 2 be amended by addition to read as follows:  (2) Any electioneering practices that distort the democratic processes of House elections, such as vote trading for the purpose of supporting candidates, are unacceptable. This principle applies between as well as within caucuses and delegations. (Modify Current HOD Policy)  **Recommendation 34:** Policy G-610.021, Guiding Principles for House Elections, principles 1, 3, 4, 5 and 6 be reaffirmed:  (1) AMA delegates should: (a) avail themselves of all available background information about candidates for elected positions in the AMA; (b) determine which candidates are best qualified to help the AMA achieve its mission; and (c) make independent decisions about which candidates to vote for.  (3) Candidates for elected positions should comply with the requirements and the spirit of House of Delegates policy on campaigning and campaign spending.  (4) Candidates and their sponsoring organizations should exercise restraint in campaign spending. Federation organizations should establish clear and detailed guidelines on the appropriate level of resources that should be allocated to the political campaigns of their members for AMA leadership positions.  (5) Incumbency should not assure the re-election of an individual to an AMA leadership position.  (6) Service in any AMA leadership position should not assure ascendancy to another leadership position. (Reaffirm HOD Policy)  **Recommendation 35:** Policy G-610.021, Guiding Principles for House Elections, be amended by addition of an additional principle 7 to read as follows:  (7) Delegations and caucuses when evaluating candidates may provide information to their members encouraging open discussion regarding the candidates but should refrain from rank order lists of candidates. (Modify Current HOD Policy)  **Recommendation 36:** Policy G-610.021, Guiding Principles for House Elections, be amended by addition of an additional principle 8 to read as follows:  (8) Delegations and caucuses should be a source of encouragement and assistance to qualified candidates. Nomination and endorsement should be based upon selecting the most qualified individuals to lead our AMA regardless of the number of positions up for election in a given race. Delegations and caucuses are reminded that all potential candidates may choose to run for office, with or without their endorsement and support. (Modify Current HOD Policy)  *The Day of the Elections*  **Recommendation 37:** Policy G-610.030, Election Process, paragraph 1 be reaffirmed:  AMA guidelines on the election process are as follows: (1) AMA elections will be held on Tuesday at each Annual Meeting; ... (Reaffirm HOD Policy)  *Election Committee*  **Recommendation 38:** In accordance with Bylaw 2.13.7, the Speaker shall appoint an Election Committee of 7 individuals for 1-year terms (maximum tenure of 4 consecutive terms and a lifetime maximum tenure of 8 terms) to report to the Speaker. These individuals would agree not to be directly involved in a campaign during their tenure and would be appointed from various regions, specialties, sections, and interest groups. The primary role of the committee would be to work with the Speakers to adjudicate any election complaint. Additional roles to be determined by the Speaker and could include monitoring election reforms, considering future campaign modifications and responding to requests from the Speaker for input on election issues that arise. (New HOD Policy)  **Recommendation 39:** The Speaker in consultation with the Election Committee will consider a more defined process for complaint reporting, validation, resolution, and potential penalties This process will be presented to the House for approval. (New HOD Policy)  **Recommendation 40:** Policy G-610.020, Rules for AMA Elections, paragraph 1 be amended by addition to read as follows:   1. The Speaker and Vice Speaker of the House of Delegates are responsible for overall administration of our AMA elections, although balloting is conducted under the supervision of the chief teller and the Committee on Rules and Credentials. The Speaker and Vice Speaker will advise candidates on allowable activities and when appropriate will ensure that clarification of these rules is provided to all known candidates. The Speaker, in consultation with the Vice Speaker and the Election Committee, is responsible for declaring a violation of the rules; (Modify Current HOD Policy)   *Review of Implementation*  **Recommendation 41:** After an interval of 2 years a review of our election process, including the adopted recommendations from this report, be conducted by the Speaker and, at the Speaker’s discretion the appointment of another election task force, with a report back to the House. (New HOD Policy)  Fiscal Note: Up to $250,000 if AMA elects to sponsor a reception, depending on the number of people and food and beverage. |
| A | CMS 02 | n/a | Continuity of Care for Patients Discharged from Hospital Settings | 1. That our American Medical Association (AMA) advocate for protections of continuity of care for medical services and medications that are prescribed during patient hospitalizations, including when there are formulary or treatment coverage changes that have the potential to disrupt therapy following discharge. (New HOD Policy)  2. That our AMA support medication reconciliation processes that include confirmation that prescribed discharge medications will be covered by a patient’s health plan and resolution of potential coverage and/or prior authorization (PA) issues prior to hospital discharge. (New HOD Policy)  3. That our AMA support strategies that address coverage barriers and facilitate patient access to prescribed discharge medications, such as hospital bedside medication delivery services and the provision of transitional supplies of discharge medications to patients. (New HOD Policy)  4. That our AMA advocate to the Office of the National Coordinator for Health Information Technology (ONC) and the Centers for Medicare & Medicaid Services (CMS) to work with physician and hospital organizations, and health information technology developers, in identifying real-time pharmacy benefit implementations and published standards that provide real-time or near-time formulary information across all prescription drug plans, patient portals and other viewing applications, and electronic health record (EHR) vendors. (New HOD Policy)  5. That our AMA advocate to the ONC and the CMS that any policies requiring health information technology developers to integrate real-time pharmacy benefit systems (RTBP) within their products do so with minimal disruption to EHR usability and cost to physicians and hospitals. (New HOD Policy)  6. That our AMA support alignment and real-time accuracy between the prescription drug data offered in physician-facing and consumer-facing RTBP tools. (New HOD Policy)  7. That our AMA reaffirm Policy H-125.979, which directs the AMA to work with pharmacy benefit managers, health insurers, and pharmacists to enable physicians to receive accurate, real-time formulary data at the point of prescribing, and promotes the value of online access to up-to-date and accurate prescription drug formulary plans from all insurance providers. (Reaffirm HOD Policy)  8. That our AMA reaffirm Policy D-330.910, which directs the AMA to explore problems with prescription drug plans, including issues related to continuity of care, prior authorization, and formularies, and work to resolve them. (Reaffirm HOD Policy)  9. That our AMA reaffirm Policy D-160.945, which directs the AMA to advocate for timely and consistent communication between physicians in inpatient and outpatient settings to decrease gaps in care coordination and improve quality and patient safety, and to explore new mechanisms to facilitate and incentivize this communication. (Reaffirm HOD Policy) |
| A | CMS 07 | n/a | Addressing Equity in Telehealth | The Council on Medical Service recommends that the following be adopted in lieu of Resolve 2, Items (a) and (c) of Alternate Resolution 203-Nov-2020, and that the remainder of the report be filed.  1. That our American Medical Association (AMA) reaffirm Policy D-480.963, which advocates 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. (Reaffirm HOD Policy)  2. That our AMA reaffirm Policy H-478.980, which advocates for the expansion of broadband and wireless connectivity to all rural and underserved areas of the United States. (Reaffirm HOD Policy)  3. That our AMA encourage initiatives to measure and strengthen digital literacy, with an emphasis on programs designed with and for historically marginalized and minoritized populations. (New HOD Policy)  4. That our AMA encourage telehealth solution and service providers to implement design functionality, content, user interface, and service access best practices with and for historically minoritized and marginalized communities, including addressing culture, language, technology accessibility, and digital literacy within these populations. (New HOD Policy)  5. That our AMA support efforts to design telehealth technology, including voice-activated technology, with and for those with difficulty accessing technology, such as older adults, individuals with vision impairment and individuals with disabilities. (New HOD Policy)  6. That our AMA reaffirm Policy D-385.957, which advocates for legislative and/or regulatory changes to require that payers including Medicaid programs and Medicaid managed care plans cover interpreter services and directly pay interpreters for such services. (Reaffirm HOD Policy)  7. That our AMA encourage hospitals, health systems and health plans to invest in initiatives aimed at designing access to care via telehealth with and for historically marginalized and minoritized communities, including improving physician and provider diversity, offering training and technology support for equity-centered participatory design, and launching new and innovative outreach campaigns to inform and educate communities about telehealth. (New HOD Policy)  8. That our AMA support expanding physician practice eligibility for programs that assist providers in purchasing necessary services and equipment in order to provide telehealth services to augment the broadband infrastructure for, and increase connected device use among historically marginalized, minoritized and underserved populations. (New HOD Policy)  9. That our AMA reaffirm Policy D-480.969, which advocates for telemedicine parity laws that require private insurers to cover telemedicine-provided services comparable to that of in-person services, and not limit coverage only to services provided by select corporate telemedicine providers. (Reaffirm HOD Policy)  10. That our AMA support efforts to ensure payers allow all contracted physicians to provide care via telehealth. (New HOD Policy)  11. That our AMA oppose efforts by health plans to use cost-sharing as a means to incentivize or require the use of telehealth or in-person care or incentivize care from a separate or preferred telehealth network over the patient’s current physicians. (New HOD Policy)  12. That our AMA advocate that payments should consider the resource costs required to provide all physician visits and payments should be fair and equitable, regardless of whether the service is performed via audio-only, two-way audio-video, or in-person. (New HOD Policy) |
| A | CMS 08 | n/a | Licensure and Telehealth | 1. That our American Medical Association (AMA) work with the Federation of State Medical Boards, state medical associations and other stakeholders to encourage states to allow an out-of-state physician to use telehealth to provide continuity of care to an existing patient in the state without penalty if the following conditions are met: 2. The physician has an active license to practice medicine in a state or US territory and has not been subjected to disciplinary action. 3. There is a pre-existing and ongoing physician-patient relationship. 4. The physician has had an in-person visit(s) with the patient. 5. The telehealth services are incident to an existing care plan or one that is being modified. 6. The physician maintains liability coverage for telehealth services provided to patients in states other than the state where the physician is licensed. 7. Telehealth use complies with Health Insurance Portability and Accountability Act privacy and security rules. (Directive to Take Action) 8. That our AMA amend Policy H-480.969[1] by addition and deletion as follows:   The Promotion of Quality Telemedicine H-480.969  (1) It is the policy of the AMA that medical boards of states and territories should require a full and unrestricted license in that state for the practice of telemedicine, unless there are other appropriate state-based licensing methods, with no differentiation by specialty, for physicians who wish to practice telemedicine in that state or territory. This license category should adhere to the following principles:  ~~(a) application to situations where there is a telemedical transmission of individual patient data from the patient’s state that results in either (i) provision of a written or otherwise documented medical opinion used for diagnosis or treatment or (ii) rendering of treatment to a patient within the board’s state~~;  (~~b~~a) exemption from such a licensure requirement for ~~traditional informal~~ physician-to-physician consultations ~~(“curbside consultations”) that are provided without expectation of compensation~~;  (~~c~~b) exemption from such a licensure requirement for telemedicine practiced across state lines in the event of an emergent or urgent circumstance, the definition of which for the purposes of telemedicine should show substantial deference to the judgment of the attending and consulting physicians as well as to the views of the patient; and  (c) allowances, by exemption or other means, for out-of-state physicians providing continuity of care to a patient, where there is an established ongoing relationship and previous in-person visits, for services incident to an ongoing care plan or one that is being modified.  (d) application requirements that are non-burdensome, issued in an expeditious manner, have fees no higher than necessary to cover the reasonable costs of administering this process, and that utilize principles of reciprocity with the licensure requirements of the state in which the physician in question practices. (Modify Current AMA Policy)   1. That our AMA continue to support state efforts to expand physician licensure recognition across state lines in accordance with the standards and safeguards outlined in Policy   H-480.946, Coverage and Payment for Telemedicine. (New HOD Policy)   1. That our AMA reaffirm Policy D-480.964, which directs the AMA to work with state medical associations to encourage states that are not part of the Interstate Medical Licensure Compact to consider joining the Compact; advocate for reduced application and state licensure(s) fees processed through the Interstate Medical Licensure Compact; and work with interested state medical associations to encourage states to pass legislation enhancing patient access to and proper regulation of telemedicine services. (Reaffirm HOD Policy) 2. That our AMA reaffirm Policy H-480.946, which delineates standards and safeguards that should be met for the coverage and payment of telemedicine, including that physicians and other health practitioners must be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by the state’s medical board. (Reaffirm HOD Policy) |
| A | Res 101 | New York | Piloting the Use of Financial Incentives to Reduce Unnecessary Emergency Room Visits | **RESOLVED, That our American Medical Association study and report on the positive and negative experiences of programs in various states that provide Medicaid beneficiaries with incentives for choosing alternative sites of care when it is appropriate to their symptoms and/or condition instead of hospital emergency departments. (Directive to Take Action)** |
| A | Res 102 | New York | Bundling Physician Fees with Hospital Fees | RESOLVED, That our American Medical Association oppose bundling of physician payments with hospital payments, unless the physician has agreed to such an arrangement in advance. (New HOD Policy) |
| A | Res 103 | New York | COBRA for College Students | RESOLVED, That our American Medical Association call for legislation similar to COBRA to allow college students to continue their healthcare coverage, at their own expense, for up to 18 months after graduation or other termination of enrollment. (Directive to Take Action) |
| A | Res 104 | New York | Medicaid Tax Benefits | RESOLVED, That our American Medical Association advocate for legislation that would allow physicians who take care of Medicaid or uninsured patients to receive some financial benefit through a tax deduction such as (a) a reduced rate of overall taxation or (b) the ability to use the unpaid charges for such patients as a tax deduction. (Directive to Take Action) |
| A | Res 105 | Florida | Effects of Telehealth Coverage and Payment Parity on Health Insurance Premiums | RESOLVED, That our American Medical Association conduct or commission a study on the effects that telemedicine services have had on health insurance premiums, focusing on the differences between states that had telehealth payment parity provisions in effect prior to the pandemic versus those that did not, and report back at the 2021 Interim Meeting of the AMA House of Delegates. (Directive to Take Action) |
| A | Res 106 | American College of Cardiology | Socioeconomics of CT Coronary Calcium: Is it Scored or Ignored? | RESOLVED, That our American Medical Association seek national and/or state legislation and/or a national coverage determination (NCD) to include coronary artery calcium scoring (CACS) for patients who meet the screening criteria set forth by the American College of Cardiology/American Heart Association 2019 Primary Prevention Guidelines, as a first-dollar covered preventive service, consistent with the current policy in the state of Texas (Directive to Take Action); and be it further  RESOLVED, That our AMA collaborate with the appropriate stakeholders to propose that hospitals strongly consider a no cost/nominal cost option for CACS in appropriate patients who are unable to afford this test, as a means to enhance disease detection, disease modification and management. (Directive to Take Action) |
| A | Res 107 | Resident and Fellow Section | Recognizing the Need to Move Beyond Employer-Sponsored Health Insurance | RESOLVED, That our American Medical Association recognize the importance of providing avenues for affordable health insurance coverage and health care access to patients who do not have employer-sponsored health insurance, or for whom employer-sponsored health insurance does not meet their needs (New HOD Policy); and be it further  RESOLVED, That our AMA recognize that a significant and increasing proportion of patients are unable to meet their health insurance or health care access needs through employer-sponsored health insurance, and that these patients must be considered in the course of ongoing efforts to reform the healthcare system in pursuit of universal health insurance coverage and health care access. (New HOD Policy) |
| A | Res 108 | Resident and Fellow Section | Implant-Associated Anaplastic Large Cell Lymphoma | RESOLVED, That our American Medical Association support appropriate coverage of cancer diagnosis, treating surgery and other systemic treatment options for implant-associated anaplastic large cell lymphoma. (New HOD Policy) |
| A | Res 109 | Illinois | Support for Universal Internet Access | RESOLVED, That our American Medical Association recognize that internet access is a social determinant of health (New HOD Policy); and be it further  RESOLVED, That our AMA support universal access to broadband home internet (New HOD Policy); and be it further  RESOLVED, That our AMA advocate for legislation to reduce barriers and increase access to broadband internet, including federal, state, and local funding of broadband internet to reduce price, the establishment of automatic applications for recipients of Medicaid or other assistance programs, and increasing the number of devices and streams covered per household. (Directive to Take Action) |
| A | Res 110 | Georgia | Healthcare Marketplace Plan Selection | RESOLVED, That our American Medical Association advocate for patients to have expanded plan options on the Healthcare Marketplace beyond the current options based solely on the zip code of their primary residence or where their physician practices, including the interstate portability of plans. (Directive to Take Action) |
| A | Res 111 | Senior Physicians Section | Towards Prevention of Hearing-Loss Associated Cognitive Impairment | RESOLVED, That our American Medical Association promote awareness of hearing impairment as a potential contributor to the development of cognitive impairment in later life, to physicians as well as to the public (Directive to Take Action); and be it further  RESOLVED, That our AMA promote, and encourage other stakeholders, including public, private, and professional organizations and relevant governmental agencies, to promote, the conduct and acceleration of research into specific patterns and degrees of hearing loss to determine those most linked to cognitive impairment and amenable to correction (Directive to Take Action); and be it further  RESOLVED, That our AMA advocate for increasing hearing screening and avenues for coverage for effective hearing loss remediation beginning in mid-life or whenever detected, including third party insurance coverage, especially when such loss is shown conclusively to contribute significantly to the development of, or to magnify the functional deficits of cognitive impairment, and/or to limit the capacity of individuals for independent living. (Directive to Take Action) |
| A | Res 112 | Young Physicians Section | Fertility Preservation Benefits for Active-Duty Military Personnel | RESOLVED, That our American Medical Association work with interested organizations to encourage TRICARE to cover fertility preservation procedures (cryopreservation of sperm, oocytes, or embryos) for medical indications, for active-duty military personnel and other individuals covered by TRICARE (Directive to Take Action); and be it further  RESOLVED, That our AMA work with interested organizations to encourage TRICARE to cover gamete preservation prior to deployment for active-duty military personnel (Directive to Take Action); and be it further  RESOLVED, That our AMA report back on this issue at the 2022 Annual Meeting of the AMA House of Delegates. (Directive to Take Action) |
| A | Res 113 | Medical Student Section | Support for Universal Internet Access | RESOLVED, That our American Medical Association amend policy H-478.980, “Increasing Access to Broadband Internet to Reduce Health Disparities,” by addition and deletion to read 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 and wireless internet and voice connectivity, especially in ~~to all~~ rural and underserved areas of the United States while at all times taking care to protecting existing federally licensed radio services from harmful interference that can be caused by broadband and wireless services.  2. Our AMA will 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. (Modify Current HOD Policy) |
| A | Res 114 | Medical Student Section | Reimbursement of School-Based Health Centers | RESOLVED, That our American Medical Association promote the implementation, use, and maintenance of school based health centers by amending H-60.921, “School-Based and School-Linked Health Centers,” by addition and deletion to read 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. (Modify Current HOD Policy) |
| A | Res 115 | Medical Student Section | Federal Health Insurance Funding and Co-Payments for People Experiencing Incarceration | RESOLVED, That our American Medical Association 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 (Directive to Take Action); and be it further  RESOLVED, That our AMA advocate for the prohibition of the use of co-payments to access healthcare services in correctional facilities (Directive to Take Action); and be it further  RESOLVED, That our AMA amend policy H-430.986 by addition to read 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.  ~~5~~6. 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.  ~~6~~7. 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.  ~~7~~8. 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.  ~~8~~9. 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.  ~~9~~10. 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 (Modify Current HOD Policy) |
| A | Res 116 | Medical Student Section | Caps on Insulin Co-Payments for Patients with Insurance | RESOLVED, That our American Medical Association amend policy H-110.984, “Insulin Affordability,” by addition and deletion to read as follows:  **Insulin Affordability H-110.984**  Our AMA will: (1) encourage the Federal Trade Commission (FTC) and the Department of Justice to monitor insulin pricing and market competition and take enforcement actions as appropriate; ~~and~~ (2) support initiatives, including those by national medical specialty societies, that provide physician education regarding the cost-effectiveness of insulin therapies~~.~~; (3) support state and national efforts to limit the copayments insured patients pay per month for prescribed insulin. (Modify Current HOD Policy) |
| A | Res 117 | Medical Student Section | Addressing Healthcare Accessibility for Current and Aged-Out Youth in the Foster Care System | RESOLVED, That our American Medical Association amend policy 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 of other publicly funded health coverage in their state until at least 26 years of age. (Modify Current HOD Policy) |
| A | Res 118 | Texas | Contracted Health Plans Must Apply the Same Level of Benefits Concerning Patient Responsibility | RESOLVED, That the American Medical Association adopt as policy that health plans in a binding contract with a physician must apply the same level of benefits concerning patient responsibility (copay, coinsurance) regardless of the contracted physician or provider rendering the service (New HOD Policy); and be it further  RESOLVED, That the AMA take this issue to the Council on Legislature for national/state statutory action. (Directive to Take Action) |
| A | Res 119 | Texas | Caps on Insulin Copayments with Insurance | RESOLVED, That our American Medical Association support limiting the copayments insured patients pay per month for prescribed insulin. (New HOD Policy) |
| A | Res 120 | Texas | Postpartum Maternal Healthcare Coverage Under Children’s Insurance | RESOLVED, That our American Medical Association work with relevant stakeholders to support coverage of and payment for postpartum maternal health care for at least 12 months postpartum under the newborn child’s health insurance plan, including Children’s Medicaid and Children’s Health Insurance Program plans for women who are otherwise uninsured or ineligible for Medicaid. (Directive to Take Action) |
| A | Res 121 | Michigan | Medicaid Dialysis Policy for Undocumented Patients | RESOLVED, That our American Medical Association work with the Centers for Medicare and Medicaid Services and state Medicaid programs to develop a dialysis policy for undocumented patients with end stage kidney disease as an emergency condition covered under Medicaid. (Directive to Take Action) |
| A | Res 122 | Integrated Physician Practice Section | Developing Best Practices for Prospective Payment Models | RESOLVED, That our American Medical Association study and identify best practices for financially viable models for prospective payment health insurance, including but not limited to appropriately attributing and allocating patients to physicians, elucidating best practices for systems with multiple payment contracts, and determining benchmarks for adequate infrastructure, capital investment, and models that accommodate variations in existing systems and practices (Directive to Take Action); and be it further  RESOLVED, That our AMA use recommendations generated by its research to actively advocate for expanded use and access to prospective payment models (Directive to Take Action) |
| A | Res 123 | Medical Student Section | Medicare Eligibility at Age 60 | RESOLVED, That our American Medical Association advocate that the eligibility threshold to receive Medicare as a federal entitlement be lowered from age 65 to age 60. (Directive to Take Action) |
| B | BOT 07 | n/a | Council on Legislation Sunset Review of 2011 House Policies | The Board of Trustees recommends that the House of Delegates policies that are listed in the appendix to this report be acted upon in the manner indicated and the remainder of this report be filed. |
| B | BOT 14 | n/a | Pharmaceutical Advertising in Electronic Health Record Systems | The Board of Trustees recommends that Policy D-478.961 be amended as follows and the remainder of the report be filed: Our AMA: (1) opposes direct-to-prescriber pharmaceutical and promotional content in electronic health records (EHR); and (2) opposes direct-to-prescriber pharmaceutical and promotional content in medical reference and e-prescribing software, unless such content complies with all provisions in Direct-to-Consumer Advertising (DTCA) of Prescription Drugs and Implantable Devices (H‑105.988); and (3) encourages the ~~federal government to~~ study of the effects of direct-to-~~physician~~prescriber advertising at the point of care, including advertising in ~~Electronic Health Record Systems~~ ~~(~~EHRs~~)~~, on physician prescribing, patient safety, data privacy, health care costs, and EHR access for ~~small~~physician practices.~~; and (2) will study the prevalence and ethics of direct-to-physician advertising at the point of care, including advertising in EHRs.~~ |
| B | BOT 18 | n/a | Digital Vaccine Credential Systems and Vaccine Mandates in COVID-19 | COVID-19 and COVID-19 vaccines raise unique challenges. To meet these challenges, our AMA:  1. Encourages the development of clear, strong, universal, and enforceable federal guidelines for the design and deployment of digital vaccination credentialing services (DVCS), and that before decisions are taken to implement use of vaccine credentials  a. vaccine is widely accessible;  b. equity-centered privacy protections are in place to safeguard data collected from individuals;  c. provisions are in place to ensure that vaccine credentials do not exacerbate inequities; and  d. credentials address the situation of individuals for whom vaccine is medically contraindicated (New HOD Policy)  2. Recommends that decisions to mandate COVID-19 vaccination be made only:  a. After a vaccine has received full approval from the U.S. Food and Drug Administration through a Biological Licenses Application;  b. In keeping with recommendations of the Advisory Committee on Immunization Practices for use in the population subject to the mandate as approved by the Director of the Centers for Disease Control and Prevention;  c. When individuals subject to the mandate have been given meaningful opportunity to voluntarily accept vaccination; and  d. Implementation of the mandate minimizes the potential to exacerbate inequities or adversely affect already marginalized or minoritized populations. (New HOD Policy)  3. Encourages the use of well-designed education and outreach efforts to promote vaccination to protect both public health and public trust. (New HOD Policy) |
| B | Res 201 | Maryland | Ensuring Continued Enhanced Access to Healthcare via Telemedicine and Telephonic Communication | RESOLVED, That our American Medical Association address the importance of at least a 365-day waiting period after the COVID-19 public health crisis is over before commencement of audits aimed at discovering the use of non-HIPAA compliant modes and platforms of telemedicine by physicians. (Directive to Take Action) |
| B | Res 202 | New York | Prohibit Ghost Guns | RESOLVED, That our American Medical Association support state and federal legislation and regulation that would subject homemade weapons to the same regulations and licensing requirements as traditional weapons. (New HOD Policy) |
| B | Res 203 | New York | Ban the Gay/Trans (LGBTQ+) Panic Defense | RESOLVED, That our American Medical Association seek a federal law banning the use of the so-called “gay/trans (LGBTQ+) panic” defense in homicide, manslaughter, physical or sexual assault cases (Directive to Take Action); and be it further  RESOLVED, That our AMA publish an issue brief and talking points on the topic of so called “gay/trans (LGBTQ+) panic” defense, that can be used by our AMA in seeking federal legislation, and can be used and adapted by state and specialty medical societies, other allies, and stakeholders as model legislation when seeking state legislation to ban the use of so-called “gay/trans (LGBTQ+) panic” defense to mitigate personal responsibility for violent crimes such as assault, rape, manslaughter, or homicide. (Directive to Take Action) |
| B | Res 204 | New York | Insurers and Vertical Integration | RESOLVED, That our American Medical Association seek legislation and regulation to prevent health payers (except non-profit HMO’s) from owning or operating other entities in the health care supply chain. (Directive to Take Action) |
| B | Res 205 | South Carolina | Protection of Peer-Review Process | RESOLVED, That our American Medical Association use its full ability and influence to oppose any new attempt(s) to make Peer Review proceedings, regardless of the venue, discoverable, even if by the US Congress or other US Governmental entity. (Directive to Take Action) |
| B | Res 206 | American Academy of Pediatrics | Redefining the Definition of Harm | RESOLVED, That our American Medical Association advocate to the Office of Civil Rights to revise the definition of harm to include mental and emotional distress. Such a revision would allow additional flexibility for clinicians under the Preventing Harm Exception, based on their professional judgement, to withhold sensitive information they believe could cause physical, mental or emotional harm to the patient (Directive to Take Action); and be it further  RESOLVED, That our AMA advocate that the Office of Civil Rights assemble a commission of medical professionals to help the office review the definition of harm and provide scientific evidence demonstrating that mental and emotional health is intertwined with physical health. (Directive to Take Action) |
| B | Res 207 | Resident and Fellow Section | Studying Physician Supervision of Allied Health Professionals Outside of Their Fields of Graduate Medical Education | RESOLVED, That our American Medical Association conduct a systematic study to collect and analyze publicly available physician supervision data from all sources to determine how many allied health professionals are being supervised by physicians in field which are not a core part of those physicians’ completed residencies and fellowships. (Directive to Take Action) |
| B | Res 208 | Pennsylvania | Increasing Residency Positions for Primary Care | RESOLVED, That our American Medical Association prioritize the number of accredited residency positions, with the goal to increase the overall number especially in specialties deemed primary care (Directive to Take Action); and  RESOLVED, That our AMA seek to increase the cap of Medicare support for graduate medical education. (Directive to Take Action) |
| B | Res 209 | Pennsylvania | Making State Health Care Cost Containment Datasets Free of Cost and Readily Available for Academic Research | RESOLVED, That our American Medical Association advocate for affordable and open access to all all-payer claims databases (APCDs) data for academic research purposes. (Directive to Take Action) |
| B | Res 210 | Illinois | Ransomware and Electronic Health Records | RESOLVED, That our American Medical Association adopt policy acknowledging that healthcare data interruptions are especially harmful due to potential physical harm to patients and calling for prosecution to the fullest extent of the law for perpetrators of ransomware and any other malware on independent physicians and their practices, healthcare organizations, or other medical entities involved in providing direct and indirect care to patients (New HOD Policy); and be it further  RESOLVED, That our AMA seek to introduce federal legislation which provides for the prosecution of perpetrators of ransomware and any other malware on any and all healthcare entities, involved in direct and indirect patient care, to the fullest extent of the law. (Directive to Take Action) |
| B | Res 211 | Illinois | Permitting the Dispensing of Stock Medications for Post Discharge Patient Use and the Safe Use of Multi-dose Medications for Multiple Patients | RESOLVED, That our American Medical Association work with national specialty societies, state medical societies and/or other interested parties to ensure that legislative and regulatory language permits the practice of dispensing stock-item medications to individual patients upon discharge in accordance with labeling and dispensing protocols that help ensure patient safety, minimize duplicated patient costs, and reduce medication waste (Directive to Take Action); and be it further  RESOLVED, That our AMA work with the Food and Drug Administration, national specialty societies, state medical societies and/or other interested parties to ensure that legislative and regulatory language permits the practice of using multi dose eye drop bottles pre-operatively in accordance with safe handling and dispensing protocols that help ensure patient safety, minimize duplicated patient costs, and reduce medication waste. (Directive to Take Action) |
| B | Res 212 | American Academy of Dermatology | ONC’s Information Blocking Regulations | RESOLVED, That our American Medical Association advocate for additional time and compliance leeway for physicians by urging the Office of the National Coordinator for Health Information Technology (ONC) to broaden and relax their current regulatory requirements based on the following critical enumerated requests:  a. Urge the ONC to strike the right balance between the demands and distress caused by the COVID-19 public health emergency (PHE) and its interoperability rule objectives.  b. Urge the ONC to earnestly consult with relevant stakeholders about unintended or unforeseen consequences that may arise from the information blocking regulations.  c. Urge the ONC, through an interim final rule moratorium, to delay the current applicability date of information blocking provisions until 12 months after the PHE is officially declared over, affording small and medium-sized medical practices time to recover and prepare.  d. Urge the Department of Health and Human Services (HHS)’s ONC and their OIG to propose future enforcement discretion that would afford small and medium-sized medical practices further compliance flexibilities given their lack of resources.  e. Call on the HHS’s ONC and OIG in future enforcement rulemaking to propose corrective action and further technical guidance rather than imposing fines or penalties.  f. Urge the ONC to broaden and relax its Patient Harm Exception through subregulatory revisions that would include patients’ emotional and mental distress to the current and narrow definition of this exception.  g. Call on the ONC to develop and offer more meaningful educational guidance, practical resources, and technical assistance to physician practices to help them meet their compliance efforts, patient care obligations and documentation requirements. (Directive to Take Action) |
| B | Res 213 | Association for Clinical Oncology | CMMI Payment Reform Models | RESOLVED, That our American Medical Association continue to advocate against mandatory Center for Medicare and Medicaid Innovation (CMMI) demonstration projects (Directive to Take Action); and be it further  RESOLVED, That our AMA advocate that the Centers for Medicare and Medicaid Services seek innovative payment and care delivery model ideas from physicians and groups such as medical specialty societies to guide recommendation of the Physician-Focused Payment Model Technical Advisory Committee (PTAC) and work of the CMMI to propose demonstration projects that are voluntary and can be appropriately tested (Directive to Take Action); and be it further  RESOLVED, That our AMA advocate that CMMI focus on the development of multiple pilot projects in many specialties, which are voluntary and tailored to the needs of local communities and the needs of different specialties. (Directive to Take Action) |
| B | Res 214 | Medical Student Section | Status of Immigration Laws, Rules, and Legislation During National Crises and Addressing Immigrant Health Disparities | RESOLVED, That our American Medical Association, in order to prioritize the unique health needs of immigrants, asylees, refugees, and migrant workers during national crises, such as a pandemic:   1. oppose the slowing or halting of the release of individuals and families that are currently part of the immigration process; and 2. oppose 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. support 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. oppose utilizing public health concerns to deny of significantly hinder eligibility for asylum status to immigrants, refugees, or migrant workers without a viable, medically sound alternative solution (New HOD Policy); and be it further   RESOLVED, That our AMA amend H-350.957, “Addressing Immigrant Health Disparities,”by addition to read as follows:  Addressing Immigrant and Refugee Health Disparities H-350.957  1. Our American Medical Association recognizes the unique health needs of immigrants and refugees and encourages the exploration of issues related to immigrant and refugee health and supports legislation and policies that address the unique health needs of immigrants and refugees.  2. Our AMA: (A) urges federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology; (B) advocates for and publicizes medically accurate information to reduce anxiety, fear, and marginalization of specific populations; and (C) advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees.  3. Our AMA will call for asylum seekers to receive all medically appropriate care, including vaccinations in a patient centered, language and culturally appropriate way upon presentation for asylum regardless of country of origin.  4. Our AMA opposes any rule, regulation, or policy that would worsen health disparities among refugee or immigrant populations by forcing them to choose between health care or future lawful residency status. (Modify Current HOD Policy) |
| B | Res 215 | Medical Student Section | Exemptions to Work Requirements and Eligibility Expansions in Public Assistance Programs | RESOLVED, That our American Medical Association support reduction and elimination of work requirements applied to the Supplemental Nutrition Assistance Program and the Temporary Assistance for Needy Families Program (New HOD Policy); and be it further  RESOLVED, That our AMA support states’ ability to expand eligibility for public assistance programs beyond federal standards, including automatically qualifying individuals for a public assistance program based on their eligibility for another program. (New HOD Policy) |
| B | Res 216 | Medical Student Section | Opposition to Federal Ban on SNAP Benefits for Persons Convicted of Drug Related Felonies | RESOLVED, That our American Medical Association oppose any lifetime ban on SNAP benefits imposed on individuals convicted of drug-related felonies. (New HOD Policy) |
| B | Res 217 | Medical Student Section | Amending H-150.962, Quality of School Lunch Program to Advocate for the Expansion and Sustainability of Nutritional Assistance Programs During COVID-19 | RESOLVED, That our American Medical Association 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. (Modify Current HOD Policy) |
| B | Res 218 | Medical Student Section | Advocating for Alternatives to Immigrant Detention Centers that Respect Human Dignity | RESOLVED, That our American Medical Association advocate for the preferential use of Alternatives to Detention programs that respect the human dignity of immigrants, migrants, and asylum seekers who are in the custody of federal agencies. (Directive to Take Action) |
| B | Res 219 | Medical Student Section | Oppose Tracking of People who Purchase Naloxone | RESOLVED, That our American Medical Association oppose any policies that require personally identifiable information associated with naloxone prescriptions or purchases to be tracked or monitored by non-health care providers. (New HOD Policy) |
| B | Res 220 | Medical Student Section | Equal Access to Adoption for the LGBTQ Community | RESOLVED, That our American Medical Association advocate for equal access to adoption services for LGBTQ individuals who meet federal criteria for adoption regardless of gender identity or sexual orientation (Directive to Take Action); 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. (Directive to Take Action) |
| B | Res 221 | Medical Student Section | Support for Mental Health Courts | RESOLVED, That American Medical Association Policy H-100.955, Support for Drug Courts, be amended by addition and deletion to read 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. (Modify Current HOD Policy) |
| B | Res 222 | Medical Student Section | Advocating for the Amendment of Chronic Nuisance Ordinances | RESOLVED, That our American Medical Association advocate for amendments to chronic nuisance ordinances that ensure calls made for safety or emergency services, are not counted towards nuisance designations (Directive to Take Action); and be it further  RESOLVED, That our AMA support initiatives to (a) gather data on chronic nuisance ordinance enforcement and (b) make that data publicly available to enable easier identification of disparities. (New HOD Policy) |
| B | Res 223 | Medical Student Section | Supporting Collection of Data on Medical Repatriation | RESOLVED, That our American Medical Association ask the Department of Health and Human Services to collect and de-identify any and all instances of medical repatriations from the United States to other countries by medical centers to further identify the harms of this practice (Directive to Take Action); and be it further  RESOLVED, That our AMA denounce the practice of forced medical repatriation. (New HOD Policy) |
| B | Res 224 | Medical Student Section | Using X-Ray and Dental Records for Assessing Immigrant Age | RESOLVED, That our American Medical Association support discontinuation of the use of non-medically necessary dental and bone forensics to assess an immigrant’s age. (New HOD Policy) |
| B | Res 225 | Texas | Insurance Coverage Transparency | RESOLVED, That our American Medical Association advocate for legislation that requires commercial insurance carriers to provide accurate information regarding the patient’s cost-sharing liability and the insurance plan’s liability when a medical office or facility provides the diagnosis and CPT codes via phone or the internet (Directive to Take Action); and be it further  RESOLVED, That our AMA advocate for legislation that requires commercial insurance carriers, during insurance eligibility verification, to provide information regarding factors that may result in denial of the claim, e.g., the insurance carrier is waiting for the primary policyholder to verify whether he or she has other health insurance coverage (Directive to Take Action); and be it further  RESOLVED, That our AMA advocate for legislation that requires commercial insurance carriers to respond to telephone inquiries about the patient’s cost-sharing liability by providing accurate information verbally and via fax confirmation (Directive to Take Action); and be it further  RESOLVED, That our AMA advocate for legislation that penalizes commercial insurance carriers, via fines and the publication of each carrier’s number of noncompliance complaints, when the above information is inaccurate or not provided in a timely manner. (Directive to Take Action) |
| B | Res 226 | Michigan | Interest-Based Debt Burden on Medical Students and Residents | RESOLVED, That our American Medical Association strongly advocate for the passage of legislation to allow borrowers to qualify for interest-free deferment on their student loans while serving in a medical or dental internship, residency, or fellowship program, as well as permitting the conversion of currently unsubsidized Stafford and Graduate Plus loans to interest free status for the duration of undergraduate and graduate medical education. (Directive to Take Action) |
| B | Res 227 | Integrated Physician Practice Section | Audio-Only Telehealth for Risk Adjusted Payment Models | RESOLVED, That our American Medical Association advocate that audio-only telehealth encounter diagnoses be included in risk adjusted payment models. (Directive to Take Action) |
| B | Res 228 | Resident and Fellow Section | COVID-19 Vaccination Rollout to Emergency Departments and Urgent Care Facilities | RESOLVED, That our American Medical Association acknowledge that our nation's COVID-19 vaccine rollout is not yet optimized, and we have a duty to vaccinate as many people in an effective manner (Directive to Take Action); and be it further  RESOLVED, That our AMA work with other relevant organizations and stakeholders to lobby the current Administration for the distribution of COVID-19 vaccinations to our nation's emergency departments and urgent care facilities (Directive to Take Action); and be it further  RESOLVED, That our AMA advocate for additional funding to be directed towards increasing COVID-19 vaccine ambassador programs in emergency departments and urgent care facilities. (Directive to Take Action) |
| B | Res 229 | Medical Student Section | Classification and Surveillance of Maternal Mortality | RESOLVED, That our American Medical Association advocate for an annual release of the national maternal mortality rate in the United States (Directive to Take Action); and be it further  RESOLVED, That our AMA collaborate with relevant stakeholders to advocate for a reliable, accurate, and standardized definition of maternal mortality that will be implemented across states for tracking data on maternal mortality (Directive to Take Action); and be it further  RESOLVED, That our AMA encourage research efforts to characterize the health needs for pregnant inmates, including efforts that utilize data acquisition directly from pregnant inmates (Directive to Take Action); and be it further  RESOLVED, That our AMA support legislation requiring all correctional facilities, including those that are privately-owned, to collect and publicly report pregnancy-related healthcare statistics with transparency in the data collection process. (Directive to Take Action) |
| B | Res 230 | Medical Student Section | Considerations for Immunity Credentials During Pandemics and Epidemics | RESOLVED, That our American Medical Association oppose the implementation of natural immunity credentials, which give an individual differential privilege on the basis of natural immunity after non-vaccine exposure status to a pathogen (Directive to Take Action); and be it further  RESOLVED, That our AMA caution that any implementation of vaccine-induced immunity credentials, which give an individual differential privilege on the basis of acquired immunity after receiving a vaccine, must strongly consider potential consequences on social inequity, including, but not limited to: (i) continued marginalization of communities historically harmed or ignored by the healthcare system; (ii) isolation of populations who may be ineligible for or unable to access vaccines; (iii) barriers preventing immigration or travel from countries with low access to vaccines and the need to offer a vaccine upon arrival to anyone entering the US from another country; and (iv) privacy of and accessibility to any systems used to implement vaccine-induced immunity passports. (Directive to Take Action) |
| B | Res 231 | Medical Student Section | Increasing Access to Menstrual Hygiene Products | RESOLVED, That our American Medical Association recognize the adverse physical and mental health consequences of limited access to menstrual products for school-aged individuals (Modify Current HOD Policy); and be it further    RESOLVED, That our AMA support the distribution of menstrual products and inclusion of menstrual product disposal systems in educational institutions (Directive to Take Action); and but it further  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 (Directive to Take Action); and be it further  RESOLVED, That our AMA amend policy H-525.974, “Considering Feminine Hygiene Products as Medical Necessities”, by addition to read 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; and (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. (Modify Current HOD Policy); and be it further  RESOLVED, That our AMA support the inclusion of medically necessary hygiene products, including, but not limited to, menstrual hygiene products and diapers, within the benefits covered by appropriate public assistance programs (Directive to Take Action); and be it further  RESOLVED, That our AMA advocate for federal legislation that increases the access to menstrual hygiene products, especially for recipients of public assistance (Directive to Take Action); and be it further  RESOLVED, That our AMA work with state medical societies to advocate for state legislation that increases access to menstrual hygiene products, especially for recipients of public assistance. (Directive to Take Action) |
| B | Res 232 | Private Practice Physicians Section | Preventing Inappropriate Use of Patient Protected Medical Information in the Vaccination Process | RESOLVED, That our American Medical Association advocate to prohibit the use of patient/customer information collected by retail pharmacies for COVID-19 vaccination scheduling and/or the vaccine administration process for commercial marketing or future patient recruiting purposes, especially any targeting based on medical history or conditions (Directive to Take Action); and be it further  RESOLVED, That our AMA oppose the sale of medical history data and contact information accumulated through the scheduling or provision of government-funded vaccinations to third parties for use in marketing or advertising. (New HOD Policy) |
| C | CME 01 | n/a | Council on Medical Education Sunset Review of 2011 House Policies | The Council on Medical Education recommends that the House of Delegates policies listed in the appendix to this report be acted upon in the manner indicated and the remainder of this report be filed. (Directive to Take Action) |
| C | CME 02 | n/a | Licensure for International Medical Graduates Practicing in U.S. Institutions with Restricted Medical Licenses (Resolution 311-A-19) | * 1. That our American Medical Association (AMA) encourage state medical licensing boards and the member boards of the American Board of Medical Specialties to develop criteria that allow 1) completion of medical school and residency training outside the U.S., 2) extensive U.S. medical practice, and 3) evidence of good standing within the local medical community to serve as a substitute for U.S. graduate medical education requirement for physicians seeking full unrestricted licensure and board certification. (Directive to Take Action)   2. That our AMA amend Policy H-255.988 (12), “AMA Principles on International Medical Graduates,” by addition to read as follows:   Our AMA supports …12. The requirement that all medical school graduates complete at least one year of graduate medical education in an accredited U.S. program in order to qualify for full and unrestricted licensure. State medical licensing boards are encouraged to allow an alternate set of criteria for granting licensure in lieu of this requirement: 1) completion of medical school and residency training outside the U.S., 2) extensive U.S. medical practice, and 3) evidence of good standing within the local medical community. (Modify Current HOD Policy)   * 1. That our AMA amend Policy H-275.934 (2), “Alternatives to the Federation of State Medical Boards Recommendations on Licensure,” by addition to read as follows:   2. All applicants for full and unrestricted licensure, whether graduates of U.S. medical schools or international medical graduates, must have completed one year of accredited graduate medical education (GME) in the U.S., have passed all state-required licensing examinations (USMLE or COMLEX USA), and must be certified by their residency program director as ready to advance to the next year of GME and to obtain a full and unrestricted license to practice medicine. State medical licensing boards are encouraged to allow an alternate set of criteria for granting licensure in lieu of this requirement for completing one year of accredited GME in the U.S.: 1) completion of medical school and residency training outside the U.S., 2) extensive U.S. medical practice, and 3) evidence of good standing within the local medical community. (Modify Current HOD Policy)   * 1. That our AMA amend Policy H-160.949 (6), “Practicing Medicine by Non-Physicians,” by addition and deletion to read as follows: Our AMA … (6) opposes special licensing pathways for “assistant physicians” (i.e., those who are not currently enrolled in an Accreditation Council for Graduate Medical Education ~~of American Osteopathic Association~~ training program, or have not completed at least one year of accredited ~~post-~~graduate ~~US~~ medical education in the U.S). (Modify Current HOD Policy)   2. That our AMA amend Policy H-275.978 (5), “Medical Licensure,” by addition to read as follows:   Our AMA … (5) urges those licensing boards that have not done so to develop regulations permitting the issuance of special purpose licenses, with the exception of special licensing pathways for “assistant physicians.” It is recommended that these regulations permit special purpose licensure with the minimum of educational requirements consistent with protecting the health, safety and welfare of the public; (Modify Current HOD Policy) |
| C | CME 03 | n/a | Optimizing Match Outcomes | 1. That our AMA reaffirm Policies D-310.977, “National Resident Matching Program Reform,” H-200.954, “US Physician Shortage,” and D-305.967, “The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education.” (Reaffirm HOD Policy) 2. That our AMA encourage the Association of American Medical Colleges, American Association of Colleges of Osteopathic Medicine, National Resident Matching Program, and other key stakeholders to jointly create a no-fee, easily accessible clearinghouse of reliable and valid advice and tools for residency program applicants seeking cost-effective methods for applying to and successfully matching into residency. (Directive to Take Action) |
| C | CME 04 | n/a | Expediting Entry of Qualified IMG Physicians to U.S. Medical Practice | 1. That American Medical Association (AMA) Policy D-255.980 (1), “Impact of Immigration Barriers on the Nation’s Health,” that reads, “Our AMA recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine” be reaffirmed. (Reaffirm HOD Policy) 2. That our AMA encourage states to study existing strategies to improve policies and processes to assist IMGs with credentialing and licensure to enable them to care for patients in underserved areas. (Directive to Take Action) 3. That our AMA encourage the Federation of State Medical Boards and state medical boards to evaluate the progress of programs aimed at reducing barriers to licensure—including successes, failures, and barriers to implementation. (Directive to Take Action) 4. That Policy D-255.978, “Study Expediting Entry of Qualified IMG Physicians to US Medical Practice,” be rescinded, as having been fulfilled by this report. (Rescind HOD Policy) |
| C | CME 05 | n/a | Promising Practices Among Pathway Programs to Increase Diversity in Medicine | 1. That our AMA recognize some people have been historically underrepresented, excluded from, and marginalized in medical education and medicine because of their race, ethnicity, sexual orientation, and gender identity due to structural racism and other systems of oppression. (New HOD Policy) 2. That our AMA commit to promoting truth and reconciliation in medical education as it relates to improving equity. (New HOD Policy) 3. That our AMA recognize the harm caused by the Flexner Report to historically Black medical schools, the diversity of the physician workforce, and the outcomes of minoritized and marginalized patient populations. (New HOD Policy) 4. That our AMA work with appropriate stakeholders to commission and enact the recommendations of a forward-looking, cross-continuum, external study of 21st century medical education focused on reimagining the future of health equity and racial justice in medical education, improving the diversity of the health workforce, and ameliorating inequitable outcomes among minoritized and marginalized patient populations. (New HOD Policy) 5. That our AMA amend Policy H-200.951, Strategies for Enhancing Diversity in the Physician Workforce by addition and deletion to read as follows: (4) encourages medical schools, health care institutions, managed care and other appropriate groups to adopt and utilize activities that bolster efforts to include and support historically underrepresented groups in medicine, by developing policies that articulate~~ing~~ the value and importance of diversity as a goal that benefits all participants, cultivating and funding programs that nurture a culture of diversity on campus, and recruiting faculty and staff who share this ~~and strategies to accomplish that~~ goal. (5) continue to study and provide recommendations to improve the future of health equity and racial justice in medical education, the diversity of the health workforce, and the outcomes of minoritized and marginalized patient populations. (Modify Current HOD Policy) 6. That our AMA amend Policy H-60.917, Disparities in Public Education as a Crisis in Public Health and Civil Rights (3) by addition to read as follows: Our AMA will support and encourage the U.S. Department of Education to develop policies and initiatives to 1) increase the high school graduation rate among historically underrepresented students 2) increase the number of historically underrepresented students participating in high school Advanced Placement courses and 3) decrease the educational opportunity gap. (Modify Current HOD Policy) 7. That our AMA amend Policy D-200.985 (13), “Strategies for Enhancing Diversity in the Physician Workforce,” by deletion to read as follows: ~~(a) supports the publication of a white paper chronicling health care career pipeline programs (also known as pathway programs) across the nation aimed at increasing the number of programs and promoting leadership development of underrepresented minority health care professionals in medicine and the biomedical sciences, with a focus on assisting such programs by identifying best practices and tracking participant outcomes; and.~~ (Modify Current HOD Policy) 8. That our AMA reaffirm Policy D-200.982, “Diversity in the Physician Workforce and Access to Care.” |
| C | Res 301 | New York | Medical Education Debt Cancellation in the Face of a Physician Shortage During the COVID-19 Pandemic | RESOLVED, That our American Medical Association study the issue of medical education debt cancellation and consider the opportunities for integration of this into a broader solution addressing debt for all medical students, physicians in training, and early career physicians. (Directive to Take Action) |
| C | Res 302 | New York | Non-Physician Post-Graduate Medical Training | RESOLVED, That our American Medical Association recognize that the terms “medical student,” “resident,” “residency,” “fellow,” “fellowship,” “doctor,” and “attending,” when used in the healthcare setting, all connote completing structured, rigorous, medical education undertaken by physicians; thus these terms should be reserved to describe physician roles (New HOD Policy); and be it further  RESOLVED, That our AMA work with relevant stakeholders to define appropriate labels for postgraduate clinical and diagnostic training programs for non-physicians that recognizes the rigor of these programs but prevents role confusion associated with the terms “resident,” “residency,” “fellow,” or “fellowship” (Directive to Take Action); and be it further  RESOLVED, That our AMA object to the American Board of Medical Specialists, the American Osteopathic Association Bureau of Osteopathic Specialists, and their member boards having designated seats for Nurse Practitioners, Physician Assistants, Certified Registered Nurse Anesthetists, Anesthesia Assistants, or any other healthcare professional that are independent from the public member seats (Directive to Take Action); and be it further  RESOLVED, That our AMA work with relevant stakeholders to assure that funds to support the expansion of postgraduate clinical training for non-physicians does not divert funding from physician graduate medical education. (Directive to Take Action) |
| C | Res 303 | American Orthopaedic Foot & Ankle Society | Improving the Standardization Process for Assessment of Podiatric Medical Students and Residents by Initiating a Process Enabling Them to Take the USMLE | RESOLVED, That our American Medical Association study, with report back at the 2021 Interim House of Delegates Meeting, whether Council on Podiatric Medical Education (CPME) accreditation standards are comparable to Liaison Committee on Medical Education (LCME) standards and sufficient to meet requirements which would allow Doctors of Podiatric Medicine (DPMs) to take all parts of the USMLE. (Directive to Take Action) |
| C | Res 304 | Resident and Fellow Section | Decreasing Financial Burdens on Residents and Fellows | RESOLVED, That our American Medical Association work with the Accreditation Council for Graduate Medical Education (ACGME), the Association of American Medical Colleges (AAMC), and other relevant stakeholders to advocate that medical trainees not be required to pay for essential amenities and/or high cost or safety-related, specialty-specific equipment required to perform clinical duties (Directive to Take Action); and be it further  RESOLVED, That our AMA work with relevant stakeholders including the AAMC to define “access to food” for medical trainees to include 24-hour access to fresh food and healthy meal options within all training hospitals (Directive to Take Action); and be it further  RESOLVED, That our AMA work with relevant stakeholders to ensure that medical trainees have access to on-site and subsidized childcare (Directive to Take Action); and be it further  RESOLVED, That the Residents and Fellows’ Bill of Rights be prominently published online on the AMA website and be disseminated to residency and fellowship programs (Directive to Take Action); and be it further  RESOLVED, That the AMA Policy H-310.912, “Residents and Fellows’ Bill of Rights,” be amended by addition and deletion to read as follows:  5. Our AMA partner with ACGME and other relevant stakeholders to encourage~~s~~ training programs to reduce financial burdens on residents and fellows by providing employee benefits including, but not limited to, on-call meal allowances, transportation support, relocation stipends, and childcare services. ~~teaching institutions to explore benefits to residents and fellows that will reduce personal cost of living expenditures, such as allowances for housing, childcare, and transportation.~~ (Modify Current HOD Policy) |
| C | Res 305 | Resident and Fellow Section | Non-Physician Post-Graduate Medical Training | RESOLVED, That our American Medical Association believe that healthcare trainee salary, benefits, and overall compensation should, at minimum, reflect length of pre-training education, hours worked, and level of independence and complexity of care allowed by an individual’s training program (for example when comparing physicians in training and midlevel providers at equal postgraduate training levels) (New HOD Policy); and be it further  RESOLVED, That our AMA amend policy H-275.925 “Protection of the Titles "Doctor," "Resident" and "Residency",” by addition and deletion to read as follows:  Our AMA:  (1) recognize that the terms “medical student,” “resident,” “residency,” “fellow,” “fellowship,” “physician,” and “attending,” when used in the healthcare setting, all connote completing structured, rigorous, medical education undertaken by physicians, as defined by the Centers for Medicare and Medicaid Services, and thus these terms must be reserved only to describe physician roles; (2) advocate that professionals in a clinical health care setting clearly and accurately identify to patients their qualifications and degree(s) attained and develop model state legislation for implementation; (3) support~~s~~ and develop model state legislation that would penalize misrepresentation of one’s role in the physician-led healthcare team, up to and including to make it a felony to misrepresent oneself as a physician (MD/DO); and (4) support and develop model state legislation that calls for statutory restrictions for non-physician post-graduate diagnostic and clinical training programs using the terms “medical student,” “resident,” “residency,” “fellow,” “fellowship,” “physician,” or “attending” in a healthcare setting except by physicians. (Modify Current HOD Policy); and be it further  RESOLVED, That our AMA study and report back, by the 2022 Annual Meeting, on curriculum, accreditation requirements, accrediting bodies, and supervising boards for graduate and postgraduate clinical training programs for non-physicians and the impact of non-physician graduate clinical education on physician graduate medical education (Directive to Take Action); and be it further  RESOLVED, That our AMA work with relevant stakeholders to assure that funds to support the expansion of post-graduate clinical training for non-physicians do not divert funding from physician GME (Directive to Take Action); and be it further  RESOLVED, That our AMA partner with the Accreditation Council for Graduate Medical Education (ACGME) to create standards requiring Designated Institutional Officials to notify the ACGME of proposed training programs for physicians or non-physicians that may impact the educational experience of trainees in currently approved residencies and fellowships (Directive to Take Action); and be it further  RESOLVED, That policy H-310.912 “Resident and Fellow Bill of Rights,” be amended by addition and deletion to read as follows:  B. Appropriate supervision by qualified physician faculty with progressive resident responsibility toward independent practice. With regard to supervision, residents and fellows ~~should expect supervision by physicians and non-physicians~~ must be ultimately supervised by physicians who are adequately qualified and ~~which~~ allows them to assume progressive responsibility appropriate to their level of education, competence, and experience. ~~It is neither feasible nor desirable to develop universally applicable and precise requirements for supervision of residents.~~ In instances where clinical education is provided by non-physicians, there must be an identified physician supervisor providing indirect supervision, along with mechanisms for reporting inappropriate, non-physician supervision to the training program, sponsoring institution or ACGME as appropriate. (Modify Current HOD Policy); and be it further  RESOLVED, That our AMA will distribute and promote the Residents and Fellows’ Bill of Rights online and individually to residency and fellowship training programs and encourage changes to institutional processes that embody these principles (Directive to Take Action); and be it further  RESOLVED, That our AMA oppose non-physician healthcare providers from holding a seat on the board of an organization that regulates and/or provides oversight of physician undergraduate and graduate medical education, accreditation, certification, and credentialing when these types of non-physician healthcare providers either possess or seek to possess the ability to practice without physician supervision as it represents a conflict of interest. (Directive to Take Action) |
| C | Res 306 | Resident and Fellow Section | Establishing Minimum Standards for Parental Leave during Graduate Medical Education Training | RESOLVED, That our American Medical Association support current efforts by the Accreditation Council for Graduate Medical Education (ACGME), the American Board of Medical Specialties (ABMS), and other relevant stakeholders to develop and align minimum requirements for parental leave during residency and fellowship training and urge these bodies to adopt minimum requirements in accordance with policy H-405.960 (Directive to Take Action); and be it further  RESOLVED, That our AMA petition the ACGME to recommend strategies to prevent undue burden on trainees related to parental leave (Directive to Take Action); and be it further  RESOLVED, That our AMA petition the ACGME, ABMS, and other relevant stakeholders to develop specialty specific pathways for residents and fellows in good standing, who take maximum allowable parental leave, to complete their training within the original time frame. (Directive to Take Action) |
| C | Res 307 | Resident and Fellow Section | Updating Current Wellness Policies and Improving Implementation | RESOLVED, That our American Medical Association work with the Accreditation Council on Graduate Medical Education (ACGME) and other appropriate stakeholders in the creation of an evidence-based best practices reference to address trainee burnout prevention and mitigation. (Directive to Take Action) |
| C | Res 308 | Pennsylvania | Rescind USMLE Step 2 CS and COMLEX Level 2 PE Examination Requirement for Medical Licensure | RESOLVED, That our American Medical Association work to rescind USMLE Step 2 CS and COMLEX Level 2 PE examination requirements and encourage a “fifty-state approach” by all individual state medical societies to engage with their respective state medical boards on this issue. (Directive to Take Action) |
| C | Res 309 | Pennsylvania | Supporting GME Program Child Care Consideration During Residency Training | RESOLVED, That our American Medical Association convene a group of interested stakeholders to examine the need for innovative childcare policies and flexible working environments for all residents in order to promote equity in all training settings. (Directive to Take Action) |
| C | Res 310 | Pennsylvania | Unreasonable Fees Charged and Inaccuracies by the American Board of Internal Medicine (ABIM) | RESOLVED, That our American Medical Association work with the American Board of Medical Specialties Boards (ABMS), in general, and American Board of Internal Medicine (ABIM), specifically, to require the ABIM stop charging physicians with two or more board certifications, who participate in Maintenance of Certification (MOC) with a board other than the ABIM, a fee to accurately list their current board status in the ABIM Directory. (Directive to Take Action) |
| C | Res 311 | Illinois | Student Loan Forgiveness | RESOLVED, That our American Medical Association study the cause for the unacceptably high denial rate of applications made to the Public Health Services Student Loan Forgiveness Program, and advocate for improvements in the administration and oversight of the Program, including but not limited to increasing transparency of and streamlining program requirements; ensuring consistent and accurate communication between loan services and borrowers; and establishing clear expectations regarding oversight and accountability of the loan servicers responsible for the program. (Directive to Take Action) |
| C | Res 312 | American College of Preventive Medicine | AMA Support for Increased Funding for the American Board of Preventive Medicine (ABPM) Residency Programs | RESOLVED, That our American Medical Association support and advocate for increased funding through the Health Resources and Services Administration (HRSA), National Institute for Occupational Safety and Health (NIOSH), Centers for Disease Control and Prevention (CDC), and other mechanisms for all residencies training physicians in the Preventive Medicine specialties of Aerospace Medicine, Occupational and Environmental Medicine and Public Health & General Preventive Medicine, and subspecialties including Undersea & Hyperbaric Medicine, Medical Toxicology, Clinical Informatics and Addiction Medicine (Directive to Take Action); and be it further  RESOLVED, That our AMA actively increase further awareness of the importance of public health training, leadership, and principles among all medical students and physicians in training and in practice. (Directive to Take Action) |
| C | Res 313 | Women Physicians Section | Fatigue Mitigation Respite for Faculty and Residents | RESOLVED, That our American Medical Association make available resources to institutions and physicians that support self-care and fatigue mitigation, help protect physician health and well-being, and model appropriate health promoting behaviors (Directive to Take Action); and be it further  RESOLVED, That the AMA advocate for policies that support fatigue mitigation programs, which include, but are not limited to, quiet places to rest and funding for alternative transport including return to work for vehicle recovery at a later time for all medical staff who feel unsafe driving due to fatigue after working. (Directive to Take Action) |
| C | Res 314 | Medical Student Section | Standard Procedure for Accommodations in USMLE and NBME Exams | RESOLVED, That our American Medical Association collaborate with medical licensing organizations to facilitate a timely accommodations application process (Directive to Take Action); and be it further  RESOLVED, That our AMA, in conjunction with the National Board of Medical Examiners, develop a plan to reduce the amount of proof required for approving accommodations to lower the burden of cost and time to medical students with disabilities. (Directive to Take) |
| C | Res 315 | Medical Student Section | Representation of Dermatological Pathologies in Varying Skin Tones | RESOLVED, That our American Medical Association encourage the inclusion of a diverse range of skin tones in preclinical and clinical dermatologic medical education materials and evaluation (New HOD Policy); 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 (New HOD Policy); and be it further  RESOLVED, That our AMA support the overrepresentation of darker skin tones in dermatologic medical education materials. (New HOD Policy) |
| C | Res 316 | Medical Student Section | Improving Support and Access for Medical Students with Disabilities | RESOLVED, That our American Medical Association amend policy D-295.929 by addition to read as follows:  D-295.929 – A STUDY TO EVALUATE BARRIERS TO MEDICAL EDUCATION FOR TRAINEES WITH DISABILITIES  Our AMA will work with relevant stakeholders to study available data on: (1) medical trainees and students with disabilities and consider revision of technical standards for medical education programs; and (2) medical graduates and students with disabilities and challenges to employment after training and medical education; and 3) work with relative stakeholders to encourage medical education institutions to make their policies for inquiring about and obtaining accommodations related to disability transparent and easily accessible through multiple avenues including, but not limited to, online platforms. (Modify Current HOD Policy); and be it further  RESOLVED, That our AMA amend policy D-90.991 by addition and deletion to read as follows:  D-90.991 – ADVOCACY FOR PHYSICIANS WITH DISABILITIES  1. Our AMA will study and report back on eliminating stigmatization and enhancing inclusion of physicians and medical students with disabilities including but not limited to: (a) enhancing representation of physicians and medical students with disabilities within the AMA, and (b) examining support groups, education, legal resources and any other means to increase the inclusion of physicians and medical students with disabilities in the AMA.  2. Our AMA will identify medical, professional and social rehabilitation, education, vocational training and rehabilitation, aid, counseling, placement services and other services which will enable physicians and medical students with disabilities to develop their capabilities and skills to the maximum and will hasten the processes of their social and professional integration or reintegration.  3. Our AMA supports physicians, ~~and~~ physicians-in-training, and medical student education programs about legal rights related to accommodation and freedom from discrimination for physicians, patients, and employees with disabilities. (Modify Current HOD Policy); and be it further  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. (Directive to Take Action) |
| C | Res 317 | Medical Student Section | Medical Honor Society Inequities and Reform | RESOLVED, That our American Medical Association recognize that demographic and socioeconomic inequities exist in medical student membership in medical honor societies (New HOD Policy); and be it further  RESOLVED, That our AMA study reforms to mitigate demographic and socioeconomic inequities in the selection of medical students for medical honor societies, including Alpha Omega Alpha and the Gold Humanism Honor Society, as well as the implications of ending the selection of medical students to these societies on equity in the residency application process and report back to the November 2021 HOD meeting. (Directive to Take Action) |
| C | Res 318 | Resident and Fellow Section | The Impact of Private Equity on Medical Training | RESOLVED, That our American Medical Association work with relevant stakeholders including specialty societies and the Accreditation Council for Graduate Medical Education to study the level of financial involvement and influence private equity firms have in graduate medical education training programs and report back at the 2021 Interim Meeting with concurrent publication of their findings in a peer-reviewed journal. (Directive to Take Action) |
| C | Res 319 | Resident and Fellow Section | The Effect of the COVID-19 Pandemic on Graduate Medical Education | RESOLVED, That our American Medical Association work with the Accreditation Council for Graduate Medical Education (ACGME) and other relevant stakeholders to provide additional benefits for compensation, such as moonlighting, hazard pay, and/or additional certifications for residents and fellows who are redeployed to fulfill service needs that are outside the scope of their specialty training (Directive to Take Action); and be it further  RESOLVED, That our AMA urge ACGME to work with relevant stakeholders including residency and fellowship programs to ensure each graduating resident or fellow is provided with documentation explicitly stating his/her board eligibility and identifying areas of training that have been impacted by COVID-19 that can be presented to the respective board certifying committee (Directive to Take Action); and be it further  RESOLVED, That our AMA urge ACGME and specialty boards to consider replacing minimums on case numbers and clinic visits with more holistic measures to indicate readiness for graduation and board certification eligibility, especially given the drastic educational barriers confronted during the COVID-19 pandemic. (Directive to Take Action) |
| D | BOT 10 | n/a | Protester Protections | Less-Lethal Weapons and Crowd Control Our American Medical Association (1) supports prohibiting the use of rubber bullets, including rubber or plastic-coated metal bullets and those with composites of metal and plastic, by law enforcement for the purposes of crowd control and management in the United States; (2) supports prohibiting the use of chemical irritants and kinetic impact projectiles to control peaceful crowds that do not pose an immediate threat; (3) recommends that law enforcement agencies have in place specific guidelines, rigorous training, and an accountability system, including the collection and reporting of data on injuries, for the use of kinetic impact projectiles and chemical irritants; (4) encourages guidelines on the use of kinetic impact projectiles and chemical irritants to include considerations such as the proximity of non-violent individuals and bystanders; for kinetic impact projectiles, a safe shooting distance and avoidance of vital organs (head, neck, chest, and abdomen), and for all less-lethal weapons, the issuance of a warning followed by sufficient time for compliance with the order prior to discharge; (5) recommends that law enforcement personnel use appropriate de-escalation techniques to minimize the risk of violence in crowd control and provide transparency about less-lethal weapons in use and the criteria for their use; and (6) encourages relevant stakeholders including, but not limited to manufacturers and government agencies to develop and test crowd-control techniques which pose a more limited risk of physical harm. (New HOD Policy) |
| D | BOT 15 | n/a | Removing the Sex Designation from the Public Portion of the Birth Certificate | Our American Medical Association will advocate for the removal of sex as a legal designation on the public portion of the birth certificate, recognizing that information on an individual’s sex designation at birth will still be submitted through the U.S. Standard Certificate of Live Birth for medical, public health, and statistical use only. (Directive to Take Action) |
| D | BOT 16 | n/a | Follow-up on Abnormal Medical Test Findings | Our American Medical Association encourages relevant national medical specialty societies to develop and disseminate evidence-based guidelines for communication and follow-up of abnormal and critical test results to promote better patient outcomes. (New HOD Policy)  Our AMA will work with appropriate state and medical specialty societies to highlight relevant education regarding the communication and follow-up of abnormal and critical medical test findings to promote better patient outcomes. (Directive to Take Action)  Our AMA supports the development of best practices and other clinical resources for communication of test results, including via patient portals and applications, and encourages additional research to ensure these innovative approaches and tools reach their potential to help advance patient care. (New HOD Policy) |
| D | CSAPH 01 | n/a | Council on Science and Public Health Sunset Review of 2011 House Policies | The Council on Science and Public Health recommends that the House of Delegates policies listed in the appendix to this report be acted upon in the manner indicated and the remainder of this report be filed. (Directive to Take Action) |
| D | CSAPH 03 | n/a | Addressing Increases in Youth Suicide | 1. That Policy H-60.937 be amended to read as follows:   ~~Teen~~ Youth and Young Adult Suicide in the United States  Our AMA:   1. Recognizes ~~teen~~ youth and young adult suicide as a serious health concern in the US; 2. Encourages the development and dissemination of educational resources and tools for physicians, especially those more likely to encounter youth or young adult patients, addressing effective suicide prevention, including screening tools, methods to identify risk factors and acuity, safety planning, and appropriate follow-up care including treatment and linkages to appropriate counseling resources; 3. Supports collaboration with federal agencies, relevant state and specialty medical societies, schools, public health agencies, community organizations, and other stakeholders to enhance awareness of the increase in youth and young adult suicide and to promote protective factors, raise awareness of risk factors, support evidence-based prevention strategies and interventions, encourage awareness of community mental health resources, and improve care for youth and young adults at risk of suicide; 4. Encourages efforts to provide youth and young adults better and more equitable access to treatment and care for depression, substance use disorder, and other disorders that contribute to suicide risk; 5. Encourages continued research to better understand suicide risk and effective prevention efforts in youth and young adults, especially in higher risk sub-populations such as Black, LGBTQ+, Latino, and Indigenous/Native Alaskan youth and young adult populations; 6. Supports the development of novel technologies and therapeutics, along with improved utilization of existing medications to address acute suicidality and underlying risk factors in youth and young adults; and 7. Supports research to identify evidence-based universal and targeted suicide prevention programs for implementation in middle schools and high schools. (Modify Current HOD policy) 8. That Policy H-515-952, “Adverse Childhood Experiences and Trauma-Informed Care” be amended by addition to read as follows: 9. 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. 10. Our AMA supports: 11. evidence-based primary prevention strategies for Adverse Childhood Experiences (ACEs); 12. 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; 13. efforts for data collection, research, and evaluation of cost-effective ACEs screening tools without additional burden for physicians. 14. 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~~ 15. 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; and 16. increased screening for ACEs in medical settings, in recognition of the intersectionality of ACEs with significant increased risk for suicide, negative substance use-related outcomes including overdose, and a multitude of downstream negative health outcomes. (Modify Current HOD policy) 17. That Policy H-145.975, “Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care,” which recognizes the role of firearms in suicides; encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling; and encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide, be reaffirmed. . (Reaffirm Current HOD Policy). 18. That Policy H-170.984, “Healthy Living Behaviors,” encouraging state medical societies and physicians to promote physical and wellness activities for children and youth and to advocate for health and wellness programs for children and youth in schools and communities, be reaffirmed. (Reaffirm Current HOD Policy) |
| D | Res 401 | Washington | Universal Access for Essential Public Health Services | RESOLVED, That our American Medical Association study the options and/or make recommendations regarding the establishment of:  1.a list of all essential public health services that should be provided in every jurisdiction of the United States;  2. a nationwide system of information sharing and intervention coordination in order to effectively manage nationwide public health issues;  3. a federal data system that can capture the amount of federal, state, and local public health capabilities and spending that occurs in every jurisdiction to assure that their populations have universal access to all essential public health services; and  4. a federal data system that can capture actionable evidence-based outcomes data from public health activities in every jurisdiction (Directive to Take Action); and be it further  RESOLVED, That our AMA prepare and publicize annual reports on current efforts and progress to achieve universal access to all essential public health services. (Directive to Take Action) |
| D | Res 402 | Oklahoma | Modernization and Standardization of Public Health Surveillance Systems | RESOLVED, That our American Medical Association advocate for the modernization and standardization of public health surveillance systems data collection by the Centers for Disease Control and Prevention and state and local health departments, including but not limited to increased federal coordination and funding. (Directive to Take Action) |
| D | Res 403 | New Jersey | Confronting Obesity as a Key Contributor to Maternal Mortality, Racial Disparity, Death from Covid-19, Unaffordable Health Care Cost while Restoring Health in America | RESOLVED, That our American Medical Association advocate for a National Task Force to be led by the medical profession along with other stakeholders to confront the epidemic of obesity primarily among minority women, prior to, during and after pregnancy, thereby reducing maternal mortality & morbidity rates, racial disparity in access to care, death from COVID-19 infection and healthcare costs while restoring health in our nation with report back at the 2021 Interim Meeting and beyond. (Directive to Take Action) |
| D | Res 404 | Resident and Fellow Section | Support for Safe and Equitable Access to Voting | RESOLVED, That our American Medical Association support measures to facilitate safe and equitable access to voting as a harm-reduction strategy to safeguard public health and mitigate unnecessary risk of infectious disease transmission by measures including but not limited to:  (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;  (e) adequate resourcing of the United States Postal Service and election operational procedures;  (f) improve access to drop off locations for mail-in or early ballots (Directive to Take Action); 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. (Directive to Take Action) |
| D | Res 405 | Resident and Fellow Section | Traumatic Brain Injury and Access to Firearms | RESOLVED, That our American Medical Association reaffirm policy H-145.972 “Firearms and High-Risk Individuals.”  RESOLVED, That our AMA amend policy H-145.975 “Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care” by addition and deletion to read as follows:  …2. Our AMA supports initiatives designed to enhance access to the comprehensive assessment and treatment of mental ~~illness~~ health and ~~concurrent~~ substance use disorders~~,~~ in patients with traumatic brain injuries, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior.  3. Our AMA work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to evaluate the risk of potential violent behavior in patients with traumatic brain injuries.  ~~3.~~ 4. Our AMA (a) recognizes the role of firearms in suicides, (b) encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling, and (c) encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide. (Modify Current HOD Policy) |
| D | Res 406 | District of Columbia | Attacking Disparities in COVID-19 Underlying Health Conditions | RESOLVED, That our American Medical Association urge federal, state, and municipal leaders to prominently note in their COVID-19 public health advisories the urgent need for individuals with underlying medical conditions, particularly obesity, type 2 diabetes, and hypertension, to consult with their physicians to assess their medical status and institute (or resume) appropriate treatment, which may range from updating medications and lifestyle changes, such as reduced-sodium and plant-based diets and physical activity, to aggressive medical therapy which may include medication, surgery, and complex multi-disciplinary care. (Directive to Take Action) |
| D | Res 407 | Oregon | Impact of SARS-CoV-2 Pandemic on Post-Acute Care Services and Long-Term Care and Residential Facilities | RESOLVED, That our American Medical Association study the impact of SARS-CoV-2 pandemic on post-acute care services and long-term care and residential facilities and collaborate with other stakeholders to develop policy to guide federal, state, and local public health authorities to ensure safe operation of these facilities during public health emergencies and natural disasters with policy recommendations to include but not limited to:  a) Planning for adequate funding and access to resources;  b) Planning for emergency staffing of health care and maintenance personnel;  c) Planning for ensuring safe working conditions of LTC staff; and  d) Planning for mitigation of the detrimental effects of increased isolation of residents during a natural disaster, other environmental emergency, or pandemic, or similar crisis. (Directive to Take Action) |
| D | Res 408 | Pennsylvania | Screening for HPV-Related Anal Cancer | RESOLVED, That our American Medical Association support advocacy efforts to implement screening for anal cancer for high-risk populations (New HOD Policy); and be it further  RESOLVED, That our AMA support national medical specialty organizations and other stakeholders in developing guidelines for interpretation, follow up, and management of anal cancer screening results. (New HOD Policy) |
| D | Res 409 | American Academy of Child and Adolescent Psychiatry | Weapons in Correctional Healthcare Settings | RESOLVED, That our American Medical Association advocate that physicians not be required to carry or use weapons in correctional facilities where they provide clinical care (Directive to Take Action); and be it further  RESOLVED, That our AMA study and make recommendations regarding the presence of weapons in correctional healthcare facilities. (Directive to Take Action) |
| D | Res 410 | American Academy of Physical Medicine and Rehabilitation | Ensuring Adequate Health Care Resources to Address the Long COVID Crisis | RESOLVED, That our American Medical Association support the development of an ICD-10 code or family of codes to recognize Post-Acute Sequelae of SARS-CoV-2 infection (“PASC” or “Long COVID”) as a distinct diagnosis (Directive to Take Action); and be it further  RESOLVED, That our AMA advocate for the development of immediate and long-term strategies for funding and research to address equitable access to appropriate clinical care for all individuals experiencing PASC (Directive to Take Action); and be it further  RESOLVED, That our AMA disseminate up-to-date information to physicians regarding best practices to mitigate the effects of PASC in a timely manner. (Directive to Take Action) |
| D | Res 411 | Connecticut | Ongoing Use of Masks by and Among High-Risk Individuals to Reduce the Risk of Spread of Respiratory Pathogens | RESOLVED, That our American Medical Association endorse the use of masks for all those wishing to reduce the risk of respiratory tract infection during the time of year when respiratory pathogens are most likely to circulate and whenever respiratory infections are known to be circulating when people are in close contact and indoors (Directive to Take Action); and be it further  RESOLVED, That our AMA promulgate scientific information to both patients and physicians about the benefits of masks to protect patients, especially those at high risk, to reduce exposure to and spread of respiratory pathogens. (Directive to Take Action) |
| D | Res 412 | Women Physicians Section | Addressing Maternal Discrimination and Support for Flexible Family Leave | RESOLVED, That our American Medical Association encourage key stakeholders to implement policies and programs that help protect against maternal discrimination and promote work-life integration for physician parents, which should encompass prenatal care, parental leave, and flexibility for childcare (Directive to Take Action); and be it further  RESOLVED, That our AMA urge key stakeholders to include physicians and frontline workers in the Families First Coronavirus Response Act as well as other legislation that provide protections and considerations for paid parental leave for issues of health and childcare. (Directive to Take Action) |
| D | Res 413 | Medical Student Section | Call for Increased Funding and Research for Post Viral Syndromes | RESOLVED, That our American Medical Association 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 (ME/CFS) (Directive to Take Action); 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 sequalae associated with COVID-19, including, but not limited to Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS) (Directive to Take Action); and be it further  RESOLVED, That our AMA collaborate with other medical and educational entities to promote education among patients about post viral syndromes and long-term sequalae 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. (Directive to Take Action) |
| D | Res 414 | Medical Student Section | Call for Improved Personal Protective Equipment (PPE) Design and Fitting | RESOLVED, That our American Medical Association encourage the diversification of personal protective equipment design to better fit all body types among healthcare workers. (Directive to Take Action) |
| D | Res 415 | Medical Student Section | Amending H-440.847 to Call for National Government and States to Maintain Personal Protective Equipment and Medical Supply Stockpiles | RESOLVED, That our American Medical Association amend policy H-440.847 by addition and deletion to read as follows:  Pandemic Preparedness ~~for Influenza~~ H-440.847  In order to prepare for a ~~potential influenza~~ pandemic, our AMA:  (1) urges the Department of Health and Human Services Emergency Care Coordination Center, in collaboration with the leadership of the Centers for Disease Control and Prevention (CDC), state and local health departments, and the national organizations representing them, to urgently assess the shortfall in funding, staffing, supplies, vaccine, drug, and data management capacity to prepare for and respond to a~~n influenza~~ a pandemic or other serious public health emergency;  (2) urges Congress and the Administration to work to ensure adequate funding and other resources: (a) for the CDC, the National Institutes of Health (NIH), the Strategic National Stockpile and other appropriate federal agencies, to support the maintenance of and the implementation of an expanded capacity to produce the necessary vaccines, ~~and~~ anti-~~viral~~ microbial drugs, medical supplies, and personal protective equipment, and to continue development of the nation's capacity to rapidly manufacture the necessary supplies needed to protect, treat, test and vaccinate the entire population and care for large numbers of seriously ill people; and (b) to bolster the infrastructure and capacity of state and local health departments to effectively prepare for and respond to~~, and protect the population from illness and death in an influenza~~ a pandemic or other serious public health emergency;  (3) encourages states to maintain medical and personal protective equipment stockpiles sufficient for effective preparedness and to respond to a pandemic or other major public health emergency;  (4) urges the federal government to meet treaty and trust obligations by adequately sourcing medical and personal protective equipment directly to tribal communities and the Indian Health Service for effective preparedness and to respond to a pandemic or other major public emergency;  (~~3~~5) urges the CDC to develop and disseminate electronic instructional resources on procedures to follow in an ~~influenza~~ epidemic, pandemic, or other serious public health emergency, which are tailored to the needs of physicians and medical office staff in ambulatory care settings;  (~~4~~6) supports the position that: (a) relevant national and state agencies (such as the CDC, NIH, and the state departments of health) take immediate action to assure that physicians, nurses, other health care professionals, and first responders having direct patient contact, receive any appropriate vaccination in a timely and efficient manner, in order to reassure them that they will have first priority in the event of such a pandemic; and (b) such agencies should publicize now, in advance of any such pandemic, what the plan will be to provide immunization to health care providers;  (7) will monitor progress in developing a contingency plan that addresses future ~~influenza~~ vaccine production or distribution problems and in developing a plan to respond to a~~n influenza~~ pandemic in the United States. (Modify Current HOD Policy) |
| D | Res 416 | Medical Student Section | Expansion on Comprehensive Sexual Health Education | RESOLVED, That our American Medical Association amend policy H-170.968 by addition and deletion to read as follows:  Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools, H-170.968  (1) ~~Recognizes that the primary responsibility for family life education is in the home, and additionally~~ ~~s~~ Supports the concept of a ~~complementary~~ family life and sexuality education program in the schools at all levels, at local option and direction;  (2) Urges schools at all education levels to implement comprehensive, developmentally appropriate sexuality education programs that: (a) are based on rigorous, peer reviewed science; (b) incorporate sexual violence prevention; (c) show promise for delaying the onset of sexual activity and a reduction in sexual behavior that puts adolescents at risk for contracting human immunodeficiency virus (HIV) and other sexually transmitted diseases and for becoming pregnant; (d) include an integrated strategy for making condoms, dental dams, and other barrier protection methods available to students and for providing both factual information and skill-building related to reproductive biology, sexual abstinence, sexual responsibility, contraceptives including condoms, alternatives in birth control, and other issues aimed at prevention of pregnancy and sexual transmission of diseases; (e) utilize classroom teachers and other professionals who have shown an aptitude for working with young people and who have received special training that includes addressing the needs of LGBTQ ~~gay, lesbian, and bisexual~~ youth; (f) appropriately and comprehensively address the sexual behavior of all people, inclusive of sexual and gender minorities; (g) include ample involvement of parents, health professionals, and other concerned members of the community in the development of the program; (h) are part of an overall health education program; and (i) include culturally competent materials that are language-appropriate for Limited English Proficiency (LEP) pupils;  (3) Continues to monitor future research findings related to emerging initiatives that include abstinence-only, school-based sexuality education, and consent communication to prevent dating violence while promoting healthy relationships, and school-based condom availability programs that address sexually transmitted diseases and pregnancy prevention for young people and report back to the House of Delegates as appropriate;  (4) Will work with the United States Surgeon General to design programs that address communities of color and youth in high risk situations within the context of a comprehensive school health education program;  (5) Opposes the sole use of abstinence-only education, as defined by the 1996 Temporary Assistance to Needy Families Act (P.L. 104-193), within school systems;  (6) Endorses comprehensive family life education in lieu of abstinence-only education, unless research shows abstinence-only education to be superior in preventing negative health outcomes;  (7) Supports federal funding of comprehensive sex education programs that stress the importance of ~~abstinence in~~ preventing unwanted teenage pregnancy and sexually transmitted infections via comprehensive education, ~~and also teach about~~ including contraceptive choices, abstinence, and safer sex, and opposes federal funding of community-based programs that do not show evidence-based benefits; and  (8) Extends its support of comprehensive family-life education to community-based programs promoting abstinence as the best method to prevent teenage pregnancy and sexually-transmitted diseases while also discussing the roles of condoms and birth control, as endorsed for school systems in this policy;  (9) Supports the development of sexual education curriculum that integrates dating violence prevention through lessons on healthy relationships, sexual health, and conversations about consent; and  (10) Encourages physicians and all interested parties to conduct research and develop best-practice, evidence-based, guidelines for sexual education curricula that are developmentally appropriate as well as medically, factually, and technically accurate. (Modify Current HOD Policy) |
| D | Res 417 | Medical Student Section | Amendment to Food Environments and Challenges Accessing Healthy Food, H-150.925 | RESOLVED, That our American Medical Association 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) recognize that food access inequalities are a major contributor to health inequities, disproportionately affecting marginalized communities and people of color; and (3) support 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. (Modify Current HOD Policy) |
| D | Res 418 | Medical Student Section | Reducing Disparities in HIV Incidence through Pre-Exposure Prophylaxis (PrEP) for HIV | RESOLVED, That our American Medical Association amend AMA Policy H-20.895 “Pre-Exposure Prophylaxis (PrEP) for HIV,” by addition to read as follows:  Pre-Exposure Prophylaxis (PrEP) for HIV, H-20.895   1. Our AMA will educate physicians, physicians-in-training, and the public about the effective use of pre-exposure prophylaxis for HIV and the US PrEP Clinical Practice Guidelines. 2. Our AMA supports the coverage of PrEP in all clinically appropriate circumstances. 3. Our AMA supports the removal of insurance barriers for PrEP such as prior authorization, mandatory consultation with an infectious disease specialist and other barriers that are not clinically relevant. 4. Our AMA advocates that individuals not be denied any insurance on the basis of PrEP use. 5. Our AMA encourages the discussion of and education about PrEP during routine sexual health counseling, regardless of a patient’s current reported sexual behaviors. (Modify Current HOD Policy) |
| D | Res 419 | Medical Student Section | Student-Centered Approaches for Reforming School Disciplinary Policies | RESOLVED, That our American Medical Association support evidence-based frameworks in K‑12 schools that focus on school-wide prevention and intervention strategies for student misbehavior (New HOD Policy); and be it further  RESOLVED, That our AMA support the inclusion of school-based mental health professionals in the student discipline process. (New HOD Policy) |
| D | Res 420 | Texas | Impact of Social Networking Services on the Health of Adolescents | RESOLVED, That our American Medical Association affirm that use of social networking services has the potential to negatively impact the physical and mental health of individuals, especially adolescents and those with preexisting psychosocial conditions, and therefore these services should have established, evidence-based, reliable safeguards to protect vulnerable populations from harm (New HOD Policy); and be it further  RESOLVED, That our AMA advocate for the study of the biological, psychological, and social effects of social networking services use, and to advocate for legislative or regulatory action, including the expansion of Children’s Online Privacy Protection Act of 1998 protections, to mitigate the potential harm from the use of social networking services to adolescents and other vulnerable populations. (Directive to Take Action) |
| D | Res 421 | Medical Student Section | Medical Misinformation in the Age of Social Media | RESOLVED, That our American Medical Association encourage social media organizations to further strengthen their content moderation policies related to medical misinformation, including, but not limited to enhanced content monitoring, augmentation of recommendation engines focused on false information, and stronger integration of verified health information (Directive to Take Action); and be it further  RESOLVED, That our AMA encourage social media organizations to recognize the spread of medical misinformation over dissemination networks and collaborate with relevant stakeholders to address this problem as appropriate, including but not limited to altering underlying network dynamics or redesigning platform algorithms (Directive to Take Action); and be it further  RESOLVED, That our AMA continue to support the dissemination of accurate medical information by public health organizations and health policy experts (Directive to Take Action); and be it further  RESOLVED, That our AMA work with public health agencies in an effort to establish relationships with journalists and news agencies to enhance the public reach in disseminating accurate medical information (Directive to Take Action); and be it further  RESOLVED, That our AMA amend existing policy D-440.921concerning COVID-19 vaccine information to increase its scope and impact regarding medical misinformation by addition to read as follows:  **An Urgent Initiative to Support COVID-19 ~~Vaccination~~ Information Programs D-440.921**  Our AMA will institute a program to promote the integrity of a COVID-19 ~~vaccination~~ information program by: (1) educating physicians on speaking with patients about COVID-19 infection and 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 up-to-date, evidence-based information regarding COVID-19 and associated infections as well as 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; (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~~.~~; (5) educating physicians and other healthcare professionals on means to disseminate accurate information and methods to combat medical misinformation online. (Modify Current HOD Policy); and be it further  RESOLVED, That our AMA study and consider public advocacy of modifications to Section 230(c) of the Communications Decency Act, Part 2, Clause A, as follows:  any action voluntarily taken in good faith to restrict access to or availability of material that the provider or user considers to be obscene, lewd, lascivious, excessively violent, harassing, pose risk to public health, or be otherwise objectionable, whether or not such material is constitutionally protected. (Directive to Take Action) |
| E | CSAPH 02 | n/a | Use of Drugs to Chemically Restrain Agitated Individuals Outside of Hospital Settings | 1. That the following new AMA policy be adopted:  Use of Drugs to Chemically Restrain Agitated Individuals Outside of Hospital Settings  Our American Medical Association:  1. Believes that current evidence does not support “excited delirium” or “excited delirium syndrome” as a medical diagnosis and opposes the use of the terms until a clear set of diagnostic criteria are validated;  2. Is concerned about law enforcement officer use of force accompanying “excited delirium” that leads to disproportionately high mortality among communities of color, particularly among Black men, and denounces “excited delirium” solely as a justification for the use of force by law enforcement officers.  3. Opposes the use of sedative/hypnotic agents, including ketamine, to chemically restrain an individual solely for a law enforcement purpose;  4. Recognizes that drugs for chemical restraint used outside of a hospital setting by non-physicians have significant risks intrinsically, in the context of underlying medical conditions, and also related to potential drug-drug interactions with agents the individual may have taken;  5. Calls for comprehensive reviews, performed by independent investigators including appropriate medical and behavioral health professionals, of law enforcement agencies and emergency medical service agencies to:  a. Investigate any cases labeled as “excited delirium” for disproportionate application of the term, including prevalence of its use by race, ethnicity, gender, age, and other demographic factors;  b. Evaluate the prevalence of ketamine use in the field in unmonitored individuals;  c. Assess that training and guidelines have been properly established by supervising medical and behavioral health specialists, are appropriate, and include de-escalation training; and  d. Assess, on an ongoing basis, that personnel are conducting themselves according to guidelines and training to ensure patient safety; and  6. Urges law enforcement and emergency medical service personnel to participate in appropriate training that minimally includes de-escalation techniques and the appropriate use of drugs used to restrain individuals; and  7. Urges medical and behavioral health specialists, not law enforcement, to serve as first responders and decision makers in medical and mental health emergencies in local communities and that administration of any pharmacological treatments in a non-hospital setting be done equitably, in an evidence-based, anti-racist, and stigma-free way.  2. That Policy H-65.954, “Policing Reform,” which recognizes police brutality as a manifestation of structural racism which disproportionately impacts Black, Indigenous, and other people of color, notes AMA’s willingness to 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, states that AMA will advocate against the utilization of racial and discriminatory profiling by law enforcement through appropriate anti-bias training, individual monitoring, and other measures, and will advocate for legislation and regulations which promote trauma-informed, community-based safety practices, be reaffirmed. (Reaffirm Current AMA Policy)  3. That Policy H-345.972, “Mental Health Crisis Interventions,” which supports jail diversion and community based treatment options for mental illness, implementation of law enforcement-based crisis intervention training programs for assisting those individuals with a mental illness, such as the Crisis Intervention Team model programs, federal funding to encourage increased community and law enforcement participation in crisis intervention training programs, and legislation and federal funding for evidence-based training programs by qualified mental health professionals aimed at educating corrections officers in effectively interacting with people with mental health and other behavioral issues in all detention and correction facilities, be reaffirmed. (Reaffirm Current AMA Policy) |
| E | Res 501 | New York | Ensuring Correct Drug Dispensing | RESOLVED, That our American Medical Association request that the United States Food and Drug Administration work with the pharmaceutical and pharmacy industries to facilitate the ability of pharmacies to ensure that a color photo of a prescribed medication and its dosage is attached to the sales receipt to ensure that the drug dispensed is that which has been prescribed. (Directive to Take Action) |
| E | Res 502 | New York | Scientific Studies which Support Legislative Agendas | RESOLVED, That our American Medical Association continue and expand its efforts to work with allied groups, health care policy influencers such as think tanks, and entities that can produce high quality scientific evidence, to help generate support for the AMA’s key advocacy goals. (Directive to Take Action) |
| E | Res 503 | American Society of Addiction Medicine | Access to Evidence-Based Addiction Treatment in Correctional Facilities | RESOLVED, That our American Medical Association amend policy H-430.987, “Opiate Replacement Therapy Programs in Correctional Facilities,” by addition and deletion to read as follows:  ~~Opiate Replacement Therapy Programs~~ Medications for Opioid Use Disorder in Correctional Facilities H-430.987  1. Our AMA endorses: (a) the medical treatment model of employing ~~opiate replacement therapy (ORT)~~ medications for opioid use disorder (OUD) as ~~an effective~~ ~~therapy in treating opiate-addicted~~ the standard of care for persons with OUD who are incarcerated; and (b) ~~ORT for opiate-addicted~~ medications for persons with OUD who are incarcerated, an endorsement in collaboration with ~~the National Commission on Correctional Health Care and~~ the American Society of Addiction Medicine.  2. Our AMA advocates for legislation, standards, policies and funding that ~~encourag~~e require correctional facilities to increase access to evidence-based treatment of OUD ~~opioid use disorder~~, including initiation and continuation of ~~opioid replacement therapy~~ medications for OUD, in conjunction with ~~counseling~~ psychosocial treatment when available and desired by the person with OUD, in correctional facilities within the United States and that this apply to all ~~incarcerated~~ individuals who are incarcerated, including ~~pregnant women~~ individuals who are pregnant, postpartum, or parenting.  3. Our AMA ~~supports~~ advocates for legislation, standards, policies, and funding that ~~encourage~~ require correctional facilities within the United States to work in ongoing collaboration with addiction treatment physician-led teams, case managers, social workers, and pharmacies in the communities where patients, including ~~pregnant~~ ~~women~~ individuals who are pregnant, postpartum, or parenting, are released to offer post-incarceration treatment plans for OUD ~~opioid use disorder~~, including education, medication for addiction treatment and counseling, and medication for preventing overdose deaths, including naloxone (or any other medication that is approved by the United States Food and Drug Administration for the treatment of an opioid overdose), and help ensure post-incarceration medical coverage and accessibility to mental health and substance use disorder treatments, including medications for addiction treatment ~~medication assisted therapy~~.  4. Our AMA advocates for all correctional facilities to use a validated screening tool to identify opioid withdrawal and take steps to determine potential need for treatment for OUD and opioid withdrawal syndrome for all persons upon entry. (Modify Current HOD Policy); and be it further  RESOLVED, That our AMA amend policy H-430.986, “Health Care While Incarcerated,” by addition and deletion to read as follows:  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. Our AMA ~~encourages~~ advocates for states to suspend rather than terminate Medicaid eligibility of juveniles and adults upon intake into the criminal ~~justice~~ legal system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community.  6. Our AMA ~~urges~~ advocates for Congress to repeal the “inmate exclusion” of the 1965 Social Security Act that bars the use of federal Medicaid matching funds from covering healthcare services in jails and prisons.~~, 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.~~  7. Our AMA advocates for Congress and the Centers for Medicare & Medicaid Services (CMS) to revise the Medicare statute and rescind related regulations that prevent payment for medical care furnished to a Medicare beneficiary who is incarcerated or in custody at the time the services are delivered.  8.~~7~~. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of ~~incarcerated~~ women and adolescent females who are incarcerated, including gynecological care and obstetrics care for ~~pregnant and postpartum~~ ~~women~~ individuals who are pregnant or postpartum.  9.~~8~~. Our AMA will collaborate with state medical societies, relevant medical specialty societies, and federal regulators to emphasize the importance of hygiene and health literacy information sessions, as well as information sessions on the science of addiction, evidence-based addiction treatment including medications, and related stigma reduction, for both ~~inmates~~ individuals who are incarcerated and staff in correctional facilities.  10.~~9~~. 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. (Modify Current HOD Policy) |
| E | Res 504 | Delaware | Healthy Air Quality | RESOLVED, That our American Medical Association champion legislation and policies at the federal level to shift our energy generation away from polluting sources like fossil fuels and toward less polluting renewables in order to drive down the generation of PM 2.5 and other pollutants. (Directive to Take Action) |
| E | Res 505 | Pennsylvania | Personal Care Products Safety | RESOLVED, That our American Medical Association advocate that the Food and Drug Administration (FDA) be given the appropriate resources and authority to effectively regulate and enforce standards for personal care products, including being authorized to mandate registration and reporting by manufacturers, conduct appropriate inspections of manufacturing facilities, ensure robust review of product safety, and require adherence with Good Manufacturing Practices while allowing flexibility for small business to comply; and reaffirm support for providing the FDA with sufficient authority to recall cosmetic products that it deems to be harmful. (Directive to Take Action) |
| E | Res 506 | Pennsylvania | Wireless Devices and Cell Tower Health and Safety | RESOLVED, That our American Medical Association oppose legislation that blocks the public's right to guard its own safety and health regarding cell tower placement (Directive to Take Action); and be it further  RESOLVED, That our AMA promote ways to reduce radiation exposure from wireless devices, especially for pregnant women and children (wired devices preferable to wireless, shielding, etc.). (Directive to Take Action) |
| E | Res 507 | Colorado | Evidence-Based Deferral Periods for MSM Donors of Blood, Corneas and Other Tissues | RESOLVED, That our American Medical Association amend current policy H-50.973, “Blood Donor Deferral Criteria,” by addition and deletion as follows:  Blood and Tissue Donor Deferral Criteria  Our AMA: (1) supports the use of rational, scientifically-based ~~blood and tissue donation~~ deferral periods for donation of blood, corneas, and other tissues that are fairly and consistently applied to donors according to their individual risk; (2) opposes all policies on deferral of blood and tissue donations that are not based on evidence; (3) supports a blood and tissue donation deferral period for those determined to be at risk for transmission of HIV that is representative of current HIV testing technology; and (4) supports research into individual risk assessment criteria for blood and tissue donation (Modify Current HOD Policy); and be it further  RESOLVED, That our AMA lobby the United States Food and Drug Administration to use modern medical knowledge to revise its decades-old deferral criteria for MSM donors of corneas and other tissues. (Directive to Take Action) |
| F | BOT 01 | n/a | Annual Report | The Consolidated Financial Statements for the years ended December 31, 2020 and 2019 and the Independent Auditor’s report have been included in a separate booklet, titled “2020 Annual Report.” This booklet is included in the Handbook mailing to members of the House of Delegates and will be discussed at the Reference Committee F hearing. |
| F | BOT 03 | n/a | AMA 2022 Dues | The Board of Trustees recommends no change to the dues levels for 2022, that the following be adopted and that the remainder of this report be filed: Regular Members $420 Physicians in Their Fourth Year of Practice $315 Physicians in Their Third Year of Practice $210 Physicians in Their Second Year of Practice $105 Physicians in Their First Year of Practice $60 Physicians in Military Service $280 Semi-Retired Physicians $210 Fully Retired Physicians $84 Physicians in Residency Training $45 Medical Students $20 |
| F | BOT 12 | n/a | Adopting the Use of the Most Recent and Updated Edition of the AMA Guides to the Evaluation of Permanent Impairment | Support for the Use of the Most Recent and Updated Edition of the AMA Guides to the Evaluation of Permanent Impairment. Our American Medical Association supports the adoption of the most current edition of the AMA Guides to the Evaluation of Permanent Impairment by all jurisdictions to provide fair and consistent impairment evaluations for patients and claimants including injured workers. (New HOD Policy) |
| F | CCB/CLRPD 01 | n/a | Joint Council Sunset Review of 2011 House Policies | The Councils on Constitution and Bylaws and Long Range Planning and Development recommend that the House of Delegates policies that are listed in the appendix to this report be acted upon in the manner indicated and the remainder of this report be filed. |
| F | Res 601 | Mississippi | $100 Member Annual Dues Payment through 2023 | RESOLVED, That our American Medical Association adjust dues to $100 per year for a trial period of two years for actively practicing physicians and senior physicians. (Directive to Take Action) |
| F | Res 602 | Senior Physicians Section | Timely Promotion and Assistance in Advance Care Planning and Advance Directives | RESOLVED, That our American Medical Association begin a low cost in-house educational effort aimed at physicians, to include relevant billing and reimbursement information, encouraging physicians to lead by example and complete their own advance directives (Directive to Take Action); and be it further  RESOLVED, That our AMA encourage practicing physicians to voluntarily publicize the fact of having executed our own advance directives, and to share readily available educational materials regarding the importance and components of advance directives in offices and on practice websites, as a way of starting the conversation with patients and families (Modify Current HOD Policy); and be it further  RESOLVED, That our AMA strongly encourage all primary care physicians to include advance care planning as a routine part of their adult patient care protocols, and also to include advance directive documentation in patients’ medical records as a suggested standard health maintenance practice (Modify Current HOD Policy); and be it further  RESOLVED, That our AMA collaborate (prioritized and made more urgent by the ongoing COVID-19 pandemic) with stakeholder groups, such as legal, medical, hospital, medical education, and faith-based communities as well as interested citizens, to promote completion of advance directives by all individuals who are of legal age and competent to make healthcare decisions (Directive to Take Action); and be it further  RESOLVED, That our AMA actively promote the officially recognized designation of April 16 as National Healthcare Decisions Day. (New HOD Policy) |
| F | Res 603 | American Association of Public Health Physicians | AMA Urges Health & Life Insurers to Divest From Investments in Fossil Fuels | RESOLVED That our American Medical Association declare that climate change is an urgent public health emergency, and call upon all governments, organizations, and individuals to work to avert catastrophe (Directive to Take Action); and be it further  RESOLVED, That our AMA urge all health and life insurance companies, including those that provide insurance for medical, dental, and long-term care, to work in a timely, incremental, and fiscally responsible manner to end all financial investments or relationships (divestment) with companies that generate the majority of their income from the exploration for, production of, transportation of, or sale of fossil fuels (New HOD Policy); and be it further  RESOLVED, That our AMA actively inform the largest health insurance and life insurance companies, and the associations representing those companies, about AMA policies concerned with climate change and with fossil fuel divestment, and will encourage such companies and associations to take similar actions (Directive to Take Action); and be it further  RESOLVED, That our AMA report the status of AMA’s implementation of our 2018 fossil fuels divestment policies (D-135.969 and H-135.921), as well as the implementation of this resolution, to the 2021 Interim Meeting of the House of Delegates. (Directive to Take Action) |
| F | Res 604 | Jerry P. Abraham, MD | Fulfilling Medicine’s Social Contract with Humanity in the Face of the Climate Health Crisis | RESOLVED, That our American Medical Association establish an internal, climate crisis‑focused center for the purpose of fulfilling our social contract with humanity in this global public health crisis by determining the highest-yield advocacy and leadership opportunities for physicians, and for coordinating, strengthening and centralizing our AMA’s efforts toward advocating for an equitable and inclusive transition to a net-zero carbon society by 2050. (Directive to Take Action) |
| F | Res 605 | Medical Student Section | Amending G-630.140 Lodging, Meeting Venues, and Social Functions | RESOLVED, That our American Medical Association amend AMA policy G-630.140, “Lodging, Meeting Venues, and Social Functions,” by addition to read as follows:  LODGING, MEETING VENUES, AND SOCIAL FUNCTIONS, G-630.140  1. Our AMA supports choosing hotels for its meetings, conferences, and conventions based on size, service, location, cost, and similar factors.  2. Our AMA shall attempt, when allocating meeting space, to locate the Section Assembly Meetings in the House of Delegates Meeting hotel or in a hotel in close proximity.  3. All meetings and conferences organized and/or primarily sponsored by our AMA will be held in a town, city, county, or state that has enacted comprehensive legislation requiring smoke-free worksites and public places (including restaurants and bars), unless intended or existing contracts or special circumstances justify an exception to this policy, and our AMA encourages state and local medical societies, national medical specialty societies, and other health organizations to adopt a similar policy.  4. It is the policy of our AMA not to hold national meetings organized and/or primarily sponsored by our AMA, in cities, counties, or states, or pay member, officer or employee dues in any club, restaurant, or other institution, that has exclusionary policies, including, but not limited to, policies based on, race, color, religion, national origin, ethnic origin, language, creed, sex, sexual orientation, gender, gender identity and gender expression, disability, or age unless intended or existing contracts or special circumstances justify an exception to this policy.  5. Our AMA staff will work with facilities where AMA meetings are held to designate an area for breastfeeding and breast pumping. (Modify Current HOD Policy) |
| F | Res 606 | Medical Student Section | AMA Funding of Political Candidates who Oppose Research-Backed Firearm Regulations | RESOLVED, That our American Medical Association amend policy G-640.020 by addition to read as follows:  G-640.020 – POLITICAL ACTION COMMITTEES AND CONTRIBUTIONS  Our AMA: (1) Believes that better-informed and more active citizens will result in better legislators, better government, and better health care; (2) Encourages AMA members to participate personally in the campaign of their choice and strongly supports physician/family leadership in the campaign process; (3) Opposes legislative initiatives that improperly limit individual and collective participation in the democratic process; (4) Supports AMPAC’s policy to adhere to a no Rigid Litmus Test policy in its assessment and support of political candidates; (5) Encourages AMPAC to continue to consider the legislative agenda of our AMA and the recommendations of state medical PACs in its decisions; (6) Urges members of the House to reaffirm their commitment to the growth of AMPAC and the state medical PACs; (7) Will continue to work through its constituent societies to achieve a 100 percent rate of contribution to AMPAC by members; ~~and~~ (8) Calls upon all candidates for public office to refuse contributions from tobacco companies and their subsidiaries; and (9) Calls upon all candidates for public office to refuse contributions from any organization that opposes public health measures to reduce firearm violence. (Modify Current HOD Policy) |
| F | Res 607 | Texas | Support for the Texas-CARES Program | RESOLVED, That our American Medical Association investigate the Texas-CARES program with the objective of implementing a similar program in other states or nationwide. (Directive to Take Action) |
| F | Res 608 | American College of Cardiology | Sharing Covid-19 Resources | RESOLVED, That our American Medical Association call for the cooperation of all governments and international agencies to share data, research and resources for the production and distribution of medicines, vaccines and personal protective equipment (Directive to Take Action); and be it further  RESOLVED, That our AMA promote and support efforts to supply COVID vaccines to health care agencies in other parts of the world to be administered to individuals who can’t afford them. (Directive to Take Action) |
| F | Res 609 | International Medical Graduates Section | COVID-19 Crisis in Asia | RESOLVED, That our American Medical Association advocate the U.S. government to continue providing all possible assistance including surplus vaccines and vaccines that have not had Emergency Use Authorization to the citizens of countries with precarious situations in this humanitarian crisis including but not limited to India, Nepal, Thailand, Myanmar, etc. (Directive to Take Action); and be it further  RESOLVED, That our AMA explore all possible assistance through the World Medical Association and the World Health Organization for the citizens of countries where the cases of COVID-19 have been exponentially increasing (Directive to Take Action); and be it further  RESOLVED, That our AMA recognize the extraordinary efforts of many dedicated physicians, physician and ethnic organizations assisting in this humanitarian crisis. (Directive to Take Action) |
| F | Res 610 | Medical Student Section | Promoting Equity in Global Vaccine Distribution | RESOLVED, That our American Medical Association amend policy H-250.988, “Low Cost Drugs to Poor Countries during Times of Pandemic Health Crises,” by addition and deletion to read as follows:  H-250.988 – AID ~~LOW-COST DRUGS~~ TO ~~POOR~~ LOW- AND MIDDLE-INCOME COUNTRIES DURING EPIDEMICS AND PANDEMICS ~~TIMES OF PANDEMIC HEALTH CRISES~~  Our AMA will: (1) ~~encourages pharmaceutical companies to provide~~ to work with governmental and appropriate regulatory authorities to encourage (a) the prioritization of equity when providing low cost or free medications, including therapeutics and vaccines, to countries; (b) the temporary waiver of intellectual property protections for necessary medications and other countermeasures; and (c) sharing of equipment, materials, scientific methods, and technological information, to facilitate production and distribution of necessary medications during epidemics and pandemics ~~during times of pandemic health crises~~; and (2) shall work with the World Health Organization (WHO), UNAIDS, and similar organizations that provide comprehensive assistance, including health care, to ~~poor~~ low- and middle-income countries in an effort to improve public health and national stability. (Modify Current HOD Policy) |
| G | BOT 09 | n/a | Preservation of the Patient-Physician Relationship | The Board of Trustees recommends that Resolution 703-A-19 not be adopted and that this report be filed. |
| G | BOT 13 | n/a | Amending the AMA's Medical Staff Rights and Responsibilities | That AMA Policy H-225.942, “Physician and Medical Staff Member Bill of Rights,” be amended by addition and deletion:  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 patients’ 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.  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 organization’s governing body.  b. The responsibility to provide leadership and work collaboratively with the health care organization’s administration and governing body to continuously improve patient care and outcomes, both in collaboration with and independent of the organization’s advocacy efforts with federal, state, and local government and other regulatory authorities.  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 staff’s 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 organization’s administration or governing body, both in collaboration with and independent of the organization’s advocacy efforts with federal, state, and local government and other regulatory authorities.  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 organization’s governing body.  f. The right to engage the health care organization’s 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.  e. 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, both in collaboration with and independent of the organization’s advocacy efforts with federal, state, and local government and other regulatory authorities.  f. The responsibility to participate and encourage others to play an active role in the governance and other activities of the medical staff.  g. The responsibility to participate in peer review activities, including submitting to review, contributing as a reviewer, and supporting member improvement.  h. The responsibility to utilize and advocate for clinically appropriate resources in a manner that reasonably includes the needs of the health care organization at large.  **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 member’s 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, or personal safety, including the right to refuse to work in unsafe situations, without fear of retaliation by the medical staff or the health care organization’s administration or governing body, including advocacy both in collaboration with and independent of the organization’s advocacy efforts with federal, state, and local government and other regulatory authorities.  e. 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.  f. 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.  g. 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.  h. The right of access to resources necessary to provide clinically appropriate patient care, including the right to participate in advocacy efforts for the purpose of procuring such resources both in collaboration with and independent of the organization’s advocacy efforts, without fear of retaliation by the medical staff or the health care organization’s administration or governing body.  (Modify Current HOD Policy) |
| G | CMS 01 | n/a | Council on Medical Service’s Sunset Review of 2011 House Policies | The Council on Medical Service recommends that the House of Delegates policies that are listed in the appendix to this report be acted upon in the manner indicated and the remainder of this report be filed. |
| G | CMS 03 | n/a | Universal Basic Income Pilot Studies | 1. That our American Medical Association (AMA) reaffirm Policy H-350.974, which states that the elimination of racial and ethnic disparities in health care are an issue of highest priority for the organization. (Reaffirm HOD Policy)  2. That our AMA reaffirm Policy H-290.986, which states that the Medicaid program is a safety net for the nation’s most vulnerable populations. (Reaffirm HOD Policy)  3. That our AMA reaffirm Policy D-290.979, which directs the AMA to work with state and specialty medical societies in advocating at the state level to expand Medicaid eligibility as authorized by the Affordable Care Act. (Reaffirm HOD Policy)  4. That our AMA reaffirm Policy D-290.985, which encourages sufficient federal and state funding for Medicaid to support enrollment and the provision of appropriate services. (Reaffirm HOD Policy)  5. That our AMA actively monitor Universal Basic Income pilot studies that intend to measure participant health outcomes and access to care. (Directive to Take Action) |
| G | CMS 04 | n/a | Promoting Accountability in Prior Authorization | 1. That our American Medical Association (AMA) reaffirm Policy H-320.939 which states that the AMA will continue its widespread prior authorization (PA) advocacy and outreach, including promotion and adoption of the Prior Authorization and Utilization Management Reform Principles, the Consensus Statement on Improving the Prior Authorization Process, AMA model legislation, the Prior Authorization Physician Survey and other PA research, and educational tools aimed at reducing administrative burdens for physicians and their staff; and advocate for such decisions to be based on the direct review of a physician of the same medical specialty/subspecialty as the prescribing/ordering physician. (Reaffirm HOD Policy)  2. That our AMA reaffirm Policies H-320.948 and H-320.961 which encourage sufficient clinical justification for any retrospective payment denial and prohibition of retrospective payment denial when treatment was previously authorized. (Reaffirm HOD Policy)  3. That our AMA reaffirm Policy H-320.949 which states that utilization management criteria should be based upon sound clinical evidence, permit variation to account for individual patient differences, and allow physicians to appeal decisions. (Reaffirm HOD Policy)  4. That our AMA reaffirm Policies H-285.998 and H-320.945 which underscore the importance of a clinical basis for health plans’ coverage decisions and policies. (Reaffirm HOD Policy)  5. That our AMA reaffirm Policy H-285.939 which states that utilization review decisions to deny payment for medically necessary care constitute the practice of medicine and that medical directors of insurance entities be held accountable and liable for medical decisions regarding contractually covered medical services. (Reaffirm HOD Policy)  6. That our AMA advocate that peer-to-peer (P2P) PA determinations must be made and actionable at the end of the P2P discussion notwithstanding mitigating circumstances, which would allow for a determination within 24 hours of the P2P discussion. (New HOD Policy)  7. That our AMA advocate that the reviewing P2P physician must have the clinical expertise to treat the medical condition or disease under review and have knowledge of the current, evidence-based clinical guidelines and novel treatments. (New HOD Policy)  8. That our AMA advocate that P2P PA reviewers follow evidence-based guidelines consistent with national medical specialty society guidelines where available and applicable. (New HOD Policy)  9. That our AMA continue to advocate for a reduction in the overall volume of health plans’ PA requirements and urge temporary suspension of all PA requirements and the extension of existing approvals during a declared public health emergency. (New HOD Policy)  10. That our AMA rescind Policy D-320.983, which directed the AMA to conduct the study herein. (Rescind HOD Policy) |
| G | CMS 05 | n/a | Medical Center Patient Transfer Policies | 1. That our American Medical Association (AMA) amend Policy H-130.982 by addition and deletion as follows:   H-130.982 Interfacility Patient Transfers ~~of~~ ~~Emergency Patients~~  Our AMA: (1) supports the following principles for ~~the~~ interfacility patient transfers ~~of emergency patients~~: (a) all physicians and health care facilities have an ethical obligation and moral responsibility to provide needed medical care to all emergency patients, regardless of their ability to pay; (b) an interfacility patient transfer ~~of an unstabilized emergency patient~~ should be undertaken only for appropriate medical purposes, i.e., when in the physician’s judgment it is in the patient’s best interest to receive needed medical ~~service~~ care at the receiving facility rather than the transferring facility; and (c) all interfacility patient transfers ~~of emergency patients~~ should be subject to the sound medical judgment and consent of both the transferring and receiving physicians to assure the safety and appropriateness of each proposed transfer; (2) urges ~~county medical societies~~ physician organizations to develop, in conjunction with their local hospitals, protocols and interhospital transfer agreements addressing the issue of economically motivated transfers of emergency patients in their communities. At a minimum, these protocols and agreements should address the condition of the patients transferred, the responsibilities of the transferring and accepting physicians and facilities, and the designation of appropriate referral facilities. The American College of Emergency Physicians’ Appropriate Interfacility Patient Transfer should be reviewed in the development of such community protocols and agreements; and (3) urges state medical associations to encourage and provide assistance to physician organizations that are ~~their county medical societies as they~~ developing such protocols and interhospital agreements with their local hospitals. (Modify Current HOD Policy)   1. That our AMA amend subsection II(d) of Policy H-225.942 by addition and deletion as follows:   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, or to transfer patients into, out of, or within the health care organization. (Modify Current HOD Policy)   1. That our AMA amend Policy H-130.965 by addition as follows:   Our AMA (1) opposes the refusal by an institution to accept patient transfers solely on the basis of economics; (2) supports working with the American Hospital Association (AHA) and other interested parties to develop model agreements for appropriate patient transfer; and (3) supports continued work by the AMA and the AHA on the problem of providing adequate financing for the care of these patients transferred. (Modify Current HOD Policy)   1. That our AMA amend Policy H-320.939 by addition of a fourth section as follows:   4. Our AMA advocates for health plans to minimize the burden on patients, physicians, and medical centers when updates must be made to previously approved and/or pending prior authorization requests. (Modify Current HOD Policy)   1. That our AMA reaffirm Policy H-225.957, which provides principles for strengthening the physician-hospital relationship. Policy H-225.957 sets forth parameters for collaboration and dispute resolution between the medical staff and the hospital governing body, and it establishes that the primary responsibility for the quality of care rendered and for patient safety is vested with the organized medical staff. (Reaffirm HOD Policy) 2. That our AMA reaffirm Policy H-225.971, which details the roles that medical staff and hospital governing bodies and management each and collectively play in quality of care and credentialing. Policy H-225.971 states that hospital administrative personnel performing quality assurance and other quality activities related to patient care should report to and be accountable to the medical staff committee responsible for quality improvement activities. (Reaffirm HOD Policy) 3. That our AMA reaffirm Policy H-285.904, which sets forth principles related to unanticipated out-of-network care. (Reaffirm HOD Policy) |
| G | CMS 06 | n/a | Urgent Care Centers | The Council on Medical Service recommends that the following be adopted and the remainder of the report be filed:  1. That our American Medical Association (AMA) reaffirm Policy D-35.985 supporting the physician-led health care team. (Reaffirm HOD Policy)  2. That our AMA reaffirm Policy H-385.926 supporting physicians’ choice of practice and method of earning a living. (Reaffirm HOD Policy)  3. That our AMA reaffirm Policy H-440.877 stating that if a vaccine is administered outside the medical home, all pertinent vaccine-related information should be transmitted to the patient’s primary care physician and the administrator of the vaccine should enter the information into an immunization registry, when one exists. (Reaffirm HOD Policy)  4. That our AMA reaffirm Policy H-385.940 advocating for fair and equitable payment of services described by Current Procedural Terminology (CPT) codes, including those for off-hour services. (Reaffirm HOD Policy)  5. That our AMA supports that any individual, company, or other entity that establishes and/or operates urgent care centers (UCCs) adhere to the following principles:  a. UCCs must help patients who do not have a primary care physician or usual source of care to identify one in the community;  b. UCCs must transfer a patient’s medical records to his or her primary care physician and to other health care providers, with the patient’s consent, including offering transfer in an electronic format if the receiving physician is capable of receiving it;  c. UCCs must produce patient visit summaries that are transferred to the appropriate physicians and other health care providers in a meaningful format that prominently highlight salient patient information;  d. UCCs should work with primary care physicians and medical homes to support continuity of care and ensure provisions for appropriate follow-up care are made;  e. UCCs should use local physicians as medical directors or supervisors;  f. UCCs should have a well-defined scope of clinical services, communicate the scope of services to the patient prior to evaluation, provide a list of services provided by the center, provide the qualifications of the on-site health care providers prior to services being rendered, describe the degree of physician supervision of any non-physician practitioners, and include in any marketing materials the qualifications of the on-site health care providers; and  g. UCCs should be prohibited from using the word “emergency” or “ED” in their name, any of their advertisements, or to describe the type of care provided. (New HOD Policy)  6. That our AMA work with interested stakeholders to improve attribution methods such that a physician is not attributed to spending for services that a patient receives at an UCC if the physician could not reasonably control or influence that spending. (New HOD Policy)  7. That our AMA support patient education including notifying patients if their physicians are providing off-hours care, informing patients what to do in urgent situations when their physician may be unavailable, informing patients of the differences between an urgent care center and an emergency department, and asking for their patients to notify their physician or usual source of care before seeking UCC services. (New HOD Policy) |
| G | CMS 09 | n/a | Addressing Payment and Delivery in Rural Hospitals | 1. That our American Medical Association (AMA) reaffirm Policy D-290.979 directing our AMA to support state efforts to expand Medicaid eligibility as authorized by the Affordable Care Act. (Reaffirm HOD Policy)  2. That our AMA reaffirm Policy H-290.976 stating that Medicaid payments to medical providers be at least 100 percent of Medicare payment rates. (Reaffirm HOD Policy)  3. That our AMA support that public and private payers take the following actions to ensure payment to rural hospitals is adequate and appropriate:  a. Create a capacity payment to support the minimum fixed costs of essential services, including surge capacity, regardless of volume;  b. Provide adequate service-based payments to cover the costs of services delivered in small communities;  c. Pay for physician standby and on-call time to enable very small rural hospitals to deliver quality services in a timely manner;  d. Use only relevant quality measures for rural hospitals and set minimum volume thresholds for measures to ensure statistical reliability;  e. Hold rural hospitals harmless from financial penalties for quality metrics that cannot be assessed due to low statistical reliability; and  f. Create voluntary monthly payments for primary care that would give physicians the flexibility to deliver services in the most effective manner with an expectation that some services will be provided via telehealth or telephone. (New HOD Policy)  4. That our AMA encourages transparency among rural hospitals regarding their costs and quality outcomes. (New HOD Policy)  5. That our AMA support better coordination of care between rural hospitals and networks of providers where services are not able to be appropriately provided at a particular rural hospital. (New HOD Policy)  6. That our AMA encourage employers and rural residents to choose health plans that adequately and appropriately reimburse rural hospitals and physicians. (New HOD Policy) |
| G | Res 701 | New York | Physician Burnout is an OSHA Issue | RESOLVED, That our American Medical Association seek legislation/regulation to add physician burnout as a Repetitive Strain (Stress) Injury and subject to Occupational Safety and Health Administration (OSHA) oversight. (Directive to Take Action) |
| G | Res 702 | New York | Addressing Inflammatory and Untruthful Online Ratings | RESOLVED, That our American Medical Association take action that would urge online review organizations to create internal mechanisms ensuring due process to physicians before the publication of negative reviews. (Directive to Take Action) |
| G | Res 703 | New York | Employed Physician Contracts | RESOLVED, That our American Medical Association advocate in support of all employed physicians receiving all rights and due process protections afforded all other members of the medical staff. (New HOD Policy) |
| G | Res 704 | Oklahoma | Eliminating Claims Data for Measuring Physician and Hospital Quality | RESOLVED, That our American Medical Association collaborate with the US Centers for Medicare and Medicaid Services (CMS) and other appropriate stakeholders to ensure physician and hospital quality measures are based on the delivery of care in accordance with established best practices (Directive to Take Action); and be it further  RESOLVED, That our AMA collaborate with CMS and other stakeholders to eliminate the use of claims data for measuring physician and hospital quality. (Directive to Take Action) |
| G | Res 705 | Arizona | Improving the Prior Authorization Process | RESOLVED, That our American Medical Association promote that all medication denials from insurance companies, pharmacy benefit managers or retail pharmacies provide the approved formulary alternatives in the same class of medications or the step edit requirements at the time of the denial to the prescribing physician (Directive to Take Action); and be it further  RESOLVED, That at the time of denial by insurance companies, pharmacy benefit managers, or retail pharmacies, that our AMA advocate they be required to inform the patient of the lowest cash or discount card price for that medication. (Directive to Take Action) |
| G | Res 706 | American Academy of Physical Medicine and Rehabilitation | Prevent Medicare Advantage Plans from Limiting Care | RESOLVED, That our American Medical Association ask the Centers for Medicare and Medicaid Services to further regulate Medicare Advantage Plans so that Medicare guidelines are followed for all Medicare patients and that care is not limited for patients who chose an Advantage Plan (Directive to Take Action); and be it further  RESOLVED, That our AMA advocate against applying proprietary criteria to determine eligibility of Medicare patients for procedures and admissions when the criteria are at odds with the professional judgment of the patient’s physician. (Directive to Take Action) |
| G | Res 707 | American College of Rheumatology | Financial Incentives for Patients to Switch Treatments | RESOLVED, That our American Medical Association oppose the practice of insurance companies providing financial incentives for patients to switch treatments (New HOD Policy); and be it further  RESOLVED, That our AMA support legislation that would ban insurer policies that provide patients financial incentives to switch treatments, and will oppose legislation that would make these practices legal (Directive to Take Action); and be it further  RESOLVED, That our AMA engage with state regulators urging review of the legality of such policies providing financial incentives to patients who switch to preferred drugs. (Directive to Take Action) |
| G | Res 708 | Georgia | Medicare Advantage Record Requests | RESOLVED, That our American Medical Association advocate for the relevant agencies and stakeholders to prevent Medicare Advantage plans from requesting records from practices solely to data mine for more funds and limit requests to 2% of plan participants, and otherwise advocate that the plan will reimburse the practices for their efforts in obtaining additional requested information. (Directive to Take Action) |
| G | Res 709 | Texas | Insurance Promotion of Preventive Care Services via Incentive-Based Programs | RESOLVED, That our American Medical Association advocate for health insurance companies to adopt cash-based incentive programs similar to the Medicare Incentives for Prevention of Chronic Disease program to promote usage of preventive care services (Directive to Take Action); and be it further  RESOLVED, That AMA support further research on health care initiatives that increase usage of preventive care services. (New HOD Policy) |
| G | Res 710 | Texas | Step-Edit Therapy Contributes to Denial of Care and Has Not Demonstrated Improved Patient Outcomes or Overall Cost Savings | RESOLVED, That our American Medical Association urge our legislators to review and make transparent the “fail-first” policy of step-edit therapy and study how it affects patient outcomes. (New HOD Policy) |
| G | Res 711 | Young Physicians Section | Opposition to Elimination of “Incident-to” Billing for Non-Physician Practitioners | RESOLVED, That our American Medical Association advocate against efforts to eliminate “incident-to” billing for non-physician practitioners among private and public payors. (Directive to Take Action) |

† Only the first organization is listed for those resolutions sponsored by multiple entities