AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION  
(June 2021)

Report of the Medical Student Section Reference Committee  

Tabitha Moses, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Resolution 006 – Medicare Eligibility at Age 60
2. Resolution 012 – Abolishment of the Resolution Committee
3. Resolution 017 – Support Harm Reduction Efforts through Decriminalization of Possessing of Non-Prescribed Buprenorphine
4. Resolution 019 – Environmental Contributors to Disease and Advocating for Social Justice
5. Resolution 020 – Increase Employment Services Funding for People with Disabilities
6. Resolution 023 – University Land Grant Status in Medical School Admissions
7. Resolution 035 – Disaggregation of Race Data for Individuals of Middle Eastern and North African (MENA) Descent
8. Resolution 059 – Access to Standard Care for Non-viable Pregnancy
9. Resolution 061 – Supporting the Further Study of Category III Sunscreen Ingredients
10. Resolution 062 – Formal Transitional Care Program for Children and Youth with Special Health Care Needs
11. CGPH WIM Report A – Increasing Regulation of Natural Cosmetic Products
12. CME MIC Report B – Exclusion of Race and Ethnicity in the First Sentence of Case Reports
15. LGBTQ+ Report A – The Importance of Consistent Terminology for LGBTQ+ Related Policy and Assessment of Current AMA-MSS Policy on LGBTQ+ Affairs
16. CGPH Report A – Decreasing Youth Access to E-Cigarettes
17. CGPH Report B – Investigation of Naturopathic Vaccine Exemptions
18. CME COLRP Report A – Study a Need-Based Scholarship to Encourage Medical Student Participation in the AMA
19. COLRP CME Report A – Understanding Philanthropic Efforts to Address the Rise of Medical School Tuition
20. CSI CGPH Report A – Protection of Antibiotic Efficacy through Water System Regulation
RECOMMENDED FOR ADOPTION AS AMENDED

22. Resolution 001 – Expanding the AMA-MSS Governing Council to Include a Diversity, Equity, & Inclusion Officer
23. Resolution 002 – Improving Access to Telehealth for those with Disabilities
24. Resolution 003 – Medical Honor Society Inequities and Reform
25. Resolution 004 – Use of Non-Police Mental Healthcare Worker Teams to Respond to Appropriate 911 Calls
26. Resolution 005 – Opposition to Sobriety Requirement for Hepatitis C Treatment
27. Resolution 007 – Pediatric Mental Health Needs during Pandemics and Crises
29. Resolution 011 – Increasing Support for Doula Services to Reduce Maternal Mortality
30. Resolution 014 – Protection of Medical Students that Advocate on Social Justice
31. Resolution 015 – Poverty-Level Wages and Health
32. Resolution 026 – Establishing Comprehensive Dental Benefits Under State Medicaid Programs
33. Resolution 027 – Increasing Transparency in the MSS Policy Process
34. Resolution 032 – Increasing Access to Innovative Glucose Monitoring for All Diabetics
35. Resolution 040 – Recommending Allyship Training in Medical Education
36. Resolution 044 – Inclusion of Hygiene Products in Supplemental Nutrition Programs
37. Resolution 045 – Advocating for the Delivery of Standardized Perinatal Care and Monitoring of Healthcare Outcomes for Incarcerated Pregnant Individuals
38. Resolution 056 – Online Medical School Interview Option
40. Resolution 073 – Support Accountable Organizations to Residents and Fellows
41. CME MIC Report A – Research the Ability of Two-Interval Grading of Clinical Clerkships to Minimize Racial Bias in Medical Education
42. CSI Report B – Supporting Daylight Saving Time as the New, Permanent Standard Time
43. CSI Report C – Improving Labeling of Over-the-Counter Medications by Including Carbohydrate Content
44. CSI COLA Report A – Regulation of Phthalates in Adult Personal Sexual Products
45. WIM Report A – Support for Family Planning for Medical Students
46. CHIT CGPH COLA Report A – Medical Misinformation in the Age of Social Media
47. GC Report B – Sunset Report

RECOMMENDED FOR ADOPTION IN LIEU OF

48. Resolution 009 – Promoting Equity in Global Vaccine Distribution
49. Resolution 037 – Advocate for Federal Involvement in Planning and Strategizing a Global COVID-19 Vaccine Distribution Plan
50. Resolution 010 – Amend D-95.987, to Support Exempting Fentanyl Test Strips and Other Drug Checking Technologies from Paraphernalia Laws
Resolution 024 – Amend H-95.958 to Decriminalize IDPE in Safe Syringe Programs
50. Resolution 033 – Studying Mortality Among Homeless Populations
51. Resolution 034 – Evidence-Based Guidelines for Corneal Donation from Men Who Have Sex with Men
52. Resolution 036 – Equitable Reporting of USMLE Step 1 Scores
53. Resolution 041 – Reporting of Residency Program-Level Demographic Data to FREIDA
Resolution 054 – Data Disclosure on Parenthood during Residency

RECOMMENDED FOR REFERRAL

54. Resolution 013 – Opposing the Use of Vulnerable Incarcerated People in Response to Public Health Emergencies
55. Resolution 025 – Studying Population-Based Insurance and Payment Policy Disparities
56. Resolution 029 – Mitigating the Impact of Air Pollution on Pediatric Health
57. Resolution 038 – Amending H-420.978, Access to Prenatal Care, to Support the Practice of and Appropriate Reimbursement for Group Prenatal Care
59. Resolution 046 – Addressing Inequity in Onsite Wastewater Treatment
60. Resolution 049 – IMG Exemptions from Immigration Caps and IMG-specific Immigration Category for Visas and Green Cards
61. Resolution 060 – Promotion and Support of Physician, Student, and Patient Participation in Government Elections
62. Resolution 080 – Mental Health Reform in Prisons
63. CSI Report A – Amend H-150.927 and H-150.933, to Include Food Products with Added Sugar
64. CEQM Report A – Support of Research on Vision Screenings and Visual Aids for Adults Covered by Medicaid

RECOMMENDED FOR NOT ADOPTION

66. Resolution 016 – Medicare Eligibility for Insulin-Dependent Patients
67. Resolution 042 – Medical Student, Resident, and Fellow Suicide Reporting
68. Resolution 043 – Generation of CPT Codes for Time Spent on Prior Authorization to Better Appreciate Physician Burden
69. Resolution 047 – Oppose Onerous and Stringent Limitations on Medical Clearances
70. Resolution 048 – Implementing Pictorial Health Warnings on Alcoholic Beverages for Sale in Containers
71. Resolution 050 – Improving Pandemic Preparedness in the Preclinical Years
72. Resolution 051 – Promoting Oral Anticancer Drug Parity
73. Resolution 063 – Advocating for Tax Incentives to Promote Food Recycling Programs and to Reduce Food Waste and Improve Health
74. Resolution 065 – Advocating for Plant-Based Meat Research and Regulation
75. Resolution 066 – Proposed Change in Mental Health Reporting and Treatment of Pilots to the FAA
76. Resolution 070 – Use of Situational Judgment and Personality Assessments in Medical School Admissions
77. Resolution 075 – Providing Patient Access to Transcranial Magnetic Stimulation for Mental Health
78. Resolution 077 – Addressing Healthcare Disparities through Personalized Medicine and Improved Representation of all Populations in Healthcare Education and Training
79. Resolution 081 – Clinical Opportunities for Unmatched Medical Students
80. Resolution 082 – Addressing Early Adolescent Mental Health and Social Media
81. Resolution 083 – Advocate for Internet Security Training for Immigrant and Refugee Populations

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

82. Resolution 018 – Addressing Low Vaccination Rates Among Minorities through Trust-Building and Elimination of Financial Barriers
83. Resolution 021 – Addressing Sexual Assault on College Campuses
84. Resolution 022 – Need for Increased Diversity in Standardized Patients
85. Resolution 028 – Amend H-60.965 to Address Adolescent Telehealth Confidentiality Concerns
86. Resolution 030 – Opposing Forced Hysterectomies and Reproductive Mistreatment of ICE Detainees and BIPOC Individuals
87. Resolution 031 – Amending Policy D-350.983, to Include Community Physician Oversight
88. Resolution 052 – Amend AMA Policy H-70.912, to Recommend the Use of “Intellectual Disability” in Lieu of “Mental Retardation” in Academic Texts, Published Literature, and Medical Education
89. Resolution 053 – Advocating for Modern Solutions to Address Food Insecurity in School-Aged Children
90. Resolution 055 – Racial Bias in Medical Technology
91. Resolution 057 – Amending to Add Racial Equity for H-130.954, Non-Emergency Patient Transportation Systems
92. Resolution 058 – Developing a Comprehensive Plan for Health Systems Reform Database
93. Resolution 064 – Advocate for the Creation of a National All-Payer Clams Database
94. Resolution 067 – Taxation Amendment to Special Needs Trusts for Patients with Huntington’s Disease
95. Resolution 068 – Equal Access Among Third Party Resources
96. Resolution 069 – Increasing Medicaid Insurance Coverage of Infertility Services
97. Resolution 071 – USMLE Step Examination Scheduling during the COVID-19 Pandemic
98. Resolution 074 – Promoting the Integration of Dietitians into Primary Care Teams
99. Resolution 076 – Amend Policy H-480.945 “Genome Editing and its Potential Clinical Use” to Align with AMA Code of Medical Ethics
100. Resolution 078 – Mental Health Screenings during All Visits to Clinical Settings
101. Resolution 079 – Supporting Revision of Medical Student Guidelines during Healthcare Crisis
RECOMMENDED FOR ADOPTION

(1) RESOLUTION 006 – MEDICARE ELIGIBILITY AT AGE 60

RECOMMENDATION:

Resolution 006 be adopted.

RESOLVED, That our AMA advocate that the eligibility threshold to receive Medicare as a federal entitlement be lowered from age 65 to age 60.

RESOLVED, That this resolution be immediately forwarded to our AMA House of Delegates at the June 2021 Special Meeting.

Resolution 006 received overwhelming support on the VRC. Region 1, Region 3, Region 4, the Massachusetts delegation, the Committee on Legislation and Advocacy (COLA), the Committee on Economics and Quality in Medicine (CEQM), and GLMA: Health Professionals Advancing LGBTQ Equality all supported the resolution as written. Region 2 was in opposition. AMA Advocacy suggested that immediate forwarding of this resolution may not be appropriate. Your Reference Committee respectfully disagrees. We believe this issue is timely, important, and aligns well with MSS priorities. We recommend Resolution 006 be adopted.

(2) RESOLUTION 012 – ABOLITION OF THE RESOLUTION COMMITTEE

RECOMMENDATION:

Resolution 012 be adopted.

RESOLVED, That our AMA abolish the Resolution Committee by amending the AMA Bylaws B-2.13.3, “Resolution Committee,” as follows by deletion:

Resolution Committee. B-2.13.3

The Resolution Committee is responsible for reviewing resolutions submitted for consideration at an Interim Meeting and determining compliance of the resolutions with the purpose of the Interim Meeting.

2.13.3.1 Appointment. The Speaker shall appoint the members of the committee. Membership on this committee is restricted to delegates.

2.13.3.2 Size. The committee shall consist of a maximum of 31 members.

2.13.3.3 Term. The committee shall serve only during the meeting at which it is appointed, unless otherwise directed by the House of Delegates.

2.13.3.4 Quorum. A majority of the members of the committee shall constitute a quorum.
2.13.3.5 Meetings. The committee shall not be required to hold meetings. Action may be taken by written or electronic communications.

2.13.3.6 Procedure. A resolution shall be accepted for consideration at an Interim Meeting upon majority vote of committee members voting. The Speaker shall only vote in the case of a tie. If a resolution is not accepted, it may be submitted for consideration at the next Annual Meeting in accordance with the procedure in Bylaw 2.11.3.1.

2.13.3.7 Report. The committee shall report to the Speaker. A report of the committee shall be presented to the House of Delegates at the call of the Speaker.

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

Resolution 012 received limited testimony on the VRC. The Massachusetts delegation spoke in favor of the resolution and one individual spoke in opposition, but we believe that was due to confusing the HOD Resolution Committee with the MSS Reference Committee. We agree with the authors that the advocacy limitation on resolutions discussed at AMA Interim Meetings is ill-defined and we are always supportive of improving the democracy of our AMA House of Delegates. Your Reference Committee recommends Resolution 012 be adopted.

(3) RESOLUTION 017 – SUPPORT HARM REDUCTION EFFORTS THROUGH DECRIMINALIZATION OF POSSESSION OF NON-PRESCRIBED BUPRENORPHINE

RECOMMENDATION:

Resolution 017 be adopted.

RESOLVED, That our AMA advocate for the removal of buprenorphine from the misdemeanor crime of possession of a narcotic; and be it further

RESOLVED, That our AMA support any efforts to decriminalize the possession of non-prescribed buprenorphine.

VRC testimony was mixed, but overall supportive of the spirit of Resolution 017. Region 1, Region 6, and the Committee on Global and Public Health (CGPH) supported Resolution 017 as written. Region 2 opposed the resolution and suggested the authors submit a Governing Council Action Item Request. Region 1 and the American Society of Addiction Medicine (ASAM) suggested combining the resolve clauses because they are redundant. However, your Reference Committee did not find this argument compelling, as we believe that the first resolve clause calls for removing charges related for non-
prescribed buprenorphine possession, while the second clause takes the ask a step further calling for decriminalization. The resolve clauses are distinct and represent two approaches to a similar goal, and are not redundant, so we chose not to incorporate this amendment.

ASAM also requested that the resolution specify that only the possession of a “therapeutic” dose be decriminalized; however, we believe this language would make the resolution vague to the point of not protecting the population it is intended to protect. We understand ASAM is probably trying to prevent this resolution from applying to people who may be illegally selling buprenorphine, but we note that sale of drugs is prosecuted differently from simple possession, so this resolution would not apply to sales. We recommend that Resolution 017 be adopted.

(4) RESOLUTION 019 – ENVIRONMENTAL CONTRIBUTORS TO DISEASE AND ADVOCATING FOR ENVIRONMENTAL JUSTICE

RECOMMENDATION:

Resolution 019 be adopted.

RESOLVED, That our AMA amend Policy D-135.997, “Research into the Environmental Contributors to Disease,” by addition and deletion to read as follows:

Research into the Environmental Contributors to Disease and Advocating for Environmental Justice D-135.997

Our AMA will (1) advocate for greater public and private funding for research into the environmental causes of disease, and urge the National Academy of Sciences to undertake an authoritative analysis of environmental causes of disease; (2) ask the steering committee of the Medicine and Public Health Initiative Coalition to consider environmental contributors to disease and environmental racism as a priority public health issue; (3) encourage federal, state, and local agencies to address and remediate environmental injustice, environmental racism, and all other environmental conditions that are adversely impacting health, especially in marginalized communities; and (4) lobby Congress to support ongoing initiatives that include reproductive health outcomes and development particularly in minority populations in Environmental Protection Agency Environmental Justice policies.

VRC testimony on Resolution 019 was mixed. Region 1, Region 2, Region 3, and Region 4 supported the resolution as written. The Massachusetts delegation recommended this be referred to "ensure remediation efforts are appropriate, effective, and driven by the communities that have been most impacted." The Committee on Global and Public Health (CGPH) recommend reaffirmation of Racism as a Public Health Threat (H-65.952, clause
5). The Section Delegates recommend making internal, to support a similar RFS resolution that is also being considered at the June 2021 Special Meeting.

We respectfully disagree with CGPH’s recommendation for reaffirmation. We believe Resolution 019 goes further than what already exists in H-65.952 to address environmental racism specifically. We also disagree with the Section Delegates’ suggestion to make this internal. In the event that this resolution’s counterpart does not pass the RFS Assembly, we believe this topic is important enough to bring forward on our own. Your Reference Committee recommends Resolution 019 be adopted.

(5) RESOLUTION 020 – INCREASE EMPLOYMENT SERVICES FUNDING FOR PEOPLE WITH DISABILITIES

RECOMMENDATION:

Resolution 020 be adopted.

RESOLVED, That our AMA support increased resources for employment services to reduce health disparities for people with disabilities.

VRC testimony was supportive of Resolution 020 as written. Region 4, the Committee on Legislation and Advocacy (COLA), the Committee on Economics and Quality in Medicine (CEQM), the Minority Issues Committee (MIC), and the Massachusetts delegation supported the resolution. Region 2 opposed the resolution and suggested the authors submit a Governing Council Action Item Request instead.

Your Reference Committee supports the spirit of this resolution and appreciates the authors bringing forward a resolution that addresses the impact of financial well-being on health status, as well as disability rights. There was some concern that this ask was too broad, but we believe that narrowing the focus would limit the impact of the resolution. We recommend Resolution 020 be adopted.

(6) RESOLUTION 023 – UNIVERSITY LAND GRANT STATUS IN MEDICAL SCHOOL ADMISSIONS

RECOMMENDATION:

Resolution 023 be adopted.

RESOLVED, That our AMA work with the Association of American Medical Colleges, Liaison Committee on Medical Education, Association of American Indian Physicians, and Association of Native American Medical Students to design and promulgate medical school admissions recommendations in line with the federal trust responsibility; and be it further

RESOLVED, That our AMA amend H-350.981 by addition:

AMA Support of American Indian Health Career Opportunities H-350.981
AMA policy on American Indian health career opportunities is as follows:

1. Our AMA, and other national, state, specialty, and county medical societies recommend special programs for the recruitment and training of American Indians in health careers at all levels and urge that these be expanded.

2. Our AMA support the inclusion of American Indians in established medical training programs in numbers adequate to meet their needs. Such training programs for American Indians should be operated for a sufficient period of time to ensure a continuous supply of physicians and other health professionals. These efforts should include, but are not limited to, priority consideration of applicants who self-identify as American Indian or Alaska Native and can provide some form of affiliation with an American Indian or Alaska Native tribe in the United States, and robust mentorship programs that support the successful advancement of these trainees.

3. Our AMA utilize its resources to create a better awareness among physicians and other health providers of the special problems and needs of American Indians and that particular emphasis be placed on the need for stronger clinical exposure and a great number of additional health professionals to work among the American Indian population.

4. Our AMA continue to support the concept of American Indian self-determination as imperative to the success of American Indian programs, and recognize that enduring acceptable solutions to American Indian health problems can only result from program and project beneficiaries having initial and continued contributions in planning and program operations.

5. Our AMA acknowledges long-standing federal precedent that membership or lineal descent from an enrolled member in a federally recognized tribe is distinct from racial identification as American Indian or Alaska Native and should be considered in medical school admissions even when restrictions on race-conscious admissions policies are in effect.

6. Our AMA will engage with the Association of Native American Medical Students and Association of American Indian Physicians to design and disseminate American Indian and Alaska Native medical education curricula that prepares trainees to serve AI-AN communities.

VRC testimony was overwhelmingly supportive of Resolution 023. Your Reference Committee points out that this topic is germane to other conversations that are occurring at the June 2021 MSS Assembly Meeting and the June 2021 Special Meeting of the House of Delegates. We find that the authors lay out a well-researched, well-reasoned argument for this ask and recommend Resolution 023 be adopted.
(7) RESOLUTION 035 – DISAGGREGATION OF RACE DATA FOR INDIVIDUALS OF MIDDLE EASTERN AND NORTH AFRICAN (MENA) DESCENT

RECOMMENDATION A:

Policy H-350.954 be reaffirmed in lieu of the second Resolve clause of Resolution 035.

RECOMMENDATION B:

The remainder of Resolution 035 be adopted.

RESOLVED, That our AMA add “Middle Eastern/North African (MENA)” as a separate race category on all AMA demographics forms; and be it further

RESOLVED, That our AMA advocate for the use of “Middle Eastern/North African (MENA)” as a separate race category in all medical records; and be it further

RESOLVED, That our AMA work with relevant stakeholders to promote the inclusion of “Middle Eastern/North African (MENA)” as a separate race category on all surveys conducted by the U.S. Census Bureau, and for all federally funded research using race categories; and be it further

RESOLVED, That our AMA work with relevant stakeholders to promote the inclusion of “Middle Eastern/North African (MENA)” as a separate race category on all medical school and residency demographics forms.

VRC testimony was overwhelmingly supportive of Resolution 035. Region 1, Region 3, Region 4, the Minority Issues Committee (MIC), the Committee on Global and Public Health (CGPH), and the Councilor on Medical Education supported the resolution as written. The Massachusetts delegation supported the resolution with amendments. The House Coordination Committee (HCC) recommended H-350.954 be reaffirmed in lieu of the second resolve clause. We agree that this is sufficiently covered under existing policy. We recommend H-350.954 be reaffirmed in lieu of the second resolve clause and the remainder of Resolution 035 be adopted.

H-350.954 – DISAGGREGATION OF DEMOGRAPHIC DATA WITHIN ETHNIC GROUPS

1. Our AMA supports the disaggregation of demographic data regarding: (a) Asian-Americans and Pacific Islanders in order to reveal the within-group disparities that exist in health outcomes and representation in medicine; and (b) ethnic groups in order to reveal the within-group disparities that exist in health outcomes and representation in medicine.

2. Our AMA: (a) will advocate for restoration of webpages on the Asian American and Pacific Islander (AAPI) initiative (similar to those from prior administrations) that specifically
address disaggregation of health outcomes related to AAPI data; (b) supports the disaggregation of data regarding AAPIs in order to reveal the AAPI ethnic subgroup disparities that exist in health outcomes; (c) supports the disaggregation of data regarding AAPIs in order to reveal the AAPI ethnic subgroup disparities that exist in representation in medicine, including but not limited to leadership positions in academic medicine; and (d) will report back at the 2020 Annual Meeting on the issue of disaggregation of data regarding AAPIs (and other ethnic subgroups) with regards to the ethnic subgroup disparities that exist in health outcomes and representation in medicine, including leadership positions in academic medicine.

(8) RESOLUTION 059 – ACCESS TO STANDARD CARE FOR NON-VIABLE PREGNANCY

RECOMMENDATION A:

5.001MSS and 5.005MSS be reaffirmed in lieu of the first resolve of Resolution 059.

RECOMMENDATION B:

The remainder of Resolution 059 be adopted.

RESOLVED, That our AMA-MSS supports patients' timely access to standard treatment of nonviable pregnancy in both emergent and non-emergent circumstances; and be it further

RESOLVED, That our AMA-MSS opposes any hospital directive, policy, or legislation that may hinder patients’ timely access to the accepted standard of care in both emergent and non-emergent cases of nonviable pregnancy.

Testimony on the VRC was universally supportive of Resolution 059. The Massachusetts delegation suggested that this resolution be made external, but your Reference Committee would not recommend this without explicit support of the American College of Obstetricians and Gynecologists (ACOG), which to our knowledge we do not have at this time. We recommend that 5.001MSS and 5.005MSS be reaffirmed in lieu of the first resolve clause and the remainder of Resolution 059 be adopted.

5.001MSS – Public Funding of Abortion Services: AMA-MSS will ask the AMA to: (1) continue its support of education and choice with respect to reproductive rights; (2) continue to actively support legislation recognizing abortion as a compensable service; and (3) continue opposition to legislative measures which interfere with medical decision making or deny full reproductive choice, including abortion, based on a patient's dependence on government funding.
5.005MSS - MSS Stance on Challenges to Women’s Right to Reproductive Health Care Access: AMA-MSS opposes legislation that would restrict a woman’s right to obtain medical services associated with her reproductive health, as defined in policy 5.001 MSS, on the grounds that they interfere with a physician's ability to provide medical care.

Resolution 061 be adopted.

RESOLVED, That our AMA-MSS supports the study of the health effects of sunscreen ingredients currently available in the United States which have not been determined to be generally recognized as safe and effective.

There was limited VRC testimony on Resolution 061. We note that this resolution could potentially have been written to be more impactful, however, we would direct the Section to also reference CGPH WIM Report B, which covers a similar topic. Your Reference Committee recommends Resolution 061 be adopted.

Resolution 062 be adopted.

RESOLVED, That our AMA amend policy H-60.974: Children and Youth with Disabilities by insertion and deletion as follows, to strengthen our AMA policy and to include a population of patients that do not fall under “disability” but also need extra care, especially when transitioning to adult health care, that they are currently not receiving due to a gap:

It is the policy of the AMA: (1) to inform physicians of the special health care needs of children and youth with disabilities and children and youth with special health care needs (CYSHCN); (2) to encourage physicians to pay special attention during the preschool physical examination to identify physical, emotional, or developmental disabilities that have not been previously noted; (3) to encourage physicians to provide services to children and youth with disabilities and CYSHCN that are family-
centered, community-based, and coordinated among the various individual providers and programs serving the child;
(4) to encourage physicians to provide schools with medical information to ensure that children and youth with disabilities and CYSHCN receive appropriate school health services;
(5) to encourage physicians to establish formal transition programs or activities that help adolescents with disabilities, and CYSHCN, and their families to plan and make the transition to the adult medical care system;
(6) to inform physicians of available educational and other local resources, as well as various manuals that would help prepare them to provide family-centered health care; and
(7) to encourage physicians to make their offices accessible to patients with disabilities and CYSHCN, especially when doing office construction and renovations.

Testimony on the VRC was supportive of the spirit of the resolution, although there were some amendments proffered. We believe that the authors clearly laid out the importance of this issue and why it was distinct from existing policy. The Section Delegates recommended making this internal, questioning the priority of this topic within the section at this time, given the MSS’ growing list of transmittals. We did not find this argument compelling and believe that this would help improve Advocacy efforts on this topic. Your Reference Committee recommends Resolution 062 be adopted.

(11) CGPH WIM REPORT A – INCREASING REGULATION OF NATURAL COSMETIC PRODUCTS

RECOMMENDATION:

Recommendations from CGPH WIM Report A be adopted and the remainder of the report be filed.

Your Women in Medicine Committee and Committee on Global and Public Health recommend that the referred resolved clauses from MSS Resolution 056 not be adopted.

VRC testimony on CGPH WIM Report A was limited. We agree with the recommendations put forward by CGPH and WIM. If there is interest to re-visit this topic in the future, we would recommend reaching out to the American Academy of Dermatology. We thank the authors for their well-written, well-researched report, and recommend the recommendations in CGPH WIM Report A be adopted and the remainder of the report be filed.

(12) CME MIC REPORT B – EXCLUSION OF RACE AND ETHNICITY IN FIRST SENTENCE OF CASE REPORTS.

RECOMMENDATION:

Recommendations from CME MIC Report B be adopted and the remainder of the report be filed.
Your MSS Committee on Medical Education and MSS Minority Issues Committee recommend that the following resolve clauses from Resolution 063 be adopted as amended and the remainder of the report be filed:

RESOLVED, That our AMA encourages curriculum and clinical practice that omits race and/or ethnicity from the first sentence of case reports and other medical documentation;

RESOLVED, That our AMA encourages the maintenance of race and ethnicity in other relevant sections of case reports and other medical documentation, either social or family history of the patient.

RESOLVED, That our AMA study common cultural processes in clinical practice that advance racism and bias.

We commend the authors of CME MIC Report B on their work on this report. Testimony on CME MIC Report B was limited. We agree with the recommended amendments made to the original resolution. Your Reference Committee recommends the recommendations in CME MIC Report B be adopted and the remainder of the report be filed.

Recommendations from WIM CEQM Report A be adopted and the remainder of the report be filed.

Your Women in Medicine Committee and Committee on Economics and Quality in Medicine recommend that the following resolve clause be adopted in lieu of Resolution 049 and the remainder of this report be filed:

RESOLVED, That our AMA amend policy D-290.974, Extending Medicaid Coverage for One Year Postpartum, by addition as follows:

EXTENDING MEDICAID COVERAGE FOR PREGNANCY AND ONE YEAR POSTPARTUM, D-290.974

1. Our AMA will work with relevant stakeholders to support extension of Medicaid coverage to 12 months postpartum; and

2. Our AMA will encourage states to expand Medicaid eligibility for pregnant non-citizen immigrants; and

3. Our AMA will support the inclusion of pregnancy as a qualifying life event on the healthcare Marketplace.

VRC testimony on WIM CEQM Report A was limited. The Section Delegates questioned the addition of pregnancy as a qualifying life event on the healthcare marketplace, but we respectfully disagree. Pregnancy is a limited event and enrolling in healthcare
coverage is critical. Pregnancy is a transient time and often a pregnant individual cannot wait until the next enrollment period to enroll in a healthcare marketplace. We thank the authors for their hard work on this very well-written and comprehensively researched report and recommend that the recommendations in WIM CEQM Report A be adopted and the remainder of the report be filed.

**(14) DELEGATE REPORT C – TRANSMITTAL REPORT**

**RECOMMENDATION:**

The Recommendation from Delegate Report C be adopted and the remainder of the report be filed.

Your Section Delegates recommend that the following resolutions be discharged from the transmittal queue, and that the remainder of the report be filed:

1. Expungement and Sealing of Drug Records
2. Report and Recommendations on the Residency Application Process
3. Encouraging Residency Program Collaboration to Allow Medical Students Fair and Equitable Application Process
4. Medical Licenses for Individuals with DACA Status
5. Advocating for the Reimbursement of Remote Patient Monitoring for the Management of Chronic Conditions
6. Recovery Homes Use of MOUD for Opioid Use Disorder

Your Reference Committee commends the Section Delegates on a job well done – not only on this report, but with their ongoing efforts in navigating the MSS policy process through a virtual world. We recommend the recommendations in Delegate Report C be adopted and the remainder of the report be filed.

**(15) LGBTQ+ REPORT A – THE IMPORTANCE OF CONSISTENT TERMINOLOGY FOR LGBTQ+ RELATED POLICY AND ASSESSMENT OF CURRENT AMA-MSS POLICY ON LGBTQ+ AFFAIRS**

**RECOMMENDATION:**

The Recommendations from LGBTQ+ Report A be adopted and the remainder of the report be filed.

Your Standing Committee on LGBTQ+ Affairs recommends the following resolve clauses be adopted and presents the remainder of this informational report for use by the Medical Student Section and recommends the report be filed.

RESOLVED, That our AMA-MSS will utilize the combined terminology recommendations and catalog of existing AMA-MSS policy to fully update existing AMA-MSS policy relating to LGBTQ+ Affairs to make it consistent with all other policies and the current best practices for language relating to the LGBTQ+ population.

RESOLVED, That our AMA-MSS amend 50.003MSS as follows:
Blood Donation by HIV Negative Homosexual Males Men who have Sex with Men (MSM)

AMA-MSS will ask the AMA to encourage the Food and Drug Administration to continue evaluation and monitoring of regulations on blood donation by men who have had sex with other men, and to consider making modifications to the current deferral policies if sufficient scientific evidence becomes available to support such a change.

RESOLVED, That our AMA-MSS amend 65.008MSS as follows:

Nondiscriminatory Policy for the Health Care Needs of the Homosexual Population LGBTQ+ Community

AMA-MSS will ask the AMA to (1) encourage physician practices, medical schools, hospitals, and clinics to broaden any nondiscriminatory statement made to patients, healthcare workers, or employees to include "sexual orientation, sex, or perceived gender identity" in any nondiscrimination statement; and (2) encourage individual physicians to display for patient and staff awareness-as one example: "This office appreciates the diversity of human beings and does not discriminate based on race, age, religion, ability, marital status, sexual orientation, sex, or perceived gender identity."

RESOLVED, That our AMA-MSS amend 65.010MSS as follows:

Promoting Awareness and Education of Lesbian, Gay, Bisexual, and Transgender LGBTQ+ Health Issues on Medical School Campuses

AMA-MSS (1) supports medical student interest groups to organize and congregate under the auspices of furthering their medical education or enhancing patient care by improving their knowledge and understanding of various communities – without regard to their gender, sexual orientation, race, religion, disability, ethnic origin, national origin or age; (2) supports students who wish to conduct on-campus educational seminars and workshops on health issues in Lesbian, Gay, Bisexual, and Transgender LGBTQ+ communities; (3) encourages the LCME to require all medical schools to incorporate GLBT LGBTQ+ health issues in their curricula; and (4) reaffirms its opposition to discrimination against any medical student on the basis of sexual orientation.

RESOLVED, That our AMA-MSS amend 65.014MSS as follows:

Marriage Equality and Repeal of the Defense of Marriage Act

(1) AMA-MSS will ask the AMA to support ending the exclusion of same-sex couples from civil marriage in order to reduce health care disparities affecting those gay and lesbian LGBTQ+ individuals and couples, their families, and their children; (2) AMA-MSS supports the repeal of the "Defense of Marriage Act," as it discriminates against married same-sex couples and their families and directly contributes to health care disparities among the gay, lesbian, bisexual, and transgender (GLBT) LGBTQ+ community.

RESOLVED, That our AMA-MSS amend 65.015MSS as follows:

Reducing Suicide Risk among LGBTQ+ Lesbian, Gay, Bisexual, Transgender, and Questioning Youth through Collaboration with Allied Organizations
AMA-MSS will ask the AMA to partner with public and private organizations dedicated to public health and public policy to reduce lesbian, gay, bisexual, transgender, and questioning LGBTQ+ youth suicide and improve health among LGBTQ+ youth.

RESOLVED, That our AMA-MSS amend 65.017MSS as follows:

Lesbian, Gay, Bisexual, and Transgendered LGBTQ+ Patient-Specific Training Programs for Healthcare Providers
AMA-MSS will ask the AMA to support the training of healthcare providers in cultural competency as well as in physical health needs for lesbian, gay, bisexual, and transgender LGBTQ+ patient populations.

RESOLVED, That our AMA-MSS amend 65.024MSS as follows:

FMLA-Equivalent for LGBTQ+ Workers:
AMA-MSS will ask the AMA to support the expansion of policies regarding family and medical leave to include any individual related by blood or affinity whose close association with the employee is the equivalent of a family relationship.

RESOLVED, That our AMA-MSS amend 65.030MSS as follows:

Sexual and Gender Minority Populations in Medical Research
AMA-MSS will ask the AMA to amend policy H-315.967 Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation by insertion and deletion as follows:

Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation
H-315.967
Our AMA: (1) supports the voluntary inclusion of a patient's biological sex, current gender identity, sexual orientation, and preferred gender pronoun(s) in medical documentation and related forms, including in electronic health records, in a culturally-sensitive and voluntary manner; and (2) will advocate for collection of patient data in medical documentation and in medical research studies, according to current best practices, that is inclusive of sexual orientation/gender identity, sexual orientation, gender identity, and other sexual and gender minority traits, such as intersex or differences/disorders of sex development for the purposes of research into patient and population health.

RESOLVED, That our AMA-MSS amend 65.031MSS as follows:

Oppose Requirements of Hormonal Treatments for Athletes
AMA-MSS will ask the AMA to: (1) oppose any regulations requiring mandatory medical treatment or surgery for intersex athletes and/or athletes with Differences in Sex Development (DSD) to be allowed to compete in alignment with their identity; and (2) oppose the creation of distinct hormonal guidelines to determine gender classification for athletic competitions.

RESOLVED, That our AMA-MSS amend 65.032MSS as follows:

Patient-Reported Outcomes in Gender Affirming Confirmation Surgery
AMA-MSS will ask the AMA to: (1) support initiatives and research to establish standardized protocols for patient selection, surgical management, and pre-operative and post-operative care for transgender patients undergoing gender affirming confirmation surgeries; and (2) support development and implementation of standardized tools, such as questionnaires to evaluate outcomes of gender affirming confirmation surgeries.

Resolved, That our AMA-MSS amend 75.008MSS as follows:

Preservation of HIV and STD Prevention Programs Involving Safer Sex Strategies and Condom Use
AMA-MSS will ask the AMA to reaffirm its policy to reiterate that HIV and STD prevention education must be comprehensive to incorporate safer sex strategies including condom use, not just abstinence, and that these programs be culturally sensitive to the LGBTQ+ Community sexual orientation minorities.

Resolved, That our AMA-MSS amend 245.020 as follows:

Supporting Autonomy for Intersex Patients and Patients with Differences of Sex Development
AMA-MSS will ask that our AMA affirm that medically unnecessary surgeries in intersex patients and individuals born with differences of sex development are unethical and should be avoided until the patient can actively participate in decision-making.

Resolved, That our AMA-MSS amend 295.190MSS as follows:

Cultural Competency Training For Medical School Faculty, Staff, and Students Concerning Individuals Who Are LGBTQ+ Lesbian, Gay, Bisexual, Transgender, Gender Nonconforming, and/or Born with Differences of Sexual Development:
Our AMA-MSS (1) supports the development and implementation of cultural competency programs by medical schools that train and guide medical school faculty, staff, and students in effective and compassionate communication with individuals of different backgrounds, including but not limited to gender, gender identity, sexual orientation, race, religion, disability, ethnic origin, national origin, or age; and (2) support the development and implementation of supportive programs and confidential counseling services by medical schools to individuals within their institutions who have faced challenges due to their gender, gender identity, sexual orientation, race, religion, disability, ethnic origin, national origin, or age.

Resolved, That our AMA-MSS amend 295.191MSS as follows:

Educating Physicians About the Importance of Cervical Cancer Screening for Transgender Men Female-to-Male Transgender Patients
AMA-MSS will ask that our AMA amend policy H-160.991 by insertion and deletion to read as follows:

Healthcare Needs of LGBTQ+ Lesbian Gay Bisexual and Transgender Populations
Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for women who have sex with women and transgender men who have sex with men female-to-male
transgender patients when medically indicated to undergo regular cancer and sexually transmitted infection screenings due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; and (iii) appropriate safe sex techniques to avoid the risk of sexually transmitted diseases.

RESOLVED, That our AMA-MSS amend 310.041MSS as follows:

Improving Primary Care Residency Training to Advance Health Care for LGBTQ+ Gay, Lesbian, Bisexual, and Transgender Patients
AMA-MSS will ask the AMA to work with the Accreditation Council for Graduate Medical Education and the American Osteopathic Association to recommend to primary care residency programs that they assess the adequacy and effectiveness of their curricula in training residents on best practices for caring for LGBTQ+ gay, lesbian, bisexual, and transgender (GLBT) pediatric patients.

RESOLVED, That our AMA-MSS amend 315.005MSS as follows:

Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation
AMA-MSS will ask (1) that our AMA support the inclusion of a patient’s biological sex, gender identity, sexual orientation, preferred gender pronoun(s), and (if applicable) surrogate identifications in medical documentation and related forms in a culturally sensitive manner; and (2) that our AMA advocate for collection of patient data that is inclusive of sexual orientation/gender identity for the purposes of research into patient health.

RESOLVED, That our AMA-MSS amend 530.025MSS as follows:

Sexual Orientation and Gender Identity Demographic Collection by the AMA and Other Medical Organizations
Our AMA-MSS will ask that our AMA develop a plan with input from the LGBTQ+ advisory committee to expand the demographics we collect about our members to include both sexual orientation and gender identity information, which will be given voluntarily by members and handled in a confidential manner.

Your Reference Committee commends the Standing Committee on LGBTQ+ Affairs on their thorough and comprehensive review of MSS policy. We believe all these changes to be timely and recommend the recommendations in LGBTQ+ Report A be adopted and the remainder of the report be filed.

(16) CGPH REPORT A – DECREASING YOUTH ACCESS TO E-CIGARETTES

RECOMMENDATION:

Recommendations in CGPH Report A be adopted and the remainder of the report be filed.
Your Committee on Global and Public Health recommends that the following resolve clause be adopted in lieu of formal support for existing HOD policy, and that the remainder of the report be filed:

RESOLVED, That our AMA-MSS support evidence-based policies at federal, state, and local levels that prevent e-cigarette use among youth, including, but not limited to:

1. Increased prices and/or taxes on e-cigarette products;
2. Clean air laws that restrict e-cigarette use in public places, such as schools;
3. Limitations on the number and location of e-cigarette retailers, and on where e-cigarette products are sold in stores;
4. Bans on flavored e-cigarette products;
5. Laws that reduce exposure to e-cigarette advertisements, such as on the internet, in TV and movies, magazines, and retail stores; and
6. Media campaigns that educate youth on the adverse effects of e-cigarette use.

We thank the authors of CGPH Report A for a thorough, well-written, and well-researched report. We agree with the recommendations made and believe having this policy on the books will well-position the MSS Caucus to act appropriately should any resolutions related to e-cigarettes be brought to the floor of the HOD. Your Reference Committee recommends the recommendations of CGPH Report A be adopted and the remainder of the report be filed.

(17) CGPH REPORT B – INVESTIGATION OF NATUROPATHIC VACCINE EXEMPTIONS

RECOMMENDATION:

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

Your Committee on Global and Public Health recommends that the following resolve clause be adopted in lieu of the original resolution and the remainder of the report be filed:

RESOLVED, That our AMA opposes medical vaccine exemptions by non-physicians by amending H-440.970 Nonmedical Exemptions from Immunizations as follows:

Nonmedical Exemptions from Immunizations, H-440.970

1. Our AMA believes that nonmedical (religious, philosophic, or personal belief) exemptions from immunizations endanger the health of the unvaccinated individual and the health of those in his or her group and the community at large.

Therefore, our AMA (a) supports the immunization recommendations of the Advisory Committee on Immunization Practices (ACIP) for all individuals without medical contraindications; (b) supports legislation eliminating nonmedical exemptions from immunization; (c) encourages state medical associations to seek removal of nonmedical exemptions in statutes requiring mandatory immunizations, including for childcare and school
(d) encourages physicians to grant vaccine exemption requests only when medical contraindications are present; (e) encourages state and local medical associations to work with public health officials to develop contingency plans for controlling outbreaks in medically-exempt populations and to intensify efforts to achieve high immunization rates in communities where nonmedical exemptions are common; and (f) recommends that states have in place: (i) an established mechanism, which includes the involvement of qualified public health physicians, of determining which vaccines will be mandatory for admission to school and other identified public venues (based upon the recommendations of the ACIP); and (ii) policies that permit immunization exemptions for medical reasons only.

2. Our AMA will actively advocate for legislation, regulations, programs, and policies that incentivize states to (a) eliminate non-medical exemptions from mandated pediatric immunizations and (b) limit medical vaccine exemption authority to only licensed physicians.

We thank the authors of CGPH Report B for a well-written report. We find this amendment to H-440.970 novel and appropriate. The amendment also aligns with H-160.949, clause 3, but expands on it to make the ask specific to vaccines. Your Reference Committee believes this is the best approach to strengthen and clarify this policy without being overtly confrontational. We recommend the recommendations in CGPH Report B be adopted and the remainder of the report be filed.

(18) CME COLRP REPORT A – STUDY A NEED-BASED SCHOLARSHIP TO ENCOURAGE MEDICAL STUDENT PARTICIPATION IN THE AMA

RECOMMENDATION:

Recommendations in CME COLRP Report A be adopted and the remainder of the report be filed.

Your Committee on Long Range Planning and your Committee on Medical Education recommend the following:

1. That our AMA-MSS Governing Council, in collaboration with Region leadership and appropriate AMA staff members, will further explore barriers to medical student participation in the AMA, including, but not limited to, costs associated with AMA conference attendance, funding sources of delegates and other conference attendees, and needs not met by state medical societies; and

2. That our AMA-MSS will ask the AMA to explore mechanisms to mitigate costs associated with medical student participation at national, in-person AMA conferences; and

3. The remainder of this report be filed.
We thank the authors of CME COLRP Report A for their hard work on this report. Your Reference Committee recommends the recommendations in CME COLRP Report A be adopted and the remainder of the report be filed.

(19) COLRP CME REPORT A – UNDERSTANDING PHILANTHROPIC EFFORTS TO ADDRESS THE RISE OF MEDICAL SCHOOL TUITION

RECOMMENDATION A:

Recommendations from COLRP CME Report A be adopted and the remainder of the report be filed.

Your Committee on Long Range Planning and your Committee on Medical Education recommend the following:

1. That our AMA-MSS study this topic every four years to gain a better understanding of the sustainability and impact of free and reduced medical tuition programs including but not limited to debt burden beyond medical school, effects of debt on medical specialty choice, as well as applicant diversity related to potential debt, and release its findings in an informational report to the Assembly at A-25; and

2. The remainder of this report be filed.

Your Reference Committee thanks the authors of COLRP CME Report A on a thorough and well-written report. We note that having a recurring report has the potential to be forgotten, especially with the high turnover in our section. However, we think a recurring report on this topic is needed and would encourage the Section to consider a mechanism to ensure that recurring reports remain part of our institutional memory and are completed as scheduled. We recommend the recommendations in COLRP CME Report be adopted and the remainder of the report be filed.

(20) CSI CGPH REPORT A – PROTECTION OF ANTIBIOTIC EFFICACY THROUGH WATER SYSTEM REGULATION

RECOMMENDATION:

Recommendations from CSI CGPH Report A be adopted and the remainder of the report be filed.

Your Committee on Scientific Issues and Committee on Global and Public Health recommends the Resolution 061 not be adopted, and the remainder of the report is filed.

We thank the authors of CSI CGPH Report A for their hard work on this report. We agree with the conclusions reached and recommend the recommendations from CSI CGPH Report A be adopted and the remainder of the report be filed.
RECOMMENDATION:

Recommendations from GC Report A be adopted and
the remainder of the report be filed.

Thus, your MSS Governing Council recommends that the following recommendations be
adopted and the remainder of this report be filed:

1. That our AMA-MSS retains the following NMSSs and PIMAs as eligible for AMA-
   MSS Assembly representation: American Academy of Family Physicians (AAFP),
   American Academy of Pediatrics (AAP), American Association of Physicians of
   Indian Origin (AAPI), American College of Emergency Physicians (ACEP),
   American College of Medical Quality (ACMQ), American College of Physicians
   (ACP), American Society of Anesthesiologists (ASA), American Society of Military
   Surgeons of the US (AMSUS), American Medical Women’s Association (AMWA),
   Student Osteopathic Medical Association (SOMA), Psychiatry Student Interest
   Group Network (PsychSIGN), and Health Professionals Advancing LGBT&A
   Equality (GLMA).

2. That our AMA-MSS retains the following NMSOs as eligible for AMA-MSS
   Assembly representation: American Physician Scientists Association (APSA),
   Asian Pacific American Medical Student Association (APAMSA), Latino Medical
   Student Association (LMSA), and Student National Medical Association (SNMA),
   and Association of Native American Medical Students (ANAMS).

3. That our AMA-MSS recognize the following NMSS, NMSO and PIMA
   organizations as newly seated organizations in the AMA-MSS Assembly: Medical
   Student Pride Alliance (MSPA).

Your Reference Committee welcomes the Medical Student Pride Alliance (MSPA) to the
AMA-MSS Assembly and recommend the recommendations in GC Report A be adopted
and the remainder of the report be filed.
RECOMMENDED FOR ADOPTION AS AMENDED

(22) RESOLUTION 001 – EXPANDING THE AMA-MSS GOVERNING COUNCIL TO INCLUDE A DIVERSITY, EQUITY, & INCLUSION OFFICER

RECOMMENDATION A:

The second resolve of Resolution 001 be amended by addition and deletion as follows:

RESOLVED, That our AMA-MSS amends its Internal Operating Procedures as follows:

Internal Operating Procedures (Various Sections)
4.1 Designations. The officers of the MSS shall be the eight nine Governing Council members: Chair, Vice Chair, AMA Delegate, Alternate Delegate, At-Large Officer, Chair-elect/Immediate Past Chair, Speaker, and Vice Speaker, and Diversity, Equity, & Inclusion Officer. The Chair-elect/Immediate Past Chair shall be non-voting members of the Governing Council. The officers of the Assembly for the purpose of business meetings will be the Speaker and Vice Speaker.

4.4.6 Diversity, Equity, & Inclusion Officer: The Diversity, Equity, & Inclusion Officer shall:
   i. 4.4.8.1 Coordinate the AMA-specific activities of the identity-based National Medical Student Organization liaisons (as defined in MSS IOPs 10.3.3), identity-based Professional Interest Medical Association liaisons (as defined in MSS IOPs 10.3.2), and appropriate AMA-MSS Standing Committees within the Section.
   ii. 4.4.8.2 Serve as a liaison between the AMA’s Center for Health Equity, the MSS, and the MSS Governing Council.
   iii. 4.4.8.3. Serve as a liaison between identity-based National Medical Student Organization and Professional Interest Medical Association leadership and the Section.
   iv. 4.4.8.4. Support the functions of the MSS liaisons to the Minority Affairs Section (MAS), the Women Physicians Section (WPS), the Gay-Lesbian Medical Alliance (GLMA), the Advisory Committee on LGBTQ Issues, and other identity-based sections or groups within the AMA.
v. 4.4.8.5 Track demographics in the Section and direct efforts to recruit and retain a more diverse and representative AMA-MSS membership and leadership.

vi. 4.4.8.6. Develop and maintain a culture of inclusivity and allyship within the Section.

6.7.3 First Ballot. At the Interim Meeting, one ballot shall be used by the credentialed MSS Delegate to cast one vote for the Chair-elect and one vote for the Medical Student Trustee. At the Annual Meeting, individual ballots for each position shall be used by the credentialed MSS Delegate to cast one for each of the four positions: the Vice Chair, AMA Delegate, At-Large Officer, and Speaker, and Diversity, Equity, & Inclusion Officer. No ballot should be counted if there is more than one vote for a position. All Governing Council positions will be determined by majority vote, that is, the candidate who has received the largest number of votes shall be elected if that nominee has received a majority of the legal votes cast.

6.8 Endorsements for Diversity, Equity, & Inclusion Officer. Given the importance of ensuring the Diversity, Equity, & Inclusion Officer represents diverse groups, candidates for this position may seek endorsements of their candidacy from the identity-based standing committees, liaisons to identity-based National Medical Student Organizations (as defined in MSS IOPs 10.3.3), liaisons to Professional Interest Medical Associations (as defined in MSS IOPs 10.3.2), and liaisons to identity-based AMA Sections and Advisory Committees (as defined in AMA Bylaw 7.0.1).

i. 6.8.1 Candidates are strongly encouraged to seek at least one endorsement, and may seek as many endorsements as they choose.

ii. 6.8.2 Committees and liaisons may endorse as many candidates as they choose. Committees and liaisons shall create internal guidelines centered around lived experiences and personal diversity by which to determine endorsements.

iii. 6.8.3 Each endorsement may be shared one (1) time on the candidate’s Facebook page.

iv. 6.8.4 Endorsements may only be made during the campaign period (as defined in MSS IOPs 6.5.2.3).

RECOMMENDATION B:

Resolution 001 be amended by addition of a new third resolve clause as follows:
RESOLVED, That our AMA-MSS amends its Internal Operating Procedures as follows:

6.5.7.3 No mode of MSS- or AMA-sponsored communication, including, but not limited to listservs, phone or email lists, or other mass communication methods shall be used for announcements of candidacy, endorsement, or campaigning unless otherwise outlined in these IOPs.

RECOMMENDATION C:

Resolution 001 be amended by addition of a new fourth resolve clause as follows:

RESOLVED, That our AMA-MSS amends its Internal Operating Procedures as follows:

6.5.9.1 Only MSS members may be involved in a candidate's campaign. MSS members should not share their opinion in favor of or in opposition to any candidate while acting under any official leadership role within or outside of the organization unless otherwise outlined in these IOPs.

RECOMMENDATION D:

Resolution 001 be amended by addition of a new fifth resolve clause as follows:

RESOLVED, That our AMA-MSS amends its Internal Operating Procedures as follows:

6.7.2 Voting Periods. There shall be one voting period at the Interim Meeting for the selection of the Chair-elect and Medical Student Trustee. There shall be one voting period at the Annual Meeting for the selection of the Vice Chair, AMA Delegate, At-Large Officer, and Speaker, and Diversity, Equity, & Inclusion Officer. An additional balloting period will be held for the elections of the Alternate Delegate and Vice Speaker.

RECOMMENDATION E:

Resolution 001 be adopted as amended.

RESOLVED, That our AMA-MSS expands its Governing Council to include an annually elected Diversity, Equity, and Inclusion Officer empowered to and charged with the sustainable prioritization of these values within our section; and be it further
RESOLVED, That our AMA-MSS amends its Internal Operating Procedures as follows:

Internal Operating Procedures (Various Sections)

4.1 Designations. The officers of the MSS shall be the eight-nine Governing Council members: Chair, Vice Chair, AMA Delegate, Alternate Delegate, At-Large Officer, Chair-elect/Immediate Past Chair, Speaker, and Vice Speaker, and Diversity, Equity, & Inclusion Officer. The Chair-elect/Immediate Past Chair shall be non-voting members of the Governing Council. The officers of the Assembly for the purpose of business meetings will be the Speaker and Vice Speaker.

4.4.6 Diversity, Equity, & Inclusion Officer: The Diversity, Equity, & Inclusion Officer shall:

i. 4.4.8.1 Coordinate the AMA-specific activities of the identity-based National Medical Student Organization liaisons (as defined in MSS IOPs 10.3.3) and appropriate AMA-MSS Standing Committees within the Section.

ii. 4.4.8.2 Serve as a liaison between the AMA’s Center for Health Equity, the MSS, and the MSS Governing Council.

iii. 4.4.8.3 Serve as a liaison between identity-based National Medical Student Organization leadership and the Section.

iv. 4.4.8.4 Support the functions of the MSS liaisons to the Minority Affairs Section (MAS), the Women Physicians Section (WPS), the Gay-Lesbian Medical Alliance (GLMA), and other identity-based sections or groups within the AMA.

v. 4.4.8.5 Track demographics in the Section and direct efforts to recruit and retain a more diverse and representative AMA-MSS membership and leadership.

vi. 4.4.8.6 Develop and maintain a culture of inclusivity and allyship within the Section.

6.7.3 First Ballot. At the Interim Meeting, one ballot shall be used by the credentialed MSS Delegate to case cast one vote for the Chair-elect and one vote for the Medical Student Trustee. At the Annual Meeting, individual ballots for each position shall be used by the credentialed MSS Delegate to case cast one for each of the four positions: the Vice Chair, AMA Delegate, At-Large Officer, and Speaker, and Diversity, Equity, & Inclusion Officer. No ballot should be counted if there is more than one vote for a position. All Governing Council positions will be determined by majority vote, that is, the candidate who has received the largest number of votes shall be elected if that nominee has received a majority of the legal votes cast.
6.8 Endorsements for Diversity, Equity, & Inclusion Officer.

Given the importance of ensuring the Diversity, Equity, & Inclusion Officer represents diverse groups, candidates for this position may seek endorsements of their candidacy from the identity-based standing committees, liaisons to identity-based National Medical Student Organizations (as defined in MSS IOPs 10.3.3), and liaisons to identity-based AMA Sections (as defined in AMA Bylaw 7.0.1).

i. 6.8.1 Candidates are strongly encouraged to seek at least one endorsement, and may seek as many endorsements as they choose.

ii. 6.8.2 Committees and liaisons may endorse as many candidates as they choose. Committees and liaisons shall create internal guidelines centered around lived experiences and personal diversity by which to determine endorsements.

iii. 6.8.3 Each endorsement may be shared one (1) time on the candidate’s Facebook page.

iv. 6.8.4 Endorsements may only be made during the campaign period (as defined in MSS IOPs 6.5.2.3).

; and be it further

RESOLVED, That our AMA-MSS Governing Council, with input from AMA-MSS identity-based Standing Committees and National Medical Student Organization liaisons, appoint an individual at the AMA-MSS 2021 Interim Business Meeting to serve as an interim Diversity, Equity, & Inclusion Officer, who will be fully empowered as a member of the Governing Council but not be allowed to vote until elected by the Section, until the AMA-MSS 2022 Annual Business Meeting election can occur.

VRC testimony was overwhelmingly supportive of Resolution 001. Region 1, Region 2, Region 3, Region 4, and Region 6 all provided testimony in favor of the resolution as written. Additionally, the Minority Issues Committee (MIC) and Standing Committee on LGBTQ+ Affairs supported the resolution as written. GLMA: Health Professionals Advancing LGBTQ Equality requested an amendment to update their name in 4.4.8.4. However, upon further examination of this IOP, your Reference Committee believes that the more appropriate entity to include in this clause would be the Advisory Committee on LGBTQ Issues, which is more similar to the Minority Affairs Section (MAS) and Women Physicians Section (WPS). The Advisory Committee is an internal stakeholder group, while GLMA is an external group.

Testimony from the MSS Section Delegates offered an amendment to replace “Facebook” with “social media” in 6.8.3. Your Reference Committee found this compelling, and opted to make this amendment with a slight change. We chose to strike 6.8.3 and 6.8.4 and add the phrase “unless otherwise outlined in these IOPs” to 6.5.7.3 and 6.5.9.1. We found this encompasses the spirit of the Section Delegates’ amendment while also streamlining the IOP. We added a new resolve clause to amend 6.7.2 which lists all the MSS officers, to also include the new position, ensuring consistency throughout our IOP.
We thank the authors for bringing forward this resolution. The addition of a Diversity, Equity, and Inclusion Officer to the MSS GC will further devote the MSS to these important initiatives. Your Reference Committee recommends Resolution 001 be adopted as amended.

(23) RESOLUTION 002 – IMPROVING ACCESS TO TELEHEALTH FOR THOSE WITH DISABILITIES

RECOMMENDATION A:

The first Resolve of Resolution 002 be amended by addition as follows:

RESOLVED, That our AMA utilize virtual platforms that are accessible to all members, including those with hearing or visual impairment, by using resources such as closed-captioning, magnification, and screen readers; and be it further

RECOMMENDATION B:

The second Resolve of Resolution 002 be amended by addition and deletion as follows:

RESOLVED, That our AMA support increased regulation policy ensuring technology companies produce telemedicine software/products that are accessible and comply with the first and seventh circuit ruling on the ADA’s meaning of “public accommodation” includes virtual spaces to persons with disabilities and in-line with the interpretation that the ADA’s use of the phrase “public accommodation” is not limited to physical structures and may be extended to virtual spaces; and be it further

RECOMMENDATION C:

Resolution 002 be adopted as amended.

RESOLVED, That our AMA utilize virtual platforms that are accessible; and be it further

RESOLVED, That AMA support increased regulation ensuring technology companies produce telemedicine software/products that are accessible and comply with the first and seventh circuit rulings on the ADA’s meaning of “public accommodation” includes virtual spaces; and be it further

RESOLVED, That AMA amend Preserving Protections of the Americans with Disabilities Act of 1990 D-90.992 by addition as follows; and be it further
Preserving Protections of the Americans with Disabilities Act of 1990, D-90.992

1. Our AMA supports legislative changes to the Americans with Disabilities Act of 1990, to educate state and local government officials and property owners on strategies for promoting access to persons with a disability.

2. Our AMA opposes legislation amending the Americans with Disabilities Act of 1990, that would increase barriers for disabled persons attempting to file suit to challenge a violation of their civil rights.

3. Our AMA will develop educational tools and strategies to help physicians and institutions make their offices and telemedicine platforms more accessible to persons with disabilities, consistent with the Americans With Disabilities Act as well as any applicable state laws.

RESOLVED, That AMA amend Enhancing Accommodations for People with Disabilities H-90.971 by addition as follows:

Enhancing Accommodations for People with Disabilities, H-90.971

Our AMA encourages physicians to make their offices both physically and virtually accessible to patients with disabilities, consistent with the Americans with Disabilities Act (ADA) guidelines.

VRC testimony was mixed on Resolution 002. Region 3 and the Committee on Legislation and Advocacy (COLA) supported the resolution as written; the Massachusetts delegation, Region 1, and the Committee on Economics and Quality in Medicine (CEQM) supported the resolution with amendments, and Region 2 and Region 6 were opposed to this resolution. Your Reference Committee supports the intent of this resolution to expand telehealth accessibility, however we were concerned that if specific accommodations were made with telehealth companies it would have unintended consequences of limiting when providers could see patients with disabilities.

We found the amendment from the Massachusetts delegation compelling and have struck the reference to the first and seventh court rulings from the second resolve clause. If these rulings were to change, this policy would keep its intent. We also found the amendments from the MSS Section Delegates compelling and offer a variation on that language in the first resolve clause. We recommend that Resolution 002 be adopted as amended.
RECOMMENDATION A:

Resolution 003 be amended by addition of a new first Resolve clause as follows:

RESOLVED, That our AMA recognize that demographic and socioeconomic inequities exist in medical student membership in medical honor societies; and be it further

RECOMMENDATION B:

The original Resolve of Resolution 003 be amended by addition and deletion as follows:

RESOLVED, That our AMA study possibilities for reforming medical school criteria used to select 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 with the intention of reducing demographic inequities in society student membership and report back by the November 2021 HOD meeting; and be it further

RECOMMENDATION C:

Resolution 003 be amended by addition of a third Resolve clause as follows:

RESOLVED, That this resolution be immediately forwarded to our AMA House of Delegates at the June 2021 Special Meeting.

RECOMMENDATION D:

Resolution 003 be adopted as amended.

RESOLVED, That our AMA study possibilities for reforming medical school criteria used to select 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 with the intention of reducing demographic inequities in society student membership.
Testimony on the VRC was supportive of the spirit of Resolution 003. The Committee on Medical Education (CME) and Region 3 supported the resolution as written. The MSS Councilor on Medical Education supported the resolution and proffered an amendment. The LGBTQ+ Affairs Standing Committee supported collaboration for a study on this topic.

Your Reference Committee understands that this is a very timely issue and in light of the preliminary recommendations from the Coalition for Physician Accountability, we believe it is important for the AMA to take a stance on this issue in conjunction with the release of that report. One of the preliminary recommendations in the Physician Coalition for Accountability report is to explore inequities in these honor societies. Having policy on the books supporting this puts the AMA in a strong position to collaborate on these efforts in an impactful way. We recommend Resolution 003 be adopted as amended.

(25) RESOLUTION 004 – USE OF NON-POLICE MENTAL HEALTHCARE WORKER TEAMS TO RESPOND TO APPROPRIATE 911 CALLS

RECOMMENDATION A:

Resolution 004 be amended by addition and deletion as follows:

RESOLVED, That our AMA-MSS (1) opposes the use of police-only emergency dispatch response teams for mental health crises, and (2) supports the expansion and funding of the use of non-police emergency behavioral health specialists and/or co-behavioral health specialists and police officer and co-response (behavioral health specialist and police officer) emergency dispatch teams where appropriate (and in compliance with the non-police team’s standards for team safety) to respond to mental health crisis calls.

RECOMMENDATION B:

Resolution 004 be adopted as amended.

RESOLVED, That our AMA (1) opposes the use of police-only emergency dispatch response teams for mental health crises, and (2) supports the expansion and funding of the use of non-police and co-response (behavioral health specialist and police officer) emergency dispatch teams where appropriate (and in compliance with the non-police team’s standards for team safety) to respond to mental health crisis calls.

VRC testimony was generally supportive of Resolution 004. Region 1 and Region 4 supported the resolution as written. The Massachusetts delegation proffered an amendment to strike clause (1). Region 2 was opposed to the resolution due to concern over the quality of research and evidence presented in the whereas clauses. Your Reference Committee found the Massachusetts amendment compelling.
We note that CSAPH Report 2 being presented at the June 2021 Special Meeting of the House of Delegates covers many of the asks in this resolution. Specifically, the report recommends that our AMA “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.”

We recommend incorporating the Massachusetts amendment, as well as making this resolution internal, to best support the recommendations from CSAPH Report 2 at the upcoming June meeting. Your Reference Committee recommends Resolution 004 be adopted as amended.

(26) RESOLUTION 005 – OPPOSITION TO SOBRIETY REQUIREMENT FOR HEPATITIS C TREATMENT

RECOMMENDATION A:

The first Resolve of Resolution 005 be amended by addition as follows:

RESOLVED, That our AMA amend policy H-440.845, Advocacy for Hepatitis C Virus Education, Prevention, Screening and Treatment, by the addition as follows:

Advocacy for Hepatitis C Virus Education, Prevention, Screening and Treatment, H-440.845

Our AMA will: (1) encourage the adoption of birth year-based screening practices for hepatitis C, in alignment with Centers for Disease Control and Prevention (CDC) recommendations; (2) encourage the CDC and state Departments of Public Health to develop and coordinate Hepatitis C Virus infection educational and prevention efforts; (3) support hepatitis C virus (HCV) prevention, screening, and treatment programs that are targeted toward maximum public health benefit; (4) support removal of sobriety requirements as a barrier to HCV treatment; (5) work with state medical societies to remove sobriety requirements for HCV treatment; (654) support programs aimed at training providers in the treatment and management of patients infected with HCV; (765) support adequate funding by, and negotiation for affordable pricing for HCV antiviral treatments between the government, insurance companies, and other third party payers, so that all Americans for whom HCV treatment would have a substantial proven benefit will be able to receive this treatment; (876) recognize correctional physicians, and physicians in other public health settings, as key
stakeholders in the development of HCV treatment
guidelines; (987) encourage equitable reimbursement
for those providing treatment.

RECOMMENDATION B:

The second Resolve of Resolution 005 be deleted:

RESOLVED, That our AMA work with state medical
societies to oppose the sobriety requirements for HCV
treatment.

RECOMMENDATION C:

Resolution 005 be adopted as amended.

RESOLVED, That our AMA amend policy H-440.845, Advocacy for Hepatitis C Virus
Education, Prevention, Screening and Treatment, by the addition as follows:

Advocacy for Hepatitis C Virus Education, Prevention,
Screening and Treatment, H-440.845

Our AMA will: (1) encourage the adoption of birth year-
based screening practices for hepatitis C, in alignment with
Centers for Disease Control and Prevention (CDC)
recommendations; (2) encourage the CDC and state
Departments of Public Health to develop and coordinate
Hepatitis C Virus infection educational and prevention
efforts; (3) support hepatitis C virus (HCV) prevention,
screening, and treatment programs that are targeted toward
maximum public health benefit; (4) support removal of
sobriety requirements as a barrier to HCV treatment;
(54) support programs aimed at training providers in the
treatment and management of patients infected with HCV;
(65) support adequate funding by, and negotiation for
affordable pricing for HCV antiviral treatments between the
government, insurance companies, and other third party
payers, so that all Americans for whom HCV treatment
would have a substantial proven benefit will be able to
receive this treatment; (76) recognize correctional
physicians, and physicians in other public health settings,
as key stakeholders in the development of HCV treatment
guidelines; (87) encourage equitable reimbursement for
those providing treatment.

; and be it further

RESOLVED, That our AMA work with state medical societies to oppose the sobriety
requirements for HCV treatment.
VRC testimony supported the spirit of Resolution 005. Region 1, Region 3, Region 6 and the Committee on Bioethics and Humanities (CBH) supported the resolution as written. The Massachusetts delegation supported with an amendment to add “non-surgical” before “treatment.” We understand the intent of this amendment but did not find it compelling. Your Reference Committee believes it would be better to leave the language broad, so it could be appropriately interpreted by those implementing this ask. We offer an amendment to incorporate the second resolve clause into the first resolve clause to streamline Resolution 005. We recommend this resolution be adopted as amended.

(27) RESOLUTION 007 – PEDIATRIC MENTAL HEALTH NEEDS DURING PANDEMICS AND CRISES

RECOMMENDATION A:

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

RESOLVED, That our AMA-MSS, in conjunction with the American Academy of Child and Adolescent Psychiatry, the Department of Education, or other appropriate stakeholders, supports and encourages the research of longitudinal mental health effects of pandemics and other disasters on the pediatric population.

RECOMMENDATION B:

The second Resolve of Resolution 007 be deleted:

RESOLVED, that our AMA amends current AMA Policy "Improving Pediatric Mental Health Screening H-345.977" by addition and deletion to read as follows:

Improving Pediatric Mental Health Screening H-345.977

Our AMA: (1) recognizes the importance of, and supports the inclusion of, mental health (including substance use, abuse, and addiction disorders) screening in routine pediatric physicals; (2) will work with mental health organizations and relevant primary care organizations to disseminate recommended and validated tools for eliciting and addressing mental health (including substance use, abuse, and addiction disorders) concerns in primary care settings; and (3) recognizes the importance of developing and implementing school-based mental health programs that ensure at-risk children and adolescents have access to appropriate mental health screening and treatment services and supports efforts to accomplish these objectives (4) collaborates with the Department of
Education or other appropriate stakeholders to support universal mental health screenings in schools.

RECOMMENDATION C:

Resolution 007 be adopted as amended.

RESOLVED, That our AMA, in conjunction with the American Academy of Child and Adolescent Psychiatry, the Department of Education, or other appropriate stakeholders, supports and encourages the research of longitudinal mental health effects of pandemics and other disasters on the pediatric population.

RESOLVED, That our AMA amends current AMA Policy "Improving Pediatric Mental Health Screening H-345.977" by addition and deletion to read as follows:

Improving Pediatric Mental Health Screening H-345.977
Our AMA: (1) recognizes the importance of, and supports the inclusion of, mental health (including substance use, abuse, and addiction disorders) screening in routine pediatric physicals; (2) will work with mental health organizations and relevant primary care organizations to disseminate recommended and validated tools for eliciting and addressing mental health (including substance use, abuse, and addiction disorders) concerns in primary care settings; and (3) recognizes the importance of developing and implementing school-based mental health programs that ensure at-risk children and adolescents have access to appropriate mental health screening and treatment services and supports efforts to accomplish these objectives (4) collaborates with the Department of Education or other appropriate stakeholders to support universal mental health screenings in schools.

VRC testimony was supportive of Resolution 007. Region 2, Region 3, the Committee on Global and Public Health (CGPH), and the Committee on Economics and Quality in Medicine (CEQM) supported the resolution as written. The Section Delegates suggested making this resolution internal and working with the American Academy of Pediatrics (AAP) to transmit at a future meeting. We found this testimony compelling and proffer those amendments. We believe this resolution will be stronger if we work in conjunction with AAP and encourage the authors to do so. Your Reference Committee recommends Resolution 007 be adopted as amended.
RESOLUTION 008 – RECTIFYING THE INEQUITABLE AND RACISTS EFFECTS OF “THE FLEXNER REPORT”

RECOMMENDATION A:

The second Resolve of Resolution 008 be amended by addition and deletion as follows:

RESOLVED, That our AMA-MSS advocate support for the creation of a task force, with representation from stakeholders within and beyond the AMA, to guide our organization’s work to promote truth, reconciliation, and healing in medicine and medical education; and be it further

RECOMMENDATION B:

The third Resolve of Resolution 008 be amended by addition and deletion as follows:

RESOLVED, That our AMA-MSS advocate support for funding to support the creation and sustainability of Historically Black College and University (HBCU) and Tribal College and University (TCU) affiliated medical schools and residency programs, with the goal of achieving a physician workforce that is proportional to the racial, ethnic, and gender composition of the United States population; and be it further

RECOMMENDATION C:

The fourth Resolve of Resolution 008 be amended by addition and deletion as follows:

RESOLVED, That our AMA-MSS advocate support for the study of the possibility of including an antiracism competency as part of graduation requirements for LCME- and COCA-accredited medical schools as well as ACGME-accredited residency programs.

RECOMMENDATION D:

Resolution 008 be adopted as amended.

RESOLVED, That our AMA-MSS (1) recognize the harm created and sustained by the adoption of “The Flexner Report” and (2) create, distribute, and/or promote materials that educate about this history; and be it further

RESOLVED, That our AMA-MSS advocate for the creation of a task force, with representation from stakeholders within and beyond the AMA, to guide our organization’s
work to promote truth, reconciliation, and healing in medicine and medical education; and be it further

RESOLVED, That our AMA-MSS advocate for funding to support the creation and sustainability of Historically Black College and University (HBCU) and Tribal College and University (TCU) affiliated medical schools and residency programs, with the goal of achieving a physician workforce that is proportional to the racial, ethnic, and gender composition of the United States population; and be it further

RESOLVED, That our AMA-MSS advocate for the study of the possibility of including an antiracism competency as part of graduation requirements for LCME- and COCA-accredited medical schools as well as ACGME-accredited residency programs.

VRC testimony was overwhelmingly supportive of Resolution 008. Region 1, Region 2, Region 3, Region 4, the Minority Issues Committee (MIC), the Committee on Medical Education (CME), GLMA: Health Professionals Advancing LGBTQ Equality, the Association of Native American Medical Students (ANAMS), and the Section Delegates supported this resolution. The Massachusetts delegation suggested a minor amendment to the first resolve clause and suggested deleting the second resolve clause. However, it is noted that the second resolve clause is included to support a similar resolution authored by the Minority Affairs Section (MAS). The Section Delegates recommended changing “advocate” to “support” which more appropriately aligns with how the MSS is able to act on Resolution 008. Your Reference Committee recommends Resolution 008 be adopted as amended.

(29) RESOLUTION 011 – INCREASING SUPPORT FOR DOULA SERVICES TO REDUCE MATERNAL MORTALITY

RECOMMENDATION A:

The first Resolve of Resolution 011 be deleted:

RESOLVED, That our AMA will collaborate with doula licensing organizations to develop policy regarding the definition of doulas as ancillary support services and outline their scope of practice; and be it further

RECOMMENDATION B:

The second Resolve of Resolution 011 be deleted:

RESOLVED, That our AMA will encourage collaboration between doula licensing and healthcare organizations to improve an understanding of the role of doulas; and be it further
RECOMMENDATION C:

The third Resolve of Resolution 011 be deleted:

RESOLVED, That our AMA will encourage state medical organizations to develop regulations regarding doula certification in accordance with developing federal recommendations; and be it further

RECOMMENDATION D:

The fourth Resolve of Resolution 011 be amended by addition and deletion as follows:

RESOLVED, That our AMA-MSS will support state medical societies’ efforts to advocate for Medicaid funding of coverage for doulas services at the state level; and be it further

RECOMMENDATION E:

The fifth Resolve of Resolution 011 be deleted:

RESOLVED, That our AMA will advocate for the continued study of the impact of doula care on maternal morbidity & mortality and within the wider healthcare team.

RECOMMENDATION F:

Resolution 011 be adopted as amended.

RESOLVED, That our AMA will collaborate with doula licensing organizations to develop policy regarding the definition of doulas as ancillary support services and outline their scope of practice; and be it further

RESOLVED, That our AMA will encourage collaboration between doula licensing and healthcare organizations to improve an understanding of the role of doulas; and be it further

RESOLVED, That our AMA will encourage state medical organizations to develop regulations regarding doula certification in accordance with developing federal recommendations; and be it further

RESOLVED, That our AMA will support state medical societies’ efforts to advocate for Medicaid funding of doulas at the state level; and be it further

RESOLVED, That our AMA will advocate for the continued study of the impact of doula care on maternal morbidity & mortality and within the wider healthcare team.
VRC testimony was mixed on Resolution 011. Region 1, the Committee on Legislation and Advocacy (COLA), and the Massachusetts delegation supported the resolution as written. The Minority Issues Committee (MIC), the Section Delegates, and the Committee on Economics and Quality in Medicine (CEQM) supported the resolution with amendments. Region 6 opposed Resolution 011, suggesting that it was out of the scope of the AMA and impractical due to the decentralized nature of doula services. The MSS Government Relations and Advocacy Fellow (GRAF) shared feedback from multiple divisions of our AMA’s Advocacy Business Unit, which agreed that there would be both scope of practice and funding issues with the asks as written.

Additionally, feedback from the American College of Obstetricians and Gynecologists (ACOG) noted that “this is a very complex issue, with nuanced policy, political, and organizational dynamics…the doula community is very decentralized so this may be logistically challenging. We have been very sensitive to not interfere with the doula community’s efforts to define themselves – something they have expressed resistance towards.”

The Section Delegates recommended making this internal policy. We found this, and the testimony from ACOG, compelling. We would be hesitant to move forward with the resolution as written, especially without support from ACOG. Therefore, we proffer amendments to address both scope and funding concerns. We recommend Resolution 011 be adopted as amended.

(30) RESOLUTION 014 – PROTECTION OF MEDICAL STUDENTS THAT ADVOCATE ON SOCIAL JUSTICE

RECOMMENDATION A:

The first Resolve clause of Resolution 014 be amended by addition and deletion as follows:

RESOLVED, That our AMA-MSS supports a physician-in-training’s expand support for the exercise of First Amendment right to express opinions relating to medical issues; and be it further to medical trainees and medical students and amend policy H-435.910, “Protection of Physician Freedom of Speech” as follows:

Protection of Physician Freedom of Speech, H-435.940
Our AMA supports a physician’s, medical trainee, and medical student’s First Amendment right to express opinions relating to medical issues

RECOMMENDATION B:

The second Resolve clause of Resolution 014 be amended by substitution as follows:
RESOLVED, That our AMA-MSS oppose any institutional actions or policy that prevent or limit physician-in-training’s availability to advocate on behalf of patients’ interests or on behalf of good patient care, including direct or indirect institutional retaliation or disciplinary action; and be it further

RESOLVED, That our AMA expand protections against retaliation for engaging in independent advocacy to medical trainees and medical students and amend policy H-285.910, “The Physician’s Right to Engage in Independent Advocacy on Behalf of Patients, the Profession and the Community” as follows:

The Physician’s Right to Engage in Independent Advocacy on Behalf of Patients, the Profession, and the Community, H-285.910

In caring for patients and in all matters related to this Agreement, the Physician, medical trainee, or medical student shall have the unfettered right to exercise his/her independent professional judgment and be guided by his/her personal and professional beliefs as to what is in the best interests of patients, the profession, and the community. Nothing in this Agreement shall prevent or limit the Physician’s, medical trainee, or medical student’s right or ability to advocate on behalf of patients’ interests or on behalf of good patient care, or to exercise his/her own medical judgment. Physician, medical trainee, or medical student shall not be deemed in breach of this Agreement, nor may Institution/Employer retaliate in any way, including but not limited to termination of this Agreement, commencement of any disciplinary action, or any other adverse action against Physician, medical trainee, or medical student directly or indirectly, based on Physician’s exercise of his/her rights under this paragraph; and be it further

RECOMMENDATION C:

The third Resolve clause of Resolution 014 be amended by addition as follows:

RESOLVED, That our AMA-MSS encourage medical schools to explicitly enumerate policy pertaining to permitted student participation in lawful movements/protests within student conduct codes; and be it further
RECOMMENDATION D:

The fourth Resolve clause of Resolution 014 be amended by addition and deletion as follows:

RESOLVED, That in line with AAMC guidance on peaceful protests, our AMA-MSS encourage medical schools and residency programs to blind admissions applications to exclude arrests with non-conviction related to social justice movements and protests.

RECOMMENDATION E:

Resolution 014 be adopted as amended.

RESOLVED, That our AMA expand support for the exercise of First Amendment rights to medical trainees and medical students and amend policy H-435.910, “Protection of Physician Freedom of Speech” as follows:

Protection of Physician Freedom of Speech, H-435.940
Our AMA supports a physician’s, medical trainee, and medical student’s First Amendment right to express opinions relating to medical issues;

RESOLVED, That our AMA expand protections against retaliation for engaging in independent advocacy to medical trainees and medical students and amend policy H-285.910, “The Physician’s Right to Engage in Independent Advocacy on Behalf of Patients, the Profession and the Community” as follows:

The Physician’s Right to Engage in Independent Advocacy on Behalf of Patients, the Profession, and the Community, H-285.910
In caring for patients and in all matters related to this Agreement, the Physician, medical trainee, or medical student shall have the unfettered right to exercise his/her independent professional judgment and be guided by his/her personal and professional beliefs as to what is in the best interests of patients, the profession, and the community. Nothing in this Agreement shall prevent or limit the Physician’s, medical trainee, or medical student’s right or ability to advocate on behalf of patients’ interests or on behalf of good patient care, or to exercise his/her own medical judgment. Physician, medical trainee, or medical student shall not be deemed in breach of this Agreement, nor may Institution/Employer retaliate in any way, including but not limited to termination of this Agreement, commencement of any disciplinary action, or any other adverse action against Physician, medical trainee, or
medical student directly or indirectly, based on Physician's exercise of his/her rights under this paragraph.

; and be it further

RESOLVED, That our AMA encourage medical schools to explicitly enumerate policy pertaining to permitted student participation in lawful movements/protests within student conduct codes; and be it further

RESOLVED, That in line with AAMC guidance on peaceful protests, our AMA encourage medical schools to blind admissions applications to exclude arrests with non-conviction related to social justice movements/protests.

VRC testimony supported the spirit of Resolution 014. Testimony notes that the Minority Affairs Section (MAS) is bringing forward a similar resolution, and suggests making this resolution internal to support their resolution in the HOD. We proffer amendments to that effect and capture the sentiment of the HOD policies that have been struck in new internal resolve clauses.

In the first resolve clause we changed the language to make it appropriate as an internal resolution, since the original clause was amending HOD policy. In the second resolve clause, we amended the language so the spirit of the amendment to policy was preserved, but was no longer an amendment to be included on an employment contract, since there were concerns raised on the VRC about the placement of the amendments originally requested by the authors. The third resolve clause was simply amended to be an internal ask. Finally, in the fourth resolve clause we adjusted the language to be independent of external statements and other organizations' definitions, and broadened the ask to include residency applications. Your Reference Committee recommends Resolution 014 be adopted as amended.

(31) RESOLUTION 015 – POVERTY-LEVEL WAGES AND HEALTH

RECOMMENDATION A:

Resolution 015 be amended by addition and deletion as follows:

RESOLVED, That our AMA support federal minimum wage regulation such that the minimum wage automatically increases with inflation or greater in order to prevent full-time workers from experiencing earning below the Federal Poverty Level, in order to mitigate the adverse health effects of poverty.

RECOMMENDATION B:

Resolution 015 be adopted as amended.
RESOLVED, That our AMA support federal minimum wage regulation such that the minimum wage increases with inflation in order to prevent full-time workers from experiencing the adverse health effects of poverty.

VRC testimony was overwhelmingly supportive of Resolution 015. Region 1, Region 2, Region 3, Region 4, Region 6, the Committee on Legislation and Advocacy (COLA), the Committee on Global and Public Health (CGPH), the Massachusetts delegation, and GLMA: Health Professionals Advancing LGBTQ Equality supported the resolution. The Committee on Economics and Quality in Medicine (CEQM) suggested that as originally written the resolve clause could be interpreted to support any raise in minimum wage, which still may not be enough to raise workers above the federal poverty line. The Section Delegates suggested the addition of the word “automatically,” so this issue isn’t something that would need to have new laws passed continually to remain in effect.

Your Reference Committee found both CEQM and the Section Delegate’s amendments compelling. We have incorporated those and recommend Resolution 015 be adopted as amended.

(32) RESOLUTION 026 – ESTABLISHING COMPREHENSIVE DENTAL BENEFITS UNDER STATE MEDICAID PROGRAMS

RECOMMENDATION A:

Resolution 026 be amended by addition and deletion as follows:

RESOLVED, That our AMA amend H-330.872, “Medicare Coverage for Dental Services” to be written as follows:

Medicare, and Medicaid, and Other Public Health Insurance Coverage for Dental Services, H-330.872

Our AMA supports: (1) continued opportunities to work with the American Dental Association and other interested national organizations to improve access to dental care for Medicare, and Medicaid, and other public health insurance program beneficiaries; and (2) initiatives to expand health services research on the effectiveness of expanded dental coverage in improving health and preventing disease among both Medicare, and Medicaid, and other public health insurance program beneficiaries populations, the optimal dental benefit plan designs to cost-effectively improve health and prevent disease in both among Medicare, and Medicaid, and other public health insurance program beneficiaries populations, and the impact of expanded dental coverage on health care costs and utilization.
RECOMMENDATION B:

Resolution 026 be adopted as amended.

RESOLVED, That our AMA amend H-330.872, “Medicare Coverage for Dental Services” to be written as follows:

Medicare and Medicaid Coverage for Dental Services, H-330.872

Our AMA supports: (1) continued opportunities to work with the American Dental Association and other interested national organizations to improve access to dental care for Medicare and Medicaid beneficiaries; and (2) initiatives to expand health services research on the effectiveness of expanded dental coverage in improving health and preventing disease in both Medicare and Medicaid populations, the optimal dental benefit plan designs to cost-effectively improve health and prevent disease in both Medicare and Medicaid populations, and the impact of expanded dental coverage on health care costs and utilization.

VRC testimony was universally supportive of Resolution 026. Region 1, Region 3, Region 4, Region 6, the Massachusetts delegation, the Committee on Medical Education (CME), the MSS Government Relations and Advocacy Fellow (GRAF), and the Section Delegates supported this resolution. The Section Delegates proposed an amendment to include all public health insurance programs. We found this compelling and incorporated those amendments. Your Reference Committee recommends Resolution 026 be adopted as amended.

(33) RESOLUTION 027 – INCREASING TRANSPARENCY IN THE MSS POLICY PROCESS

RECOMMENDATION A:

The first Resolve of Resolution 027 be deleted:

RESOLVED, Our AMA-MSS GC conduct a study on the process of MSS reaffirmations of policy to consider the practical outcomes of both internal and external reaffirmations, whether an alternative process would be more appropriate, and how to ensure that the practice of reaffirmation enactment aligns with the section’s perception of reaffirmation and policy passage; and be it further...
RECOMMENDATION B:

The second Resolve of Resolution 027 be amended by addition to read as follows:

RESOLVED, To improve institutional memory, our AMA-MSS amend policy 645.031MSS “Policy-Making Procedures” as follows:

Policy-Making Procedures, 645.031MSS
A list of all GC Action Items received during the period between MSS national meetings will be included in the Meeting Handbook as official MSS Actions, along with their implementation status. Additionally, the MSS should create an opportunity for the Governing Council to discuss GC Action Item implementation status with interested students.

RECOMMENDATION C:

Resolution 027 be adopted as amended.

RESOLVED, Our AMA-MSS GC conduct a study on the process of MSS reaffirmations of policy to consider the practical outcomes of both internal and external reaffirmations, whether an alternative process would be more appropriate, and how to ensure that the practice of reaffirmation enactment aligns with the section’s perception of reaffirmation and policy passage; and be it further

RESOLVED, To improve institutional memory, our AMA-MSS amend policy 645.031MSS “Policy-Making Procedures” as follows:

Policy-Making Procedures, 645.031MSS
A list of all GC Action Items received during the period between MSS national meetings will be included in the Meeting Handbook as official MSS Actions, along with their implementation status. Additionally, the MSS should create an opportunity for the Governing Council to discuss GC Action Item implementation status with interested students.

VRC testimony was supportive of Resolution 027. Region 2, Region 3, Region 4, and Region 6 supported the resolution as written. The Massachusetts delegation offered an amendment to strike the first resolve clause, which your Reference Committee found compelling. We agree with Massachusetts testimony that the reaffirmation process is important, and we believe that the outcomes of reaffirmation are clear and distinct from “not adopt.” It was noted that the MSS House Coordination Committee (HCC) does share an information sheet about the reasoning and outcomes of reaffirmation with all resolution authors. Furthermore, reaffirmation is a distinct term with consistent meaning throughout the AMA, not just the MSS, and we don’t know if conducting a study would yield information that would lead to substantial change. If knowledge about the process
amongst the Section is lacking, we would recommend potentially utilizing the HCC to educate members on the value and purpose of the reaffirmation process.

Transparency in the MSS resolution process is crucial. Increasing transparency will strengthen our Section’s policy-making process both internally within the section and externally in the House of Delegates. We recommend Resolution 027 be adopted as amended.

(34) RESOLUTION 032 – INCREASING ACCESS TO INNOVATIVE GLUCOSE MONITORING FOR ALL DIABETICS

RECOMMENDATION A:

The second Resolve clause of Resolution 032 be amended by addition and deletion as follows:

RESOLVED, That our AMA amend AMA Policy H-330.885 to read as follows:

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

Our AMA supports efforts to achieve Medicare coverage of continuous and flash glucose monitoring systems for all diabetic patients with diabetes with insulin-dependent diabetes by all public insurance programs.

RECOMMENDATION B:

Resolution 032 be adopted as amended.

RESOLVED, Our AMA advocates for broadening the classification criteria of Durable Medical Equipment to include all clinically effective and cost-saving diabetic glucose monitors; and be it further

RESOLVED, That our AMA amend AMA Policy H-330.885 to read as follows:

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

Our AMA supports efforts to achieve Medicare coverage of continuous and flash glucose monitoring systems for all diabetic patients with insulin-dependent diabetes by all public insurance programs.
VRC testimony was mostly supportive of Resolution 032. Region 1, Region 2, Region 4, the Massachusetts delegation, the Committee on Economics and Quality in Medicine (CEQM), and the Committee on Health Information Technology (CHIT) supported this resolution as written. Region 6 was opposed to this resolution. One individual commented on the importance of person-first language. We agree and have made these amendments to the resolution.

The Section Delegates highlight that this is very similar to a pending transmittal, which originally made the amendments to expand H-330.885 to include “all public insurance programs.” The pending transmittal’s resolve clause is being further amended by this resolution’s authors in their second resolve clause to include “flash” glucose monitoring systems. We agree with the Section Delegate’s strategy to incorporate Resolution 032 into the language of the pending transmittal before sending to the House of Delegates. Your Reference Committee recommends Resolution 032 be adopted as amended.

(35) RESOLUTION 040 – RECOMMENDING ALLYSHIP TRAINING IN MEDICAL EDUCATION

RECOMMENDATION A:

Resolution 040 be amended by addition as follows:

RESOLVED, That our AMA-MSS supports the inclusion of allyship trainings, which educate participants to use power and privilege to support individuals who experience oppression, in undergraduate, graduate, and continuing medical education.

RECOMMENDATION B:

Resolution 040 be adopted as amended.

RESOLVED, That our AMA-MSS supports the inclusion of allyship training in undergraduate, graduate, and continuing medical education.

VRC testimony was supportive of Resolution 040 as written. There were some suggestions to include a definition for allyship training in the resolve clause, which your Reference Committee found compelling. We have added this definition and recommend that Resolution 040 be adopted as amended.
RESOLUTION 044 – INCLUSION OF HYGIENE PRODUCTS IN SUPPLEMENTAL NUTRITION PROGRAMS

RECOMMENDATION A:

The first Resolve of Resolution 044 be amended by substitution:

RESOLVED, That our AMA will 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; and be it further

RESOLVED, Our AMA recognizes the importance of increasing access to medically necessary hygiene products to low-income individuals through amending Policy H-150.937, “Improvements to Supplemental Nutrition Programs,” by addition as follows:

Improvements to Supplemental Nutrition Programs, H-150.937

1. Our AMA supports: (a) improvements to the Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) that are designed to promote adequate nutrient intake and reduce food insecurity and obesity; (b) efforts to decrease the price gap between calorie-dense, nutrition-poor foods and naturally nutrition-dense foods to improve health in economically disadvantaged populations by encouraging the expansion, through increased funds and increased enrollment, of existing programs that seek to improve nutrition and reduce obesity, such as the Farmer’s Market Nutrition Program as a part of the Women, Infants, and Children program; and (c) the novel application of the Farmer’s Market Nutrition Program to existing programs such as the Supplemental Nutrition Assistance Program (SNAP), and apply program models that incentivize the consumption of naturally nutrition-dense foods in wider food-distribution venues than solely farmer’s markets as part of the Women, Infants, and Children program.

2. Our AMA will request that the federal government support SNAP initiatives to (a) incentivize healthful foods and disincentivize or eliminate unhealthful foods and (b) harmonize SNAP food offerings with those of WIC.
3. Our AMA will actively lobby Congress to preserve and protect the Supplemental Nutrition Assistance Program through the reauthorization of the 2018 Farm Bill in order for Americans to live healthy and productive lives.

4. Our AMA will support the inclusion of medically necessary hygiene products including, but not limited to, menstrual hygiene products and diapers within the benefits covered by Supplemental Nutrition Assistance Program and Special Supplemental Women’s, Infants, and Children Program, and other appropriate programs; and be it further

RECOMMENDATION B:

The second resolve of Resolution 044 be amended by addition and deletion:

RESOLVED, That our AMA advocate at the House of Representatives and Senate levels to pass existing for federal legislation that increases the access to menstrual hygiene products, especially for recipients of public assistance; and be it further

RECOMMENDATION C:

The third resolve of Resolution 044 be amended by addition and deletion:

RESOLVED, That our AMA work with state medical societies associations to advocate for state legislation that increases access to menstrual hygiene products, especially for recipients of public assistance.

RECOMMENDATION D:

Resolution 044 be adopted as amended.

RESOLVED, Our AMA recognizes the importance of increasing access to medically necessary hygiene products to low-income individuals through amending Policy H-150.937, “Improvements to Supplemental Nutrition Programs,” by addition as follows:

Improvements to Supplemental Nutrition Programs, H-150.937

1. Our AMA supports: (a) improvements to the Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) that are designed to promote adequate nutrient intake and reduce food insecurity and obesity; (b) efforts to decrease the price gap between
calorie-dense, nutrition-poor foods and naturally nutrition-dense foods to improve health in economically disadvantaged populations by encouraging the expansion, through increased funds and increased enrollment, of existing programs that seek to improve nutrition and reduce obesity, such as the Farmer's Market Nutrition Program as a part of the Women, Infants, and Children program; and (c) the novel application of the Farmer's Market Nutrition Program to existing programs such as the Supplemental Nutrition Assistance Program (SNAP), and apply program models that incentivize the consumption of naturally nutrition-dense foods in wider food distribution venues than solely farmer's markets as part of the Women, Infants, and Children program.

2. Our AMA will request that the federal government support SNAP initiatives to (a) incentivize healthful foods and disincentivize or eliminate unhealthful foods and (b) harmonize SNAP food offerings with those of WIC.

3. Our AMA will actively lobby Congress to preserve and protect the Supplemental Nutrition Assistance Program through the reauthorization of the 2018 Farm Bill in order for Americans to live healthy and productive lives.

4. Our AMA will support the inclusion of medically necessary hygiene products including, but not limited to, menstrual hygiene products and diapers within the benefits covered by Supplemental Nutrition Assistance Program and Special Supplemental Women’s, Infants, and Children Program, and other appropriate programs; and be it further

RESOLVED, That our AMA advocate at the House of Representatives and Senate levels to pass existing legislation that increase the access to menstrual hygiene products; and be it further

RESOLVED, That our AMA work with state associations to further state level legislation that increase access to menstrual hygiene products.

Testimony on the VRC was supportive of the spirit of Resolution 044. Some concerns were raised over the issue that SNAP and WIC are nutrition programs that only cover select food items (not even all food) and equipment directly related to nutrition, such as breastmilk pumps. However, the resolution’s whereas clauses and authors’ VRC testimony note that some states have proposed legislation to expand SNAP or WIC benefits to include these items or provide additional parallel funds to recipients of these programs to purchase these items.

Additionally, questions were raised as to why we would cover menstrual hygiene products and diapers, but not other necessary personal hygiene products such as toothpaste or toilet paper. However, your Reference Committee discussed that unlike toothpaste and
toilet paper, access to menstrual hygiene products and diapers specifically affects people who menstruate and young children, respectively. Targeting inequities for these groups in particular is similar in spirit to our AMA Policy H-270.953, which supports removal of a tax on menstrual hygiene products.

There was one amendment proposed by the Massachusetts delegation. The Section Delegates point out that this would be beneficial to add to the pending MSS transmittal Increasing Access to Menstrual Hygiene Products. Your Reference Committee considered broadening the resolves to cover many ways states may choose to offer these benefits (whether in existing programs or as additional subsidies) and maintain the focus of the second and third resolves on low-income persons. We agree with the Section Delegates and proffer amendments to make the language and actions more feasible and recommend that this be added to the pending transmittal list. Your Reference Committee recommends Resolution 044 be adopted as amended.

(37) RESOLUTION 045 – ADVOCATING FOR THE DELIVERY OF STANDARDIZED PERINATAL CARE AND MONITORING OF HEALTHCARE OUTCOMES FOR INCARCERATED PREGNANT INDIVIDUALS

RECOMMENDATION A:

Policies H-430.986 and D-430.997 be reaffirmed in lieu of the first Resolve of Resolution 045.

RECOMMENDATION B:

The third Resolve of Resolution 045 be deleted.

RESOLVED, That our AMA advocate for better surveillance of maternal mortality and pregnancy-related morbidity in incarcerated populations; and be it further

RECOMMENDATION C:

The fourth Resolve of Resolution 045 be amended by addition as follows:

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.

RECOMMENDATION D:

Resolution 045 be adopted as amended.
RESOLVED, That our AMA advocate for legislation that would improve compliance of correctional facilities with evidence-based guidelines from national physician organizations regarding the care and management of incarcerated pregnant women; 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; and be it further

RESOLVED, That our AMA advocate for better surveillance of maternal mortality and pregnancy-related morbidity in incarcerated populations; and be it further

RESOLVED, That our AMA support legislation requiring all correctional facilities, including those that are privately-owned, to collect and report pregnancy-related healthcare statistics with transparency in the data collection process.

Testimony on the VRC was supportive of Resolution 045. The Massachusetts delegation proffered minor, friendly amendments. Testimony from the Section Delegates suggested that the first resolve clause of Resolution 045 was a reaffirmation of existing policy and your Reference Committee agrees. The Section Delegates also point out that this would be beneficial to add to the pending MSS transmittal Classification and Surveillance of Maternal Mortality. We agree with the Section Delegates and hope these amendments will make the language and actions more feasible and recommend that this be added to the pending transmittal.

The asks of the first resolve clause are adequately covered in H-430.986 (clause 8) and D-430.997 (clause 2). We also find the third and fourth resolve clauses to be redundant so we propose striking the third resolve clause to streamline this resolution. We offer a clarifying amendment to the fourth resolve clause and recommend that Resolution 045 be adopted as amended.

H-430.986 – HEALTH CARE WHILE INCARCERATED

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 states 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. 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. 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. 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. 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.

D-430.992 – SUPPORT FOR HEALTH CARE SERVICES TO INCARCERATED PERSONS

Our AMA will:

(1) express its support of the National Commission on Correctional Health Care Standards that improve the quality of health care services, including mental health services, delivered to the nation’s correctional facilities;

(2) encourage all correctional systems to support NCCHC accreditation;

(3) encourage the NCCHC and its AMA representative to work with departments of corrections and public officials to
find cost effective and efficient methods to increase 
correctional health services funding; 
(4) continue support for the programs and goals of the 
NCCHC through continued support for the travel expenses 
of the AMA representative to the NCCHC, with this decision 
to be reconsidered every two years in light of other AMA 
financial commitments, organizational memberships, and 
programmatic priorities; 
(5) work with an accrediting organization, such as National 
Commission on Correctional Health Care (NCCHC) in 
developing a strategy to accredit all correctional, detention 
and juvenile facilities and will advocate that all correctional, 
detention and juvenile facilities be accredited by the NCCHC 
no later than 2025 and will support funding for correctional 
facilities to assist in this effort; and 
(6) support an incarcerated person’s right to: (a) accessible, 
comprehensive, evidence-based contraception education; 
(b) access to reversible contraceptive methods; and (c) 
autonomy over the decision-making process without 
coercion.  

(38) RESOLUTION 056 – ONLINE MEDICAL SCHOOL 
INTERVIEW OPTION 

RECOMMENDATION A: 

Resolution 056 be amended by addition and deletion as 
follows: 

RESOLVED, That our AMA-MSS’s Committee on 
Medical Education will work with relevant stakeholders 
to study the advantages and disadvantages of an online 
medical school interview option for future medical 
school applicants, including but not limited to financial 
implications and potential solutions, long term 
success, and well-being of students/residents. 

RECOMMENDATION B: 

Resolution 056 be adopted as amended. 

RESOLVED, That our AMA-MSS’s Committee on Medical Education will study the 
advantages and disadvantages of an online medical school interview option for future 
medical school applicants.

Testimony on the VRC was generally supportive of Resolution 056. Region 1 and the 
Massachusetts delegation supported the resolution as written. The Committee on Medical 
Education (CME) suggested this be made external. We found this compelling and have 
made that amendment. Additionally, we proffer our own amendment to include a non-
exhaustive list of topics we think would be important to include in the study. Your Reference Committee recommends Resolution 056 be adopted as amended.

(39) RESOLUTION 072 – AMENDING D-440.985, HEALTH CARE PAYMENT FOR UNDOCUMENTED PERSONS, TO STUDY METHODS TO INCREASE HEALTH CARE ACCESS FOR UNDOCUMENTED IMMIGRANTS

RECOMMENDATION A:

Resolution 072 be amended by addition and deletion as follows:

RESOLVED, That our AMA amend D-440.985 Health Care Payment for Undocumented Persons by addition as follows:

Health Care Payment for Undocumented Persons D-440.985

Our AMA: (1) shall assist states on the issue of the lack of reimbursement for care given to undocumented immigrants in an attempt to solve this problem on a national level.; and (2) study methods and develop recommendations for rules, laws, or regulations that would expand health insurance access to undocumented immigrants through means such as, but not limited to, allowing participation in health care marketplaces, Medicaid expansion, and use of state funding, support methods to increase health insurance access for undocumented immigrants, such as allowing them to purchase health insurance on the Affordable Care Act marketplaces.

RECOMMENDATION B:

Resolution 072 be adopted as amended.

RESOLVED, That our AMA amend D-440.985 Health Care Payment for Undocumented Persons by addition as follows:

Health Care Payment for Undocumented Persons D-440.985

Our AMA: (1) shall assist states on the issue of the lack of reimbursement for care given to undocumented immigrants in an attempt to solve this problem on a national level. (2) study methods and develop recommendations for rules, laws, or regulations that would expand health insurance access to undocumented immigrants through means such
as, but not limited to, allowing participation in health care
marketplaces, Medicaid expansion, and use of state
funding.

VRC testimony on Resolution 072 was mixed. Region 1, the Minority Issues Committee (MIC), the Committee on Economics and Quality in Medicine (CEQM), and the Massachusetts delegation were in support of the resolution. CEQM and the Section Delegates proffered amendments for consideration. We, like the Section Delegates, appreciate the authors’ attempt to mitigate controversy by asking our AMA to study this issue, but we agree with the Section Delegates’ logic that our MSS Caucus can push for outright adoption of this policy and use referral as a secondary option depending on the progress of debate.

Additionally, we found the Section Delegates’ amendment compelling and have added language to “support methods” to increase coverage. This amendment is broad enough to capture the intent of this resolution, but goes on to suggest a potential specific method (“such as allowing them to purchase insurance on the Affordable Care Act marketplaces”) that could be helpful to those acting on this request.

We recognize that the issue may be politically contentious at the House of Delegates level, but believe it is an important issue that needs to be addressed. Furthermore, allowing undocumented immigrants to purchase private health insurance on the Affordable Care Act marketplaces, as opposed to enrollment in public entitlements, may garner more support in the HOD, particularly among physicians who may prefer the typically higher reimbursements of private insurance. Your Reference Committee recommends Resolution 072 be adopted as amended.

(40) RESOLUTION 073 - SUPPORT ACCOUNTABLE ORGANIZATIONS TO RESIDENTS AND FELLOWS

RECOMMENDATION A:

Resolution 073 be amended by deletion to read as follows:

RESOLVED, Our AMA-MSS supports efforts to:
(1) determine which organizations or governmental entities are best suited for being permanently responsible for and accountable to residents and fellows without conflicts of interests; and
(2) determine how such an organization may be created in the event that no organizations or entities are identified that meet the above criteria; and
(3) identify effective methods of advocacy for residents and fellows that avoid jeopardizing their current and future employability.
RECOMMENDATION B:
Resolution 073 be **adopted as amended.**

RESOLVED, Our AMA-MSS supports efforts to:
(1) determine which organizations or governmental entities are best suited for being permanently responsible for and accountable to residents and fellows without conflicts of interests; and
(2) determine how such an organization may be created in the event that no organizations or entities are identified that meet the above criteria; and
(3) identify effective methods of advocacy for residents and fellows that avoid jeopardizing their current and future employability.

VRC testimony on Resolution 073 was mixed. Region 6 and the Committee on Medical Education (CME) supported the resolution, while Region 2 and the Massachusetts delegation opposed the resolution. The Committee on Economics and Quality in Medicine (CEQM) recommended this be referred for study. The MSS Councilor on Medical Education suggested that we review CME Report 3-I-20, which addressed many of the same concerns. The MSS CME Councilor also suggested that submitting this resolution via the Residents and Fellows Section (RFS) may be preferable.

Your Reference Committee is aware that RFS is submitting a resolution with similar resolve clauses to the June 2021 Special Meeting of the House of Delegates. We discussed how MSS passage of the first clause would provide general support for and encompass the asks of the other two clauses, allowing us to subsequently support RFS when their resolution is introduced in the House of Delegates (HOD).

After reviewing this testimony and the paired resolution being presented by the RFS this upcoming HOD meeting, your Reference Committee recommends striking the second and third clauses of this resolution. We believe that adopting only the first clause in this resolution as internal policy would be sufficient for our MSS Caucus to support the proposed RFS resolution this meeting, given our existing policy on working with the RFS to advance our common interests (650.001MSS and 650.002MSS). We recommend Resolution 073 be adopted as amended.

(41) CME MIC REPORT A – TWO-INTERVAL GRADING OF CLINICAL CLERKSHIPS

RECOMMENDATION A:
The second Recommendation from CME MIC Report A be deleted:

2) That AMA Policy H-295.866 be amended by addition as follows:

Supporting Two-Interval Grading Systems for Medical Education H-295.866
1. Our AMA will work with stakeholders to encourage the establishment of a two-interval grading system in medical colleges and universities in the United States for the non-clinical curriculum.

2. Our AMA encourages research to evaluate the impact of two-interval clinical clerkship grading systems on residency application outcomes and clinical performance during residency.

**RECOMMENDATION B:**

Recommendations in CME MIC Report A be adopted as amended and the remainder of the report be filed.

Your MSS Committee on Medical Education and MSS Minority Issues Committee recommend that the following recommendations be adopted and the remainder of the report be filed:

1) That our AMA will study the impact of two-interval clinical clerkship grading systems on residency application outcomes and clinical performance during residency.

2) That AMA Policy H-295.866 be amended by addition as follows:

```
Supporting Two-Interval Grading Systems for Medical Education H-295.866

1. Our AMA will work with stakeholders to encourage the establishment of a two-interval grading system in medical colleges and universities in the United States for the non-clinical curriculum.

2. Our AMA encourages research to evaluate the impact of two-interval clinical clerkship grading systems on residency application outcomes and clinical performance during residency.
```

Testimony on CME MIC Report A was limited. The report was well-written and well-researched. The MSS Councilor on Medical Education suggested that the recommendations were redundant and recommend striking the second recommendation. We found this compelling. Your Reference Committee thanks the authors for their work on this report and recommends the recommendations in CME MIC Report A be adopted as amended and the remainder of the report be filed.
CSI REPORT B – SUPPORTING DAYLIGHT SAVING TIME AS THE NEW, PERMANENT STANDARD TIME

RECOMMENDATION A:

The first Recommendation from CSI Report B be amended by addition as follows:

RESOLVED, That our AMA recognize the adverse health effects of biannual time changes and support the elimination of biannual time changing; and be it further

RECOMMENDATION B:

The second Recommendation from CSI Report B be amended by addition as follows:

RESOLVED, That our AMA recognize the positive health effects of daylight savings time and support daylight saving time as the permanent standard time.

RECOMMENDATION C:

CSI Report B be adopted as amended and the remainder of the report be filed.

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

RESOLVED, That our AMA support the elimination of biannual time changing; and be it further

RESOLVED, That our AMA support daylight saving time as the permanent standard time.

We thank the authors of CSI Report B for the time spent putting together this report. Based on concerns from the Section Delegates regarding the direct relationship between health and daylight savings time, your Reference Committee offers two friendly amendments to broaden and strengthen the report recommendations. We recommend the recommendations in CSI Report B be adopted as amended and the remainder of the report be filed.
CSI REPORT C – IMPROVING LABELING OVER-THE-COUNTER MEDICATIONS BY INCLUDING CARBOHYDRATE CONTENT

RECOMMENDATION A:

The Recommendation from CSI Report C be amended by addition and deletion as follows:

Your Committee on Scientific Issues recommends that the following resolve clause is adopted, and the remainder of the report is filed:

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

RECOMMENDATION B:

The Recommendation from CSI Report C be adopted as amended and the remainder of the report be filed.

Your Committee on Scientific Issues recommends that the following resolve clause is adopted, and the remainder of the report is filed:

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

VRC testimony was limited on CSI Report C. The Section Delegates’ concern about the recommendation being external was compelling and we proffer amendments to make this recommendation internal and clarify the ask to make feasible as internal MSS policy. If there is interest to re-visit this topic in the future, we would recommend reaching out to the American Association of Clinical Endocrinology and the American Academy of Neurology. We thank the authors for the time spent on this report and recommend the recommendations in CSI Report C be adopted as amended and the remainder of the report be filed.

CSI COLA REPORT A – REGULATION OF PHthalates IN ADULT PERSONAL SEXUAL PRODUCTS

RECOMMENDATION A:

The Recommendation from CSI COLA Report A be amended by addition and deletion as follows:

Your Committee on Scientific Issues and Committee on Legislation and Advocacy recommend that AMA policy
ENCOURAGING ALTERNATIVES TO PVC/PHTHALATE DEHP PRODUCTS IN HEALTH, H-135.945

Our AMA:
(1) encourages hospitals and physicians to reduce and phase out polyvinyl chloride (PVC) medical device products, especially those containing phthalates such as Di(2-ethylhexyl)phthalate (DEHP), and urge adoption of safe, cost-effective, alternative products where available; and
(2) urges expanded manufacturer development of safe, cost-effective alternative products to PVC medical device products, especially those containing phthalates such as DEHP.; and
(3) encourages the U.S. Consumer Product Safety Commission to conduct a risk assessment of adult personal sexual products, including adult personal sexual products, as a source of phthalates; and
(4) supports consumer education about the potential for exposure to toxic substances in adult personal sexual products.

RECOMMENDATION B:

The Recommendation from CSI COLA Report A be adopted as amended and the remainder of the report be filed.

Your Committee on Scientific Issues and Committee on Legislation and Advocacy recommend that AMA policy H-135.945 be amended by addition and deletion as follows, and the remainder of the report be filed:

ENCOURAGING ALTERNATIVES TO PVC/PHTHALATE DEHP PRODUCTS IN HEALTH, H-135.945

Our AMA:
(1) encourages hospitals and physicians to reduce and phase out polyvinyl chloride (PVC) medical device products, especially those containing Di(2-ethylhexyl)phthalate (DEHP), and urge adoption of safe, cost-effective, alternative products where available; and
(2) urges expanded manufacturer development of safe, cost-effective alternative products to PVC medical device products, especially those containing DEHP.; and
(3) encourages the U.S. Consumer Product Safety Commission to conduct a risk assessment of adult personal sexual products as a source of phthalates; and

(4) supports consumer education about the potential for exposure to toxic substances in adult personal sexual products.

VRC testimony was limited on CSI COLA Report A. We incorporated the Section Delegates’ amendments into our recommendation to broaden the language to adult personal consumer products in general, as we found them compelling, while still maintaining the focus on the safety of sexual products in particular. Your Reference Committee thanks the authors of CSI COLA Report A and recommends the recommendations in the report be adopted as amended and the remainder of the report be filed.

(45) WIM REPORT A – SUPPORT FOR FAMILY PLANNING FOR MEDICAL STUDENTS

RECOMMENDATION A:

The first Recommendation from WIM Report A be amended by addition and deletion as follows:

RESOLVED, That our AMA-MSS amend policy 295.207MSS as follows:

FAMILY PLANNING FOR MEDICAL STUDENTS, 295.207MSS

AMA-MSS (1) encourages medical schools to create informative resources that promote a culture that is supportive of their students who are parents and to provide openly accessible information to prospective and current students regarding family planning in the specific medical school including parental maternity and paternity leave and relevant make up work, options to preserve fertility, breastfeeding policies, accommodations during pregnancy, and resources for childcare that span the institution and surrounding area; and (2) supports the development of comprehensive requirements for medical schools regarding guidelines and resources for family leave and parenthood; and (3) supports medical schools providing 6 weeks of parental leave for medical students of all genders male and female medical students, medical school or broader licensure-related policies that allow for students to take a full six week leave without delaying graduation, and (4) encourages medical schools to make these formal policies easily accessible for both current and prospective students; and be it further
RECOMMENDATION B:

The Recommendations from WIM Report A be adopted as amended and the remainder of the report be filed.

Your Women in Medicine Committee recommends that the follow resolve clauses be adopted in lieu of Resolution 51-I-19 and the remainder of this report be filed:

RESOLVED, That our AMA-MSS amend policy 295.207MSS as follows:

FAMILY PLANNING FOR MEDICAL STUDENTS, 295.207MSS
AMA-MSS (1) encourages medical schools to create informative resources that promote a culture that is supportive of their students who are parents and to provide openly accessible information to prospective and current students regarding family planning in the specific medical school including maternity and paternity leave and relevant make up work, options to preserve fertility, breastfeeding policies, accommodations during pregnancy, and resources for childcare that span the institution and surrounding area; and (2) supports the development of comprehensive requirements for medical schools regarding guidelines and resources for family leave and parenthood; and (3) supports medical schools providing 6 weeks of parental leave for male and female medical students, medical school or broader licensure-related policies that allow for students to take a full six week leave without delaying graduation, and (4) encourages medical schools to make these formal policies easily accessible for both current and prospective students.

; and be it further

RESOLVED, That our AMA-MSS continue to support family leave related policies brought forth by other delegations so as not to diminish incremental advancement in advocacy related to this topic.

There was no VRC testimony on WIM Report A. Your Reference Committee offers two friendly amendments to strike “male and female medical students” and replace with “medical students of all genders,” as well as replace “maternity and paternity” with “parental” to make this recommendation more inclusive. We thank the authors for their hard work and recommend the recommendations in WIM Report A be adopted as amended and the remainder of the report be filed.
RECOMMENDATION A:

The second Recommendation from CHIT CGPH COLA Report A be amended by deletion as follows:

RESOLVED, 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 segmenting misinformation groups on public platforms, altering underlying network dynamics, or redesigning platform algorithms; and be it further

RECOMMENDATION B:

CHIT CGPH COLA Report A be adopted as amended and the remainder of the report be filed.

Your Committee on Health Information Technology and Committee on Global and Public Health recommend that the following recommendations are adopted, and the remainder of the report is filed:

RESOLVED, Our AMA 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; and be it further

RESOLVED, 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 segmenting misinformation groups on public platforms, altering underlying network dynamics, or redesigning platform algorithms; and be it further

RESOLVED, Our AMA continue to support the dissemination of accurate medical information by public health organizations and health policy experts; and be it further

RESOLVED, 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; and be it further

RESOLVED, Our AMA amend existing policy concerning COVID-19 vaccine information to increase its scope and impact regarding medical misinformation 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.

RESOLVED, 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.

VRC testimony on CHIT CGPH COLA Report A was limited, but compelling. The Section Delegates recommended striking “segmenting misinformation groups on public platforms” from the second resolve clause, as this could end up backfiring. This could silo off these groups and allow misinformation to propagate further amongst them. We agree with this amendment. We thank the authors of CHIT CGPH COLA Report A for their hard work and recommend the recommendations be adopted as amended and the remainder of the report be filed.
RECOMMENDATION A:

GC Report B be amended by addition of a third Recommendation as follows:

3. That the language in the following policies be updated to industry-accepted, person-first language as indicated:

a. 30.001MSS – “Alcoholism” be changed to “Substance Use Disorder,” and “addicted students” be changed to “students with substance use disorders.”

b. 60.002MSS – “mother” be changed to “parent.”

c. 65.010MSS – Add “or gender identity or expression” at the end of clause (4).

d. 65.014MSS – Change “gay and lesbian” to “LGBTQ+.”

e. 95.001MSS – Change “abuse” to “misuse.”

f. 95.002MSS – Change “abuse” to “misuse.”

g. 100.007 – Change “Heroin” to “Opioid”; change “opiate addiction and abuse” to “opioid use disorder”; change “opiate addiction” to “opioid use disorder.”

h. 160.031MSS – In clause (4), replace “his or her” with “their.”

i. 170.016MSS – In clause (e), change “gay, lesbian, and bisexual” to “LGBTQ+.”

j. 180.008MSS – Change “same sex and opposite sex partners” to “domestic partners, regardless of gender,”

k. 245.010MSS – Change “mothers” to “parents.”

l. 270.004MSS – Change “his or her” to “their.”

m. 270.028MSS – Change “Drug use and addiction” to “Substance Use Disorders”; update language from addiction and abuse to substance use disorders.

n. 295.002MSS – Add “patients who are” in front of “deaf.”

o. 295.035MSS – Add the word “made” to the end of the policy.

p. 295.067MSS – Change “Rape Crises” to “Sexual Assault”; change “rape victims” to “survivors of sexual assault.”

q. 295.104MSS – Change “his or her” to “their.”

r. 295.150MSS – Add “and COMLEX” after “USMLE”

s. 345.001MSS – Change “of Mental Patients” to “Patients with Psychiatric Disorders”; and “psychiatric patients” to “patients with psychiatric disorders.”

t. 345.008MSS – Change “the Mentally Ill” to “person with psychiatric disorders” in the title and throughout policy.
RECOMMENDATION B:

The recommendations in GC Report B be adopted as amended and the remainder of the report be filed.

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

1. That the policies specified for retention in Appendix 1 of this report be retained as official, active policies of the AMA-MSS.
2. That the AMA-MSS Governing Council review the AMA-MSS Digest of Policy Actions every five years for redundant and outdated statements of support.

Your Reference Committee thanks the MSS Governing Council and Standing Committees for their review of the Sunset Policies. This is no small undertaking and their work is much appreciated. We offer friendly amendments to update language in several policies to industry-accepted, person-first language.

An observation was made regarding the sunset process as a whole as your Reference Committee did their review; it appears that the Section has adopted several policies that call for studies, and there is often no clear indication or record on whether those have been accomplished. We bring this up not as a criticism of this report, but as something for the Section to strategically consider in our future policy-making process.

Again, we thank the GC and Standing Committee members for their review and recommend GC Report B be adopted as amended.
RECOMMENDED FOR ADOPTION IN LIEU OF

RESOLUTION 009 – REDUCING COMPLEXITY IN THE PUBLIC SERVICE LOAN FORGIVENESS PROGRAM
RESOLUTION 037 – ADVOCATE FOR FEDERAL INVOLVEMENT IN PLANNING AND STRATEGIZING A GLOBAL COVID-19 VACCINE DISTRIBUTION PLAN

RECOMMENDATION:

Substitute Resolution 009 be adopted in lieu of Resolution 009 and Resolution 037:

RESOLVED, That our AMA amend policy H-250.988, “Low-Cost Drugs to Poor Countries during Times of Pandemic Health Crises,” by addition as follows:

H-250.988 – AID LOW-COST DRUGS TO POOR LOW- AND MIDDLE-INCOME COUNTRIES DURING EPIDEMICS AND PANDEMICS TIMES OF PANDEMIC HEALTH-CRISSES

Our AMA: (1) encourages pharmaceutical companies to (a) prioritize equity when providing low cost or free medications, including therapeutics and vaccines, to countries; (b) work with the federal government to temporarily waive intellectual property provisions for necessary medications; and (c) share technological information, ingredients, and equipment to facilitate production of necessary medications during epidemics and pandemics 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.

Resolution 009
RESOLVED, That our AMA work with United States stakeholders to support mechanisms for equitable global distribution of vaccines and therapeutics during pandemics, including but not limited to the open sharing of pharmaceutical data and technology as well as possible temporary waivers of intellectual property rules when applicable; and be it further

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

Resolution 037
RESOLVED, That Our AMA-MSS supports global vaccination efforts for the COVID-19 vaccine; and

RESOLVED, That Our AMA-MSS encourages providing logistical, financial, and manufacturing support to developing countries in order to bolster their vaccination endeavors; and be it further

RESOLVED, That Our AMA-MSS advocates for working with global partners to plan and strategize an equitable global Covid-19 vaccine distribution plan.

VRC testimony was mixed on Resolution 009 and 037. There was extensive debate on both these resolutions. We believe the asks to be novel and find that the resolutions are stronger together. Most compelling was testimony specifically regarding Intellectual Property of mRNA vaccine manufacturing facilities – we strongly believe this needs to be codified in AMA policy to guide future efforts. However, we recommend removing the immediate forward clause, as the Biden Administration has already supported a TRIPS waiver and is engaging in other efforts discussed here in response to the increasing number of COVID-19 cases internationally. Given these developments, we recommend Substitute Resolution 009 be adopted in lieu of Resolution 009 and Resolution 037.

(49) RESOLUTION 010 – AMEND D-95.987, TO SUPPORT EXEMPTING FENTANYL TEST STRIPS AND OTHER DRUG CHECKING TECHNOLOGIES FROM PARAPHERNALIA LAWS

RESOLUTION 024 – AMEND H-95.958, TO DECRIMINALIZE IDPE IN SAFE SYRINGE PROGRAMS

RECOMMENDATION:

Substitute Resolution 010 be adopted in lieu of Resolution 010 and Resolution 024:

RESOLVED, That our AMA-MSS will ask the AMA to amend policy D-95.987 by addition and deletion as follows:

Prevention of Opioid Drug-Related Overdose D-95.987

1. Our AMA: (A) recognizes the great burden that opioid addiction and prescription drug abuse substance use disorders (SUDs) and drug-related overdoses and death places on patients and society alike and reaffirms its support for the compassionate treatment of such patients with a SUD and people who use drugs; (B) urges that community-based programs offering naloxone and other opioid overdose and drug safety and prevention services continue to be implemented in order to further develop best practices in this area; and (C) encourages the education of health care workers and people who use drugs opioid users about the use of naloxone and other harm reduction measures in
preventing opioid and other drug-related overdose fatalities; and (D) will continue to monitor the progress of such initiatives and respond as appropriate.

2. Our AMA will: (A) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of opioid a drug-related overdose; and (B) encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for opioid a drug-related overdose.

3. Our AMA will support the development and implementation of appropriate education programs for persons receiving treatment for a SUD or in recovery from opioid addiction a SUD and their friends/families that address harm reduction measures how a return to opioid use after a period of abstinence can, due to reduced opioid tolerance, result in overdose and death.

4. Our AMA will advocate for, and encourage state and county medical societies to advocate for harm reduction policies that provide civil and criminal immunity for the use of “drug paraphernalia” designed to support safe use of drugs, including drug contamination testing and injection drug preparation, use, and disposal supplies.

Resolution 010
RESOLVED, That our AMA-MSS will ask the AMA to amend policy D-95.987 by insertion as follows

Prevention of Opioid Overdose D-95.987
1. Our AMA: (A) recognizes the great burden that opioid addiction and prescription drug abuse places on patients and society alike and reaffirms its support for the compassionate treatment of such patients; (B) urges that community-based programs offering naloxone and other opioid overdose prevention services continue to be implemented in order to further develop best practices in this area; and (C) encourages the education of health care workers and opioid users about the use of naloxone in preventing opioid overdose fatalities; and (D) will continue to monitor the progress of such initiatives and respond as appropriate.

2. Our AMA will: (A) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of opioid overdose; and (B) encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for opioid overdose.

3. Our AMA will support the development and implementation of appropriate education programs for
persons in recovery from opioid addiction and their friends/families that address how a return to opioid use after a period of abstinence can, due to reduced 4. Our AMA will support policy modifying drug paraphernalia laws to exempt the use and distribution of fentanyl test strips and the use of other drug-checking technologies to identify non-fentanyl related contaminants of illicit and controlled drugs.

Resolution 024

RESOLVED, AMA-MSS will ask the AMA to amend policy H-95.958 by insertion as follows:

Syringe and Needle Exchange Programs, H-95.958

Our AMA: (1) encourages all communities to establish needle exchange programs and physicians to refer their patients to such programs; (2) will initiate and support legislation providing funding for needle exchange programs for injecting drug users; and (3) strongly encourages state medical associations to initiate state legislation modifying drug paraphernalia laws so that injection drug users can purchase and possess needles, and syringes, and other injection drug preparation equipment without a prescription and needle exchange program employees are protected from prosecution for disseminating syringes and other injection drug preparation equipment.

Your Reference Committee considered Resolution 010 in conjunction with Resolution 024. We believe the combination results in a stronger, more streamlined resolution. VRC testimony was supportive of both Resolution 010 and 024 separately. Region 2, the Committee on Legislation and Advocacy (COLA) and the Massachusetts delegation supported Resolution 010 as written. COLA, the Massachusetts delegation and the Committee on Global and Public Health (CGPH) supported Resolution 024 as written. The MSS Section Delegates recommended that existing policy be reaffirmed in lieu of Resolution 024. We disagree with reaffirmation, and hope that by combining and streamlining Resolution 010 and 024 we address the concerns of the Section Delegates. Your Reference Committee incorporated the asks of Resolution 010 and Resolution 024 into amendments to existing AMA policy, D-95.987. Given that the addition of drug contamination testing supplies brings up the important point of overdose risk from all substances, not just opiates, we felt it was appropriate to broaden the language of the existing AMA policy in addition to incorporating the authors’ suggestions. By expanding to include all substance use disorders and all drug paraphernalia, and per AMA Advocacy suggestion, we are broadening the policy to make it more actionable and impactful. We recommend Substitute Resolution 010 be adopted in lieu of Resolution 010 and 024.
RESOLUTION 033 – STUDYING MORTALITY AMONG HOMELESS POPULATIONS

RECOMMENDATION:

Substitute Resolution 033 be adopted in lieu of Resolution 033.

RESOLVED, That our AMA amend Policy H-160.903, “Eradicating Homelessness,” by addition and deletion as follows:

Our AMA: (1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost-effective approaches which recognize the positive impact of stable and affordable housing coupled with social services;

(2) encourages research aimed at improving the gap in knowledge in areas that significantly impact the health and wellbeing of those experiencing homelessness, such as mortality among different demographic groups experiencing homelessness;

(23) recognizes that stable, affordable housing as a first priority, without mandated therapy or services compliance, is effective in improving housing stability and quality of life among individuals who are chronically homeless;

(34) recognizes adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address this societal problem on a long-term basis;

(45) recognizes the need for an effective, evidence-based national plan to eradicate homelessness;

(56) encourages the National Health Care for the Homeless Council to study the funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons;

(67) will partner with relevant stakeholders to educate physicians about the unique healthcare and social needs of homeless patients and the importance of holistic, cost-effective, evidence-based discharge planning, and physicians’ role therein, in addressing these needs;

(78) encourages the development of holistic, cost-effective, evidence-based discharge plans for homeless patients who present to the emergency department but are not admitted to the hospital;
(89) encourages the collaborative efforts of communities, physicians, hospitals, health systems, insurers, social service organizations, government, and other stakeholders to develop comprehensive homelessness policies and plans that address the healthcare and social needs of homeless patients; (910) (a) supports laws protecting the civil and human rights of individuals experiencing homelessness, and (b) opposes laws and policies that criminalize individuals experiencing homelessness for carrying out life-sustaining activities conducted in public spaces that would otherwise be considered non-criminal activity (i.e., eating, sitting, or sleeping) when there is no alternative private space available; and (4011) recognizes that stable, affordable housing is essential to the health of individuals, families, and communities, and supports policies that preserve and expand affordable housing across all neighborhoods.

RESOLVED, That our AMA recognize the limited available data regarding (1) the life expectancy of individuals experiencing homelessness and (2) cause-specific mortality among different demographic groups experiencing homelessness as a gap in knowledge; and be it further

RESOLVED, That our AMA support research aimed at improving the gap in knowledge in areas that significantly impact the health and wellbeing of those experiencing homelessness.

VRC testimony was supportive of Resolution 033. Region 1, Region 2, Region 3, Region 6, the Committee on Economics and Quality in Medicine (CEQM) and the Committee on Global and Public Health (CGPH) supported the resolution. The Massachusetts delegation supported reaffirmation of existing policy (H-160.903) in lieu of Resolution 033. The American College of Emergency Physicians (ACEP) suggested changing the original language in the first resolve from “support” to “encourage” to reduce the fiscal note associated with this resolution.

After reviewing testimony, your Reference Committee believes that the spirit of Resolution 033 could be captured and most efficiently added onto H-160.903 instead of creating an entirely new policy. We have incorporated ACEP’s suggestion, streamlined the language from the original resolve clauses and recommend that Substitute Resolution 033 be adopted in lieu of Resolution 033.
RESOLUTION 034 – EVIDENCE-BASED GUIDELINES FOR CORNEAL DONATION FROM MEN WHO HAVE SEX WITH MEN

RECOMMENDATION:

Substitute Resolution 034 be adopted in lieu of Resolution 034 with a title change:

Title: “Blood and Tissue Donor Deferral Criteria”

RESOLVED, That our AMA-MSS (1) supports the use of rational, scientifically-based blood and tissue donation deferral periods that are fairly and consistently applied to donors according to their individual risk; (2) opposes all policies on deferral of blood and tissue donations that are not based on evidence; (3) supports a blood and corneal 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 corneal tissue donation.

RESOLVED, That our AMA amend Policy H-50.973, “Blood Donor Deferral Criteria,” by addition to read as follows:

Blood and Tissue Donor Deferral Criteria, H-50.973
Our AMA: (1) supports the use of rational, scientifically-based blood and tissue donation deferral periods that are fairly and consistently applied to donors according to their individual risk; (2) opposes all policies on deferral of blood and tissue donations that are not based on evidence; (3) supports a blood and corneal 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 corneal tissue donation.

VRC testimony was supportive of Resolution 034. Region 1 Region 2, Region 3, Region 4, the Standing Committee on LGBTQ+ Affairs, Committee on Bioethics and Humanities (CBH), Committee on Economics and Quality in Medicine (CEQM), the Massachusetts delegation, and GLMA: Health Professionals Advancing LGBTQ Equality support the resolution as written. The MSS House Coordination Committee (HCC) deemed this to be a novel ask. The Section Delegates mentioned in their testimony that the GLMA delegation would be bringing forward a similar resolution to the June 2021 Special Meeting of the House of Delegates (HOD), and recommended making this policy internal in order to support GLMA at the HOD. We found this testimony compelling and have adjusted Resolution 034 to be internal and explicitly reflect the language in H-50.973. We also suggest a title change to be in line with the existing HOD policy that is being amended by GLMA. We recommend Substitute Resolution 034 be adopted in lieu of Resolution 034.
(52) RESOLUTION 036 – EQUITABLE REPORTING OF
USMLE STEP 1 SCORES

RECOMMENDATION:

Substitute Resolution 036 be adopted in lieu of
Resolution 036.

RESOLVED, That our AMA works with appropriate
stakeholders to release guidance for residency and
fellowship program directors on equitably comparing
students who received 3-digit USMLE Step 1 or
COMLEX Level 1 scores and students who received
Pass/Fail scores.

RESOLVED, That our AMA will engage the National Board of Medical Examiners (NBME), National Board of Osteopathic Medical Examiners (NBOME) and the Federation of State Medical Boards (FSMB) to retroactively convert all 3-digit USMLE Step 1 scores to a Pass/Fail format for students who will be applying for residency during and beyond the
year 2024.

VRC testimony was mixed on Resolution 036. The Committee on Medical Education (CME) opposed the resolution as written due to the unfairness of changing score rules now for students who have already taken Step 1/Level 1. Without taking a stance on the resolution, the MSS Councilor on Medical Education recommended amending to reflect USMLE/COMLEX parity, noted the complexity of the issue, and expressed that this could both advantage and unfairly disadvantage various groups of students, depending on their scores and potential plans to delay residency application for gap years to pursue dual degrees and other opportunities.

Region 1 and the Massachusetts delegation both supported with an amendment to shift the year indicated in the resolve clause from the 2023-2024 residency application cycle up to the 2022-2023 residency application cycle, to account for medical schools where students take Step 1/Level1 in the spring of third year, just a few months before residency applications. Your Reference Committee weighed the pros and cons of this resolution heavily and expressed the difficulty of deciding on the issue, when NBME and FSMB themselves declined to make this decision upon initially announcing the pass/fail change for Step 1 and then waited another five months before announcing that 3-digit scores would not be retroactively converted, followed five months later by NBOME announcing the pass/fail change for Level 1. This means that for the past 15 months since the Step 1 change was announced and five months since the Level 1 change announced, students prepared for an took these exams under the impression that they would receive a 3-digit score. While your Reference Committee broadly supports the transition to a pass/fail score, there was discussion regarding how taking Step 1/Level 1 under 3-digit score conditions is a very different preparation and examination experience from taking the exam pass/fail.

In response to Region 1 and Massachusetts, we noted that only 10-15% of medical schools allow students to take Step 1/Level 1 in the third year and would therefore have
students applying with pass/fail scores next year. Implementing this policy for the 2022-2023 cycle would change the rules for the other 85-90% of schools where students have already or will soon be receiving 3-digit scores, the gravity of which concerned your Reference Committee. Furthermore, since this resolution’s asks were not implemented earlier by NBME, NBOME, and FSMB, the only students who would even still be applying with 3-digit scores in the 2023-2024 residency application cycle would be: (1) students taking more than 1 gap year during their medical education, such as PhD and JD dual-degree students, approximately 3% of students, and (2) osteopathic students taking Level 1 before it turns pass/fail in May 2022, many of whom may choose to schedule their exam around this deadline based on whether they prefer a 3-digit or pass/fail score. The vast majority of applicants in that cycle would have pass/fail scores. Moving forward, the number of students with 3-digit scores would progressively decrease from 3%. Your Reference Committee did not find retroactive conversion of scores for a relatively small portion of medical students to be an equitable solution to this problem.

We are unsure why NBME, NBOME, and FSMB did not tie the pass/fail change to a specific residency application cycle in the first place, to ensure consistency in score reporting. A major benefit of this policy—reduction of stress on medical students due to Step 1/Level 1 preparation—could have been realized earlier. If students knew at some point in the last year that their scores would be retroactively converted to pass/fail, they could have adjusted their preparation accordingly, functionally making the pass/fail change sooner than January 2022. Now, more than a year after the initial Step 1 announcement and with only 8 months before Step 1 turns pass/fail, the window for advocacy is extremely narrow. Even if this resolution were to pass our MSS, we are unsure when this would transmit to our House of Delegates and actually impact any efforts by NBME, NBOME, and FSMB.

As an additional note, we did discuss the possibility that while students with “high” 3-digit scores would be perceived positively by residency and fellowship program directors, and students with pass scores may be given the benefit of the doubt regarding their standardized exam ability, students with “low” 3-digit scores would be at a particular disadvantage in this system. On the other hand, we also discussed that students who received a 3-digit score with which they were satisfied may have a compelling right to keep that score and not have it converted by external agents, after all their hard work has been realized.

Your Reference Committee found the amendment from CME compelling and proffer that amendment as a substitute resolution. We believe that this issue greatly impacts most, if not all of our members, and we do not want this resolution to negatively impact any student. We also recognize the important representative role that the MSS plays in speaking for the broader medical student community in discussions with AMA, AAMC, NBME, NBOME, and FSMB and want to ensure that various perspectives on this issue are being heard accordingly, without missing anyone. We believe that guidance for residency and fellowship program directors in navigating the change from 3-digit scores to pass/fail is crucial. We recommend Substitute Resolution 036 be adopted in lieu of Resolution 036.
(53)  RESOLUTION 041 – REPORTING OF RESIDENCY  
PROGRAM-LEVEL DEMOGRAPHIC DATA TO FREIDA  
RESOLUTION 054 – DATA DISCLOSURE ON  
PARENTHOOD DURING RESIDENCY

RECOMMENDATION:

Substitute Resolution 041 be adopted in lieu of  
Resolution 041 and Resolution 054:

RESOLVED, Our AMA-MSS study the topic of residency  
programs publishing and sharing with FREIDA  
demographic data, including but not limited to age,  
disability status, gender identity, Underrepresented in  
Medicine (URM) status, and LGBTQ+ status of their  
programs, as well as data on use of family planning  
policies in the residency program.

Resolution 041  
RESOLVED, Our AMA will encourage residency programs to annually publish and share  
with FREIDA demographic data, including but not limited to age, gender identity, URM  
status, and LGBTQIA+ status of their programs from over the last 5 years.

Resolution 054  
RESOLVED, That our AMA encourage the Accreditation Council for Graduate Medical  
Education and other relevant stakeholders to annually collect data on pregnancy,  
childbirth, and parenthood (disaggregated by gender identity and specialty) from all  
accredited US residency programs in their current and all future resident cohorts; and be  
it further,

RESOLVED, That our AMA encourage all accredited US residency programs to annually  
publish data on their individual parental leave policies and the number of residents who  
have utilized this leave in the past 5 years on the official websites for individual programs  
in a manner that respects the privacy of individual residents.

VRC testimony supported the spirit of both Resolution 041 and Resolution 054. The  
Standing Committee on LGBTQ+ Affairs suggested adding “disability status” to the  
resolution. However, your Reference Committee questions the legality of asking residents  
to disclose their disability status. This concern was shared by the Committee on Medical  
Education (CME). CME noted privacy concerns in their VRC testimony, but did not offer  
amendments to address these concerns. The Councilor on Medical Education also noted  
privacy concerns with Resolution 041 as written. The Section Delegates recommended  
both Resolution 041 and 054 be made internal.

Your Reference Committee notes that the Resident and Fellows Section (RFS) is  
discussing a similar resolution at their upcoming meeting. We also highlight that the first  
resolve of the original Resolution 054 was placed on the reaffirmation consent calendar.
by the House Coordination Committee (HCC), so we did not include that language in our final recommendation.

We believe the privacy concerns raised by CME and the Councilor on Medical Education are important and warrant further study. We encourage the Standing Committee(s) to which this is assigned to specifically include the legality, or lack thereof, of disclosing this information. We recommend these resolutions be combined, LGBTQ+’s amendment be incorporated, and Substitute Resolution 041 be adopted in lieu of Resolution 041 and 054.
RECOMMENDED FOR REFERRAL

(54) RESOLUTION 013 – OPPOSING USE OF VULNERABLE INCARCERATED PEOPLE IN RESPONSE TO PUBLIC HEALTH EMERGENCIES OF INFECTIOUS DISEASE ORIGIN

RECOMMENDATION:

Resolution 013 be referred.

RESOLVED, That our AMA oppose the inclusion of labor carried out by incarcerated people within epidemic and pandemic emergency response plans and/or as an impromptu measure.

VRC testimony on Resolution 013 was robust and mixed, with several amendments proposed. We found the Section Delegates' amendment compelling, but wonder if there would be any unintended consequences – specifically with adding the word "significantly" (how would this threshold be set?) and with defining who decides what health risks could prevent an individual from performing these jobs. The Committee on Bioethics and Humanities (CBH) and the Minority Issues Committee (MIC) asked for referral on the VRC.

We agree with this testimony and believe Resolution 013 would benefit from further study. We would specifically ask the MSS Standing Committees to which this will be assigned to address the concerns laid out above, as well as explore potential ways to broaden this resolution to benefit this population more extensively. We recommend Resolution 012 be referred for study.

(55) RESOLUTION 025 – STUDYING POPULATION-BASED INSURANCE AND PAYMENT POLICY DISPARITIES

RECOMMENDATION:

Resolution 025 be referred.

RESOLVED, That our AMA oppose insurance and payment policy disparities that impact physicians in different specialties who treat distinct patient populations but provide similar services for these distinct patient populations, as well as insurance and payment policy disparities for similar care performed on distinct population; and be it further

RESOLVED, That our AMA work with the CPT Editorial Panel, the AMA/Specialty Society RVU Update Committee (RUC) and other relevant stakeholders to study the allocation of RVUs and the creation of CPT codes for services performed by specialties that predominantly serve historically underserved populations (including, but not limited to, pediatrics, obstetrics and gynecology, geriatrics, and psychiatry) and potential effects of such allocation methods on health disparities associated with race, socioeconomic status, gender, age, and other demographic factors to address root structural causes for reimbursement disparities, and report back to the House of Delegates; and be it further
RESOLVED, That our AMA work with the CPT Editorial Panel, the RUC, and other relevant stakeholders to address potential insufficiencies in coding and relative valuation for care performed for underserved populations and report back to the House of Delegates.

VRC testimony on Resolution 025 was mixed. Region 2, Region 3, Region 4, Region 5, and the Committee on Economics and Quality in Medicine (CEQM) supported the resolution as written. Region 6 and the Committee on Global and Public Health (CGPH) opposed the resolution, suggesting that this topic is out of scope and not within the purview of the MSS to bring to the House of Delegates (HOD). The MSS Government Relations and Advocacy Fellow (GRAF) offered several amendments to improve feasibility of this resolution and also suggested that H-290.997, Medicaid – Towards Reforming the Program, could be reaffirmed in lieu of Resolution 025.

It is clear after reviewing testimony that this is a very nuanced topic and we share the concerns of Region 6 and CGPH concerning scope. As a section we need to carefully consider the optics of the MSS bringing forward such as resolution, and if we do move forward we need to ensure that the ask is well-supported by research and the language is crafted in a way to be feasible for AMA Advocacy staff to act upon. For these reasons, we recommend Resolution 025 be referred for study.

(56) RESOLUTION 029 – MITIGATING THE IMPACT OF AIR POLLUTION ON PEDIATRIC HEALTH

RECOMMENDATION A:


RECOMMENDATION B:

The remainder of Resolution 029 be referred.

RESOLVED, That our AMA collaborates with the US Department of Education and other appropriate stakeholders to encourage all schools to monitor the local air quality index and follow AirNow guidelines prior to planning outdoor activities, including but not limited to recess and outdoor sports; and be it further

RESOLVED, That our AMA collaborates with the Environmental Protection Agency and the Children's Environmental Health Network, and other appropriate stakeholders to develop policies that limit children’s exposure to harmful pollutants according to EPA advisories and increase student and parent education on the impact of poor air quality on pediatric health including actions such as:

- Encouraging all schools to send communication (such as text messages) to parents on days with a poor local air quality index to recommend children avoid outdoor activities.
- Incorporate environmental health topics, such as air pollution, into school curriculums in action-oriented ways.
- Encouraging parents to join AirNow’s Air Quality Flag Program to increase community awareness about local air quality levels; and be it further

RESOLVED, That our AMA encourages the Department of Education, Environmental Protection Agency, and the Children’s Environmental Health Network to use EPA tools to monitor air quality levels in and around schools in order to understand which communities face greater levels of air pollution and further the AMA’s goal of promoting childhood environmental health and safety in an equitable manner; and be it further

RESOLVED, That in order to reduce sources of diesel exhaust surrounding schools, our AMA amends:

Reducing Sources of Diesel Exhaust D-135.996
Our AMA will: (1) encourage the US Environmental Protection Agency (EPA) to set and enforce the most stringent feasible standards to control pollutant emissions from both large and small non-road engines including construction equipment, farm equipment, boats and trains; (2) encourage all states to continue to pursue opportunities to reduce diesel exhaust pollution, including reducing harmful emissions from glider trucks and existing diesel engines; (3) call for all trucks traveling within the United States, regardless of country of origin, to be in compliance with the most stringent and current diesel emissions standards promulgated by US EPA; and (4) send a letter to US EPA Administrator opposing the EPA’s proposal to roll back the “glider Kit Rule” which would effectively allow the unlimited sale of re-conditioned diesel truck engines that do not meet current EPA new diesel engine emission standards; and (5) Ask the U.S. Department of Education to work with state and local leaders, and appropriate stakeholders to advocate for the transition from diesel to electric (zero-emission) or retrofitted (reduced-emission) school buses.

VRC testimony on Resolution 029 was mixed. Region 3, the New York delegation, and the Committee on Global and Public Health (CGPH) supported the resolution. The Section Delegates and the MSS Government Relations and Advocacy Fellow (GRAF) shared feedback from several divisions of our AMA’s Advocacy Business Unit that was opposed to the resolution as written, but supported the intent. The first three resolve clauses of Resolution 029 were placed on the reaffirmation consent calendar by the House Coordination Committee (HCC). Your Reference Committee agrees with this reaffirmation. We have concerns that the novel resolve clause is too narrow in focus. We question why only school buses are addressed, as there could be other sources of pollution associated with schools, and are not convinced that the U.S. Department of Education would be the correct agency to work with on this initiative.

Your Reference Committee supports the intent of the resolution but we believe it could be strengthened by further study. We note that although the first three resolve clauses were placed on the reaffirmation calendar, we encourage the Standing Committee assigned this
report to take those into consideration as well when doing their research and writing their report. Are there novel aspects of the first three resolves that should be considered? Your Reference Committee recommends that the first three resolve clauses reaffirm existing policies (H-135.996, H-135.998, and H-135.999) and the remainder of Resolution 029 be referred for study.

H-135.996 — POLLUTION CONTROL AND ENVIRONMENTAL HEALTH
Our AMA supports (1) efforts to alert the American people to health hazards of environmental pollution and the need for research and control measures in this area; and (2) its present activities in pollution control and improvement of environmental health.

H-135.998 — AMA POSITION ON AIR POLLUTION
Our AMA urges that: (1) Maximum feasible reduction of all forms of air pollution, including particulates, gases, toxicants, irritants, smog formers, and other biologically and chemically active pollutants, should be sought by all responsible parties.

(2) Community control programs should be implemented wherever air pollution produces widespread environmental effects or physiological responses, particularly if these are accompanied by a significant incidence of chronic respiratory diseases in the affected community.

(3) Prevention programs should be implemented in areas where the above conditions can be predicted from population and industrial trends.

(4) Governmental control programs should be implemented primarily at those local, regional, or state levels which have jurisdiction over the respective sources of air pollution and the population and areas immediately affected, and which possess the resources to bring about equitable and effective control.

H-135.999 — FEDERAL PROGRAMS
The AMA believes that the problem of air pollution is best minimized through the cooperative and coordinated efforts of government, industry, and the public. Current progress in the control of air pollution can be attributed primarily to such cooperative undertakings. The Association further believes that the federal government should play a significant role in these continuing efforts. This may be done by federal grants for (1) the development of research activity and (2) the encouragement of local programs for the prevention and control of air pollutants.
RESOLUTION 038 – AMENDING H-420.978, ACCESS TO PRENATAL CARE, TO SUPPORT THE PRACTICE OF AND APPROPRIATE REIMBURSEMENT FOR GROUP PRENATAL CARE

RECOMMENDATION:

Resolution 038 be referred.

RESOLVED, Our AMA amend H-420.978 Access to Prenatal Care by addition and deletion as follows:

Access to Individual and Group Prenatal Care H-420.978

(1) The Our AMA supports development of legislation or other appropriate means to provide for access to and equitable reimbursement for individual and group prenatal care for all women, with alternative methods of funding, including private payment, third party coverage, and/or governmental funding, depending on the individual's economic circumstances. (2) Our AMA will work with appropriate stakeholders and state medical associations to draft model legislation to ensure equitable Medicaid reimbursements for individual and group prenatal care in all states. (32) In developing such legislation, the our AMA urges that the effect of medical liability in restricting access to prenatal and natal care be taken into account.

Limited VRC testimony supported the spirit of Resolution 038. Region 1 supported the resolution and the Massachusetts delegation supported the intent but noted that a robust body of evidence must be established before being able to support the resolution in its entirety. The American College of Obstetricians and Gynecologists (ACOG) provided feedback suggesting there may be benefits to group prenatal care for some patients, but group care models generally warrant additional study.

We considered amending the language to internal MSS policy to support future efforts in our House of Delegates, but we found the testimony from Massachusetts and ACOG compelling. We believe that this resolution can be strengthened with additional research from our Standing Committees and recommend Resolution 038 be referred.
RESOLUTION 039 – TOWARDS A COMPREHENSIVE PLAN TO LOWER DRUG PRICES WHILE PRESERVING INNOVATION

RECOMMENDATION:

Resolution 039 be referred.

RESOLVED, that our AMA-MSS advocate for a systematic plan to lower drug prices wherein a statutorily empowered authority would negotiate drug prices with manufacturers, prioritizing the most expensive medications, and be it further

RESOLVED, that our AMA-MSS support such an authority taking into account the following information during the course of a negotiation:

a) The comparative efficacy of the drug relative to the standard of care,
b) The unmet need of the disease(s) for which the drug is intended to treat,
c) The costs of the drug’s development and manufacturing,
d) The amount of public investment used to develop the drug,
e) The prices charged for the drug in other peer countries if available, taking into account rebates, discounts, and other price modifications, and be it further

RESOLVED, that our AMA-MSS advocate that these negotiated prices would be used by all public and private insurance providers unless those providers choose to opt-out; and be it further

RESOLVED, that our AMA-MSS support the imposition of reasonable penalties to enforce pharmaceutical manufacturer compliance with negotiated prices; and be it further

RESOLVED, that our AMA-MSS support a ban on rebates from pharmaceutical manufacturers to pharmacy benefit managers or a requirement that the savings derived from a rebate must be passed on to insurance plan beneficiaries in their entirety.

VRC testimony was supportive of the spirit of Resolution 039, with several suggested amendments. Support was centered around the rising costs of medication in the United States and the desire for a central regulatory body for pricing. Your Reference Committee notes that several of the original asks are out of scope of the MSS as written. The MSS does not have the ability to advocate on behalf of the AMA, or direct the AMA Advocacy staff to act upon certain topics. That remains in the power of the full House of Delegates (HOD).

We appreciate the amendments proffered by several groups; however, we don’t believe any of them fully address all of our concerns. Further, we believe this resolution represents an important and significant policy change which merits greater consideration by our Section’s subject matter experts on the topic. For this reason, we believe that Resolution 039 would benefit from further refinement by the appropriate MSS Standing Committee(s).

Your Reference Committee recommends Resolution 039 be referred.
(59) RESOLUTION 046 – ADDRESSING INEQUITY IN ONSITE WASTEWATER TREATMENT

RECOMMENDATION A:

Policy D-440.924 be reaffirmed in lieu of the first Resolve of Resolution 046.

RECOMMENDATION B:

The remainder of Resolution 046 be referred.

RESOLVED, That our AMA encourages federal, state, and local governments to recognize and address the problem of inadequate onsite wastewater treatment systems in order to reduce the risk of wastewater-related disease; and be it further

RESOLVED, That our AMA encourages federal, state, and local governments to abate financial and criminal penalties for insufficient wastewater management for individuals in order to reduce the perpetuation of systemic poverty and systemic racism.

VRC testimony on Resolution 046 was mixed. Region 4 supported the resolution as written and the Massachusetts delegation supported the resolution with amendments. Region 2 and Region 6 opposed the resolution. The MSS House Coordination Committee (HCC) placed the first resolve clause on the reaffirmation consent calendar. We agree that the first resolve is covered by D-440.924. Additionally, we believe the second resolve clause could benefit from further refinement and study by the appropriate MSS Standing Committee(s). While we recognize that the Committee on Scientific Issues (CSI) and Committee on Global and Public Health (CGPH) just wrote a report for this cycle on filtration of antibiotics in our water system (CSI CGPH Report A), we note that the ask of the resolve clause is different by focusing on criminal penalties for insufficient wastewater management and their relationship to systemic poverty and racism. We hope that the assigned Committee(s) can learn useful background information from CSI CGPH Report A. Your Reference Committee recommends D-440.924 be reaffirmed in lieu of the first resolve clause of Resolution 046 and the remainder of the report be referred.

D-440.924 – UNIVERSAL ACCESS FOR ESSENTIAL PUBLIC HEALTH SERVICES

Our AMA: (1) supports updating The Core Public Health Functions Steering Committee’s “The 10 Essential Public Health Services” to bring them in line with current and future public health practice; (2) encourages state, local, tribal, and territorial public health departments to pursue accreditation through the Public Health Accreditation Board (PHAB); (3) will work with appropriate stakeholders to develop a comprehensive list of minimum necessary programs and services to protect the public health of citizens in all state and local jurisdictions and ensure adequate provisions of public health, including, but not limited to clean water,
functional sewage systems, access to vaccines, and other
public health standards; and (4) will work with the National
Association of City and County Health Officials (NACCHO),
the Association of State and Territorial Health Officials
(ASTHO), the Big Cities Health Coalition, the Centers for
Disease Control and Prevention (CDC), and other related
entities that are working to assess and assure appropriate
funding levels, service capacity, and adequate infrastructure
of the nation's public health system.

RESOLUTION 049 – IMG EXEMPTIONS FROM
IMMIGRATION CAPS AND IMG-SPECIFIC
IMMIGRATION CATEGORY FOR VISAS AND GREEN
CARDS

RECOMMENDATION:

Resolution 049 referred.

RESOLVED, Our AMA-MSS support the implementation of a healthcare worker visa
category specifically for IMGs, which could ease post-visa foreign residence requirements
and allow for appropriate visa travel guidelines to continue patient care; and be it further
RESOLVED, Our AMA-MSS support the creation of broad and accessible IMG-specific
bridge programs between education-based and employment-based visas to increase
retention of J-1 visa recipients who complete medical training in the US; and be it further
RESOLVED, Our AMA-MSS support the implementation of profession-specific or
education-level exemptions for residents and physicians from the annual caps for EB-1,2
green cards and H1-B temporary work visas in order to decrease barriers of non-citizen
International Medical Graduates from practicing in the US.

VRC testimony was limited on Resolution 049. Debate in the Reference Committee was
extensive on this resolution, and ultimately we believe this item could benefit from further
study. We would recommend the Standing Committee(s) assigned to this resolution look
into the impact of including International Medical Students, in addition to International
Medical Graduates (IMGs). We also would recommend that the assigned Committee(s)
reach out to the IMG Section for their input, especially as this is a resolution that would
greatly affect an entire community of physicians whose experiences US medical students
may not understand, and we are wary of unintended consequences. The assigned
Committee(s) could also evaluate whether this might be suited for an external resolution
to our House of Delegates in collaboration with the IMG Section. Your Reference
Committee recommends that Resolution 049 be referred.
(61) **RESOLUTION 060 – PROMOTION AND SUPPORT OF PHYSICIAN, STUDENT AND PATIENT PARTICIPATION IN GOVERNMENT ELECTIONS**

**RECOMMENDATION:**

Resolution 060 be referred.

RESOLVED, That our AMA recognize voting as a dimension of public health; and be it further

RESOLVED, That our AMA formally support non-partisan voter registration in healthcare settings; and be it further

RESOLVED, That our AMA promote civic engagement among its members through actions, including, but not limited to:

a) Partnering with Civic Health Month or another stakeholder at the crossroads of civic engagement and health
b) Disseminating non-partisan election information for national elections to its members
c) Encourage its members to identify patients who may require additional assistance to vote in national elections; and be it further

RESOLVED, That our AMA encourage medical schools and entities employer healthcare professional to target and facilitate 100% eligible employee voter registration and participation.

VRC testimony on Resolution 060 was mixed. Region 1 and the Committee on Legislation and Advocacy (COLA) supported the resolution as written and the Massachusetts delegation supported the resolution with amendments. The Section Delegates noted that there are already a number of voting-related resolutions authored by the MSS currently in our transmittal queue. Your Reference Committee had extensive debate on this resolution, and while we agree that this is an important topic that should be addressed by the MSS, we believe that the language in Resolution 060 would benefit from further study and refinement by our MSS Standing Committees. We recommend Resolution 060 be referred.

(62) **RESOLUTION 080 – MENTAL HEALTH REFORM IN PRISONS**

**RECOMMENDATION A:**

Policy H-430.986 be reaffirmed in lieu of the first Resolve of Resolution 080.

**RECOMMENDATION B:**

The second Resolve of Resolution 080 be referred.
RESOLVED, The AMA encourages an increase access to mental health care for inmates by requiring prison systems to adopt a national standard for mental health screening and sharing mental health diagnoses between authorized medical professionals and the criminal justice system, while adhering to national standards on patient data privacy and protection; and be it further

RESOLVED, The AMA supports conducting mental health screening of all individuals entering or reentering the prison system in order to improve diversion practices as well as treatment access.

There was limited testimony on the VRC for Resolution 080, with support from the Committee on Global and Public Health (CGPH) and the Massachusetts delegation. The House Coordination Committee (HCC) recommend H-430.986 be reaffirmed in lieu of the first resolve, and the Section Delegates recommend that the second resolve be referred for further study. We agree with this testimony and recommend the first resolve of Resolution 080 be added to the reaffirmation calendar and the second resolve be referred for study.

H-430.986 – HEALTH CARE WHILE INCARCERATED

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 states 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. 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. 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. 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. 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.

(63) CSI REPORT A – AMEND H-150.927 AND H-150.933, TO INCLUDE FOOD PRODUCTS WITH ADDED SUGAR

RECOMMENDATION:

Recommendations from CSI Report A be referred.

Your Committee on Scientific Issues recommends that the following original resolve clauses be amended as follows, and the remainder of the report is filed:

RESOLVED, That our AMA amend H-150.927, “Strategies to Reduce the Consumption of Beverages with Added Sweeteners” by addition to read as follows:

Strategies to Reduce the Consumption of Food and Beverages with Added Sweeteners, H-150.927

Our AMA: (1) acknowledges the adverse health impacts of sugar-sweetened beverage (SSB) consumption and food products with added sugars, and support evidence-based strategies to reduce the consumption of SSBs and food products with added sugars, including but not limited to, excise taxes on SSBs and food products with added sugars, removing options to purchase SSBs and food products with added sugars in primary and secondary schools, the use of warning labels to inform consumers about the health consequences of SSB consumption and food products with added sugars, and the use of plain packaging; (2)
encourages continued research into strategies that may be effective in limiting SSB consumption and food products with added sugars, such as controlling portion sizes; limiting options to purchase or access SSBs and food products with added sugars in early childcare settings, workplaces, and public venues; restrictions on marketing SSBs and food products with added sugars to children; and changes to the agricultural subsidies system; (3) encourages hospitals and medical facilities to offer healthier beverages, such as water, unflavored milk, coffee, and unsweetened tea, for purchase in place of SSBs and apply calorie counts for beverages in vending machines to be visible next to the price; and (4) encourages physicians to (a) counsel their patients about the health consequences of SSB consumption and food products with added sugars and replacing SSBs and food products with added sugars with healthier beverage and food choices, as recommended by professional society clinical guidelines; and (b) work with local school districts to promote healthy beverage and food choices for students.

RESOLVED, That our AMA amend H-150.933, “Taxes on Beverages with Added Sweeteners” by addition to read as follows:

1. Our AMA recognizes the complexity of factors contributing to the obesity epidemic and the need for a multifaceted approach to reduce the prevalence of obesity and improve public health. A key component of such a multifaceted approach is improved consumer education on the adverse health effects of excessive consumption of beverages and food products containing added sweeteners. Taxes on beverages and food products with added sweeteners are one means by which consumer education campaigns and other obesity related programs could be financed in a stepwise approach to addressing the obesity epidemic.

2. Where taxes on beverages and food products with added sweeteners are implemented, the revenue should be used primarily for programs to prevent and/or treat obesity and related conditions, such as educational ad campaigns and improved access to potable drinking water, particularly in schools and communities disproportionately affected by obesity and related conditions, as well as on research into population health outcomes that may be affected by such taxes.

3. Our AMA will advocate for continued research into the potentially adverse effects of long-term consumption of non-
caloric sweeteners in beverages and food products, particularly in children and adolescents.

4. Our AMA will: (a) encourage state and local medical societies to support the adoption of state and local excise taxes on sugar-sweetened beverages and food products, with the investment of the resulting revenue in public health programs to combat obesity; and (b) assist state and local medical societies in advocating for excise taxes on sugar-sweetened beverages and food products as requested.

We thank the authors of CSI Report A on their work thus far. We found CSI Report A to be well-written and incredibly detailed, and we agree with their conclusions, but still have concerns over the nuances of presenting this recommendation to our House of Delegates (HOD). We agree that there is robust evidence suggesting foods with added sugar negatively impact health and a paucity of evidence that increased taxes on foods with added sugars decreases consumption of these foods or improves health significantly.

We similarly question if raising taxes, and thus the overall price, of foods with added sugars would negatively impact those with lower socioeconomic status (SES). Since these communities often lack access to healthy, organic food products, raising the cost of foods with added sugar may not lead to a substitution of healthier food, as that may not be a choice for some communities especially as foods—even those with added sugars—may play a more essential role in household meals than SSBs. It may just result in higher costs for foods, but no expanded healthy options. We agree with CSI that other strategies to reduce consumption of these foods are more appropriate.

Your Reference Committee noticed that the way our current AMA policy is written indicates support for taxation in both of the policies being amended. Even though CSI struck the second resolve clause of the original resolution (amending H-150.933) to avoid supporting food taxation, the addition of foods with added sugars alongside SSBs at each point in the first resolve clause (amending H-150.927) still indicates that the AMA would support food taxation (“excise taxes on SSBs and food products with added sugars”). Your Reference Committee struggled with how best to account for this language and ensure that we maintain our AMA’s support for SSB taxation, but explicitly note our lack of support for food taxation, so that this is not misinterpreted by our House of Delegates in debate and eventually our Board of Trustees in implementation. This could be accomplished in a number of ways, from striking the redundant phrasing on “excise taxes” in H-150.927 to explicitly stating our lack of support for food taxation in a separate clause to writing a separate policy altogether on strategies to reduce consumption of foods with added sugars specifically, with a structure similar to H-150.927.

Your Reference Committee asks the Committee on Scientific Issues (CSI) to reconvene and discuss the best language to progress this forward to our House of Delegates, to ensure that your commendable work in this report is represented accurately in AMA advocacy. We recommend CSI Report A be referred.
(64) CEQM REPORT A – SUPPORT OF RESEARCH ON
VISION SCREENINGS AND VISUAL AIDS FOR ADULTS
COVERED BY MEDICAID

RECOMMENDATION:

The Recommendation from CEQM Report A be referred.

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

RESOLVED, That our AMA work with the Centers for Medicare and Medicaid Services
(CMS) appropriate scientific and medical to evaluate the value and feasibility of
incorporating routine comprehensive eye exams and visual aids into the minimum
mandatory benefits for Medicaid beneficiaries.

We thank the authors of CEQM Report A for their work thus far. Your Reference
Committee questions the references cited and asks the Committee to re-visit the
literature to review this topic in more detail and perhaps provide additional and more up-
to-date references, including further scientific research and evidence-based analyses
from the last five years on the benefits of routine vision care.

We appreciate that this recommendation translates the original resolve clause to be
more actionable, by turning to CMS as presumably the most appropriate funder and data
source for any self-initiated or contracted analysis in this area, rather than our AMA
encouraging research efforts at large. However, we would also appreciate more
discussion of the pros and cons, both health and economic, of including routine vision
care in Medicaid benefits. We recommend CEQM Report A be referred for further
clarification and refinement.

(65) CSI CHIT REPORT A – INVESTIGATING THE
IMPLEMENTATION OF ELECTRONIC IMMUNITY
PASSPORTS FOR COVID-19 AND PUBLIC HEALTH
EMERGENCIES

RECOMMENDATION:

Recommendations from CSI CHIT Report A be referred.

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

RESOLVED, Our AMA amend policy H-20.901, HIV, Immigration, and Travel Restrictions,
to reflect important changes to international travel restrictions and potentially
discriminatory practices in the midst of a public health emergency:

HIV—Opposition to medically unfounded Immigration,
Asylum, and Travel Restrictions, H-20.901
Our AMA recommends that: (1) decisions on testing and exclusion of immigrants to the United States be made only by the U.S. Public Health Service, based on the best available medical, scientific, and public health information; (2) non-immigrant travel into the United States not be restricted because of HIV or other infectious/ non-infectious disease status unless warranted according to the U.S. Public Health service; and (3) confidential medical information, such as HIV and/or other infectious/ non-infectious disease status, not be indicated on a passport or visa document without a valid medical purpose.

; and be it further

RESOLVED, Our AMA-MSS immediately forward this recommendation to the AMA-HOD as an addition to resolution 315.008MSS.

VRC testimony was limited on CSI CHIT Report A. If passed at the June 2021 MSS Assembly meeting the Section Delegates recommended adding this to a pending transmittal. While we appreciate the timeliness of this topic, we believe the report could benefit from further research and refinement before being sent to the House of Delegates (HOD). There are concerns that vaccine passports could affect the rights of citizens and negatively impact some communities over others. As the report notes, complex issues exist regarding access, equity and trust/mistrust that need to be fully considered. However, we also recognize that many physicians are now supportive of vaccine passports, even while they opposed natural immunity passports, and that considering these differences more closely—and the possible, specific conditions under which a vaccine passport might be acceptable—is of high importance.

We are concerned that the recommendations in this report could potentially conflict with CDC guidelines or state laws, limit the advocacy our AMA can exercise on this topic by deferring to the U.S. Public Health Service (USPHS), leaves the potential conditions under which such passports may be acceptable too vague (“unless warranted,” “valid medical purpose”), or potentially impact whether or not the 2021 November 2021 AMA Meeting is held in person or virtually.

In light of all of these concerns, we recommend holding the pending transmittal of 315.008MSS to add whatever recommendations come of this report after the Committees reconvene to discuss further. Given the variety of debate heard on this report and the limited research available to support these asks, your Reference Committee recommends CSI CHIT Report A be referred for study.
RECOMMENDED FOR NOT ADOPTION

(66) RESOLUTION 016 – MEDICARE ELIGIBILITY FOR INSULIN-DEPENDENT PATIENTS

RECOMMENDATION:

Resolution 016 not be adopted.

RESOLVED, That our AMA will support legislation that would add insulin-dependence as an eligibility criterion for Medicare.

VRC testimony was broadly opposed to Resolution 016. The Committee on Legislation and Advocacy (COLA), Region 2, and the Section Delegates opposed the resolution as written. The Massachusetts delegation supported the resolution. Feedback from The Endocrine Society noted that there are other avenues to reduce insulin costs besides Medicare Eligibility. The addition of a new condition to Medicare eligibility alongside ESRD and ALS (which both have additional requirements) is a substantial ask, and AMA Advocacy questioned why this resolution would expand Medicare eligibility for insulin-dependent diabetes, but not a range of other chronic conditions.

Medicare eligibility for individuals below 65 with chronic conditions is primarily based on an individual’s disability status due to those conditions. AMA Advocacy noted that if someone with diabetes did experience significant disability (such as inability to work or care for themselves), they could potentially qualify for Social Security Disability Insurance (SSD) and subsequently be eligible for Medicare. We appreciate the spirit of the resolution and would recommend that the authors collaborate with The Endocrine Society on these other initiatives and perhaps submit another resolution in the future. We also point out that an MSS resolution on caps on insulin copayments was adopted by our MSS Assembly as 100.026MSS at the November 2020 Special Meeting and is pending transmittal to the House of Delegates (HOD), as is a similar resolution from the Texas Delegation to HOD, originally authored by MSS members of the Texas Medical Association. Your Reference Committee recommends Resolution 016 not be adopted.

(67) RESOLUTION 042 – MEDICAL STUDENT, RESIDENT, AND FELLOW SUICIDE REPORTING

RECOMMENDATION:

Resolution 042 not be adopted.

RESOLVED, That the following policy be amended as follows:

Study of Medical Student, Resident, and Physician Suicide D-345.983

Our AMA will: (1) explore the viability and cost-effectiveness of regularly collecting National Death Index (NDI) data and confidentially maintaining manner of death information for
physicians, residents, and medical students listed as deceased in the AMA Physician Masterfile for long-term studies; (2) monitor progress by the Association of American Medical Colleges and the Accreditation Council for Graduate Medical Education (ACGME) to collect data on medical student and resident/fellow suicides to identify patterns that could predict such events; (3) support the education of faculty members, residents and medical students in the recognition of the signs and symptoms of burnout and depression and supports access to free, confidential, and immediately available stigma-free mental health and substance use disorder services; and (4) collaborate with other stakeholders to study the incidence of and risk factors for depression, substance misuse and addiction, and suicide among physicians, residents, and medical students; and (5) that our AMA work with appropriate stakeholders to develop a standardized reporting mechanism and publicly accessible database, stratified by institution, to include pertinent suicide information of trainees in medical schools, residency, and fellowship programs, to inform and promote meaningful mental health and wellness interventions in these populations.

VRC testimony on Resolution 042 was mixed. Region 1, Region 2, Region 4, the Committee on Medical Education (CME), and the Massachusetts delegation supported the resolution. The MSS liaison to the Council on Medical Education, the MSS Section Delegates, and Region 6 opposed the resolution due to privacy concerns of institutionally stratified data and potential inadvertent consequences.

Your Reference Committee believes that this is an issue of the utmost importance; however, we agree with your CME Councilor and Region 6 about the privacy concerns. We discussed possibilities to stratify this data while keeping privacy intact, but did not find a feasible way to do so. We also raise the concern of perverse incentives – medical schools, residencies and/or fellowship programs may choose not to release this data if it negatively impacts the number of applicants to their programs, and it may also result in further discrimination against students who might be at higher risk of suicide, including students with any psychiatric diagnosis. Additionally, some fellowship programs are highly specialized with only a handful of positions in each state or region, which would prohibit stratification there as well.

We appreciate the intent of this resolution, but don’t think it would be feasible or actionable. There were amendments to strike “stratified by institution,” but we believe stratification is the novel part of the ask. Without it, the ask is covered in existing policy. Your Reference Committee recommends that Resolution 042 not be adopted.
(68) RESOLUTION 043 – GENERATION OF CPT CODES
FOR TIME SPENT ON PRIOR AUTHORIZATION TO
BETTER APPRECIATE PHYSICIAN BURDEN

RECOMMENDATION:

Resolution 043 not be adopted.

RESOLVED, That, in conjunction with our AMA’s important work to reform the PA process, our AMA work with the CPT Editorial Panel for the development of new, standardized, CPT codes related to clinician time spent on the prior authorization process; and be it further

RESOLVED, That current AMA policy be amended as follows to better reflect the effect of the prior authorization process on clinicians:

Prior Authorization and Utilization Management Reform, H-320.939
3. Our AMA supports efforts to track and quantify the impact of health plans’ prior authorization and utilization management processes on patient access to necessary care and patient clinical outcomes, including the extent to which these processes contribute to patient harm, as well as the impact on physician administrative burden and the costs associated, both to individual physicians and to the healthcare sector as a whole.

VRC testimony was mixed on Resolution 043. Region 1 and the Massachusetts delegation supported this resolution. The MSS House Coordination Committee (HCC) did not place this resolution on the Reaffirmation Consent Calendar, however the Massachusetts delegation highlighted that this ask may already be covered in H-385.391. The Committee on Economics and Quality in Medicine (CEQM) supported the resolution with amendments. The MSS Section Delegates mentioned that the newly formed Private Practice Physician Section (PPPS) is bringing forward a similar resolution and cautioned against the MSS bringing forth a resolution on which we have little personal experience compared to practicing physicians. We considered the possibility of amending the resolves to create internal MSS policy and then support the PPPS resolution whenever it is introduced in our House of Delegates, but additional AMA staff comments gave us pause.

The AMA is extremely active in the fight to improve and ultimately remove prior authorizations. Your Reference Committee believes the first resolve is novel, however we note that this was already studied by the Council on Medical Service in 2017. The report concluded that advocating for reimbursement for time spent on prior authorization divided advocacy focus and may actually legitimize the prior authorization process, when the goal is to reduce, if not completely eliminate them. For these reasons, we recommend Resolution 043 not be adopted.
(69) RESOLUTION 047 – OPPOSE ONEROUS AND STRINGENT LIMITATIONS ON MEDICAL CLEARANCES

RECOMMENDATION:

Resolution 047 not be adopted.

RESOLVED, That our AMA encourages the primacy of physician authority to review and evaluate medical clearance policy and procedures covering pre-employment, credentialing, or other phases of physician evaluation to ensure accuracy and fairness.

RESOLVED, That our AMA supports the development of evidence-based guidelines to prevent onerous and stringent limitations on those with controlled pre-existing medical conditions in careers requiring medical clearance.

RESOLVED, That our AMA encourages regulations that facilitate individuals in careers with medical clearances to seek mental or physical health care when appropriate.

Testimony on the VRC was mixed on Resolution 047. The Massachusetts delegation and the Committee on Economics and Quality in Medicine wanted to refer this resolution for study. The Section Delegates were opposed to Resolution 047 as written. However, the most compelling testimony was from the American College of Occupational & Environmental Medicine, American College of Preventive Medicine, and Aerospace Medicine. These specialty societies were strongly opposed to the resolution and thought it was inappropriate. Feedback from the American College of Occupational and Environmental Medicine suggested that the asks of this resolution “disregards the importance of public health and public safety as part of the intent of clearances.” The American College of Preventive Medicine suggested that Resolution 047 “shows a lack of understanding about occupational standards.” Although the Reference Committee was supportive of the spirit of the resolution, we found this testimony very compelling.

However, these specialty societies were happy to hear medical students were interested in this topic and offered to work with these authors, and any others who may be interested in this topic, on future resolutions and research. We recommend that the authors be put in contact with these societies and that Resolution 047 not be adopted.

(70) RESOLUTION 048 – IMPLEMENTING PICTORIAL HEALTH WARNINGS ON ALCOHOLIC BEVERAGES FOR SALE IN CONTAINERS

RECOMMENDATION:

Resolution 048 not be adopted.

RESOLVED, That our American Medical Association (AMA) will advocate for the implementation of pictorial health warnings on alcoholic beverages for sale in containers; and be it further

RESOLVED, That our AMA will amend Policy H-30.940 “AMA Policy Consolidation: Labeling Advertising, and Promotion of Alcoholic Beverages” as follows:
AMA Policy Consolidation: Labeling Advertising, and Promotion of Alcoholic Beverages H-30.940
1. (a) Supports accurate and appropriate labeling disclosing the alcohol content of all beverages, including so-called "nonalcoholic" beer and other substances as well, including over-the-counter and prescription medications, with removal of "nonalcoholic" from the label of any substance containing any alcohol; (b) supports efforts to educate the public and consumers about the alcohol content of so-called "nonalcoholic" beverages and other substances, including medications, especially as related to consumption by minors; (c) urges the Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF) and other appropriate federal regulatory agencies to continue to reject proposals by the alcoholic beverage industry for authorization to place beneficial health claims for its products on container labels; and (d) urges the development of federal legislation to require nutritional labels on alcoholic beverages in accordance with the Nutritional Labeling and Education Act; and (e) advocates for pictorial warnings on the hazards of alcohol consumption by specific population groups especially at risk, such as pregnant women, as well as the dangers of irresponsible use to all sectors of the populace.

VRC testimony on Resolution 048 was mixed. The Massachusetts delegation and the Committee on Economics and Quality in Medicine (CEQM) recommended referral for further study. The Section Delegates opposed this resolution as written. Your Reference Committee did not believe there was enough evidence supporting these asks and recommend that Resolution 048 not be adopted.

RESOLUTION 050 – IMPROVING PANDEMIC PREPAREDNESS IN THE PRECLINICAL YEARS

RECOMMENDATION:

Resolution 050 not be adopted.

RESOLVED, That our AMA encourages the introduction of co-curricular training and certification in vaccine administration, preparation, and storage across all accredited U.S. medical schools in the preclinical years; and be it further

RESOLVED, That our AMA encourages the cultivation of relationships between hospitals, health departments, pandemic response teams, and any other relevant stakeholders with local medical schools to establish a volunteer network of medical students.

VRC testimony was mostly opposed to Resolution 050. The Committee on Medical Education (CME), Committee on Global and Public Health (CGPH), and the Councilor on Medical Education opposed this resolution as written. The CME Councilor notes that the Council on Medical Education introduced an informational report (CME Report 4) at the
November 2020 HOD meeting regarding the impact of the COVID-19 pandemic across medical education, which addresses the concerns of this resolution. Your Reference Committee recommends Resolution 050 not be adopted.

(72) RESOLUTION 051 – PROMOTING ORAL ANTICANCER DRUG PARITY

**RECOMMENDATION:**

Resolution 051 not be adopted.

RESOLVED, That our AMA advocates for patient cost sharing for oral and other self-administered anticancer drugs that is no less favorable than for traditional IV medication administered in an office setting. Testimony on the VRC noted that this is a very niche topic that would be better introduced by an oncology specialty society. Your Reference Committee agrees and recommends that the authors collaborate with the appropriate specialty societies and Resolution 051 not be adopted.

(73) RESOLUTION 063 – ADVOCATING FOR TAX INCENTIVES TO PROMOTE FOOD RECYCLING PROGRAMS AND TO REDUCE FOOD WASTE TO IMPROVE HEALTH

**RECOMMENDATION A:**

G-630.135 be reaffirmed in lieu of the first and third Resolve clauses of Resolution 063.

**RECOMMENDATION B:**

The remainder of Resolution 063 not be adopted.

RESOLVED, That our American Medical Association (AMA) will advocate for tax incentives to promote the implementation of food recycling programs nationally; and be it further

RESOLVED, That our AMA will provide guidelines for safe recovery, donation, and distribution of food; and be it further

RESOLVED, That our AMA will amend Policy G-630.135 “Eliminating Food Waste Through Recovery” as follows:

Eliminating Food Waste Through Recovery, G-630.135

(1) consider sustainability and mitigation of food waste in vendor and venue selection

(2) encourage vendors and relevant third parties to practice sustainability and mitigate food waste through donations

(3) Advocate for a coordinated national effort on combating food waste
(4) Support sustainability and mitigation of food waste at a national level via food recovery programs.

VRC testimony broadly opposed Resolution 063. Region 1, Region 2, the Committee on Legislation and Advocacy (COLA), the Committee on Economics and Quality in Medicine (CEQM) opposed the resolution as written. The MSS Government Relations and Advocacy Fellow (GRAF) provide testimony from multiple divisions of our AMA’s Advocacy Business Unit that opposed the resolution and cited that it was out of scope. The Massachusetts delegation and the Section Delegates proffered amendments. The House Coordination Committee (HCC) placed the first and third resolve clauses on the reaffirmation calendar, and we agree that these asks are already covered by G-130.135. After looking at the remaining resolve clause, we agree that it is out of scope for the AMA to “provide guidelines for safe recovery, donation and distribution of food.” Therefore, your Reference Committee recommends G-130.135 be reaffirmed in lieu of the first and third resolve clauses and the remainder of Resolution 063 not be adopted.

G-630.135 – ELIMINATING FOOD WASTE THROUGH RECOVERY
Our AMA will: (1) consider sustainability and mitigation of food waste in vendor and venue selection; and (2) encourage vendors and relevant third parties to practice sustainability and mitigate food waste through donations.

(74) RESOLUTION 065 – ADVOCATING FOR PLANT-BASED MEAT RESEARCH AND REGULATION

RECOMMENDATION:

Resolution 065 not be adopted.

RESOLVED, That our AMA supports plant-based meat research; and be it further RESOLVED, That our AMA supports federal regulation and oversight of plant-based meat producers.

VRC testimony was broadly supportive of Resolution 065, highlighting that this ask was novel. The Committee on Legislation and Advocacy (COLA) and the Massachusetts delegation supported the resolution, while the Section Delegates proposed an amendment to include lab-grown meats. However, your Reference Committee does not feel that the whereas clauses sufficiently support an ask for lab-grown meat, since this resolution is focused on the potential health benefits of plant-based meat which may not be seen in lab-grown meat, and decided not to consider that amendment.

We appreciate the authors bringing forward a resolution on an interesting and novel topic, but we are not sure these asks are addressing a problem at this time. We are concerned that the first resolve clause would not lead to significant action on the part of the AMA. For the second resolve clause, we considered that the AMA does have policy about regulating meat and seafood so there is precedent for support of regulations; however, we did not find that this issue falls under that umbrella, as meat and seafood are known to cause serious infections, if improperly handled. We are not convinced that risk exists with plant-
based meat, and believe the second ask to be well covered under general federal
regulation of food production. We commend the authors’ intentions, but believe the
resolution as written would have minimal impact on AMA advocacy at this time, and would
recommend the authors consider re-submitting with more actionable proposals, such as
couraging the use of plant-based meats or advocating for efforts to increase its nutrient
diversity and promote it publicly. For these reasons, we recommend Resolution 065 not
be adopted.

(75) RESOLUTION 066 – PROPOSED CHANGE IN MENTAL
HEALTH REPORTING AND TREATMENT OF PILOTS TO
THE FAA

RECOMMENDATION:

Resolution 066 not be adopted.

RESOLVED, That our AMA opposes mandatory disclosure of anxiety and depression of
pilots in the absence of severe symptoms that currently impair his/her judgement or would
adversely affect the safety of individuals to the Federal Aviation Administration; and be it
further

RESOLVED, That our AMA advocates for pilots to seek mental health treatment while
eliminating detrimental repercussions from the Federal Aviation Administration; and be it
further

RESOLVED, That our AMA advocates for an expanded selection of therapy for these
mental health disorders among pilots beyond SSRI monotherapy; and be it further

RESOLVED, That our AMA advocates for removing the requirement of pilots to have no
history of psychosis, suicidal ideation, electroconvulsive therapy; and be it further

RESOLVED, That our AMA advocates for removing the requirement of pilots to have no
history of treatment with multiple SSRIs.

VRC testimony was supportive of the spirit of Resolution 066, however your Reference
Committee did not find that the resolve clauses were supported by the whereas clauses.
Due to the nature of this topic, we think it would be important to solicit feedback from
relevant specialty societies. Please see feedback from Resolution 047 to understand
these concerns. A resolution on this topic may be best proposed by one of these specialty
societies, as this may not fall within the expertise of the AMA-MSS. We also note that this
issue came up at the HOD at I-17 and did not move forward. (Please reference BOT
Report 7 and the I-17 HOD Reference Committee Report for further information.) We
recommend Resolution 066 not be adopted.
RESOLUTION 070 – USE OF SITUATIONAL JUDGMENT AND PERSONALITY ASSESSMENTS IN MEDICAL SCHOOL ADMISSIONS

RECOMMENDATION A:


RECOMMENDATION B:

The remainder of Resolution 070 not be adopted.

RESOLVED, That our AMA study the use of situational judgment and personality assessments in medical school admissions, and issue a recommendation on whether they a) provide significant value to the process, and b) if found valuable, issue a recommendation on whether or not transparent release of results to applicants would compromise their value; and be it further:

RESOLVED, That our AMA encourage medical schools that require these assessments to be considered for admission to assume the associated costs themselves, rather than passing the expenses to applicants.

VRC testimony was mixed on Resolution 070. Region 1 and Region 2 opposed the resolution as written. The Massachusetts delegation and the Committee on Medical Education (CME) supported the spirit, but proffered amendments to address their concerns. We found the testimony from Region 2 compelling. While we agree that incurring additional costs in medical school is frustrating, and the use of these personality assessments is questionable, we find that the ultimate asks of this resolutions are not feasible and out of scope. Like CME, we also questioned why the authors chose to focus on this particular cost in the medical school admissions process, which at $12 is relatively low for prospective applicants compared to other components such as MCAT and application fees, even if this ask is unfeasible for the AMA in general.

The first resolve clause of this resolution was placed on the reaffirmation consent calendar by the House Coordination Committee (HCC). We agree with this decision and we do not feel as if the whereas clauses provided enough evidence for the second resolve clause to stand on its own. Therefore, your Reference Committee recommends H-295.975, H-295.888, and H-295.961 be reaffirmed in lieu of the first resolve clause and the remainder of Resolution 070 not be adopted.

H-295.975 – EDUCATING COMPETENT AND CARING HEALTH PROFESSIONALS

(1) Programs of health professions education should foster educational strategies that encourage students to be independent learners and problem-solvers. Faculty of programs of education for the health professions should ensure that the mission statements of the institutions in
which they teach include as an objective the education of practitioners who are both competent and compassionate.

(2) Admission to a program of health professions education should be based on more than grade point average and performance on admissions tests. Interviews, applicant essays, and references should continue to be part of the application process in spite of difficulties inherent in evaluating them. Admissions committees should review applicants’ extra-curricular activities and employment records for indications of suitability for health professions education. Admissions committees should be carefully prepared for their responsibilities, and efforts should be made to standardize interview procedures and to evaluate the information gathered during interviews. Research should continue to focus on improving admissions procedures. Particular attention should be paid to improving evaluations of subjective personal qualities.

(3) Faculty of programs of education for the health professions must continue to emphasis than they have in the past on educating practitioners who are skilled in communications, interviewing and listening techniques, and who are compassionate and technically competent. Faculty of health professions education should be attentive to the environment in which education is provided; students should learn in a setting where respect and concern are demonstrated. The faculty and administration of programs of health professions education must ensure that students are provided with appropriate role models; whether a faculty member serves as an appropriate role model should be considered when review for promotion or tenure occurs. Efforts should be made by the faculty to evaluate the attitudes of students toward patients. Where these attitudes are found lacking, students should be counseled. Provisions for dismissing students who clearly indicate personality characteristics inappropriate to practice should be enforced.

(4) In spite of the high degree of specialization in health care, faculty of programs of education for the health professions must prepare students to provide integrated patient care; programs of education should promote an interdisciplinary experience for their students.

H-295.888 – PROGRESS IN MEDICAL EDUCATION: THE MEDICAL SCHOOL ADMISSION PROCESS
1. Our AMA encourages: (A) research on ways to reliably evaluate the personal qualities (such as empathy, integrity, commitment to service) of applicants to medical school and support broad dissemination of the results. Medical schools should be encouraged to give significant weight to these qualities in the admissions process; (B) premedical coursework in the humanities, behavioral sciences, and
social sciences, as a way to ensure a broadly educated applicant pool; and (C) dissemination of models that allow medical schools to meet their goals related to diversity in the context of existing legal requirements, for example through outreach to elementary schools, high schools, and colleges.

2. Our AMA: (A) will continue to work with the Association of American Medical Colleges (AAMC) and other relevant organizations to encourage improved assessment of personal qualities in the recruitment process for medical school applicants including types of information to be solicited in applications to medical school; (B) will work with the AAMC and other relevant organizations to explore the range of measures used to assess personal qualities among applicants, including those used by related fields; (C) encourages the development of innovative methodologies to assess personal qualities among medical school applicants; (D) will work with medical schools and other relevant stakeholder groups to review the ways in which medical schools communicate the importance of personal qualities among applicants, including how and when specified personal qualities will be assessed in the admissions process; (E) encourages continued research on the personal qualities most pertinent to success as a medical student and as a physician to assist admissions committees to adequately assess applicants; and (F) encourages continued research on the factors that impact negatively on humanistic and empathetic traits of medical students during medical school.

H-295.961 – MEDICOLEGAL, POLITICAL, ETHICAL AND ECONOMIC MEDICAL SCHOOL COURSE
(1) The AMA urge every medical school and residency program to teach the legal, political, ethical, and economic issues which will affect physicians. (2) The AMA will work with state and county medical societies to identify and provide speakers, information sources, etc., to assist with the courses. (3) An assessment of professional and ethical behavior, such as exemplified in the AMA Principles of Medical Ethics, should be included in internal evaluations during medical school and residency training, and also in evaluations utilized for licensure and certification. (4) The Speaker of the HOD shall determine the most appropriate way for assembled physicians at the opening sessions of the AMA House of Delegates Annual and Interim Meetings to renew their commitment to the standards of conduct which define the essentials of honorable behavior for the physician, by reaffirming or reciting the seven Principles of Medical Ethics which constitute current AMA policy. (5) There should be attention to subject matter related to ethics and to the doctor-patient relationship at all levels of medical
education: undergraduate, graduate, and continuing. Role modeling should be a key element in helping medical students and resident physicians to develop and maintain professionalism and high ethical standards. (6) There should be exploration of the feasibility of improving an assessment of ethical qualities in the admissions process to medical school. (7) Our AMA pledges support to the concept that professional attitudes, values, and behaviors should form an integral part of medical education across the continuum of undergraduate, graduate, and continuing medical education.

(77) RESOLUTION 075 – PROVIDING PATIENT ACCESS TO TRANSCRANIAL MAGNETIC STIMULATION FOR MENTAL HEALTH

RECOMMENDATION:

Resolution 075 **not be adopted.**

RESOLVED that our AMA support research initiatives that further investigate the efficacy of Repetitive Transcranial Magnetic Stimulation (rTMS) as a routine treatment for Major Depressive Disorder and other psychiatric disorders that it has been proven to be effective for; and be it further,

RESOLVED, that our AMA encourage the Centers for Medicare and Medicaid and private payer insurance organizations to lower the threshold for rTMS coverage for major depressive disorder and other approved psychiatric disorders.

VRC testimony on Resolution 075 was mixed. Region 1 supported the resolution with amendments. The Committee on Bioethics and Humanities (CBH), the Committee on Economics and Quality in Medicine (CEQM), and the Massachusetts delegation supported the resolution as written and the Section Delegates opposed the resolution coming from the MSS, as they believe the American Psychiatric Association (APA) would be a more appropriate delegation to bring forward a resolution on this topic.

We note that the resolve clauses are contradictory in both supporting research and encouraging easier coverage of a treatment modality and would agree with the Section Delegates that this would be more appropriate coming from APA, if they chose to bring it forward to our House of Delegates (HOD). We found the phrase “lower the threshold” particularly problematic, as this would be a moving target and would not necessarily create lasting policy. We also question why we are singling out rTMS and not including other more novel treatment options, such as ECT, that have similarly high thresholds for insurance coverage and which is also generally used for treatment-resistant depression after failed pharmacological trials. While we considered amending the resolve to be internal MSS policy, significant concerns were also raised over the MSS taking a stance on an issue that may be seen as akin to clinical decision-making, which would be out of our scope as medical students even though many of us are sympathetic to the asks. We were also unsure if the asks accurately align with current APA clinical guidelines on rTMS.
Your Reference Committee would recommend the authors reach out to APA for input and collaboration. At this time, your Reference Committee recommends Resolution 075 not be adopted.

(78) RESOLUTION 077 – ADDRESSING HEALTHCARE DISPARITIES THROUGH PERSONALIZED MEDICINE AND IMPROVED REPRESENTATION OF ALL POPULATIONS IN HEALTHCARE EDUCATION AND TRAINING

RECOMMENDATION:

Resolution 077 not be adopted.

RESOLVED, The AMA supports ophthalmology education including a more diverse group of patient presentations since the relative hue in retina color seen amongst different ethnicities can make diagnoses difficult in an inexperienced practitioner; and be it further

RESOLVED, The AMA supports pharmaceutical treatment transitioning from a generalized to a more personalized approach since studies have demonstrated differences in drug pharmacodynamics amongst various populations; and be it further

RESOLVED, The AMA supports the development of personalized medicine and genetic testing as an avenue to improve patient outcomes and take into account differences in drug pharmacodynamics.

VRC testimony broadly opposed Resolution 077 as written. The Massachusetts delegation opposed, and suggested that overarching policy towards racial essentialism and addressing diversity in medical education has already been undertaken at recent meetings. The Committee on Medical Education (CME) also stated that policies on racial essentialism (namely D-350.981, 295.081MSS, and H-350.974) supersede the asks presented in this resolution. The Committee on Economics and Quality in Medicine (CEQM) generally opposed the resolution and Region 6 opposed the resolution as written stating that the resolve clauses are not cohesive.

We found all this testimony compelling and agree that the resolve clauses are not cohesive. We also argue that some of the whereas clauses are actually contradictory to existing policy on racial essentialism. Overall, your Reference Committee found the evidence supporting these resolves lacking. While we did find the first resolve clause about retinal differences interesting, we did not feel there was enough evidence presented to support this resolve and the inclusion of ophthalmology education specifically, as the majority of the whereas clauses were about precision medicine in general. We believe the broad topic of racial essentialism is sufficiently covered by existing policy and the specificity of this resolution was not well-supported by the whereas clauses and references presented. Therefore, your Reference Committee recommends Resolution 077 not be adopted.
RECOMMENDATION A:

Policies D-305.984 and H-305.925 be reaffirmed in lieu of the first and third Resolves of Resolution 081.

RECOMMENDATION B:

The remainder of Resolution 081 not be adopted.

RESOLVED, our AMA support policies that ease debt burden on unmatched medical students; and further be it

RESOLVED, our AMA advocate for one year suspension of interest on student loans for US MD and DO medical students that are unsuccessful in the Match and SOAP on their first attempt; and further be it

RESOLVED, our AMA investigate potential ways to relieve debt burden in unmatched medical students.

VRC testimony was mixed, but broadly opposed Resolution 081. Region 2, The Committee on Medical Education (CME), the Committee on Legislation and Advocacy (COLA), and the MSS Councilor on Medical Education opposed the resolution. The Massachusetts delegation suggested an amendment to the first resolve clause, however, both the first and third resolve clauses were placed on the reaffirmation consent calendar by the House Coordination Committee (HCC).

Your Reference Committee agrees with HCC that the first and third resolve clauses are sufficiently covered by both D-305.945 and H-305.925. Specifically, the first resolve is covered by H-305.925, which states that the AMA “vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs...” Similarly, the third resolve is covered by D-305.984, which states that the AMA will “work with appropriate organizations, such as ACGME and AAMC, to collect data and report on student indebtedness that includes total loan costs at completion of GME training.”

We found the opposing testimony from COLA, Region 2, CME, and the Councilor on Medical Education compelling. We do not believe the second resolve clause is adequately supported by the evidence presented and therefore does not justify this ask. The Councilor on Medical Education asks the authors to clarify if this is for U.S. medical graduates, IMGs, or both, in addition to further addressing healthcare workforce shortages. We agree with the Councilor that the authors should clarify these points and potentially re-submit this resolution at a future meeting. At this time, your Reference Committee recommends D-305.945 and H-305.925 be reaffirmed in lieu of the first and third resolve clauses and the remainder of Resolution 081 not be adopted.

D-305.984 – REDUCTION IN STUDENT LOAN INTEREST RATES
1. Our AMA will actively lobby for legislation aimed at establishing an affordable student loan structure with a variable interest rate capped at no more than 5.0%.

2. Our AMA will work in collaboration with other health profession organizations to advocate for a reduction of the fixed interest rate of the Stafford student loan program and the Graduate PLUS loan program.

3. Our AMA will consider the total cost of loans including loan origination fees and benefits of federal loans such as tax deductibility or loan forgiveness when advocating for a reduction in student loan interest rates.

4. Our AMA will advocate for policies which lead to equal or less expensive loans (in terms of loan benefits, origination fees, and interest rates) for Grad-PLUS loans as this would change the status quo of high-borrowers paying higher interest rates and fees in addition to having a higher overall loan burden.

5. Our AMA will work with appropriate organizations, such as the Accreditation Council for Graduate Medical Education and the Association of American Medical Colleges, to collect data and report on student indebtedness that includes total loan costs at completion of graduate medical education training.

H-305.925 – PRINCIPLES OF AND ACTIONS TO ADDRESS MEDICAL EDUCATION COSTS AND STUDENT DEBT

The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty. To help address this issue, our American Medical Association (AMA) will:

1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.

2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs--such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector--to promote practice in underserved areas, the military, and academic medicine or clinical research.

3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.

4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure
adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.

5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.

6. Work to reinstate the economic hardship deferment qualification criterion known as the “20/220 pathway,” and support alternate mechanisms that better address the financial needs of trainees with educational debt.

7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.

8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.

9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).

10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided.

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

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

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

14. Take an active advocacy role during reauthorization of
the Higher Education Act and similar legislation, to achieve
the following goals: (a) Eliminating the single holder rule; (b)
Making the availability of loan deferment more flexible,
including broadening the definition of economic hardship
and expanding the period for loan deferment to include the
entire length of residency and fellowship training; (c)
Retaining the option of loan forbearance for residents
ineligible for loan deferment; (d) Including, explicitly,
dependent care expenses in the definition of the “cost of
attendance”; (e) Including room and board expenses in the
definition of tax-exempt scholarship income; (f) Continuing
the federal Direct Loan Consolidation program, including the
ability to “lock in” a fixed interest rate, and giving
consideration to grace periods in renewals of federal loan
programs; (g) Adding the ability to refinance Federal
Consolidation Loans; (h) Eliminating the cap on the student
loan interest deduction; (i) Increasing the income limits for
taking the interest deduction; (j) Making permanent the
education tax incentives that our AMA successfully lobbied
for as part of Economic Growth and Tax Relief
Reconciliation Act of 2001; (k) Ensuring that loan repayment
programs do not place greater burdens upon married
couples than for similarly situated couples who are
cohabitating; (l) Increasing efforts to collect overdue debts
from the present medical student loan programs in a manner
that would not interfere with the provision of future loan funds to medical students.

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

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

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

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

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

20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician benefits the program, and will: (a) Advocate that all resident/fellow physicians have access to PSLF during their training years; (b) Advocate against a monetary cap on PSLF and other federal loan forgiveness programs; (c) Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed; (d) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note; (e) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the PSLF program qualifying status of the employer; (f) Advocate that the profit status of a physicians training institution not be a factor for PSLF eligibility; (g) Encourage medical school financial advisors to counsel wise borrowing by medical
students, in the event that the PSLF program is eliminated or severely curtailed; (h) Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas; (i) Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes.

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

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

(80) RESOLUTION 082 – ADDRESSING EARLY ADOLESCENT MENTAL HEALTH AND SOCIAL MEDIA

RECOMMENDATION:

Resolution 082 not be adopted.

RESOLVED, That our AMA-MSS support policies that will minimize the time that early adolescents spend on social media; and be it further

RESOLVED, That our AMA-MSS support regulations to raise the minimum age for Social Media users.

VRC testimony was opposed to Resolution 082. Region 1, the Committee on Bioethics and Humanities (CBH), the Membership Engagement and Recruitment Committee (MERC), the Massachusetts delegation, and the Section Delegates opposed this resolution as written. The Committee on Global and Public Health (CGPH) supported only the first resolve clause. The main concern from those opposed was the lack of evidence cited. Your Reference Committee agrees. The term social media is too broad, especially since the reliance on the internet has become so important in the past year. For example, would social media include Zoom or Google Classroom, which have been integral to teenagers’ virtual education? We also note the lack of clear evidence to whether this is correlation or causation – do teenagers utilize social media more because they are depressed, or does the increased use cause depression in this group? Due to the lack of evidence cited and the lack of specificity in the resolve clauses, your Reference Committee recommends Resolution 082 not be adopted.
(81) RESOLUTION 083 – ADVOCATE FOR INTERNET
SECURITY TRAINING FOR IMMIGRANT AND REFUGEE POPULATIONS

RECOMMENDATION:

Resolution 083 not be adopted.

RESOLVED, That our AMA recognizes the unique challenges refugees face navigating telecommunications and internet-related fraud; and be it further

RESOLVED, That our AMA (1) supports legislation providing centralized resources on internet and (2) advocate for cyber safety literacy and training for refugee children.

VRC testimony was mixed on Resolution 083. The Committee on Legislation and Advocacy (COLA), the Massachusetts delegation, and the Section Delegates opposed this resolution, suggesting it was out of scope. While MSS realizes income and wealth undoubtedly have an important relationship to health, concerns were raised over the need to pass policy against every potential detrimental effect to someone’s income. The Committee on Health Information Technology (CHIT) supported this resolution. Your Reference Committee agrees with COLA, Massachusetts, and the Section Delegates. We find this ask to be too narrowly focused and out of scope. We question why this only addresses immigrant and refugee populations, and not all children. Your Reference Committee recommends Resolution 083 not be adopted.
RECOMMENDED FOR REAFFIRMATION IN LIEU OF

(82) RESOLUTION 018 – ADDRESSING LOW VACCINATION RATES AMONG MINORITIES THROUGH TRUST-BUILDING AND ELIMINATION OF FINANCIAL BARRIERS

RECOMMENDATION:


RESOLVED, The AMA supports eliminating the cost barrier for vaccines by making them free of charge to patients and also reimbursing patients for ancillary costs (such as transportation to vaccine clinics) in an effort to increase the vaccination rates of both minorities and the general population; and be it further

RESOLVED, The AMA recognize that eliminating vaccine costs for patients is fiscally responsible because higher vaccination rates ultimately lead to less healthcare costs, increased productivity due to healthier workers, and economic growth stemming from a reallocation of money away from procedures/treatments and towards other sectors; and be it further

RESOLVED, The AMA supports taking a multidimensional approach to improving vaccination rates by not only eliminating the cost barrier, but also through education campaigns, trust-building, community outreach, prenatal vaccine consultation, and other proven methods.

Testimony on the VRC supported reaffirmation of existing policies in lieu of Resolution 018. The third Resolve clause was placed on the reaffirmation consent calendar by the House Coordination Committee (HCC). The Massachusetts delegation suggested amending H-440.860, H-440.992, and H-440.928 instead of reaffirmation. The Minority Issues Committee (MIC) proffered amendments to the first and second resolve clauses.

Your Reference Committee supports HCC’s decision to reaffirm existing policy in lieu of the third resolve clause. In regard to the first resolve clause, we believe this is already being done, and AMA staff indicated that this would not meaningfully change advocacy. Medicare, ACA marketplace plans, and most other private health insurance plans all provide reimbursement for vaccines, without copayments or coinsurance. While some state Medicaid programs do not cover all vaccines for adults, H-440.860 would already over these asks, and many state and local health departments and the CDC’s Vaccines for Children (VFC) program offer free vaccines for both adults and children. In the second resolve clause, we note that this is already being done at the federal level.

If the authors chose to introduce a similar resolution at a future meeting, we would recommend potentially amending H-440.860, H-440.992, and/or H-440.928 as suggested by the Massachusetts delegation, or incorporating other amendments to improve the novelty of this ask. However, at this time we recommend H-350.974, H-350.957, H-440.830, H-440.860, and H-440.992 be reaffirmed in lieu of Resolution 018.
H-350.974 – RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE

1. Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in health care an issue of highest priority for the American Medical Association.

2. The AMA emphasizes three approaches that it believes should be given high priority:
   A. Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform.
   B. Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities.
   C. Practice parameters - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decision-making process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities.

3. Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our AMA supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons.

4. Our AMA: (a) actively supports the development and implementation of training regarding implicit bias, diversity and inclusion in all medical schools and residency programs; (b) will identify and publicize effective strategies for educating residents in all specialties about disparities in
their fields related to race, ethnicity, and all populations at increased risk, with particular regard to access to care and health outcomes, as well as effective strategies for educating residents about managing the implicit biases of patients and their caregivers; and (c) supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations.

H-350.957 – ADDRESSING IMMIGRANT HEALTH DISPARITIES
1. Our American Medical Association recognizes the unique health needs of refugees, and encourages the exploration of issues related to refugee health and support legislation and policies that address the unique health needs of refugees.
2. Our AMA: (A) urges federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology; (B) advocates for and publicizes medically accurate information to reduce anxiety, fear, and marginalization of specific populations; and (C) advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees.
3. Our AMA will call for asylum seekers to receive all medically appropriate care, including vaccinations in a patient centered, language and culturally appropriate way upon presentation for asylum regardless of country of origin.

H-440.830 – EDUCATION AND PUBLIC AWARENESS ON VACCINE SAFETY AND EFFICACY
1. Our AMA (a) encourages the development and dissemination of evidence-based public awareness campaigns aimed at increasing vaccination rates; (b) encourages the development of educational materials that can be distributed to patients and their families clearly articulating the benefits of immunizations and highlighting the exemplary safety record of vaccines; (c) supports the development and evaluation, in collaboration with health care providers, of evidence-based educational resources to assist parents in educating and encouraging other parents who may be reluctant to vaccinate their children; (d) encourages physicians and state and local medical associations to work with public health officials to inform those who object to immunizations about the benefits of vaccinations and the risks to their own health and that of the general public if they refuse to accept them; (e) will promote the safety and efficacy of vaccines while rejecting claims
that have no foundation in science; (f) supports state policies allowing minors to override their parent’s refusal for vaccinations; and encourages state legislatures to establish comprehensive vaccine and minor consent policies; and (g) will continue its ongoing efforts with other immunization advocacy organizations to assist physicians and other health care professionals in effectively communicating to patients, parents, policy makers, and the media that vaccines do not cause autism and that decreasing immunization rates have resulted in a resurgence of vaccine-preventable diseases and deaths.

2. Our AMA: (a) supports the rigorous scientific process of the Advisory Committee on Immunization Practices as well as its development of recommended immunization schedules for the nation; (b) recognizes the substantial body of scientific evidence that has disproven a link between vaccines and autism; and (c) opposes the creation of a new federal commission on vaccine safety whose task is to study an association between autism and vaccines.

H-440.860 – FINANCING OF ADULT VACCINES: RECOMMENDATIONS FOR ACTION

1. Our AMA supports the concepts to improve adult immunization as advanced in the Infectious Diseases Society of America’s 2007 document “Actions to Strengthen Adult and Adolescent Immunization Coverage in the United States,” and support the recommendations as advanced by the National Vaccine Advisory Committee’s 2008 white paper on pediatric vaccine financing.

2. Our AMA will advocate for the following actions to address the inadequate financing of adult vaccination in the United States:

Provider-related

a. Develop a data-driven rationale for improved vaccine administration fees.

b. Identify and explore new methods of providing financial relief for adult immunization providers through, for example, vaccine company replacement systems/deferred payment/funding for physician inventories, buyback for unused inventory, and patient assistance programs.

c. Encourage and facilitate adult immunization at all appropriate points of patient contact; e.g., hospitals, visitors to long-term care facilities, etc.

d. Encourage counseling of adults on the importance of immunization by creating a mechanism through which immunization counseling alone can be reimbursed, even when a vaccine is not given.

Federal-related
a. Increase federal resources for adult immunization to: (i) Improve Section 317 funding so that the program can meet its purpose of improving adult immunizations; (ii) Provide universal coverage for adult vaccines and minimally, uninsured adults should be covered; (iii) Fund an adequate universal reimbursement rate for all federal and state immunization programs.

b. Optimize use of existing federal resources by, for example: (i) Vaccinating eligible adolescents before they turn 19 years of age to capitalize on VFC funding; (ii) Capitalizing on public health preparedness funding.

c. Ease federally imposed immunization burdens by, for example: (i) Providing coverage for Medicare-eligible individuals for all vaccines, including new vaccines, under Medicare Part B; (ii) Creating web-based billing mechanisms for physicians to assess coverage of the patient in real time and handle the claim, eliminating out-of-pocket expenses for the patient; (iii) Simplifying the reimbursement process to eliminate payment-related barriers to immunization.

d. The Centers for Medicare & Medicaid Services should raise vaccine administration fees annually, synchronous with the increasing cost of providing vaccinations.

State-related

a. State Medicaid programs should increase state resources for funding vaccines by, for example: (i) Raising and funding the maximum Medicaid reimbursement rate for vaccine administration fees; (ii) Establishing and requiring payment of a minimum reimbursement rate for administration fees; (iii) Increasing state contributions to vaccination costs; and (iv) Exploring the possibility of mandating immunization coverage by third party payers.

b. Strengthen support for adult vaccination and appropriate budgets accordingly.

Insurance-related

1. Provide assistance to providers in creating efficiencies in vaccine management by: (i) Providing model vaccine coverage contracts for purchasers of health insurance; (ii) Creating simplified rules for eligibility verification, billing, and reimbursement; (iii) Providing vouchers to patients to clarify eligibility and coverage for patients and providers; and (iv) Eliminating provider/public confusion over insurance payment of vaccines by universally covering all Advisory Committee on Immunization Practices (ACIP)-recommended vaccines.

b. Increase resources for funding vaccines by providing first-dollar coverage for immunizations.
c. Improve accountability by adopting performance measurements.

d. Work with businesses that purchase private insurance to include all ACIP-recommended immunizations as part of the health plan.

e. Provide incentives to encourage providers to begin immunizing by, for example: (i) Including startup costs (freezer, back up alarms/power supply, reminder-recall systems, etc.) in the formula for reimbursing the provision of immunizations; (ii) Simplifying payment to and encouraging immunization by nontraditional providers; (iii) Facilitating coverage of vaccines administered in complementary locations (e.g., relatives visiting a resident of a long-term care facility).

Manufacturer-related

Market stability for adult vaccines is essential. Thus: (i) Solutions to the adult vaccine financing problem should not deter research and development of new vaccines; (ii) Solutions should consider the maintenance of vibrant public and private sector adult vaccine markets; (iii) Liability protection for manufacturers should be assured by including Vaccine Injury Compensation Program coverage for all ACIP-recommended adult vaccines; (iv) Educational outreach to both providers and the public is needed to improve acceptance of adult immunization.

3. Our AMA will conduct a survey of small- and middle-sized medical practices, hospitals, and other medical facilities to identify the impact on the adult vaccine supply (including influenza vaccine) that results from the large contracts between vaccine manufacturers/distributors and large non-government purchasers, such as national retail health clinics, other medical practices, and group purchasing programs, with particular attention to patient outcomes for clinical preventive services and chronic disease management.

H-440.992 – NATIONAL IMMUNIZATION PROGRAM

Our AMA believes the following principles are required components of a national immunization program and should be given high priority by the medical profession and all other segments of society interested and/or involved in the prevention and control of communicable disease: (1) All US children should receive recommended vaccines against diseases in a continuing and ongoing program.

(2) An immunization program should be designed to encourage administration of vaccines as part of a total preventive health care program, so as to provide effective
entry into a continuous and comprehensive primary care system. 
(3) There should be no financial barrier to immunization of children.
(4) Existing systems of reimbursement for the costs of administering vaccines and follow-up care should be utilized.
(5) Any immunization program should be either (a) part of a continuing physician/patient relationship or (b) the introductory link to a continuing physician/patient relationship wherever possible.
(6) Professionals and allied health personnel who administer vaccines and manufacturers should be held harmless for adverse reactions occurring through no fault of the procedure.
(7) Provision should be made for a sustained, multi-media promotional campaign designed to educate and motivate the medical profession and the public to expect and demand immunizations for children and share responsibility for their completion.
(8) An efficient immunization record-keeping system should be instituted.
(83) RESOLUTION 021 – ADDRESSING SEXUAL ASSAULT ON COLLEGE CAMPUS (AMENDMENT)

RECOMMENDATION:

Policies H-515.956 and H-515.952 be reaffirmed in lieu of Resolution 021.

RESOLVED, That our current AMA policy be amended to include comprehensive evidence-based campus sexual assault response programs that prioritize the survivors’ physical and psychological healthcare needs.

Addressing Sexual Assault on College Campuses, H-515.956

RESOLVED, That our AMA support universities’ implementation of evidence-driven sexual assault prevention programs as well as comprehensive, patient-specific, and trauma-informed multidisciplinary response programs that specifically address the needs of college students and the unique challenges of the collegiate setting.

Resolution 021 was placed on the Reaffirmation Consent Calendar by the MSS House Coordination Committee (HCC). Testimony on the VRC was mixed. Region 1, Region 4, Region 6 and the MSS Women in Medicine Committee (WIM) supported Resolution 021 as written while Region 2 and the Massachusetts delegation supported HCC’s decision for Reaffirmation. We support the spirit of this resolution, but ultimately agree with HCC
that the asks of Resolution 021 are covered in existing policies H-515.956 and H-515.952. Your Reference Committee recommends these policies be reaffirmed in lieu of Resolution 021.

H-515.956 – ADDRESSING SEXUAL ASSAULT ON COLLEGE CAMPUSES
Our AMA: (1) supports universities' implementation of evidence-driven sexual assault prevention programs that specifically address the needs of college students and the unique challenges of the collegiate setting; (2) will work with relevant stakeholders to address the issues of rape, sexual abuse, and physical abuse on college campuses; and (2) will strongly express our concerns about the problems of rape, sexual abuse, and physical abuse on college campuses.

H-515.952 – ADVERSE CHILDHOOD EXPERIENCES AND TRAUMA-INFORMED CARE
1. Our AMA recognizes trauma-informed care as a practice that recognizes the widespread impact of trauma on patients, identifies the signs and symptoms of trauma, and treats patients by fully integrating knowledge about trauma into policies, procedures, and practices and seeking to avoid re-traumatization.

2. Our AMA supports:
   a. evidence-based primary prevention strategies for Adverse Childhood Experiences (ACEs);
   b. evidence-based trauma-informed care in all medical settings that focuses on the prevention of poor health and life outcomes after ACEs or other trauma at any time in life occurs;
   c. efforts for data collection, research, and evaluation of cost-effective ACEs screening tools without additional burden for physicians;
   d. efforts to educate physicians about the facilitators, barriers and best practices for providers implementing ACEs screening and trauma-informed care approaches into a clinical setting; and
   e. funding for schools, behavioral and mental health services, professional groups, community, and government agencies to support patients with ACEs or trauma at any time in life.
RESOLUTION 022 – NEED FOR INCREASED DIVERSITY IN STANDARDIZED PATIENTS

RECOMMENDATION:

Policies H-295.897 and H-295.874 be reaffirmed in lieu of Resolution 022.

RESOLVED, Our AMA supports the importance of diversity among standardized patients in medical education, and be it further

RESOLVED, Our AMA encourage more diverse hiring practices for medical institutions for standardized patients, and be it further

RESOLVED, Our AMA promotes practices that increase the retention of standardized patients at medical institutions.

VRC testimony was opposed to Resolution 022 as written. The Committee on Medical Education (CME), the Standing Committee on LGBTQ+ Affairs, the MSS Councilor on Medical Education, and the Massachusetts delegation opposed the resolution as written. The Minority Issues Committee (MIC) suggested an amendment and the Section Delegates recommended reaffirmation. We found the recommendations for reaffirmation compelling, particularly because H-295.897, clause (5), explicitly states that “Our AMA supports initiatives for medical schools to incorporate diversity in their Standardized Patient programs.” We did not feel that the authors’ amendment to add “and emphasize retention” to this clause significantly contributed to the policy. Your Reference Committee recommends H-295.897 and H-295.874 be reaffirmed in lieu of Resolution 022.

H-295.897 – ENHANCING THE CULTURAL COMPETENCE OF PHYSICIANS

1. Our AMA continues to inform medical schools and residency program directors about activities and resources related to assisting physicians in providing culturally competent care to patients throughout their life span and encourage them to include the topic of culturally effective health care in their curricula.

2. Our AMA continues to support research into the need for and effectiveness of training in cultural competence, using existing mechanisms such as the annual medical education surveys.

3. Our AMA will assist physicians in obtaining information about and/or training in culturally effective health care through dissemination of currently available resources from the AMA and other relevant organizations.

4. Our AMA encourages training opportunities for students and residents, as members of the physician-led team, to learn cultural competency from community health workers, when this exposure can be integrated into existing rotation and service assignments.
5. Our AMA supports initiatives for medical schools to incorporate diversity in their Standardized Patient programs as a means of combining knowledge of health disparities and practice of cultural competence with clinical skills.

6. Our AMA will encourage the inclusion of peer-facilitated intergroup dialogue in medical education programs nationwide.

H-295.874 – EDUCATING MEDICAL STUDENTS IN THE SOCIAL DETERMINANTS OF HEALTH AND CULTURAL COMPETENCE

Our AMA: (1) Supports efforts designed to integrate training in social determinants of health, cultural competence, and meeting the needs of underserved populations across the undergraduate medical school curriculum to assure that graduating medical students are well prepared to provide their patients safe, high quality and patient-centered care. (2) Supports faculty development, particularly clinical faculty development, by medical schools to assure that faculty provide medical students' appropriate learning experiences to assure their cultural competence and knowledge of social determinants of health. (3) Supports medical schools in their efforts to evaluate the effectiveness of their social determinants of health and cultural competence teaching of medical students, for example by the AMA serving as a convener of a consortium of interested medical schools to develop Objective Standardized Clinical Exams for use in evaluating medical students' cultural competence. (4) Will conduct ongoing data gathering, including interviews with medical students, to gain their perspective on the integration of social determinants of health and cultural competence in the undergraduate medical school curriculum. (5) Recommends studying the integration of social determinants of health and cultural competence training in graduate and continuing medical education and publicizing successful models.

(85) RESOLUTION 028 – AMEND H-60.965, TO ADDRESS ADOLESCENT TELEHEALTH CONFIDENTIALITY CONCERNS

RECOMMENDATION:

Policies H-60.965 and H-160.937 be reaffirmed in lieu of Resolution 028.

RESOLVED, That our AMA amend AMA policy H-60.965 by addition to read as follows:

Confidential Health Services for Adolescents, H-60.965

Our AMA:
(1) reaffirms that confidential care for adolescents is critical to improving their health;
(2) encourages physicians to allow emancipated and mature minors to give informed consent for medical, psychiatric, and surgical care without parental consent and notification, in conformity with state and federal law;
(3) encourages physicians to involve parents in the medical care of the adolescent patient, when it would be in the best interest of the adolescent. When, in the opinion of the physician, parental involvement would not be beneficial, parental consent or notification should not be a barrier to care;
(4) urges physicians to discuss their policies about confidentiality with parents and the adolescent patient, as well as conditions under which confidentiality would be abrogated. This discussion should include possible arrangements for the adolescent to have independent access to health care (including financial arrangements);
(5) encourages physicians to offer adolescents an opportunity for examination and counseling apart from parent. The same confidentiality will be preserved between the adolescent patient and physician as between the parent (or responsible adult) and the physician;
(6) encourages state and county medical societies to become aware of the nature and effect of laws and regulations regarding confidential health services for adolescents in their respective jurisdictions. State medical societies should provide this information to physicians to clarify services that may be legally provided on a confidential basis;
(7) urges undergraduate and graduate medical education programs and continuing education programs to inform physicians about issues surrounding minors' consent and confidential care, including relevant law and implementation into practice;
(8) encourages health care payers to develop a method of listing of services which preserves confidentiality for adolescents; and
(9) encourages medical societies to evaluate laws on consent and confidential care for adolescents and to help eliminate laws which restrict the availability of confidential care; and
(10) encourages physicians to adapt telehealth visits based on the unique privacy and confidentiality concerns of adolescents and their parents.

VRC testimony on Resolution 028 was mixed. We found the most compelling testimony to be from the Standing Committee on LGBTQ+ Affairs. Physicians have a responsibility to all patients to ensure confidentiality, and while we understand that teenagers are a
unique population, this concern could also apply to geriatric patients or any patients with
a caregiver. We are not denying that the issue of telehealth confidentiality for teens exists;
however, we do believe the policy covering the ask does, specifically in H-60.965 (5).
Clause (5) would apply to all scenarios, including telehealth visits, so we don’t believe the
addition of clause (10) is necessary. Your Reference Committee recommends H-60.965
and H-160.937 be reaffirmed in lieu of Resolution 028.

H-60.965 – CONFIDENTIAL HEALTH SERVICES FOR
ADOLESCENTS
RESOLVED, That our AMA amend AMA policy H-60.965 by
addition to read as follows:

Confidential Health Services for Adolescents, H-60.965
Our AMA:
(1) reaffirms that confidential care for adolescents is critical
to improving their health;
(2) encourages physicians to allow emancipated and
mature minors to give informed consent for medical,
psychiatric, and surgical care without parental consent and
notification, in conformity with state and federal law;
(3) encourages physicians to involve parents in the medical
care of the adolescent patient, when it would be in the best
interest of the adolescent. When, in the opinion of the
physician, parental involvement would not be beneficial,
parental consent or notification should not be a barrier to
care;
(4) urges physicians to discuss their policies about
confidentiality with parents and the adolescent patient, as
well as conditions under which confidentiality would be
abrogated. This discussion should include possible
arrangements for the adolescent to have independent
access to health care (including financial arrangements);
(5) encourages physicians to offer adolescents an
opportunity for examination and counseling apart from
parent. The same confidentiality will be preserved between
the adolescent patient and physician as between the parent
(or responsible adult) and the physician;
(6) encourages state and county medical societies to
become aware of the nature and effect of laws and
regulations regarding confidential health services for
adolescents in their respective jurisdictions. State medical
societies should provide this information to physicians to
clarify services that may be legally provided on a
confidential basis;
(7) urges undergraduate and graduate medical education
programs and continuing education programs to inform
physicians about issues surrounding minors’ consent and
confidential care, including relevant law and implementation
into practice;
(8) encourages health care payers to develop a method of listing of services which preserves confidentiality for adolescents; and
(9) encourages medical societies to evaluate laws on consent and confidential care for adolescents and to help eliminate laws which restrict the availability of confidential care.

H-160.937 – THE PROMOTION OF QUALITY TELEMEDICINE
1. The AMA adopts the following principles for the supervision of nonphysician providers and technicians when telemedicine is used:
   A. The physician is responsible for, and retains the authority for, the safety and quality of services provided to patients by nonphysician providers through telemedicine.
   B. Physician supervision (e.g. regarding protocols, conferencing, and medical record review) is required when nonphysician providers or technicians deliver services via telemedicine in all settings and circumstances.
   C. Physicians should visit the sites where patients receive services from nonphysician providers or technicians through telemedicine, and must be knowledgeable regarding the competence and qualifications of the nonphysician providers utilized.
   D. The supervising physician should have the capability to immediately contact nonphysician providers or technicians delivering, as well as patients receiving, services via telemedicine in any setting.
   E. Nonphysician providers who deliver services via telemedicine should do so according to the applicable nonphysician practice acts in the state where the patient receives such services.
   F. The extent of supervision provided by the physician should conform to the applicable medical practice act in the state where the patient receives services.
   G. Mechanisms for the regular reporting, recording, and supervision of patient care delivered through telemedicine must be arranged and maintained between the supervising physician, nonphysician providers, and technicians.
   H. The physician is responsible for providing and updating patient care protocols for all levels of telemedicine involving nonphysician providers or technicians.
2. The AMA urges those who design or utilize telemedicine systems to make prudent and reasonable use of those technologies necessary to apply current or future confidentiality and privacy principles and requirements to telemedicine interactions.
3. The AMA emphasizes to physicians their responsibility to ensure that their legal and ethical requirements with respect
to patient confidentiality and data integrity are not compromised by the use of any particular telemedicine modality.

4. The AMA advocates that continuing medical education conducted using telemedicine adhere to the standards of the AMA's Physician Recognition Award and the Accreditation Criteria of the Accreditation Council for Continuing Medical Education.

5. Our AMA supports the appropriate use of telemedicine in the education of medical students, residents, fellows and practicing physicians.

(86) RESOLUTION 030 – OPPOSING FORCED HYSTERECTOMIES AND REPRODUCTIVE MISTREATMENT OF ICE DETAINES AND BIPOC INDIVIDUALS

RECOMMENDATION:


RESOLVED, That our AMA condemns forced hysterectomy procedures on immigrants in ICE detention centers; and be it further

RESOLVED, That our AMA advocates for safe and equitable maternal and reproductive health practices and proper access to physicians for ICE detainees; and be it further

RESOLVED, That our AMA advocates for standardized and equitable recommendations for contraception use in all environments to promote reproductive autonomy across all populations, regardless of race, ethnicity, or documentation status.

VRC testimony was mixed on Resolution 030. Region 4 supported the resolution as written. The Women in Medicine Committee (WIM), the Minority Issues Committee (MIC), and the Massachusetts delegation supported the resolution with amendments. Region 2 suggested that this may be appropriate for a Governing Council Action Item (GCAI) Request.

The House Coordination Committee (HCC) recommended Resolution 030 be placed on the reaffirmation consent calendar and we agree. They note that the first resolve has been addressed by the AMA via a letter to ICE and Homeland Security condemning these practices. The second resolve is covered by existing policy D-350.983 and H-350.957, and the third resolve is covered by D-430.997, H-350.955, and D-350.983. Your Reference Committee recommends policies D-350.983, H-350.957, D-430.997, and H-350.955 be reaffirmed in lieu of Resolution 030

D-350.983 – IMPROVING MEDICAL CARE IN IMMIGRANT DETENTION CENTERS

Our AMA will: (1) issue a public statement urging U.S. Immigrations and Customs Enforcement Office of Detention
Oversight to (a) revise its medical standards governing the conditions of confinement at detention facilities to meet those set by the National Commission on Correctional Health Care, (b) take necessary steps to achieve full compliance with these standards, and (c) track complaints related to substandard healthcare quality; (2) recommend the U.S. Immigrations and Customs Enforcement refrain from partnerships with private institutions whose facilities do not meet the standards of medical, mental, and dental care as guided by the National Commission on Correctional Health Care; and (3) advocate for access to health care for individuals in immigration detention.

H-350.957 – ADDRESSING IMMIGRANT HEALTH DISPARITIES
1. Our American Medical Association recognizes the unique health needs of refugees, and encourages the exploration of issues related to refugee health and support legislation and policies that address the unique health needs of refugees.
2. Our AMA: (A) urges federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology; (B) advocates for and publicizes medically accurate information to reduce anxiety, fear, and marginalization of specific populations; and (C) advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees.
3. Our AMA will call for asylum seekers to receive all medically appropriate care, including vaccinations in a patient centered, language and culturally appropriate way upon presentation for asylum regardless of country of origin.

D-430.997 – SUPPORT FOR HEALTH CARE SERVICES TO INCARCERATED PERSONS
Our AMA will:

(1) express its support of the National Commission on Correctional Health Care Standards that improve the quality of health care services, including mental health services, delivered to the nation's correctional facilities;
(2) encourage all correctional systems to support NCCHC accreditation;
(3) encourage the NCCHC and its AMA representative to work with departments of corrections and public officials to find cost effective and efficient methods to increase correctional health services funding;
(4) continue support for the programs and goals of the NCCHC through continued support for the travel expenses of the AMA representative to the NCCHC, with this decision to be reconsidered every two years in light of other AMA financial commitments, organizational memberships, and programmatic priorities;
(5) work with an accrediting organization, such as National Commission on Correctional Health Care (NCCHC) in developing a strategy to accredit all correctional, detention and juvenile facilities and will advocate that all correctional, detention and juvenile facilities be accredited by the NCCHC no later than 2025 and will support funding for correctional facilities to assist in this effort; and
(6) support an incarcerated person’s right to: (a) accessible, comprehensive, evidence-based contraception education; (b) access to reversible contraceptive methods; and (c) autonomy over the decision-making process without coercion.

H-350.955 – CARE OF WOMEN AND CHILDREN IN FAMILY IMMIGRATION DETENTION
1. Our AMA recognizes the negative health consequences of the detention of families seeking safe haven.
2. Due to the negative health consequences of detention, our AMA opposes the expansion of family immigration detention in the United States.
3. Our AMA opposes the separation of parents from their children who are detained while seeking safe haven.
4. Our AMA will advocate for access to health care for women and children in immigration detention.

(87) RESOLUTION 031 – AMENDING POLICY D-350.983, TO INCLUDE COMMUNITY PHYSICIAN OVERSIGHT

RECOMMENDATION:


RESOLVED, Our AMA amend policy D-350.983, Improving Medical Care in Immigrant Detention Centers, by addition and deletion as follows:

Improving Medical Care in Immigrant Detention Centers, D-350.983

Our AMA will: (1) issue a public statement urging U.S. Immigrations and Customs Enforcement Office of Detention Oversight to (a) revise its medical standards governing the conditions of confinement at detention facilities to meet
those set by the National Commission on Correctional Health Care, (b) take necessary steps to achieve full compliance with these standards, and (c) track complaints related to substandard healthcare quality; (2) recommend the U.S. Immigrations and Customs Enforcement refrain from partnerships with private institutions whose facilities do not meet the standards of medical, mental, and dental care as guided by the National Commission on Correctional Health Care; and (3) support allowing community physicians oversight in U.S. Immigration Enforcement and Customs and Border Protection facilities; and (34) advocate for access to health care for individuals in immigration detention.

VRC testimony was mixed on Resolution 031. This resolution was placed on the reaffirmation consent calendar by the House Coordination Committee (HCC). Region 2, Region 6, and the Massachusetts delegation supported reaffirmation. Region 1, Region 3, and Region 4 supported the resolution as written.

Your Reference Committee agrees with HCC that the asks in Resolution 031 are already covered by existing policy. We also note concern with physician oversight in general. We believe this is a slippery slope that could open the door for other governmental organizations to oversee healthcare settings. We recommend policies D-160.921, D-65.992, H-350.957, H-60.906, 270.041MSS, and 65.039MSS be reaffirmed in lieu of Resolution 031.

D-160.921 – PRESENCE AND ENFORCEMENT ACTIONS OF IMMIGRATION AND CUSTOMS ENFORCEMENT (ICE) IN HEALTHCARE
Our AMA: (1) advocates for and supports legislative efforts to designate healthcare facilities as sensitive locations by law; (2) will work with appropriate stakeholders to educate medical providers on the rights of undocumented patients while receiving medical care, and the designation of healthcare facilities as sensitive locations where U.S. Immigration and Customs Enforcement (ICE) enforcement actions should not occur; (3) encourages healthcare facilities to clearly demonstrate and promote their status as sensitive locations; and (4) opposes the presence of ICE enforcement at healthcare facilities.

D-65.992 – MEDICAL NEEDS OF UNACCOMPANIED, UNDOCUMENTED IMMIGRANT CHILDREN
1. Our AMA will take immediate action by releasing an official statement that acknowledges that the health of unaccompanied immigrant children without proper documentation is a humanitarian issue.
2. Our AMA urges special consideration of the physical, mental, and psychological health in determination of the
legal status of unaccompanied minor children without proper documentation.

3. Our AMA will immediately meet and work with other physician specialty societies to identify the main obstacles to the physical health, mental health, and psychological well-being of unaccompanied children without proper documentation.

4. Our AMA will participate in activities and consider legislation and regulations to address the unmet medical needs of unaccompanied minor children without proper documentation status, with issues to be discussed to include the identification of: (A) the health needs of this unique population, including standard pediatric care as well as mental health needs; (B) health care professionals to address these needs, to potentially include but not be limited to non-governmental organizations, federal, state, and local governments, the US military and National Guard, and local and community health professionals; (C) the resources required to address these needs, including but not limited to monetary resources, medical care facilities and equipment, and pharmaceuticals; and (D) avenues for continuity of care for these children during the potentially extended multi-year legal process to determine their final disposition.

H-350.957 – ADDRESSING IMMIGRANT HEALTH DISPARITIES

1. Our American Medical Association recognizes the unique health needs of refugees, and encourages the exploration of issues related to refugee health and support legislation and policies that address the unique health needs of refugees.

2. Our AMA: (A) urges federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology; (B) advocates for and publicizes medically accurate information to reduce anxiety, fear, and marginalization of specific populations; and (C) advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees.

3. Our AMA will call for asylum seekers to receive all medically appropriate care, including vaccinations in a patient centered, language and culturally appropriate way upon presentation for asylum regardless of country of origin.

H-60.906 – OPPOSING THE DETENTION OF MIGRANT CHILDREN

Our AMA: (1) opposes the separation of migrant children from their families and any effort to end or weaken the
Flores Settlement that requires the United States Government to release undocumented children “without unnecessary delay” when detention is not required for the protection or safety of that child and that those children that remain in custody must be placed in the “least restrictive setting” possible, such as emergency foster care; (2) supports the humane treatment of all undocumented children, whether with families or not, by advocating for regular, unannounced, auditing of the medical conditions and services provided at all detention facilities by a non-governmental, third party with medical expertise in the care of vulnerable children; and (3) urges continuity of care for migrant children released from detention facilities.

270.041MSS – SUPPORTING EXTERNAL ACCOUNTABILITY FOR ICE AND CBP
AMA-MSS promotes the health and well-being of immigrants and their families who are affected by immigration raids and/or held in detention by U.S. Immigration and Customs Enforcement or U.S. Customs and Border Protection.

65.039MSS – ADVOCATING FOR ALTERNATIVES TO IMMIGRANT DETENTION CENTERS THAT RESPECT HUMAN DIGNITY
Our AMA-MSS will ask our AMA to advocate for the preferential use of community-based, non-custodial Alternatives to Detention programs within the United States that respect the human dignity of immigrants, migrants, and asylum seekers who are in the custody of federal agencies.

(88) RESOLUTION 052 – AMEND AMA POLICY H-70.912, TO RECOMMEND THE USE OF “INTELLECTUAL DISABILITY” IN LIEU OF “MENTAL RETARDATION” IN ACADEMIC TEXTS, PUBLISHED LITERATURE AND MEDICAL EDUCATION

RECOMMENDATION:

Policy H-70.912 be reaffirmed in lieu of Resolution 052.

RESOLVED, That our AMA amend AMA policy H-70.912 by addition to read as follows:

Eliminating Use of the Term "Mental Retardation" by Physicians in Clinical Settings, H-70.912
Our AMA recommends that physicians adopt the term "intellectual disability" instead of "mental retardation" in clinical settings, academic texts, published literature, and medical education.
VRC testimony was supportive of Resolution 052. Region 1, Region 2, the Massachusetts delegation, and the Minority Issues Committee (MIC) supported this resolution. The House Coordination Committee (HCC) recommended H-70.912 be reaffirmed in lieu of Resolution 052. HCC did not believe the additional language added enough context to change the existing policy, and that H-70.912 already covers the phrase the authors are adding.

Your Reference Committee questions if the term “clinical settings” sufficiently covers “academic texts, published literature, and medical education,” and would recommend the authors potentially revisit their language to create a novel ask. We recommend H-70.912 be reaffirmed in lieu of Resolution 052.

H-70.912 – ELIMINATING THE USE OF THE TERM “MENTAL RETARDATION” BY PHYSICIANS IN CLINICAL SETTINGS
Our AMA recommends that physicians adopt the term “intellectual disability” instead of “mental retardation” in clinical settings.

RESOLUTION 053 – ADVOCATING FOR MODERN SOLUTIONS TO ADDRESS FOOD INSECURITY IN SCHOOL-AGED CHILDREN

RECOMMENDATION:

Policy H-150.962 be reaffirmed in lieu of Resolution 053.

RESOLVED, That our AMA support the extension of SNAP benefits under the American Relief Act currently set to expire September 30, 2021 through the 2021-2022 school year; and be it further

RESOLVED, That our AMA support the permanent implementation of electronic waivers nationally to help expand accessibility to more nutritional food options by supporting policies outlined in the SNAP Options Act of 2021.

VRC testimony supported the spirit of Resolution 053. The Committee on Legislation and Advocacy (COLA), the Committee on Global and Public Health (CGPH), and Region 3 supported the resolution as written. The Section Delegates recommended reaffirmation, noting that it is an important topic, but one that is already actively being addressed by the AMA Advocacy team. The House Coordination Committee (HCC) recommended this resolution be placed on the reaffirmation consent calendar, indicating that this is already covered by an existing MSS transmittal, which amends H-150.962, Quality of School Lunch Program. HCC recommends the authors submit a Governing Council Action Item request if they feel more action is needed on this topic. We agree with HCC and recommend H-150.962 be reaffirmed in lieu of Resolution 053.

H-150.962 – QUALITY OF SCHOOL LUNCH PROGRAM
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.

(90) RESOLUTION 055 – RACIAL BIAS IN MEDICAL TECHNOLOGY

RECOMMENDATION:

Policy H-65.952 be reaffirmed in lieu of Resolution 055.

RESOLVED, That AMA policy D-350.981 be amended by addition and deletion as follows:

Racial Essentialism in Medicine D-350.981
1. Our AMA recognizes that the false conflation of race with inherent biological or genetic traits leads to inadequate examination of true underlying disease risk factors, which exacerbates existing health inequities.
2. Our AMA encourages characterizing race as a social construct, rather than an inherent biological trait, and recognizes that when race is described as a risk factor, it is more likely to be a proxy for influences including structural racism than a proxy for genetics.
3. Our AMA will collaborate with the AAMC, AACOM, NBME, NBOME, ACGME and other appropriate stakeholders, including minority physician organizations and content experts, to identify and address aspects of medical education and board examinations which may perpetuate teachings, assessments, and practices that reinforce institutional and structural racism.
4. Our AMA will collaborate with appropriate stakeholders and content experts to develop recommendations on how to interpret or improve clinical algorithms that currently include race-based correction factors.
5. Our AMA will support research that promotes antiracist strategies to mitigate algorithmic bias in clinical algorithms and medical technology.
6. Our AMA will support the creation of innovative medical technology that does not perpetuate racial bias.

The House Coordination Committee (HCC) recommended that H-65.952 be reaffirmed in lieu of Resolution 055. VRC testimony broadly supported reaffirmation, as this resolution is not a significant departure from existing policy. The amendments proposed here are already covered in H-65.952 which states that the AMA will work to “prevent and combat the influences of racism and bias in innovative health technologies.” Your Reference Committee agrees that this ask is already covered in existing policy. We recommend H-65.952 be reaffirmed in lieu of Resolution 055.
1. Our AMA acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health care delivery have caused and continue to cause harm to marginalized communities and society as a whole.

2. Our AMA recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care.

3. Our AMA will identify a set of current, best practices for healthcare institutions, physician practices, and academic medical centers to recognize, address, and mitigate the effects of racism on patients, providers, international medical graduates, and populations.

4. Our AMA encourages the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of: (a) the causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism; and (b) how to prevent and ameliorate the health effects of racism.

5. Our AMA: (a) supports the development of policy to combat racism and its effects; and (b) encourages governmental agencies and nongovernmental organizations to increase funding for research into the epidemiology of risks and damages related to racism and how to prevent or repair them.

6. Our AMA will work to prevent and combat the influences of racism and bias in innovative health technologies.

(91) RESOLUTION 057 – AMENDING TO ADD RACIAL EQUITY FOR H-130.954, NON-EMERGENCY PATIENT TRANSPORTATION SYSTEMS

RECOMMENDATION A:


RESOLVED, That our AMA amend H-130.954 “Non-Emergency Patient Transportation Systems” as follows:

Non-Emergency Patient Transportation Systems, H-130.954

Our AMA: (1) supports the education of physicians, first responders, and the public about the costs associated with inappropriate use of emergency patient transportation systems, as well as how access to transportation can impact
health; and (2) encourages the development of non-emergency patient transportation systems that are affordable to the patient and are easily accessible to underserved populations, including racial minorities, thereby ensuring cost effective and accessible health care for all patients.

VRC testimony on Resolution 057 was limited. After reviewing several existing AMA policies, your Reference Committee has determined that this resolution does not depart significantly from what is already covered in H-130.954, H-165.822, D-440.922, H-350.953, and H-180.944. These existing policies sufficiently cover both health equity and access to healthcare concerns, including issues of both affordability and access for minoritized populations. The proposed amendments to H-130.954 proposed in Resolution 057 would not change AMA action on these topics. Your Reference Committee recommends policies H-130.954, H-165.822, D-440.922, H-350.953, and H-180.944 be reaffirmed in lieu of Resolution 057.

H-130.954 – NON-EMERGENCY PATIENT TRANSPORTATION SYSTEMS
Our AMA: (1) supports the education of physicians, first responders, and the public about the costs associated with inappropriate use of emergency patient transportation systems; and (2) encourages the development of non-emergency patient transportation systems that are affordable to the patient, thereby ensuring cost effective and accessible health care for all patients.

H-165.822 – HEALTH PLAN INITIATIVES ADDRESSING SOCIAL DETERMINANTS OF HEALTH
Our AMA:
1. recognizing that social determinants of health encompass more than health care, encourages new and continued partnerships among all levels of government, the private sector, philanthropic organizations, and community- and faith-based organizations to address non-medical, yet critical health needs and the underlying social determinants of health;
2. supports continued efforts by public and private health plans to address social determinants of health in health insurance benefit designs;
3. encourages public and private health plans to examine implicit bias and the role of racism and social determinants of health, including through such mechanisms as professional development and other training;
4. supports mechanisms, including the establishment of incentives, to improve the acquisition of data related to social determinants of health, while minimizing burdens on patients and physicians;
5. supports research to determine how best to integrate and finance non-medical services as part of health insurance
benefit design, and the impact of covering non-medical benefits on health care and societal costs; and
6. encourages coverage pilots to test the impacts of addressing certain non-medical, yet critical health needs, for which sufficient data and evidence are not available, on health outcomes and health care costs.

D-440.922 – FULL COMMITMENT BY OUR AMA TO THE BETTERMENT AND STRENGTHENING OF PUBLIC HEALTH SYSTEMS
Our AMA will: (1) champion the betterment of public health by enhancing advocacy and support for programs and initiatives that strengthen public health systems, to address pandemic threats, health inequities and social determinants of health outcomes; and (2) study the most efficacious manner by which our AMA can continue to achieve its mission of the betterment of public health by recommending ways in which to strengthen the health and public health system infrastructure.

H-350.953 – RACIAL HOUSING SEGREGATION AS A DETERMINANT OF HEALTH AND PUBLIC ACCESS TO GEOGRAPHIC INFORMATION SYSTEMS (GIS)
Our AMA will: (1) oppose policies that enable racial housing segregation; and (2) advocate for continued federal funding of publicly accessible geospatial data on community racial and economic disparities and disparities in access to affordable housing, employment, education, and healthcare, including but not limited to the Department of Housing and Urban Development (HUD) Affirmatively Furthering Fair Housing (AFFH) tool.

H-180.944 – PLAN FOR CONTINUED PROGRESS TOWARDS HEALTH EQUITY
Health equity, defined as optimal health for all, is a goal toward which our AMA will work by advocating for health care access, research, and data collection; promoting equity in care; increasing health workforce diversity; influencing determinants of health; and voicing and modeling commitment to health equity.

(92) RESOLUTION 058 – DEVELOPING A COMPREHENSIVE PLAN FOR HEALTH SYSTEMS REFORM

RECOMMENDATION:

Policies 165.004MSS, 165.011MSS, and 165.012MSS be reaffirmed in lieu of Resolution 058.
RESOLVED, that our AMA-MSS advocate for the following vision for health systems reform until a single payer plan becomes practically viable:

a) further expansion of fully refundable tax credits for patients to purchase individual insurance, including those intended to reduce premiums and those intended to reduce cost-sharing requirements,
b) elimination of the income cap for the determination of premium tax credit eligibility,
c) elimination of the requirement that patients need to lack access to affordable insurance through their employer or public insurance programs in order to qualify for premium tax credits,
d) encouraging expansion of options that allow employers to provide tax-exempt benefits for employees to enroll in an individual health plan of their choice,
e) federal requirements that healthcare insurance exchanges include personalized plan cost estimates to enhance price transparency and choice,
f) state and/or federal reinsurance programs to reduce the cost of insurance,
g) auto-enrollment in healthcare plans with the highest actuarial value for which prospective enrollees are eligible for coverage at no cost after the application of all relevant subsidies,
h) the establishment of a revenue-neutral, affordable public insurance option to be offered by the federal government without regard to income eligibility that achieves the following goals:
   i) expands access to high-quality health insurance coverage,
   ii) lowers costs for patients, including premiums and out-of-pocket costs,
   iii) only receives the subsidies available to competing insurers,
   iv) reimburses hospitals, physicians, and all other healthcare providers at rates sufficient to support their participation without imposing an undue financial burden on those providers,
   v) all-payer rate negotiation as a means to reduce the cost of healthcare.

VRC testimony was broadly supportive of Resolution 058, including support from the Section Delegates. Your Reference Committee thanks the authors for bringing forward this important topic for the Section’s discussion and debate, however, we agree with the House Coordination Committee (HCC) that this would be a reaffirmation of existing MSS policies 165.004MSS, 165.011MSS, and 165.012MSS. The asks in this resolution are very comprehensive, but we argue that they are not novel. We would suggest that this is a topic on which the Section as a whole needs to be better educated. We would recommend that this topic be included in future educational programs to increase robust debate on this topic among members. At this time, we recommend policies 165.004MSS, 165.011MSS, and 165.012MSS be reaffirmed in lieu of Resolution 058.

165.004MSS – Health Insurance Premium Subsidies for Affordable Universal Coverage: AMA-MSS will ask the AMA to expand health system reform efforts to integrate other federal health insurance premium subsidies in addition to refundable health insurance tax credits for attaining affordable universal access to health care.

165.011MSS – Medicaid Reform and Coverage for the Uninsured: Beyond Tax Credits: AMA-MSS will: (1) actively support the ongoing efforts of the AMA to reform Medicaid
in order to increase access to health care among the uninsured and underinsured of our nation; (2) support the ongoing AMA efforts to implement graduated, refundable tax credits as a replacement for Medicaid; (3) make the active promotion and education of the AMA plan for health insurance reform a top priority; (4) work with the AMA to create and fund programming that will educate both physicians and patients about the AMA plan for insurance reform and publicize that plan to the general public.

165.012MSS – Covering the Uninsured as AMA’s Top Priority: AMA-MSS will ask the AMA to make the number one priority of the American Medical Association comprehensive health system reform that achieves reasonable health insurance for all Americans and that emphasizes prevention, quality, and safety while addressing the broken medical liability system, flaws in Medicare and Medicaid, and improving the physician practice environment.

(93) RESOLUTION 064 – ADVOCATE FOR THE CREATION OF A NATIONAL ALL-PAYER CLAIMS DATABASE

RECOMMENDATION:

Policy D-155.987 be reaffirmed in lieu of Resolution 064.

RESOLVED, Our AMA advocates for the creation of a centralized, comprehensive national all-payer claims database that requires health insurance issuers, including but not limiting to group health plans (self-insured and fully insured), and non-federal governmental plans to submit claims data; and be it further

RESOLVED, Our AMA supports integrating data from existing state claims databases into the national all-payer claims database; and be it further

RESOLVED, Our AMA urges the creation of a standardized data submission format through the use of a Common Data Layout like that endorsed by major stakeholders to assure standardized all-payer claims database data submission format.

The MSS House Coordination Committee (HCC) recommended policy D-155.987 be reaffirmed in lieu of Resolution 064. Your Reference Committee agrees and finds that the asks of this resolution are sufficiently covered in existing policy, specifically clause (4), which states “Our AMA will work with states and the federal government to support and strengthen the development of all-payer claims databases.” We recommend Resolution 064 reaffirm existing policy D-155.987.

D-155.987 – PRICE TRANSPARENCY

1. Our AMA encourages physicians to communicate information about the cost of their professional services to individual patients, taking into consideration the insurance
status (e.g., self-pay, in-network insured, out-of-network insured) of the patient or other relevant information where possible.

2. Our AMA advocates that health plans provide plan enrollees or their designees with complete information regarding plan benefits and real time cost-sharing information associated with both in-network and out-of-network provider services or other plan designs that may affect patient out-of-pocket costs.

3. Our AMA will actively engage with health plans, public and private entities, and other stakeholder groups in their efforts to facilitate price and quality transparency for patients and physicians, and help ensure that entities promoting price transparency tools have processes in place to ensure the accuracy and relevance of the information they provide.

4. Our AMA will work with states and the federal government to support and strengthen the development of all-payer claims databases.

5. Our AMA encourages electronic health records vendors to include features that assist in facilitating price transparency for physicians and patients.

6. Our AMA encourages efforts to educate patients in health economics literacy, including the development of resources that help patients understand the complexities of health care pricing and encourage them to seek information regarding the cost of health care services they receive or anticipate receiving.

7. Our AMA will request that the Centers for Medicare and Medicaid Services expand its Medicare Physician Fee Schedule Look-up Tool to include hospital outpatient payments.

(94) RESOLUTION 067 – TAXATION AMENDMENT TO SPECIAL NEEDS TRUSTS FOR PATIENTS WITH HUNTINGTON’S DISEASE

RECOMMENDATION:

Policy H-280.991 be reaffirmed in lieu of Resolution 067.

RESOLVED, That our AMA supports the decrease in income tax for the Huntington’s disease patient population as their retirement assets are transferred to Special Needs Trusts.

Testimony on the VRC was mixed regarding Resolution 067. This topic is very niche and we are not convinced this topic falls within the expertise of the MSS. We also note that we question the reasoning of singling out one condition – in this case Huntington’s Disease – without also addressing other progressive or chronic illnesses. Additionally, H-280.991 contains language regarding taxes for individuals in long-term care, and Clause (9) in particular covers this resolution’s asks. This resolution was placed on the reaffirmation
calendar by the House Coordination Committee (HCC) and your Reference Committee agrees with reaffirmation of H-280.991 in lieu of Resolution 067.

H-280.991 – POLICY DIRECTIONS FOR THE FINANCING OF LONG-TERM CARE

The AMA believes that programs to finance long-term care should: (1) assure access to needed services when personal resources are inadequate to finance care; (2) protect personal autonomy and responsibility in the selection of LTC service providers; (3) prevent impoverishment of the individual or family in the face of extended or catastrophic service costs; (4) cover needed services in a timely, coordinated manner in the least restrictive setting appropriate to the health care needs of the individual; (5) coordinate benefits across different LTC financing program; (6) provide coverage for the medical components of long-term care through Medicaid for all individuals with income below 100 percent of the poverty level; (7) provide sliding scale subsidies for the purchase of LTC insurance coverage for individuals with income between 100-200 percent of the poverty level; (8) encourage private sector LTC coverage through an asset protection program; equivalent to the amount of private LTC coverage purchased; (9) create tax incentives to allow individuals to prospectively finance the cost of LTC coverage, encourage employers to offer such policies as a part of employee benefit packages and otherwise treat employer-provided coverage in the same fashion as health insurance coverage, and allow tax-free withdrawals from IRAs and Employee Trusts for payment of LTC insurance premiums and expenses; and (10) authorize a tax deduction or credit to encourage family care giving. Consumer information programs should be expanded to emphasize the need for prefunding anticipated costs for LTC and to describe the coverage limitations of Medicare, Medicaid, and traditional medigap policies. State medical associations should be encouraged to seek appropriate legislation or regulation in their jurisdictions to: (a) provide an environment within their states that permit innovative LTC financing and delivery arrangements, and (b) assure that private LTC financing and delivery systems, once developed, provide the appropriate safeguards for the delivery of high-quality care. The AMA continues to evaluate and support additional health system reform legislative initiatives that could increase states' flexibility to design and implement long-term care delivery and financing programs. The AMA will also encourage and support the legislative and funding changes needed to enable more accurate and disaggregated collection and reporting of data on health
care spending by type of service, so as to enable more informed decisions as to those social components of long-term care that should not be covered by public or private health care financing mechanisms.

(95) RESOLUTION 068 – EQUAL ACCESS AMONG THIRD PARTY RESOURCES

RECOMMENDATION:

Policy H-305.925 be reaffirmed in lieu of Resolution 068.

RESOLVED, That our AMA work in collaboration with the LCME and other relevant stakeholders to update standard 12.1 Financial Aid/Debt Management Counseling/Student Education Debt to include a set budget used solely for third party resources in undergraduate education; and be it further

RESOLVED, That AMA policy H-305.925 be amended by insertion as follows to better encompass the importance of third-party resource research and implementation:

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

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

VRC testimony was mixed on Resolution 068. Region 2 and Region 6 opposed the resolution. The Committee on Medical Education (CME) and the Massachusetts delegation supported the resolution. The House Coordination Committee (HCC) recommended reaffirmation of H-305.925 in lieu of Resolution 068 and your Reference Committee agrees. We don’t believe the additional phrases add substantially to the existing policy and recommend H-350.925 be reaffirmed in lieu of Resolution 068.

H-305.925 – PRINCIPLES OF AND ACTIONS TO ADDRESS MEDICAL EDUCATION COSTS AND STUDENT DEBT

The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty. To help address this issue, our American Medical Association (AMA) will:

1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.

2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs--such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector--to promote practice in underserved areas, the military, and academic medicine or clinical research.

3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.

4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.

5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.
6. Work to reinstate the economic hardship deferment qualification criterion known as the “20/220 pathway,” and support alternate mechanisms that better address the financial needs of trainees with educational debt.

7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.

8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.

9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).

10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided.

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

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

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

14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals: (a) Eliminating the single holder rule; (b) Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training; (c) Retaining the option of loan forbearance for residents ineligible for loan deferment; (d) Including, explicitly, dependent care expenses in the definition of the “cost of attendance”; (e) Including room and board expenses in the definition of tax-exempt scholarship income; (f) Continuing the federal Direct Loan Consolidation program, including the ability to “lock in” a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs; (g) Adding the ability to refinance Federal Consolidation Loans; (h) Eliminating the cap on the student loan interest deduction; (i) Increasing the income limits for taking the interest deduction; (j) Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001; (k) Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating; (l) Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.

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

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

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

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

20. Related to the Public Service Loan Forgiveness (PSLF)
Program, our AMA supports increased medical student and
physician benefits the program, and will: (a) Advocate that
all resident/fellow physicians have access to PSLF during
their training years; (b) Advocate against a monetary cap on
PSLF and other federal loan forgiveness programs; (c) Work
with the United States Department of Education to ensure
that any cap on loan forgiveness under PSLF be at least
equal to the principal amount borrowed; (d) Ask the United
States Department of Education to include all terms of PSLF
in the contractual obligations of the Master Promissory Note;
(e) Encourage the Accreditation Council for Graduate
Medical Education (ACGME) to require residency/fellowship
programs to include within the terms, conditions, and
benefits of program appointment information on the PSLF
program qualifying status of the employer; (f) Advocate that
the profit status of a physicians training institution not be a
factor for PSLF eligibility; (g) Encourage medical school
financial advisors to counsel wise borrowing by medical
students, in the event that the PSLF program is eliminated
or severely curtailed; (h) Encourage medical school
financial advisors to increase medical student engagement
in service-based loan repayment options, and other federal
and military programs, as an attractive alternative to the
PSLF in terms of financial prospects as well as providing the
opportunity to provide care in medically underserved areas;
(i) Strongly advocate that the terms of the PSLF that existed
at the time of the agreement remain unchanged for any
program participant in the event of any future restrictive changes.

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

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

(96) RESOLUTION 069 – INCREASING MEDICAID INSURANCE COVERAGE OF INFERTILITY SERVICES

RECOMMENDATION:

Policies H-420.952 and H-185.990 be reaffirmed in lieu of Resolution 069.

RESOLVED, That our AMA declare fertility an essential component of health; and be it further

RESOLVED, That our AMA advocate for Medicaid to expand coverage for fertility services, such as IVF, including diagnostic studies and treatments, regardless of reason for seeking fertility treatment.

VRC testimony supported the spirit of Resolution 069. The Standing Committee on LGBTQ+ Affairs supported with a friendly amendment, the New York delegation supported as written, and the Massachusetts delegation and the Committee on Economics and Quality in Medicine (CEQM) supported the first resolve as novel and the second resolve as reaffirmation.

The House Coordination Committee (HCC) placed the entirety of Resolution 069 on the reaffirmation consent calendar. Your Reference Committee agrees with HCC. H-420.952 states that the AMA supports the designation of infertility as a disease state requiring multiple interventions and H-185.990 states that the AMA encourages third party insurers to cover infertility treatments, which includes IVF. Thus, we do not believe that Resolution 069 addresses a gap in current policy and would not change AMA advocacy efforts on this topic. Your Reference Committee recommends H-420.952 and H-185.990 be reaffirmed in lieu of Resolution 069.

H-140.952 – RECOGNITION OF INFERTILITY AS A DISEASE

Our AMA supports the World Health Organization’s designation of infertility as a disease state with multiple etiologies requiring a range of interventions to advance fertility treatment and prevention.

H-185.990 – INFERTILITY AND FERTILITY PRESERVATION INSURANCE COVERAGE
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.

(97) RESOLUTION 071 – USMLE STEP EXAMINATION SCHEDULING DURING THE COVID-19 PANDEMIC

RECOMMENDATION:


RESOLVED, That our AMA will study the cause, magnitude, and effects of the current disorganization in the USMLE Step Exam scheduling and administration that has come to light due to the COVID-19 pandemic in order to identify the current gaps facing medical students in trying to register and take USMLE Step Exams; and be it further

RESOLVED, That our AMA will inquire from the Federation of State Medical Boards (FSMB) and National Board of Medical Examiners (NBME), who coordinate the USMLE administration through Prometric Testing Centers, as to the reason for the lack of consistent communication between them and our AMA during the COVID-19 pandemic to ensure this does not occur again in the event of a future pandemic.

VRC testimony on Resolution 071 was limited and mixed. The Massachusetts delegation supported the resolution, while the Committee on Medical Education (CME) and the MSS Councilor on Medical Education opposed the resolution. The House Coordination Committee (HCC) recommended that existing policies D-295.939, H-275.934, D-275.958, and D-275.951 be reaffirmed in lieu of Resolution 071. The asks of the second resolve clause are broadly covered by D-295.939. The language of the first resolve clause is not explicitly covered in existing policy, but it would not actively change AMA action on this topic.

The MSS Councilor on Medical Education noted that the AMA Council on Medical Education has been actively and directly engaged in conversations with various stakeholders, including FSMB, NBME, and USMLE, throughout the pandemic to address this, and other issues.

Your Reference Committee believes that the AMA is already active in this space and this resolution would not add to existing policy efforts. Therefore, we recommend D-295.939, H-275.934, D-275.958, and D-275.951 be reaffirmed in lieu of Resolution 071.
D-295.939 – INDEPENDENT REGULATION OF PHYSICIAN LICENSING EXAMS

Our AMA will: (1) continue to work with the National Board of Medical Examiners to ensure that the AMA is given appropriate advance notice of any major potential changes in the examination system; (2) continue to collaborate with the organizations who create, validate, monitor, and administer the United States Medical Licensing Examination; (3) continue to promote and disseminate the rules governing USMLE in its publications; (4) continue its dialog with and be supportive of the process of the Committee to Evaluate the USMLE Program (CEUP); and (5) work with American Osteopathic Association and National Board of Osteopathic Medical Examiners to stay apprised of any major potential changes in the Comprehensive Osteopathic Medical Licensing Examination (COMLEX).

H-275.934 – ALTERNATIVES TO THE FEDERATION OF STATE MEDICAL BOARDS RECOMMENDATIONS ON LICENSURE

Our AMA adopts the following principles: (1) Ideally, all medical students should successfully complete Steps 1 and 2 of the United States Medical Licensing Examination (USMLE) or Levels 1 and 2 of the Comprehensive Osteopathic Medical Licensing Examination (COMLEX USA) prior to entry into residency training. At a minimum, individuals entering residency training must have successfully completed Step 1 of the USMLE or Level 1 of COMLEX USA. There should be provision made for students who have not completed Step 2 of the USMLE or Level 2 of the COMLEX USA to do so during the first year of residency training. (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 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. The candidate for licensure should have had education that provided exposure to general medical content. (3) There should be a training permit/educational license for all resident physicians who do not yet have a full and unrestricted license to practice medicine. To be eligible for an initial training permit/educational license, the resident must have completed Step 1 of the USMLE or Level 1 of COMLEX USA. (4) Residency program directors shall report only
those actions to state medical licensing boards that are reported for all licensed physicians. (5) Residency program directors should receive training to ensure that they understand the process for taking disciplinary action against resident physicians, and are aware of procedures for dismissal of residents and for due process. This requirement for residency program directors should be enforced through Accreditation Council for Graduate Medical Education accreditation requirements. (6) There should be no reporting of actions against medical students to state medical licensing boards. (7) Medical schools are responsible for identifying and remediating and/or disciplining medical student unprofessional behavior, problems with substance abuse, and other behavioral problems, as well as gaps in student knowledge and skills. (8) The Dean’s Letter of Evaluation should be strengthened and standardized, to serve as a better source of information to residency programs about applicants.

D-275.958 – DISCOURAGING THE USE OF LICENSING EXAMS FOR INTERNAL PROMOTION IN MEDICAL SCHOOLS

It is the policy of the AMA to encourage the discontinuation of the use of the USMLE Step 1 Exam as a requirement for the promotion of medical students to the clinical phase.

D-275.951 – USMLE AND COMLEX EXAMINATION FAILURES DURING THE COVID-19 PANDEMIC

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

(98) RESOLUTION 074 – PROMOTING THE INTEGRATION OF DIETITIANS INTO PRIMARY CARE TEAMS

RECOMMENDATION:

Policies H-150.931, H-425.972, and D-35.985 be reaffirmed in lieu of Resolution 074.
RESOLVED, That our AMA support the routine inclusion of registered dietitians as part of primary healthcare delivery, not only interventionally but also preventively; and be it further

RESOLVED, That our AMA supports federal and state subsidization to provide greater access to registered dietitians; and be it further

RESOLVED, That our AMA amend the existing policy, Payment for Nutrition Support Services H-150.931, by addition as follows:

Payment for Nutrition Support Services H-150.931

Our AMA recognizes the value of nutrition support teams services and their role in positive patient outcomes and supports equitable payment for the provision of their services, regardless of pre-existing conditions or lack thereof.

VRC testimony was mixed on Resolution 074. The Committee on Economics and Quality in Medicine (CEQM) and the Massachusetts delegation suggested several amendments. The House Coordination Committee (HCC) recommended policies H-150.931, H-425.972, and D-35.985 be reaffirmed in lieu of this resolution. The Section Delegates agreed with reaffirmation of H-150.931. We agree with HCC and the Section Delegates. If the authors felt their asks were not sufficiently covered by these policies we would recommend submitting a resolution to a future meeting more thoroughly amending this existing language. However, at this time, your Reference Committee recommends H-150.931, H-425.972 and D-35.985 be reaffirmed in lieu of Resolution 074.

H-150.931 – PAYMENT FOR NUTRITION SUPPORT SERVICES

Our AMA recognizes the value of nutrition support teams services and their role in positive patient outcomes and supports payment for the provision of their services.

H-425.972 – HEALTHY LIFESTYLES

1. Our AMA: (A) recognizes the 15 competencies of lifestyle medicine as defined by a blue ribbon panel of experts convened in 2009 whose consensus statement was published in the Journal of the American Medical Association in 2010; (B) will urge physicians to acquire and apply the 15 clinical competencies of lifestyle medicine, and offer evidence-based lifestyle interventions as the first and primary mode of preventing and, when appropriate, treating chronic disease within clinical medicine; and (C) will work with appropriate federal agencies, medical specialty societies, and public health organizations to educate and assist physicians to routinely address physical activity and nutrition, tobacco cessation and other lifestyle factors with their patients as the primary strategy for chronic disease prevention and management.
2. Our AMA supports policies and mechanisms that incentivize and/or provide funding for the inclusion of lifestyle medicine education and social determinants of health in undergraduate, graduate and continuing medical education.

D-35.985 – SUPPORT FOR PHYSICIAN LED, TEAM BASED CARE

Our AMA:
2. Will identify and review available data to analyze the effects on patients' access to care in the opt-out states (states whose governor has opted out of the federal Medicare physician supervision requirements for anesthesia services) to determine whether there has been any increased access to care in those states.
3. Will identify and review available data to analyze the type and complexity of care provided by all non-physician providers, including CRNAs in the opt-out states (states whose governor has opted out of the federal Medicare physician supervision requirements for anesthesia services), compared to the type and complexity of care provided by physicians and/or the anesthesia care team.
4. Will advocate to policymakers, insurers, and other groups, as appropriate, that they should consider the available data to best determine how non-physicians can serve as a complement to address the nation's primary care workforce needs.
5. Will continue to recognize non-physician providers as valuable components of the physician-led health care team.
6. Will continue to advocate that physicians are best qualified by their education and training to lead the health care team.
7. Will call upon the Robert Wood Johnson Foundation to publicly announce that the report entitled, "Common Ground: An Agreement between Nurse and Physician Leaders on Interprofessional Collaboration for the Future of Patient Care" was premature; was not released officially; was not signed; and was not adopted by the participants.
(99) RESOLUTION 076 – AMEND POLICY H-480.945, “GENOME EDITING AND ITS POTENTIAL CLINICAL USE” TO ALIGN WITH AMA CODE OF MEDICAL ETHICS

RECOMMENDATION:

Policy H-480.945 be reaffirmed in lieu of Resolution 076.

RESOLVED, That our AMA-MSS amend H-480.945 Genome Editing and its Potential Clinical Use by addition to read as follows:

Our AMA (1) encourages continued research into the therapeutic use of somatic genome editing; (2) urges continued development of consensus international principles, grounded in science and ethics, to determine permissible therapeutic applications of germline genome editing.

VRC testimony was mixed on Resolution 076, with the Massachusetts delegation, Committee on Bioethics and Humanities (CBH), and the Section Delegates in opposition. The House Coordination Committee (HCC) recommended this resolution be placed on the reaffirmation consent calendar. Your Reference Committee does not find this to be a significant change in policy and also notes that an internal MSS resolution cannot amend HOD policy as this resolution is aiming to do.

While both HCC and we understand that the intent of adding “somatic” was to exclude germline genome editing, HCC noted that AMA Code of Medical Ethics 7.3.6 explicitly states that “Physicians should not engage in research involved gene therapy or genetic engineering with human participants…unless…Gene therapy is restricted to somatic cell interventions, in light of the far-reaching implications of germ-line interventions.”

Therefore, under H-480.945, the AMA would be unable to encourage research using germline genome editing and can only urge “continued development of consensus international principles” as long as 7.3.6 is in place. We believe this addresses the concerns of the authors on this subject and we recommend H-480.945 be reaffirmed in lieu of Resolution 076.
RESOLUTION 078 – MENTAL HEALTH SCREENING DURING ALL VISITS TO CLINICAL SETTINGS

RECOMMENDATION:

Policy H-345.984 be reaffirmed in lieu of Resolution 078.

RESOLVED, That our AMA will work with relevant stakeholders to encourage the implementation of a routine protocol for mental health screening for all patients during all visits to clinical settings which include, but not limited to, primary care visits and urgent care visits.

Resolution 078 was placed on the reaffirmation calendar by the House Coordination Committee (HCC). Your Reference Committee agrees that this ask is sufficiently covered by existing policy, specifically H-345.984. We also note that the ask is not entirely necessary, and there could be unintended consequences. While we support improving access to mental health resources, requiring every specialty to perform mental health screenings at every visit may not be the most productive approach. We recommend H-345.984 be reaffirmed in lieu of Resolution 078.

H-345.984 – AWARENESS, DIAGNOSIS, AND TREATMENT OF DEPRESSION AND OTHER MENTAL ILLNESSES

1. Our AMA encourages: (a) medical schools, primary care residencies, and other training programs as appropriate to include the appropriate knowledge and skills to enable graduates to recognize, diagnose, and treat depression and other mental illnesses, either as the chief complaint or with another general medical condition; (b) all physicians providing clinical care to acquire the same knowledge and skills; and (c) additional research into the course and outcomes of patients with depression and other mental illnesses who are seen in general medical settings and into the development of clinical and systems approaches designed to improve patient outcomes. Furthermore, any approaches designed to manage care by reduction in the demand for services should be based on scientifically sound outcomes research findings.

2. Our AMA will work with the National Institute on Mental Health and appropriate medical specialty and mental health advocacy groups to increase public awareness about depression and other mental illnesses, to reduce the stigma associated with depression and other mental illnesses, and to increase patient access to quality care for depression and other mental illnesses.

3. Our AMA: (a) will advocate for the incorporation of integrated services for general medical care, mental health care, and substance use disorder care into existing psychiatry, addiction medicine and primary care training programs’ clinical settings; (b) encourages graduate
medical education programs in primary care, psychiatry, and addiction medicine to create and expand opportunities for residents and fellows to obtain clinical experience working in an integrated behavioral health and primary care model, such as the collaborative care model; and (c) will advocate for appropriate reimbursement to support the practice of integrated physical and mental health care in clinical care settings.

4. Our AMA recognizes the impact of violence and social determinants on women’s mental health.

(101) RESOLUTION 079 – SUPPORTING REVISION OF MEDICAL STUDENT GUIDELINES DURING HEALTHCARE CRISIS

RECOMMENDATION:

Policy H-295.995 be reaffirmed in lieu of Resolution 079.

RESOLVED, That our AMA-MSS collaborate with relevant AMA stakeholders in order to update recommendations every four years regarding the role medical students are able to safely fill in healthcare settings during a crisis that results in a significant departure from normal medical education as determined by the MSS governing council.

VRC testimony was largely opposed to Resolution 079 as written. The MSS Councilor on Medical Education and the MSS Committee on Medical Education (CME) opposed this resolution. The Massachusetts delegation recommended this be referred for study. Your Reference Committee agrees with the House Coordination Committee (HCC) that this ask is already covered by H-295.995. We also highlight the testimony provided by the MSS Councilor on Medical Education stating that the AMA Council on Medical Education has “already released guidelines for protecting learners (and residents and fellows) during the COVID-19 pandemic.” We believe these guidelines are thorough enough to provide sufficient guidance for the current pandemic, and could be updated accordingly should the need arise in the future. Your Reference Committee recommends reaffirmation of H-295.995 in lieu of Resolution 079.

H-295.995 – RECOMMENDATIONS FOR FUTURE DIRECTIONS FOR MEDICAL EDUCATION

Our AMA supports the following recommendations relating to the future directions for medical education:

(1) The medical profession and those responsible for medical education should strengthen the general or broad components of both undergraduate and graduate medical education. All medical students and resident physicians should have general knowledge of the whole field of medicine regardless of their projected choice of specialty.

(2) Schools of medicine should accept the principle and should state in their requirements for admission that a broad cultural education in the arts, humanities, and social
sciences, as well as in the biological and physical sciences, is desirable.

(3) Medical schools should make their goals and objectives known to prospective students and premedical counselors in order that applicants may apply to medical schools whose programs are most in accord with their career goals.

(4) Medical schools should state explicitly in publications their admission requirements and the methods they employ in the selection of students.

(5) Medical schools should require their admissions committees to make every effort to determine that the students admitted possess integrity as well as the ability to acquire the knowledge and skills required of a physician.

(6) Although the results of standardized admission testing may be an important predictor of the ability of students to complete courses in the preclinical sciences successfully, medical schools should utilize such tests as only one of several criteria for the selection of students. Continuing review of admission tests is encouraged because the subject content of such examinations has an influence on premedical education and counseling.

(7) Medical schools should improve their liaison with college counselors so that potential medical students can be given early and effective advice. The resources of regional and national organizations can be useful in developing this communication.

(8) Medical schools are chartered for the unique purpose of educating students to become physicians and should not assume obligations that would significantly compromise this purpose.

(9) Medical schools should inform the public that, although they have a unique capability to identify the changing medical needs of society and to propose responses to them, they are only one of the elements of society that may be involved in responding. Medical schools should continue to identify social problems related to health and should continue to recommend solutions.

(10) Medical school faculties should continue to exercise prudent judgment in adjusting educational programs in response to social change and societal needs.

(11) Faculties should continue to evaluate curricula periodically as a means of insuring that graduates will have the capability to recognize the diverse nature of disease, and the potential to provide preventive and comprehensive medical care. Medical schools, within The framework of their respective institutional goals and regardless of the organizational structure of the faculty, should provide a broad general education in both basic sciences and the art and science of clinical medicine.
(12) The curriculum of a medical school should be designed to provide students with experience in clinical medicine ranging from primary to tertiary care in a variety of inpatient and outpatient settings, such as university hospitals, community hospitals, and other health care facilities. Medical schools should establish standards and apply them to all components of the clinical educational program regardless of where they are conducted. Regular evaluation of the quality of each experience and its contribution to the total program should be conducted.

(13) Faculties of medical schools have the responsibility to evaluate the cognitive abilities of their students. Extramural examinations may be used for this purpose, but never as the sole criterion for promotion or graduation of a student.

(14) As part of the responsibility for granting the MD degree, faculties of medical schools have the obligation to evaluate as thoroughly as possible the non-cognitive abilities of their medical students.

(15) Medical schools and residency programs should continue to recognize that the instruction provided by volunteer and part-time members of the faculty and the use of facilities in which they practice make important contributions to the education of medical students and resident physicians. Development of means by which the volunteer and part-time faculty can express their professional viewpoints regarding the educational environment and curriculum should be encouraged.

(16) Each medical school should establish, or review already established, criteria for the initial appointment, continuation of appointment, and promotion of all categories of faculty. Regular evaluation of the contribution of all faculty members should be conducted in accordance with institutional policy and practice.

(17a) Faculties of medical schools should reevaluate the current elements of their fourth or final year with the intent of increasing the breadth of clinical experience through a more formal structure and improved faculty counseling. An appropriate number of electives or selected options should be included. (17b) Counseling of medical students by faculty and others should be directed toward increasing the breadth of clinical experience. Students should be encouraged to choose experience in disciplines that will not be an integral part of their projected graduate medical education.

(18) Directors of residency programs should not permit medical students to make commitments to a residency program prior to the final year of medical school.

(19) The first year of postdoctoral medical education for all graduates should consist of a broad year of general training. (a) For physicians entering residencies in internal medicine, pediatrics, and general surgery, postdoctoral medical
education should include at least four months of training in a specialty or specialties other than the one in which the resident has been appointed. (A residency in family practice provides a broad education in medicine because it includes training in several fields.) (b) For physicians entering residencies in specialties other than internal medicine, pediatrics, general surgery, and family practice, the first postdoctoral year of medical education should be devoted to one of the four above-named specialties or to a program following the general requirements of a transitional year stipulated in the "General Requirements" section of the "Essentials of Accredited Residencies." (c) A program for the transitional year should be planned, designed, administered, conducted, and evaluated as an entity by the sponsoring institution rather than one or more departments. Responsibility for the executive direction of the program should be assigned to one physician whose responsibility is the administration of the program. Educational programs for a transitional year should be subjected to thorough surveillance by the appropriate accrediting body as a means of assuring that the content, conduct, and internal evaluation of the educational program conform to national standards. The impact of the transitional year should not be deleterious to the educational programs of the specialty disciplines.

(20) The ACGME, individual specialty boards, and respective residency review committees should improve communication with directors of residency programs because of their shared responsibility for programs in graduate medical education.

(21) Specialty boards should be aware of and concerned with the impact that the requirements for certification and the content of the examination have upon the content and structure of graduate medical education. Requirements for certification should not be so specific that they inhibit program directors from exercising judgment and flexibility in the design and operation of their programs.

(22) An essential goal of a specialty board should be to determine that the standards that it has set for certification continue to assure that successful candidates possess the knowledge, skills, and the commitment to upgrade continually the quality of medical care.

(23) Specialty boards should endeavor to develop a consensus concerning the significance of certification by specialty and publicize it so that the purposes and limitations of certification can be clearly understood by the profession and the public.

(24) The importance of certification by specialty boards requires that communication be improved between the specialty boards and the medical profession as a whole,
particularly between the boards and their sponsoring, nominating, or constituent organizations and also between the boards and their diplomats.

(25) Specialty boards should consider having members of the public participate in appropriate board activities.

(26) Specialty boards should consider having physicians and other professionals from related disciplines participate in board activities.

(27) The AMA recommends to state licensing authorities that they require individual applicants, to be eligible to be licensed to practice medicine, to possess the degree of Doctor of Medicine or its equivalent from a school or program that meets the standards of the LCME or accredited by the American Osteopathic Association, or to demonstrate as individuals, comparable academic and personal achievements. All applicants for full and unrestricted licensure should provide evidence of the satisfactory completion of at least one year of an accredited program of graduate medical education in the US. Satisfactory completion should be based upon an assessment of the applicant's knowledge, problem-solving ability, and clinical skills in the general field of medicine. The AMA recommends to legislatures and governmental regulatory authorities that they not impose requirements for licensure that are so specific that they restrict the responsibility of medical educators to determine the content of undergraduate and graduate medical education.

(28) The medical profession should continue to encourage participation in continuing medical education related to the physician's professional needs and activities. Efforts to evaluate the effectiveness of such education should be continued.

(29) The medical profession and the public should recognize the difficulties related to an objective and valid assessment of clinical performance. Research efforts to improve existing methods of evaluation and to develop new methods having an acceptable degree of reliability and validity should be supported.

(30) Methods currently being used to evaluate the readiness of graduates of foreign medical schools to enter accredited programs in graduate medical education in this country should be critically reviewed and modified, as necessary. No graduate of any medical school should be admitted to or continued in a residency program if his or her participation can reasonably be expected to affect adversely the quality of patient care or to jeopardize the quality of the educational experiences of other residents or of students in educational programs within the hospital.

(31) The Educational Commission for Foreign Medical Graduates should be encouraged to study the feasibility of
including in its procedures for certification of graduates of foreign medical schools a period of observation adequate for the evaluation of clinical skills and the application of knowledge to clinical problems.

(32) The AMA, in cooperation with others, supports continued efforts to review and define standards for medical education at all levels. The AMA supports continued participation in the evaluation and accreditation of medical education at all levels.

(33) The AMA, when appropriate, supports the use of selected consultants from the public and from the professions for consideration of special issues related to medical education.

(34) The AMA encourages entities that profile physicians to provide them with feedback on their performance and with access to education to assist them in meeting norms of practice; and supports the creation of experiences across the continuum of medical education designed to teach about the process of physician profiling and about the principles of utilization review/quality assurance.

(35) Our AMA encourages the accrediting bodies for MD- and DO-granting medical schools to review, on an ongoing basis, their accreditation standards to assure that they protect the quality and integrity of medical education in the context of the emergence of new models of medical school organization and governance.

(36) Our AMA will strongly advocate for the rights of medical students, residents, and fellows to have physician-led (MD or DO as defined by the AMA) clinical training, supervision, and evaluation while recognizing the contribution of non-physicians to medical education.

(37) Our AMA will publicize to medical students, residents, and fellows their rights, as per Liaison Committee on Medical Education and Accreditation Council for Graduate Medical Education guidelines, to physician-led education and a means to report violations without fear of retaliation.