AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-22)

Preliminary Document of Reference Committee D

_Pursuant to Policy D-600.956, adopted at the November 2021 Special Meeting, commentary submitted to the online member forums will be used to generate a preliminary document to inform the discussion at the in-person reference committee hearings._

Ankush Kumar Bansal, MD, Chair

The following items are under consideration by Reference Committee D:

1. Board of Trustees Report 15 – Addressing Public Health Disinformation
4. Resolution 401 – Air Quality and the Protection of Citizen Health
5. Resolution 402 – Support for Impairment Research
6. Resolution 403 – Addressing Maternal Discrimination and Support for Flexible Family Leave
7. Resolution 404 – Weapons in Correctional Healthcare Settings
8. Resolution 405 – Universal Childcare and Preschool
10. Resolution 407 – Study of Best Practices for Acute Care of Patients in the Custody of Law Enforcement or Corrections
12. Resolution 409 – Increasing HPV Vaccination Rates in Rural Communities
13. Resolution 410 – Increasing Education for School Staff to Recognize Prodromal Symptoms of Schizophrenia in Teens and Young Adults to Increase Early Intervention
14. Resolution 411 – Anonymous Prescribing Option for Expedited Partner Therapy
15. Resolution 412 – Advocating for the Amendment of Chronic Nuisance Ordinances
16. Resolution 413 – Expansion on Comprehensive Sexual Health Education
17. Resolution 414 – Improvement of Care and Resource Allocation for Homeless Persons in the Global Pandemic
18. Resolution 415 – Creation of an Obesity Task Force
20. Resolution 417 – Tobacco Control
21. Resolution 418 – Lung Cancer Screening Awareness
22. Resolution 419 – Advocating for the Utilization of Police and Mental Health Care Co-Response Teams for 911 Mental Health Emergency Calls
23. Resolution 420 – Declaring Climate Change a Public Health Crisis
24. Resolution 421 – Screening for HPV-Related Anal Cancer
25. Resolution 422 – Voting as a Social Determinant of Health
26. Resolution 423 – Awareness Campaign for 988 National Suicide Prevention Lifeline
27. Resolution 424 – Physician Interventions Addressing Environmental Health and Justice
28. Resolution 425 – Mental Health Crisis
29. Resolution 426 – Mental Health First Aid Training
30. Resolution 427 – Pictorial Health Warnings on Alcoholic Beverages
31. Resolution 428 – Amending H-90.968 to Expand Policy on Medical Care of Persons with Disabilities
32. Resolution 429 – Increasing Awareness and Reducing Consumption of Food and Drink of Poor Nutritional Quality
33. Resolution 430 – Longitudinal Capacity-Building to Address Climate Action and Justice
34. Resolution 431 – Protections for Incarcerated Mothers and Infants in the Perinatal Period
35. Resolution 432 – Recognizing Loneliness as a Public Health Issue
36. Resolution 433 – Support for Democracy
37. Resolution 434 – Support for Pediatric Siblings of Chronically Ill Children
40. Resolution 437 – Air Pollution and COVID: A Call to Tighten Regulatory Standards for Particulate Matter
42. Resolution 439 – Informing Physicians, Health Care Providers, and the Public That Cooking with a Gas Stove Increases Household Air Pollution and the Risk of Childhood Asthma
The Board of Trustees recommends that the following be adopted, and the remainder of this report be filed.

1. That Policy D-440.914, “Addressing Public Health Disinformation Disseminated by Health Professionals,” be amended by addition and deletion to read as follows:

   Our AMA will: (1) collaborate with relevant health professional societies and other stakeholders: (a) on efforts to combat public health disinformation disseminated by health professionals in all forms of media, and (b) to address disinformation that undermines public health initiatives by, and (c) implement a comprehensive strategy to address health-related disinformation disseminated by health professionals that includes:

   (1) Maintaining AMA as a trusted source of evidence-based information for physicians and patients.
   (2) Ensuring that evidence-based medical and public health information is accessible by engaging with publishers, research institutions and media organizations to develop best practices around paywalls and preprints to improve access to evidence-based information and analysis.
   (3) Addressing disinformation disseminated by health professionals via social media platforms and addressing the monetization of spreading disinformation on social media platforms.
   (4) Educating health professionals and the public on how to recognize disinformation as well as how it spreads.
   (5) Considering the role of health professional societies in serving as appropriate fact-checking entities for health-related information disseminated by various media platforms.
   (6) Encouraging continuing education to be available for health professionals who serve as fact-checker to help prevent the dissemination of health-related disinformation.
   (7) Ensuring licensing boards have the authority to take disciplinary action against health professionals for spreading health-related disinformation and affirms that all speech in which a health professional is utilizing their credentials is professional conduct and can be scrutinized by their licensing entity.
   (8) Ensuring specialty boards have the authority to take action against board certification for health professionals spreading health-related disinformation.
   (9) Encouraging state and local medical societies to engage in dispelling disinformation in their jurisdictions.; and
   (2) study disinformation disseminated by health professionals and its impact on public health and present a comprehensive strategy to address this issue with a report back at the next meeting of the House of Delegates. (Modify Current HOD Policy)


Testimony on Board of Trustees Report 15 was mixed. While some thought the report was well done in proposing a broad strategy to address the public health crisis of health-related disinformation spread by health professionals, others raised concerns. One comment noted that the report avoids addressing the issue of unjustified punishment of health professionals in which there is a difference of opinion on scientific evidence. Another comment noted that the report should be referred for further clarification of the proposed definition of disinformation.
and the intent to cause harm. Another comment noted that one of the objectives in the
appendix needs to be re-worked or deleted.

(2) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT
1 – SUNSET REVIEW OF 2012 HOUSE POLICIES

The Council on Science and Public Health recommends that the House of Delegates policies
listed in the appendix to this report be acted upon in the manner indicated and the remainder
of this report be filed. (Directive to Take Action)

Testimony suggested two amendments to the Council’s recommendations for disposition of
2012 House of Delegates policies. Specifically, one comment called for amending H-440.472
another comment called for H-170.961 to be rescinded.

(3) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT
2 – TRANSFORMATION OF RURAL COMMUNITY
PUBLIC HEALTH SYSTEMS

The Council on Science and Public Health recommends that the following be adopted, and
the remainder of the report be filed.

1. That our AMA amend Policy H-465.994, “Improving Rural Health,” by addition and deletion
to read as follows:

   1. Our AMA (a) supports continued and intensified efforts to develop and implement proposals
      for improving rural health care and public health, (b) urges physicians practicing in rural areas
      to be actively involved in these efforts, and (c) advocates widely publicizing AMA’s policies
      and proposals for improving rural health care and public health to the profession, other
      concerned groups, and the public.

2. Our AMA will work with other entities and organizations interested in public health to:

   - Encourage more research to identify the unique needs and models for delivering public health
     and health care services in rural communities,
   - Identify and disseminate concrete examples of administrative leadership and funding
     structures that support and optimize local, community-based rural public health.
   - Develop an actionable advocacy plan to positively impact local, community-based rural public
     health including but not limited to the development of rural public health networks, training of
     current and future rural physicians and public health professionals in core public health
     techniques and novel funding mechanisms to support public health initiatives that are led and
     managed by local public health authorities.
   - Advocate for adequate and sustained funding for public health staffing and programs.
   - Study efforts to optimize rural public health.

   Services” by addition and deletion to read as follows:

   Our AMA: (1) supports equitable access to the 10 Essential Public Health Services and the
   Foundational Public Health Services to protect and promote the health of all people in all
   communities 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, including for rural jurisdictions. (Amend HOD Policy)


Testimony provided online was generally supportive of the Council’s report and recommendations. One comment noted that there is a failure to clearly distinguish essential “functions” from “services” and those terms continue to be muddled in public health circles. Another comment noted that a robust AMA Rural Health Caucus might be a cost-effective way for our AMA to support rural medical care and rural public health.

(4) RESOLUTION 401 – AIR QUALITY AND THE PROTECTION OF CITIZEN HEALTH

RESOLVED, That our American Medical Association review the Environmental Protection Agency’s guidelines for monitoring the air quality which is emitted from smokestacks, taking into consideration the risks to citizens living downwind of smokestacks (Directive to Take Action); and be it further RESOLVED, That our AMA develop a report based on a review of the EPA’s guidelines for monitoring air quality emitted from smokestacks ensuring that recommendations to protect the public’s health are included in the report. (Directive to Take Action)

Your Reference Committee reviewed online testimony for this resolution, which was very limited, and mixed. On one hand it was stated that industrial impacts on the environment have repeatedly been proven to predispose or worsen certain health conditions and regulation can improve health. On the other hand, the possibility of unintended consequences was raised, with a caution that we should not rush into changes until the full effects are known.

(5) RESOLUTION 402 – SUPPORT FOR IMPAIRMENT RESEARCH

RESOLVED, That our American Medical Association study the impairment of drivers and other operators of mechanized vehicles by substances, fatigue, medical or mental health conditions, and that this report include whether there are office or hospital-based methods to efficiently and effectively assess impairment of drivers with recommendations for further research that may be needed. (Directive to Take Action)

Online testimony for this resolution was limited, but supportive. It was indicated that further clarification is needed on the scope of the study, particularly whether the focus is the ability to drive secondary to chronic conditions or measures that can be employed on a daily basis prior to operating a motor vehicle.
(6) RESOLUTION 403 – ADDRESSING MATERNAL DISCRIMINATION AND SUPPORT FOR FLEXIBLE FAMILY LEAVE

RESOLVED, That our American Medical Association encourage key stakeholders to implement policies and programs that help protect against maternal discrimination and promote work-life integration for physician parents, which should encompass prenatal care, parental leave, and flexibility for childcare (Directive to Take Action); and be it further
RESOLVED, That our AMA urge key stakeholders to include physicians and frontline workers in legislation that provides protections and considerations for paid parental leave for issues of health and childcare. (Directive to Take Action)

The limited testimony provided on the online forum was in strong support of the resolution, noting that physicians whether in training or post-training face discrimination for parental leave and maternal leave. Maternal discrimination is associated with higher rates of self-reported burnout and this resolution will benefit the social and mental well-being of physicians and their families.

(7) RESOLUTION 404 – WEAPONS IN CORRECTIONAL HEALTHCARE SETTINGS

RESOLVED, That our American Medical Association advocate that physicians not be required to carry or use weapons in correctional facilities where they provide clinical care (Directive to Take Action); and be it further
RESOLVED, That our AMA study and make recommendations regarding the presence of weapons in correctional healthcare facilities. (Directive to Take Action)

Testimony on the online forum was supportive of this resolution. It was noted that new policies require correctional staff, including physicians, to carry less-lethal weapons such as pepper spray and rapid rotation batons. Concern was raised that such a policy interferes with the physician-patient relationship as patients must have trust that health professionals are there to care for them. Furthermore, it was noted that physicians must have a choice, in whether they carry weapons. Whether or not weapons in health care settings, including in correctional health care settings, does more harm than good is an issue deserving of study.

(8) RESOLUTION 405 – UNIVERSAL CHILDCARE AND PRESCHOOL

RESOLVED, That our American Medical Association advocate for universal access to high-quality and affordable childcare and preschool. (Directive to Take Action)

There was limited, but supportive testimony presented on the online forum for Resolution 405. Enrollment in preschool or high-quality childcare directly and indirectly improves children’s health outcomes. Universal preschool or high-quality childcare is also an issue of equity. Enabling children from all socioeconomic backgrounds to access early childhood education that will prepare them for success is an important step towards disrupting cycles of poverty.
RESOLVED, That our American Medical Association advocate for all employees working in a correctional facility to be up to date with vaccinations against COVID-19, unless there is a valid medical contraindication/religious exception (Directive to Take Action); and be it further
RESOLVED, That our AMA advocate for all employees not up to date with vaccination for COVID-19 to be COVID rapid tested each time they enter a correctional facility (Directive to Take Action); and be it further
RESOLVED, That our AMA advocate for correctional facility policies that require non-employed, non-residents (e.g. visitors, contractors, etc.) to either show evidence of being up to date for COVID-19 or show proof of negative COVID test completed within 24 hours prior to each entry into a correctional facility (Directive to Take Action); and be it further
RESOLVED, That our AMA advocate that all people inside a correctional facility wear an appropriate mask at all times, except while eating or drinking or at a safe (6 ft.) distance from anyone else if local transmission rate is above low risk as determined by the Centers for Disease Control and Prevention (Directive to Take Action); and be it further
RESOLVED, That our AMA advocate that correctional facilities be able to request and receive all necessary funding for the above endemic COVID-19 vaccination and testing. (Directive to Take Action)

Testimony presented on the online forum was supportive of the intent of Resolution 406, noting that such aggregate settings may house persons at increased risk for disease morbidity and mortality from COVID-19 illness. Several amendments were offered including the removal of the mention of religious exemptions in the first Resolve as that is contradictory to existing AMA policy on non-medical exemptions to vaccinations. Another amendment suggested adding detention centers, in addition to correctional facilities. A concern was also raised about required testing of visitors, which may increase inequities and make it more difficult for families to visit their loved ones. It was suggested to add a phrase which encourages funding to allow for free testing to be available for families that cannot access or afford testing on their own.

RESOLVED, That our American Medical Association study best practices for interactions between hospitals, clinicians, and members of law enforcement or correctional agencies to ensure that patients in custody of such law enforcement or correctional agencies (including patients without decision-making capacity), their surrogates, and the health care providers caring for them are provided the autonomy and privacy protections afforded to them by law and in concordance with professional ethical standards and report its findings to the AMA House of Delegates by the 2023 Annual Meeting. (Directive to Take Action)

The testimony presented online was in support of this resolution. It was noted that a study of best practices would be of great value in standardizing and providing appropriate acute care, especially in facilities where their providers have little guidelines. Further, it was noted that a clear statement of best practices will help improve health care for those who are incarcerated.
11) RESOLUTION 408 – SUPPORTING INCREASED
RESEARCH ON IMPLEMENTATION OF NONVIOLENT
DE-ESCALATION TRAINING AND MENTAL ILLNESS
AWARENESS IN LAW ENFORCEMENT

RESOLVED, That our American Medical Association support increased research on non-
vviolent de-escalation tactics for law enforcement encounters with the mentally ill (New HOD
Policy); and be it further
RESOLVED, That our AMA support research of fatal encounters with law enforcement and
the prevention thereof. (New HOD Policy)

There was limited, but supportive testimony presented on Resolution 408. It was noted that
the lack of a national governmental database for arrest related deaths, results in a reliance on
incomplete data procured by third-party databases, thereby making it difficult to understand
the role mental illness plays in arrest related deaths. It was also noted that de-escalation
tactics have shown to enhance civilian compliance and are effective in minimizing arrest
related deaths. Unfortunately, law enforcement officials are often not adequately trained to
respond or deescalate situations involving individuals in a state of psychiatric crisis.

12) RESOLUTION 409 – INCREASING HPV VACCINATION
RATES IN RURAL COMMUNITIES

RESOLVED, That our American Medical Association advocate for increased HPV vaccination
access and education in rural communities. (Directive to Take Action)

The testimony presented online was limited, but supportive of Resolution 409. It was noted
that immunization is one of the most important steps individuals can take to protect
themselves, those around them, and their communities from infectious diseases and in the
case of HPV infection, pathogen induced neoplasms. It was also noted that rural communities
have disproportionately low rates of HPV vaccination.

13) RESOLUTION 410 – INCREASING EDUCATION FOR
SCHOOL STAFF TO RECOGNIZE PRODROMAL
SYMPTOMS OF SCHIZOPHRENIA IN TEENS AND
YOUNG ADULTS TO INCREASE EARLY
INTERVENTION

RESOLVED, That our American Medical Association work with the American Psychiatric
Association and other entities to support research of establishing education programs to teach
high school and university staff to recognize the early prodromal symptoms of schizophrenia
to increase early intervention. (Directive to Take Action)

The testimony presented online was limited but supportive of this resolution. It was suggested
that educational programs on the prodromal symptoms of schizophrenia could be integrated
into education that should already be taking place to train staff in schools to recognize abuse
and depression.
(14) RESOLUTION 411 – ANONYMOUS PRESCRIBING OPTION
FOR EXPEDITED PARTNER THERAPY

RESOLVED, That our American Medical Association work with electronic medical record vendors to create an anonymous prescribing option for the purpose of expedited partner therapy. (Directive to Take Action)

The testimony presented online was generally supportive of the intent of this resolution, with several individuals suggesting referral was appropriate to better understand the nuances involved in the implementation of anonymous prescribing for expedited partner therapy. An amendment suggesting two additional resolve statements was also proposed to address public and private health plan coverage, without cost-sharing for expedited partner therapy prescriptions and collaboration with malpractice insurers to limit risks to physicians for such prescriptions.

(15) RESOLUTION 412 – ADVOCATING FOR THE
AMENDMENT OF CHRONIC NUISANCE ORDINANCES

RESOLVED, That our American Medical Association advocate for amendments to chronic nuisance ordinances that ensure calls made for safety or emergency services are not counted towards nuisance designations (Directive to Take Action); and be it further
RESOLVED, That our AMA support initiatives to (a) gather data on chronic nuisance ordinance enforcement and (b) make that data publicly available to enable easier identification of disparities. (New HOD Policy)

Online testimony on this resolution was limited to support by the authors who noted that the AMA would be taking an important step in reducing housing inequalities among marginalized populations by recognizing chronic nuisance ordinances should not be used against those who call emergency services for health or safety reasons.

(16) RESOLUTION 413 – EXPANSION ON
COMPREHENSIVE SEXUAL HEALTH EDUCATION

RESOLVED, That our American Medical Association amend Policy H-170.968, “Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools,” by addition and deletion to read as follows:

(1) Recognizes that the primary responsibility for family life education is in the home, and

(2) Urges schools at all education levels to implement comprehensive, developmentally appropriate sexuality education programs that: (a) are based on rigorous, peer reviewed science; (b) incorporate sexual violence prevention; (c) show promise for delaying the onset of sexual activity and a reduction in sexual behavior that puts adolescents at risk for contracting human immunodeficiency virus (HIV) and other sexually transmitted diseases and for becoming pregnant; (d) include an integrated strategy for making condoms dental dams, and other barrier protection methods available to students and for providing both factual information and skill-building related to reproductive biology, sexual abstinence, sexual responsibility, contraceptives including condoms, alternatives in birth control, and other issues aimed at prevention of pregnancy and sexual transmission of diseases; (e) utilize classroom teachers and other professionals who have shown an aptitude for working with young people and who have received special training that includes addressing the needs of LGBTQ+ gay,
lesbian, and bisexual youth; (f) appropriately and comprehensively address the sexual behavior of all people, inclusive of sexual and gender minorities; (g) include ample involvement of parents, health professionals, and other concerned members of the community in the development of the program; (h) are part of an overall health education program; and (i) include culturally competent materials that are language-appropriate for Limited English Proficiency (LEP) pupils;

(3) Continues to monitor future research findings related to emerging initiatives that include abstinence-only, school-based sexuality education, and consent communication to prevent dating violence while promoting healthy relationships, and school-based condom availability programs that address sexually transmitted diseases and pregnancy prevention for young people and report back to the House of Delegates as appropriate;

(4) Will work with the United States Surgeon General to design programs that address communities of color and youth in high risk situations within the context of a comprehensive school health education program;

(5) Opposes the sole use of abstinence-only education, as defined by the 1996 Temporary Assistance to Needy Families Act (P.L. 104-193), within school systems;

(6) Endorses comprehensive family life education in lieu of abstinence-only education, unless research shows abstinence-only education to be superior in preventing negative health outcomes;

(7) Supports federal funding of comprehensive sex education programs that stress the importance of abstinence in preventing unwanted teenage pregnancy and sexually transmitted infections via comprehensive education, and also teach about including contraceptive choices, abstinence, and safer sex, and opposes federal funding of community-based programs that do not show evidence-based benefits; and

(8) Extends its support of comprehensive family-life education to community-based programs promoting abstinence as the best method to prevent teenage pregnancy and sexually-transmitted diseases while also discussing the roles of condoms and birth control, as endorsed for school systems in this policy;

(9) Supports the development of sexual education curriculum that integrates dating violence prevention through lessons on healthy relationships, sexual health, and conversations about consent; and

(10) Encourages physicians and all interested parties to conduct research and develop best-practice, evidence-based, guidelines for sexual education curricula that are developmentally appropriate as well as medically, factually, and technically accurate. (Modify Current HOD Policy)

While the authors presented testimony in support of this resolution, there was testimony in favor of retaining the line in policy H-170.968, indicating that the primary responsibility for family life education is in the home.

(17) RESOLUTION 414 – IMPROVEMENT OF CARE AND RESOURCE ALLOCATION FOR HOMELESS PERSONS IN THE GLOBAL PANDEMIC

RESOLVED, That our American Medical Association support training to understand the needs of housing insecure individuals for those who encounter this vulnerable population through their professional duties (New HOD Policy); and be it further

RESOLVED, That our AMA support the establishment of multidisciplinary mobile homeless outreach teams trained in issues specific to housing insecure individuals (New HOD Policy); and be it further
RESOLVED, That our AMA reaffirm existing policies H-160.903, “Eradicating Homelessness,” and H-345.975, “Maintaining Mental Health Services by States” (Reaffirm HOD Policy); and be it further
RESOLVED, That our AMA reaffirm existing policy H-160.978, “The Mentally Ill Homeless,” with a title change “Housing Insecure Individuals with Mental Illness”. (Reaffirm HOD Policy)

The limited testimony presented on Resolution 414 was unanimously supportive. Access to safe and affordable housing is a social determinant of health. Housing instability creates significant barriers to accessing health care treatment and preventive services and puts people at greater risk for worse health outcomes. Supporting training on the needs of this population and the establishment of mobile-outreach units will help improve the health of this population.

(18) RESOLUTION 415 – CREATION OF AN OBESITY TASK FORCE

RESOLVED, That our American Medical Association create an obesity task force to evaluate and disseminate relevant scientific evidence to healthcare clinicians, other providers and the public (Directive to Take Action); and be it further
RESOLVED, That the obesity task force address issues including but not limited to:
- Promotion of awareness amongst practicing physicians and trainees that obesity is a treatable chronic disease along with evidence-based treatment options.
- Advocacy efforts at the state and federal level to impact the disease obesity.
- Health disparities, stigma and bias affecting people with obesity.
- Lack of insurance coverage for evidence-based treatments including intensive lifestyle intervention, anti-obesity pharmacotherapy and bariatric and metabolic surgery.
- Increasing obesity rates in children, adolescents and adults.
- Drivers of obesity including lack of healthful food choices, over-exposure to obesogenic foods and food marketing practices. (Directive to Take Action)

Testimony presented online was supportive of this resolution, noting obesity affects a large portion of the US population and often contributes to comorbidities such as hypertension and diabetes. There was support for forming an obesity task force to come up with a strategy to prevent and reverse obesity.

(19) RESOLUTION 416 – SCHOOL RESOURCE OFFICER VIOLENCE DE-ESCALATION TRAINING AND CERTIFICATION

RESOLVED, That our American Medical Association highly recommend mandatory conflict de-escalation training for all school resource officers (New HOD Policy); and be it further
RESOLVED, That our AMA actively advocate to the National Association of School Resource Officers to develop a program for certification of School Resource Officers including but not limited to violence de-escalation training requirements, expiration date, renewal continuing education requirements and a revocation procedure in the rare event of misconduct. (Directive to Take Action)

Testimony online was mostly supportive of this resolution, noting that mandatory conflict de-escalation training is needed and not all school resource officers across the country currently receive this nationally recognized basic and advanced training. One comment noted that rather than a certification program for school resource officers, best practice guidelines
should be developed as a “one-size” certification may not fit the needs of all individual school
districts.

(20) RESOLUTION 417 – TOBACCO CONTROL

RESOLVED, That American Medical Association policy H-490.913, “Smoke-Free and Vape-
Free Environments and Workplaces,” be amended by addition and deletion to read as follows:
On the issue of the health effects of environmental tobacco smoke (ETS), passive smoke, and
vape aerosol exposure in the workplace and other public facilities, our AMA: (1)(a) supports
classification of ETS as a known human carcinogen, and (b) concludes that passive smoke
exposure is associated with increased risk of sudden infant death syndrome and of
cardiovascular disease, and (c) encourages physicians and medical societies to take a
leadership role in defending the health of the public from ETS risks and from political assaults
by the tobacco industry, and and (d) encourages the concept of establishing smoke-free and
vape-free campuses for business, labor, education, and government, and (2) (a) honors
companies and governmental workplaces that go smoke-free and vape-free, and (b) will
petition the Occupational Safety and Health Administration (OSHA) to adopt regulations
prohibiting smoking and vaping in the workplace, and will use active political means to
encourage the Secretary of Labor to swiftly promulgate an OSHA standard to protect
American workers from the toxic effects of ETS in the workplace, preferably by banning
smoking and vaping in the workplace, and (c) encourages state medical societies (in
collaboration with other anti-tobacco organizations) to support the introduction of local and
state legislation that prohibits smoking and vaping around the public entrances to buildings
and in all indoor public places, restaurants, bars, and workplaces, and and (d) will update draft
model state legislation to prohibit smoking and vaping in public places and businesses, which
would include language that would prohibit preemption of stronger local laws. (3) (a)
encourages state medical societies to: (i) support legislation for states and counties
mandating smoke-free and vape-free schools and eliminating smoking and vaping in public
places and businesses and on any public transportation, and (ii) enlist the aid of county
medical societies in local anti-smoking and anti-vaping campaigns, and and (iii) through an
advisory to state, county, and local medical societies, urge county medical societies to join or
to increase their commitment to local and state anti-smoking and anti-vaping coalitions and to
reach out to local chapters of national voluntary health agencies to participate in the promotion
of anti-smoking and anti-vaping control measures, and (b) urges all restaurants, particularly
fast food restaurants, and convenience stores to immediately create a smoke-free and vape-
free environment, and (c) strongly encourages the owners of family-oriented theme parks to
make their parks smoke-free and vape-free for the greater enjoyment of all guests and to
further promote their commitment to a happy, healthy life style for children, and (d) encourages
state or local legislation or regulations that prohibit smoking and vaping in stadia and
encourages other ball clubs to follow the example of banning smoking in the interest of the
health and comfort of baseball fans as implemented by the owner and management of the
Oakland Athletics and others, and (e) urges eliminating cigarette, pipe and cigar smoking and
vaping in any indoor area where children live or play, or where another person’s health could
be adversely affected through passive smoking inhalation, and (f) urges state and county
medical societies and local health professionals to be especially prepared to alert
communities to the possible role of the tobacco industry whenever a petition to suspend a
nonsmoking or non-vaping ordinance is introduced and to become directly involved in
community tobacco control activities, and (g) will report annually to its membership about
significant anti-smoking and anti-vaping efforts in the prohibition of smoking and vaping in
open and closed stadia, and (4) calls on corporate headquarters of fast-food franchisers to
require that one of the standards of operation of such franchises be a no smoking and no
vaping policy for such restaurants, and endorses the passage of laws, ordinances and regulations that prohibit smoking and vaping in fast-food restaurants and other entertainment and food outlets that target children in their marketing efforts, and (5) advocates that all American hospitals ban tobacco and supports working toward legislation and policies to promote a ban on smoking, vaping, and use of tobacco products in, or on the campuses of, hospitals, health care institutions, retail health clinics, and educational institutions, including medical schools, and (6) will work with the Department of Defense to explore ways to encourage a smoke-free and vape-free environment in the military through the use of mechanisms such as health education, smoking and vaping cessation programs, and the elimination of discounted prices for tobacco products in military resale facilities, and (7) encourages and supports collaborates with local and state medical societies and tobacco control coalitions to work with (a) Native American casino and tribal leadership to voluntarily prohibit smoking and vaping in their casinos, and (b) legislators and the gaming industry to support the prohibition of smoking and vaping in all casinos and gaming venues. (Modify Current HOD Policy)

Testimony online was limited, but supportive, noting that the collective power of the AMA is needed to have tribal leaders voluntarily prohibit smoking and vaping in their casinos.

(21) RESOLUTION 418 – LUNG CANCER SCREENING AWARENESS

RESOLVED, That our American Medical Association empower the American public with knowledge through an education campaign to raise awareness of lung cancer screening with low-dose CT scans in high-risk patients to improve screening rates and decrease the leading cause of cancer death in the United States. (Directive to Take Action)

Testimony presented online was limited, but supportive, noting that lung cancer is the leading cause of cancer death in the United States. It was noted that an educational campaign focused on raising awareness of lung cancer screening in high-risk patients is essential to improve screening rates. The authors also noted that pursuant to Policy G-600.064, “AMA Endorsement of Screening Tests or Standards,” they are asking for referral for study.

(22) RESOLUTION 419 – ADVOCATING FOR THE UTILIZATION OF POLICE AND MENTAL HEALTH CARE CO-RESPONSE TEAMS FOR 911 MENTAL HEALTH EMERGENCY CALLS

RESOLVED, That our American Medical Association support efforts to increase the use of co-response (police and mental health worker) teams for non-violent mental health-related 911 calls. (New HOD Policy)

Testimony online was limited, with an amendment proffered to strike “non-violent” noting that only including non-violent situations would exclude many situations where violence is a result of mental illness. It was also noted that the co-response team approach should extend to all mental health emergency calls.
(23) RESOLUTION 420 – DECLARING CLIMATE CHANGE A PUBLIC HEALTH CRISIS

RESOLVED, That our American Medical Association declare climate change a public health crisis that threatens the health and well-being of all individuals (Directive to Take Action); and be it further RESOLVED, That our AMA protect patients by advocating for policies that: (1) limit global warming to no more than 1.5 degrees Celsius, (2) reduce US greenhouse gas emissions, and (3) achieve a reduced-emissions economy (Directive to Take Action); and be it further RESOLVED, That our AMA develop a strategic plan for how we will enact our climate change policies including advocacy priorities and strategies to decarbonize physician practices and the health sector with report back to the House of Delegates at the 2023 Annual Meeting. (Directive to Take Action)

Testimony presented online was unanimously supportive, noting that climate change affects human health and disease. It was noted that the asks of the resolution are meant to ensure that organized medicine is leading on this public health issue like we have led on COVID and many other issues.

(24) RESOLUTION 421 – SCREENING FOR HPV-RELATED ANAL CANCER

RESOLVED, That our American Medical Association support advocacy efforts to implement screening for anal cancer for high-risk populations (New HOD Policy); and be it further RESOLVED, That our AMA support national medical specialty organizations and other stakeholders in developing guidelines for interpretation, follow up, and management of anal cancer screening results. (New HOD Policy)

The limited testimony presented online was unanimously supportive of this resolution, noting that preventing and protecting patients from HPV-related cancers, particularly within populations such as men who have sex with men and HIV-infected patient population, is essential. One comment noted that the lack of specifically defining "high-risk populations" allows specialty societies to work further on defining high-risk.

(25) RESOLUTION 422 – VOTING AS A SOCIAL DETERMINANT OF HEALTH

RESOLVED, That our American Medical Association acknowledge voting is a social determinant of health and significantly contributes to the analyses of other social determinants of health as a key metric (New HOD Policy); and be it further RESOLVED, That our AMA recognize gerrymandering as a partisan effort that functions in part to limit access to health care, including but not limited to the expansion of comprehensive medical insurance coverage, and negatively impacts health outcomes (New HOD Policy); and be it further RESOLVED, That our AMA collaborate with appropriate stakeholders and provide resources to firmly establish a relationship between voter participation and health outcomes. (Directive to Take Action)

Testimony presented online was mostly supportive, noting that participation in the electoral process by voting greatly impacts health of a community. One comment noted that while the barriers and facilitators to voting may be viewed as a social determinant of health, the act of
voting itself is an exercise of a right. Several comments noted support for a specific callout to
gerrymandering as an effort to undermine the health and wealth of historically marginalized
communities. Another comment stated that more needs to be done to increase voter
participation to positively affect the social determinants of health and called for referral of this
resolution. The authors proposed amendments to all three resolve clauses aiming to address
concerns raised and simultaneously strengthen the resolution.

(26) RESOLUTION 423 – AWARENESS CAMPAIGN FOR 988
NATIONAL SUICIDE PREVENTION LIFELINE

RESOLVED, That our American Medical Association utilize their existing communications
channels to educate the physician community and the public on the new 9-8-8 program.
(Directive to Take Action)

Testimony presented online was largely supportive of this resolution. The AMA has a long
history of supporting public service campaigns aimed at improving public health and the rollout
of the 988 program will depend on awareness of its existence. It was also noted that state
funding of the 988 program is important, but only a handful have done this so far. One
comment noted that Resolutions 423 and 425 should be merged into a comprehensive
document recognizing our nation’s mental health crisis.

(27) RESOLUTION 424 – PHYSICIAN INTERVENTIONS
ADDRESSING ENVIRONMENTAL HEALTH AND
JUSTICE

RESOLVED, That our American Medical Association amend policy H-135.938, “Global
Climate Change and Human Health,” by addition to read as follows:

1. Supports the findings of the Intergovernmental Panel on Climate Change’s fourth
assessment report and concurs with the scientific consensus that the Earth is undergoing
adverse global climate change and that anthropogenic contributions are significant. These
climate changes will create conditions that affect public health, with disproportionate impacts
on vulnerable populations, including children, the elderly, and the poor.
2. Supports educating the medical community on the potential adverse public health effects
of global climate change and incorporating the health implications of climate change into the
spectrum of medical education, including topics such as population displacement, heat waves
and drought, flooding, infectious and vector-borne diseases, and potable water supplies.
3. (a) Recognizes the importance of physician involvement in policymaking at the state,
national, and global level and supports efforts to search for novel, comprehensive, and
economically sensitive approaches to mitigating climate change to protect the health of the
public; and (b) recognizes that whatever the etiology of global climate change, policymakers
should work to reduce human contributions to such changes.
4. Encourages physicians to assist in educating patients and the public on environmentally
sustainable practices, and to serve as role models for promoting environmental sustainability.
5. Encourages physicians to work with local and state health departments to strengthen the
public health infrastructure to ensure that the global health effects of climate change can be
anticipated and responded to more efficiently, and that the AMA’s Center for Public Health
Preparedness and Disaster Response assist in this effort.
6. Supports epidemiological, translational, clinical and basic science research necessary for
evidence-based global climate change policy decisions related to health care and treatment.
7. Encourages physicians to assess for environmental determinants of health in patient history-taking and encourages the incorporation of assessment for environmental determinants of health in patient history-taking into physician training. (Modify Current HOD Policy)

Testimony presented online was very limited, but supportive, noting that environmental factors are causing detrimental effects on human health and have far-reaching consequences on public health aims. Educating medical trainees is one way to inform physicians about the deleterious effects of climate change and environmental hazards on health.

(28) RESOLUTION 425 – MENTAL HEALTH CRISIS

RESOLVED, That our American Medical Association work expediently with all interested national medical organizations, national mental health organizations, and appropriate federal government entities to convene a federally-sponsored blue ribbon panel and develop a widely disseminated report on mental health treatment availability and suicide prevention in order to:

1) Improve suicide prevention efforts, through support, payment and insurance coverage for mental and behavioral health and suicide prevention services, including, but not limited to, the National Suicide Prevention Lifeline;

2) Increase access to affordable and effective mental health care through expanding and diversifying the mental and behavioral health workforce;

3) Expand research into the disparities in youth suicide prevention;

4) Address disparities in suicide risk and rate through education, policies and development of suicide prevention programs that are culturally and linguistically appropriate;

5) Develop and support resources and programs that foster and strengthen healthy mental health development; and

6) Develop best practices for minimizing emergency department delays in obtaining appropriate mental health care for patients who are in mental health crisis. (Directive to Take Action)

RESOLVED, That our American Medical Association support physician acquisition of emergency mental health response skills by promoting education courses for physicians, fellows, residents, and medical students including, but not limited to, mental health first aid training (Directive to Take Action); and be it further

RESOLVED, That our AMA reaffirm AMA Policy D-345.994 and H-345.984. (Reaffirm HOD Policy)

Testimony presented online was very limited, but supportive. One comment noted that a special emphasis should be placed on mental health resources for our rural communities. Another comment suggested that Resolutions 423 and 425 should be merged.

(29) RESOLUTION 426 – MENTAL HEALTH FIRST AID TRAINING

RESOLVED, That our American Medical Association support physician acquisition of emergency mental health response skills by promoting education courses for physicians, fellows, residents, and medical students including, but not limited to, mental health first aid training (Directive to Take Action); and be it further

RESOLVED, That our AMA reaffirm AMA Policy D-345.994 and H-345.984. (Reaffirm HOD Policy)
Testimony presented online was limited, but supportive, noting that mental health first aid training, is a proven tool, but physicians lack the tools and training to implement it.

(30) RESOLUTION 427 – PICTORIAL HEALTH WARNINGS ON ALCOHOLIC BEVERAGES

RESOLVED, That our AMA amend Policy H-30.940, “AMA Policy Consolidation: Labeling Advertising, and Promotion of Alcoholic Beverages,” by addition to read 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.

(2.) (a) Expresses its strong disapproval of any consumption of "nonalcoholic beer" by persons under 21 years of age, which creates an image of drinking alcoholic beverages and thereby may encourage the illegal underaged use of alcohol; (b) recommends that health education labels be used on all alcoholic beverage containers and in all alcoholic beverage advertising (with the messages focusing on the hazards of alcohol consumption by specific population groups especially at risk, such as pregnant women, as well as the dangers of irresponsible use to all sectors of the populace); and (c) recommends that the alcohol beverage industry be encouraged to accurately label all product containers as to ingredients, preservatives, and ethanol content (by percent, rather than by proof); and (d) advocates that the alcohol beverage industry be required to include pictorial health warnings on alcoholic beverages.

(3.) Actively supports and will work for a total statutory prohibition of advertising of all alcoholic beverages except for inside retail or wholesale outlets. Pursuant to that goal, our AMA (a) supports continued research, educational, and promotional activities dealing with issues of alcohol advertising and health education to provide more definitive evidence on whether, and in what manner, advertising contributes to alcohol abuse; (b) opposes the use of the radio and television to promote drinking; (c) will work with state and local medical societies to support the elimination of advertising of alcoholic beverages from all mass transit systems; (d) urges college and university authorities to bar alcoholic beverage companies from sponsoring athletic events, music concerts, cultural events, and parties on school campuses, and from advertising their products or their logo in school publications; and (e) urges its constituent state associations to support state legislation to bar the promotion of alcoholic beverage consumption on school campuses and in advertising in school publications.

(4.) (a) Urges producers and distributors of alcoholic beverages to discontinue advertising directed toward youth, such as promotions on high school and college campuses; (b) urges advertisers and broadcasters to cooperate in eliminating television program content that depicts the irresponsible use of alcohol without showing its adverse consequences (examples of such use include driving after drinking, drinking while pregnant, or drinking to
enhance performance or win social acceptance); (c) supports continued warnings against
the irresponsible use of alcohol and challenges the liquor, beer, and wine trade groups to
include in their advertising specific warnings against driving after drinking; and (d)
commends those automobile and alcoholic beverage companies that have advertised
against driving while under the influence of alcohol. (Modify Current HOD Policy); and be it
further
RESOLVED, That our AMA advocate for the implementation of pictorial health warnings on
alcoholic beverages. (Directive to Take Action)

Testimony presented online was limited to an individual indicating their support for including
pictorial health warnings on alcoholic beverages.

(31) RESOLUTION 428 – AMENDING H-90.968 TO EXPAND
POLICY ON MEDICAL CARE OF PERSONS WITH
DISABILITIES

RESOLVED, That, in order to address the shared healthcare barriers of people with
disabilities and the need for curricula in medical education on the care and treatment of people
with a range of disabilities, our American Medical Association amend by addition and deletion
H-90.968 “Medical Care of Persons with Developmental Disabilities” to include those with a
broad range of disabilities while retaining goals specific to the needs of those with
developmental disabilities:

Medical Care of Persons with Developmental Disabilities, H-90.968
1. Our AMA encourages: (a) clinicians to learn and appreciate variable presentations of
complex functioning profiles in all persons with developmental disabilities including but not
limited to physical, sensory, developmental, intellectual, learning, and psychiatric disabilities
and chronic illnesses; (b) medical schools and graduate medical education programs to
acknowledge the benefits of education on how aspects in the social model of disability (e.g.
ableism) can impact the physical and mental health of persons with Developmental
Disabilities; (c) medical schools and graduate medical education programs to acknowledge
the benefits of teaching about the nuances of uneven skill sets, often found in the functioning
profiles of persons with developmental disabilities, to improve quality in clinical care; (d)
education of physicians on how to provide and/or advocate for quality, developmentally
appropriate and accessible medical, social and living support for patients with developmental
disabilities so as to improve health outcomes; (e) medical schools and residency programs to
encourage faculty and trainees to appreciate the opportunities for exploring diagnostic and
therapeutic challenges while also accruing significant personal rewards when delivering care
with professionalism to persons with profound developmental disabilities and multiple co-
morbid medical conditions in any setting; (f) medical schools and graduate medical education
programs to establish and encourage enrollment in elective rotations for medical students and
residents at health care facilities specializing in care for the developmentally disabled; and (g)
cooperation among physicians, health & human services professionals, and a wide variety of
adults with developmental disabilities to implement priorities and quality improvements for the
care of persons with developmental disabilities.

2. Our AMA seeks: (a) legislation to increase the funds available for training physicians in the
care of individuals with intellectual disabilities/developmentally disabled individuals, and to
increase the reimbursement for the health care of these individuals; and (b) insurance industry
and government reimbursement that reflects the true cost of health care of individuals with
intellectual disabilities/developmentally disabled individuals.

3. Our AMA entreats health care professionals, parents, and others participating in decision-
making to be guided by the following principles: (a) All people with developmental disabilities,
regardless of the degree of their disability, should have access to appropriate and affordable medical and dental care throughout their lives; and (b) An individual’s medical condition and welfare must be the basis of any medical decision. Our AMA advocates for the highest quality medical care for persons with profound developmental disabilities; encourages support for health care facilities whose primary mission is to meet the health care needs of persons with profound developmental disabilities; and informs physicians that when they are presented with an opportunity to care for patients with profound developmental disabilities, that there are resources available to them.

4. Our AMA will continue to work with medical schools and their accrediting/licensing bodies to encourage disability related competencies/objectives in medical school curricula so that medical professionals are able to effectively communicate with patients and colleagues with disabilities, and are able to provide the most clinically competent and compassionate care for patients with disabilities.

4. Our AMA will collaborate with appropriate stakeholders to create a model general curriculum/objective that (a) incorporates critical disability studies; and (b) includes people with disabilities as patient instructors in formal training sessions and preclinical and clinical instruction.

5. Our AMA recognizes the importance of managing the health of children and adults with developmental and intellectual disabilities as a part of overall patient care for the entire community.

6. Our AMA supports efforts to educate physicians on health management of children and adults with intellectual and developmental disabilities, as well as the consequences of poor health management on mental and physical health for people with intellectual and developmental disabilities.

7. Our AMA encourages the Liaison Committee on Medical Education, Commission of Osteopathic College Accreditation, and allopathic and osteopathic medical schools to develop and implement a curriculum on the care and treatment of people with a range of developmental disabilities.

8. Our AMA encourages the Accreditation Council for Graduate Medical Education and graduate medical education programs to develop and implement curriculum on providing appropriate and comprehensive health care to people with a range of developmental disabilities.

9. Our AMA encourages the Accreditation Council for Continuing Medical Education, specialty boards, and other continuing medical education providers to develop and implement continuing programs that focus on the care and treatment of people with a range of developmental disabilities.

10. Our AMA will advocate that the Health Resources and Services Administration include persons with intellectual and developmental disabilities (IDD) as a medically underserved population.

11. Specific to people with developmental and intellectual disabilities, a uniquely underserved population, our AMA encourages: (a) medical schools and graduate medical education programs to acknowledge the benefits of teaching about the nuances of uneven skill sets, often found in the functioning profiles of persons with developmental and intellectual disabilities, to improve quality in clinical education; (b) medical schools and graduate medical education programs to establish and encourage enrollment in elective rotations for medical students and residents at health care facilities specializing in care for individuals with developmental and intellectual disabilities; and (c) cooperation among physicians, health and human services professionals, and a wide variety of adults with intellectual and developmental disabilities to implement priorities and quality improvements for the care of persons with intellectual and developmental disabilities.

(Modify Current HOD Policy)
Testimony presented online was limited, but supportive, noting current AMA policy, which
somewhat addresses the need for better disability-focused medical training and treatment,
falls short in addressing a wide range of disabilities and does not include care and treatment
of people with disabilities in curricula and continuing education.

(32) RESOLUTION 429 – INCREASING AWARENESS AND
REDUCING CONSUMPTION OF FOOD AND DRINK OF
POOR NUTRITIONAL QUALITY

H-150.927 – STRATEGIES TO REDUCE THE CONSUMPTION OF FOOD
AND BEVERAGES WITH ADDED SWEETENERS

RESOLVED, That our American Medical Association advocate for the end of tax subsidies for
advertisements that promote among children the consumption of food and drink of poor
nutritional quality, as defined by appropriate nutritional guiding principles (Directive to Take
Action); and be it further
RESOLVED, That our AMA amend H-150.927, “Strategies to Reduce the Consumption of
Beverages with Added Sweeteners” by addition to read as follows:
H-150.927 – STRATEGIES TO REDUCE THE CONSUMPTION OF FOOD AND
BEVERAGES WITH ADDED SWEETENERS

Our AMA: (1) acknowledges the adverse health impacts of sugar- sweetened beverage (SSB)
consumption and food products with added sugars, and support evidence-based strategies to
reduce the consumption of SSBs and food products with added sugars, including but not
limited to, excise taxes on SSBs and food products with added sugars, removing options to
purchase SSBs and food products with added sugars in primary and secondary schools, the
use of warning labels to inform consumers about the health consequences of SSB
consumption and food products with added sugars, and the use of plain packaging; (2)
encourages continued research into strategies that may be effective in limiting SSB
consumption and food products with added sugars, such as controlling portion sizes; limiting
options to purchase or access SSBs and food products with added sugars in early childcare
settings, workplaces, and public venues; restrictions on marketing SSBs and food products
with added sugars to children; and changes to the agricultural subsidies system; (3)
encourages hospitals and medical facilities to offer healthier beverages, such as water,
unflavored milk, coffee, and unsweetened tea, for purchase in place of SSBs and apply calorie
counts for beverages in vending machines to be visible next to the price; and (4) encourages
physicians to (a) counsel their patients about the health consequences of SSB consumption
and food products with added sugars and replacing SSBs and food products with added
sugars with healthier beverage and food choices, as recommended by professional society
clinical guidelines; and (b) work with local school districts to promote healthy beverage and
food choices for students; and (5) recommends that taxes on food and beverage products
with added sugars be enacted in such a way that the economic burden is borne by companies
and not by individuals and families with limited access to food alternatives; and (6) supports
that any excise taxes are reinvested in community programs promoting health. (Modify
Current HOD Policy)

Limited testimony indicated support for the concept of this resolution, noting that advertising
heavily informs children’s food knowledge, preferences, and consumption patterns that can
lead to excess calorie intake. An individual raised concern regarding calling for more taxes of
members of our society who can least afford more expenses.
RESOLVED, That our American Medical Association: (1) Declare climate change an urgent public health emergency that threatens the health and well-being of all individuals; (2) Aggressively advocate for prompt passage of legislation and policies that limit global warming to no more than 1.5 degrees Celsius over pre-industrial levels and address the health and social impacts of climate change through rapid reduction in greenhouse gas emissions aimed at carbon neutrality by 2050, rapid implementation and incentivization of clean energy solutions, and significant investments in climate resilience through a climate justice lens; (3) Study opportunities for local, state, and federal policy interventions and advocacy to proactively respond to the emerging climate health crisis and advance climate justice with report back to the House of Delegates; and (4) Consider the establishment of a longitudinal task force or organizational unit within the AMA to coordinate and strengthen efforts toward advocacy for an equitable and inclusive transition to a net-zero carbon society by 2050, with report back to the House of Delegates. (Directive to Take Action)

Testimony presented online was limited, but supportive, stating that climate change poses an unprecedented challenge for the medical system, and it is important that our AMA be able to advocate for these issues with specific goals and a well-developed climate advocacy infrastructure. It was also noted that the United States health care system is a major contributor to greenhouse gas emissions, negatively impacting the climate. It was noted that Resolution 605 is similar in its ask and it was thus suggested that the items be combined. Another individual noted support for 605 in lieu of 430 as it goes further in its action items.

RESOLVED, That our American Medical Association encourage research efforts to characterize the health needs for pregnant inmates, including efforts that utilize data acquisition directly from pregnant inmates (Directive to Take Action); and be it further
RESOLVED, That our AMA support legislation requiring all correctional facilities, including those that are privately-owned, to collect and report pregnancy-related healthcare statistics with transparency in the data collection process (Directive to Take Action); and be it further
RESOLVED, That our AMA oppose the immediate separation of infants from incarcerated pregnant individuals post-partum; (Directive to Take Action) and be it further
RESOLVED, That our AMA support solutions, such as community-based programs, which allow infants and incarcerated postpartum individuals to remain together (Directive to Take Action); and be it further
RESOLVED, That our AMA amend policy H-430.990 by addition to read as follows:
Bonding Programs for Women Prisoners and their Newborn Children H-430.990

Because there are insufficient data at this time to draw conclusions about the long-term effects of prison nursery programs on mothers and their children, the AMA supports and encourages further research on the impact of infant bonding programs on incarcerated women and their children. However, since there are established benefits of breast milk for infants and breast milk expression for mothers, the AMA advocates for policy and legislation that extends the right to breastfeed and/or pump and store breast milk to include incarcerated mothers. The AMA recognizes the prevalence of mental health and substance abuse problems among incarcerated women and continues to support access to appropriate services for women in
prisons. The AMA recognizes that a large majority of incarcerated females who may not have
developed appropriate parenting skills are mothers of children under the age of 18. The AMA
encourages correctional facilities to provide parenting skills and breastfeeding/breast pumping
training to all female inmates in preparation for their release from prison and return to their
children. The AMA supports and encourages further investigation into the long-term effects of
prison nurseries on mothers and their children. (Modify Current HOD Policy)

Testimony presented online was mostly supportive, noting that it is essential to protect
bonding between a mother and their newborn which has been shown to have a positive effect
on the child’s development. One comment noted that there are many unanswered questions
which would make it difficult to accomplish the stated goals in the resolution, and therefore
recommended referral. Another comment spoke in support of adopting Resolves 3 and 4 and
against referral, given the data that already exists, as well as the experience in the eight states
that have already established Correctional Center Nursery Program.

(35) RESOLUTION 432 – RECOGNIZING LONELINESS AS A
PUBLIC HEALTH ISSUE

RESOLVED, That our American Medical Association release a statement identifying
loneliness as a public health issue with consequences for physical and mental health
(Directive to Take Action;) and be it further
RESOLVED, That our AMA support evidence-based efforts to combat loneliness. (New HOD
Policy)

The limited testimony presented online was unanimously supportive, noting that there is a
growing body of research demonstrating a strong link between social isolation and loneliness
and adverse health outcomes. It was also noted that recognizing loneliness as a public health
issue is the best next step in combating loneliness.

(36) RESOLUTION 433 – SUPPORT FOR DEMOCRACY

RESOLVED, That our American Medical Association unequivocally support the democratic
process, wherein representatives are regularly chosen through free and fair elections, as
essential for maximizing the health and well-being of all Americans (New HOD Policy); and
be it further
RESOLVED, That our AMA strongly oppose attempts to subvert the democratic process
(Directive to Take Action); and be it further
RESOLVED, That our AMA assert that every candidate for political office and every
officeholder in the public trust must support the democratic process and never take steps or
support steps by others to subvert it. (Directive to Take Action)

Testimony presented online was very limited, but supportive, stating that the democratic
process ensures the needs of citizens are considered by legislators and policymakers. It was
also noted that research has shown that functioning democracies with free and fair elections
are associated with better health outcomes compared to autocracies.
(37) RESOLUTION 434 – SUPPORT FOR PEDIATRIC SIBLINGS OF CHRONICALLY ILL CHILDREN

RESOLVED, That our American Medical Association support programs and resources that improve the mental health, physical health, and social support of pediatric siblings of chronically ill pediatric patients. (Directive to Take Action)

Testimony presented online was limited, but supportive, stating that it is important to ensure support and resources are provided to family members and siblings of chronically ill pediatric patients. Interventions exist that have demonstrated positive outcomes for the children who participated, including improvement in emotional, physical, and self-esteem functioning.

(38) RESOLUTION 435 – SUPPORT REMOVAL OF BMI AS A STANDARD MEASURE IN MEDICINE AND RECOGNIZING CULTURALLY-DIVERSE AND VARIED PRESENTATIONS OF EATING DISORDERS

RESOLVED, That our American Medical Association recognize the significant limitations and potential harms associated with the widespread use of body mass index (BMI) in clinical settings and supports its use only in a limited screening capacity when used in conjunction with other more valid measures of health and wellness (Directive to Take Action); and be it further

RESOLVED, That our AMA support the use of validated, easily obtained alternatives to BMI (such as relative fat mass, body adiposity index, and the body volume index) for estimating risk of weight-related disease (New HOD Policy); and be it further

RESOLVED, That our AMA amend policy H-440.866, “The Clinical Utility of Measuring Body Mass Index and Waist Circumference in the Diagnosis and Management of Adult Overweight and Obesity,” by addition and deletion to read as follows:

Our AMA supports:
(1) greater emphasis in physician educational programs on the risk differences among ethnic and age within and between demographic groups at varying weights and levels of adiposity BMI and the importance of monitoring waist circumference in all individuals with BMIs below 35 kg/m2;
(2) additional research on the efficacy of screening for overweight and obesity, using different indicators, in improving various clinical outcomes across populations, including morbidity, mortality, mental health, and prevention of further weight gain; and
(3) more research on the efficacy of screening and interventions by physicians to promote healthy lifestyle behaviors, including healthy diets and regular physical activity, in all of their patients to improve health and minimize disease risks. (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA amend policy H-150.965, by addition to read as follows in order to support increased recognition of disordered eating behaviors in minority populations and culturally appropriate interventions:

H-150.965 – EATING DISORDERS
The AMA (1) adopts the position that overemphasis of bodily thinness is as deleterious to one’s physical and mental health as obesity; (2) asks its members to help their patients avoid obsessions with dieting and to develop balanced, individualized approaches to finding the body weight that is best for each of them; (3) encourages training of all school-based physicians, counselors, coaches, trainers, teachers and nurses to recognize unhealthy eating, binge-eating, dieting, and weight restrictive behaviors in adolescents and to offer education and appropriate referral of adolescents and their families for culturally-informed interventional counseling; and (4) participates in this effort by consulting with appropriate and culturally informed educational and counseling materials pertaining to unhealthy eating, binge-eating, dieting, and weight restrictive behaviors. (Modify Current HOD Policy)

Testimony presented online was mixed, with more opposition than support for some of the resolve clauses. One comment in support noted that studies have demonstrated BMI’s inadequacy for use as a measure in diverse populations because it was developed based upon European male characteristics. Others noted that while BMI is not perfect, it is currently the most readily obtainable measurement in an office setting to screen for overweight and obesity. One comment recommend research to look at alternative metric(s) to BMI. Another comment noted support for alternative measures of obesity through various tools, but noted that these tools should be used in conjunction with BMI. Further, comments noted that the alternatives in the second Resolve are not widely accepted alternatives or standard of care. One comment also noted that the fourth Resolve should be a separate resolution.

(39) RESOLUTION 436 – TRAINING AND REIMBURSEMENT FOR FIREARM SAFETY COUNSELING

RESOLVED, That our American Medical Association support the inclusion of gun violence epidemiology and evidence-based firearm-related injury prevention education in medical school curricula (Directive to Take Action); and be it further RESOLVED, That our AMA amend Policy H-145.976, “Firearm Safety Counseling in Physician-Led Health Care Teams,” by addition to read as follows:

1. Our AMA: (a) will oppose any restrictions on physicians' and other members of the physician-led health care team's ability to inquire and talk about firearm safety issues and risks with their patients; (b) will oppose any law restricting physicians' and other members of the physician-led health care team's discussions with patients and their families about firearms as an intrusion into medical privacy; and (c) encourages dissemination of educational materials related to firearm safety to be used in undergraduate medical education.

2. Our AMA will work with appropriate stakeholders to develop state-specific guidance for physicians on how to counsel patients to reduce their risk for firearm-related injury or death, including guidance on when and how to ask sensitive questions about firearm ownership, access, and use, and clarification on the circumstances under which physicians are permitted or may be required to disclose the content of such conversations to family members, law enforcement, or other third parties.

3. Our AMA will support the development of reimbursement structures that incentivize physicians to counsel patients on firearm-related injury risk and prevention. (Modify Current HOD Policy)

Testimony presented online was supportive of this resolution, noting that firearm violence is a largely preventable public health crisis and all members of the medical team, especially physicians, should be trained and incentivized to talk about firearm safety with their patients.
The Council on Medical Education indicated their support for the first Resolve. An amendment proferred to the first Resolve suggested that in addition to the medical school curricula, firearm-related injury prevention education also be added to appropriate graduate medical education training.

(40) RESOLUTION 437 – AIR POLLUTION AND COVID: A CALL TO TIGHTEN REGULATORY STANDARDS FOR PARTICULATE MATTER

RESOLVED, That our American Medical Association recognize the health, safety, and climate risks of current methods of producing fossil fuel-derived hydrogen and the dangers of adding hydrogen to natural gas (HP) (New HOD Policy); and be it further RESOLVED, That our AMA educate its members, and, to the extent possible, health care professionals and the public, about the health, safety, and climate risks of current methods of producing fossil fuel-derived hydrogen and the dangers of adding hydrogen to natural gas (Directive to Take Action); and be it further RESOLVED, That our AMA advocate to appropriate government agencies such as the EPA and the Department of Energy, and federal legislative bodies, regarding the health, safety and climate risks of current methods of producing fossil fuel derived hydrogen and the dangers of adding hydrogen to natural gas. (Directive to Take Action)

Testimony presented online was limited, but supportive, stating that deaths attributable to air pollution, most notably cardiovascular disease, would be much reduced with more stringent enforcement of air quality measures. It was also noted that the Environmental Protection Agency expects to issue proposed rulemaking on this issue in Summer 2022 and this resolution will ensure that the AMA weighs in.

(41) RESOLUTION 438 – INFORMING PHYSICIANS, HEALTH CARE PROVIDERS, AND THE PUBLIC OF THE HEALTH DANGERS OF FOSSIL-FUEL DERIVED HYDROGEN

RESOLVED, That our American Medical Association AMA advocate for stronger federal particulate matter air quality standards than currently in place and improved enforcement that will better protect the public’s health. (Directive to Take Action)

Testimony presented online was limited, but supportive, noting that although the use of hydrogen is a proposed method to reduce carbon emissions, much of the currently available hydrogen is derived from fossil fuels, which contributes to climate change. It was also noted that the use of hydrogen technologies directly contributes to climate change by increasing methane leakage due to increased pipeline corrosion and increasing indoor air pollution due to the increase in nitrogen oxide when hydrogen is burned with methane.

(42) RESOLUTION 439 – INFORMING PHYSICIANS, HEALTH CARE PROVIDERS, AND THE PUBLIC THAT COOKING WITH A GAS STOVE INCREASES HOUSEHOLD AIR POLLUTION AND THE RISK OF CHILDHOOD ASTHMA

RESOLVED, That our American Medical Association recognize the association between the use of gas stoves, indoor nitrogen dioxide levels and asthma (New HOD Policy); and be it further
RESOLVED, That our AMA inform its members and, to the extent possible, health care providers, the public, and relevant organizations that use of a gas stove increases household air pollution and the risk of childhood asthma and asthma severity; which can be mitigated by reducing the use of the gas cooking stove, using adequate ventilation, and/or using an appropriate air filter (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for innovative programs to assist with mitigation of cost to encourage the transition from gas stoves to electric stoves in an equitable manner. (Directive to Take Action)

Testimony presented online was limited, but supportive noting the increases in nitrogen dioxide in household air due to the use of gas stoves are well documented as is increased asthma among children living in the home. It was also noted that asthma disproportionately burdens communities of color and low income communities.