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<td>.Con</td>
<td>CEJA 03</td>
<td><strong>Amendment to Opinion E-9.3.2, “Physician Responsibilities to Impaired Colleagues”</strong></td>
<td>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.</td>
<td>Support</td>
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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.

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
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)

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<th>CMS 08</th>
<th>Licensure and Telehealth</th>
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<td>1.</td>
<td>That our American Medical Association (AMA) work with the Federation of State Medical Boards, state medical associations and other stakeholders to</td>
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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:

a) The physician has an active license to practice medicine in a state or US territory and has not been subjected to disciplinary action.

b) There is a pre-existing and ongoing physician-patient relationship.

c) The physician has had an in-person visit(s) with the patient.

d) The telehealth services are incident to an existing care plan or one that is being modified.

e) The physician maintains liability coverage for telehealth services provided to patients in states other than the state where the physician is licensed.

f) Telehealth use complies with Health Insurance Portability and Accountability Act privacy and security rules. (Directive to Take Action)

2. 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) exemption from such a licensure requirement for traditional informal physician-to-physician consultations (“curbside consultations”) that are provided without expectation of compensation;

(eb) 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)

3. 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)

4. 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)

5. 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)

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**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)

**Support**

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**A Res 111**
**Towards Prevention of Hearing-Loss**

RESOLVED, That our American Medical Association promote awareness of hearing impairment as a potential contributor to the development of cognitive impairment.

**Support**
### Associated Cognitive Impairment

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)

### 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:

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 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)

### Digital Vaccine Credential Systems and Vaccine

COVID-19 and COVID-19 vaccines raise unique challenges. To meet these challenges, our AMA:
Mandates in COVID-19

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)
| Res. 211 (Illinois) | Permitting the Dispensing of Stock Medications for Post Discharge Patient Use and the Safe Use of Mult-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) | Support |
| 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 |
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)

| D | Res 401 | 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 |

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<tr>
<td>Res. 410</td>
<td>(American Academy of Physical Medicine and Rehabilitation)</td>
<td>Ensuring Adequate Health Care Resources to Address the Long COVID Crisis</td>
<td>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 (&quot;PASC&quot; or &quot;Long COVID&quot;) 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)</td>
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<td>Res. 601</td>
<td>(Mississippi)</td>
<td>S100 Member Annual Dues Payment through 2023</td>
<td>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)</td>
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<td>Res. 602</td>
<td>Senior Physicians Section</td>
<td>Timely Promotion and Assistance in Advance Care Planning and Advance Directives</td>
<td>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</td>
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<td>Res 706</td>
<td>American Academy of Physical Medicine and Rehabilitation</td>
<td>Prevent Medicare Advantage Plans from Limiting Care</td>
<td>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)</td>
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