

APPENDIX - REPORTS OF REFERENCE COMMITTEES
2022 Annual Meeting of the American Medical Association House of Delegates

Reference committee reports from the House of Delegates meeting are provided for the sake of convenience and because they are part of the record of each meeting.

The Proceedings reflect the official record of the actions taken by the House of Delegates and have precedence over reference committee reports, as the Proceedings are prepared using multiple sources, including a transcript of debate. Policies deriving from House actions are recorded in PolicyFinder, which is updated following each House of Delegates meeting.

Note: The original language of report recommendations and the original resolve clauses from resolutions are included in the reference committee reports with a gray background as in this example:

The Board of Trustees recommends that the following be adopted in lieu of the resolution and the remainder of this report be filed.

In addition, where the reference committee proposes changes in addition to or different from changes proposed by the original item of business, those changes are shown with double underscore or ~~double strikethrough~~, and in some cases are highlighted in yellow.

REPORT OF REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION AND BYLAWS

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Board of Trustees Report 2 – New Specialty Organizations Representation in the House of Delegates
2. Board of Trustees Report 22 – Nonconsensual Audio/Video Recording at Medical Encounters (Resolution 7-June-21)
3. Board of Trustees Report 23 – Specialty Society Representation in the House of Delegates – Five-Year Review
4. Council on Ethical and Judicial Affairs Report 3 – Amendment to E-9.3.2, Physician Responsibilities to Colleagues with Illness, Disability or Impairment
5. Council on Ethical and Judicial Affairs Report 4 – CEJA’s Sunset Review of 2012 House Policies
6. Resolution 2 – Opposition to Discriminatory Treatment of Haitian Asylum Seekers
7. Resolution 3 – Gender Equity and Female Physician Work Patterns During the Pandemic
8. Resolution 7 – Equal Access to Adoption for the LGBTQ Community
9. Resolution 18 – Hardship for International Medical Graduates from Russia and Belarus
10. Resolution 19 – Hardship for International Medical Graduates from Ukraine
11. Resolution 24 – Pharmaceutical Equity for Pediatric Populations
12. Resolution 26 – Establishing Ethical Principles for Physicians Involved in Private Equity Owned Practices
13. Resolution 28 – Preserving Access to Reproductive Health Services

RECOMMENDED FOR ADOPTION WITH CHANGE IN TITLE

14. Resolution 4 – Recognizing LGBTQ+ Individuals as Underrepresented in Medicine

RECOMMENDED FOR ADOPTION AS AMENDED

15. Board of Trustees Report 13 – Use of Psychiatric Advance Directives
16. Board of Trustees Report 14 – Amendment to Truth and Transparency in Pregnancy Counseling Centers, H-420.954
17. Council on Constitution and Bylaws Report 1 - Clarification to the Bylaws: Delegate Representation
18. Resolution 1 – Increasing Public Umbilical Cord Blood-Donations in Transplant Centers
19. Resolution 6 – Combating Natural Hair and Cultural Headwear Discrimination in Medicine and Medical Professionalism
20. Resolution 8 – Student-Centered Approaches for Reforming School Disciplinary Policies
21. Resolution 10 – Improving the Health and Safety of Sex Workers
22. Resolution 11 – Evaluating Scientific Journal Articles for Racial and Ethnic Bias
23. Resolution 12 – Expanding the Definition of Iatrogenic Infertility to Include Gender Affirming Interventions
24. Resolution 13 – Recognition of National Anti-Lynching Legislation as Public Health Initiative
25. Resolution 15 – Increasing Mental Health Screenings by Refugee Resettlement Agencies and Improving Mental Health Outcomes for Refugee Women
26. Resolution 16 – Addressing and Banning Unjust and Invasive Medical Procedures Among Migrant Women at the Border
27. Resolution 17 – Humanitarian and Medical Aid Support to Ukraine
28. Resolution 22 – Organ Transplant Equity for Persons with Disabilities
29. Resolution 23 – Promoting and Ensuring Safe, High Quality, and Affordable Elder Care Through Examining and Advocating for Better Regulation of and Alternatives to the Current, Growing For-Profit Long Term Care Options
30. Resolution 25 – Use of Social Media for Product Promotion and Compensation

RECOMMENDED FOR ADOPTION IN LIEU OF

- 31. Resolution 14 – Healthcare Equity Through Informed Consent and a Collaborative Healthcare Model for the Gender Diverse Population
- 32. Resolution 27 – Protecting Access to Abortion and Reproductive Healthcare

RECOMMENDED FOR REFERRAL

- 33. Board of Trustees Report 21 – Opposition to Requirements for Gender-Based Treatments for Athletes
- 34. Council on Ethical and Judicial Affairs Report 1 – Short-Term Medical Service Trips
- 35. Council on Ethical and Judicial Affairs Report 2 – Amendment to Opinion 10.8, Collaborative Care
- 36. Resolution 5 – Supporting the Study of Reparations as a Means to Reduce Racial Inequalities
- 37. Resolution 21 – National Cancer Research Patient Identifier
- 38. Council on Ethical and Judicial Affairs Report 5 – Pandemic Ethics and the Duty of Care (D-130.960)

RECOMMENDED FOR NOT ADOPTION

- 39. Resolution 9 - Privacy Protection and Prevention of Further Trauma for Victims of Distribution of Intimate Videos and Images Without Consent
- 40. Resolution 20 – Council on Ethical and Judicial Affairs Guidelines for Treating Unvaccinated Individuals

RECOMMENDED FOR ADOPTION

(1) BOARD OF TRUSTEES REPORT 2 – NEW SPECIALTY ORGANIZATIONS REPRESENTATION IN THE HOUSE OF DELEGATES

RECOMMENDATION:

Recommendations in Board of Trustees Report 2 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendations in Board of Trustees Report 2 adopted and the remainder of the Report filed.

Therefore, the Board of Trustees recommends that the American Contact Dermatitis Society, American Society of Regional Anesthesia and Pain Medicine, Americas Hernia Society, and the Outpatient Endovascular and Interventional Society be granted representation in the AMA House of Delegates and that the remainder of the report be filed. (Directive to Take Action)

The report was introduced by the author, and no other testimony was heard. Your reference committee recommends that Board of Trustees Report 2 be adopted and the remainder of the report be filed.

(2) BOARD OF TRUSTEES REPORT 22 – NONCONSENSUAL AUDIO/VIDEO RECORDING AT MEDICAL ENCOUNTERS (RESOLUTION 7-JUNE-21)

RECOMMENDATION:

Recommendations in Board of Trustees Report 22 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendations in Board of Trustees Report 22 adopted and the remainder of the Report filed.

In consideration of the foregoing, your Board of Trustees recommends that Policy H-315.983, “Patient Privacy and Confidentiality,” be reaffirmed in lieu of Resolution 7-June-21 and the remainder of this report be filed.

The report was introduced by the authors and no further testimony was heard. Your reference committee recommends that BOT report 22 be adopted.

(3) BOARD OF TRUSTEES REPORT 23 – SPECIALTY SOCIETY REPRESENTATION IN THE HOUSE OF DELEGATES – FIVE-YEAR REVIEW

RECOMMENDATION:

Recommendations in Board of Trustees Report 23 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendations in Board of Trustees Report 23 adopted and the remainder of the Report filed.

The Board of Trustees recommends that the following be adopted, and the remainder of this report be filed:

1. That the Academy of Physicians in Clinical Research, American Society for Reproductive Medicine, American Thoracic Society, College of American Pathologists, Congress of Neurological Surgeons, International College of Surgeons – US Section, Society for Cardiovascular Angiography and Interventions, and the Society for Investigative Dermatology, retain representation in the AMA House of Delegates. (Directive to Take Action)

2. Having failed to meet the requirements for continued representation in the AMA House of Delegates as set forth in AMA Bylaw B-8.5, the American Society of General Surgeons, American Society of Hematology, American Society of Transplant Surgeons, International Society of Hair Restoration Surgery and United States and Canadian Academy of Pathology be placed on probation and be given one-year to work with AMA membership staff to increase their AMA membership. (Directive to Take Action)
3. Having failed to meet the requirements for continued representation in the AMA House of Delegates as set forth in AMA Bylaw B-8.5 the Eye and Contact Lens Association not retain representation in the House of Delegates. (Directive to Take Action)

The report was introduced by the authors and no further testimony was heard. Your reference committee recommends that BOT report 23 be adopted.

- (4) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS REPORT 3 – AMENDMENT TO E-9.3.2, “PHYSICIAN RESPONSIBILITIES TO COLLEAGUES WITH ILLNESS, DISABILITY OR IMPAIRMENT”

RECOMMENDATION:

Recommendations in Council on Ethical and Judicial Affairs Report 3 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendations in Council on Ethical and Judicial Affairs Report 3 adopted and the remainder of the Report filed.

The Council believes that a more general formulation that did not delineate specific actors would better emphasize the importance of fairness whenever and by whomever such assessment is sought and would help ensure that guidance remains evergreen. The Council therefore proposes to amend Opinion 9.3.2 by insertion as follows:

E-9.3.2 – Physician Responsibilities to Colleagues with Illness, Disability or Impairment

Providing safe, high-quality care is fundamental to physicians’ fiduciary obligation to promote patient welfare. Yet a variety of physical and mental health conditions—including physical disability, medical illness, and substance use—can undermine physicians’ ability to fulfill that obligation. These conditions in turn can put patients at risk, compromise physicians’ relationships with patients, as well as colleagues, and undermine public trust in the profession.

While some conditions may render it impossible for a physician to provide care safely, with appropriate accommodations or treatment many can responsibly continue to practice, or resume practice once those needs have been met. In carrying out their responsibilities to colleagues, patients, and the public, physicians should strive to employ a process that distinguishes conditions that are permanently incompatible with the safe practice of medicine from those that are not and respond accordingly.

As individuals, physicians should:

- (a) Maintain their own physical and mental health, strive for self-awareness, and promote recognition of and resources to address conditions that may cause impairment.
- (b) Seek assistance as needed when continuing to practice is unsafe for patients, in keeping with ethics guidance on physician health and competence.
- (c) Intervene with respect and compassion when a colleague is not able to practice safely. Such intervention should strive to ensure that the colleague is no longer endangering patients and that the individual receive appropriate evaluation and care to treat any impairing conditions.

(d) Protect the interests of patients by promoting appropriate interventions when a colleague continues to provide unsafe care despite efforts to dissuade them from practice.

(e) Seek assistance when intervening, in keeping with institutional policies, regulatory requirements, or applicable law.

Collectively, physicians should nurture a respectful, supportive professional culture by:

(f) Encouraging the development of practice environments that promote collegial mutual support in the interest of patient safety.

(g) Encouraging development of inclusive training standards that enable individuals with disabilities to enter the profession and have safe, successful careers.

(h) Eliminating stigma within the profession regarding illness and disability.

(i) Advocating for supportive services, including physician health programs, and accommodations to enable physicians and physicians-in-training who require assistance to provide safe, effective care.

(j) Advocating for respectful and supportive, evidence-based peer review policies and practices to ensure fair, objective, and independent assessment of potential impairment whenever and by whomever assessment is deemed appropriate to that will ensure patient safety and practice competency. (II)

Testimony was heard in strong support of CEJA Report 3. The authors of the original resolution noted that this report is much improved and is of significant benefit to physicians. Testimony noted that physicians have an ethical responsibility to be self-regulatory. Your reference committee recommends that CEJA Report 3 be adopted and the remainder of the report be filed.

(5) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS REPORT 4 – CEJA’S
SUNSET REVIEW OF 2012 HOUSE POLICIES

RECOMMENDATION:

Recommendations in Council on Ethical and Judicial Affairs Report 4 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendations in Council on Ethical and Judicial Affairs Report 4 adopted and the remainder of the Report filed.

The Council on Ethical and Judicial Affairs recommends that the House of Delegates policies that are listed in the Appendix to this report be acted upon in the manner indicated and the remainder of this report be filed. (Directive to Take Action)

The report was introduced by the authors and no further testimony was heard. Your reference committee recommends that CEJA Report 4 be adopted and the remainder of the report be filed.

(6) RESOLUTION 2 – OPPOSITION TO DISCRIMINATORY TREATMENT OF
HAITIAN ASYLUM SEEKERS

RECOMMENDATION:

Resolution 2 be adopted

HOD ACTION: Resolution 2 adopted.

RESOLVED, That our American Medical Association oppose discrimination against Haitian asylum seekers which denies them the same opportunity to attain asylum status as individuals from other nations. (New HOD Policy)

Testimony was heard in general support of Resolution 2, noting that the AMA must strive to mitigate threats to public health as they arise. Testimony noted that the treatment of Haitian asylum seekers has been an embarrassment, that physician leaders must make a statement that asylum seekers should be granted the same protections, and that it is a moral obligation to oppose harm being done to asylum seekers. Your reference committee recommends that Resolution 2 be adopted.

(7) RESOLUTION 3 – GENDER EQUITY AND FEMALE PHYSICIAN WORK PATTERNS DURING THE PANDEMIC

RECOMMENDATION:

Resolution 3 be adopted.

HOD ACTION: Resolution 3 adopted.

RESOLVED, That our American Medical Association advocate for research on physician-specific data analyzing changes in work patterns and employment outcomes among female physicians during the pandemic including, but not limited to, understanding potential gaps in equity, indications for terminations and/or furloughs, gender differences in those who had unpaid additional work hours, and issues related to intersectionality (Directive to Take Action); and be it further

RESOLVED, That our AMA collaborate with relevant organizations to evaluate obstacles affecting female physicians and medical students during the pandemic. (Directive to Take Action)

Testimony was heard in strong support of Resolution 3. Supporting testimony noted that the pandemic required female physicians to take on additional roles both at work and at home without any additional support, and that burnout and anxiety increased during the pandemic among all health care workers, and particularly among minoritized health care workers and physicians in vulnerable populations. Speakers noted that equity in all areas is something we strive for, and when inequities arise, it is important that they are addressed. Limited testimony in opposition noted that single-parent fathers should not be excluded, and while your reference committee agrees, the spirit of this resolution was to address the challenges faced by female physicians during the pandemic. Your reference committee recommends that Resolution 3 be adopted.

(8) RESOLUTION 7 – EQUAL ACCESS TO ADOPTION FOR THE LGBTQ COMMUNITY

RECOMMENDATION:

Resolution 7 be adopted.

HOD ACTION: Resolution 7 adopted.

RESOLVED, That our American Medical Association advocate for equal access to adoption services for LGBTQ individuals who meet federal criteria for adoption regardless of gender identity or sexual orientation (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage allocation of government funding to licensed child welfare agencies that offer adoption services to all individuals or couples including those with LGBTQ identity. (New HOD Policy)

Testimony was heard in unanimous support of this resolution. Testimony noted that there are many children that do not get adopted in a timely fashion and move from foster care to foster care and expanding access to adoption services for LGBTQ individuals could help. It was noted that gender and sexual identity have no impact on an individual's ability to care for a child. Testimony also noted that this resolution is consistent with ACOG policy.

Further testimony observed that children need both of their parents to be recognized as legal guardians or are more likely to end up in foster care. Your reference committee recommends that Resolution 7 be adopted.

(9) RESOLUTION 18 – HARDSHIP FOR INTERNATIONAL MEDICAL GRADUATES FROM RUSSIA AND BELARUS

RECOMMENDATION:

Resolution 18 be adopted.

HOD ACTION: Resolution 018 adopted.

RESOLVED, That our American Medical Association study the impact of the current political crisis on international medical graduates with medical degrees from Russia and Belarus who are already in the U.S. either in training or practicing in regards to their ability to obtain primary source verification and report back during the 2022 Interim House of Delegates meeting. (Directive to Take Action)

The resolution was introduced by the author and no further testimony was heard. Your reference committee recommends that Resolution 18 be adopted.

(10) RESOLUTION 19 – HARDSHIP FOR INTERNATIONAL MEDICAL GRADUATES FROM UKRAINE

RECOMMENDATION:

Resolution 19 be adopted.

HOD ACTION: Resolution 19 adopted.

RESOLVED, That our American Medical Association advocate with relevant stakeholders that advise state medical boards to grant hardship waiver for primary source verification of medical education for all licensing requirements for physicians who graduated from medical schools in Ukraine until the current humanitarian crisis in Ukraine is resolved. (Directive to Take Action)

The resolution was introduced by the author and no further testimony was heard. Your reference committee recommends that Resolution 19 be adopted.

(11) RESOLUTION 24 – PHARMACEUTICAL EQUITY FOR PEDIATRIC POPULATIONS

RECOMMENDATION:

Resolution 24 be adopted.

HOD ACTION: Resolution 24 adopted.

RESOLVED, That our American Medical Association amend Policy H-100.987, “Insufficient Testing of Pharmaceutical Agents in Children,” by addition to read as follows:
 Insufficient Testing of Pharmaceutical Agents in Children H-100.987
 1. The AMA supports the FDA's efforts to encourage the development and testing of drugs in the pediatric age groups in which they are used.
 2. The AMA supports collaboration between stakeholders, including but not limited to the FDA, the American Academy of Pediatrics, and nonprofit organizations such as the Institute for Advanced Clinical Trials for Children, to improve the efficiency and safety of pediatric pharmaceutical trials in pursuit of pharmaceutical equity for pediatric populations. (Modify Current HOD Policy)

Testimony was heard in support of Resolution 24. Testimony noted the problem of insufficient clinical trials of pediatric pharmaceuticals and appreciated how the resolution responds to this important problem. Individual testimony suggested also including pregnant patients in the resolution, as they are also a patient population with insufficient representation within clinical trials. However, this testimony is beyond the scope of the current resolution which is focused on pediatrics and no other testimony voiced support for expanding its scope to other patient populations. Therefore, our reference committee recommends that Resolution 24 be adopted.

(12) RESOLUTION 26 – ESTABLISHING ETHICAL PRINCIPLES FOR
PHYSICIANS INVOLVED IN PRIVATE EQUITY OWNED PRACTICES

RECOMMENDATION:

Resolution 26 be adopted.

HOD ACTION: Resolution 26 adopted.

RESOLVED, That our American Medical Association study and clarify the ethical challenges and considerations regarding physician professionalism raised by the advent and expansion of private equity ownership or management of physician practices and report back on the status of any ethical dimensions inherent in these arrangements, including consideration of the need for ethical guidelines as appropriate. Such a study should evaluate the impact of private equity ownership, including but not limited to the effect on the professional responsibilities and ethical priorities for physician practices (Directive to Take Action).

Testimony was heard in unanimous support of Resolution 26, noting that having principles outlined by the AMA will be incredibly important. Private equity can allow private practice physicians to compete and has led to increased physician reimbursement. Additionally, testimony noted the downsides of private equity and how it may improperly interfere with the patient-physician relationship and the quality of care of patient. An amendment suggested potential positive and negative impacts of private equity. However, your reference committee notes that the resolution calls for evaluating the “impact” of private equity, which encompasses both positive and negative aspects of the issue. Testimony was also offered that this study would be useful for students and trainees. Therefore, your reference committee recommends that Resolution 26 be adopted.

(13) RESOLUTION 28 – PRESERVING ACCESS TO REPRODUCTIVE
HEALTH SERVICES

RECOMMENDATION:

Resolution 28 be adopted.

HOD ACTION: Resolution 28 adopted.

RESOLVED, That our AMA:

1. Recognizes that healthcare, including reproductive health services like contraception and abortion, is a human right;
2. Opposes limitations on access to evidence-based reproductive health services, including fertility treatments, contraception, and abortion;
3. Will work with interested state medical societies and medical specialty societies to vigorously advocate for broad, equitable access to reproductive health services, including fertility treatments, contraception, and abortion;
4. Supports shared decision-making between patients and their physicians regarding reproductive healthcare;
5. Opposes any effort to undermine the basic medical principle that clinical assessments, such as viability of the pregnancy and safety of the pregnant person, are determinations to be made only by healthcare professionals with their patients;
6. Opposes the imposition of criminal and civil penalties or other retaliatory efforts against patients, patient advocates, physicians, other healthcare workers, and health systems for receiving, assisting in, referring patients to, or providing reproductive health services;

7. Will advocate for legal protections for patients who cross state lines to receive reproductive health services, including contraception and abortion, or who receive medications for contraception and abortion from across state lines, and legal protections for those that provide, support, or refer patients to these services;
8. Will review the AMA policy compendium and recommend policies which should be amended or rescinded to reflect these core values, with report back at I-22; and be it further

Testimony was heard in strong and passionate support of Resolution 28. Testimony noted that the probable overruling of *Roe vs. Wade* this month will criminalize and restrict access to abortion in many parts of the United States. Testimony noted that with *Roe's* reversal, many physicians who offer reproductive health care could face criminal and civil legal jeopardy and those physicians performing abortions in the case of ectopic pregnancies and miscarriages could be charged with crimes and those physicians offering abortions to patients who cross state lines could be criminally charged. Testimony strongly reflected that physicians should not be criminalized for the practice of medicine and that physicians are best authorities to define healthcare, not politicians or the government. Testimony further noted that the AMA has long standing policy supporting access to abortion care and this resolution is aligned with such policy and will help AMA leaders defined against legislative inference in the practice of medicine. Testimony noted that issue is larger than only reproductive health: it is about the criminalization of providing health care broadly, i.e., issues of reproductive health touch on many other health related matters. Limited testimony proposed that it would be better for the AMA to wait and see where national policy lands and then react. Limited testimony also reflected that the AMA has already been advocating on this issue, noting the AMA's amicus brief before the Supreme Court and that this policy is unnecessary. However, testimony noted that many laws have already been passed that are already limiting access to health care and are putting physicians at risk. The problem carries immediate risk with its impact clearly unfolding in the present. Limited testimony was heard in favor of referral of the first resolve, noting that such a statement supports healthcare as a human right. Responding testimony noted that the first resolve clause is congruent with AMA policy as the AMA has already passed policy supporting health care as human right reflected in H-65.960. Another statement in favor of referral noted that the resolution mixes two separate issues: women's health and the criminalization of physicians. It would better to separate and addressed independently with further study. However, the balance of testimony reflected that the AMA cannot wait to take a strong stand on these issues. Your reference committee recommends that Resolution 28 be adopted.

RECOMMENDED FOR ADOPTION WITH CHANGE IN TITLE

- (14) RESOLUTION 4 – RECOGNIZING LGBTQ+ INDIVIDUALS AS UNDERREPRESENTED IN MEDICINE

RECOMMENDATION A:

The title of Resolution 4 be changed to:

ENCOURAGING LGBTQ+ REPRESENTATION IN MEDICINE

RECOMMENDATION B:

Resolution 4 be adopted with change in title.

HOD ACTION: Resolution 4 adopted with change in title.

ENCOURAGING LGBTQ+ REPRESENTATION IN MEDICINE

RESOLVED, That our American Medical Association advocate for the creation of targeted efforts to recruit sexual and gender minority students in efforts to increase medical student, resident, and provider diversity (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage the inclusion of sexual orientation and gender identity data in all surveys as part of standard demographic variables, including but not limited to governmental, AMA, and the Association of American Medical Colleges surveys, given respondent confidentiality and response security can be ensured (New HOD Policy); and be it further

RESOLVED, That our AMA work with the Association of American Medical Colleges to disaggregate data of LGBTQ+ individuals in medicine to better understand the representation of the unique experiences within the LGBTQ+ communities and their overlap with other identities. (Directive to Take Action)

Testimony was heard in strong support of the resolution. Testimony noted that there is not adequate data on LGBTQ+ representation in medicine and that gathering further data on the issue is necessary. Passionate testimony noted how important it is for some LGBTQ+ patients to have patient-physician concordance in order to further strengthen the patient-physician and quality of care, thus underscoring the need to encourage and better understand the representation of LGBTQ+ physicians in the medical profession. Testimony noted that underrepresented is an official title in medicine and cannot be used without adequate data to support the designation and therefore an amendment was offered to change the title. Your reference committee recommends that Resolution 4 be adopted with a change in title.

RECOMMENDED FOR ADOPTION AS AMENDED

(15) BOARD OF TRUSTEES REPORT 13 – USE OF PSYCHIATRIC ADVANCE DIRECTIVES

RECOMMENDATION A:

Recommendation 2 in Board of Trustees Report 13 be amended by addition to read as follows:

2. Urges the mental health community to continue to study the role of advance care planning in therapeutic relationships and the use of psychiatric advance directives to promote the interests and well-being of patients, and support efforts to increase awareness and appropriate utilization of psychiatric advance directives. (New HOD Policy)

RECOMMENDATION B:

Board of Trustees Report 13 be adopted as amended and the remainder of the Report be filed.

HOD ACTION: Board of Trustees Report 13 adopted as amended and the remainder of the Report filed.

Your Board of Trustees recommends that the following be adopted in lieu of Resolution 1-I-19 and the remainder of this report be filed:

That our AMA:

1. Recognizes the potential for advance care planning to promote the autonomy of patients with mental illness; (New HOD Policy) and
2. Urges the mental health community to continue to study the role of advance care planning in therapeutic relationships and the use of psychiatric advance directives to promote the interests and well-being of patients. (New HOD Policy)

Limited testimony was heard in support of Board of Trustees Report 13. An amendment was proffered to remove the study of the role of advance care planning in favor of supporting efforts to increase awareness and utilization of psychiatric advance directives. Your reference committee found that keeping the resolve urging study, along with awareness, best captures the reflected supportive testimony. Therefore, your Reference Committee recommends that Board of Trustees Report 13 be adopted as amended.

(16) BOARD OF TRUSTEES REPORT 14 – AMENDMENT TO TRUTH AND TRANSPARENCY IN PREGNANCY COUNSELING CENTERS, POLICY H-420.954

RECOMMENDATION A:

Recommendation 5 Board of Trustees Report 14 be amended by addition to read as follows:

5. Our AMA urges that public funding only support programs that provide complete, non-directive, medically accurate, health information to support patients' informed, voluntary decisions. (Modify Current HOD Policy)

RECOMMENDATION B:

Recommendations in Board of Trustees Report 14 be adopted as amended and the remainder of the Report be filed.

HOD ACTION: Recommendations in Board of Trustees Report 14 adopted as amended and the remainder of the Report filed.

For the reasons discussed above, your Board of Trustees recommends that Policy H-420.954 be amended by insertion and deletion to read as follows in lieu of Resolution 8-N-21 and that the remainder of this report be filed:

H-420.954, “Truth and Transparency in Pregnancy Counseling Centers”

1. It is AMA’s position that any entity that represents itself as offering health-related services should uphold the standards of truthfulness, transparency, and confidentiality that govern health care professionals.
2. Our AMA urges the development of effective oversight for entities offering pregnancy-related health services and counseling.
3. Our AMA ~~supports~~ advocates that any entity offering crisis pregnancy services
disclose information
 - a. truthfully describe the services they offer or for which they refer—including prenatal care, family planning, termination, or adoption services—in communications on site, and in its their advertising, and before any services are provided to an individual patient; and concerning medical services, contraception, termination of pregnancy or referral for such services, adoption options or referral for such services that it provides,
 - b. be transparent with respect to their funding and sponsorship relationships.
4. Our AMA advocates that any entity licensed to provide ~~providing~~ medical or health services to pregnant women
that ~~markets medical or any clinical services~~ abide by licensing and have the
 - a. ensure that care is provided by appropriately qualified, licensed personnel; ~~to do so~~ and
 - b. abide by federal health information privacy laws.
5. Our AMA urges that public funding only support programs that provide complete, medically accurate, health information to support patients’ informed, voluntary decisions. (Modify Current HOD Policy)

Testimony was heard in general support of Board of Trustees Report 14, noting that the report urges Pregnancy Counseling Centers to provide complete and medically accurate information to patients. Testimony also noted that this report made necessary amendments to the original policy, and that it is important to support this report in light of recent events impacting abortion rights in this country. An amendment was offered to add “non-directive” before “complete” in the fifth clause, with which your reference committee agreed. Limited testimony supported referral for the sake of clarity, including defining “effective oversight” in clause 2, and at what funding/sponsorship levels would donors be required to be disclosed in clause 3b, however your reference committee did not believe referral to be reflective of testimony. Your reference committee recommends that the recommendations in Board of Trustees Report 14 be adopted as amended, and the remainder of the report be filed.

(17) COUNCIL ON CONSTITUTION AND BYLAWS REPORT 1 –
CLARIFICATION TO THE BYLAWS: DELEGATE REPRESENTATION

RECOMMENDATION A:

Council on Constitution and Bylaws Report 1 be amended by addition to read as follows:

2.4.1 Qualifications. Delegates and alternate delegates from the Resident and Fellow Section must be active members of the Resident and Fellow Section of the AMA. In addition, resident and fellow physician delegates and alternate

delegates must be members of their endorsing society or organization currently seated in the HOD, in a capacity appropriate to their level of training.

RECOMMENDATION B:

Recommendations in Council on Constitution and Bylaws Report 1 be adopted as amended and the remainder of the Report be filed.

HOD ACTION: Recommendations in Council on Constitution and Bylaws Report 1 adopted as amended and the remainder of the Report filed.

The Council on Constitution and Bylaws recommends that the following amendments to the AMA Bylaws be adopted and that the remainder of this report be filed. Adoption requires the affirmative vote of two-thirds of the members of the House of Delegates present and voting.

2.0.1 Composition and Representation. The House of Delegates is composed of delegates selected by recognized constituent associations and specialty societies, and other delegates as provided in this bylaw.

2.0.1.1 Qualification of Members of the House of Delegates. Members of the House of Delegates must be active members of the AMA and of the entity they represent.

2.8 Alternate Delegates. Each organization represented in the House of Delegates may select an alternate delegate for each of its delegates entitled to be seated in the House of Delegates.

2.8.1 Qualifications. Alternate delegates must be active members of the AMA and of the entity they represent.

2.3 Medical Student Regional Delegates. In addition to the delegate and alternate delegate representing the Medical Student Section, ~~regional~~ medical student regional delegates and regional alternate delegates shall be apportioned and elected as provided in this bylaw.

2.3.1 Qualifications. Medical ~~S~~student ~~R~~regional delegates and alternate delegates must be active medical student members of the AMA. In addition, medical student regional delegates and alternate delegates must be members of their endorsing constituent association. The region in which the endorsing society is located determines the student's region, and a medical student may serve as a regional delegate, alternate delegate or any form of substitute (pursuant to Bylaws 2.8.5 or 2.10.4) only for that region.

2.3.3 Medical ~~S~~student ~~R~~regional delegates and alternates shall be elected by the Medical Student Section in accordance with procedures adopted by the Section. Each elected delegate and alternate ~~delegate~~ must receive written endorsement from ~~the~~ their constituent association ~~representing the jurisdiction within which the medical student's educational program is located,~~ in accordance with procedures adopted by the Medical Student Section and approved by the Board of Trustees. Delegates and alternate delegates shall be elected at the Business Meeting of the Medical Student Section prior to the Interim Meeting of the House of Delegates. Delegates and alternate delegates shall be seated at the next Annual Meeting of the House of Delegates.

2.4 Delegates from the Resident and Fellow Section. In addition to the delegate and alternate delegate representing the Resident and Fellow Section, resident and fellow physician delegates and alternate delegates shall be apportioned and elected in a manner as provided in this bylaw.

2.4.1 Qualifications. Delegates and alternate delegates from the Resident and Fellow Section must be active members of the Resident and Fellow Section of the AMA. In addition, resident and fellow physician delegates and alternate delegates must be members of their endorsing society or organization currently seated in the HOD.

2.4.2 Apportionment. The apportionment of delegates from the Resident and Fellow Section is one delegate for each 2,000 active resident and fellow physician members of the AMA, as recorded by the AMA on December 31 of each year.

2.4.3 Election. Delegates and alternate delegates shall be elected by the Resident and Fellow Section in accordance with procedures adopted by the Section. Each delegate and alternate delegate must receive written endorsement from ~~his or her~~ a society or organization currently seated in the House of Delegates and a constituent association or national medical specialty society, in accordance with procedures adopted by the Resident and Fellow Section and approved by the Board of Trustees.

2.10.8 Medical Student Seating. Each ~~M~~medical ~~S~~student ~~R~~regional delegate shall be seated with the student's endorsing constituent association ~~representing the jurisdiction within which such delegate's educational program is~~

~~located. Alternate or substitute delegates shall be assigned to the original regional delegate's seat location during the time they are seated for the original delegate.~~

2.10.9 Resident and Fellow Seating. Each delegate from the Resident and Fellow Section shall be seated with the physician's endorsing ~~society or organization~~ constituent association or specialty society. In the case where a delegate has been endorsed by ~~multiple entities~~ both a constituent association and specialty society, the delegate must choose, prior to the election, with which delegation the delegate wishes to be seated. Alternate or substitute delegates shall be assigned to the original delegate's seat location during the time they are seated for the original delegate.

Testimony was heard in unanimous support of CCB Report 1. An amendment was offered to section 2.4.1 to clarify that the resident delegate must be a member of their supporting society, appropriate to their level of training. This was felt to better clarify that membership in some societies may be different from a "full member" for those who are currently in training. The Council testified in support of the amendment. Your reference committee recommends that CCB Report 1 be adopted as amended and the remainder of the report be filed.

(18) RESOLUTION 1 – INCREASING PUBLIC UMBILICAL CORD BLOOD DONATIONS IN TRANSPLANT CENTERS

RECOMMENDATION A:

Resolution 1 be amended by addition of a third resolve to read as follows:

RESOLVED, That our AMA encourage access to public cord banking and the creation of public cord blood banks to support altruistic cord blood donation.
(Directive to take action)

RECOMMENDATION B:

Resolution 1 be adopted as amended.

HOD ACTION: Resolution 1 adopted as amended and resolve 1 of Resolution 1 referred.

RESOLVED, That our American Medical Association encourage all hospitals with obstetrics programs to make available to patients and reduce barriers to public (altruistic) umbilical cord blood donation (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage the availability of altruistic cord blood donations in all states. (Directive to Take Action)

Testimony was heard in support of Resolution 1. Increased umbilical cord blood donation will increase access to this life-saving procedure, which typically requires no matching, but for which there is limited access. Limited testimony supported referral of the first resolve clause, suggesting that the emphasis is misplaced, since some hospitals do not have the capability to make umbilical cord blood donation on site, and that it would be preferable to reframe that clause to focus on making available access to public umbilical cord banks, but your reference committee believes that the amendment offered addresses that issue. Your reference committee recommends that resolution 1 be adopted as amended.

(19) RESOLUTION 6 – COMBATING NATURAL HAIR AND CULTURAL HEADWEAR DISCRIMINATION IN MEDICINE AND MEDICAL PROFESSIONALISM

RECOMMENDATION A:

Amended by the addition of a fifth resolve to read as follows:

RESOLVED, that our AMA encourage healthcare institutions to provide adequate protective equipment in accordance with appropriate patient safety for healthcare workers with natural hair/hairstyles or cultural headwear.

RECOMMENDATION B:

Resolution 6 be adopted as amended.

HOD ACTION: Resolution 6 adopted as amended.

RESOLVED, That our American Medical Association recognize that discrimination against natural hair/hairstyles and cultural headwear is a form of racial, ethnic and/or religious discrimination (New HOD Policy); and be it further RESOLVED, That our AMA oppose discrimination against individuals based on their hair or cultural headwear in health care settings (New HOD Policy); and be it further RESOLVED, That our AMA acknowledge the acceptance of natural hair/hairstyles and cultural headwear as crucial to professionalism in the standards for the health care workplace (New HOD Policy); and be it further RESOLVED, That our AMA encourage medical schools, residency and fellowship programs, and medical employers to create policies to oppose discrimination based on hairstyle and cultural headwear in the interview process, medical education, and the workplace. (New HOD Policy)

Testimony was heard in unanimous support of Resolution 6, noting that this policy is about professionalism and what professionals should look like, and that a person's hair or headwear has no bearing on professionalism. Testimony noted that we should end the notion that hairstyles and headpieces, particularly those that are prominent in communities of color, are unprofessional. Speakers noted that this resolution aligns the AMA with other organizations, including the American Academy of Pediatrics. An amendment was offered by Great Lakes to put the onus on healthcare institutions to provide adequate protective equipment in accordance with appropriate patient safety. Further testimony noted that the belief that one should have to take on Euro-centric features in order to be viewed as professional needs to be eliminated. Your reference committee recommends that Resolution 6 be adopted as amended.

(20) RESOLUTION 8 – STUDENT-CENTERED APPROACHES FOR REFORMING SCHOOL DISCIPLINARY POLICIES

RECOMMENDATION A:

That the second resolve of Resolution 8 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA support the ~~inclusion of~~ consultation with school-based mental health professionals in the student discipline process. (New HOD Policy)

RECOMMENDATION B:

Resolution 8 be adopted as amended.

HOD ACTION: Resolution 8 adopted as amended.

RESOLVED, That our American Medical Association support evidence-based frameworks in K-12 schools that focus on school-wide prevention and intervention strategies for student misbehavior (New HOD Policy); and be it further

RESOLVED, That our AMA support the inclusion of school-based mental health professionals in the student discipline process. (New HOD Policy)

Testimony was heard in general support of Resolution 8. An amendment was offered to the second resolve clause. Testimony highlighted taking a disciplinary role could compromise mental health treatment efforts. Testimony asks to consider racial and disability bias in adoption of this measure. Therefore, your reference committee recommends that Resolution 8 be adopted as amended

(21) RESOLUTION 10 – IMPROVING THE HEALTH AND SAFETY OF SEX WORKERS

RECOMMENDATION A:

The first resolve in Resolution 10 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association recognize the adverse health outcomes of criminalizing ~~consensual sex work~~ individuals who offer sex in return for money, goods or other considerations (New HOD Policy)

RECOMMENDATION B:

The second resolve be amended by addition and deletion to read as follows:

RESOLVED, That our AMA: 1) support legislation that decriminalizes individuals who offer sex in return for money, ~~or goods, or other considerations~~; 2) oppose legislation that decriminalizes the purchase of sex services, buying as well as ownership and operation of and brothels keeping and other entities that provide such services; and 3) support the expungement of criminal records of those previously convicted of sex work, including trafficking survivors (New HOD Policy); and be it further

RECOMMENDATION C:

Resolution 10 be adopted as amended.

RECOMMENDATION D:

The title of Resolution 10 be changed to:

IMPROVING THE HEALTH AND SAFETY OF INDIVIDUALS WHO OFFER SEX IN RETURN FOR MONEY, GOODS OR OTHER CONSIDERATIONS

HOD ACTION: Resolution 10 adopted as amended with a change in title.

IMPROVING THE HEALTH AND SAFETY OF INDIVIDUALS WHO OFFER SEX IN RETURN FOR MONEY, GOODS OR OTHER CONSIDERATIONS

RESOLVED, That our American Medical Association recognize the adverse health outcomes of criminalizing consensual sex work (New HOD Policy); and be it further

RESOLVED, That our AMA: 1) support legislation that decriminalizes individuals who offer sex in return for money or goods; 2) oppose legislation that decriminalizes sex buying and brothel keeping; and 3) support the expungement of criminal records of those previously convicted of sex work, including trafficking survivors (New HOD Policy); and be it further

RESOLVED, That our AMA support research on the long-term health, including mental health, impacts of decriminalization of the sex trade. (New HOD Policy)

The resolution was introduced by the authors, who also expressed support for the amendments offered by the AAFP, which the authors believe clarify and improve the original language. Testimony was heard in general support of the resolution. Another amendment suggested changing the term “consensual sex work” to “people who sell sex,” which is person first language. Subsequent testimony supported the proposed amendments. Other testimony expressed concern about part 2 of the second resolve clause dealing with sex buying and brothel keeping, which the speaker noted to be a separate and complex issue, but your reference committee believes that component to be aligned with the spirit of the resolution. Your reference committee recommends amendments to make the language more precise and recommends that Resolution 10 be adopted as amended.

(22) RESOLUTION 11 – EVALUATING SCIENTIFIC JOURNAL ARTICLES FOR RACIAL AND ETHNIC BIAS

RECOMMENDATION A:

The first resolve in Resolution 11 be amended by deletion to read as follows:

That our American Medical Association support major journal publishers issuing guidelines for interpreting ~~previous~~ research which define race and ethnicity by outdated means (New HOD Policy); and be it further

RECOMMENDATION B:

Resolution 11 be adopted as amended.

HOD ACTION: Resolution 11 adopted as amended.

RESOLVED, That our American Medical Association support major journal publishers issuing guidelines for interpreting previous research which define race and ethnicity by outdated means (New HOD Policy); and be it further

RESOLVED, That our AMA support major journal publishers implementing a screening method for future research submission concerning the incorrect use of race and ethnicity. (New HOD Policy)

Testimony was heard in general support of Resolution 11, noting that structural racism has caused inequities not only in research, but in outcomes as well. Maintaining a standard in the way we communicate research is essential. An amendment was offered to add an additional Resolve clause, that AMA should encourage JAMA to create guidelines for interpreting previous research which defines race and ethnicity by outdated means. Your reference committee notes that the AMA and JAMA are completely separate for editorial purposes. Additionally, the resolution, as proffered, asks the AMA to encourage major journals to make such guidelines making this amendment redundant. Therefore, your reference committee recommends that Resolution 11 be adopted as amended.

(23) RESOLUTION 12 – EXPANDING THE DEFINITION OF IATROGENIC INFERTILITY TO INCLUDE GENDER AFFIRMING INTERVENTIONS

RECOMMENDATION A:

The first resolve in Resolution 12 be amended by addition to read as follows:

RESOLVED, That our American Medical Association amend policy H-185.990, “Infertility and Fertility Preservation Insurance Coverage.” by addition to read as follows:

Infertility and Fertility Preservation Insurance Coverage H-185.990

It is the policy of the AMA that (1) Our AMA encourages third party payer health insurance carriers to make available insurance benefits for the diagnosis and treatment of recognized male and female infertility; (2) Our AMA supports payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician, and will lobby for appropriate federal legislation requiring payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician; and (3) Our AMA encourages the inclusion of impaired fertility as a consequence of gender-affirming hormone therapy and gender-affirming surgery within legislative definitions of iatrogenic infertility, and supports access to fertility preservation services for those affected. (Modify Current HOD Policy); and be it further

RECOMMENDATION B:

That Policy H-185-950 be reaffirmed in lieu of the second resolve of Resolution 12.

RECOMMENDATION C:

Resolution 12 be adopted as amended.

HOD ACTION: Resolution 12 adopted as amended.

RESOLVED, That our American Medical Association amend policy H-185.990, “Infertility and Fertility Preservation Insurance Coverage.” by addition to read as follows:

Infertility and Fertility Preservation Insurance Coverage H-185.990

It is the policy of the AMA that (1) Our AMA encourages third party payer health insurance carriers to make available insurance benefits for the diagnosis and treatment of recognized male and female infertility; (2) Our AMA supports payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician, and will lobby for appropriate federal legislation requiring payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician; and (3) Our AMA encourages the inclusion of impaired fertility as a consequence of gender-affirming hormone therapy and gender-affirming surgery within legislative definitions of iatrogenic infertility. (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA amend policy H-185.950, “Removing Financial Barriers to Care for Transgender Patients,” by addition to read as follows:

Removing Financial Barriers to Care for Transgender Patients H-185.950

Our AMA supports public and private health insurance coverage for medically necessary treatment of gender dysphoria as recommended by the patient’s physician, including gender-affirming hormone therapy and gender-affirming surgery. (Modify Current HOD Policy)

An amendment was offered to the first resolve clause, adding “And support access to fertility preservation services to those affected.” Testimony expressed hesitancy around the term “medically necessary,” noting that the term has been weaponized against patients seeking gender-affirming therapy. Further testimony supported the amendment striking the words medically necessary. Testimony also supported striking the second resolve clause and reaffirming policy H-185.950. Therefore, your reference committee recommends that Resolution 12 be adopted as amended.

(24) RESOLUTION 13 – RECOGNITION OF NATIONAL ANTI-LYNCHING
LEGISLATION AS PUBLIC HEALTH INITIATIVE

RECOMMENDATION A:

The third resolve in Resolution 13 be amended by deletion to read as follows:

RESOLVED, That our current AMA policy H-65.965, Support of Human Rights and Freedom, be amended by addition to read as follows:

Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual’s sex, sexual orientation, gender, gender identity or transgender status, race, religion, disability, ethnic origin, national origin or age; (3) opposes any discrimination based on an individual’s sex, sexual orientation, gender identity, race, ~~phenotypic appearance~~, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage for appropriate hate crimes prevention legislation in accordance with our AMA’s policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States (Modify Current HOD Policy); and be it further

RECOMMENDATION B:

Resolution 13 be adopted as amended.

HOD ACTION: Resolution 13 adopted as amended.

RESOLVED, That our American Medical Association support national legislation that recognizes lynching and mob violence towards an individual or group of individuals as hate crimes (New HOD Policy); and be it further

RESOLVED, That our AMA work with relevant stakeholders to support medical students, trainees and physicians receiving education on the inter-generational health outcomes related to lynching and its impact on the health of vulnerable populations (Directive to Take Action); and be it further

RESOLVED, That our current AMA policy H-65.965, Support of Human Rights and Freedom, be amended by addition to read as follows:

Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges and responsibilities commensurate with his or ger individual capabilities and ethical character because of an individual’s sex, sexual orientation, gender, gender identity or transgender status, race, religion, disability, ethnic origin, national origin or age; (3) opposes any discrimination based on an individual’s sex, sexual orientation, gender identity, race, ~~phenotypic appearance~~, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage for appropriate hate crimes prevention legislation in accordance with our AMA’s policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA reaffirm policy H-65.952 “Racism as a Public Health Threat”. (Reaffirm HOD Policy)

Limited testimony was heard in support of Resolution 13. Testimony against the first resolve clause noted federal legislation has already been passed on this issue: therefore, asking for national legislation is unnecessary. However, your reference committee believes that policy supporting national legislation is appropriate, even in light of recently passed legislation and having a strong policy in place can help with future legislative advocacy. Additional testimony reflected that the word “phenotypic” may cause confusion as it could be construed as endorsing some genetic basis or bias. Elimination of the word avoids any confusion and broadens the scope and the author of the resolution supports this change. Therefore, your reference committee recommends Resolution 13 be adopted as amended.

(25) **RESOLUTION 15 – INCREASING MENTAL HEALTH SCREENINGS BY REFUGEE RESETTLEMENT AGENCIES AND IMPROVING MENTAL HEALTH OUTCOMES FOR REFUGEE WOMEN**

RECOMMENDATION A:

That the second resolve of Resolution 15 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association advocate for increased research funding to evaluate the validity, efficacy, and implementation challenges of existing mental health screening tools for refugee and migrant populations and, if necessary, create rapid-brief, accessible, clinically-validated, culturally-sensitive, and patient centered mental health screening tools for ~~pertaining to~~ refugee and migrant populations (Directive to Take Action); and be it further

RECOMMENDATION B:

That the third resolve of Resolution 15 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA advocate for increased funding ~~to the National Institutes of Health~~ for more research on evidence-based ~~designs on delivery of~~ mental health services to refugees and migrant populations and the sex and gender factors that could increase the risk for mental disorders in refugee women and girls who experience sexual violence (Directive to Take Action); and be it further

RECOMMENDATION C:

That the fourth resolve of Resolution 15 be amended by addition to read as follows:

RESOLVED, That our AMA advocate for increased mental health training support and service delivery funding to increase the number of trained mental health providers to carry out mental health screenings and treatment (Directive to Take Action);

RECOMMENDATION D:

Resolution 15 be adopted as amended.

HOD ACTION: Resolution 15 adopted as amended.

RESOLVED, That our American Medical Association advocate for increased research funding to create rapid, accessible, and patient centered mental health screening tools pertaining to refugee and migrant populations (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for increased funding to the National Institutes of Health for more research on evidence-based designs on delivery of mental health services to refugees and migrant populations (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for increased mental health funding to increase the number of trained mental health providers to carry out mental health screenings and treatment (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for and encourage culturally responsive mental health counseling specifically. (Directive to Take Action)

Testimony was heard in general support of the resolution. The authors opposed an amendment offered to remove the term refugees, noting that while all populations need mental health screenings, the goal of this resolution is to address the issues specifically for refugees, who often lack mental health screening tools. An amendment was offered with language that helps clarify and strengthen the resolution. Therefore, your reference committee recommends that Resolution 15 be adopted as amended.

(26) RESOLUTION 16 – ADDRESSING AND BANNING UNJUST AND INVASIVE MEDICAL PROCEDURES AMONG MIGRANT WOMEN AT THE BORDER

RECOMMENDATION A:

The first resolve of Resolution 16 be amended by deletion to read as follows:

RESOLVED, That our American Medical Association condemn the performance of nonconsensual, ~~unnecessary~~, invasive medical procedures (Directive to Take Action); and

RECOMMENDATION B:

Resolution 16 be adopted as amended.

RECOMMENDATION C:

The title of Resolution 16 be changed:

ADDRESSING AND BANNING NONCONSENSUAL MEDICAL PROCEDURES AMONG MIGRANT WOMEN AT THE BORDER

HOD ACTION: Resolution 16 adopted as amended with change in title.

ADDRESSING AND BANNING NONCONSENSUAL MEDICAL PROCEDURES AMONG MIGRANT WOMEN AT THE BORDER

RESOLVED, That our American Medical Association condemn the performance of nonconsensual, unnecessary, invasive medical procedures (Directive to Take Action); and

RESOLVED, That our AMA advocate against forced sterilizations of any kind, including against migrant women in detention facilities, and advocate for appropriate associated disciplinary action (including license revocation) (Directive to Take Action); and

RESOLVED, That our AMA advocate for safer medical practices and protections for migrant women. (Directive to Take Action)

Testimony was heard in general support of Resolution 16. An amendment was proposed to eliminate the word “unnecessary,” as the term is vague and could be misused. The authors agreed with the proposed amendment. Testimony also noted that bodily autonomy and informed consent should be minimum standards in all healthcare

settings, and that all practitioners should abide by medically indicated, evidence-based care. Additionally, your reference committee recommends eliminating the word “invasive” from the title, as the word is ambiguous and limiting in scope. Your reference committee recommends that Resolution 16 be adopted as amended.

(27) RESOLUTION 17 – HUMANITARIAN AND MEDICAL AID SUPPORT TO UKRAINE

RECOMMENDATION A:

The second resolve in Resolution 17 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA advocate for an early implementation of mental health measures, including suicide prevention efforts, and address war-related trauma and post-traumatic stress disorder when dealing with Ukrainian refugees with special attention to vulnerable populations including but not limited to young children, mothers, ~~and pregnant women~~, and the elderly (Directive to Take Action);

RECOMMENDATION B:

The third resolve in Resolution 17 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA advocate for educational measures to enhance the understanding of war-related trauma in war survivors and promote broad protective factors (e.g., financial, employment, housing, and food stability) that can improve adjustment and outcomes for efforts to increase resilience in war-affected people, particularly when applied to targeting-vulnerable categories of people. (Directive to Take Action)

RECOMMENDATION C:

Resolution 17 be adopted as amended.

HOD ACTION: Resolution 17 adopted as amended.

RESOLVED, That our American Medical Association advocate for continuous support of organizations providing humanitarian missions and medical care to Ukrainian refugees in Ukraine, at the Polish-Ukrainian border, in nearby countries, and/or in the US; (Directive to Take Action) and be it further
RESOLVED, That our AMA advocate for an early implementation of mental health measures and address war-related trauma and post-traumatic stress disorder when dealing with Ukrainian refugees with special attention to vulnerable populations including but not limited to young children, mothers, and pregnant women (Directive to Take Action); and be it further
RESOLVED, That our AMA advocate for educational measures to enhance the understanding of war-related trauma in war survivors and promote efforts to increase resilience in war-affected people targeting vulnerable categories of people. (Directive to Take Action)

Testimony was heard in strong support of this resolution. Amendments were offered suggesting clarifying and precise language. Your reference committee find these amendments strengthen the resolution and recommends that Resolution 17 be adopted as amended.

(28) RESOLUTION 22 – ORGAN TRANSPLANT EQUITY FOR PERSONS WITH DISABILITIES

RECOMMENDATION A:

The second resolve in Resolution 22 be amended by addition to read as follows:

RESOLVED, That our AMA support individuals with IDD who can fulfill transplant center protocols having equal access to organ transplant services and protection from discrimination in rendering these services (New HOD Policy); and be it further

RECOMMENDATION B:

Resolution 22 be adopted as amended.

HOD ACTION: Resolution 22 adopted as amended.

RESOLVED, That our American Medical Association support equitable inclusion of people with Intellectual and Developmental Disabilities (IDD) in eligibility for transplant surgery (New HOD Policy); and be it further
RESOLVED, That our AMA support individuals with IDD having equal access to organ transplant services and protection from discrimination in rendering these services (New HOD Policy); and be it further
RESOLVED, That our AMA support the goal of the Organ Procurement and Transplantation Network (OPTN) in adding disability status to their Nondiscrimination policy under the National Organ Transplant Act of 1984 (New HOD Policy); and be it further
RESOLVED, That our AMA work with relevant stakeholders to distribute antidiscrimination education materials for healthcare providers related to equitable inclusion of people with IDD in eligibility for transplant surgery. (Directive to Take Action)

Limited testimony was heard in support of the resolution. An amendment was offered to the second resolve clause adding the words with IDD “who can fulfill transplant center protocols,” which was viewed as friendly. Additional amendments were offered, which recommended the addition of two new resolve clauses, however they did not receive significant discussion at the hearing and therefore your reference committee declines to add them. Your reference committee recommends that Resolution 22 be adopted as amendment.

(29) RESOLUTION 23 – PROMOTING AND ENSURING SAFE, HIGH QUALITY, AND AFFORDABLE ELDER CARE THROUGH EXAMINING AND ADVOCATING FOR BETTER REGULATION OF AND ALTERNATIVES TO THE CURRENT, GROWING FOR-PROFIT LONG TERM CARE OPTIONS

RECOMMENDATION A:

The second resolve in Resolution 23 be amended by addition to read as follows:

RESOLVED, That our AMA, in collaboration with other stakeholders, including major payers, advocate for further research into alternatives to current options for long term care to promote the highest quality and value long term care services and supports (LTSS) models as well as functions and structures which best support these models for care. (Directive to Take Action)

RECOMMENDATION B:

Resolution 23 be adopted as amended.

HOD ACTION: Resolution 23 adopted as amended.

RESOLVED, That our American Medical Association advocate for business models in long term care for the elderly which incentivize and promote the ethical use of resources to maximize care quality, staff and resident safety, and resident quality of life, and which hold patients' interests as paramount over maximizing profit (Directive to Take Action); and be it further

RESOLVED, That our AMA, in collaboration with other stakeholders, advocate for further research into alternatives to current options for long term care to promote the highest quality and value long term care services and supports (LTSS) models as well as functions and structures which best support these models for care. (Directive to Take Action)

Testimony was heard in unanimous support of Resolution 23. An amendment was offered and agreed to by the authors. Your reference committee recommends that Resolution 23 be adopted as amended.

(30) RESOLUTION 25 – USE OF SOCIAL MEDIA FOR PRODUCT PROMOTION AND COMPENSATION

RECOMMENDATION A:

Resolution 25 be amended by deletion to read as follows:

RESOLVED, That our American Medical Association study the ethical issues of medical students, residents, fellows, and physicians endorsing ~~non-health-related~~ products through social and mainstream media for personal or financial gain. (Directive to Take Action)

RECOMMENDATION B:

Resolution 25 be adopted as amended.

HOD ACTION: Resolution 25 is referred.

RESOLVED, That our American Medical Association study the ethical issues of medical students, residents, fellows, and physicians endorsing non-health related products through social and mainstream media for personal or financial gain. (Directive to Take Action)

Resolution 25 was introduced by the author, and no further testimony was heard. Your reference committee recommends the removal of “non-health” to help broaden the scope of the proposed study and explore various facets of this timely and important issue. Your reference committee recommends that Resolution 25 be adopted as amended

RECOMMENDED FOR ADOPTION IN LIEU OF

- (31) RESOLUTION 14 – HEALTHCARE EQUITY THROUGH INFORMED CONSENT AND A COLLABORATIVE HEALTHCARE MODEL FOR THE GENDER DIVERSE POPULATION

RECOMMENDATION:

That Alternate Resolution 14 be adopted in lieu of Resolution 14

Resolved, that our American Medical Association supports shared decision making between gender diverse individuals, their health care team, and, where applicable, their families and caregivers.

Resolved, that our American Medical Association supports treatment models for gender diverse people that promotes informed consent, personal autonomy, increased access for gender affirming treatments and eliminates unnecessary third party involvement outside of the physician-patient relationship in the decision making process.

HOD ACTION: Alternate Resolution 14 adopted in lieu of Resolution 14

RESOLVED, That our American Medical Association support shared decision making between gender diverse individuals, their families, their primary care physician, and a multidisciplinary team of physicians and other health care professionals including, but not limited to, those in clinical genetics, endocrinology, surgery, and behavioral health, to support informed consent and patient personal autonomy, increase access to beneficial gender affirming care treatment options and preventive care, avoid medically unnecessary surgeries, reduce long term patient dissatisfaction or regret following gender affirming treatments, and protect federal civil rights of sex, gender identity, and sexual orientation. (New HOD Policy)

The authors introduced the resolution and expressed support for a proposed amendment. That amendment replaced the current Resolve with two alternate Resolve clauses and addressed concerns regarding the conflation between DSD and trans patients. Care for trans patients and DSD patients can be very different and often opposed. Further testimony noted that the subject is important and complex and recommended referral to make sure the language is handled properly. Your references committee believes that the language of the alternate resolution addresses those concerns and recommends adoptions of Alternate Resolution 14 in lieu of the original Resolution 14.

- (32) RESOLUTION 27 – PROTECTING ACCESS TO ABORTION AND REPRODUCTIVE HEALTHCARE

RECOMMENDATION A:

The first resolve in Resolution 27 be amended by addition to read as follows:

~~Ending the Risk Evaluation and Mitigation Strategy (REMS) Policy on Supporting Access to Mifepristone (Mifeprex), H-100.948~~

Our AMA will support mifepristone availability for reproductive health indications, including via telemedicine, telehealth, and at retail pharmacies and continue efforts urging the Food and Drug Administration to lift the Risk Evaluation and Mitigation Strategy on mifepristone. (Modify Current HOD Policy)

RECOMMENDATION B:

Resolution 27 be adopted as amended.

HOD ACTION: Resolution 27 adopted as amended.

RESOLVED, That our AMA amends policy H-100.948, “Ending the Risk Evaluation and Mitigation Strategy (REMS) Policy on Mifepristone (Mifeprex),” by addition and deletion as follows:

~~Ending the Risk Evaluation and Mitigation Strategy (REMS) Policy on~~ Supporting Access to Mifepristone (Mifeprex), H-100.948

Our AMA will support mifepristone availability for reproductive health indications, including via telemedicine, telehealth, and at retail pharmacies ~~efforts urging the Food and Drug Administration to lift the Risk Evaluation and Mitigation Strategy on mifepristone.~~ (Modify Current HOD Policy)

RESOLVED, That our AMA amends policy H-5.980, “Oppose the Criminalization of Self Induced Abortion,” by addition and deletion as follows:

Oppose the Criminalization of Self-Induced Abortion, H-5.980

Our AMA: (1) opposes the criminalization of self-~~induced~~ managed abortion and the criminalization of patients who access abortions as it increases patients’ medical risks and deters patients from seeking medically necessary services; and (2) will advocate against any legislative efforts to criminalize self-~~induced~~ managed abortion and the criminalization of patients who access abortions; and (3) will oppose efforts to enforce criminal and civil penalties or other retaliatory efforts against these patients and requirements that physicians function as agents of law enforcement – gathering evidence for prosecution rather than as a provider of treatment. (Modify Current HOD Policy)

Testimony was heard in unanimous support of the goal of the resolution. An amendment was proffered to retain of the portion of the first resolve that struck efforts to urge the FDA to lift the Risk Evaluation and Mitigation Strategy (REMS) on mifepristone, because REMS still exists but are temporally suspended due to the pandemic. Further testimony was heard in support of this amendment. Testimony noted that reproductive rights are under attack and physicians should not be criminalized for providing reproductive services. It was noted that this resolution maintains AMA policy but updates it to reflect current FDA recommendations and supports AMA policy opposing punitive measures against pregnant people. Your reference committee recommends that Resolution 27 be adopted as amended.

RECOMMENDED FOR REFERRAL

(33) BOARD OF TRUSTEES REPORT 21 – OPPOSITION TO REQUIREMENTS FOR GENDER-BASED TREATMENTS FOR ATHLETES

RECOMMENDATION:

Recommendations in Board of Trustees Report 21 be referred.

HOD ACTION: Recommendations in Board of Trustees Report 21 referred.

In view of these considerations, your Board of Trustees recommends that the following recommendations be adopted in lieu of Resolution 19-A-19 and the remainder of this report be filed:

1. That our American Medical Association (AMA) oppose mandatory medical treatment or surgery for athletes with Differences of Sex Development (DSD) to be allowed to compete in alignment with their identity; (New HOD Policy)
2. That our AMA oppose use of specific hormonal guidelines to determine gender classification for athletic competitions. (New HOD Policy)

The authors of the report stated that as a result of testimony in the online forum, the Board would accept referral to address certain issues within the report. Further testimony was heard in support of the report as written, noting that athletes, particularly female athletes, may be subjected to unnecessary medical examinations and inappropriate medical interventions. Further testimony expressed the desire for definitions in the report, including DSD, women with differences of sexual development, and female athletes. An amendment was offered, and subsequent testimony was heard in support, that would add the words “examination, testing, or” before hormonal guidelines. The amendment from will be offered to the Board of Trustees for consideration. Therefore your reference committee recommend that Board of Trustees of Report 21 be referred.

(34) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS REPORT 1 – SHORT-TERM MEDICAL SERVICE TRIPS

RECOMMENDATION:

Recommendations in Council on Ethical and Judicial Affairs Report 1 be referred.

HOD ACTION: Recommendations in Council on Ethical and Judicial Affairs Report 1 referred.

In light of these deliberations, the Council on Ethical and Judicial Affairs recommends that the following be adopted and the remainder of this report be filed:

Short-term medical service trips, which send physicians and physicians in training from wealthier countries to provide care in resource-limited settings for a period of days or weeks, have been promoted as a strategy to provide needed care to individual patients and, increasingly, as a means to address global health inequities. To the extent that such service trips also provide training and educational opportunities, they may offer benefit both to the communities that host them and the medical professionals and trainees who volunteer their time and clinical skills.

By definition, short-term medical service trips take place in contexts of scarce resources and in the shadow of colonial histories. These realities define fundamental ethical responsibilities for volunteers, sponsors, and hosts to jointly prioritize activities to meet mutually agreed-on goals; navigate day-to-day collaboration across differences of culture, language, and history; and fairly allocate host and team resources in the local setting. Participants and sponsors must focus not only on enabling good health outcomes for individual patients, but on promoting justice and sustainability, minimizing burdens on host communities, and respecting persons and local cultures. Responsibly carrying out short-term medical service trips requires diligent preparation on the part of participants and sponsors in collaboration with host communities.

Physicians and trainees who are involved with short-term medical service trips should ensure that the trips with which they are associated:

(a) Focus prominently on promoting justice and sustainability by collaborating with the host community to define mission parameters, including identifying community needs, mission goals, and how the volunteer medical team will integrate with local health care professionals and the local health care system. In collaboration with the host community, short-term medical service trips should identify opportunities for and priority of efforts to support the community in building health care capacity. Trips that also serve secondary goals, such as providing educational opportunities for trainees, should prioritize benefits as defined by the host community over benefits to members of the volunteer medical team.

(b) Seek to proactively identify and minimize burdens the trip may place on the host community, including not only direct, material costs of hosting volunteers, but on possible disruptive effects the presence of volunteers could have for local practice and practitioners as well. Sponsors and participants should ensure that team members practice only within their skill sets and experience, and that resources are available to support the success of the trip, including arranging for appropriate supervision of trainees, local mentors, translation services, and volunteers' personal health needs as appropriate.

(c) Seek to become broadly knowledgeable about the communities in which they will work and take advantage of resources to begin to cultivate the "cultural sensitivity" they will need to provide safe, respectful, patient-centered care in the context of the specific host community. Members of the volunteer medical team are expected to uphold the ethics standards of their profession and volunteers should insist that strategies are in place to address ethical dilemmas as they arise. In cases of irreducible conflict with local norms, volunteers may withdraw from care of an individual patient or from the mission after careful consideration of the effect that will have on the patient, the medical team, and the mission overall, in keeping with ethics guidance on the exercise of conscience.

Sponsors of short-term medical service trips should:

(d) Ensure that resources needed to meet the defined goals of the trip will be in place, particularly resources that cannot be assured locally.

(e) Proactively define appropriate roles and permissible range of practice for members of the volunteer team, including the training, experience, and oversight of team members required to provide acceptable safe, high-quality care in the host setting. Team members should practice only within the limits of their training and skills in keeping with the professional standards of the sponsor's country.

(f) Put in place a mechanism to collect data on success in meeting collaboratively defined goals for the trip in keeping with recognized standards for the conduct of health services research and quality improvement activities in the sponsor's country.

Limited testimony noted that while the report is much improved, a number of issues remained including the need to address minimizing burdens to host, noting that care can do more harm than good, e.g., medication errors, side effects and complications. Testimony noted that the term cultural sensitivity is outdated and has been replaced by cultural humility. Testimony further noted that the report did not have adequate discussion regarding cost-effectiveness, state stakeholders, about positive and negative impacts, about people practicing beyond their expertise, and continuity of care. Your reference committee recommends that CEJA Report 1 be referred.

(35) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS REPORT 2 –
AMENDMENT TO OPINION 10.8, COLLABORATIVE CARE

RECOMMENDATION:

Recommendations in Council on Ethical and Judicial Affairs Report 2 be referred.

HOD ACTION: Recommendations in Council on Ethical and Judicial Affairs Report 2 referred.

In light of the foregoing, the Council on Ethical and Judicial Affairs recommends that Opinion 10.8, Collaborative Care be amended as follows and the remainder of this report be filed:

In health care, teams that collaborate effectively can enhance the quality of care for individual patients. By being prudent stewards and delivering care efficiently, teams also have the potential to expand access to care for populations of patients. Such teams are defined by their dedication to providing patient-centered care, protecting and promoting the integrity of the patient-professional relationship, sharing mutual respect and trust, communicating effectively, sharing accountability and responsibility, and upholding common ethical values as team members.

Health care teams often include members of multiple health professions, including physicians, nurse practitioners, physician assistants, pharmacists, physical therapists, and care managers among others. To foster the trust essential to patient-professional relationships, all members of the team should be candid about their professional credentials, their experience, and the role they will play in the patient's care.

An effective team requires the vision and direction of an effective leader. In medicine, this means having a clinical leader who will ensure that the team as a whole functions effectively and facilitates decision-making. Physicians are uniquely situated to serve as clinical leaders. By virtue of their thorough and diverse training, experience, and knowledge, physicians have a distinctive appreciation of the breadth of health issues and treatments that enables them to synthesize the diverse professional perspectives and recommendations of the team into an appropriate, coherent plan of care for the patient.

As clinical leaders within health care teams, physicians individually should:

(a) Model ethical leadership by:

- (i) Understanding the range of their own and other team members' skills and expertise and roles in the patient's care
- (ii) Clearly articulating individual responsibilities and accountability
- (iii) Encouraging insights from other members and being open to adopting them and
- (iv) Mastering broad teamwork skills

(b) Promote core team values of honesty, discipline, creativity, humility and curiosity and commitment to continuous improvement.

(c) Help clarify expectations to support systematic, transparent decision making.

(d) Encourage open discussion of ethical and clinical concerns and foster a team culture in which each member's opinion is heard and considered and team members share accountability for decisions and outcomes.

(e) Communicate appropriately with the patient and family, including being forthright when describing their profession and role, and respecting the unique relationship of patient and family as members of the team.

As leaders within health care institutions, physicians individually and collectively should:

(f) Advocate for the resources and support health care teams need to collaborate effectively in providing high-quality care for the patients they serve, including education about the principles of effective teamwork and training to build teamwork skills.

(g) Encourage their institutions to identify and constructively address barriers to effective collaboration.

(h) Promote the development and use of institutional policies and procedures, such as an institutional ethics committee or similar resource, to address constructively conflicts within teams that adversely affect patient care.

(i) Promote a culture of respect, collegiality and transparency among all health care personnel.

Testimony supported much of the report, but concerns were expressed about the change from patient-physician relationship to patient-professional relationship, which speakers noted is a unique relationship that needs to be protected. Limited testimony supported the report as written, noting that the report addresses not only physicians, but other professionals on the team and the relationships they should have with patients. Your reference committee recommends that CEJA Report 2 be referred.

(36) RESOLUTION 5 – SUPPORTING THE STUDY OF REPARATIONS AS A MEANS TO REDUCE RACIAL INEQUALITIES

RECOMMENDATION:

Resolution 5 be referred.

HOD ACTION: Resolution 5 referred.

RESOLVED, That our American Medical Association study potential mechanisms of national economic reparations that could improve inequities associated with institutionalized, systematic racism and report back to the House of Delegates (Directive to Take Action); and be it further
RESOLVED, That our AMA study the potential adoption of a policy of reparations by the AMA to support the African American community currently interfacing with, practicing within, and entering the medical field and report back to the House of Delegates (Directive to Take Action); and be it further
RESOLVED, That our AMA support federal legislation that facilitates the study of reparations. (New HOD Policy)

Testimony was heard in general support of Resolution 5. Supporting testimony noted that the Center for Health Equity has shown where the AMA has stood over the years, and where we need to make amends for past wrongs. Further testimony also noted that this resolution is about reparative justice. Testimony noted that the issue of national reparations is outside the scope of our AMA. However, recognizing and taking steps to make reparations for prior racist actions taken by the AMA should be addressed. Testimony noted that national reparations could have beneficial effects on the nation's health. Limited testimony was heard in support of referral, noting that actions being requested should be accomplished by federal legislation. Additionally, your reference committee notes that the call for supporting federal legislation is quite broad and in need of better clarity. Therefore, your reference committee recommend that this resolution be referred.

(37) RESOLUTION 21 – NATIONAL CANCER RESEARCH PATIENT IDENTIFIER

RECOMMENDATION:

Resolution 21 be referred.

HOD ACTION: Resolution 21 referred.

RESOLVED, That in order to increase the power of medical research, our American Medical Association propose a novel approach to linking medical information while still maintaining patient confidentiality through the creation of a National Cancer Research Identifier (NCRI) (Directive to Take Action); and be it further
RESOLVED, That our AMA encourage the formation of an organization or organizations to oversee the NCRI process, specific functions, and engagement of interested parties to improve care for patients with cancer. (Directive to Take Action)

Testimony was strongly in support of referral. The resolution's author testified in support of referral, noted that the issue may be best evaluated by a council. Testimony noted the complexity of the issue; i.e., a national patient identifier may exclude some people from clinical trials, may dissuade some people with privacy concerns from joining trials, may put undue burdens (e.g., further EHR responsibilities) on some physicians, and it may implicate privacy, trust, and surveillance concerns. Testimony also noted concern about what organizations would be involved

in overseeing the NCRI process. Testimony further questioned why the resolution should be limited to cancer rather than be broader in scope. Considering testimony reflecting the complexity of the issue and the need for greater evaluation, your reference committee recommends that Resolution 21 be referred.

- (38) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS REPORT 5 –
PANDEMIC ETHICS AND THE DUTY OF CARE (D-130.960)

RECOMMENDATION:

Council on Ethical and Judicial Affairs Report 5 be referred.

HOD ACTION: Council on Ethical and Judicial Affairs Report 5 referred.

Testimony in favor of referral to the report noted that the report recognizes a gap in the Code of Medical Ethics, but does not address that gap. Testimony asks CEJA to consider modifying the Code of Medical Ethics to address that gap. Therefore, your reference committee recommends that Council on Ethical Judicial Affairs Report 5 be referred.

RECOMMENDED FOR NOT ADOPTION

- (39) RESOLUTION 9 – PRIVACY PROTECTION AND PREVENTION OF FURTHER TRAUMA FOR VICTIMS OF DISTRIBUTION OF INTIMATE VIDEOS AND IMAGES WITHOUT CONSENT

RECOMMENDATION:

Resolution 9 be not adopted.

HOD ACTION: Resolution 9 adopted.

RESOLVED, That our American Medical Association amend policy H-515.967, “Protection of the Privacy of Sexual Assault Victims,” by addition to read as follows:

Protection of the Privacy of Sexual Assault Victims H-515.967

The AMA opposes the publication or broadcast of sexual assault victims' names, addresses, images or likenesses without the explicit permission of the victim. The AMA additionally opposes the publication (including posting) or broad cast of videos, images, or recordings of any illicit activity of the assault. The AMA opposes the use of such video, images, or recordings for financial gain and/or any form of benefit by any entity. (Modify Current HOD Policy)

RESOLVED, That our AMA research issues related to the distribution of intimate videos and images without consent to find ways to protect these victims to prevent further harm to their mental health and overall well-being. (Directive to Take Action)

No testimony was heard during live testimony or on the online forum for this resolution. Therefore, your reference committee recommends that Resolution 9 not be adopted.

- (40) RESOLUTION 20 – COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS GUIDELINES FOR TREATING UNVACCINATED INDIVIDUALS

RECOMMENDATION:

Resolution 20 not be adopted.

HOD ACTION: Resolution 20 not adopted.

RESOLVED, That our American Medical Association and the Council on Ethical and Judicial Affairs issue new ethical guidelines for medical professionals for care of individuals who have not been vaccinated for COVID-19. (Directive to Take Action)

Testimony was heard in opposition to this resolution, noting that CEJA has already provided tremendous guidance throughout the pandemic, and as COVID continues to evolve, there is no way to know whether current vaccinations will be effective against future COVID variants. Testimony also noted that this resolution asks for very specific guidance from CEJA, which is unnecessary. Your reference committee recommends that Resolution 20 not be adopted.

REPORT OF REFERENCE COMMITTEE A

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Resolution 121 – Increase Funding, Research and Education for Post-Intensive Care Syndrome
2. Resolution 125 – Education, Forewarning and Disclosure regarding Consequences of Changing Medicare Plans

RECOMMENDED FOR ADOPTION AS AMENDED

3. Council on Medical Service Report 3 – Preventing Coverage Losses After the Public Health Emergency Ends
4. Council on Medical Service Report 4 – Parameters of Medicare Drug Price Negotiation
5. Resolution 101 – Fertility Preservation Benefits for Active-Duty Military Personnel
6. Resolution 109 – Piloting the Use of Financial Incentives to Reduce Unnecessary Emergency Room Visits
7. Resolution 116 – Reimbursement of School-Based Health Centers
8. Resolution 118 – Caps on Insulin Co-Payments for Patients with Insurance
9. Resolution 122 – Medicaid Expansion
10. Resolution 127 – Continuity of Care Upon Release from Correctional Systems

RECOMMENDED FOR ADOPTION IN LIEU OF

11. Resolution 108 – Payment for Regadenoson (Lexiscan)
12. Resolution 113 – Prevention of Hearing Loss-Associated-Cognitive-Impairment through Earlier Recognition and Remediation
- Resolution 114 – Oral Healthcare Is Healthcare
- Resolution 119 – Medicare Coverage of Dental, Vision, and Hearing Services
13. Resolution 120 – Expanding Coverage for and Access to Pulmonary Rehabilitation
14. Resolution 123 - Advocating for All Payer Coverage of Cosmetic Treatment for Survivors of Domestic Abuse and Intimate Partner Violence

RECOMMENDED FOR REFERRAL

15. Resolution 111 – Bundled Payments and Medically Necessary Care

RECOMMENDED FOR NOT ADOPTION

16. Resolution 103 – COBRA for College Students
17. Resolution 110 – Private Payor Payment Integrity

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

18. Resolution 117 – Expanding Medicaid Transportation to Include Healthy Grocery Destinations
19. Resolution 124 – To Require Insurance Companies Make the “Coverage Year” and the “Deductible Year” Simultaneous for Their Policies

The following resolutions were handled via the reaffirmation consent calendar:

- Resolution 102 – Bundling Physician Fees with Hospital Fees
- Resolution 104 – Consumer Operated and Oriented Plans (CO-OPs) as a Public Option for Health Care Financing
- Resolution 105 – Health Insurance that Fairly Compensates Physicians
- Resolution 106 – Hospice Recertification for Non-Cancer Diagnosis
- Resolution 107 – Medicaid Tax Benefits

- Resolution 112 – Support for Easy Enrollment Federal Legislation
- Resolution 115 – Support for Universal Internet Access
- Resolution 126 – Providing Recommended Vaccines Under Medicare Parts B And C
- Resolution 128 – Improving Access to Vaccinations for Patients

RECOMMENDED FOR ADOPTION

(1) RESOLUTION 121 – INCREASE FUNDING, RESEARCH AND EDUCATION FOR POST-INTENSIVE CARE SYNDROME

RECOMMENDATION:

Resolution 121 be adopted.

HOD ACTION: Resolution 121 adopted.

RESOLVED, That our American Medical Association support the development of an ICD-10 code or family of codes to recognize Post-Intensive Care Syndrome (PICS) (New HOD Policy); and be it further

RESOLVED, That our AMA advocate for legislation to provide funding for research and treatment of PICS, including for those cases related to COVID-19. (Directive to Take Action)

Your Reference Committee heard testimony in strong support of Resolution 121. Limited opposition wished to ensure that COVID research did not get narrowed to only focusing on PICS, which your Reference Committee did not feel that this resolution would do. Therefore, your Reference Committee recommends that Resolution 121 be adopted.

(2) RESOLUTION 125 – EDUCATION, FOREWARNING AND DISCLOSURE REGARDING CONSEQUENCES OF CHANGING MEDICARE PLANS

RECOMMENDATION:

Resolution 125 be adopted.

HOD ACTION: Resolution 125 adopted.

RESOLVED, That our American Medical Association amend policy H-330.870, “Transparency of Costs to Patients for Their Prescription Medications Under Medicare Part D and Medicare Advantage Plans,” by addition and deletion to read as follows:

Our AMA will: (1) advocate for provision of transparent print and audio/video patient educational resources to patients and families in multiple languages from health care systems and from Medicare - directly accessible - by consumers and families, explaining clearly the different benefits, as well as the varied, programmatic and other out-of-pocket costs for their medications under Medicare, Medicare Supplemental and Medicare Advantage plans on their personal costs for their medications under Medicare and Medicare Advantage plans both printed and online video which health care systems could provide to patients and which consumers could access directly; and

(2) advocate for printed and audio/video patient educational resources regarding personal costs, changes in benefits and provider panels that may be incurred when switching (voluntarily or otherwise) between Medicare, Medical Supplemental and Medicare Advantage or other plans, including additional information regarding federal and state health insurance assistance programs that patients and consumers could access directly; and

(23) support advocate for increased funding for federal and state health insurance assistance programs and educate physicians, hospitals, and patients about the availability of and access to these such programs. (Modify Current HOD Policy)

Testimony was very supportive of Resolution 125. Several commenters emphasized that choosing and changing Medicare plans is complex and confusing for enrollees—and physicians—and that more transparency, education, and guidance is needed. Although testimony noted that new resources and educational materials will not guarantee greater understanding of Medicare and Medicare Advantage plans, several speakers also maintained that Resolution 125 makes important additions to Policy H-330.870. There was also a suggestion to refer the Resolution 125;

however, there was insufficient support for referral. Therefore, your Reference Committee recommends that Resolution 125 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

(3) COUNCIL ON MEDICAL SERVICE REPORT 3 – PREVENTING
COVERAGE LOSSES AFTER THE PUBLIC HEALTH EMERGENCY ENDS

RECOMMENDATION A:

Recommendation 1 in Council on Medical Service Report 3 be amended by addition to read as follows:

1. That our American Medical Association (AMA) encourage states to facilitate transitions, including automatic transitions, from health insurance coverage for which an individual is no longer eligible to alternate health insurance coverage for which the individual is eligible, and that auto-transitions meet the following standards:
 - a. Individuals must provide consent to the applicable state and/or federal entities to share information with the entity authorized to make coverage determinations.
 - b. Individuals should only be auto-transitioned in health insurance coverage if they are eligible for coverage options that would be of no cost to them after the application of any subsidies.
 - c. Individuals should have the opportunity to opt out from health insurance coverage into which they are auto-transitioned.
 - d. Individuals should not be penalized if they are auto-transitioned into coverage for which they are not eligible.
 - e. Individuals eligible for zero-premium marketplace coverage should be randomly assigned among the zero-premium plans with the highest actuarial values.
 - f. There should be targeted outreach and streamlined enrollment mechanisms promoting health insurance enrollment, which could include raising awareness of the availability of premium tax credits and cost-sharing reductions, and special enrollment periods. (New HOD Policy)
 - g. Auto-transitions should preserve existing medical home and patient-physician relationships whenever possible.
 - h. Individuals auto-transitioned into a plan that does not include their physicians in-network should be able to receive transitional continuity of care from those physicians, consistent with Policy H-285.952.

RECOMMENDATION B:

Council on Medical Service Report 3 be amended by addition of a new Recommendation to read as follows:

That our AMA reaffirm Policy H-285.952, which supports patients in an active course of treatment who switch to a new health plan having the opportunity to receive continued transitional care from their treating out-of-network physicians and hospitals. (Reaffirm HOD Policy)

RECOMMENDATION C:

Recommendations in Council on Medical Service Report 3 be adopted as amended and the remainder of the Report be filed.

HOD ACTION: Recommendations in Council on Medical Service Report 3 adopted as amended and the remainder of the Report filed.

The Council on Medical Service recommends that the following be adopted and the remainder of the report be filed:

1. That our American Medical Association (AMA) encourage states to facilitate transitions, including automatic transitions, from health insurance coverage for which an individual is no longer eligible to alternate health insurance coverage for which the individual is eligible, and that auto-transitions meet the following standards:
 - a. Individuals must provide consent to the applicable state and/or federal entities to share information with the entity authorized to make coverage determinations.
 - b. Individuals should only be auto-transitioned in health insurance coverage if they are eligible for coverage options that would be of no cost to them after the application of any subsidies.
 - c. Individuals should have the opportunity to opt out from health insurance coverage into which they are auto-transitioned.
 - d. Individuals should not be penalized if they are auto-transitioned into coverage for which they are not eligible.
 - e. Individuals eligible for zero-premium marketplace coverage should be randomly assigned among the zero-premium plans with the highest actuarial values.
 - f. There should be targeted outreach and streamlined enrollment mechanisms promoting health insurance enrollment, which could include raising awareness of the availability of premium tax credits and cost-sharing reductions, and special enrollment periods. (New HOD Policy)
2. That our AMA support coordination between state agencies overseeing Medicaid, Affordable Care Act marketplaces, and workforce agencies that will help facilitate health insurance coverage transitions and maximize coverage. (New HOD Policy)
3. That our AMA support federal and state monitoring of Medicaid retention and disenrollment, successful transitions to quality affordable coverage, and uninsured rates. (New HOD Policy)
4. That our AMA reaffirm Policy H-290.982, which calls for states to streamline Medicaid/Children's Health Insurance Program (CHIP) enrollment processes, use simplified enrollment forms, and undertake Medicaid/CHIP educational and outreach efforts. (Reaffirm HOD Policy)
5. That our AMA reaffirm Policy H-165.855, which calls for adoption of 12-month continuous eligibility across Medicaid, CHIP, and exchange plans to limit churn and assure continuity of care. (Reaffirm HOD Policy)
6. That our AMA reaffirm Policy H-165.823, which supports states and/or the federal government pursuing auto-enrollment in health insurance coverage that meets certain standards related to consent, cost, ability to opt out, and other guardrails. (Reaffirm HOD Policy)

Testimony was supportive of Council on Medical Service Report 3 and its approach to facilitating coverage as the COVID-19 public health emergency (PHE) unwinds. A member of the Council on Medical Service explained that the Council had initiated this report so that the AMA has policy to help ensure that, once the PHE expires and state eligibility redeterminations begin, individuals who remain eligible for Medicaid retain their coverage and those no longer eligible successfully transition to other affordable coverage for which they are eligible. A member of the Council on Legislation noted the potential for significant coverage losses in the post-PHE period while testifying in support of the report's recommendations.

An amendment to Recommendation 1 was proffered to make sure that the patient-physician relationship is not disrupted when enrollees are auto-transitioned into new coverage, and to ensure that individuals auto-transitioned into plans that do not include their physicians in network receive continuity of care from those physicians, consistent with Policy H-285.952. The authors of the amendment also requested reaffirmation of Policy H-285.952. Having heard testimony that supported these changes, your Reference Committee recommends that the recommendations in Council on Medical Service Report 3 be adopted as amended.

(4) COUNCIL ON MEDICAL SERVICE REPORT 4 – PARAMETERS OF MEDICARE DRUG PRICE NEGOTIATION

RECOMMENDATION A:

Recommendation 2 in Council on Medical Service Report 4 be amended by addition and deletion to read as follows:

~~2. That our AMA reaffirm Policy H-110.980, which outlines principles to guide AMA support for arbitration as well as the use of international drug price averages/indices in determining domestic drug prices. (Reaffirm HOD Policy)~~

2. That our AMA amend Policy H-110.980[2] by addition and deletion to read as follows:

2. Our AMA will advocate that any use of international price indices and averages in determining the price of and payment for drugs should abide by the following principles:

~~a. Any international drug price index or average should exclude countries that have single payer health systems and use price controls;~~

ab. Any international drug price index or average should not be used to determine or set a drug's price, or determine whether a drug's price is excessive, in isolation;

be. The use of any international drug price index or average should preserve patient access to necessary medications;

cd. The use of any international drug price index or average should limit burdens on physician practices; and

de. Any data used to determine an international price index or average to guide prescription drug pricing should be transparent and updated regularly. (Modify HOD Policy)

RECOMMENDATION B:

Recommendation 4 in Council on Medical Service Report 4 be amended by addition to read as follows:

4. That our AMA encourage the development of voluntary models under the auspices of the CMS Innovation Center (CMMI) to test the impact of offering Medicare beneficiaries additional enhanced alternative health plan choices that offer lower, consistent, and predictable out-of-pocket costs for select prescription drugs. (New HOD Policy)

RECOMMENDATION C:

Recommendations in Council on Medical Service Report 4 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Service Report 4 adopted as amended and the remainder of the report filed.

The Council on Medical Service recommends that the following be adopted in lieu of the second resolve of Alternate Resolution 113-N-21, as well as the referred amendment proffered during consideration of Alternate Resolution 113-N-21, and that the remainder of the report be filed.

1. That our American Medical Association (AMA) reaffirm Policy D-330.954, which states that our AMA will support federal legislation which gives the Secretary of the Department of Health and Human Services the authority

to negotiate contracts with manufacturers of covered Part D drugs; work toward eliminating Medicare prohibition on drug price negotiation; and prioritize its support for the Centers for Medicare & Medicaid Services (CMS) to negotiate pharmaceutical pricing for all applicable medications covered by CMS. (Reaffirm HOD Policy)

2. That our AMA reaffirm Policy H-110.980, which outlines principles to guide AMA support for arbitration as well as the use of international drug price averages/indices in determining domestic drug prices. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy H-110.983, which advocates standards that any revised Medicare Part B Competitive Acquisition Program must meet. (Reaffirm HOD Policy)

4. That our AMA encourage the development of models under the auspices of the CMS Innovation Center (CMMI) to test the impact of offering Medicare beneficiaries additional enhanced alternative health plan choices that offer lower, consistent, and predictable out-of-pocket costs for select prescription drugs. (New HOD Policy)

Testimony on Council on Medical Service Report 4 was mixed, supporting amendment or referral. Amendments were proffered to the recommendations of the report to 1) support price negotiation for Medicare Part D drugs using a volume-weighted average percentage of the prices paid in comparable industrialized nations; 2) develop a proposal with interested physician organizations and submit it to the Centers for Medicare and Medicaid Services (CMS) that allows Medicare to negotiate drug prices for Medicare Part B physician-administered drugs based on the volume-weighted net average drug price in comparable industrialized nations; 3) reaffirm Policy H-110.987 that supports legislation that limits Medicare annual drug price increases to the rate of inflation; and 4) stipulate that the models encouraged in the fourth recommendation of the report should be voluntary in nature. Testimony in support of the amendments indicated that they were necessary so that our AMA could more actively “be at the table” as relevant legislation or regulations were put forward. Overall, testimony in support of the amendments stressed that current AMA policy guiding the use of international drug price averages/indices in Medicare drug price negotiation was too restrictive.

While there was substantial support for the amendments proffered, speakers raised concerns that amending Policy H-110.980 as proposed would have unintended consequences. The chair of the Council on Medical Service underscored that existing Policy H-110.980 as currently worded provides the AMA with a solid foundation upon which to assess legislative and regulatory proposals that attempt to use international drug price averages to determine domestic drug prices. In the end, the chair shared that the Council believes that arbitration would serve as a more sustainable and effective lever in Medicare drug price negotiation, versus the use of an international price index.

The chair of the Council on Medical Service also stressed that our AMA already has policy addressing the value-based pricing of prescription drugs. Changing Policy H-110.980 to explicitly support the use of international price indices to determine domestic drug prices, in the end, amounts to importing the value assessments of other countries into our pricing system, thereby undermining existing AMA policy on the value-based pricing of drugs.

The chair of the Council on Medical Service and other speakers noted that that openly supporting an international price index to price domestic prescription drugs would invite more gaming into our pharmaceutical marketplace, not less. Testimony implicated that utilizing an international price index in Medicare drug price negotiation may incentivize pharmaceutical manufacturers to increase drug prices and delay new product introductions globally to impact the U.S. market. The chair of the Council also stated that evidence is lacking as to whether the savings achieved by any international price index would be sustainable, which is why our AMA has been multifaceted and diverse in its approach to lowering prescription drug costs. Medicare prescription drug price negotiation is only a piece of the larger drug pricing puzzle, which requires interventions to improve transparency and competition in the pharmaceutical marketplace; strengthen regulation of PBMs; limit drug price increases in Medicare to the rate of inflation; and ensure benefit design improves patient medication adherence.

The chair of the Council on Medical Services indicated during testimony that striking subpart 2a from Policy H-110.980 may serve as an acceptable compromise for how AMA policy can best move forward. It is the understanding of your Reference Committee that the sponsor of the amendments also agreed to this compromise. Your Reference Committee agrees with the compromise reached, and stresses that the remaining safeguards in AMA Policy H-110.980 will be absolutely critical as our AMA reviews relevant legislation and regulations on drug pricing in the coming months. Therefore, your Reference Committee recommends that the recommendations of Council on Medical Service Report 4 be adopted as amended, and the remainder of the report filed.

(5) RESOLUTION 101 – FERTILITY PRESERVATION BENEFITS FOR ACTIVE-DUTY MILITARY PERSONNEL

RECOMMENDATION A:

The second resolve of Resolution 101 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA work with interested organizations to encourage TRICARE to cover gamete preservation ~~prior to deployment~~ for active-duty military personnel and activated reservist military personnel. (Directive to Take Action); ~~and be it further~~

RECOMMENDATION B:

The third resolve of Resolution 101 be deleted.

~~RESOLVED, That our AMA report back on this issue at the 2023 Annual Meeting of the AMA House of Delegates. (Directive to Take Action)~~

RECOMMENDATION C:

Resolution 101 be adopted as amended.

HOD ACTION: Resolution 101 adopted as amended.

RESOLVED, That our American Medical Association work with interested organizations to encourage TRICARE to cover fertility preservation procedures (cryopreservation of sperm, oocytes, or embryos) for medical indications, for active-duty military personnel and other individuals covered by TRICARE (Directive to Take Action); and be it further

RESOLVED, That our AMA work with interested organizations to encourage TRICARE to cover gamete preservation prior to deployment for active-duty military personnel (Directive to Take Action); and be it further

RESOLVED, That our AMA report back on this issue at the 2023 Annual Meeting of the AMA House of Delegates. (Directive to Take Action)

Testimony was supportive of the intent of Resolution 101. The potential cost of covering fertility preservation services for military personnel was raised, as was the potential benefit to service member morale, retention, and well-being. While speakers acknowledged existing AMA policy on coverage of and payment for fertility preservation and gamete preservation services by all payers, a preponderance of the testimony—from active-duty military members and others—supported Resolution 101 and the need for new policy specific to coverage of these services under TRICARE. Testimony further supported a proffered amendment to include “activated reservist military personnel” and delete “prior to deployment” in the second resolve clause.

A member of the Council on Medical Service testified that the report requested in the third resolve clause is not needed because the Council presented a report in 2016 on infertility benefits provided through the Department of Defense (DOD), which administers TRICARE. No testimony was offered in support of the third resolve clause, and your Reference Committee recommends that it be deleted and that Resolution 101 be adopted as amended.

(6) RESOLUTION 109 – PILOTING THE USE OF FINANCIAL INCENTIVES TO REDUCE UNNECESSARY EMERGENCY ROOM VISITS

RECOMMENDATION A:

Resolution 109 be amended by addition to read as follows:

RESOLVED, That our American Medical Association study and report on the positive and negative experiences of programs in various states that provide Medicaid beneficiaries with incentives for choosing alternative sites of care, for physical and mental health conditions, when it is appropriate to their symptoms and/or conditions instead of hospital emergency departments. (Directive to Take Action)

RECOMMENDATION B:

Resolution 109 be adopted as amended with a change in title.

RECOMMENDATION C:

The title of Resolution 109 be changed to:

STUDY OF INCENTIVES TO ENCOURAGE EFFICIENT USE OF EMERGENCY DEPARTMENTS

HOD ACTION: Resolution 109 adopted as amended with a change in title.

STUDY OF INCENTIVES TO ENCOURAGE EFFICIENT USE OF EMERGENCY DEPARTMENTS

RESOLVED, That our American Medical Association study and report on the positive and negative experiences of programs in various states that provide Medicaid beneficiaries with incentives for choosing alternative sites of care when it is appropriate to their symptoms and/or condition instead of hospital emergency departments. (Directive to Take Action)

Testimony was supportive of Resolution 109 and the need for additional study of incentives designed to encourage Medicaid enrollees to choose alternate sites of care instead of emergency departments. Although the need for another report on financial incentives was questioned, a preponderance of the testimony maintained that additional study specific to Medicaid and emergency department use was needed. An amendment was proffered to add “for physical and mental health conditions” to Resolution 109. Additional testimony questioned use of the term “unnecessary” in the title and also highlighted a range of reasons, beyond financial incentives, that people utilize emergency departments, including some patients not having access to primary care. Therefore, your Reference Committee recommends that Resolution 109 be adopted as amended with a change in title.

(7) RESOLUTION 116 – REIMBURSEMENT OF SCHOOL-BASED HEALTH CENTERS

RECOMMENDATION A:

Resolution 116 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association amend Policy H-60.921, “School-Based and School-Linked Health Centers,” by addition and deletion as follows:

School-Based and School-Linked Health Centers, H-60.921

1. Our AMA supports ~~the concept of adequately equipped and staffed the~~ implementation, maintenance, and equitable expansion of physician-led school-based or school-linked health centers (SBHCs) for the comprehensive management of conditions of childhood and adolescence.
2. Our AMA recognizes that school-based health centers increase access to care ~~in underserved~~ disproportionately affected child and adolescent populations.
3. Our AMA supports identifying school-based health centers in claims data from Medicaid and other payers for research and quality improvement purposes.
4. Our AMA supports efforts to extend ~~Medicaid reimbursement insurance~~ payments to school-based health centers at the state and federal level, including, but not limited to the recognition of school-based health centers as a provider under Medicaid. (Modify Current HOD Policy)

RECOMMENDATION B:

Resolution 116 be adopted as amended.

HOD ACTION: Resolution 116 adopted as amended.

RESOLVED, That our American Medical Association amend Policy H-60.921, “School-Based and School-Linked Health Centers,” by addition and deletion to read as follows:

School-Based and School-Linked Health Centers, H-60.921

1. Our AMA supports ~~the concept of adequately equipped and staffed the~~ implementation, maintenance, and equitable expansion of school-based or school-linked health centers (SBHCs) for the comprehensive management of conditions of childhood and adolescence.
2. Our AMA recognizes that school-based health centers increase access to care in underserved child and adolescent populations.
3. Our AMA supports identifying school-based health centers in claims data from Medicaid and other payers for research and quality improvement purposes.
4. Our AMA supports efforts to extend Medicaid reimbursement to school-based health centers at the state and federal level, including, but not limited to the recognition of school-based health centers as a provider under Medicaid. (Modify Current HOD Policy)

Testimony was supportive of Resolution 116 and highlighted a variety of benefits of school-based health centers. It was noted in testimony that the Centers for Medicare & Medicaid Services will be issuing guidance on school-based health centers later this year. An amendment was offered to clarify that school-based health centers should be physician-led. Another speaker suggested using the term “disproportionately affected” in place of “underserved” in the second clause. Testimony also requested that efforts to expand payment from private insurers, in addition to Medicaid, be supported. Your Reference Committee recommends incorporation of these three amendments. Your Reference Committee does not believe that a fourth proffered amendment, to include colleges and trade schools within the scope of Policy H-60.921, is needed since that policy does not specify that it applies only to kindergarten through twelfth grades. Your Reference Committee recommends that Resolution 116 be adopted as amended.

(8) RESOLUTION 118 – CAPS ON INSULIN CO-PAYMENTS FOR PATIENTS WITH INSURANCE

RECOMMENDATION A:

Resolution 118 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association amend Policy H-110.984, “Insulin Affordability,” by addition to read as follows:

Insulin Affordability H-110.984

Our AMA will: (1) encourage the Federal Trade Commission (FTC) and the Department of Justice to ~~monitor~~ investigate insulin pricing and market competition and take enforcement actions as appropriate; and (2) support initiatives, including those by national medical specialty societies, that provide physician education regarding the cost-effectiveness of insulin therapies.; and (3) support state and national efforts to limit the copayments ultimate expenses incurred by insured patients pay per month for prescribed insulin. (Modify Current HOD Policy)

RECOMMENDATION B:

Resolution 118 be adopted as amended.

HOD ACTION: Resolution 118 adopted as amended.

RESOLVED, That our American Medical Association amend Policy H-110.984, “Insulin Affordability,” by addition to read as follows:

Insulin Affordability H-110.984

Our AMA will: (1) encourage the Federal Trade Commission (FTC) and the Department of Justice to monitor insulin pricing and market competition and take enforcement actions as appropriate; ~~and~~ (2) support initiatives, including those by national medical specialty societies, that provide physician education regarding the cost-effectiveness of insulin therapies.; and (3) support state and national efforts to limit the copayments insured patients pay per month for prescribed insulin. (Modify Current HOD Policy)

There was highly supportive testimony on the intent of Resolution 118. Testimony stressed the impacts that high insulin cost-sharing has on medication adherence and health outcomes. An amendment was proffered to change “monitor” to “investigate” in Policy H-110.984, because the root cause of high insulin pricing reaches beyond the level at which co-pays are set by health plans. Other speakers noted that co-pay limits should be applied to other prescription drugs with high cost-sharing requirements that impede medication adherence. However, your Reference Committee notes that as Resolution 118 asks to amend AMA policy specific to insulin affordability, suggestions to broaden Resolution 118 to include more drugs are outside the scope of the resolution.

Other speakers supported reaffirming AMA policy in lieu of Resolution 118. A member of the Council on Medical Service noted that the Council presented a report in 2018 that addressed the issue of insulin affordability. In addition, in 2016, the Council presented a report that established policy supporting value-based pricing for pharmaceuticals. Further, existing policy already encourages payers to determine patient cost-sharing based on the clinical value of a health care service or treatment. The policy stipulates that consideration should be given to further tailoring cost-sharing requirements to patient income and other factors known to impact compliance. Other policy states that cost-sharing requirements for prescription drugs should be based on considerations such as the unit cost of medication, availability of therapeutic alternatives, medical condition being treated, personal income, and other factors known to affect patient compliance. Finally, policy advocates for economic assistance, including coupons and other discounts for patients, whether they are enrolled in government health insurance programs, enrolled in commercial insurance plans, or are uninsured.

While relevant existing policy is strong, your Reference Committee believes that our AMA needs to establish new policy that addresses the ultimate expenses incurred by insured patients for prescribed insulin. Your Reference Committee believes that AMA policy needs to address all of the underlying factors contributing to high insulin out-of-pocket requirements – based on the actions of pharmaceutical companies, pharmacy benefit managers and health plans. Without a more holistic look at this issue, simply limiting out-of-pocket expenses for insulin could cause higher health insurance premiums. As such, your Reference Committee is recommending an amendment to Resolution 118, and believes the resolution should be adopted as amended.

(9) RESOLUTION 122 – MEDICAID EXPANSION

RECOMMENDATION A:

Second Resolve of Resolution 122 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA ~~produce informational brochures and other communications that can be distributed by~~ work with interested state medical associations and national medical specialty societies to provide AMA resources on Medicaid expansion and covering the uninsured to health care professionals to inform the public of the importance of expanded health insurance coverage to all. (Directive to Take Action)

RECOMMENDATION B:

Resolution 122 be adopted as amended with a change in title.

RECOMMENDATION C:

The title of Resolution 122 be changed to:

PROVIDING EDUCATIONAL RESOURCES ON MEDICAID EXPANSION

HOD ACTION: Resolution 122 adopted as amended with a change in title.

PROVIDING EDUCATIONAL RESOURCES ON MEDICAID EXPANSION

RESOLVED, That our American Medical Association continue to advocate strongly for expansion of the Medicaid program to all states and reaffirm existing policies D-290.979, H 290.965 and H-165.823 (Directive to Take Action); and be it further

RESOLVED, That our AMA produce informational brochures and other communications that can be distributed by health care professionals to inform the public of the importance of expanded health insurance coverage to all. (Directive to Take Action)

Testimony was supportive of Resolution 122, with several speakers highlighting the benefits to patients of Medicaid expansion. A member of the Council on Medical Service pointed to resources that the AMA has already developed on the benefits of Medicaid expansion and the AMA's plan to cover the uninsured, adding that these resources are available on the AMA website. An amendment to the first resolve clause aimed to clarify that Medicaid payment rates should be increased to at least Medicare rates. However, a majority of the testimony opposed linking support for Medicaid expansion with increased payment rates. Your Reference Committee notes that existing AMA policy maintains that Medicaid should pay physicians a minimum of 100 percent of Medicare rates (Policy H-385.921 and H-290.976).

Because the AMA has already developed resources that can be shared with physicians and the public, your Reference Committee recommends amending the second resolve clause to direct the AMA to work with interested organizations to make those resources available. Your Reference Committee recommends that Resolution 122 be adopted as amended with a change in title that better reflects the resolution's intent.

(10) RESOLUTION 127 – CONTINUITY OF CARE UPON RELEASE FROM CORRECTIONAL SYSTEMS

RECOMMENDATION A:

Resolution 127 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA amend policy AMA Policy H-430.986, “Health Care While Incarcerated,” by addition and deletion to read as follows:

1. Our AMA advocates for adequate payment to health care providers, including primary care and mental health, and addiction treatment professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process from intake to re-entry into the community.
2. Our AMA advocates and requires a smooth transition including 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. Our AMA encourages 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 advocates for states to suspend rather than terminate Medicaid eligibility of juveniles and adults upon intake into the criminal legal system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community.
6. Our AMA advocates for Congress to repeal the “inmate exclusion” of the 1965 Social Security Act that bars the use of federal Medicaid matching funds from covering healthcare services in jails and prisons.
7. Our AMA advocates for Congress and the Centers for Medicare & Medicaid Services (CMS) to revise the Medicare statute and rescind related regulations that prevent payment for medical care furnished to a Medicare beneficiary who is incarcerated or in custody at the time the services are delivered.
8. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of women and adolescent females who are incarcerated, including gynecological care and obstetrics care for individuals who are pregnant or postpartum.
9. Our AMA will collaborate with state medical societies, relevant medical specialty societies, and federal regulators to emphasize the importance of hygiene and health literacy information sessions, as well as information sessions on the science of addiction, evidence-based addiction treatment including medications, and related stigma reduction, for both individuals who are incarcerated and staff in correctional facilities.
10. Our AMA supports: (a) linkage of those incarcerated to community clinics upon release in order to accelerate access to comprehensive health care, including mental health and substance use 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; and (c) the provision of longitudinal care from state supported social workers, to perform foundational check-ins that not only assess mental health but also develop lifestyle plans with newly released people to support their employment, education, housing, healthcare, and safety; and (d)

collaboration with community-based organizations and integrated models of care that support formerly incarcerated people with regard to their health care, safety, and social determinant of health needs, including employment, education, and housing.

11. Our AMA advocates for the continuation of federal funding for health insurance benefits, including Medicaid, Medicare, and the Children's Health Insurance Program, for otherwise eligible individuals in pre-trial detention.

12. Our AMA advocates for the prohibition of the use of co-payments to access healthcare services in correctional facilities. (Modify Current HOD Policy)

RECOMMENDATION B:

Resolution 127 be adopted as amended.

HOD ACTION: Resolution 127 adopted as amended.

RESOLVED, That our AMA amend policy AMA Policy H-430.986, "Health Care While Incarcerated," by addition and deletion to read as follows:

1. Our AMA advocates for adequate payment to health care providers, including primary care and mental health, and addiction treatment professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process from intake to re-entry into the community.
2. Our AMA advocates and requires a smooth transition including 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. Our AMA encourages 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 advocates for states to suspend rather than terminate Medicaid eligibility of juveniles and adults upon intake into the criminal legal system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community.
6. Our AMA advocates for Congress to repeal the "inmate exclusion" of the 1965 Social Security Act that bars the use of federal Medicaid matching funds from covering healthcare services in jails and prisons.
7. Our AMA advocates for Congress and the Centers for Medicare & Medicaid Services (CMS) to revise the Medicare statute and rescind related regulations that prevent payment for medical care furnished to a Medicare beneficiary who is incarcerated or in custody at the time the services are delivered.
8. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of women and adolescent females who are incarcerated, including gynecological care and obstetrics care for individuals who are pregnant or postpartum.
9. Our AMA will collaborate with state medical societies, relevant medical specialty societies, and federal regulators to emphasize the importance of hygiene and health literacy information sessions, as well as information sessions on the science of addiction, evidence-based addiction treatment including medications, and related stigma reduction, for both individuals who are incarcerated and staff in correctional facilities.
10. Our AMA supports: (a) linkage of those incarcerated to community clinics upon release in order to accelerate access to comprehensive health care, including mental health and substance use 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; and (c) the provision of longitudinal care from state supported social workers to perform foundational check-ins that not only assess mental health but also develop lifestyle plans with newly released people to support their employment, education, housing, healthcare, and safety.
11. Our AMA advocates for the continuation of federal funding for health insurance benefits, including Medicaid, Medicare, and the Children's Health Insurance Program, for otherwise eligible individuals in pre-trial detention.

12. Our AMA advocates for the prohibition of the use of co-payments to access healthcare services in correctional facilities. (Modify Current HOD Policy)

Testimony was very supportive of Resolution 127 and the importance of providing continuity of care to people released from incarceration. Alternate language was offered to broaden the resolution's scope to support care beyond that offered by state-supported social workers, since these social workers may not be available in every state. Your Reference Committee believes the intent of the alternate language differs from the original Resolution 127 and recommends that Policy H-430.986[10] be amended to incorporate both the original and alternate language. Therefore, your Reference Committee recommends that Resolution 127 be adopted as amended.

RECOMMENDED FOR ADOPTION IN LIEU OF

(11) RESOLUTION 108 – PAYMENT FOR REGADENOSON (LEXISCAN)

RECOMMENDATION:

Alternate Resolution 108 be adopted in lieu of Resolution 108.

PAYMENT FOR PHYSICIAN-PURCHASED MEDICATIONS AND
DIAGNOSTIC IMAGING AGENTS

RESOLVED, That our AMA advocate that health plan payments for drugs fully cover the physician's acquisition, inventory and carrying cost and that payments for drug administration and related services are adequate to ensure continued patient access to needed services and treatments. (New HOD Policy)

HOD ACTION: Alternate Resolution 108 adopted in lieu of Resolution 108.

RESOLVED, That our American Medical Association petition the Centers for Medicare and Medicaid Services to investigate the disparity between the cost of medical agents and the reimbursement by insurance companies and develop a solution so physicians are not financially harmed when providing medical agents. (Directive to Take Action) (Modify Current HOD Policy)

Your Reference Committee heard mixed testimony on Resolution 108 with inclination of support given two separate amendments that were offered. A member of the Council on Medical Service proffered alternate Resolved wording to ensure the new policy is applicable to all scenarios raised in the resolution. This amendment was supported by other delegates; therefore, your Reference Committee is offering this alternate resolution language in lieu of original Resolution 108. Additionally, there was supportive testimony on the proffered title amendment to broaden the intent of the resolution beyond the sole pharmacologic agent “Regadenoson (Lexiscan)”. Therefore, your Reference Committee recommends adoption of Alternate Resolution 108 in lieu of Resolution 108.

(12) RESOLUTION 113 – PREVENTION OF HEARING LOSS-ASSOCIATED-
COGNITIVE-IMPAIRMENT THROUGH EARLIER RECOGNITION AND
REMEDICATION
RESOLUTION 114 – ORAL HEALTHCARE IS HEALTHCARE
RESOLUTION 119 – MEDICARE COVERAGE OF DENTAL, VISION, AND
HEARING SERVICES

RECOMMENDATION:

Alternate Resolution 113 be adopted in lieu of Resolutions 113, 114 and 119.

INCREASING PATIENT ACCESS TO HEARING, DENTAL AND VISION
SERVICES

RESOLVED, That our American Medical Association promote awareness of hearing impairment as a potential contributor to the development of cognitive impairment or dementia in later life, to physicians as well as to the public (Directive to Take Action); and be it further

RESOLVED, That our AMA promote, and encourage other stakeholders, including public, private, and professional organizations and relevant governmental agencies, to promote the conduct and acceleration of research into specific patterns and degrees of hearing loss to determine those most linked to

cognitive impairment or dementia and amenable to correction (Directive to Take Action); and be it further

RESOLVED, That our AMA work with interested national medical specialty societies and state medical associations to encourage and promote research into hearing loss as a contributor to cognitive impairment, and to increase patient access to hearing loss identification and remediation services. (New HOD Policy); and be it further

RESOLVED, That our AMA work with interested national medical specialty societies and state medical associations to encourage and promote research into vision and dental health and to increase patient access to vision and dental services. (New HOD Policy)

HOD ACTIONS: Alternate Resolution 113 adopted in lieu of Resolutions 113, 114 and 119.

The following amendment referred:

~~RESOLVED, That our AMA study the impacts of covering vision, hearing, and dental benefits under the Medicare program. (Directive to Take Action)~~

RESOLVED, That our American Medical Association support new funding that is independent of the physician fee schedule for Medicare coverage of 1) preventive dental care, including dental cleanings and x-rays, and restorative services, including fillings, extractions, and dentures; 2) visual aids, including eyeglasses and contact lenses; and 3) aural rehabilitative services and hearing aids. (New HOD Policy)

RESOLUTION 113

RESOLVED, That our American Medical Association promote awareness of hearing impairment as a potential contributor to the development of cognitive impairment in later life, to physicians as well as to the public (Directive to Take Action); and be it further

RESOLVED, That our AMA promote, and encourage other stakeholders, including public, private, and professional organizations and relevant governmental agencies, to promote the conduct and acceleration of research into specific patterns and degrees of hearing loss to determine those most linked to cognitive impairment and amenable to correction (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for increased hearing screening, and expanding all avenues for third party coverage for effective hearing loss remediation beginning in mid-life or whenever detected, especially when such loss is shown conclusively to contribute significantly to the development of, or to magnify the functional deficits of cognitive impairment, and/or to limit the capacity of individuals for independent living. (Directive to Take Action)

RESOLUTION 114

RESOLVED, That our American Medical Association reaffirm that dental and oral health are integral components of basic health care and maintenance regardless of age (Reaffirm HOD Policy); and be it further

RESOLVED, That our AMA, through the Center for Health Equity, highlight the substantial contribution of dental and oral healthcare disparities to health inequity as well as to social and economic disparities (Directive to Take Action); and be it further

RESOLVED, That our AMA support ongoing research, legislative actions and administrative efforts to promote access to and adequate coverage by public and private payers for preventative and therapeutic dental services as integral parts of overall health maintenance to all populations (New HOD Policy); and be it further

RESOLVED, That our AMA work with other organizations to explore avenues to promote efforts to expand Medicare benefits to include preventative and therapeutic dental services, without additional decreases in Medicare Part B Reimbursements. (Directive to Take Action)

RESOLUTION 119

RESOLVED, That our American Medical Association support Medicare coverage of preventive dental care, including dental cleanings and x-rays, and restorative services, including fillings, extractions, and dentures (New HOD Policy); and be it further

RESOLVED, That our AMA support Medicare coverage of routine eye examinations and visual aids, including eyeglasses and contact lenses (New HOD Policy); and be it further

RESOLVED, That our American Medical Association amend Policy H-185.929, “Hearing Aid Coverage,” by addition to read as follows:

Hearing Aid Coverage H-185.929

1. Our AMA supports public and private health insurance coverage that provides all hearing-impaired infants and children access to appropriate physician-led teams and hearing services and devices, including digital hearing aids.
2. Our AMA supports hearing aid coverage for children that, at minimum, recognizes the need for replacement of hearing aids due to maturation, change in hearing ability and normal wear and tear.
3. Our AMA encourages private health plans to offer optional riders that allow their members to add hearing benefits to existing policies to offset the costs of hearing aid purchases, hearing-related exams and related services.
4. Our AMA supports coverage of hearing tests administered by a physician or physician-led team, aural rehabilitative services, and hearing aids as part of Medicare's Benefit.
5. Our AMA supports policies that increase access to hearing aids and other technologies and services that alleviate hearing loss and its consequences for the elderly.
6. Our AMA encourages increased transparency and access for hearing aid technologies through itemization of audiologic service costs for hearing aids.
7. Our AMA supports the availability of over-the-counter hearing aids for the treatment of mild-to-moderate hearing loss. (Modify Current HOD Policy)

Testimony on Resolution 113, Resolution 114 and Resolution 119 was mixed, each with calls for referral. Despite the mixed testimony, your Reference Committee heard numerous speakers in support of what each resolution is aiming to achieve – ultimately ensuring that our patients have access to and coverage of needed hearing, dental and vision services.

However, commenters noted that some of the asks of the resolutions did not align with USPSTF recommendations. Speakers noted that the USPSTF has concluded that there is insufficient evidence to recommend for or against screening for hearing loss in adults 50 years and over. Likewise, another commenter noted that the USPSTF concluded that the current evidence is insufficient to assess the balance of benefits and harms of screening for impaired visual acuity in older adults. As a result, there were calls for our AMA to support research into vision and dental health, as well as hearing loss as a contributor to cognitive impairment.

Testimony stressed that the expansion of health insurance coverage, and potentially Medicare benefits, of hearing, dental and vision services needs to be considered not only from the patient perspective but within the context of a Medicare payment infrastructure that is unsustainable for physician practices. In response to concerns raised regarding how coverage of these services in Medicare was going to be paid for, an amendment was proffered to ensure that our AMA supports new Medicare funding that is independent of the physician fee schedule to pay for the coverage of these services. However, your Reference Committee notes that expanding hearing, dental and vision coverage will still require “pay-fors” in the current congressional environment, pitting this against other AMA priorities that need funding. Also, other programs and issues of priority to our AMA could still be targets to achieve

the necessary cost savings to pay for this dramatic expansion of Medicare coverage. In addition, there are other complicating factors in covering these services under Medicare, including the FDA's recent ruling enabling hearing aids for mild to moderate hearing loss to be made available over the counter. The FDA's action complicates the coverage issue since OTC items generally aren't covered by insurance.

A member of Council on Medical Service offered alternate language to address the intent of Resolutions 113, 114 and 119, which your Reference Committee is proposing as part of Alternate Resolution 113. Your Reference Committee also recognizes that recent debates in Congress about expanding Medicare benefits have garnered substantial attention, underscoring the need for our AMA to study the impacts of covering vision, hearing, and dental benefits under the Medicare program. Accordingly, your Reference Committee recommends that Alternate Resolution 113 be adopted in lieu of Resolutions 113, 114 and 119.

(13) RESOLUTION 120 – EXPANDING COVERAGE FOR AND ACCESS TO PULMONARY REHABILITATION

RECOMMENDATION:

Alternate Resolution 120 be adopted in lieu of Resolution 120.

RESOLVED, That our American Medical Association work with interested national medical specialty societies and state medical associations to support improved availability of pulmonary rehabilitation services, such as through better insurance coverage, for patients with chronic lung disease or chronic shortness of breath. (New HOD Policy)

HOD ACTION: Alternate Resolution 120 adopted in lieu of Resolution 120.

RESOLVED, That our American Medical Association advocate for insurance coverage for and access to pulmonary rehabilitation for any patient with chronic lung disease or chronic shortness of breath. (Directive to Take Action)

Your Reference Committee heard supportive testimony on Resolution 120. A majority of testimony supported expanding access to pulmonary rehabilitation and noted the increased need for this service because of COVID-19. One commenter cautioned against adopting policy that advocates for new benefit mandates while another suggested changing the resolution's scope to support access to pulmonary rehabilitation for symptomatic patients with moderate to severe respiratory impairment. However, testimony favored using the terms "chronic lung disease or chronic shortness of breath" instead of moderate to severe respiratory impairment. A member of the Council on Medical Service offered alternate language that is consistent with AMA policy on benefit mandates while addressing the resolution's intent. Because testimony supported this alternate language, your Reference Committee recommends that Alternate Resolution 120 be adopted.

(14) RESOLUTION 123 – ADVOCATING FOR ALL PAYER COVERAGE OF COSMETIC TREATMENT FOR SURVIVORS OF DOMESTIC ABUSE AND INTIMATE PARTNER VIOLENCE

RECOMMENDATION:

Alternate Resolution 123 be adopted in lieu of Resolution 123.

ADVOCATING FOR ALL-PAYER COVERAGE OF RECONSTRUCTIVE TREATMENT FOR SURVIVORS OF INTIMATE PARTNER VIOLENCE

RESOLVED, That our American Medical Association work with interested national medical specialty societies and state medical associations, payers, and other relevant stakeholders to encourage insurance coverage of and payment for

reconstructive services for the treatment of physical injury sustained from intimate partner violence. (New HOD Policy)

HOD ACTION: Alternate Resolution 123 adopted in lieu of Resolution 123.

RESOLVED, That our American Medical Association urge all payers to consider aesthetic treatments for physical lesions sustained from injuries of domestic and intimate partner violence as restorative treatments (Directive to Take Action); and be it further

RESOLVED, That our AMA work with relevant stakeholders such as medical specialty societies, third party payers, the Centers for Medicare and Medicaid Service, and other national stakeholders as deemed appropriate to require third party payers to include reimbursement for necessary aesthetic service for the treatment of physical injury sustained along with medically necessary restorative care for victims of domestic abuse. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 123. Amendments and alternate Resolve clauses were proffered, including alternate language and a change in title submitted by the resolution's author. A member of the Council on Medical Service testified in support of the resolution's intent but suggested alternate language that would be more consistent with AMA policy on benefit mandates. Testimony generally supported deletion of references to aesthetic services with the focus instead on payment for reconstructive services for the treatment of physical injuries sustained from intimate partner violence. Your Reference Committee recommends adoption of Alternate Resolution 123 in lieu of Resolution 123.

RECOMMENDED FOR REFERRAL

(15) RESOLUTION 111 – BUNDLED PAYMENTS AND MEDICALLY NECESSARY CARE

RECOMMENDATION:

Resolution 111 be referred.

HOD ACTION: Resolution 111 referred

RESOLVED, That our American Medical Association advocate that coverage rules for Medicaid “Episodes of Care” be carefully reviewed to ensure that they do not incentivize limiting medically necessary services for patients to allow better reimbursement for recipients of the bundled payment (Directive to Take Action); and be it further

RESOLVED, That our AMA study the issue of “Bundled Payments and Medically Necessary Care” with a report back to the AMA House of Delegates to explore the unintended long-term consequences on health care expenditures, physician reimbursement, and patient outcomes (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate that functional improvement be a key target outcome for bundled payments. (Directive to Take Action)

Your Reference Committee heard mixed testimony on the Resolution 111, with calls for referral. A member of the Council on Medical Service welcomed referral of the resolution and suggested that further study is needed on Medicaid episodes of care. Your Reference Committee believes that such a comprehensive study will be helpful in guiding future AMA policy development pertaining to payment reform. Accordingly, your Reference Committee recommends that Resolution 111 be referred.

RECOMMENDED FOR NOT ADOPTION

(16) RESOLUTION 103 – COBRA FOR COLLEGE STUDENTS

RECOMMENDATION:

Resolution 103 not be adopted.

HOD ACTION: Resolution 103 not adopted.

RESOLVED, That our American Medical Association call for legislation similar to COBRA to allow college students to continue their healthcare coverage, at their own expense, for up to 18 months after graduation or other termination of enrollment. (Directive to Take Action)

Testimony on Resolution 103 was mixed. Testimony, including from a member of the Council on Medical Service, noted that graduating college students already have access to four avenues for accessing health insurance coverage: 1) they can stay on their parents' health plan up to age 26; 2) they can qualify for premium tax credits to purchase coverage on ACA marketplaces (made even more affordable under the American Rescue Plan); 3) they can secure coverage through new employment; or 4) they can qualify for Medicaid based on their income and state of residence. In addition, the member of the Council on Medical Service underscored that numerous AMA policies already address health insurance coverage of young adults, including graduating college students. Another noted that the continuous-coverage rationale for COBRA was obviated due to the aforementioned ACA mechanisms. Testimony in support of Resolution 103 indicated that the existing avenues for coverage available to graduating college students are difficult to navigate and insufficient in some circumstances.

With the existing coverage options available to graduating college students, your Reference Committee believes that requiring continuous coverage for plans offered to college students would require a tremendous legislative lift without offering substantial benefits to the affected population. Significantly, modeling continuous student coverage after COBRA would mean that graduating college students may face higher premiums for the same coverage, as they would be responsible for the full cost. In addition, your Reference Committee notes that requiring continuing coverage for graduating colleges students would have unintended consequences. First, not all health plans targeting college students are considered "student health plans" under current law, including short-term plans that do not have to be ACA-compliant. Also, if universities choose to self-insure their student health plans, these plans are not required to come into compliance with the ACA and therefore would not be subject to HHS regulation. Finally, even for some universities that have ACA-compliant health plans, there is not guaranteed coverage of contraceptives due to existing exemptions available. As such, your Reference Committee recommends that Resolution 103 not be adopted.

(17) RESOLUTION 110 – PRIVATE PAYOR PAYMENT INTEGRITY

RECOMMENDATION:

Resolution 110 not be adopted.

HOD ACTION: Resolution 110 referred.

RESOLVED, That our American Medical Association advocate for private insurers to require, at a minimum, to pay for diagnosis and treatment options that are covered by government payers such as Medicare (Directive to Take Action); and be it further

RESOLVED, That our AMA seek to ensure by legislative or regulatory means that private insurers shall not be allowed to deny payment for treatment options as "experimental and/or investigational" when they are covered under the government plans; such coverage shall extend to managed Medicaid, Workers' Compensation plans, and auto liability insurance companies. (Directive to Take Action)

Your Reference Committee heard testimony that was mixed, but generally opposed to Resolution 110. A member of the Council on Medical Service noted that Medicare coverage determinations should not be the default for what private health plans should cover. In addition, the member of the Council added that existing AMA policy states that benefit mandates should be minimized to allow markets to determine benefit packages and permit a wide choice of coverage options. This testimony, and others, highlighted the complex issues of private and government payor coverage. Accordingly, your Reference Committee recommends that Resolution 110 not be adopted.

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

(18) RESOLUTION 117 – EXPANDING MEDICAID TRANSPORTATION TO INCLUDE HEALTHY GROCERY DESTINATIONS

RECOMMENDATION:

Policies H-165.822 and H-150.925 be reaffirmed in lieu of Resolution 117.

HOD ACTION: Alternate Resolution 117 adopted in lieu of Resolution 117.

RESOLVED, that our AMA advocate for CMS and other relevant agencies to develop, test, and then implement evidence-based innovative models to address food insecurity, such as food delivery and transportation services to supermarkets, food banks and pantries, and local farmers markets for healthy food options. (New HOD Policy)

RESOLVED, That our American Medical Association: (1) support the implementation and expansion of transportation services for accessing healthy grocery options; and (2) advocate for inclusion of supermarkets, food banks and pantries, and local farmers markets as destinations offered by Medicaid transportation at the federal level; and (3) support efforts to extend Medicaid reimbursement to non-emergent medical transportation for healthy grocery destinations. (Directive to Take Action)

Testimony on Resolution 117 was mixed. Alternate Resolved wording was introduced by the sponsor of Resolution 117 for our AMA to advocate for CMS and other relevant agencies to develop, test, and implement innovative models to address food insecurity, such as food delivery and transportation to locations such as supermarkets, food banks, pantries, and local farmer's markets for healthy food options. Another alternate Resolved wording option was offered for the AMA to advocate for the creation and support of programs that provide patients eligible for Medicaid transportation to supermarkets, food banks and pantries, and local farmers' markets.

Testimony raised concerns regarding the cost of covering non-medical transportation under Medicaid, and the difficulties associated with implementing the asks of Resolution 117. A speaker noted that there are certain opportunities for states to cover certain non-clinical services under the Medicaid benefit package. States may use the 1915(i) state plan option to cover case management services (such as providing assistance signing up for other social services), the 1915(c) waiver authority to cover home and community based services, and the 1115 demonstration waiver authority to make other changes to Medicaid that would otherwise not be permitted. Your Reference Committee notes that the avenues through which social determinants of health such as transportation and access to food and food security can be addressed in the Medicaid program was recently studied by the Council on Medical Service in 2020.

The resulting policy, Policy H-165.822, supports continued efforts by public and private health plans to address social determinants of health – including access to food and food security – in health insurance benefit designs. In addition, the policy 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. Accordingly, a member of the Council on Medical Service recommended that this policy be reaffirmed in lieu of Resolution 117. Your Reference Committee notes that Policy H-150.925 also addresses challenges accessing healthy foods. Your Reference Committee recommends that Policies H-165.822 and H-150.925 be reaffirmed in lieu of Resolution 117.

Health Plan Initiatives Addressing Social Determinants of Health H-165.822
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. (CMS Rep. 7, I-20; Reaffirmed: CMS Rep. 5, I-21)

Food Environments and Challenges Accessing Healthy Food H-150.925

Our AMA (1) encourages the U.S. Department of Agriculture and appropriate stakeholders to study the national prevalence, impact, and solutions to challenges accessing healthy affordable food, including, but not limited to, food environments like food mirages, food swamps, and food deserts; (2) recognizes that food access inequalities are a major contributor to health inequities, disproportionately affecting marginalized communities and people of color; and (3) supports policy promoting community-based initiatives that empower resident businesses, create economic opportunities, and support sustainable local food supply chains to increase access to affordable healthy food. (Res. 921, I-18; Modified: Res. 417, A-21)

- (19) **RESOLUTION 124 – TO REQUIRE INSURANCE COMPANIES MAKE THE “COVERAGE YEAR” AND THE “DEDUCTIBLE YEAR” SIMULTANEOUS FOR THEIR POLICIES**

RECOMMENDATION:

Policy H-180.955 be reaffirmed in lieu of Resolution 124.

HOD ACTION: Policy H-180.955 reaffirmed in lieu of Resolution 124.

RESOLVED, That our American Medical Association advocate and support legislation to require all commercial insurance carriers to align their policies such that a policy holder’s “deductible year” and “coverage year” be the same time period for all policies. (Directive to Take Action)

There was limited testimony on Resolution 124. A member of the Council on Medical Service testified that existing policy more effectively addresses the underlying issues raised in the resolution. Policy H-180.955 supports legislation, regulation or other appropriate relief to require insurers to prorate annual deductibles to the date of contract enrollment. As such, your Reference Committee recommends that existing policy be reaffirmed in lieu of Resolution 124.

Deductibles Should Be Prorated to Make Them Equitable for Enrollees H-180.955

Our AMA seeks legislation, regulation or other appropriate relief to require insurers to prorate annual deductibles to the date of contract enrollment. (Res. 235, A-01; Reaffirmed: CMS Rep. 7, A-11; Reaffirmed: BOT Rep. 7, A-21)

REPORT OF REFERENCE COMMITTEE B

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. BOT Report 9 –Council on Legislation Sunset Review of 2012 House Policies
2. BOT Report 17 –Expungement, Destruction, and Sealing of Criminal Records for Legal Offenses Related to Cannabis Use or Possession
Resolution 213 –Resentencing for Individuals Convicted of Marijuana-Based Offenses
3. Resolution 219 –Due Process and Independent Contractors
4. Resolution 225 –Public Listing of Medical Directors for Nursing Facilities
5. Resolution 226 –Coverage for Clinical Trial Ancillary Costs

RECOMMENDED FOR ADOPTION AS AMENDED

6. Resolution 203 –Ban the Gay/Trans (LGBTQ+) Panic Defense
7. Resolution 208 –Prohibit Ghost Guns
8. Resolution 209 –Supporting Collection of Data on Medical Repatriation
9. Resolution 210 –Reducing the Prevalence of Sexual Assault by Testing Sexual Assault Evidence Kits
10. Resolution 212 –Medication for Opioid Use Disorder in Physician Health Programs
11. Resolution 216 –Advocating for the Elimination of Hepatitis C Treatment Restrictions
12. Resolution 218 –Expedited Immigrant Green Card Visa for J-1 Visa Waiver Physicians Serving in Underserved Areas
Resolution 229 –Expedited Immigrant Green Card for J-1 Visa Waiver Physicians Serving in Underserved Areas
13. Resolution 220 –Vital Nature of Board-Certified Physicians in Aerospace Medicine
14. Resolution 222 –To Study the Economic Impact of Mid-Level Provider Employment in the United States of America
15. Resolution 223 –National Drug Shortages of Lidocaine and Saline Preparations
16. Resolution 227 –Supporting Improvements to Patient Data Privacy
17. Resolution 228 –Expanded Child Tax Credit
Resolution 247 –Recognizing Child Poverty and the Racial Wealth Gap as Public Health Issues and Extending the Child Tax Credit for Low-Income Families
18. Resolution 230 –Advancing the Role of Outdoor Recreation in Public Health
19. Resolution 231 –Amending Policy H-155.955, "Increasing Accessibility to Incontinence Products to Include Diaper Tax Exemption"
20. Resolution 232 –Expansion of Epinephrine Entity Stocking Legislation
21. Resolution 233 –Support for Warning Labels on Firearm Ammunition Packaging
22. Resolution 236 –Out-of-Network Care
23. Resolution 245 –Definition and Encouragement of the Appropriate Use of the Word "Physician"
Resolution 249 –Clarification of Healthcare Physician Identification: Consumer Truth & Transparency
24. Resolution 254 –Stakeholder Engagement in Medicare Administrative Contractor Policy Processes

RECOMMENDED FOR REFERRAL

25. Resolution 201 –The Impact of Midlevel Providers on Medical Education
26. Resolution 224 –HPSA and MUA Designation for SNFs
27. Resolution 237 –Prescription Drug Dispensing Policies

RECOMMENDED FOR REFERRAL FOR DECISION

28. Resolution 246 –Further Action to Respond to the Gun Violence Public Health Crisis

RECOMMENDED FOR NOT ADOPTION

- 29. Resolution 205 –Insurers and Vertical Integration
- 30. Resolution 207 –Physician Tax Fairness
- 31. Resolution 241 –Unmatched Graduate Physician Workforce

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

- 32. Resolution 202 –AMA Position on All Payer Database Creation
- 33. Resolution 215 –Transforming Professional Licensure to the 21st Century
- 34. Resolution 234 –Updating Policy on Immigration Laws, Rules, Legislation, and Health Disparities
- 35. Resolution 239 –Virtual Services When Patients Are Away From Their Medical Home
- 36. Resolution 250 –Opposition to Criminalization of Physicians' Medical Practice
- 37. Resolution 252 –The Criminalization of Health Care Decision Making and Practice

RECOMMENDED FOR ADOPTION IN LIEU OF

- 38. Resolution 211 –Repeal or Modification of the Medicare Appropriate Use Criteria (AUC) Program
- 39. Resolution 217 –Preserving the Practice of Medicine
- Resolution 251 –Physician Medical License Use in Clinical Supervision
- 40. Resolution 238 –COVID-19 Economic Injury Disaster Loan (EIDL) Forgiveness for Physician Groups of Five or Fewer Physicians
- 41. Resolution 240 –Physician Payment Reform and Equity
- Resolution 242 –Public Awareness and Advocacy Campaign to Reform the Medicare Physician Payment System
- Resolution 243 –Appropriate Physician Payment for Office-Based Services
- Resolution 253 –Physician Payment Reform & Equity
- 42. Resolution 248 –Promoting Proper Oversight and Reimbursement for Specialty Physician Extenders and Non Physician Practitioners

RECOMMENDED FOR ADOPTION

- (1) BOT 9 COUNCIL ON LEGISLATION SUNSET REVIEW OF 2012 HOUSE POLICIES

RECOMMENDATION:

Recommendation in Board of Trustees Report 9 be adopted and the remainder of the report filed.

HOD ACTION: Board of Trustees Report 9 adopted and the remainder of the report filed.

The Board of Trustees recommends that the House of Delegates policies that are listed in the appendix to this report be acted upon in the manner indicated and the remainder of this report be filed.

BOT Report 09 should be adopted and filed. The Sunset Report has been approved by the Council on Legislation and Board and vetted and reviewed by AMA staff to ensure appropriate policies are retained.

- (2) BOT 17–EXPUNGEMENT, DESTRUCTION, AND SEALING OF CRIMINAL RECORDS FOR LEGAL OFFENSES RELATED TO CANNABIS USE OR POSSESSION
RESOLUTION 213 –RESENTENCING FOR INDIVIDUALS CONVICTED OF MARIJUANA-BASED OFFENSES

RECOMMENDATION:

Recommendations in Board of Trustees Report 17 be adopted in lieu of Resolution 213 and the remainder of the report filed.

HOD ACTION: Board of Trustees Report 17 adopted as amended by addition in clause 1 and the addition of a 5th clause in lieu of Resolution 213 and the remainder of report filed.

1. That our American Medical Association (AMA) support automatic expungement, sealing, and similar efforts regarding an arrest or conviction for a cannabis-related offense for use or possession that would be legal or criminalized under subsequent state legalization or decriminalization of adult use or medicinal cannabis. (New HOD Policy)

5. That our American Medical Association (AMA) support ending conditions such as parole, probation, or other court-required supervision because of a cannabis-related offense for use or possession that would be legal or decriminalized under subsequent state legalization or decriminalization of adult use or medicinal cannabis. (New HOD Policy)

BOT 17

The Board recommends that the following recommendations be adopted, and the remainder of the report be filed:

1. That our American Medical Association (AMA) support automatic expungement, sealing, and similar efforts regarding an arrest or conviction for a cannabis-related offense for use or possession that would be legal under subsequent state legalization of adult use or medicinal cannabis. (New HOD Policy)

2. That our AMA support automatic expungement, sealing, and similar efforts regarding an arrest or conviction of a cannabis-related offense for use or possession for a minor upon the minor reaching the age of majority. (New HOD Policy)

3. That our AMA inquire to the Association of American Medical Colleges, Accreditation Council for Graduate Medical Education, Federation of State Medical Boards, and other relevant medical education and licensing authorities, as to the effects of disclosure of a cannabis related offense on a medical school, residency, or licensing application. (Directive to Take Action)

4. That AMA Policy D-95.960, “Public Health Impacts of Cannabis Legalization” be rescinded since this report fulfills the directive contained in the policy. (Rescind HOD Policy)

Resolution 213

RESOLVED, That our American Medical Association adopt policy supporting the expungement, destruction, or sealing of criminal records for marijuana offenses that would now be considered legal (New HOD Policy); and be it further

RESOLVED, That our AMA adopt policy supporting the elimination of violations or other penalties for persons under parole, probation, pre-trial, or other state or local criminal supervision for a marijuana offense that would now be considered legal. (New HOD Policy)

Your Reference Committee heard strong support for the issues raised in BOT 17. Testimony reflected the understanding that individuals should not suffer collateral consequences for past illegal acts concerning cannabis possession or use when nearly two-thirds of the nation has made those acts legal today. Your Reference Committee commends the Board for highlighting the public health consequences and inequities related to cannabis-related offenses for possession and use. Your Reference Committee agrees that fundamental fairness requires expungement of those past acts that now would be legal. As explained in the Board’s report, expungement would foster increased opportunities for employment, housing, and other necessary social determinants of health.

Your Reference Committee also appreciates that the Board has separated the issues of expungement from the issues related to the health effects of cannabis use itself, and AMA policy that continues to oppose the legalization of cannabis. Your Reference Committee acknowledges that cannabis-related policy continues to evolve. Your Reference Committee appreciates that the Board has narrowly focused the report on expungement related to past acts relating to cannabis use and possession that now would be legal. Your Reference Committee heard testimony that supporting expungement of past acts that would still be illegal in certain states would be in conflict with AMA policy opposing legalization of cannabis. Your Reference Committee appreciates that there still are collateral consequences, but therein lays one of the many nuances of our AMA policy related to cannabis. States have more general expungement laws relating to many different criminal acts. Your Reference Committee is pleased that our Board has focused its report on a tangible, actionable area to support public health and reduce health inequities.

Your Reference Committee heard from our Council on Legislation that a side-by-side analysis of BOT 17 and Resolution 213 shows that Resolution 213 raises substantively the same issues as contained in BOT 17. Moreover, testimony was given, that based on a side-by-side comparison of the recommendations in Resolution 213 and BOT 17, the Board’s recommendations have the additional precision and detail that will allow our AMA to take the policy and clearly advocate in state legislatures and other appropriate venues. For these reasons, your Reference Committee recommends that Board of Trustees Report 17 be adopted in lieu of Resolution 213.

(3) RESOLUTION 219 –DUE PROCESS AND INDEPENDENT CONTRACTORS

RECOMMENDATION:

Resolution 219 be adopted.

HOD ACTION: Resolution 219 adopted.

RESOLVED, That our American Medical Association develop a model state legislative template and principles for federal legislation in order to protect physicians from corporate, workplace, and/or employer retaliation when reporting safety, harassment, or fraud concerns at the places of work (licensed health care institution) or in the government, which includes independent and third-party contractors providing patient services at said facilities. (Directive to Take Action)

Your Reference Committee heard unanimous testimony supporting the adoption of Resolution 219. Testimony emphasized that safeguarding physician autonomy is essential so that physicians may exercise their independent judgment and satisfy their ethical obligation to always act in the best interests of patients. However, testimony indicated that physicians have had their employment or contractor agreements terminated because they spoke up about issues negatively impacting their autonomy and patients, particularly during the COVID-19 pandemic. Your Reference Committee also heard that because of the prospect of retaliation, many physicians were reluctant to speak up. Testimony supported broadening AMA policy to ensure that independent contractor physicians, as well as employees, are protected from retaliation for raising concerns, and to protect physicians from retaliation by any entity employing or contracting with the physician. Therefore, your Reference Committee recommends adoption of Resolution 219.

(4) RESOLUTION 225 –PUBLIC LISTING OF MEDICAL DIRECTORS FOR NURSING FACILITIES

RECOMMENDATION:

Resolution 225 be adopted.

HOD ACTION: Resolution 225 adopted.

RESOLVED, That our American Medical Association advocate for the Centers for Medicare & Medicaid Services to promote health care transparency and consumer access to quality health care by hosting a public listing of medical directors of all nursing facilities (NFs) in the country. (Directive to Take Action)

Your Reference Committee heard only testimony in support of Resolution 225 based on a need to have contact information for nursing facility medical directors readily available for attending physicians and families of patients in a nursing facility. Your Reference Committee heard from supporters of this resolution that it is often difficult for those caring for nursing facility patients to access the name and contact information for medical directors for the nursing facilities but that this information is important for continuity of care purposes, as well as for addressing quality issues in a timely fashion. Additionally, testimony stated the potential feasibility of this information being housed on existing federal webpages. Therefore, your Reference Committee recommends that Resolution 225 be adopted.

(5) RESOLUTION 226 –COVERAGE FOR CLINICAL TRIAL ANCILLARY COSTS

RECOMMENDATION:

Resolution 226 be adopted.

HOD ACTION: Resolution 226 adopted.

RESOLVED, that our AMA amend Policy H-460.965, Viability of Clinical Research Coverages and Reimbursement, as follows “...(11) legislation and regulatory reform should be supported that establish program integrity/fraud and abuse safe harbors that permit sponsors to cover co-pays/coinsurance/ deductibles, ~~and~~ otherwise not covered clinical care, and non-clinical ancillary costs in the context of nationally approved clinical trials (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA actively advocate for federal and state legislation that would allow coverage of non-clinical ancillary costs by sponsors of clinical trials. (Directive to Take Action)

Your Reference Committee heard unanimous support for Resolution 226. Your Reference Committee heard that clinical trials are key to advancing new standards of care that can improve survival and quality of life for people with cancer and other conditions. Testimony also stated that the inability of a clinical trial sponsor to defray participant's ancillary expenses (e.g., meals, transportation costs, childcare, lodging) prohibits many Medicare and Medicaid beneficiaries from participating in clinical trials since participation might otherwise be cost prohibitive. Testimony indicated that paying for ancillary services would increase diversity of clinical trial participants, and also promote health equity. Your Reference Committee also heard that pilot financial assistance programs that provide compensation for ancillary costs have demonstrated promise in improving clinical trial accrual and clinical outcomes. Finally, testimony noted that our AMA has already engaged in advocacy with respect to the Anti-Kickback Statute (AKS) and the Civil Monetary Penalties Law (CMP), through extensive correspondence to the U.S. Department of Health and Human Services that addressed health equity issues in relation to the AKS and CMP law. Therefore, your Reference Committee recommends that Resolution 226 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

(6) RESOLUTION 203 –BAN THE GAY/TRANS (LGBTQ+) PANIC DEFENSE

RECOMMENDATION A:

That the first resolve of Resolution 203 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association support ~~seek a federal legislation law~~ banning the use of the so-called “gay/trans (LGBTQ+) panic” defense in homicide, manslaughter, physical or sexual assault cases (Directive to Take Action New HOD Policy); and be it further

RECOMMENDATION B:

That the second resolve of Resolution 203 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA develop ~~publish~~ an issue brief and talking points on the topic of so called “gay/trans (LGBTQ+) panic” defense, that can be used by our AMA in support of seeking federal legislation, and can be used and adapted by state and specialty medical societies, other allies, and stakeholders as model legislation when seeking state legislation to ban the use of so-called “gay/trans (LGBTQ+) panic” defense to mitigate personal responsibility for violent crimes such as assault, rape, manslaughter, or homicide. (Directive to Take Action); and be it further

RECOMMENDATION C:

That Resolution 203 be amended by addition of a third resolve to read as follows:

RESOLVED, That our AMA reaffirm AMA Policy H-65.965 –Support of Human Rights and Freedom.

RECOMMENDATION D:

Resolution 203 be adopted as amended.

HOD ACTION: Resolution 203 adopted as amended.

RESOLVED, That our American Medical Association seek a federal law banning the use of the so-called “gay/trans (LGBTQ+) panic” defense in homicide, manslaughter, physical or sexual assault cases (Directive to Take Action); and be it further

RESOLVED, That our AMA publish an issue brief and talking points on the topic of so called “gay/trans (LGBTQ+) panic” defense, that can be used by our AMA in seeking federal legislation, and can be used and adapted by state and specialty medical societies, other allies, and stakeholders as model legislation when seeking state legislation to ban the use of so-called “gay/trans (LGBTQ+) panic” defense to mitigate personal responsibility for violent crimes such as assault, rape, manslaughter, or homicide. (Directive to Take Action)

Your Reference Committee heard strong and impassioned testimony in support of Resolution 203. Your Reference Committee heard that the gay or trans panic defense strategy is a legal strategy that uses a victim’s sexual orientation or gender identity/expression as an excuse for a defendant’s violent reaction, seeking to legitimize and even to excuse violent and lethal behavior. Testimony stated that many murder sentences have been reduced, or defendants have been acquitted, by using the LGBTQ+ “panic” defense strategy such as in the Matthew Shepard case, and that

this defense has only been banned in 11 states as of February 2, 2021. Your Reference Committee also heard that this is a medical, behavioral health, and equity issue, which is important for our AMA to act on in a timely fashion. Further testimony was heard in strong support for efforts to protect LGBTQ+ individuals from further violence and discrimination. Limited testimony was provided against adoption that noted that the “gay and trans panic defense” is not commonly employed and no state recognizes it as an affirmative defense as highlighted by a 2020 study that found the defense strategy was employed in only 104 cases across 35 states over a half century. Your Reference Committee also heard a recommendation to reaffirm existing AMA policy in support of human rights and freedom in lieu of adoption. Your Reference Committee agrees that this is an important equity issue, with those who testified overwhelmingly in support of adoption, but that minor amendments are needed. Additionally, testimony was offered that Policy H-65.965 Support of Human Rights and Freedom should be reaffirmed. Therefore, your Reference Committee recommends that Resolution 203 be adopted as amended.

Support of Human Rights and Freedom H-65.965

Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age; (3) opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage of appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States.

(7) RESOLUTION 208 –PROHIBIT GHOST GUNS

RECOMMENDATION A:

Resolution 208 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association support state and federal legislation and regulation that would subject homemade ~~weapons firearms~~, including ghost guns, to the same laws and regulations and licensing requirements as traditional regulated firearms ~~weapons~~. (New HOD Policy)

RECOMMENDATION B:

Resolution 208 be adopted as amended.

RECOMMENDATION C:

That the title of Resolution 208 be changed to read as follows:

REGULATION OF HOMEMADE FIREARMS

HOD ACTION: Resolution 208 adopted as amended with a change in title.

REGULATION OF HOMEMADE FIREARMS

RESOLVED, That our American Medical Association support state and federal legislation and regulation that would subject homemade weapons to the same regulations and licensing requirements as traditional weapons. (New HOD Policy)

Your Reference Committee heard mostly supportive testimony in favor of Resolution 208, with a few minor language modifications. Your Reference Committee heard that ghost guns should be treated just like other firearms and that they are a real problem, especially in cities such as New York. Testimony stated that homemade, difficult to trace firearms, are increasingly turning up at crime scenes. Further testimony was provided that the most important part of a gun is the lower receiver, the “chassis” of the weapon, the part housing vital components such as the hammer and trigger. Your Reference Committee also heard testimony that under federal law, the lower receiver is considered a firearm –while it is not clear whether other gun components require a background check for purchase and that dozens of companies sell what are known as “80%” lower receivers –ones that are 80% finished, lack a serial number, and can be used to make a homemade gun. Further testimony was presented that ghost guns provide an easy avenue for people banned from owning guns to obtain them and that according to the Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF) 30% of all weapons recovered by the bureau in California were homemade.

Your Reference Committee heard testimony that our AMA already has long-standing, strong, and clear policy that covers the goals of Resolution 208. Specifically, H-145.996, Firearm Availability, applies to waiting periods and background checks for all firearm purchasers, and advocates for legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic, ceramics, or other non-metallic materials that cannot be detected by airport and weapon detection devices. Testimony was also heard that our AMA has policy supporting a ban on the manufacture, importation, or sale of 3-D printed firearms. Your Reference Committee heard testimony that these policies already cover ghost guns. Further testimony was provided that our AMA is actively working at both the state and federal levels on increasing regulation and background checks of all firearm purchasers, and that based on existing policy, our AMA submitted comments supporting a proposed rule issued by the Bureau of Alcohol, Tobacco, Firearms, and Explosives in the Department of Justice that would specifically regulate ghost guns. Testimony was provided that a final rule prohibiting the manufacture of ghost guns was released in April.

Your Reference Committee heard testimony that, if adopted, an amendment to the Resolution is needed to appropriately tailor the Resolution to firearms rather than all weapons. Your Reference Committee concluded that, considering the significant testimony in support of this Resolution, Resolution 208 should be adopted as amended, along with a change in the title. Accordingly, your Reference Committee recommends that Resolution 208 be adopted as amended.

(8) RESOLUTION 209 –SUPPORTING COLLECTION OF DATA ON MEDICAL REPATRIATION

RECOMMENDATION A:

Resolution 209 be amended by deletion of the first resolve:

~~RESOLVED, That our American Medical Association ask the Department of Health and Human Services to collect and de-identify any and all instances of medical repatriations from the United States to other countries by medical centers to further identify the harms of this practice (Directive to Take Action); and be it further~~

RECOMMENDATION B:

Resolution 209 be adopted as amended.

HOD ACTION: Resolution 209 adopted as amended.

RESOLVED, That our American Medical Association ask the Department of Health and Human Services to collect and de-identify any and all instances of medical repatriations from the United States to other countries by medical centers to further identify the harms of this practice (Directive to Take Action); and be it further

RESOLVED, That our AMA denounce the practice of forced medical repatriation. (New HOD Policy)

Your Reference Committee heard mixed testimony regarding Resolution 209. Your Reference Committee heard testimony that the concept of forced medical repatriation involves the involuntary transfer of a patient to a foreign country despite their health status, provoking an unwarranted intersection between immigration enforcement and the health care system. Testimony stated that, although it is unclear how widespread the issue of medical repatriation actually is, it does seem to disproportionately impact vulnerable immigrant patients. Testimony also stated that our AMA has advocated that every person should have access to essential health care and that Resolution 209 falls in line with this principle. However, your Reference Committee also heard that it is likely that the Department of Homeland Security (DHS), rather than the Department of Health and Human Services, would collect this data, or at the very least that DHS would be able to acquire this data. Testimony stated that once DHS had the information about these patients they could, and likely would, use it to initiate deportation proceedings, going against the intent of the Resolution. Therefore, your Reference Committee recommends that Resolution 209 be adopted as amended.

(9) RESOLUTION 210 –REDUCING THE PREVALENCE OF SEXUAL ASSAULT BY TESTING SEXUAL ASSAULT EVIDENCE KITS

RECOMMENDATION A:

Part 5 of Resolution 210 be amended by addition and deletion to read as follows:

~~5. Our AMA will advocate at the state and federal level for (a) the immediate processing of all “backlogged” and new sexual assault examination kits; and (b) additional funding to facilitate the immediate testing of sexual assault evidence kits. (Modify Current HOD Policy)~~

5. Our AMA will advocate at the state and federal level for (a) the timely processing of all sexual examination kits upon patient consent; (b) timely processing of “backlogged” sexual assault examination kits with patient consent; and (c) additional funding to facilitate the timely testing of sexual assault evidence kits. (Modify Current HOD Policy)

RECOMMENDATION B:

Resolution 210 be adopted as amended.

HOD ACTION: Resolution 210 adopted as amended.

RESOLVED, That our American Medical Association amend Policy H-80.999, “Sexual Assault 1 Survivors,” by addition to read as follows:

H-80.999 – SEXUAL ASSAULT SURVIVORS

1. Our AMA supports the preparation and dissemination of information and best practices intended to maintain and improve the skills needed by all practicing physicians involved in providing care to sexual assault survivors.

2. Our AMA advocates for the legal protection of sexual assault survivors’ rights and work with state medical societies to ensure that each state implements these rights, which include but are not limited to, the right to: (a) receive a medical forensic examination free of charge, which includes but is not limited to HIV/STD testing and treatment, pregnancy testing, treatment of injuries, and collection of forensic evidence; (b) preservation of a sexual assault evidence collection kit for at least the maximum applicable statute of limitations (c) notification of any intended disposal of a sexual assault evidence kit with the opportunity to be granted further preservation; (d) be informed of these rights and the policies governing the sexual assault evidence kit; and (e) access to emergency contraception information and treatment for pregnancy prevention.

3. Our AMA will collaborate with relevant stakeholders to develop recommendations for implementing best practices in the treatment of sexual assault survivors, including through engagement with the joint working group established for this purpose under the Survivor’s Bill of Rights Act of 2016.

4. Our AMA will advocate for increased post-pubertal patient access to Sexual Assault Nurse Examiners, and other trained and qualified clinicians, in the emergency department for medical forensic examinations.

5. Our AMA will advocate at the state and federal level for (a) the immediate processing of all “backlogged” and new sexual assault examination kits; and (b) additional funding to facilitate the immediate testing of sexual assault evidence kits. (Modify Current HOD Policy)

Your Reference Committee heard overwhelming and emotional testimony from sexual assault survivors in strong support of Resolution 210. Your Reference Committee commends the courage of those who testified and shared their personal experiences, highlighting the importance of this Resolution. Your Reference Committee heard that our AMA has extensive policy advocating for appropriate care and rights for victims of sexual assault. Testimony highlighted that our current AMA policy does not speak to the timely processing of sexual assault examination kits, which often provide important evidence to support prosecution of offenders. Testimony stated that adoption of Resolution 210 is a needed and an appropriate extension of current policy, but that amendments are needed to change “immediate” processing of exam kits to “timely,” and to add patient consent for the processing of exam kits. Your Reference Committee agrees that the suggested amendments improve the Resolution, and, for clarity’s sake, your Reference Committee recommends that Resolution 210 be adopted as amended.

(10) RESOLUTION 212 –MEDICATION FOR OPIOID USE DISORDER IN PHYSICIAN HEALTH PROGRAMS

RECOMMENDATION A:

Resolution 212 be amended by addition to read as follows:

RESOLVED, That our American Medical Association reaffirm policy H-95.913, “Discrimination Against Physicians in Treatment with Medication for Opioid Use Disorders” (Reaffirm HOD Policy); and be it further

RESOLVED, That our AMA modify policy D-405.990, “Educating Physicians About Physician Health Programs and Advocating for Standards,” by addition to read as follows:

Our AMA will:

(1) work closely with the Federation of State Medical Boards (FSMB) and Federation of State Physician Health Programs (FSPHP) to educate our members as to the availability and services of state physician health programs to continue to create opportunities to help ensure physicians and medical students are fully knowledgeable about the purpose of physician health programs and the relationship that exists between the physician health program and the licensing authority in their state or territory;

(2) continue to collaborate with relevant organizations on activities that address physician health and wellness;

(3) in conjunction with the FSMB and the FSPHP, develop model state legislation and/or legislative guidelines addressing the design and implementation of physician health programs including, but not limited to, the allowance for safe-haven or non-reporting of physicians to a licensing board, and/or acceptance of Physician Health Program compliance as an alternative to disciplinary action when public safety is not at risk, and especially for any physicians who voluntarily self-report their physical, mental, and substance use disorders and engage with a Physician Health Program and who successfully complete the terms of participation;

(4) work with FSMB and FSPHP to develop messaging for all Federation members to consider regarding elimination of stigmatization of mental illness and illness in general in physicians and physicians in training;

(5) continue to work with and support FSMB and FSPHP efforts already underway to design and implement the physician health program review process, Performance Enhancement and Effectiveness Review (PEER™), to improve accountability, consistency and excellence among its state member PHPs. The AMA will partner with the FSPHP to help advocate for additional national sponsors for this project; and

(6) continue to work with the FSMB and FSPHP and other appropriate stakeholders on issues of affordability, cost effectiveness, and diversity of treatment options.

RECOMMENDATION B:

Resolution 212 be adopted as amended.

HOD ACTION: Resolution 212 adopted as amended.

RESOLVED, That our American Medical Association reaffirm policy H-95.913, “Discrimination Against Physicians in Treatment with Medication for Opioid Use Disorders” (Reaffirm HOD Policy); and be it further

RESOLVED, That our AMA modify policy D-405.990, “Educating Physicians About Physician Health Programs and Advocating for Standards,” by addition to read as follows:

Our AMA will:

(1) work closely with the Federation of State Physician Health Programs (FSPHP) to educate our members as to the availability and services of state physician health programs to continue to create opportunities to help ensure physicians and medical students are fully knowledgeable about the purpose of physician health programs and the relationship that exists between the physician health program and the licensing authority in their state or territory;

(2) continue to collaborate with relevant organizations on activities that address physician health and wellness;

(3) in conjunction with the FSPHP, develop model state legislation and/or legislative guidelines addressing the design and implementation of physician health programs including, but not limited to, the allowance for safe-haven or non-reporting of physicians to a licensing board, and/or acceptance of Physician Health Program compliance as an alternative to disciplinary action when public safety is not at risk, and especially for any physicians who voluntarily self-report their physical, mental, and substance use disorders and engage with a Physician Health Program and who successfully complete the terms of participation;

(4) work with FSPHP to develop messaging for all Federation members to consider regarding elimination of stigmatization of mental illness and illness in general in physicians and physicians in training;

(5) continue to work with and support FSPHP efforts already underway to design and implement the physician health program review process, Performance Enhancement and Effectiveness Review (PEER™), to improve accountability, consistency and excellence among its state member PHPs. The AMA will partner with the FSPHP to help advocate for additional national sponsors for this project; and

(6) continue to work with the FSPHP and other appropriate stakeholders on issues of affordability, cost effectiveness, and diversity of treatment options. (Modify Current HOD Policy)

Your Reference Committee heard supportive testimony regarding Resolution 212. Your Reference Committee agrees that physician health programs (PHPs) provide an essential resource to physicians. Your Reference

Committee appreciates the support of AMA efforts from the Federation of State Physician Health Programs (FSPHP). Your Reference Committee wants to recognize any physicians that have been brave enough to come forward to participate in a PHP or a safe-haven program. Your Reference Committee strongly supports physicians and other health care professionals seeking care in a PHP or safe-haven type program to do so voluntarily and for there to be strong confidentiality protections for physicians who seek and receive care in a PHP or safe-haven type program. Testimony was offered concerning a potential amendment to Resolution 212 which requested expanding coverage to include independent physician experts who do not practice under a structure that allows safe harbor protections. Your Reference Committee did not accept this amendment because adequate protections would not be provided to physicians in this situation. Your Reference also heard about the important role that the Federation of State Medical Boards (FSMB) plays in supporting PHPs and confidentiality protections, and the need to acknowledge the role of FSMB in our AMA policy. Your Reference Committee further appreciates that the American Boards of Medical Specialties (ABMS) are working to develop policy on these issues. Your Reference Committee also understands that whether a physician seeks care in a PHP or safe-haven type program, confidentiality is essential. Your Reference Committee is pleased to hear of AMA advocacy wins to support these goals at the state and federal levels and believes that the partnership and support of the FSPHP, FSMB and other stakeholders will strengthen our AMA's efforts and support physicians' ability to receive evidence-based care when sought. As a result, your Reference Committee recommends that Resolution 212 be adopted as amended.

(11) RESOLUTION 216 –ADVOCATING FOR THE ELIMINATION OF HEPATITIS C TREATMENT RESTRICTION

RECOMMENDATION A:

Resolution 216 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association amend policy H-440.845, "Advocacy for Hepatitis C Virus Education, Prevention, Screening and Treatment," by addition to read as follows:

Our AMA will: (1) encourage the adoption of ~~birth-year-based~~ universal hepatitis C screening of all adults for hepatitis C, in alignment with Centers for Disease Control and Prevention (CDC) recommendations;

(2) encourage the CDC, Indian Health Service (IHS), 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) advocate, in collaboration with state and specialty medical societies, as well as patient advocacy groups, for the elimination of sobriety requirements, fibrosis restrictions, and prescriber restrictions for coverage of HCV treatment by public and private payers/payers;

(45) support programs aimed at training physicians ~~providers~~ in the screening, treatment and management of patients infected with HCV;

(56) 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;

(67) recognize correctional physicians, and physicians in other public health settings, as key stakeholders in the development of HCV treatment guidelines;

(78) encourage equitable reimbursement for those providing treatment;

(9) encourage the allocation of targeted funding to increase HCV treatment for IHS patients insured by plans subject to HCV treatment restrictions.

RECOMMENDATION B:

Resolution 216 be adopted as amended.

HOD ACTION: Resolution 216 adopted as amended.

RESOLVED, That our American Medical Association amend policy H-440.845, “Advocacy for Hepatitis C Virus Education, Prevention, Screening and Treatment,) by addition to read 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, Indian Health Service (IHS), 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) advocate, in collaboration with state and specialty medical societies, as well as patient advocacy groups, for the elimination of sobriety requirements, fibrosis restrictions, and prescriber restrictions for coverage of HCV treatment by public and private payors;
 (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;
 (9) encourage the allocation of targeted funding to increase HCV treatment for IHS patients insured by plans subject to HCV treatment restrictions. (Modify Current HOD Policy)

Your Reference Committee heard overwhelmingly positive testimony on Resolution 216. Testimony was heard that the resolution would fill a gap in existing AMA policy on hepatitis C virus (HCV) prevention, screening, and treatment programs and is consistent with our AMA’s equity policy and goals since it would encourage the allocation of targeted funding to increase HCV treatment for Indian Health Service patients insured by plans subject to HCV treatment restrictions and expand access to HCV treatment for American Indian/Alaska Native populations, who have disproportionately higher HCV incidence rates compared to non-Hispanic whites and the highest rates of HCV-related mortality of any racial/ethnic group.

Your Reference Committee also heard that Consensus guidelines from the American Association for the Study of Liver Diseases and the Infectious Diseases Society of America recommend that nearly all people with acute or chronic HCV should receive treatment with direct-acting antivirals, which can cure over 95 percent of individuals with HCV, but that many state Medicaid programs, prisons and jails, and private insurers impose non-medically indicated restrictions on treatment, including fibrosis restrictions, sobriety restrictions, and limits on the type of clinician that can prescribe HCV treatment.

Your Reference Committee also heard an amendment offered by the US Public Health Service that recommends updating the language to conform with current Centers for Disease Control and Prevention (CDC) recommendations on universal screening for all adults for HCV. Your Reference Committee believes that clause 3 will allow the CDC to advocate for screening and treatment of patients with housing insecurity. Your Reference Committee, therefore, recommends that Resolution 216 be adopted as amended.

- (12) RESOLUTION 218 –EXPEDITED IMMIGRANT GREEN CARD VISA FOR J-1 VISA WAIVER PHYSICIANS SERVING IN UNDERSERVED AREAS
 RESOLUTION 229 –EXPEDITED IMMIGRANT GREEN CARD FOR J-1 VISA WAIVER PHYSICIANS SERVING IN UNDERSERVED AREAS

RECOMMENDATION A:

Resolution 218 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association ~~advocate lobby US Congress and the US Administration that the J-1 visa waiver~~ physicians who are on J-1 visas be granted a waiver and H-1B status for serving in underserved areas, be given highest priority in visa conversion to green cards upon completion of their service commitment obligation, and be exempted from the per country limitation of H-1B visa to green card visa conversion.

RECOMMENDATION B:

Resolution 218 be adopted as amended in lieu of 229.

HOD ACTION: Resolution 218 adopted as amended in lieu of 229.

Resolution 218

RESOLVED, That our American Medical Association lobby US Congress and the US Administration that the J-1 visa waiver physicians serving in underserved areas be given highest priority in visa conversion to green cards upon completion of their service commitment obligation and be exempted from per country limitation of H-1 to green card visa conversion. (Directive to Take Action)

Resolution 229

RESOLVED, That our American Medical Association lobby U.S. Congress and the U.S. Administration that the J-1 visa waiver physicians serving in underserved areas be given highest priority in visa conversion to green cards upon completion of their service commitment obligation and be exempted from the per country limitation of H-1B to green card visa conversion. (Directive to Take Action)

Your Reference Committee heard mixed testimony concerning Resolution 218. Your Reference Committee heard considerable testimony stating that our AMA should stand beside our IMG colleagues and support their right to remain and work in the United States, especially after they spend time serving our underserved communities. Multiple testimonies highlighted the much-needed work that international medical graduates provide to our country and our underserved communities and discussed the importance of international medical graduates, especially when considering the current and projected physician shortage. Testimony highlighted that our AMA is already supporting our IMG colleagues and their work within Congress and specifically that we are already doing the work requested in the mandate when it comes to the Conrad 30 legislation. However, testimony stated that the Resolution needs to have technical edits made to ensure that our Resolution is legally correct. Your Reference Committee heard that as the Resolution currently reads it is asking for J-1 visa holders that complete service in an underserved area to be granted priority when obtaining green cards. J-1 visas are nonimmigrant visas meaning that one cannot be issued a green card when on J-1 visa status. Rather, the J-1 visa waiver allows individuals to forgo the home country return requirement and obtain an H-1B visa, which is an immigrant visa, in exchange for service in an underserved area. An H-1B visa can then, overtime, be converted to a green card. Additionally, your Reference Committee was informed that Resolution 218 and 229 are identical and as such only one should be adopted. Therefore, your Reference Committee recommends that Resolution 218 be adopted as amended in lieu of Resolution 229.

(13) RESOLUTION 220 –VITAL NATURE OF BOARD-CERTIFIED PHYSICIANS IN AEROSPACE MEDICINE

RECOMMENDATION A:

That the second resolve of Resolution 220 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA support ~~advocate for~~ compliance with international aerospace health care agreements, to include supporting the appropriate use of physicians and opposing inappropriate scope expansion by non-physicians, to protect ~~advocating against other mid-level provider scope of practice expansions~~

~~that threaten~~ the safety, health, and well-being of aircrew, ~~patients~~, support personnel, and the flying public. (Directive to Take Action)

RECOMMENDATION B:

Resolution 220 be adopted as amended.

HOD ACTION: Resolution 220 adopted as amended.

RESOLVED, That our American Medical Association recognize the unique contributions and advanced qualifications of aerospace medicine professionals, and specifically oppose any and all efforts to remove, reduce or replace aerospace medicine physician leadership in civilian, corporate or government aerospace medicine programs and aircrew healthcare support teams; (Directive to Take Action) and be it further

RESOLVED, That our AMA advocate for compliance with international agreements, to include advocating against other mid-level provider scope of practice expansions that threaten the safety, health, and well-being of aircrew, patients, support personnel and the flying public. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 220. Your Reference Committee heard that with the spread of COVID-19 and the public health implications that come along with that, physicians are needed in the aerospace industry now more than ever. However, testimony also stated that our AMA has robust existing policy on the crux of Resolution 220, including policy on physician lead teams and scope of practice. Your Reference Committee heard that our policy includes clear guidelines for health care teams and principles guiding physician supervision of non-physicians. Moreover, testimony stated that our AMA continues to zealously advocate for physician lead care and for the appropriate oversight and scope restrictions for mid-level providers. Your Reference Committee heard that scope of practice is a top legislative priority for our AMA as is evident by our robust and well-rounded campaign that includes comprehensive resources on the education and training of non-physicians, access to care, state laws charts, national and state-level patient surveys, social media cards, model op-eds, and model state legislation. Testimony highlighted that these resources are the foundation for our ongoing advocacy at the state and federal level to defend the practice of medicine and support physician-led care. Your Reference Committee heard that just this year our AMA has worked with more than 30 state medical associations to defeat laws that would have expanded the scope of practice of non-physicians. Your Reference Committee heard that our AMA has also followed numerous federal bills and, when needed, worked with state and specialty societies to amend, or defeat legislation. Testimony stated that our AMA continues to engage in its scope of practice work for all physicians, including aerospace physicians, and as such, the work that is being requested within this resolution is already within the purview of existing policy. However, testimony also stated that this is an important issue that needs to have attention brought to it and that advocacy, including letters, needs to be focused on the issues in aerospace medicine. Your Reference Committee also heard that focusing on supporting our aerospace medicine colleagues will provide our AMA with more flexibility which will allow our AMA to better assist our aerospace colleagues. Therefore, your Reference Committee recommends that Resolution 220 be adopted as amended.

(14) RESOLUTION 222 –TO STUDY THE ECONOMIC IMPACT OF MID-LEVEL PROVIDER EMPLOYMENT IN THE UNITED STATES OF AMERICA

RECOMMENDATION A:

The first resolve of Resolution 222 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association encourage and support studies ~~sponsored by relevant state and federal agencies~~ to determine the cost and quality economic impact of ~~mid-level non-physician~~ unsupervised practice on ~~American all consumers~~ patients. (Directive to Take Action); ~~and further be it~~

RECOMMENDATION B:

The second resolve of Resolution 222 be deleted:

RESOLVED, That our AMA develop model state legislation that opposes enactment of legislation and supports reversal of such legislation, if present, that would authorize the independent practice of medicine by any individual who is not a physician. (Directive to Take Action).

RECOMMENDATION C:

Resolution 222 be adopted as amended.

HOD ACTION: Resolution 222 adopted as amended with a change of title.

TO STUDY THE COST AND QUALITY IMPACT OF NON-PHYSICIAN
PROVIDER EMPLOYMENT IN THE UNITED STATES OF AMERICA

RESOLVED, That our American Medical Association encourage and support studies sponsored by relevant state and federal agencies to determine the economic impact of mid-level unsupervised practice on American consumers (Directive to Take Action); and further be it

RESOLVED, That our AMA develop model state legislation that opposes enactment of legislation and reversal of such legislation, if present, that would authorize the independent practice of medicine by any individual who is not a physician. (Directive to Take Action)

Your Reference Committee heard overwhelmingly positive testimony in support of Resolution 222. Your Reference Committee received amendments to Resolution 222 which would allow our AMA to support a wider range of studies, including studies which address the cost or quality of care as well as studies conducted by a variety of authors such as those referenced in the resolution. The authors of the Resolution supported this friendly amendment. Testimony also stated that our AMA has existing model state legislation, An Act to Support Physician-Led Team-Based Health Care, as well as extensive policy supporting physician-led care and opposing inappropriate scope expansions that align with this Resolution, including (Independent Practice of Medicine by Advanced Practice Registered Nurses H-35.988, Scope of Practice Model Legislation D-35.996, Physician Assistants H-35.989, Opposition to the Department of Veterans Affairs Proposed Rulemaking on APRN Practices D-35.979, AMA Support for States in Their Development of Legislation to Support Physician-Led, Team Based Care D-35.982, Protecting Physician Led Health Care H-35.966, Physician Assistants and Nurse Practitioners H-160.947, Guidelines for Integrated Practice of Physician and Nurse Practitioner H-160.950). Your Reference Committee also understands our AMA regularly works with state medical associations on state legislative language and other solutions, therefore, your Reference Committee does not think the second resolve is necessary as this is already found in existing policy, existing model legislation, and is being accomplished as part of our AMA's ongoing advocacy. Your Reference Committee, therefore, recommends Resolution 222 be adopted as amended.

(15) RESOLUTION 223 –NATIONAL DRUG SHORTAGES OF LIDOCAINE
AND SALINE PREPARATION

RECOMMENDATION A:

The first resolve of Resolution 223 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association work with national specialty societies and other relevant stakeholders to advocate that ~~draft a letter to the FDA calling for take~~ direct and prompt actions to alleviate current national shortages of lidocaine, ~~and~~ normal saline preparations, and iodinated contrast media.

RECOMMENDATION B:

The second resolve of Resolution 223 be deleted:

~~RESOLVED, That our AMA amend existing HOD policy H-100.956 on National Drug Shortages by addition and deletion to read as follows:~~

~~“8. Our AMA supports the view that wholesalers should routinely institute a transparent allocation-based system for distribution of drugs in short supply that does not discriminate against small, independent or new medical practices or those with less purchasing power that attempts to fairly distribute drugs in short supply based on remaining inventory and considering the customer’s purchase history.” (Modify Current HOD Policy)~~

RECOMMENDATION C:

Resolution 223 be adopted as amended.

RECOMMENDATION C:

That the title of Resolution 223 be amended to read as follows:

NATIONAL SHORTAGES OF LIDOCAINE, SALINE PREPARATION, AND
IODINATED CONTRAST MEDIA

HOD ACTION: Resolution 223 adopted as amended with a change in title.

NATIONAL SHORTAGES OF LIDOCAINE, SALINE PREPARATION,
AND IODINATED CONTRAST MEDIA

RESOLVED, That our American Medical Association work with national specialty societies and other relevant stakeholders to draft a letter to the FDA calling for direct and prompt actions to alleviate current national shortages of lidocaine and normal saline preparations (Directive to Take Action); and be it further

RESOLVED, That our AMA amend existing HOD policy H-100.956 on National Drug Shortages by addition and deletion to read as follows:

“8. Our AMA supports the view that wholesalers should routinely institute a transparent allocation-based system for distribution of drugs in short supply that does not discriminate against small, independent or new medical practices or those with less purchasing power that attempts to fairly distribute drugs in short supply based on remaining inventory and considering the customer’s purchase history.” (Modify Current HOD Policy)

Your Reference Committee heard supportive testimony for this resolution. Your Reference Committee overwhelmingly heard that shortages in the supply of saline and lidocaine have clear, adverse effects on patient care. Your Reference Committee also appreciates testimony that highlighted the similar shortage of iodinated contrast media and the need for immediate attention of this shortage as well. Your Reference Committee heard how our AMA has worked closely with many specialty and state society partners to better understand and mitigate drug shortages when possible. Your Reference Committee thanks the Council on Science, Medicine and Public Health (CSAPH) for reminding the Reference Committee that there will be a CSAPH report on drug shortages, including saline and lidocaine, to the House at the Interim Meeting. Your Reference Committee questions whether there is a benefit for amending the language in H-100.956, National Drug Shortages, to reflect “less purchasing power” compared to a practice’s “purchasing history.” Your Reference Committee also appreciates testimony about the wide range of drug shortages, but points to H-100.956, which provides our AMA with strong policy to address the wide range of drug shortages. In recognition of testimony urging a broader advocacy on this matter your Reference Committee recommends an amendment that would extend our AMA advocacy beyond writing a letter and allow for a more holistic approach. Your Reference Committee, therefore, recommends that our AMA amend our policy

specific to the limited number of medications delineated in testimony today. Your Reference Committee therefore recommends that Resolution 223 be adopted as amended.

(16) RESOLUTION 227 –SUPPORTING IMPROVEMENTS TO PATIENT DATA PRIVACY

RECOMMENDATION A:

Resolution 227 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association ~~support legislation to strengthen patient data privacy protections by making health information collected or stored~~ advocating for legislation that reflects the AMA's Privacy Principles on smartphones and similar consumer devices subject to the same privacy protections as standard medical records with particular focus on mobile health apps and other digital health tools. (New HOD Policy)

RECOMMENDATION B:

Resolution 227 be adopted as amended.

HOD ACTION: Resolution 227 adopted as amended.

RESOLVED, That our American Medical Association support legislation to strengthen patient data privacy protections by making health information collected or stored on smartphones and similar consumer devices subject to the same privacy protections as standard medical records. (New HOD Policy)

Your Reference Committee heard mixed testimony regarding Resolution 227. Your Reference Committee heard testimony that data collected through smartphones, connected consumer devices, and cloud-based applications are not currently protected under Health Insurance Portability and Accountability Act (HIPAA) because software and technology companies and vendors are not classified as covered entities. Testimony stated that federal legislation has been introduced to expand the health data protections to include this type of device-collected information. Your Reference Committee also heard that our AMA has strong policy supporting the protection of patient data. Testimony highlighted that HIPAA is a permissive law and provides covered entities the ability to access, exchange, and use patients' medical information for broad purposes, i.e., treatment, payment, and operations. Your Reference Committee also heard that in late 2019, our AMA, developed a set of data privacy principles that apply to entities other than those already considered covered entities under HIPAA. Testimony further stated that our [AMA's Privacy Principles](#) (link provided, content not included in the printed version because it is four pages long) provide individuals with rights and protections from discrimination and shift the responsibility for privacy from individuals to data holders other than HIPAA-covered entities. Your Reference Committee heard that extending HIPAA protections for protected health information to non-HIPAA covered technology companies and vendors could create a gap in needed privacy policies. Your Reference Committee also heard that our AMA has advocated to incorporate our Privacy Principles in several regulatory policies, including an Office for Civil Rights HIPAA proposed rule and multiple CMS' Quality Payment Program proposed rules, and we are aware that Congressional Committees are incorporating certain principles in legislative language. Therefore, your Reference Committee recommends that Resolution 227 be adopted as amended.

(17) RESOLUTION 228 –EXPANDED CHILD TAX CREDIT
RESOLUTION 247–RECOGNIZING CHILD POVERTY AND THE RACIAL WEALTH GAP AS PUBLIC HEALTH ISSUES AND EXTENDING THE CHILD TAX CREDIT FOR LOW-INCOME FAMILIES

RECOMMENDATION A:

That the third resolve of Resolution 247 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA advocate for fully refundable, expanded child tax credit ~~payments~~ and other evidence-based cash assistance programs to alleviate child poverty, ameliorate the racial wealth gap, and advance health equity for ~~low-income U.S. residents~~ families in need.

RECOMMENDATION B:

Resolution 247 be adopted as amended in lieu of Resolution 228.

HOD ACTION: Resolution 247 adopted as amended in lieu of Resolution 228.

Resolution 228

RESOLVED, That our American Medical Association actively support the American Families Plan of 2021 and/or similar policies that aim to institute a permanent, expanded child tax credit at the federal level. (Directive to Take Action)

Resolution 247

RESOLVED, That our AMA recognize child poverty as a public health issue and a crucial social determinant of health across the life course; and be it further

RESOLVED, That our AMA recognize that the disproportionate concentration of child poverty and generational wealth gaps experienced by Black, American Indian or Alaska Native, and Hispanic families are a consequence of structural racism and a barrier to achieving racial health equity; and be it further

RESOLVED, That our AMA advocate for fully refundable expanded child tax credit payments and other evidence-based cash assistance programs to alleviate child poverty, ameliorate the racial wealth gap, and advance health equity for low-income U.S. residents.

Your Reference Committee heard mixed testimony regarding Resolutions 228 and 247. Your Reference Committee heard that rates of child poverty in the United States grew from 14.4% in 2019 to 16.1% in 2020, with a disproportionate impact among Black, Indigenous, and Latinx families, which widened the racial wealth gap. Testimony also stated that child poverty negatively impacts children's physical, mental, and emotional health and development, and this effect continues into adulthood. Your Reference Committee heard that direct assistance to families in the form of tax credits paid on a regular basis boosts the academic and economic performance of children over time. However, testimony also stated that any reference to specific federal legislation substantially limits our AMA's ability to be nimble and flexible in its work to advocate for a permanent tax credit in whatever legislative form or policy opportunity arises in the future. Therefore, your Reference Committee recommends that Resolution 247 be adopted as amended in lieu of 228.

(18) RESOLUTION 230 –ADVANCING THE ROLE OF OUTDOOR RECREATION IN PUBLIC HEALTH

RECOMMENDATION A:

That the first resolve of Resolution 230 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA ~~encourages federal, state and local governments to create~~ support the creation and maintenance of new and maintain existing public lands and outdoor spaces for the purposes of outdoor recreation; ~~(Directive to Take Action)~~ and be it further and support continued research on the clinical uses of outdoor recreation therapy. (New AMA Policy)

RECOMMENDATION B:

That the second resolve of Resolution 230 be deleted:

~~RESOLVED, That our AMA work with the Centers for Disease Control and Prevention, National Institute of Environmental Health Science, National Recreation and Park Association, and other relevant stakeholders to encourage continued research on the clinical uses of outdoor recreation therapy. (Directive to Act) (New AMA Policy)~~

RECOMMENDATION C:

Resolution 230 be adopted as amended.

HOD ACTION: Resolution 230 adopted as amended.

RESOLVED, That our AMA encourages federal, state and local governments to create new and maintain existing public lands and outdoor spaces for the purposes of outdoor recreation; (Directive to Take Action) and be it further

RESOLVED, That our AMA work with the Centers for Disease Control and Prevention, National Institute of Environmental Health Science, National Recreation and Park Association, and other relevant stakeholders to encourage continued research on the clinical uses of outdoor recreation therapy. (Directive to Take Action)

Your Reference Committee heard mostly positive testimony regarding Resolution 230. Your Reference Committee heard that outdoor recreation has been shown to have a positive impact on physical, mental, and social health and can result in savings related to chronic disease. Testimony also noted that, considering its proven health benefits, outdoor recreation is now being considered as a potential clinical tool via park prescriptions and outdoor organization referrals. However, your Reference Committee heard that public spaces available for outdoor recreation are increasingly threatened by decreased public availability, and that spending has remained stagnant or fallen in the National Parks and state parks, with billions of dollars in maintenance backlogs even as visits have risen. Testimony was also heard that decreased spending on recreation spaces is an equity issue, disproportionately affecting lower socioeconomic and minority communities that already have lower quality public spaces for recreation, decreased accessibility, and increased rates of space loss, despite these groups disproportionately benefiting from outdoor recreation. Your Reference Committee also heard that adoption of Resolution 230 would fill a gap in AMA policy by providing specific policy on outdoor recreation and the health benefits of such activity. Limited testimony was heard against adoption, based on the realities and difficulties of implementing the resolution and the complexities of land and natural resources policy. Your Reference Committee also was presented with an amendment that recommended broadening the language from specific directives to supportive policy in order for our AMA advocacy to be as effective as possible. Testimony also stated that broadening the asks in the Resolution to be supportive policy rather than directives would provide our AMA staff with more flexibility to engage with, and support, other organizations that may already have specific experience with these issues and may have existing advocacy campaigns. Your Reference Committee, therefore, recommends adoption of Resolution 230 as amended.

- (19) RESOLUTION 231 –AMENDING POLICY H-155.955: INCREASING ACCESSIBILITY TO INCONTINENCE PRODUCTS TO INCLUDE DIAPER TAX EXEMPTION

RECOMMENDATION A:

Resolution 231 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA amend Policy H-155.955, “Increasing Accessibility to Incontinence Products,” by addition and deletion as follows:

Increasing Accessibility to Incontinence Products H-155.955

Our AMA supports increased access to ~~affordable~~ incontinence products, ~~for children and adults, including the removal of sales tax on child and adult diapers, including single use and reusable diapers, and the inclusion of child diapers as qualified~~ and ensuring eligibility of these products as medical expenses for Health Savings Accounts (HSAs), Health Reimbursement Arrangements (HRAs), and Flexible Spending Accounts (FSAs). (Modify Current HOD Policy)

RECOMMENDATION B:

Resolution 231 be adopted as amended.

HOD ACTION: Resolution 231 adopted as amended.

RESOLVED, That our AMA amend Policy H-155.955, "Increasing Accessibility to Incontinence Products," by addition and deletion as follows:

Increasing Accessibility to Incontinence Products H-155.955

Our AMA supports increased access to affordable incontinence products., the removal of sales tax on child and adult diapers, including single-use and reusable diapers, and the inclusion of child diapers as qualified medical expenses for Health Savings Accounts (HSAs), Health Reimbursement Arrangements (HRAs), and Flexible Spending Accounts (FSAs). (Modify Current HOD Policy)

Your Reference Committee heard overwhelmingly supportive testimony in favor Resolution 231. Your Reference Committee heard that AMA policy, H-155.955, Increasing Accessibility to Incontinence Products, supports increased access to affordable incontinence products but is not specific about how to increase such access. Testimony further highlighted that AMA policy H-270.953, Tax Exemptions for Feminine Hygiene Products, recognizes access to feminine hygiene products as a public health issue and supports the removal of sales tax on all feminine hygiene products. Testimony also was heard that stated that a lack of affordable access to diapers can result in diapers not being changed in a timely manner, resulting in health issues, such as increased risk of urinary tract infections and diaper dermatitis and creating an environment for the creation of pressure ulcers. Your Reference Committee heard that access to affordable incontinence products is an equity issue, disproportionately impacting vulnerable patient groups such as infants/toddlers, the elderly, adults with physical disabilities, and adults with intellectual disabilities, as well as low-income individuals. Testimony was also heard that adopting Resolution 231 would be consistent with, and a logical extension of, existing AMA policy. Your Reference Committee heard recommendations on a few minor amendments, which your Reference Committee believes improve the original resolution. Therefore, your Reference Committee recommends that Resolution 231 be adopted, as amended.

(20) RESOLUTION 232 –EXPANSION OF EPINEPHRINE ENTITY STOCKING LEGISLATION

RECOMMENDATION A:

Resolution 232 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA support the adoption of state laws that ~~authorize entities with emergency food allergy guidelines and staff trained in recognizing and responding to a food allergy emergencies to have~~ allow state-authorized entities to permit the storage of auto-injectable epinephrine for use in case of ~~anaphylaxis an emergency~~. (Directive to Take Action)

RECOMMENDATION B:

Resolution 232 be adopted as amended.

HOD ACTION: Resolution 232 adopted as amended.

RESOLVED, That our AMA support the adoption of laws that allow state-authorized entities to permit the storage of auto-injectable epinephrine for use in case of an emergency. (Directive to Take Action)

Your Reference Committee heard generally supportive testimony for Resolution 232. Increased access to epinephrine in the event of a food allergy emergency will help save lives. Testimony highlighted that recognizing the signs and indications of an anaphylactic reaction is important so as to know when to administer epinephrine. Your Reference Committee heard that existing AMA policy already provides a guide to amend the resolution to focus on education and training. Testimony stated that businesses or others who want to have epinephrine on their premises in the event of a food allergy should be able to do so—as long as they have education or other protocols in place to ensure its safe storage and administration. Current AMA Policy H-440.884, Food Allergic Reactions in Schools and Airplanes, provides a model on which to amend this resolution. Your Reference Committee, therefore, recommends that Resolution 232 be adopted as amended.

(21) **RESOLUTION 233 –SUPPORT FOR WARNING LABELS ON FIREARM AMMUNITION PACKAGING**

RECOMMENDATION A:

Resolution 233 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA support ~~legislation requiring that packaging for any firearm ammunition produced in, sold in, or exported from the United States carry a legible, boxed warning that includes research on the effectiveness of~~ warning labels on packaging for firearm ammunition, that includes at a minimum (a) text-based statistics and/or graphic picture-based warning labels related to the risks, harms, and mortality associated with firearm ownership and use, and (b) explicit recommendations that ammunition be stored securely and separately from firearms.

RECOMMENDATION B:

Resolution 233 be adopted as amended.

HOD ACTION: Resolution 233 adopted.

RESOLVED, That our AMA supports legislation requiring that packaging for any firearm ammunition produced in, sold in, or exported from the United States carry a legible, boxed warning that includes, at a minimum, (a) text-based statistics and/or graphic picture-based warning labels related to the risks, harms, and mortality associated with firearm ownership and use, and (b) explicit recommendations that ammunition be stored securely and separately from firearms. (Directive to Take Action)

Your Reference Committee heard mostly positive testimony regarding Resolution 233. Your Reference Committee heard that text-based warning labels have been shown to be, and may be, effective in reducing harmful health behaviors such as consumption of high-sugar or nutritionally poor foods, consumption of alcohol, and misuse of medications. Moreover, testimony was heard that there is a large body of evidence that graphic warning labels on tobacco packaging consistently reduce tobacco use, are more effective at changing behaviors and cognitive patterns than text-only warnings and are equally effective for many diverse population subgroups. Your Reference Committee also heard that given the public health crisis of gun violence, innovative solutions are needed, and warning labels on ammunition is such a solution.

However, your Reference Committee also heard that our AMA already has strong, clear, and well-developed policies on firearm safety, including policy that specifically addresses storage of ammunition, as well as policy on the importance of education for the public about safe storage, especially in households with children. Further testimony stated that there is no pending federal legislation to date that calls for graphic warning labels or text-based messaging on ammunition packaging and there is no evidence to support ammunition warning labels as a means to reduce or prevent firearm injuries or deaths. Your Reference Committee acknowledges the strong testimony in

support of adoption of Resolution 233, but also recognizes that without evidence on the specific effectiveness of warning labels on packaging for firearm ammunition, it will be difficult for our AMA staff to implement the directive to advocate for legislation requiring such labeling. Therefore, your Reference Committee believes that our AMA should support research of such labeling as a first step. Your Reference Committee, therefore, recommends that Resolution 233 be adopted as amended.

(22) RESOLUTION 236 –OUT-OF-NETWORK CARE

RECOMMENDATION A:

Resolution 236 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association amend, by substitution, AMA Policy H-285.904, “Out-of-Network Care,” item H, to read as follows:

~~H. Mediation should be permitted in those instances where a physician’s unique background or skills (e.g. the Gould Criteria) are not accounted for within a 18 minimum coverage standard.~~

H. Mediation and/or Independent Dispute Resolution (IDR) should be permitted allowed in all circumstances as an option or alternative to come to payment resolution between insurers and physicians providers.

RECOMMENDATION B:

Resolution 236 be adopted as amended.

HOD ACTION: Resolution 236 adopted as amended.

RESOLVED, That our American Medical Association amend, by substitution, AMA Policy H-285.904, “Out-of-Network Care,” item H, to read as follows:

~~H. Mediation should be permitted in those instances where a physician’s unique background or skills (e.g. the Gould Criteria) are not accounted for within a 18 minimum coverage standard.~~

H. Mediation and/or Independent Dispute Resolution (IDR) should be permitted in all circumstances as an option or alternative to come to payment resolution between insurers and providers. (Modify Current HOD Policy)

Your Reference Committee heard testimony in support of Resolution 236. Testimony noted that current AMA policy does not fully reflect the comprehensive solution to surprise billing in terms of a backstop for payment disputes with an Independent Resolution Process. Testimony also stated that our AMA and the Federation have successfully advocated for federal and state legislative proposals. Your Reference Committee also heard support for an amendment to the resolution that removes reference to “mediation,” instead keeping the focus on an independent dispute resolution process for physicians who are not satisfied with the initial payment from an insurer. Your reference committee agrees that mediation is not the appropriate tool to resolve out-of-network billing disputes. Testimony also stated that the amended language would more accurately reflect principles agreed to by most members of the Federation during debate over the language of the No Surprises Act and the advocacy that continues in the states on surprise billing. Additionally, your Reference Committee received a friendly amendment to replace “permitted” with “allowed” in the Resolution. Therefore, your Reference Committee recommends that 236 be adopted as amended.

- (23) RESOLUTION 245 –DEFINITION AND ENCOURAGEMENT OF THE APPROPRIATE USE OF THE WORD "PHYSICIAN"
RESOLUTION 249 –CLARIFICATION OF HEALTHCARE PHYSICIAN IDENTIFICATION: CONSUMER TRUTH & TRANSPARENCY

RECOMMENDATION A:

That the second resolve of Resolution 249 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA advocate for “Truth & Transparency” legislation that would combat medical title misappropriation; that such legislation would require non-physician healthcare practitioners to clearly and accurately state their level of training, credentials, and ~~licensing board licensure, and practice qualifications~~ in all professional interactions with patients including hospital and other health care facility identifications, as well as in advertising and marketing materials; and that such legislation would prohibit non-physician healthcare practitioners from using any identifying terms (i.e. ~~doctor~~, -ologist) that can mislead the public (Directive to Take Action).

RECOMMENDATION B:

Resolution 249 be adopted as amended in lieu of Resolution 245.

HOD ACTION: Resolution 249 adopted as amended in lieu of Resolution 245.

Resolution 245

RESOLVED, That our American Medical Association independently, or in coordination with any other appropriate medical organizations that have similar policy regarding the use of the term “physician,” develop and implement a sustained and wide-reaching public relations campaign to utilize the term “physician” and discontinue use of the term “provider.” (Directive to Take Action)

Resolution 249

RESOLVED, That our American Medical Association will advocate for legislation that would establish clear legal definitions for use of words or terms “physician,” “surgeon,” “medical doctor,” “doctor of osteopathy,” “M.D.” , “D.O.,” or any other allopathic or osteopathic medical specialist (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate “Truth & Transparency” legislation that would combat medical title misappropriation; that such legislation would require non-physician healthcare practitioners to clearly and accurately state their level of training, credentials, licensing board, and practice qualifications in all professional interactions with patients including hospital and other health care facility identifications, as well as in advertising and marketing materials; and that such legislation would prohibit non-physician healthcare practitioners from using any identifying terms (i.e. doctor, -ologist) that can mislead the public (Directive to Take Action).

Your Reference Committee heard testimony generally supportive of Resolutions 245 and 249. Your Reference Committee heard that our AMA has extensive policy supporting truth in advertising laws and opposing misappropriation of medical specialties titles. Testimony also stated that our AMA has model truth in advertising legislation and a TIA campaign. Your Reference Committee understands that our advocacy team works regularly with state medical associations to support state Truth in Advertising legislation, including legislation that opposes misappropriation of medical specialty titles. Several amendments were offered to Resolution 249, including a recommendation from the Council on Legislation, to delete the term “practice qualifications” as this is a subjective term that will be difficult for the non-physician to convey to patients accurately and succinctly in each encounter, as well as removal of the term “doctor” as this term is already widely used by non-physicians, such as dentists,

pharmacists, optometrists, and chiropractors. Your Reference Committee supports these amendments and, therefore, your Reference Committee recommends that Resolution 249 be adopted as amended in lieu of Resolution 245.

(24) RESOLUTION 254 –STAKEHOLDER ENGAGEMENT IN MEDICARE ADMINISTRATIVE CONTRACTOR POLICY PROCESSES

RECOMMENDATION A:

That the second resolve of Resolution 254 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA advocate and work with the Centers for Medicare and Medicaid Services (CMS) to improve the instructions to MACs regarding development of local coverage policies in such a manner as to prevent ~~ensure no~~ LCAs that could have the effect of restricting coverage or access from being adopted ~~are issued by MACs~~ without the MAC providing public data, decision criteria, and evidentiary review and allowing comment, or without an associated LCD and the required LCD stakeholder review and input process, ~~through the modernization requirement of the 21st Century Cures Act (Directive to Take Action); and be it further~~

RECOMMENDATION B:

That the third resolve of Resolution 254 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA work with specialty and state medical societies and other interested stakeholders to identify ~~advocate to CMS that the agency immediately invalidate any~~ LCAs that ~~are identified as~~ potentially restricting coverage or access and that were issued without the MACs providing opportunities for stakeholder input, public data, decision criteria, and evidentiary review, ~~or that were issues without an associated LCD and the required stakeholder processes;~~ and advocate that CMS require MACs to revise the policies by restart those processes taking any such proposed changes through an appropriate CLDs and associated requirements for stakeholder engagement, public data, and evidentiary review (Directive to Take Action); and be it further

RECOMMENDATION C:

That the fourth resolve of Resolution 254 be deleted:

~~RESOLVED, That our AMA advocate that Congress and the Department of Health and Human Services consider clarifying language that reinstates a role for local Carrier Advisory Committees in review processes going forward, addressing unintended outcomes of changes in the 21st Century Cures Act that allowed local CACs to be left without a voice or purpose (Directive to Take Action).~~

RECOMMENDATION D:

Resolution 254 be adopted as amended.

HOD ACTION: Resolution 254 adopted as amended.

RESOLVED, That our American Medical Association opposes Medicare Administrative Contractors (MACs) using Local Coverage Articles (LCAs) that could have the effect of restricting coverage or access without providing data

and evidentiary review or without issuing associated Local Coverage Determinations (LCDs) and following required stakeholder processes (New HOD Policy); and be it further

RESOLVED, That our AMA advocate and work with the Centers for Medicare and Medicaid Services (CMS) to ensure no LCAs that could have the effect of restricting coverage or access are issued by MACs without the MAC providing public data, decision criteria, and evidentiary review and allowing comment, or without an associated LCD and the required LCD stakeholder review and input process, through the modernization requirement of the 21st Century Cures Act (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate to CMS that the agency immediately invalidate any LCAs that are identified as potentially restricting coverage or access and that were issued without the MACs providing public data, decision criteria, and evidentiary review, or that were issues without an associated LCD and the required stakeholder processes, and that CMS require MACs to restart those processes taking any such proposed changes through CLDs and associated requirements for stakeholder engagement, public data, and evidentiary review (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate that Congress and the Department of Health and Human Services consider clarifying language that reinstates a role for local Carrier Advisory Committees in review processes going forward, addressing unintended outcomes of changes in the 21st Century Cures Act that allowed local CACs to be left without a voice or purpose (Directive to Take Action).

Your Reference Committee heard testimony primarily in favor of adopting Resolution 254. While testimony was in favor of adopting the first resolve, an amendment was offered that modifies the second and third resolve and deletes the fourth resolve. Testimony was received that expressed concern that it is not feasible to expect the Centers for Medicare & Medicaid Services to identify the problematic local policies on its own and get them revised. Instead, testimony was heard that our AMA should work with medical societies and others to identify the policies that need to be revised. Testimony also was heard that it would be problematic to refer to the 21st Century Cures Act as the source of the problem because that could imply that these changes cannot be made without action by Congress, which is not the case. Local Coverage Articles were typically published by a local Medicare Administrative Contractor to provide coding/billing guidelines or other provider education that was complementary to an existing National Coverage Decision or Local Coverage Decision. Additional testimony was heard in support of the offered amendment. Therefore, your Reference Committee recommends that Resolution 254 be adopted as amended.

RECOMMENDED FOR REFERRAL

(25) RESOLUTION –201 THE IMPACT OF MIDLEVEL PROVIDERS ON MEDICAL EDUCATION

RECOMMENDATION:

Resolution 201 be referred.

HOD ACTION: Resolution 201 referred.

RESOLVED, That our American Medical Association study, using surveys among other tools that protect identities, how commonly bias against physician-led healthcare is experienced within undergraduate medical education and graduate medical education, interprofessional learning and team building work and publish these findings in peer-reviewed journals (Directive to Take Action); and be it further

RESOLVED, That our AMA work with the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education to ensure all physician undergraduate and graduate training programs recognize and teach physicians that they are the leaders of the healthcare team and are adequately equipped to diagnose and treat patients independently only because of the intensive, regulated, and standardized education they receive (Directive to Take Action); and be it further

RESOLVED, That our AMA study the harms and benefits of establishing mandatory postgraduate clinical training for nurse practitioners and physician assistants prior to working within a specialty or subspecialty field (Directive to Take Action); and be it further

RESOLVED, That our AMA study the harms and benefits of establishing national requirements for structured and regulated continued education for nurse practitioners and physician assistants in order to maintain licensure to practice. (Directive to Take Action)

Your Reference Committee heard mixed testimony regarding Resolution 201. Your Reference Committee heard testimony from multiple specialties, including primary care, and multiple Councils, but no clear consensus emerged. Testimony provided recommendations ranging from not adopt to support and received multiple amendments. Testimony highlighted that our AMA has extensive policy on scope of practice, including support for physician-led team-based care, as well as policy that medical education should prepare students to practice in physician-led teams, and that physician-led interprofessional education should be incorporated into medical education and residency programs. Your Reference Committee also heard support for interprofessional collaboration and the role of non-physicians as important members of the care team. General support was heard for further studies about scope of practice, but also testimony was provided that our AMA has extensive information and existing resources outlining the differences in post graduate education and training of nonphysicians. Moreover, your Reference Committee heard that the directives in Resolution 201 are not feasible and may not be possible to complete. As an example, our AMA does not have authority over post-graduate clinical training or continuing education requirements for non-physicians. These requirements are set by the individual profession's accrediting bodies and other regulatory bodies and are likely not to follow AMA directives. Therefore, your Reference Committee recommends that Resolution 201 be referred.

(26) RESOLUTION 224 –HPSA AND MUA DESIGNATION FOR SNFS

RECOMMENDATION:

Resolution 224 be referred.

HOD ACTION: Resolution 224 referred.

RESOLVED, That our American Medical Association advocate for legislative action directing the United States Department of Health and Human Services to designate all skilled nursing facilities, irrespective of their geographic

location, as health professional shortage areas and/or medically underserved areas to facilitate recruitment and retention of health professionals using the usual and customary support made available for such designations. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 224. Your Reference Committee heard that Health Professional Shortage Areas (HPSAs) and medically underserved areas (MUAs) are areas, population groups, and facilities designated by the United States Department of Health and Human Services as having met criteria indicating a significant need for additional primary health care resources, such that limited resources can be prioritized and directed to those areas to assist in addressing that need. Testimony also stated that due to a rapidly aging population, lack of commensurate increase in medical school and residency positions, early retirement of healthcare professionals from burnout and effects of the pandemic, and a lack of direct incentives to practice in senior living communities, there is an acute shortage of healthcare professionals including Physicians, nurses, and clinical practitioners in skilled nursing facilities. However, your Reference Committee also heard that our AMA has ample policy that supports legislation to address the need to enhance resources for physicians practicing in rural counties and other areas where the poverty rate exceeds a certain threshold. Testimony also stated that our AMA policy includes clear instruction for our AMA to support such legislation, encourage federal and state governments to provide financial assistance to assist physicians with shortage area practices, support legislative and/or regulatory changes necessary to establish a waiver process through which shortage area practices can seek exemption from specific elements of regulatory requirements when improved access, without significant detriment to quality, will result, and support legislation that would allow shortage area physician practices to qualify as Rural Health Clinics without the need to employ one or more physician extenders, and undertake a study of structural urbanism, federal payment policies, and the impact on rural workforce disparities. In addition, your Reference Committee heard that our AMA continues to advocate, as a top legislative priority, to provide HPSAs and MUAs the resources needed to help bolster physician practices in these areas evidenced by our AMA providing exhaustive comments to CMS and written testimony to our Congressional leaders. Due to the conflicting testimony provided, your Reference Committee recommends that Resolution 224 be referred.

(27) RESOLUTION 237 –PRESCRIPTION DRUG DISPENSING POLICIES

RECOMMENDATION:

Resolution 237 be referred.

HOD ACTION: Resolution 237 referred.

RESOLVED, That our American Medical Association work with pharmacy benefit managers to eliminate financial incentives for patients to receive a supply of medication greater than prescribed (Directive to Take Action); and be it further

RESOLVED, That our AMA create model state legislation that would restrict dispensing medication quantities greater than prescribed (Directive to Take Action); and be it further

RESOLVED, That our AMA support any legislation that would remove financial barriers favoring dispensing quantities of medication greater than prescribed. (New HOD Policy)

Your Reference Committee heard testimony in support of physicians communicating clearly on a prescription. Your Reference Committee also heard clear support for improving medication adherence for patients with a chronic condition, including supporting having multiple 30-day prescriptions converted into a 90-day prescription when clinically appropriate. Your Reference Committee appreciates that there are some prescriptions, such as trial medications, that would not benefit the patient if the prescription were converted into a 90-day prescription. Your Reference Committee agrees with the Council on Legislation that the prescribing physician should take care and clearly write on the prescription, “dispense as written” or “no refills” if the physician does not want the pharmacist to take matters into his or her own hands. Testimony emphasized that our AMA has longstanding and extensive policies supporting individualized patient care decisions. This includes our AMA supporting patients with chronic conditions being able to receive a 90-day prescription when clinically appropriate. Your Reference Committee, however, also agrees with testimony that directions such as “dispense as written” may not stop a pharmacist or

pharmacy benefit manager (PBM) from inappropriately extending a 30-day prescription to 90 days, which could create patient safety concerns. Testimony highlighted that some harms could be accidental overdose or treatment failure, but there also was testimony that such harms could result from many different types of medications and not just opioids or prescription medication. Your Reference Committee notes that our colleagues from the U.S. Public Health Service provided pro- and con- testimony to different parts of the resolution, underscoring the nuances that would benefit from further study. Your Reference Committee, therefore, recommends that Resolution 237 be referred.

RECOMMENDED FOR REFERRAL FOR DECISION

(28) 246 –FURTHER ACTION TO RESPOND TO THE GUN VIOLENCE
PUBLIC HEALTH CRISIS

RECOMMENDATION:

Resolution 246 be referred for decision.

HOD ACTION: Resolution 246 referred for report back at the 2022 Interim Meeting.

RESOLVED, Our AMA convene a task force for the purposes of working with advocacy groups and other relevant stakeholders to advocate for federal, state, and local efforts to end the gun violence public health crisis; identifying and supporting evidence-based community interventions to prevent gun injury, trauma, and death; monitoring federal, state, and local legislation, regulation, and litigation relating to gun violence; and reporting annually to the House of Delegates on the AMA's efforts to reduce gun violence.

Your Reference Committee heard mixed testimony on Resolution 246. Your Reference Committee heard that gun violence is a major public health crisis in the US that only continues to worsen every year, with the Centers for Disease Control and Prevention (CDC) most recently reporting 45,222 gun deaths in 2020. This report on gun deaths was the highest on record at the time, a 14% increase from 2019, a 25% increase from 2015, and a 43% increase from 2010. Your Reference Committee heard further testimony that the CDC reported that gun-related injuries were one of the five leading causes of death for people aged 1-44 in the US in 2020, and a May 2022 a letter in The New England Journal of Medicine suggested that gun-related injuries may have surpassed motor vehicle crashes becoming the leading cause of death for children and young adults aged 1-19. Testimony also stated that 246 mass shootings took place in the first five months of 2022 according to the Gun Violence Archive, and that 27 school shootings took place in this same period according to Education Week, compared to 34 school shootings in all of 2021. Your Reference Committee further heard that given this rash of firearm violence, AMA advocacy could benefit from unified efforts to collaborate and partner with stakeholders to bolster our efforts and navigate the difficult US landscape on gun violence. Your Reference Committee heard support for the creation of an AMA task force to develop actionable recommendations for our AMA to be a leader in responding to the gun violence crisis.

However, your Reference Committee heard testimony against adoption of this resolution. Testimony stated that preventing firearm violence is already an advocacy priority for our AMA, and our AMA is already engaged in advocacy activities similar to what is called for in this resolution, such as most recently working with other medical specialties, including the American Academy of Pediatrics, to advocate to Congress for increased funding on research to prevent firearm violence. Your Reference Committee also heard that our AMA Advocacy staff is already monitoring state and federal legislation and regulation, as well as litigation, related to firearm violence, and our AMA is engaged in litigation on firearms, including cases pending in the Supreme Court this term. Moreover, testimony stated that our AMA recently sent a letter to the House Judiciary Committee in support of H.R. 7910, the "Protecting Our Kids Act," which includes provisions to increase the purchasing age for semi-automatic rifles from 18 to 21 and close the ghost-gun loophole. In addition, testimony highlighted that our AMA has issued several press statements in recent weeks reiterating that gun violence is a public health crisis and needs real-world, common-sense federal actions. Your Reference Committee also heard that creating an AMA task force is not necessary, since our AMA is already engaged in the activities that would be done by a task force.

Your Reference Committee agrees that our AMA is already engaged in the advocacy, litigation, and coalition activities that Resolution 246 calls for, and believes that creating a task force would take time. Given the mixed testimony presented, your Reference Committee believes that our Board of Trustees is in the best position to weigh the competing factors regarding whether an AMA task force on preventing firearm violence should be created and can act in a timely manner to decide on how the AMA can best continue its advocacy and initiatives on preventing firearm violence. Therefore, your Reference Committee recommends that Resolution 246 be referred to the Board of Trustees for decision.

RECOMMENDED FOR NOT ADOPTION

(29) RESOLUTION 205 –INSURERS AND VERTICAL INTEGRATION

RECOMMENDATION:

Resolution 205 not be adopted.

HOD ACTION: Resolution 205 not adopted.

RESOLVED, That our American Medical Association seek legislation and regulation to prevent health payers (except non-profit HMO's) from owning or operating other entities in the health care supply chain. (Directive to Take Action)

Your Reference Committee heard mixed testimony concerning Resolution 205. Those in favor pointed out that health payers vertically integrating with other entities in the health care supply chain may result in competitive harm to patients and physicians, pointing to the CVS-Aetna merger. Testimony against adoption indicated that adopting Resolution 205 would result in our AMA having to take the position that every proposed vertical merger is bad, regardless of the entities involved-which might include AMA member organizations. Strong testimony highlighted that requiring our AMA to pursue legislation and regulation that would ban all proposed payer vertical mergers in effect requires our AMA to advocate against all such mergers, even if they are small and pose no threat to competition, have procompetitive effects, or might even be sought by AMA group constituents or AMA members. Further, our AMA is a nationally recognized leader when it comes to challenging anti-competitive mergers involving payers, both horizontal and vertical mergers. Testimony highlighted that the last two mergers that our AMA has taken on have been proposed vertical mergers involving payers. Moreover, your Reference Committee heard that our AMA was very aggressive in opposing the proposed CVS-Aetna merger, being one of only a very few organizations invited by a federal judge to provide testimony in federal court against a proposed settlement agreement between the U.S. Department of Justice (DOJ) and CVS that allowed the merger to proceed. More recently, our AMA has asked the DOJ to closely scrutinize the proposed Optum-Change Healthcare merger, and in April 2022, our AMA sent a letter to both the Federal Trade Commission and the DOJ urging both agencies to modernize enforcement of the antitrust laws regarding mergers. Your Reference Committee heard that our AMA will continue to closely monitor all proposed payer mergers and will challenge any such mergers that might hurt patients or physicians. Therefore, your Reference Committee recommends that Resolution 205 not be adopted.

(30) RESOLUTION 207 –PHYSICIAN TAX FAIRNESS

RECOMMENDATION:

Resolution 207 not be adopted.

HOD ACTION: Resolution 207 not adopted.

RESOLVED, That our American Medical Association lobby that physicians be excluded from being considered a specified service business as defined by the Internal Revenue Service. (Directive to Take Action)

Your Reference Committee heard limited testimony regarding Resolution 207. One comment was received that Resolution 207 would benefit physicians. However, opposing testimony commented that the purpose of the tax law change for pass-through entities was to provide relief for small businesses that rely on capital investment to generate their income (rather than their own professional expertise). Other professionals, such as attorneys and CPAs, are treated the same way. Rather than being harmed by the tax provision for pass-through entities, physicians and other professionals simply do not benefit from it. Your Reference Committee also heard that, depending on their circumstances, physicians may realize a net benefit from the tax law change because of reductions in most of the individual tax brackets and other business tax provisions. Therefore, your Reference Committee recommends that Resolution 207 not be adopted.

(31) RESOLUTION 241 –UNMATCHED GRADUATE PHYSICIAN
WORKFORCE

RECOMMENDATION:

Resolution 241 not be adopted.

HOD ACTION: Resolution 241 not adopted.

RESOLVED, That our American Medical Association work with state societies to support these unmatched graduate physicians through their legislators and regulators to allow these physicians to work in underserved areas, in primary care, only in collaboration with a licensed physician (Directive to Take Action); and be it further

RESOLVED, That our AMA work with appropriate parties and the Centers for Medicare and Medicaid Services to reimburse for services rendered by these graduating physicians working in their collaborative practices as do private insurers and state Medicaid programs (Directive to Take Action); and be it further

RESOLVED, That the AMA allow these graduating physicians, working in collaboration with a licensed physician, to become members of an AMA subgroup (Directive to Take Action); and be it further

RESOLVED, That our AMA oppose any effort by these graduating physicians working in collaboration with licensed physicians, to become independent licensed physicians without satisfactorily completing formal residency training. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 241. Your Reference Committee heard that some young physicians are not able to match and are stuck with medical school debt and no professional pathway forward. However, testimony also noted that a very small percentage of physicians never match. Furthermore, your Reference Committee heard that our AMA has existing policy that is opposed to assistant physicians and would need to be changed in order to support this resolution. Testimony also noted that the first resolve clause assumes that physicians at these underserved communities have the time and resources to supervise these physicians that were unable to match. Furthermore, testimony noted that there could be equity issues sending those that did not match to communities that are most in need and potentially those with the least economic mobility. These communities deserve care from the most qualified individuals. Your Reference Committee heard that, with regard to the second resolve, our AMA is working to increase the number of GME positions, so that medical school graduates can receive appropriate training. However, testimony stated that if our AMA begins to advocate for funding for these individuals that did not match it will weaken our current advocacy for additional slots. Testimony highlighted that it is likely that more funding will not be appropriated for these unmatched physicians to be trained and so, if anything, money will be taken from the existing pot and potentially away from our current funding for GME slots for residents that matched. Your Reference Committee also heard that technically a request for Section status can be made via a resolution. However, testimony noted that every Section established thus far has been through the Council on Long Range Planning and Development (CLRPD) route. Additionally, testimony highlighted that the proposed Section will still need to prove that it has met the threshold for creating a section including issues of concern, consistency, appropriateness, representation threshold, stability, and accessibility. Testimony stated that this request would be more appropriately handled by an application to CLRPD. Your Reference Committee also heard that the fourth resolve aligns with AMA Policy H-160.949 which opposes special licensing pathways for physicians. Therefore, your Reference Committee recommends that Resolution 241 not be adopted.

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

(32) RESOLUTION 202 –AMA POSITION ON ALL PAYER DATABASE CREATION

RECOMMENDATION:

That AMA Policy H-225.964 be reaffirmed in lieu of Resolution 202.

HOD ACTION: AMA Policy H-225.964 reaffirmed in lieu of Resolution 202.

RESOLVED, That our American Medical Association advocate that any All Payer Database should also provide true payments that hospitals are making to their employed physicians, not just the amount of payment that the insurer is making on the physician's behalf to the hospital. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 202. Your Reference Committee heard testimony in support of the resolution suggesting the inclusion of data in claims databases on direct payments to employed physicians should be required to establish more accurate payment benchmarks. However, testimony questioned both the feasibility of collecting this data, and the risk of doing so in a public (or publicly accessible) database, including privacy, accuracy, and antitrust concerns. Your Reference Committee shares such concerns. Additional testimony called for reaffirmation of existing policy, H-225.964 –Hospital Employed/Contracted Physicians Reimbursement, that requires hospitals to provide payment information at the time of contracting, offering a more feasible way for physicians to access such information and incorporate it into their contracting negotiations. Therefore, your Reference Committee recommends reaffirmation of H-225.964 in lieu of Resolution 202.

H-225.964 –Hospital Employed/Contracted Physicians Reimbursement

AMA policy states that: (1) all hospital employed/contracted physicians be prospectively involved if the hospital negotiates for them for capitation and global billing contracts; (2) hospital employed/contracted physicians be informed about the actual payment amount allocated to the physician component of the total hospital payment received by the contractual arrangement; and (3) all potential hospital/contracted physicians request a bona fide hospital plan which delineates the actual payment amount allocated to the employed or contracted physicians.

(33) RESOLUTION 215 –TRANSFORMING PROFESSIONAL LICENSURE TO THE 21ST CENTURY

RECOMMENDATION:

That AMA Policies D-275.994, D-275.996, and D-480.960 be reaffirmed in lieu of Resolution 215.

HOD ACTION: AMA Policies D-275.994, D-275.996, and D-480.960 reaffirmed in lieu of Resolution 215.

RESOLVED, That our American Medical Association address the issue of state licensure in a comprehensive manner including studying the best mechanisms to ensure interstate licensure for practitioners practicing in multiple states, optimizing state licensure practices to allow for seamless telemedicine practice across state lines, and addressing long delays in practitioners obtaining state licensures which lead to delays in medical care (Directive to Take Action); and be it further

RESOLVED, That our AMA research the feasibility of convening a meeting of appropriate stakeholders, including but not limited to state medical boards, medical specialty societies, state medical societies, payers, organizations representing non-physician medical professionals, Centers for Medicare and Medicaid Services-approved accrediting agencies, and patients to develop recommendations to modernize the state medical licensure system

including creating mechanisms for multi-state licensure, streamlining the process of obtaining medical licensure, and facilitate practice across state lines(Directive to Take Action); and be it further

RESOLVED, That our AMA report back on these recommendations by the 2022 Interim Meeting. (Directive to Take Action)

Your Reference Committee heard testimony expressing concern that the current licensure system has failed to utilize existing technological advancements, is slow and outdated, and results in a long wait for states to approve physician licenses. Testimony stated that these negative aspects of the current licensure system have in turn negatively impacted a physician's ability to care for patients, including through telehealth. However, your Reference Committee also heard that our AMA has extensive policy, model state telehealth legislation, and has already worked with the Federation of State Medical Boards (FSMB), which has a number of viable solutions to address the concerns raised in Resolution 215. Your Reference Committee heard directly from the FSMB, which outlined many programs they have in place utilizing the most up to date technology, including digital certification, to streamline the licensure process and aid states in primary source verification, as well as updated policy which includes some narrow exceptions to licensure for care provided via telehealth across state lines. Testimony also stated that our AMA has been working with FSMB to expedite and facilitate multi-state licensure through the Interstate Medical Licensure Compact, which now includes 36 states plus DC and Guam, and has processed more than 32,000 licenses with an average processing time of 18 days and more than half the applications taking 7 days or less. Finally, your Reference Committee heard that our AMA has existing policy supporting limited exceptions to licensure for care provided via telehealth across state lines, such as physician-to-physician consultations, and for physicians providing ongoing or follow-up care by a physician to an existing patient, when that patient is temporarily out of state. Given the ongoing collaboration with FSMB and existing AMA policy addressing the issues outlined in Resolution 215, your Reference Committee recommends that existing policies D-275.994, D-275.996, and D-480.960 be reaffirmed in lieu of Resolution 215.

D-275.994 –Facilitating Credentialing for State Licensure

Our AMA: (1) encourages the Federation of State Medical Boards to urge its Portability Committee to complete its work on developing mechanisms for greater reciprocity between state licensing jurisdictions as soon as possible; (2) will work with the Federation of State Medical Boards (FSMB) and the Association of State Medical Board Executive Directors to encourage the increased standardization of credentials requirements for licensure, and to increase the number of reciprocal relationships among all licensing jurisdictions; (3) encourages the Federation of State Medical Boards and its licensing jurisdictions to widely disseminate information about the Federation's Credentials Verification Service, especially when physicians apply for a new medical license; and (4) supports the FSMB Interstate Compact for Medical Licensure and will work with interested medical associations, the FSMB and other interested stakeholders to ensure expeditious adoption by the states of the Interstate Compact for Medical Licensure and creation of the Interstate Medical Licensure Compact Commission.

D-275.996 –Creation of AMA Data Bank on Interstate Practice of Medicine

Our AMA will: (1) continue to study interstate practice of medicine issues as they relate to the quality of care available to patients; (2) explore the provision of information on physician licensure, including telemedicine, to members and others through the internet and other media; and (3) continue to make information on state legal parameters on the practice of medicine, including telemedicine, available for members and others.

D-480.960 –Licensure and Telehealth

1. Our AMA will work with the Federation of State Medical Boards, state medical associations and other stakeholders to encourage states to allow an out-of-state physician to use telehealth to provide continuity of care to an existing patient in the state without penalty if the following conditions are met:

- (a) The physician has an active license to practice medicine in a state or US territory and has not been subjected to disciplinary action.
- (b) There is a pre-existing and ongoing physician-patient relationship.

- (c) The physician has had an in-person visit(s) with the patient.
- (d) The telehealth services are incident to an existing care plan or one that is being modified.
- (e) The physician has verified that the telehealth services are covered under the physician's medical liability insurance policy that satisfies applicable state legal requirements.
- (f) Telehealth use complies with Health Insurance Portability and Accountability Act privacy and security rules.

2. It is the policy of the AMA that a state with a patient compensation fund should consider the impact on the fund of telehealth use by out-of-state physicians providing continuity of care to existing patients in the fund's state. Physicians and patients should be made aware that a state's patient compensation fund may not be applicable when care using interstate telehealth is provided.

(34) **RESOLUTION 234 –UPDATING POLICY ON IMMIGRATION LAWS, RULES, LEGISLATION, AND HEALTH DISPARITIES**

RECOMMENDATION:

That AMA Policies H-350.955, D-255.980, D-255.991, H-60.906, H-65.960, and H-80.993 be reaffirmed in lieu of Resolution 234.

HOD ACTION: AMA Policies H-350.955, D-255.980, D-255.991, H-60.906, H-65.960, and H-80.993 reaffirmed in lieu of Resolution 234.

RESOLVED, That our AMA, in order to prioritize the unique health needs of immigrants, asylees, refugees, and migrant workers during national crises, such as a pandemic:

- (1) opposes the slowing or halting of the release of individuals and families that are currently part of the immigration process; and
- (2) opposes continual detention when the health of these groups is at risk and supports releasing immigrants on recognizance, community support, bonding, or a formal monitoring program during national crises that impose a health risk; and
- (3) supports the extension or reauthorization of visas that were valid prior to a national crisis if the crisis causes the halting of immigration processing; and
- (4) opposes utilizing public health concerns to deny or significantly hinder eligibility for asylum status to immigrants, refugees, or migrant workers without a viable, medically sound alternative solution; (New HOD Policy) and be it further

RESOLVED, That our AMA support discontinuation of the use of non-medically necessary dental and bone forensics to assess an immigrant's age. (Directive to Take Action)

Your Reference Committee heard mixed testimony in favor of Resolution 234. Your Reference Committee heard that our AMA already has existing policy on most of the issues raised in the Resolution and is already engaged in most of the advocacy requested by the Resolution. Your Reference Committee heard that our AMA has already done advocacy championing the use of alternatives to detention for immigrants. Alternatives to detention include things like releasing immigrants on recognizance, community support, bonding, or formal monitoring programs. Your Reference Committee heard that our AMA also supports alternatives to detention. Testimony also stated that our AMA adopted policy on alternatives to detention at our 2021 June Meeting and that our AMA has sent a letter to the Administration on this topic and submitted comments supporting the increased use of release programs within Department of Homeland Security (DHS). Moreover, testimony highlighted that during the beginning of the pandemic our AMA wrote multiple letters to the Administration asking for extensions of physician visas that were valid prior to a national crisis but could not be renewed due to DHS shutting down/slowing down considerably in their review of visas. Testimony also stated that our AMA has been opposing the utilization of public health concerns to deny or significantly hinder eligibility for asylum status to immigrants, refugees, or migrant workers

without a viable, medically sound alternative solution. Your Reference Committee also heard that our AMA has policies, and has written comment letters, concerning allowing immigrants into the U.S. in line with best health practices and has offered alternatives like quarantining before individuals are allowed into the U.S. rather than providing no alternatives to immigration. Therefore, your Reference Committee recommends that existing AMA Policies H-350.955, D-255.980, D-255.991, H-60.906, H-65.960, and H-80.993 be reaffirmed in lieu of Resolution 234.

D-255.980 –Impact of Immigration Barriers on the Nation's Health

1. Our AMA recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine.
2. Our AMA will oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion.
3. Our AMA will oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.
4. Our AMA will advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care.
5. Our AMA will advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice.
6. Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S.

D-255.991 –Visa Complications for IMGs in GME

1. Our AMA will: (A) work with the ECFMG to minimize delays in the visa process for International Medical Graduates applying for visas to enter the US for postgraduate medical training and/or medical practice; (B) promote regular communication between the Department of Homeland Security and AMA IMG representatives to address and discuss existing and evolving issues related to the immigration and registration process required for International Medical Graduates; and (C) work through the appropriate channels to assist residency program directors, as a group or individually, to establish effective contacts with the State Department and the Department of Homeland Security, in order to prioritize and expedite the necessary procedures for qualified residency applicants to reduce the uncertainty associated with considering a non-citizen or permanent resident IMG for a residency position.
2. Our AMA International Medical Graduates Section will continue to monitor any H-1B visa denials as they relate to IMGs? inability to complete accredited GME programs.
3. Our AMA will study, in collaboration with the Educational Commission on Foreign Medical Graduates and the Accreditation Council for Graduate Medical Education, the frequency of such J-1 Visa reentry denials and its impact on patient care and residency training.
4. Our AMA will, in collaboration with other stakeholders, advocate for unfettered travel for IMGs for the duration of their legal stay in the US in order to complete their residency or fellowship training to prevent disruption of patient care.

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.

H-65.960 –Health, In All Its Dimensions, Is a Basic Right

Our AMA acknowledges: (1) that enjoyment of the highest attainable standard of health, in all its dimensions, including health care is a basic human right; and (2) that the provision of health care services as well as optimizing the social determinants of health is an ethical obligation of a civil society.

H-80.993 –Ending Money Bail to Decrease Burden on Lower Income Communities

Our AMA: (1) recognizes the adverse health effects of pretrial detention; and (2) will support legislation that promotes the use of non-financial release options for individuals charged with nonviolent crimes.

(35) RESOLUTION 239 –VIRTUAL SERVICES WHEN PATIENTS ARE AWAY FROM THEIR MEDICAL HOME

RECOMMENDATION:

That AMA Policies H-480.969, H-480,946, D-480.963, and D-480.969 be reaffirmed in lieu of Resolution 239.

HOD ACTION: AMA Policies H-480.969, H-480,946, D-480.963, and D-480.969 reaffirmed in lieu of Resolution 239.

RESOLVED, That our American Medical Association support Medicare coverage of virtual continuity of care follow-up services for patients within the physician’s established medical home when the patient has an established relationship with the provider and such care is not prohibited by the state in which the patient is geographically situated at the time of service (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate with the Centers for Medicare and Medicaid Services (CMS), and Congress if necessary, to cover virtual continuity follow-up care services provided by a patient’s established medical home or usual source of care, as if they were in person, even if the patient is temporarily located outside of the region or state of their medical home. (Directive to Take Action)

Your Reference Committee heard limited testimony regarding Resolution 239. Your Reference Committee heard generally supportive testimony of allowing physicians to provide ongoing care to patients across state lines via telehealth. Testimony also stated that Medicare regulations currently do not impact a physician’s ability to provide care via telehealth across state lines. Rather, this is an issue related to licensure. Your Reference Committee heard that our AMA has ample policy supporting Medicare coverage and payment of telehealth and has been aggressively advocating for Medicare to permanently extend waivers lifting originating site and geographic restrictions. Testimony also stated that our AMA has extensive policy on licensure and telehealth, including policy that physicians must be licensed in the state where the patient is located and policy supporting limited exceptions to licensure for continuity of care such as when a physician provides episodic or follow-up care to an existing patient located in another state. Together these policies address the concerns in Resolution 239. Therefore, your Reference Committee recommends that existing AMA Policies H-480.969, H-480,946, D-480.963, and D-480.969 be reaffirmed in lieu of Resolution 239.

H-480.969 –The Promotion of Quality Telemedicine

(1) It is the policy of the AMA that medical boards of states and territories should require a full and unrestricted license in that state for the practice of telemedicine, unless there are other appropriate state-based licensing methods, with no differentiation by specialty, for physicians who wish to practice telemedicine in that state or territory. This license category should adhere to the following principles:

- (a) exemption from such a licensure requirement for physician-to-physician consultations;
- (b) exemption from such a licensure requirement for telemedicine practiced across state lines in the event of an emergent or urgent circumstance, the definition of which for the purposes of telemedicine should show substantial deference to the judgment of the attending and consulting physicians as well as to the views of the patient;
- (c) allowances, by exemption or other means, for out-of-state physicians providing continuity of care to a patient, where there is an established ongoing relationship and previous in-person visits, for services incident to an ongoing care plan or one that is being modified; and
- (d) application requirements that are non-burdensome, issued in an expeditious manner, have fees no higher than necessary to cover the reasonable costs of administering this process, and that utilize principles of reciprocity with the licensure requirements of the state in which the physician in question practices.

(2) The AMA urges the FSMB and individual states to recognize that a physician practicing certain forms of telemedicine (e.g., teleradiology) must sometimes perform necessary functions in the licensing state (e.g., interaction with patients, technologists, and other physicians) and that the interstate telemedicine approach adopted must accommodate these essential quality-related functions.

(3) The AMA urges national medical specialty societies to develop and implement practice parameters for telemedicine in conformance with: Policy 410.973 (which identifies practice parameters as "educational tools"); Policy 410.987 (which identifies practice parameters as "strategies for patient management that are designed to assist physicians in clinical decision making," and states that a practice parameter developed by a particular specialty or specialties should not preclude the performance of the procedures or treatments addressed in that practice parameter by physicians who are not formally credentialed in that specialty or specialties); and Policy 410.996 (which states that physician groups representing all appropriate specialties and practice settings should be involved in developing practice parameters, particularly those which cross lines of disciplines or specialties).

H-480.946 –Coverage of and Payment for Telemedicine

1. Our AMA believes that telemedicine services should be covered and paid for if they abide by the following principles:

- a) A valid patient-physician relationship must be established before the provision of telemedicine services, through:
 - A face-to-face examination, if a face-to-face encounter would otherwise be required in the provision of the same service not delivered via telemedicine; or
 - A consultation with another physician who has an ongoing patient-physician relationship with the patient. The physician who has established a valid physician-patient relationship must agree to supervise the patient's care; or
 - Meeting standards of establishing a patient-physician relationship included as part of evidence-based clinical practice guidelines on telemedicine developed by major medical specialty societies, such as those of radiology and pathology.

Exceptions to the foregoing include on-call, cross coverage situations; emergency medical treatment; and other exceptions that become recognized as meeting or improving the standard of care. If a medical home does not exist, telemedicine providers should facilitate the identification of medical homes and treating physicians where in-person services can be delivered in coordination with the telemedicine services.

- b) Physicians and other health practitioners delivering telemedicine services must abide by state licensure laws and state medical practice laws and requirements in the state in which the patient receives services.
- c) Physicians and other health practitioners delivering telemedicine services must be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state's medical board.
- d) Patients seeking care delivered via telemedicine must have a choice of provider, as required for all medical services.

- e) The delivery of telemedicine services must be consistent with state scope of practice laws.
- f) Patients receiving telemedicine services must have access to the licensure and board certification qualifications of the health care practitioners who are providing the care in advance of their visit.
- g) The standards and scope of telemedicine services should be consistent with related in-person services.
- h) The delivery of telemedicine services must follow evidence-based practice guidelines, to the degree they are available, to ensure patient safety, quality of care and positive health outcomes.
- i) The telemedicine service must be delivered in a transparent manner, to include but not be limited to, the identification of the patient and physician in advance of the delivery of the service, as well as patient cost-sharing responsibilities and any limitations in drugs that can be prescribed via telemedicine.
- j) The patient's medical history must be collected as part of the provision of any telemedicine service.
- k) The provision of telemedicine services must be properly documented and should include providing a visit summary to the patient.
- l) The provision of telemedicine services must include care coordination with the patient's medical home and/or existing treating physicians, which includes at a minimum identifying the patient's existing medical home and treating physicians and providing to the latter a copy of the medical record.
- m) Physicians, health professionals and entities that deliver telemedicine services must establish protocols for referrals for emergency services.

2. Our AMA believes that delivery of telemedicine services must abide by laws addressing the privacy and security of patients' medical information.

3. Our AMA encourages additional research to develop a stronger evidence base for telemedicine.

4. Our AMA supports additional pilot programs in the Medicare program to enable coverage of telemedicine services, including, but not limited to store-and-forward telemedicine.

5. Our AMA supports demonstration projects under the auspices of the Center for Medicare and Medicaid Innovation to address how telemedicine can be integrated into new payment and delivery models.

6. Our AMA encourages physicians to verify that their medical liability insurance policy covers telemedicine services, including telemedicine services provided across state lines if applicable, prior to the delivery of any telemedicine service.

7. Our AMA encourages national medical specialty societies to leverage and potentially collaborate in the work of national telemedicine organizations, such as the American Telemedicine Association, in the area of telemedicine technical standards, to the extent practicable, and to take the lead in the development of telemedicine clinical practice guidelines.

D-480.963 –COVID-19 Emergency and Expanded Telemedicine Regulations

Our AMA: (1) will continue to advocate for the widespread adoption of telehealth services in the practice of medicine for physicians and physician-led teams post SARS-COV-2; (2) will advocate that the Federal government, including the Centers for Medicare & Medicaid Services (CMS) and other agencies, state governments and state agencies, and the health insurance industry, adopt clear and uniform laws, rules, regulations, and policies relating to telehealth services that: (a) provide equitable coverage that allows patients to access telehealth services wherever they are located, and (b) provide for the use of accessible devices and technologies, with appropriate privacy and security protections, for connecting physicians and patients; (3) will advocate for equitable access to telehealth services, especially for at-risk and under-resourced patient populations and communities, including but not limited to supporting increased funding and planning for telehealth infrastructure such as broadband and internet-connected devices for both physician practices and patients; and (4) supports the use of telehealth to reduce health disparities and promote access to health care.

D-480.969 –Insurance Coverage Parity for Telemedicine Service

1. Our AMA will advocate for telemedicine parity laws that require private insurers to cover telemedicine-provided services comparable to that of in-person services, and not limit coverage only to services provided by select corporate telemedicine providers.

2. Our AMA will develop model legislation to support states' efforts to achieve parity in telemedicine coverage policies.

3. Our AMA will work with the Federation of State Medical Boards to draft model state legislation to ensure telemedicine is appropriately defined in each state's medical practice statutes and its regulation falls under the jurisdiction of the state medical board.

(36) RESOLUTION 250 –OPPOSITION TO CRIMINALIZATION OF PHYSICIANS' MEDICAL PRACTICE

RECOMMENDATION:

That AMA Policies D-125.997, H-270.959, H-160.954, and H-160.946 be reaffirmed in lieu of Resolution 250.

HOD ACTION: AMA Policies D-125.997, H-270.959, H-160.954, and H-160.946 reaffirmed in lieu of Resolution 250.

RESOLVED, That our American Medical Association affirms that government and other third-party interference in evidence-based medical care compromises the physician-patient relationship and may undermine the provision of quality healthcare (Directive to Take Action); and be it further

RESOLVED, That our AMA opposes any government regulation or legislative action which would criminalize physicians for providing evidence-based medical care within the accepted standard of care according to the scope of a physician's training and professional judgment (New HOD Policy).

Your Reference Committee received testimony stating that government and third-party interference with medical practice hurts the patient-physician relationship and quality of care. Your Reference Committee also heard testimony expressing concern that a recent criminal prosecution of a nurse for a medication error, resulting in a patient death, may signal a trend in which physicians may be subject to criminal liability for medical errors or other medical liability allegations, and that our AMA needs to vigorously challenge any attempts by the government to criminalize any aspect of medical practice. At the same time, testimony indicated that our AMA already has strong policy in place mandating that our AMA oppose any governmental or third-party interference with the practice of medicine. Similarly, our AMA has policy mandating our AMA oppose any attempts to impose criminal liability on physicians with respect to any health care decisions, errors in medical decision-making, and medical records documentation. Testimony also indicated that our AMA has recently expanded its model bill prohibiting the criminalization of health care decisions to provide the maximum possible protection from any criminal allegations stemming from medical liability allegations. Therefore, your Reference Committee recommends that existing AMA policies D-125.997, H-270.959, H-160.954, and H-160.946 be reaffirmed in lieu of Resolution 250.

D-125.997–Interference in the Practice of Medicine

Our AMA shall initiate action by whatever means to bring a halt to the interference in medical practice by pharmacy benefit managers and others.

H-270.959 –AMA Stance on the Interference of the Government in the Practice of Medicine

1. Our AMA opposes the interference of government in the practice of medicine, including the use of government-mandated physician recitations.

2. Our AMA endorses the following statement of principles concerning the roles of federal and state governments in health care and the patient-physician relationship:

A. Physicians should not be prohibited by law or regulation from discussing with or asking their patients about risk factors, or disclosing information to the patient (including proprietary information on exposure to potentially dangerous chemicals or biological agents), which may affect their health, the health of their families, sexual partners, and others who may be in contact with the patient.

B. All parties involved in the provision of health care, including governments, are responsible for acknowledging and supporting the intimacy and importance of the patient-physician relationship and the ethical obligations of the physician to put the patient first.

C. The fundamental ethical principles of beneficence, honesty, confidentiality, privacy, and advocacy are central to the delivery of evidence-based, individualized care and must be respected by all parties.

D. Laws and regulations should not mandate the provision of care that, in the physician's clinical judgment and based on clinical evidence and the norms of the profession, are either not necessary or are not appropriate for a particular patient at the time of a patient encounter.

H-160.954 –Criminalization of Medical Judgment

(1) Our AMA continues to take all reasonable and necessary steps to insure that errors in medical decision-making and medical records documentation, exercised in good faith, do not become a violation of criminal law. (2) Henceforth our AMA opposes any future legislation which gives the federal government the responsibility to define appropriate medical practice and regulate such practice through the use of criminal penalties.

H-160.946 –The Criminalization of Health Care Decision Making

The AMA opposes the attempted criminalization of health care decision-making especially as represented by the current trend toward criminalization of malpractice; it interferes with appropriate decision making and is a disservice to the American public; and will develop model state legislation properly defining criminal conduct and prohibiting the criminalization of health care decision-making, including cases involving allegations of medical malpractice, and implement an appropriate action plan for all components of the Federation to educate opinion leaders, elected officials and the media regarding the detrimental effects on health care resulting from the criminalization of health care decision-making.

(37) RESOLUTION 252 –THE CRIMINALIZATION OF HEALTH CARE DECISION MAKING AND PRACTICE

RECOMMENDATION:

That AMA policies H-160.954 and H-160.946 be reaffirmed in lieu of Resolution 252.

HOD ACTION: AMA policies H-160.954 and H-160.946 reaffirmed in lieu of Resolution 252

RESOLVED, That Policy H-160.946, “The Criminalization of Health Care Decision Making” be amended by addition and deletion with a change in title to read as follows:

The Criminalization of Health Care Decision Making and Practice H-160.946

That our AMA: (1) opposes the attempted criminalization of health care decision-making, practice, malpractice, and medical errors, including medication errors related to electronic medical record or other system errors, especially as represented by the current trend toward criminalization of malpractice; it interferes with appropriate decision making and is a disservice to the American public; and (2) actively update and promote will develop model state legislation properly defining criminal conduct and prohibiting the criminalization of health care decision-making and practice, including cases involving allegations of medical malpractice and medical errors; and (3) implement an appropriate action plan for all components of the Federation to educate opinion leaders, elected officials and the media regarding the detrimental effects on health care resulting from the criminalization of health care decision-making, practice, malpractice, and medical errors. (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA study the increasing criminalization of health care decision-making, practice, malpractice, and medical errors with report back on our advocacy to oppose this trend; and be it further

RESOLVED, That our AMA study the ramifications of trying all health care decision-making, practice, malpractice, and medical error cases in health courts instead of criminal courts; and be it further

RESOLVED, That our AMA reaffirm Policies H-120.921, H-160.954, H-375.984, H-375.997, and H-435.950 (Reaffirm HOD Policy); and be it further

Your Reference Committee heard testimony supporting adoption of Resolution 252, and testimony favoring reaffirmation. The testimony in favor of adoption pointed to the recent criminal conviction of a nurse, based on a medical error she herself reported, and wanted to ensure that our AMA oppose any attempt to criminalize medical errors or anything else that might expose a physician to medical liability. Supportive testimony also called for a study on increasing criminalization of the medical practice setting, and a second study regarding the ramifications of litigating all medical liability cases in health courts instead of criminal courts. However, testimony supporting reaffirmation pointed out that AMA policy already opposes any attempts to criminalize health care decision-making, errors in medical decision-making, and errors in medical records documentation. Testimony also indicated that a study regarding criminalization at this point was premature based on only one prosecution, and a study about litigating cases in health courts as opposed to criminal courts was likely to yield little information, given that at this time there are no medical liability health courts. Finally, your Reference Committee heard that our AMA is making significant revisions to a model bill that was created in response to AMA policy calling for model legislation prohibiting the criminalization of health care decision-making, including cases involving allegations of medical malpractice. These revisions significantly expand the bill's protections and remedies. Your Reference Committee, therefore, recommends that existing AMA policies H-160.954 and H-160.946 be reaffirmed in lieu of Resolution 252.

H-160.954 –Criminalization of Medical Judgment

(1) Our AMA continues to take all reasonable and necessary steps to insure that errors in medical decision-making and medical records documentation, exercised in good faith, do not become a violation of criminal law.

(2) Henceforth our AMA opposes any future legislation which gives the federal government the responsibility to define appropriate medical practice and regulate such practice through the use of criminal penalties.

H-160.946 –The Criminalization of Health Care Decision Making

The AMA opposes the attempted criminalization of health care decision-making especially as represented by the current trend toward criminalization of malpractice; it interferes with appropriate decision making and is a disservice to the American public; and will develop model state legislation properly defining criminal conduct and prohibiting the criminalization of health care decision-making, including cases involving allegations of medical malpractice, and implement an appropriate action plan for all components of the Federation to educate opinion leaders, elected officials and the media regarding the detrimental effects on health care resulting from the criminalization of health care decision-making.

RECOMMENDED FOR ADOPTION IN LIEU OF

(38) RESOLUTION 211 –REPEAL OR MODIFICATION OF THE MEDICARE APPROPRIATE USE CRITERIA (AUC) PROGRAM

RECOMMENDATION:

Alternative Resolution 211 be adopted in lieu of Resolution 211 to read as follows:

MODIFICATION OF THE MEDICARE APPROPRIATE USE CRITERIA (AUC) PROGRAM

RESOLVED, That our American Medical Association Policy H-320.940, “Medicare’s Appropriate Use Criteria Program,” be amended by addition and deletion to read as follows:

Our AMA will ~~continue to~~ advocate to Congress and the Centers for Medicare & Medicaid Services (CMS) to delay implementation of the effective date and advance modifications to of the Medicare Appropriate Use Criteria (AUC) Program until the Centers for Medicare & Medicaid Services (CMS) can in such a manner that exempts care mandated by EMTALA, adequately addresses technical and workflow challenges that add to clinician’s administrative burden and practice expenses, with its implementation and any interaction between maximizes alignment with the Quality Payment Program (QPP), and the use of creates provider flexibility for the consultation of physician-developed, evidence-based and transparent AUC or advanced diagnostic imaging appropriate use criteria guidelines using a mechanism best suited for their practice, specialty and workflow. (Modify Current HOD Policy)

HOD ACTION: Alternate Resolution 211 adopted in lieu of Resolution 211.

RESOLVED, That our American Medical Association Policy H-320.940, “Medicare’s Appropriate Use Criteria Program,” be amended by addition and deletion to read as follows:

Our AMA will ~~continue to~~ advocate to Congress for delay the effective date either the full repeal of the Medicare Appropriate Use Criteria (AUC) Program or legislative modifications to the program in such a manner that until the Centers for Medicare & Medicaid Services (CMS) can adequately addresses technical and workflow challenges, with its implementation and any interaction between maximizes alignment with the Quality Payment Program (QPP), and the use of advanced diagnostic imaging appropriate use criteria. creates provider flexibility for the consultation of AUC or advanced diagnostic imaging guidelines using a mechanism best suited for their practice, specialty and workflow. (Modify Current HOD Policy)

Your Reference Committee heard overwhelming testimony in support of Alternative Resolution 211. Your Reference Committee heard that eight years after the bipartisan enactment of Protecting Access to Medicare Act (PAMA), CMS continues to face challenges in completing the rulemaking and implementation of the AUC program. This delay fuels ongoing concerns about the complexity of the law, associated costs, and regulatory burden sustained by physicians and other health care providers to meet the program requirements. Testimony also stated that the AUC program, if ever fully implemented, would apply to every clinician who orders or furnishes an advanced diagnostic imaging test, unless a statutory or hardship exemption applies. Further, testimony highlighted that practitioners whose ordering patterns are considered outliers will be subject to prior authorization — at a time when physicians are working to advance policies that reduce the administrative burdens associated with these types of utilization management policies. Your Reference Committee also heard concerns that a CMS analysis of CY2020 claims concluded that only 9 to 10 percent of all claims subject to the AUC program reported sufficient information to be considered compliant with the provisions within PAMA. However, there was testimony in opposition to fully repealing the AUC program due to concerns that it would be replaced with additional prior authorization

requirements. This conflicting testimony favored adopting Alternative Resolution 211 to provide our AMA with the flexibility needed to achieve the best outcome for physicians. With respect to critiques that the imaging AUC policy conflicts with the QPP, your Reference Committee heard that consultation of imaging AUC already qualifies as a Merit-Based Incentive Payment System (MIPS) high-weight improvement activity. The concerns about the CMS claims analysis were also tempered by the reality that CMS did not mandate consultation during the education and testing period. Furthermore, testimony stated that CMS has attempted to address all major concerns surrounding challenges with claims-based reports of imaging AUC information. Your Reference Committee also heard concerns that full repeal of the imaging AUC policy would prompt federal lawmakers to revisit policies mandating prior authorization for all advanced diagnostic imaging services within Medicare. Testimony highlighted the absence of policies advocating for prior authorization for advanced diagnostic imaging services within annual Presidential budgets following the passage of the PAMA AUC policy. Your Reference Committee also heard that Congress has multiple health care priorities to consider before the end of 2022, thus making it unlikely that federal lawmakers will attempt to repeal a portion of the complicated PAMA statute. Therefore, your Reference Committee recommends that Alternative Resolution 211 be adopted in lieu of Resolution 211.

(39) RESOLUTION 217 –PRESERVING THE PRACTICE OF MEDICINE
RESOLUTION 251 –PHYSICIAN MEDICAL LICENSE USE IN CLINICAL
SUPERVISION

RECOMMENDATION A:

Resolution 217 be amended by addition of a new resolve clause to read as follows:

RESOLVED, That our AMA support whistleblower protections for physicians who report unsafe care provided by non-physicians to the appropriate regulatory board.

RECOMMENDATION B:

That resolves 2–6 of Resolution 217 be referred for decision.

RECOMMENDATION C:

That resolves 1-3 of Resolution 251 be referred for decision.

RECOMMENDATION D:

Resolution 217 be adopted as amended in lieu of Resolve 4 of Resolution 251.

HOD ACTION: Resolution 217 adopted as amended in lieu of Resolve 4 of Resolution 251.

Resolves 2–6 of Resolution 217 referred for decision.

Resolves 1-3 of Resolution 251 referred for decision.

Resolution 217

RESOLVED, That our American Medical Association oppose mandates from employers to supervise non-physician providers as a condition for physician employment and in physician employment contracts (New HOD Policy); and be it further

RESOLVED, That our AMA work with relevant regulatory agencies to ensure physicians are notified in writing when their license is being used to “supervise” non-physician providers (Directive to Take Action); and be it further

RESOLVED, That our AMA conduct a systematic study to collect and analyze publicly available physician supervision data from all sources to determine how many allied health professionals are being supervised by

physicians in fields which are not a core part of those physicians' completed residencies and fellowships (Directive to Take Action); and be it further

RESOLVED, That our AMA study the impact scope-of practice advocacy by physicians has had on physician employment and termination (Directive to Take Action); and be it further

RESOLVED, That our AMA study the views of patients on physician and non-physician care to identify best practices in educating the general population on the value of physician-led care, and study the utility of a physician-reported database to track and report institutions that replace physicians with non-physician providers in order to aid patients in seeking physician-led medical care (Directive to Take Action); and be it further

RESOLVED, That our AMA work with relevant stakeholders to commission an independent study comparing medical care provided by physician-led health care teams vs. care provided by unsupervised non-physician providers, which reports on the quality of health outcomes, cost effectiveness, and access to necessary medical care, and to publish the findings in a peer-reviewed medical journal. (Directive to Take Action)

Resolution 251

RESOLVED, That our American Medical Association work with relevant regulatory agencies to ensure physicians receive written notification when their license is being used to document "supervision" of non-physician practitioners (Directive to Take Action); and be it further

RESOLVED, That our AMA oppose mandatory physician supervision of non-physician practitioners as a condition for physician employment (New HOD Policy); and be it further

RESOLVED, That our AMA advocate for the right of physicians to deny participation in "supervision" of any non-physician practitioner with whom they have concerns for patient safety and/or clinical care (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate that physicians be able to report unsafe care provided by non-physician practitioners to the appropriate regulatory board with whistleblower protections for the physician and their employment (Directive to Take Action).

Your Reference Committee heard extensive testimony in support of Resolutions 217 and 251. Your Reference Committee heard that scope of practice is a top legislative priority for our AMA and that we have extensive resources supporting our advocacy at the state and federal level to protect patient access to physician-led care and defend the practice of medicine. Strong testimony stated support for policy opposing mandates from employers to supervise non-physician providers as a condition for physician employment and in physician employment contracts. General support was also heard for whistleblower protections of physicians who report unsafe care of non-physicians to the appropriate regulatory board. Your Reference Committee heard supportive testimony of the need for studies to support our scope campaign, particularly studies comparing the cost and quality of care provided by physicians to non-physicians. Testimony also stated that, while our AMA is supportive of conducting studies or surveys to support our scope campaign, these types of studies are expensive and time-intensive and must be considered as part of our broader scope agenda to ensure they will have the greatest impact. Your Reference Committee understands the concerns raised by the authors of Resolutions 217 and 251 and also recognizes the need for such studies to be focused, aligned, and in coordination with other activities in our AMA's scope of practice campaign. Your Reference Committee also agrees expediency is necessary. Therefore, Your Reference Committee recommends adoption of Resolution 217 in lieu of 251 and referral of Resolution 217's second through sixth resolves and referral of Resolution 251's first through third resolves.

(40) RESOLUTION 238 –COVID-19 ECONOMIC INJURY DISASTER LOAN (EIDL) FORGIVENESS FOR PHYSICIAN GROUPS OF FIVE OR FEWER PHYSICIANS

RECOMMENDATION:

Alternative Resolution 238 be adopted in lieu of Resolution 238 to read as follows:

RESOLVED, That our American Medical Association advocate at the federal level for support debt-relief or loan forgiveness for independent physician practices facing COVID-related financial jeopardy.

HOD ACTION: Alternate Resolution 238 adopted as amended in lieu of Resolution 238.

RESOLVED, That our American Medical Association advocate for Economic Injury Disaster Loan (EIDL) forgiveness for physician groups of five or fewer physicians for loans of less than \$150,000 granted by the Small Business Administration by whatever mechanism is available, with no stipulations based on productivity or profit/loss reports to receive this forgiveness. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 238. Testimony noted that small medical practices were hit hard financially during the COVID-19 pandemic and that many of these practices are still struggling to stay afloat. One commentator testified that forgiveness of EIDL loans would greatly help these small practices and negate the expense of creating a new federal program to identify deserving recipients. Additional testimony noted that financial assistance was provided to multiple other sectors of the economy during the pandemic and argued that small physician practices should be provided with additional relief due to the increased financial burdens they had to undertake during and after the pandemic. However, your Reference Committee heard testimony that it is unclear whether Resolution 238 is based upon up-to-date information on the EIDL loan program, and it appears to conflate the EIDL program with other COVID-19 relief programs as well as ask for retroactive forgiveness for loans received under the EIDL program even though the program makes clear that these loans need to be repaid. Your Reference Committee also heard that our AMA worked vigorously and successfully with Congress and the Administration during the height of the pandemic to protect the viability of physician practices and continues to advocate for repayment extensions and other relief related to the Provider Relief Fund. Finally, testimony stated that the limit on the practice size of five or fewer physicians and loan amount of \$150,000 appear arbitrary and heard that an alternative resolution would apply more broadly to physicians facing COVID-related financial jeopardy. Your Reference Committee agrees that broadening the language would provide more flexibility to our AMA staff in advocating for implementation of the resolution. Therefore, your Reference Committee recommends that Alternative Resolution 238 be adopted in lieu of Resolution 238.

(41) RESOLUTION 240 –PHYSICIAN PAYMENT REFORM & EQUITY (PPR&E)
 RESOLUTION 242 –PUBLIC AWARENESS AND ADVOCACY CAMPAIGN TO REFORM THE MEDICARE PHYSICIAN PAYMENT SYSTEM
 RESOLUTION 243 –APPROPRIATE PHYSICIAN PAYMENT FOR OFFICE-BASED SERVICES
 RESOLUTION 253 –PHYSICIAN PAYMENT REFORM & EQUITY

RECOMMENDATION:

Alternative Resolution 240 be adopted in lieu of Resolutions 240, 242, 243, and 253 to read as follows:

RESOLVED, That our AMA develop a comprehensive advocacy campaign to achieve enactment of reforms to the Medicare physician payment system

consistent with AMA policy and in accord with the principles (Characteristics of a Rational Medicare Payment System) endorsed by over 120 state and medical specialty Federation of Medicine members.

RESOLVED, That our AMA reaffirm AMA Policy [H-390-849](#), Physician Payment Reform, which states, among other things, that our AMA will advocate for the development and adoption of physician payment reforms that are designed with input from the physician community, not require budget neutrality within Medicare Part B, and be based on payment rates that are sufficient to cover the full cost of sustainable medical practice.

RESOLVED, That our AMA reaffirm AMA Policy [D-390.946](#), Sequestration, which states, among other things, that our AMA will continue to seek positive inflation-adjusted annual physician payment updates that keep pace with rising practice costs, ensure Medicare physician payments are sufficient to safeguard beneficiary access to care, work towards the elimination of budget neutrality requirements within Medicare Part B, advocate strongly to the current administration and Congress that additional funds must be put into the Medicare physician payment system to address increasing costs of physician practices, and advocate for payment policies that allow the Centers for Medicare & Medicaid Services to retroactively adjust overestimates of volume of services.

HOD ACTION: Alternative Resolution 240 adopted in lieu of Resolutions 240, 242, 243, and 253

Resolution 240

RESOLVED, That our American Medical Association define Physician Payment Reform and Equity (PPR & E) as “improvement in physician payment by Medicare and other third-party payers so that physician reimbursement covers current office practice expenses at rates that are fair and equitable, and that said equity include annual updates in payment rates” (Directive to Take Action); and be it further

RESOLVED, That our AMA place PPR & E as the single highest advocacy priority of our organization (Directive to Take Action); and be it further

RESOLVED, That our AMA use every resource at its disposal (including but not limited to elective, legislative, regulatory, and lobbying efforts) to advocate for an immediate increase in

Medicare physician payments to help cover the expense of office practice (Directive to Take Action); and be it further

RESOLVED, That in addition to an immediate increase in Medicare physician payments, our AMA advocate for a statutory annual update in such payments that would equal or exceed the Medicare Economic Index or the Consumer Price Index, whichever is most advantageous in covering the continuously inflating costs of running an office practice (Directive to Take Action); and be it further

RESOLVED, That our AMA establish a Task Force appointed by the Board of Trustees to outline a specific set of steps that are needed to accomplish the goals of PPR & E and report back to the HOD at the 2022 Interim Meeting regarding that plan (Directive to Take Action); and be it further

RESOLVED, That our AMA Board of Trustees report back to the HOD at each subsequent meeting regarding their progress on meeting the goals of PPR & E, until PPR & E is accomplished. (Directive to Take Action)

Resolution 242

RESOLVED, That our American Medical Association immediately launch and sustain a well-funded comprehensive public awareness and advocacy campaign, that includes paid advertising, social and earned media, and patient and physician grassroots, to prevent/mitigate future Medicare payment cuts and lay the groundwork to pass federal legislation that reforms the current Medicare physician payment system by incorporating annual inflation updates,

eliminating/replacing or revising budget neutrality requirements, offering a variety of payment models and incentives to promote value-based care and safeguarding access to high-quality care by advancing health equity and reducing disparities. (Directive to Take Action)

Resolution 243

RESOLVED, That our American Medical Association advocate for improvement in physician payment by Medicare and other third-party payers so that physician reimbursement covers current office practice expenses at rates that are fair and equitable, and that said equity include annual updates in payment rates to account for increased costs of running a medical practice. (Directive to Take Action)

Resolution 253

RESOLVED, That our American Medical Association define Physician Payment Reform and Equity (PPR & E) as “improvement in physician payment by Medicare and other third-party payers so that physician reimbursement covers current office practice expenses at rates that are fair and equitable, and that said equity include annual updates in payment rates” (New HOD Policy); and be it further

RESOLVED, That our AMA place Physician Payment Reform & Equity as the advocacy priority of our organization (Directive to Take Action); and be it further

RESOLVED, That our AMA use multiple resources, including but not limited to elective, legislative, regulatory, and lobbying efforts, to advocate for an immediate increase in Medicare physician payments to help cover the expense of office practices (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for a statutory annual update in such payments that would equal or exceed the Medicare Economic Index or the Consumer Price Index, whichever is most advantageous in covering the continuously inflating costs of running an office practice (Directive to Take Action); and be it further

RESOLVED, That our AMA establish a Task Force appointed by the Board of Trustees to outline a specific set of steps that are needed to accomplish the goals of Physician Payment Reform & Equity and report back to the HOD at each subsequent Annual meeting regarding their progress on meeting the goals of Physician Payment Reform & Equity (PPR&E) until PPR&E is accomplished (Directive to Take Action).

Your Reference Committee received mixed testimony on Resolutions 240, 242, 243, and 253. In general, testimony was heard in strong support of the goals of these resolutions. Several commented that our AMA already has extensive policy on the physician payment reforms called for in all of these resolutions, including advocating for positive inflation-adjusted annual physician payment updates that keep pace with rising practice costs, Medicare physician payments sufficient to safeguard beneficiary access to care, allowing the Centers for Medicare & Medicaid Services to retroactively adjust overestimates of volume of services, development and adoption of physician payment reforms that are designed with input from the physician community, and eliminating budget neutrality requirements within Medicare Part B. Some testimony argued in favor of the type of additional action called for in Resolutions 240, 242, and 253. Additional testimony noted that physicians are tired of having to fight each year to avoid payment cuts, and that a permanent solution is needed. Other testimony was opposed to these Resolutions and argued that they would be counterproductive and not achieve its intended goals. Testimony also raised concerns of the substantial fiscal notes for Resolutions 240, 242, and 253. Testimony was also heard that our AMA is already leading an effort with Federation members to reshape the Medicare payment system as called for in these resolutions. Just two weeks ago (May 25), over 120 state and specialty Federation members—including most of the cosponsors of Resolutions 242 and 243—endorsed a set of principles ([Characteristics of a Rational Medicare Payment System](#)) developed in collaboration with Federation organizations. These principles include establishing a rational Medicare physician payment system that provides financial stability through positive annual payment updates that reflect inflation in practice costs, and eliminating, replacing, or revising budget neutrality requirements. Your Reference Committee also heard testimony that our AMA advocacy is already working to build awareness of the problems with the current system with Congress and the Administration. Furthermore, last Friday (June 10) our AMA launched the [Recovery Plan for America’s Physicians](#)—#FightingforDocs—which is a comprehensive campaign designed to increase visibility on the Medicare Payment Reform principles broadly endorsed by

Federation members, as well as other top AMA priorities. Your Reference Committee also heard testimony in strong agreement that our AMA should continue to build awareness of the problems with the Medicare physician payment system, but that the specific strategy, tactics, and financing are in the purview of the Board. On this point, a member of the Board of Trustees, as well as some others who testified, indicated support for referring these resolutions to the Board for decision. Testimony from some others opposed referral and called for the House of Delegates to make a point by adopting these resolutions. Your Reference Committee also received testimony in support of adopting an alternative resolution that captures the essence of these resolutions while leaving the strategy and tactics to the Board. Your Reference Committee agrees with this approach and recommends that Alternative Resolution 240 be adopted in lieu of Resolutions 240, 242, 243, and 253.

(42) **RESOLUTION 248 –PROMOTING PROPER OVERSIGHT AND REIMBURSEMENT FOR SPECIALTY PHYSICIAN EXTENDERS AND NON PHYSICIAN PRACTITIONERS**

RECOMMENDATION:

Alternative Resolution 248 be adopted in lieu of Resolution 248 to read as follows:

PROMOTING PROPER OVERSIGHT OF NON-PHYSICIAN PRACTITIONERS

RESOLVED, That our AMA support state medical board oversight of non-physician practitioners who are practicing without physician supervision, collaboration, or direction.

HOD ACTION: Resolution 248 referred.

RESOLVED, That our AMA work with state medical boards to improve oversight and coordination of the work done with physician extenders and non-physician practitioners (Directive to Take Action); and be it further

RESOLVED, That our AMA adopt the position that Boards of Medical Examiners or its equivalent in each state should have oversight of cases involving specialty care as boards with oversight over physician extenders and non-physician practitioners do not have the training to oversee specialty care (New HOD Policy); and be it further

RESOLVED, That our AMA adopt the position that in each state the Board of Medical Examiners or its equivalent should have oversight over physician extenders and non-physician practitioners if billing independently or in independent practice as their respective oversight boards do not have experience providing accurate oversight for specialty care (New HOD Policy).

Your Reference Committee heard that the AMA has existing policy on point regarding physician supervision of non-physicians, state medical board oversight of physician led teams, and medical board oversight of physician agreements with non-physicians. Your Reference Committee heard concerns with the language of the second resolve clause and agrees the intent is unclear. Your Reference Committee also heard that while the third resolve is overly broad, the general objective is supported by existing AMA policy. Your Reference Committee received alternative language that seeks to achieve the goal of the third resolve and adds to existing AMA policy. Based on this testimony, your Reference Committee recommends Alternative Resolution 248 be adopted in lieu of Resolution 248.

REPORT OF REFERENCE COMMITTEE C

RECOMMENDED FOR ADOPTION

1. Council on Medical Education Report 1 – Council on Medical Education Sunset Review of 2012 House Policies
2. Council on Medical Education Report 3 – Onsite and Subsidized Childcare for Medical Students, Residents and Fellows (Resolution 304-J-21, Resolve 3)
3. Resolution 310 – Support for Standardized Interpreter Training
4. Resolution 316 – Providing Transparent and Accurate Data Regarding Students and Faculty at Medical Schools
5. Resolution 322 – Standards in Cultural Humility Training Within Medical Education

RECOMMENDED FOR ADOPTION AS AMENDED

6. Council on Medical Education Report 2 – An Update on Continuing Board Certification
7. Council on Medical Education Report 4 – Protection of Terms Describing Physician Education and Practice (Resolution 305-J-21, Alternate Resolve 2)
Resolution 329 – Use of the Terms "Residency" and "Fellowship" by Health Professionals Outside of Medicine
8. Council on Medical Education Report 5 – Education, Training, and Credentialing of Non-Physician Health Care Providers and Their Impact on Physician Education and Training (Resolution 305-J-21, Resolve 8)
9. Council on Medical Education Report 6 – Clinical Applications of Pathology and Laboratory Medicine for Medical Students, Residents and Fellows
10. Resolution 301 – Medical Education Debt Cancellation in the Face of a Physician Shortage During the COVID-19 Pandemic
11. Resolution 302 – Resident and Fellow Access to Fertility Preservation
12. Resolution 307 – Parental Leave and Planning Resources for Medical Students
13. Resolution 309 – Decreasing Bias in Evaluations of Medical Student Performance
14. Resolution 315 – Modifying Eligibility Criteria for the Association of American Medical Colleges' Financial Assistance Program
15. Resolution 319 – Senior Living Community Training for Medical Students and Residents
16. Resolution 321 – Improving and Standardizing Pregnancy and Lactation Accommodations for Medical Board Examinations
17. Resolution 323 – Cultural Leave for American Indian Trainees
18. Resolution 324 – Sexual Harassment Accreditation Standards for Medical Training Programs
19. Resolution 325 – Single Licensing Exam Series for Osteopathic and Allopathic Medical Students
20. Resolution 326 – Standardized Wellness Initiative Reporting
Resolution 317 – Medical Student, Resident and Fellow Suicide Reporting
21. Resolution 327 – Leadership Training Must Become an Integral Part of Medical Education
22. Resolution 328 – Increasing Transparency of the Resident Physician Application Process

RECOMMENDED FOR REFERRAL

23. Resolution 304 – Accountable Organizations to Resident and Fellow Trainees
24. Resolution 305 – Reducing Overall Fees and Making Costs for Licensing, Exam Fees, Application Fees, etc., Equitable for IMGs
25. Resolution 306 – Creating a More Accurate Accounting of Medical Education Financial Costs
26. Resolution 314 – Support for Institutional Policies for Personal Days for Undergraduate Medical Students

RECOMMENDED FOR REFERRAL FOR DECISION

27. Resolution 308 – University Land Grant Status in Medical School Admissions

Resolutions handled via the Reaffirmation Consent Calendar:

Resolution 303 – Fatigue Mitigation Respite for Faculty and Residents

Resolution 311 – Discontinue State Licensure Requirement for COMLEX Level 2 PE

Resolution 312 – Reduce Financial Burden to Medical Students of Medical Licensure Examinations

Resolution 313 – Decreasing Medical Student Debt and Increasing Transparency in Cost of Medical School Attendance

Resolution 318 – CME for Preceptorship

Resolution 320 – Tuition Cost Transparency

RECOMMENDED FOR ADOPTION

- (1) COUNCIL ON MEDICAL EDUCATION REPORT 1 – COUNCIL ON MEDICAL EDUCATION SUNSET REVIEW OF 2012 HOUSE POLICIES

RECOMMENDATION:

Recommendations in Council on Medical Education Report 1 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Education Report 1 adopted and the remainder of report filed.

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

Your Reference Committee received limited yet supportive testimony on this item. Therefore, your Reference Committee recommends that the recommendations of Council on Medical Education Report 1 be adopted and the remainder of the report be filed.

- (2) COUNCIL ON MEDICAL EDUCATION REPORT 3 – ONSITE AND SUBSIDIZED CHILDCARE FOR MEDICAL STUDENTS, RESIDENTS AND FELLOWS (RESOLUTION 304-J-21, RESOLVE 3)

RECOMMENDATION:

Recommendations in Council on Medical Education Report 3 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Education Report 3 adopted and the remainder of report filed.

The Council on Medical Education therefore recommends that the following recommendations be adopted in lieu of Resolution 304-J-21, Resolve 3, and the remainder of this report be filed:

1. That our AMA recognize the unique childcare challenges faced by medical students, residents and fellows, which result from a combination of limited negotiating ability (given the matching process into residency), non-traditional work hours, extended or unpredictable shifts, and minimal autonomy in selecting their work schedules. (New HOD Policy)
2. That our AMA recognize the fiscal challenges faced by medical schools and graduate medical education institutions in providing onsite and/or subsidized childcare to students and employees, including residents and fellows. (New HOD Policy)
3. That our AMA encourage provision of onsite and/or subsidized childcare for medical students, residents, and fellows. (New HOD Policy)
4. That our AMA work with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, and American Association of Colleges of Osteopathic Medicine to identify barriers to childcare for medical trainees and innovative methods and best practices for instituting on-site and/or subsidized childcare that meets the unique needs of medical students, residents, and fellows. (Directive to Take Action)

Your Reference Committee received unanimously supportive testimony for this item. Testimony referenced current models for onsite childcare and the benefit they have provided for residents and trainees. Therefore, your Reference Committee recommends that the recommendations in Council on Medical Education Report 3 be adopted and the remainder of the report be filed.

(3) RESOLUTION 310 – SUPPORT FOR STANDARDIZED INTERPRETER TRAINING

RECOMMENDATION:

Resolution 310 be adopted.

HOD ACTION: Resolution 310 adopted.

RESOLVED, That our American Medical Association recognize the importance of using medical interpreters as a means of improving quality of care provided to patients with Limited English Proficiency (LEP) including patients with sensory impairments (New HOD Policy); and

RESOLVED, That our AMA encourage physicians and physicians in training to improve interpreter-use skills and increase education through publicly available resources such as the American Association of Medical College's "Guidelines for Use of Medical Interpreter Services" (New HOD Policy); and be it further

RESOLVED, That our AMA work with the Commission for Medical Interpreter Education, National Hispanic Medical Association, National Council of Asian Pacific Islander Physicians, National Medical Association, Association of American Indian Physicians, and other relevant stakeholders to develop a cohesive Continuing Medical Education module offered through the AMA Ed Hub for physicians to effectively and appropriately use interpreter services to ensure optimal patient care. (Directive to Take Action)

Your Reference Committee received testimony that was unanimously in support of this item. Online testimony was proffered with a suggestion that the AMA work with stakeholders on a national accreditation system of educational programs for interpreters, with these services provided at no cost to physicians, and with immunity from litigation for any physicians using these interpreters. Your Reference Committee believes that this language could have unintended legal consequences and would not be feasible to implement. It was also noted that the AMA is engaged with the Certification Commission for Healthcare Interpreters (CCHI); this relationship could provide an opportunity for implementation of this item. Therefore, your Reference Committee recommends that Resolution 310 be adopted as drafted.

(4) RESOLUTION 316 – PROVIDING TRANSPARENT AND ACCURATE DATA REGARDING STUDENTS AND FACULTY AT MEDICAL SCHOOLS

RECOMMENDATION:

Resolution 316 be adopted.

HOD ACTION: Resolution 316 adopted.

RESOLVED, That our American Medical Association work with the Liaison Committee on Medical Education and Commission on Osteopathic College Accreditation to encourage their respective accredited medical schools to make publicly available without charge transparent and accurately reported race and ethnicity demographic data regarding students and faculty. (Directive to Take Action)

Your Reference Committee received unanimous supportive testimony on this item. Therefore, your Reference Committee recommends that Resolution 316 be adopted.

(5) RESOLUTION 322 – STANDARDS IN CULTURAL HUMILITY TRAINING WITHIN MEDICAL EDUCATION

RECOMMENDATION:

Resolution 322 be adopted.

HOD ACTION: Resolution 322 adopted.

RESOLVED, That our AMA amend policy H-295.897, “Enhancing the Cultural Competence of Physicians,” by addition to read as follows:

Enhancing the Cultural Competence of Physicians H-295.897

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 and cultural humility, 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.
7. Our AMA supports the development of national standards for cultural humility training in the medical school curricula. (Modify Current HOD Policy)

Your Reference Committee received testimony that was unanimously supportive of adoption. Testimony indicated that proposed additions would strengthen existing policy. It was noted that cultural humility reflects self-evaluation and lifelong learning, and an attitude of change, versus cultural competence, which is more an endpoint (and thereby relatively limited in scope). The Council on Medical Education expressed support in the online testimony for research into the need for, and effectiveness of, training in cultural humility and acknowledged there is not an explicit curricular mandate in the additional language proffered. Therefore, your Reference Committee recommends that Resolution 322 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

(6) COUNCIL ON MEDICAL EDUCATION REPORT 2 – AN UPDATE ON CONTINUING BOARD CERTIFICATION

RECOMMENDATION A:

Recommendation 1 in Council on Medical Education Report 2 be amended by addition and deletion to read as follows:

1. (1), “Continue to monitor the evolution of Continuing Board Certification (CBC), continue its active engagement in discussions regarding their implementation, encourage specialty boards to investigate and/or establish alternative approaches for CBC, and prepare a ~~yearly~~ report ~~to the House of Delegates~~ regarding the CBC process at the request of the House of Delegates or when deemed necessary, as determined by the Council on Medical Education.”

RECOMMENDATION B:

Recommendations in Council on Medical Education Report 2 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Education Report 2 adopted as amended and the remainder of the report filed.

That our American Medical Association (AMA) amend Policy D-275.954 clauses 1, 22, and 38 by addition and deletion to read as follows:

1. (1), “Continue to monitor the evolution of Continuing Board Certification (CBC), continue its active engagement in discussions regarding their implementation, encourage specialty boards to investigate and/or establish alternative approaches for CBC, and prepare a ~~yearly~~ report to the House of Delegates regarding the CBC process, when necessary, as determined by the Council on Medical Education.”

2. (22), “Continue to participate in the Coalition for Physician Accountability, formerly known as the National Alliance for Physician Competence forums.”

3. (38), “Our AMA, through its Council on Medical Education, will continue to work with the American Board of Medical Specialties (ABMS) and ABMS member boards to implement key recommendations outlined by the Continuing Board Certification: Vision for the Future Commission in its final report, including the development and release of new, integrated standards for continuing certification programs ~~by 2020~~ that will address the Commission’s recommendations for flexibility in knowledge assessment and advancing practice, feedback to diplomates, and consistency.” (Modify Current HOD Policy)

Your Reference Committee received supportive testimony on this item which thanked the Council on Medical Education for its efforts to keep the AMA apprised of Continuing Board Certification (CBC). Your Reference Committee is assured that the Council is well suited to determine the cadence for this report as it continues to monitor CBC, and also acknowledges the purview of the House of Delegates to request a report. Therefore, your Reference Committee recommends that the recommendations of Council on Medical Education Report 2 be adopted as amended and the remainder of the report be filed.

- (7) COUNCIL ON MEDICAL EDUCATION REPORT 4 – PROTECTION OF TERMS DESCRIBING PHYSICIAN EDUCATION AND PRACTICE (RESOLUTION 305-J-21, ALTERNATE RESOLVE 2) RESOLUTION 329 – USE OF THE TERMS "RESIDENCY" AND "FELLOWSHIP" BY HEALTH PROFESSIONALS OUTSIDE OF MEDICINE

RECOMMENDATION A:

Recommendation 1 in Council on Medical Education Report 4 be amended by addition and deletion to read as follows:

1. That our AMA engage with academic institutions across the nation that develop educational programs for training of non-physicians in health care careers, and their associated professional organizations, to create alternative, clarifying nomenclature in place of “resident,” “residency,” “fellow,” “fellowship” and “attending” and other related terms to reduce confusion ~~with~~ among the public. (Directive to Take Action)

RECOMMENDATION B:

Recommendations in Council on Medical Education Report 4 be adopted as amended in lieu of Resolution 329 and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Education Report 4 adopted as amended in lieu of Resolution 329 and the remainder of the report filed.

Council on Medical Education Report 4:

The Council on Medical Education therefore recommends that the following recommendations be adopted in lieu of Resolution 305-J-21, Alternate Resolve 2, and the remainder of this report be filed:

1. That our AMA engage with academic institutions that develop educational programs for training of non-physicians in health care careers, and their associated professional organizations, to create alternative, clarifying nomenclature in place of “resident,” “residency,” “fellow,” “fellowship” and “attending” and other related terms to reduce confusion with the public. (Directive to Take Action)

2. That AMA Policy H-275.925, “Protection of the Titles ‘Doctor,’ ‘Resident’ and ‘Residency’” be amended by insertion and deletion as follows:

Our AMA: (1) will advocate that all health professionals in a clinical health care setting clearly and accurately ~~identify~~ communicate to patients and relevant others their qualifications, ~~and~~ degree(s) attained, and current training status within their training program; (2) ~~and~~ develop model state legislation for implementation to this effect; and (2) (3) supports state legislation that would make it a felony to misrepresent oneself as a physician (MD/DO); and (4) will expand efforts in educational campaigns that: a) address the differential education, training and licensure/certification requirements for non-physician health professionals versus physicians (MD/DO) and b) provide clarity regarding the role that physicians (MD/DO) play in providing patient care relative to other health professionals as it relates to nomenclature, qualifications, degrees attained and current training status. (Modify Current HOD Policy)

Resolution 329:

RESOLVED, That our American Medical Association hold a national discussion about the historical value and current nature of the terms “residency” and “fellowship” to describe physician postgraduate training and address the ramifications of nonphysician clinician groups using similar nomenclature that can confuse the general public. (Directive to Take Action)

Your Reference Committee received testimony in support of Council on Medical Education Report 4 and Resolution 329. Testimony recommended consistency on the use of “physician” versus “professional” as referenced in the Council on Ethical and Judicial Affairs Report 2-A-22 regarding Opinion 10.8 Collaborative Care, which was taken under advisement. Testimony from the author of Resolution 329 suggested amendment by addition to Recommendation 1 of Council on Medical Education Report 4 to include the language from its resolution, which asks our AMA to “hold a national discussion” on terms used to describe physician education, along with additional language regarding the significance of the terms (which was not offered in the original Resolution 329). Your Reference Committee acknowledged these amendments, which were supported by others in testimony and included language indicating that academic institutions across the country should engage in this discussion. Testimony also advocated that words matter and referred to current confusion among patients and health care professionals alike. It was also articulated that any national discussion regarding use of terminology to distinguish among health care professionals should include stakeholders beyond academic institutions and be inclusive of allied health professional organizations. Therefore, your Reference Committee recommends that Council on Medical Education Report 4 be adopted as amended in lieu of Resolution 329 and that the remainder of the report be filed.

- (8) COUNCIL ON MEDICAL EDUCATION REPORT 5 – EDUCATION, TRAINING, AND CREDENTIALING OF NON-PHYSICIAN HEALTH CARE PROVIDERS AND THEIR IMPACT ON PHYSICIAN EDUCATION AND TRAINING (RESOLUTION 305-J-21, RESOLVE 8)

RECOMMENDATION A:

Recommendation 4 in Council on Medical Education Report 5 be amended by addition and deletion, to read as follows:

4. That our AMA ~~encourage medical education work with key~~ regulatory bodies involved with physician education, accreditation, certification, licensing, and credentialing to a) increase transparency of the process by encouraging them to openly disclose how their board is composed and members are selected and b) review their conflict of interest and other policies related to non-physician health care professionals holding formal leadership positions (e.g., board, committee) when that non-physician professional represents a field that either possesses or seeks to possess the ability to practice without physician supervision. (Directive to Take Action)

RECOMMENDATION B:

Recommendations in Council on Medical Education Report 5 be adopted as amended and the remainder of the report be filed.

RECOMMENDATION C:

The title of Council on Medical Education Report 5 be changed, to read as follows:

EDUCATION, TRAINING, AND CREDENTIALING OF NON-PHYSICIAN HEALTH CARE PROFESSIONALS AND THEIR IMPACT ON PHYSICIAN EDUCATION AND TRAINING (RESOLUTION 305-J-21, RESOLVE 8)

HOD ACTION: Recommendations in Council on Medical Education Report 5 adopted as amended with a change in title.

EDUCATION, TRAINING, AND CREDENTIALING OF NON-PHYSICIAN HEALTH CARE PROFESSIONALS AND THEIR IMPACT ON PHYSICIAN EDUCATION AND TRAINING (RESOLUTION 305-J-21, RESOLVE 8)

The Council on Medical Education therefore recommends that the following recommendations be adopted in lieu of Resolve 8 of Resolution 305-J-21 and the remainder of this report be filed:

1. That our AMA support the concept that interprofessional education include a mechanism by which members of interdisciplinary teams learn about, with, and from each other; and that this education include learning about differences in the depth and breadth of their educational backgrounds, experiences, and knowledge and the impact these differences may have on patient care. (New HOD Policy)
2. That our AMA support a clear mechanism for medical school and appropriate institutional leaders to intervene when undergraduate and graduate medical education is being adversely impacted by undergraduate, graduate, and postgraduate clinical training programs of non-physicians. (New HOD Policy)
3. That Policies D-295.934, "Encouragement of Interprofessional Education Among Health Care Professions Students," and D-275.979, "Non-Physician 'Fellowship' Programs," be reaffirmed. (Reaffirm HOD Policy)
4. That our AMA encourage medical education regulatory bodies to review their conflict of interest and other policies related to non-physician health care professionals holding formal leadership positions (e.g., board, committee) when that non-physician professional represents a field that either possesses or seeks to possess the ability to practice without physician supervision. (Directive to Take Action)
5. That Policy D-275.949, "Non-Physician Postgraduate Medical Training," be rescinded, as having been accomplished by the writing of this report.

~~Our AMA will study and report back to the House of Delegates on curriculum, accreditation requirements, accrediting bodies, and supervising boards for undergraduate, graduate and postgraduate clinical training programs for non-physicians and the impact on undergraduate and graduate medical education. (Rescind HOD Policy)~~

Your Reference Committee received unanimous supportive testimony for this item. Several amendments were offered including removal of the word "provider" in the title and replacing with "professional" to be more in line with AMA policy; this amendment was supported in further online testimony and your Reference Committee agrees. There was also testimony to support increasing transparency on how boards of organizations choose members and handle conflicts of interest; an amendment offered to recommendation 4 addresses this concern. Additional amendments received by your Reference Committee proposed edits to Policy H-235.970, "Conflict of Interest Issues Related to Physician Medical Board and Staff Leaders"; however, this policy was not analyzed in the body of the original report and therefore does not merit inclusion in our recommendations. Testimony also suggested creation of a definition of "conflict of interest," but this is beyond the purview of your Reference Committee and the Council on Medical Education. Therefore, your Reference Committee recommends that Council on Medical Education Report 5 be adopted as amended with a change in title and that the remainder of the report be filed.

(9) COUNCIL ON MEDICAL EDUCATION REPORT 6 – CLINICAL APPLICATIONS OF PATHOLOGY AND LABORATORY MEDICINE FOR MEDICAL STUDENTS, RESIDENTS AND FELLOWS

RECOMMENDATION A:

Recommendations in Council on Medical Education Report 6 be amended by addition and deletion to read as follows:

~~(2) Our AMA will promote awareness of the Choosing Wisely initiative and encourage medical schools and their teaching hospitals to incorporate concepts from the campaign into their educational offerings.~~

(2) That our AMA work with relevant stakeholders, including specialty societies in the Federation of Medicine, such as the American Society for Clinical Pathology and College of American Pathologists, to promote educational

resources regarding appropriate test ordering and interpretation. (Modify Current HOD Policy)

RECOMMENDATION B:

Recommendations in Council on Medical Education Report 6 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Education Report 6 adopted as amended and the remainder of the report filed.

The Council on Medical Education therefore recommends that the following recommendations be adopted and the remainder of this report be filed:

1. That our AMA modify Policy D-155.988, “Support for the Concepts of the Choosing Wisely Program,” by addition to read as follows:

(1) Our AMA supports the concepts of the American Board of Internal Medicine Foundation's Choosing Wisely program.

(2) Our AMA will promote awareness of the Choosing Wisely initiative and encourage medical schools and their teaching hospitals to incorporate concepts from the campaign into their educational offerings. (Modify Current HOD Policy)

2. That our AMA rescind Policy D-295.930, “Clinical Applications of Pathology and Laboratory Medicine for Medical Students, Residents and Fellows,” as having been fulfilled by this report. (Rescind HOD Policy)

Your Reference Committee heard testimony in support for this item. Testimony also indicated a need for further educational resources on appropriate test ordering and interpretation. Your Reference Committee appreciates the information shared regarding the Choosing Wisely program; however, most testimony stood in support of the Council’s recommendations. An amendment was offered to add a new recommendation to increase the AMA’s ability to work with relevant stakeholders on the development of such education resources. The Council was receptive to this addition. Your Reference Committee agrees with the addition and therefore recommends that Council on Medical Education Report 6 be adopted as amended and the remainder of the report be filed.

(10) RESOLUTION 301 – MEDICAL EDUCATION DEBT CANCELLATION IN THE FACE OF A PHYSICIAN SHORTAGE DURING THE COVID-19 PANDEMIC

RECOMMENDATION A:

Resolution 301 be amended by deletion, to read as follows:

RESOLVED, That our American Medical Association study the issue of medical education debt cancellation and consider the opportunities for integration of this into a broader solution addressing debt for all medical students and physicians ~~in training, and early career~~. (Directive to Take Action)

RECOMMENDATION B:

Resolution 301 be adopted as amended.

HOD ACTION: Resolution 301 adopted as amended.

RESOLVED, That our American Medical Association study the issue of medical education debt cancellation and consider the opportunities for integration of this into a broader solution addressing debt for all medical students, physicians in training, and early career physicians. (Directive to Take Action)

Your Reference Committee heard unanimous testimony in support of the AMA undertaking a study on this issue, including testimony from the Council on Medical Education. An amendment was offered to be inclusive of physicians who may benefit from debt cancellation and are no longer at the early stage of their career. Therefore, your Reference Committee recommends that Resolution 301 be adopted as amended.

(11) RESOLUTION 302 – RESIDENT AND FELLOW ACCESS TO FERTILITY PRESERVATION

RECOMMENDATION A:

The first resolve of Resolution 302 be deleted:

~~RESOLVED, That our American Medical Association support education for residents and fellows regarding the natural course of female fertility in relation to the timing of medical education, and the option of fertility preservation and infertility treatment (New HOD Policy); and be it further~~

RECOMMENDATION B:

The second resolve of Resolution 302 be amended by addition and deletion, to read as follows:

RESOLVED, That our AMA ~~advocate inclusion of~~ encourage insurance coverage for fertility preservation and infertility treatment within health insurance benefits for residents and fellows offered through graduate medical education programs (Directive to Take Action); and be it further

RECOMMENDATION C:

The third resolve of Resolution 302 be amended by addition and deletion, to read as follows:

RESOLVED, That our AMA support the accommodation of residents and fellows who elect to pursue fertility preservation and infertility treatment, including but not limited to, the need to attend medical visits to complete the ~~oocyte~~ gamete preservation process and to administer medications in a time-sensitive fashion. (New HOD Policy)

RECOMMENDATION D:

Resolution 302 be adopted as amended.

HOD ACTION: Resolution 302 adopted as amended.

RESOLVED, That our American Medical Association support education for residents and fellows regarding the natural course of female fertility in relation to the timing of medical education, and the option of fertility preservation and infertility treatment (New HOD Policy); and be it further

RESOLVED, That our AMA advocate inclusion of insurance coverage for fertility preservation and infertility treatment within health insurance benefits for residents and fellows offered through graduate medical education programs (Directive to Take Action); and be it further

RESOLVED, That our AMA support the accommodation of residents and fellows who elect to pursue fertility preservation and infertility treatment, including the need to attend medical visits to complete the oocyte preservation process and to administer medications in a time-sensitive fashion. (New HOD Policy)

Your Reference Committee heard testimony in support of Resolution 302. The Council on Medical Education suggested the first resolve not be adopted given the implications of such education on an already busy curriculum. Also, the Council suggested the third resolve not be adopted because ACGME Common Program Requirements VI.C.1.d)(1) provides adequate coverage for these medical appointments; your Reference Committee, however, received significant testimony in support of retaining this language. Further, the Council suggested a minor amendment to the second resolve to support the original intent while maintaining consistency with current AMA policy by not requiring or mandating that graduate medical education programs provide this benefit. Your Reference Committee therefore recommends that Resolution 302 be adopted as amended.

(12) **RESOLUTION 307 – PARENTAL LEAVE AND PLANNING RESOURCES FOR MEDICAL STUDENTS**

RECOMMENDATION A:

AMA Policy H-405.960 be amended by addition in lieu of the second resolve to read as follows:

Our AMA encourages medical schools, residency programs, specialty boards, and medical group practices to incorporate into their parental leave policies a six-week minimum leave allowance, with the understanding that no parent should be required to take a minimum leave.

RECOMMENDATION B:

The third resolve of Resolution 307 be deleted:

~~RESOLVED, That our AMA encourage that medical schools formulate, and make readily available, plans for each year of schooling such that parental leave may be flexibly incorporated into the curriculum (New HOD Policy); and be it further~~

RECOMMENDATION C:

The fourth resolve of Resolution 307 be amended by addition and deletion, to read as follows:

RESOLVED, That our AMA work with key stakeholders to advocate that~~with~~urge medical schools to adopt policy that will prevent parties involved in medical training (including but not limited to residency programs, administration, fellowships, away rotations, physician evaluators, and research opportunities) do not discriminate ~~discriminating~~ against students who take family/parental leave (New HOD Policy); and be it further

RECOMMENDATION D:

Policy H-405.960(14) be reaffirmed in lieu of the fifth Resolve of Resolution 307.

RECOMMENDATION E:

Resolution 307 be adopted as amended.

HOD ACTION: Resolution 307 adopted as amended.

RESOLVED, That our American Medical Association encourage medical schools to create comprehensive informative resources that promote a culture that is supportive of their students who are parents, including information and policies on parental leave and relevant make up work, options to preserve fertility, breastfeeding, accommodations during pregnancy, and resources for childcare that span the institution and the surrounding area (New HOD Policy); and be it further

RESOLVED, That our AMA encourage medical schools to give students a minimum of 6 weeks of parental leave without academic or disciplinary penalties that would delay anticipated graduation based on time of matriculation (New HOD Policy); and be it further

RESOLVED, That our AMA encourage that medical schools formulate, and make readily available, plans for each year of schooling such that parental leave may be flexibly incorporated into the curriculum (New HOD Policy); and be it further

RESOLVED, That our AMA urge medical schools to adopt policy that will prevent parties involved in medical training (including but not limited to residency programs, administration, fellowships, away rotations, physician evaluators, and research opportunities) from discriminating against students who take family/parental leave (New HOD Policy); and be it further

RESOLVED, That our AMA advocate for medical schools to make resources and policies regarding family leave and parenthood transparent and openly accessible to prospective and current students. (Directive to Take Action)

Your Reference Committee received supportive testimony for the intent of this resolution. The Council on Medical Education recommended the following: adoption of the first resolve; amendment of AMA Policy H-405.960(4) in lieu of the second resolve to include “medical schools” thereby achieving the author’s stated goal; not adoption of the third resolve because most, if not all, medical schools already make a general schedule available for their curriculum and this resolved clause does not establish whether access to plans for the curriculum are a barrier to accessing parental leave services; amendment to the fourth resolve to include additional relevant stakeholders; and reaffirmation of Policy H-405.960(14) in lieu of the fifth resolve as it seeks to accomplish the same goal. Your Reference Committee recognizes that by amending AMA Policy H-405.960, it would essentially reaffirm the entire amended policy which eliminates the need to reaffirm it. Your Reference Committee appreciates the Council’s thorough analysis of this resolution and therefore recommends that Resolution 307 be adopted as amended.

Policy Recommended for Reaffirmation:

Policies for Parental, Family and Medical Necessity Leave H-405.960

AMA adopts as policy the following guidelines for, and encourages the implementation of, Parental, Family and Medical Necessity Leave for Medical Students and Physicians:

1. Our AMA urges medical schools, residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement.
2. Recommended components of parental leave policies for medical students and physicians include: (a) duration of leave allowed before and after delivery; (b) category of leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for continuation of insurance benefits during leave, and who pays the premium; (e) whether sick leave and vacation time may be accrued from year to year or used in advance; (f) how much time must be made up in order to be considered board eligible; (g) whether make-up time will be paid; (h) whether schedule accommodations are allowed; and (i) leave policy for adoption.
3. AMA policy is expanded to include physicians in practice, reading as follows: (a) residency program directors and group practice administrators should review federal law concerning maternity leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled; (b) staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other

physicians' workloads, particularly in residency programs; and (c) physicians should be able to return to their practices or training programs after taking parental leave without the loss of status.

4. Our AMA encourages residency programs, specialty boards, and medical group practices to incorporate into their parental leave policies a six-week minimum leave allowance, with the understanding that no parent should be required to take a minimum leave.

5. Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave.

6. Medical students and physicians who are unable to work because of pregnancy, childbirth, and other related medical conditions should be entitled to such leave and other benefits on the same basis as other physicians who are temporarily unable to work for other medical reasons.

7. Residency programs should develop written policies on parental leave, family leave, and medical leave for physicians. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); (d) whether leave is paid or unpaid; (e) whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (f) whether sick leave and vacation time may be accrued from year to year or used in advance; (g) extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (h) how time can be made up in order for a resident physician to be considered board eligible; (i) what period of leave would result in a resident physician being required to complete an extra or delayed year of training; (j) whether time spent in making up a leave will be paid; and (k) whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling.

8. Our AMA endorses the concept of equal parental leave for birth and adoption as a benefit for resident physicians, medical students, and physicians in practice regardless of gender or gender identity.

9. Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs.

10. Physicians should be able to return to their practices or training programs after taking parental leave, family leave, or medical leave without the loss of status.

11. Residency program directors must assist residents in identifying their specific requirements (for example, the number of months to be made up) because of leave for eligibility for board certification and must notify residents on leave if they are in danger of falling below minimal requirements for board eligibility. Program directors must give these residents a complete list of requirements to be completed in order to retain board eligibility.

12. Our AMA encourages flexibility in residency training programs, incorporating parental leave and alternative schedules for pregnant house staff.

13. In order to accommodate leave protected by the federal Family and Medical Leave Act, our AMA encourages all specialties within the American Board of Medical Specialties to allow graduating residents to extend training up to 12 weeks after the traditional residency completion date while still maintaining board eligibility in that year.

14. These policies as above should be freely available online and in writing to all applicants to medical school, residency or fellowship.

(13) **RESOLUTION 309 – DECREASING BIAS IN EVALUATIONS OF MEDICAL STUDENT PERFORMANCE**

RECOMMENDATION A:

The first resolve of Resolution 309 be amended by addition and deletion, to read as follows:

RESOLVED, That our American Medical Association work with appropriate stakeholders, such as the Liaison Committee on Medical Education and the Commission on Osteopathic College Accreditation to support: 1) increased

~~diversity and implementation of implicit bias training to individuals responsible for assessing medical students' performance, including the evaluation of professionalism and investigating and ruling upon disciplinary matters involving medical students; and 2) that all reviews of medical student professionalism and academic performance be conducted in a blinded manner when doing such does not interfere with appropriate scoring (Directive to Take Action); and be it further~~

RESOLVED, That our American Medical Association work with appropriate stakeholders to promote efforts to evaluate methods for decreasing the impact of bias in medical student performance evaluation as well as reducing the impact of bias in the review of disciplinary actions. (Directive to Take Action)

RECOMMENDATION B:

The second resolve of Resolution 309 be referred.

RECOMMENDATION C:

The remainder of Resolution 309 be adopted as amended.

HOD ACTION: First Resolve of Resolution 309 amended by addition and deletion and Second Resolve referred.

RESOLVED, That our American Medical Association work with appropriate stakeholders, such as the Liaison Committee on Medical Education and the Commission on Osteopathic College Accreditation to support: 1) increased diversity and implementation of implicit bias training to individuals responsible for assessing medical students' performance, including the evaluation of professionalism and investigating and ruling upon disciplinary matters involving medical students; and 2) that all reviews of medical student professionalism and academic performance be conducted in a blinded manner when doing such does not interfere with appropriate scoring (Directive to Take Action); and be it further

RESOLVED, That our AMA study the impact of two-interval clinical clerkship grading systems on residency application outcomes and clinical performance during residency. (Directive to Take Action)

Your Reference Committee received supportive testimony for this item. The Council on Medical Education recommended substitute language to allow the AMA to work with all appropriate stakeholders, as the organizations named in the resolution serve to accredit based upon adherence to broad-based policy recommendations rather than enforce any prescriptive standards. Also, the Council noted that the substitute language allows our AMA to evaluate mechanisms to reduce the impact of bias within the current landscape of medical education. The Council recommended deleting the second resolve given the difficulty in accessing the data needed to inform such a study. It was noted that work is underway via the Accelerating Change in Medical Education initiative looking at longitudinal tracking, as recently published in *Academic Medicine*. Your Reference Committee agrees with the rationale presented by the Council regarding the substitute language for the first resolve. Regarding the second resolve, your Reference Committee discussed the challenges faced by program directors, the delicate balance of wanting more data versus ensuring unbiased data, and concern for inequity in current grading models. Your Reference Committee felt that these concerns warrant study. Therefore, your Reference Committee recommends that Resolution 309 be adopted as amended and that the second resolve be referred.

(14) RESOLUTION 315 – MODIFYING ELIGIBILITY CRITERIA FOR THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES' FINANCIAL ASSISTANCE PROGRAM

RECOMMENDATION A:

Resolution 315 be amended by addition and deletion, to read as follows:

~~RESOLVED, That our American Medical Association encourage the Association of American Medical Colleges to conduct a study of the financial impact of the current Fee Assistance Program policy to medical school applicants. (New HOD Policy)~~

RESOLVED, That our AMA work with the Association of American Medical Colleges, American Association of Colleges of Osteopathic Medicine, and other appropriate stakeholders to study process reforms that could help mitigate the high cost of applying to medical school for low-income applicants, including better targeting application fee waivers through broadened eligibility criteria. (New HOD Policy)

RECOMMENDATION B:

Resolution 315 be adopted as amended.

RECOMMENDATION C:

The title of Resolution 315 be changed, to read as follows:

MODIFYING FINANCIAL ASSISTANCE ELIGIBILITY CRITERIA FOR MEDICAL SCHOOL APPLICANTS

HOD ACTION: Resolution 315 adopted as amended with a change in title.
MODIFYING FINANCIAL ASSISTANCE ELIGIBILITY CRITERIA
FOR MEDICAL SCHOOL APPLICANTS

RESOLVED, That our American Medical Association encourage the Association of American Medical Colleges to conduct a study of the financial impact of the current Fee Assistance Program policy to medical school applicants. (New HOD Policy)

Your Reference Committee received testimony in support of this item. The Council on Medical Education offered substitute language, such that the AMA work with appropriate stakeholders, including the Association of American Medical Colleges (AAMC) and American Association of Colleges of Osteopathic Medicine, to examine reforms to the financial assistance programs and other aspects of the medical school application process that might better ensure resources are targeted towards individuals struggling to afford the high costs of applying to medical school. The Council also acknowledged inclusion of the American Association of Colleges of Osteopathic Medicine Application Service Fee Waiver Program for osteopathic medical school applicants, alongside the AAMC program which was the focus of the original resolution. Your Reference Committee concurs with the Council and therefore recommends that substitute language be adopted as amended and that the title be changed to expand the scope of this resolution to incorporate both allopathic and osteopathic medical schools.

(15) RESOLUTION 319 – SENIOR LIVING COMMUNITY TRAINING FOR MEDICAL STUDENTS AND RESIDENTS

RECOMMENDATION A:

Resolution 319 be amended by addition and deletion, to read as follows:

~~RESOLVED, That our American Medical Association advocate to require training of medical students and residents in senior living communities (to include nursing homes and assisted living facilities) during their primary care rotations (internal medicine, family medicine and geriatric medicine). (Directive to Take Action)~~

RESOLVED, That our American Medical Association encourage development of opportunities for medical students and resident/fellow physicians to train in senior living communities (for example, nursing homes and assisted living facilities), as appropriate to the educational objectives of the program. (Directive to Take Action)

RECOMMENDATION B:

Resolution 319 be adopted as amended.

HOD ACTION: Resolution 319 adopted as amended.

RESOLVED, That our American Medical Association advocate to require training of medical students and residents in senior living communities (to include nursing homes and assisted living facilities) during their primary care rotations (internal medicine, family medicine and geriatric medicine). (Directive to Take Action)

Your Reference Committee received testimony in support of this item. Your Reference Committee acknowledged that such education and experience can benefit trainees as well as this growing patient population. Testimony noted concern that this resolution may be misconstrued as a curricular mandate, and that such education and experience may not be prioritized for all specialties. Your Reference Committee appreciates this sensitivity and offers substitute language which may address the concerns while also upholding the spirit of the resolution. Your Reference Committee recommends that Resolution 319 be adopted as amended.

(16) RESOLUTION 321 – IMPROVING AND STANDARDIZING PREGNANCY AND LACTATION ACCOMMODATIONS FOR MEDICAL BOARD EXAMINATIONS

RECOMMENDATION A:

The first resolve of Resolution 321 be amended by addition and deletion, to read as follows:

RESOLVED, That our American Medical Association support and advocate for the implementation of a minimum of 60 minutes of additional, scheduled break time for medical students and residents who have pregnancy complications and/or lactation needs ~~all test takers who are pregnant and/or lactating for during~~ all medical licensure and certification NBME-administered examinations; ~~consistent with American Board of Internal Medicine accommodations~~ (New HOD Policy); and be it further

RECOMMENDATION B:

The second resolve of Resolution 321 be amended by addition and deletion, to read as follows:

RESOLVED, That our AMA support and advocate for the addition of pregnancy comfort aids, including but not limited to; ginger teas, saltines, wastebaskets, and antiemetics, to any medical licensure or certification examination's ~~the~~ USMLE pre-approved list of Personal Item Exemptions (PIEs) permitted in the secure testing area for all test takers who are pregnant and/or lactating ~~individuals~~. (New HOD Policy)

RECOMMENDATION C:

Resolution 321 be adopted as amended.

HOD ACTION: Resolution 321 adopted as amended.

RESOLVED, That our American Medical Association support and advocate for the implementation of 60 minutes of additional, scheduled break time for medical students and residents who have pregnancy complications and/or lactation needs for all NBME administered examinations, consistent with American Board of Internal Medicine accommodations (New HOD Policy); and be it further

RESOLVED, That our AMA support and advocate for the addition of pregnancy comfort aids, including but not limited to, ginger teas, saltines, wastebaskets, and antiemetics, to the USMLE pre-approved list of Personal Item Exemptions (PIEs) permitted in the secure testing area for pregnant individuals. (New HOD Policy)

Your Reference Committee received testimony that was largely supportive. The Council on Medical Education recommended amendments to the first resolve to include all medical licensure and certification examinations, and to emphasize that 60 minutes be the minimum amount of break time. Similar amendments were also offered to the second resolve. Therefore, your Reference Committee recommends that Resolution 321 be adopted as amended.

(17) RESOLUTION 323 – CULTURAL LEAVE FOR AMERICAN INDIAN TRAINEES

RECOMMENDATION A:

The first resolve of Resolution 323 be amended by addition and deletion, to read as follows:

Eliminating Religious and Cultural Discrimination from Residency and Fellowship Programs and Medical Schools H-310.923

Our AMA encourages residency programs, fellowship programs, and medical schools to: (1) ~~make an effort to accommodate~~ allow residents' trainees to take leave and attend religious and cultural holidays and observances, ~~including those practiced by American Indians and Alaskan Natives~~, provided that patient care and the rights of other ~~residents~~ trainees are not compromised; and (2) explicitly inform applicants and entrants about their policies and procedures related to accommodation for religious and cultural holidays and observances; (Modify Current HOD Policy), and be it further

RECOMMENDATION B:

The second resolve of Resolution 323 be deleted:

~~RESOLVED, That our AMA will work with the Association of American Indian Physicians, Association of Native American Medical Students, and other appropriate stakeholders to design model cultural leave policies for undergraduate and graduate medical education programs and healthcare employers. (Directive to Take Action)~~

RECOMMENDATION C:

Resolution 323 be amended by addition of a new Resolve, to read as follows:

RESOLVED, Our AMA recognizes the importance of cultural identity in fostering trainee success and encourages residency programs, fellowship programs, and medical schools to accommodate cultural observances for trainees from American Indian, Alaska Native, and Native Hawaiian communities. (New HOD Policy)

RECOMMENDATION D:

Resolution 323 be adopted as amended.

HOD ACTION: Resolution 323 adopted as amended.

RESOLVED, That our AMA amend H-310.923, Eliminating Religious Discrimination from Residency Programs, by addition as follows:

Eliminating Religious and Cultural Discrimination from Residency and Fellowship Programs and Medical Schools
H-310.923

Our AMA encourages residency programs, fellowship programs, and medical schools to:

(1) ~~make an effort to accommodate~~ Allow residents' trainees to take leave and attend religious and cultural holidays and observances, including those practiced by American Indians and Alaskan Natives, provided that patient care and the rights of other ~~residents~~ trainees are not compromised; and (2) explicitly inform applicants and entrants about their policies and procedures related to accommodation for religious and cultural holidays and observances; (Modify Current HOD Policy) and be it further

RESOLVED, That our AMA will work with the Association of American Indian Physicians, Association of Native American Medical Students, and other appropriate stakeholders to design model cultural leave policies for undergraduate and graduate medical education programs and employers. (Directive to Take Action)

Your Reference Committee received supportive testimony for this item. Amendments were proffered by the MSS Committee on American Indian Affairs (CAIA) and the Council on Medical Education to the first resolve to delete “including those practiced by American Indians and Alaskan Natives,” as well as a substitute second resolve to recognize the political relationship between the United States and American Indian, Alaska Native, and Native Hawaiian communities and affirms greater institutional support for American Indian, Alaska Native, and Native Hawaiian trainees across the medical education continuum, so that these trainees may then go back and serve their communities through culturally responsive medical practice. Further testimony supported the amendments. Therefore, your Reference Committee recommends that Resolution 323 be adopted as amended.

(18) RESOLUTION 324 – SEXUAL HARASSMENT ACCREDITATION
STANDARDS FOR MEDICAL TRAINING PROGRAMS

RECOMMENDATION A:

The first resolve of Resolution 324 be amended by addition and deletion, to read as follows:

RESOLVED, That our AMA encourage ~~the LCME and ACGME~~ key stakeholders to create a standard for accreditation that includes sexual harassment training, policies, and repercussions for sexual harassment in undergraduate and graduate medical education programs; (Directive to Take Action) and be it further

RECOMMENDATION B:

The second resolve of Resolution 324 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA encourage ~~the LCME and ACGME~~ key stakeholders to assess: 1) medical trainees’ perception of institutional culture regarding sexual harassment and preventative trainings and 2) sexual harassment

prevalence, reporting, investigation of allegations, and Title IX resource utilization in order to recommend best practices. (Directive to Take Action)

RECOMMENDATION C:

Resolution 324 be adopted as amended.

RECOMMENDATION D:

The title of Resolution 324 be changed, to read as follows:

ACCREDITATION STANDARDS TO ADDRESS SEXUAL HARASSMENT
IN MEDICAL TRAINING PROGRAMS

HOD ACTION: Resolution 324 adopted as amended with a change in title.
ACCREDITATION STANDARDS TO ADDRESS SEXUAL
HARASSMENT IN MEDICAL TRAINING PROGRAMS

RESOLVED, That our AMA encourage the LCME and ACGME to create a standard for accreditation that includes sexual harassment training, policies, and repercussions for sexual harassment in undergraduate and graduate medical programs; (Directive to Take Action) and be it further

RESOLVED, That our AMA encourage the LCME and ACGME to assess: 1) medical trainees' perception of institutional culture regarding sexual harassment and preventative trainings and 2) sexual harassment prevalence, reporting, investigation of allegations, and Title IX resource utilization in order to recommend best practices. (Directive to Take Action)

Your Reference Committee received testimony that was supportive and acknowledges the importance of the provision and maintenance of a safe environment for all trainees. The Council on Medical Education referenced the policies and safeguards developed by the AMA, LCME, ACGME, AOA, and COCA at all levels of training throughout the educational continuum. While the Council recommended that AMA Policy H-295.955 be reaffirmed in lieu of this resolution, testimony noted that this policy is only focused on teachers and learners, which does not cover the full spectrum of sexual harassment. Minor edits are proffered to incorporate "key stakeholders," versus attempting to list the totality of relevant organizations for this issue, to provide flexibility for our AMA staff in operationalizing the asks of this item. Testimony also noted that the title may need to be reworded in light of potential misinterpretation. Your Reference Committee appreciates the sensitive nature of this resolution and therefore recommends that Resolution 324 be adopted as amended with a change in title.

(19) RESOLUTION 325 – SINGLE LICENSING EXAM SERIES FOR
OSTEOPATHIC AND ALLOPATHIC MEDICAL STUDENTS

RECOMMENDATION A:

Resolution 325 be amended by addition, to read as follows:

RESOLVED, That our AMA work with key stakeholders to encourage the development of a single licensing examination series for all medical students attending a medical school accredited by the Liaison Committee on Medical Education (LCME) or the Commission on Osteopathic College Accreditation (COCA), with a separate, additional osteopathic-specific subject test for osteopathic medical students. (Directive to Take Action)

RECOMMENDATION B:

Resolution 325 be adopted as amended.

HOD ACTION: Resolution 325 adopted as amended.

RESOLVED, That our AMA encourage the development of a single licensing examination series for all medical students attending a medical school accredited by the Liaison Committee on Medical Education (LCME) or the Commission on Osteopathic College Accreditation (COCA), with a separate, additional osteopathic-specific subject test for osteopathic medical students. (Directive to Take Action)

Your Reference Committee received online testimony that was largely supportive of this item, with the exception of the National Board of Osteopathic Medical Examiners (NBOME) and the American Osteopathic Association, both of which expressed opposition to adoption. The NBOME testimony noted differences in osteopathic versus allopathic education, called attention to perceived bias against DO versus MD graduates in residency program selection, and encouraged equitable and fair treatment of all applicants. Your Reference Committee considered concerns raised by members of the financial hardship placed upon osteopathic trainees that perceive a need to take both the USMLE and the COMLEX exams in order to be competitive among their peers seeking a residency program slot and the importance of assessing competencies related to Osteopathic Philosophy/Osteopathic Manipulative Medicine for osteopathic students. Your Reference Committee also believes that policies such as H-275.953, The Grading Policy for Medical Licensure Examinations, are helping to shift the culture of medical education, and this resolution builds upon that shift. Your Reference Committee agrees that these are real issues and appreciates the engagement of the NBOME, and believes that this resolution could provide opportunities to work with key stakeholders to develop new assessment tools that reduce cost burdens for osteopathic trainees and assess competencies related to their unique training. Therefore, your Reference Committee recommends that Resolution 325 be adopted as amended.

- (20) RESOLUTION 326 – STANDARDIZED WELLNESS INITIATIVE REPORTING
RESOLUTION 317 – MEDICAL STUDENT, RESIDENT AND FELLOW SUICIDE REPORTING

RECOMMENDATION A:

Resolution 326 be amended by addition and deletion, to read as follows:

RESOLVED, That our AMA amend Study of Medical Student, Resident, and Physician Suicide D-345.983 as follows:

D-345.983 – STUDY OF MEDICAL STUDENT, RESIDENT, AND PHYSICIAN SUICIDE

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, the American Association of Colleges of Osteopathic Medicine, 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~~ substance use disorders, and attempted and completed suicide among physicians, residents, and medical students-; and (5) work with appropriate stakeholders to explore the viability of developing a standardized reporting mechanism for the collection of current wellness initiatives that institutions have in place to inform and promote meaningful mental health and wellness interventions in these populations. (Modify Current HOD Policy)

RECOMMENDATION B:

Resolution 326 be adopted as amended in lieu of Resolution 317.

HOD ACTION: Resolution 326 adopted as amended in lieu of Resolution 317.

Resolution 326:

RESOLVED, That our AMA amend Study of Medical Student, Resident, and Physician Suicide D-345.983 as follows:

D-345.983 – STUDY OF MEDICAL STUDENT, RESIDENT, AND PHYSICIAN SUICIDE

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, the American Association of Colleges of Osteopathic Medicine, 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) work with appropriate stakeholders to explore the viability of developing a standardized reporting mechanism for the collection of current wellness initiatives that institutions have in place to inform and promote meaningful mental health and wellness interventions in these populations. (Modify Current HOD Policy)

Resolution 317:

RESOLVED, That our American Medical Association amend Policy D-345.983 by addition to read 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, the American Association of Colleges of Osteopathic Medicine, 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-; (5) work with appropriate stakeholders to develop a standardized reporting mechanism for the confidential collection of pertinent suicide information of trainees in medical schools, residency, and fellowship programs, along with current wellness initiatives, to inform and promote meaningful interventions at these institutions; and (6) create a publicly accessible database that stratifies medical institutions based on relative rate of trainee suicide over a period of time, in order to raise awareness and promote the implementation of initiatives to prevent medical trainee suicide, while maintaining confidentiality of the deceased. (Modify Current HOD Policy)

Your Reference Committee noted that both Resolutions 326 and 317 seek to amend the same policy in a similar fashion, with one focused on wellness promotion and the second on suicide prevention. Your Reference Committee received testimony in support of the spirit of both resolutions. While your Reference Committee acknowledged the intent of Resolution 317 and the need to address the troubling rise in suicide among medical students and resident/fellow physicians, some testimony expressed concern for the sensitivity and confidentiality of these data, the difficulty in obtaining accurate cause of death statistics, the use of the data, and the challenge of achieving a

balance between respecting privacy while promoting action. In addition, concerns were voiced that the proposed new sixth clause of this resolution could inadvertently stigmatize mental health among students and trainees, discourage an institution from addressing these problems, and cause misperceptions as to that institution's commitment to an environment of wellness. Your Reference Committee believes that Resolution 326 accomplishes the overall goals of both resolutions without amplifying the concerns raised regarding Resolution 317. Testimony also supported consideration of suicide attempts. The Reference Committee noted that changes to language in The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition uses "substance use disorder" instead of "addiction"; therefore, your Reference Committee included an amendment to update AMA Policy D-345.983. In sum, your Reference Committee recommends that amended Resolution 326 be adopted in lieu of Resolution 317.

(21) RESOLUTION 327 – LEADERSHIP TRAINING MUST BECOME AN INTEGRAL PART OF MEDICAL EDUCATION

RECOMMENDATION A:

The first resolve of Resolution 327 be amended by deletion, to read as follows:

RESOLVED, That our American Medical Association study the extent of the impact of AMA Policy D-295.316, "Management and Leadership for Physicians," on elective curriculum ~~and provide a report at the interim annual meeting~~ (Directive to Take Action); and be it further

RECOMMENDATION B:

The second resolve of Resolution 327 be amended by addition and deletion, to read as follows:

RESOLVED, That our AMA expand efforts to promote advocate for the implementation of concrete steps to incorporate leadership training as an integral part of the core curriculum of medical school education, post- the tenets of health systems science to prepare trainees for leadership roles and address prevalent challenges in the practice of medicine and public health.

RECOMMENDATION C:

Resolution 327 be adopted as amended.

HOD ACTION: Resolution 327 adopted as amended.

RESOLVED, That our American Medical Association study the extent of the impact of AMA Policy D-295.316, "Management and Leadership for Physicians," on elective curriculum and provide a report at the interim meeting (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for the implementation of concrete steps to incorporate leadership training as an integral part of the core curriculum of medical school education, post-graduate training, and for practicing physicians.

Your Reference Committee received supportive testimony on the need for physician leaders and the development of necessary leadership and communication skills, which aligns with our AMA's work to inculcate health systems science throughout the medical education curriculum as part of its Accelerating Change in Medical Education initiative. Testimony was offered by the Council on Medical Education regarding the timing of the study called for in the resolution, given the policy backlog due to two years of virtual meetings, which limited items of business. Testimony also noted that study of this issue is important and should be prioritized above the second resolve. Following this study, your Reference Committee thought that consideration should be given to the implementation of the findings as related to leadership training across the professional continuum. Therefore, your Reference Committee recommends that Resolution 327 be adopted as amended.

(22) RESOLUTION 328 – INCREASING TRANSPARENCY OF THE RESIDENT PHYSICIAN APPLICATION PROCESS

RECOMMENDATION A:

Resolution 328 be amended by addition and deletion, to read as follows:

That our American Medical Association work with appropriate, and interested stakeholders, to study options for improving transparency in the resident application process. (Directive to Take Action)

RECOMMENDATION B:

Resolution 328 be adopted as amended.

HOD ACTION: Resolution 328 adopted as amended.

RESOLVED, That our American Medical Association, and interested stakeholders, study options for improving transparency in the resident application process. (Directive to Take Action)

Your Reference Committee received supportive testimony on Resolution 328, which seeks to lessen the growing burden on residency program personnel and applicants alike and increase the odds of a more holistic review process, which has the added benefit of improved diversity of entrants into graduate medical education and, ultimately, the physician workforce. Testimony raised concerns regarding the need to facilitate increased transparency and accountability for protecting the rights and well-being of resident and fellow trainees. A minor amendment was offered that supports the intent of the resolution. Therefore, your Reference Committee recommends that Resolution 328 be adopted as amended.

RECOMMENDED FOR REFERRAL

(23) RESOLUTION 304 – ACCOUNTABLE ORGANIZATIONS TO RESIDENT AND FELLOW TRAINEES

RECOMMENDATION:

Resolution 304 be referred.

HOD ACTION: Resolution 304 referred.

RESOLVED, That our American Medical Association work with relevant stakeholders to: (1) determine which organizations or governmental entities are best suited for being permanently responsible for resident and fellow interests without conflicts of interests; (2) determine how organizations can be held accountable for fulfilling their duties to protect the rights and wellbeing of resident and fellow trainees as detailed in the Residents and Fellows' Bill of Rights; (3) determine methods of advocating for residents and fellows that are timely and effective without jeopardizing trainees' current and future employability; (4) study and report back by the 2023 Annual Meeting on how such an organization may be created, in the event that no organizations or entities are identified that meet the above criteria; and (5) determine transparent methods to communicate available residency positions to displaced residents. (Directive to Take Action)

Your Reference Committee received mixed testimony on this item. While the fourth resolve specifically asks for study, the Council on Medical Education recommended that the entire resolution be referred to properly address house staff representation as well as transparent methods for communicating available training positions to displaced trainees. The balance of testimony agreed as to the complexity of the issue and with referral for study. Additionally, your Reference Committee recommends that time for completion of a study should be determined by the Council on Medical Education. Therefore, your Reference Committee recommends that Resolution 304 be referred.

(24) RESOLUTION 305 – REDUCING OVERALL FEES AND MAKING COSTS FOR LICENSING, EXAM FEES, APPLICATION FEES, ETC., EQUITABLE FOR IMGs

RECOMMENDATION:

Resolution 305 be referred.

HOD ACTION: Resolution 305 referred.

RESOLVED, That our American Medical Association work with all relevant stakeholders to reduce application, exam, licensing fees and related financial burdens for international medical graduates (IMGs) to ensure cost equity with US MD and DO trainees (Directive to Take Action); and be it further

RESOLVED, That our AMA amend current policy H-255.966, "Abolish Discrimination in Licensure of IMGs," by addition to read as follows:

2. Our AMA will continue to work with the FSMB to encourage parity in licensure requirements, and associated costs, for all physicians, whether U.S. medical school graduates or international medical graduates. (Modify Current HOD Policy)

Your Reference Committee received testimony in support of this item. The Council on Medical Education noted concern that there may be an unintended consequence which could stimulate debate on the total costs of medical education, of which licensing fees constitute a small portion. The Council offered substitute language for the first resolve asking the AMA to study the most equitable approach to achieving parity between US MD and DO trainees and international medical graduates with regard to application, exam, licensing fees and related financial burdens; they also suggested the second resolve be not adopted. Your Reference Committee encourages the Council to consider the presence and nature of differential application and examination costs for US medical graduate and IMG

applicants. Your Reference Committee appreciates the recognition of the need for study and therefore recommends that Resolution 305 be referred.

(25) RESOLUTION 306 – CREATING A MORE ACCURATE ACCOUNTING OF MEDICAL EDUCATION FINANCIAL COSTS

RECOMMENDATION:

Resolution 306 be referred.

HOD ACTION: Resolution 306 referred.

RESOLVED, That our American Medical Association study the costs of medical education, taking into account medical student tuition and accrued loan interest, to come up with a more accurate description of medical education financial costs. (Directive to Take Action)

Your Reference Committee received mixed testimony on this item. Testimony expressed concern that there would be numerous variables associated with medical student tuition and accrued loan interest and that the issue is more complex than it might initially appear. An amendment was offered to specify the intent of this resolution. The Council on Medical Education recommended that AMA Policy D-305.984 be reaffirmed in lieu of this resolution as it already addresses the purpose of Resolution 306. Your Reference Committee recognizes that the ability to absorb unexpected costs represents an underlying equity issue in medical education. There may be value in a study of models across different types of institutions and geographic areas (e.g., public versus private school, urban versus rural, and allopathic versus osteopathic). Therefore, your Reference Committee recommends that Resolution 306 be referred so that the totality of medical education financial costs to students can be studied.

(26) RESOLUTION 314 – SUPPORT FOR INSTITUTIONAL POLICIES FOR PERSONAL DAYS FOR UNDERGRADUATE MEDICAL STUDENTS

RECOMMENDATION:

Resolution 314 be referred.

HOD ACTION: Resolution 314 referred.

RESOLVED, That our American Medical Association encourage medical schools to accept flexible uses for excused absences from clinical clerkships (New HOD Policy); and be it further

RESOLVED, That our AMA support a clearly defined number of easily accessible personal days for medical students per academic year, which should be explained to students at the beginning of each academic year and a subset of which should be granted without requiring an explanation on the part of the students. (New HOD Policy)

Your Reference Committee received mixed testimony on this item. The Council on Medical Education recommended that AMA Policy D-310.968 be reaffirmed and amended in lieu of Resolution 314, such that the key elements of the first resolve be added to Policy D-310.968(3) and the second resolve be added as a new tenth clause of Policy D-310.968(10). Some testimony indicated support for this resolution, while others recommended referral for further study due to concerns that using excessive personal days during a given clerkship could have significant repercussions on the quality of education. While your Reference Committee supports use of personal days by medical students, it was noted that determining a defined number of personal days per academic year may be difficult given the variances across medical schools. Your Reference Committee appreciates the recommendation from the Council and therefore recommends that Resolution 314 be referred.

RECOMMENDED FOR REFERRAL FOR DECISION

(27) RESOLUTION 308 – UNIVERSITY LAND GRANT STATUS IN MEDICAL SCHOOL ADMISSIONS

RECOMMENDATION:

Resolution 308 be referred for decision.

HOD ACTION: Resolution 308 referred for decision.

RESOLVED, That our American Medical Association 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 (Directive to Take Action); and be it further

RESOLVED, That our AMA amend Policy H-350.981, “AMA Support of American Indian Health Career Opportunities,” by addition to read as follows:

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 greater number of 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. (Modify Current HOD Policy)

Your Reference Committee received testimony in support of this item. Amendments were offered to clarify and strengthen the resolution. The Council on Medical Education recommended that some of the clauses in this resolution be referred for decision due to concerns about legal implications related to the current status of both federal and state laws regarding affirmative action. It was noted that the correct term is “Alaska Native,” not “Alaskan,” and that COCA was missing from the first resolve. Amendments were offered by the Medical Student

Section with clarifying language on the term “land grant” as it relates to the scope of the resolution. These amendments will be shared with our Board of Trustees as it deliberates this item and reaches a decision. Your Reference Committee acknowledged the sensitivities regarding this important matter and echoed the concerns cited by the Council. Therefore, your Reference Committee recommends referral for decision.

REPORT OF REFERENCE COMMITTEE D

Your reference committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Council on Science and Public Health Report 1 – Sunset Review of 2012 House Policies
2. Council on Science and Public Health Report 2 – Transformation of Rural Community Public Health Systems
3. Resolution 412 – Advocating for the Amendment of Chronic Nuisance Ordinances
4. Resolution 415 – Creation of an Obesity Task Force
5. Resolution 417 – Tobacco Control
6. Resolution 418 – Lung Cancer Screening Awareness
7. Resolution 421 – Screening for HPV-Related Anal Cancer
8. Resolution 424 – Physician Interventions Addressing Environmental Health and Justice
9. Resolution 427 – Pictorial Health Warnings on Alcoholic Beverages
10. Resolution 428 – Amending H-90.968 to Expand Policy on Medical Care of Persons with Disabilities
11. Resolution 429 – Increasing Awareness and Reducing Consumption of Food and Drink of Poor Nutritional Quality
12. Resolution 432 – Recognizing Loneliness as a Public Health Issue
13. Resolution 433 – Support for Democracy
14. Resolution 434 – Support for Pediatric Siblings of Chronically Ill Children
15. Resolution 438 – Informing Physicians, Health Care Providers, and the Public of the Health Dangers of Fossil-Fuel Derived Hydrogen
16. 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
17. Resolution 442 – Opposing the Censorship of Sexuality and Gender Identity Discussions in Public Schools

RECOMMENDED FOR ADOPTION AS AMENDED

18. Resolution 401 – Air Quality and the Protection of Citizen Health
19. Resolution 403 – Addressing Maternal Discrimination and Support for Flexible Family Leave
20. Resolution 404 – Weapons in Correctional Healthcare Settings
21. Resolution 405 – Universal Childcare and Preschool
22. Resolution 406 – COVID-19 Preventive Measures for Correctional Facilities: AMA Policy Position
23. Resolution 407 – Study of Best Practices for Acute Care of Patients in the Custody of Law Enforcement or Corrections
24. Resolution 408 – Supporting Increased Research on Implementation of Nonviolent De-escalation Training and Mental Illness Awareness in Law Enforcement
25. Resolution 410 – Increasing Education for School Staff to Recognize Prodromal Symptoms of Schizophrenia in Teens and Young Adults to Increase Early Intervention
26. Resolution 411 – Anonymous Prescribing Option for Expedited Partner Therapy
27. Resolution 413 – Expansion on Comprehensive Sexual Health Education
28. Resolution 414 – Improvement of Care and Resource Allocation for Homeless Persons in the Global Pandemic
29. Resolution 422 – Voting as a Social Determinant of Health
30. Resolution 425 – Mental Health Crisis
31. Resolution 431 – Protections for Incarcerated Mothers and Infants in the Perinatal Period
32. Resolution 436 – Training and Reimbursement for Firearm Safety Counseling
33. Resolution 440 – Addressing Social Determinants of Health Through Health IT
34. Resolution 441 – Addressing Adverse Effects of Active Shooter Drills on Children's Health
35. Resolution 443 – Addressing the Longitudinal Healthcare Needs of American Indian Children in Foster Care

RECOMMENDED FOR ADOPTION IN LIEU OF

- 36. Resolution 420 – Declaring Climate Change a Public Health Crisis
Resolution 430 – Longitudinal Capacity-Building to Address Climate Action and Justice
- 37. Resolution 423 – Awareness Campaign for 988 National Suicide Prevention Lifeline
- 38. Resolution 437 – Air Pollution and COVID: A Call to Tighten Regulatory Standards for Particulate Matter

RECOMMENDED FOR REFERRAL

- 39. Board of Trustees Report 15 – Addressing Public Health Disinformation
- 40. Resolution 416 – School Resource Officer Violence De-Escalation Training and Certification

RECOMMENDED FOR NOT ADOPTION

- 41. Resolution 402 – Support for Impairment Research
- 42. Resolution 435 – Support Removal of BMI as a Standard Measure in Medicine and Recognizing Culturally-Diverse and Varied Presentations of Eating Disorders

RECOMMENDED FOR ADOPTION

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

RECOMMENDATION:

Recommendation in Council on Science and Public Health Report 1 be adopted.

HOD ACTION: Recommendation in Council on Science and Public Health Report 1 adopted.

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)

The Council introduced their 2012 sunset report. Testimony on the Council's recommendations for disposition of 2012 House of Delegates policies was limited to individual comments. With limited testimony along with the nature of the sunset report it is surmised that amendments should not change the intent of the policy, your Reference Committee recommends that Council on Science and Public Health Report 1 be adopted.

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

RECOMMENDATION:

Recommendations in Council on Science and Public Health Report 2 be adopted.

HOD ACTION: Recommendations in Council on Science and Public Health Report 2 adopted.

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.~~

2. That our AMA amend Policy D-440.924, "Universal Access for Essential 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)

3. That our AMA reaffirm Policy H-478.980, "Increasing Access to Broadband Internet to Reduce Health Disparities." (Reaffirm HOD Policy)

Testimony provided was supportive of the Council's report and recommendations. The Council was commended for addressing rural public health and the need for adequate and sustained funding. It was also noted that appropriate models for delivering public health in rural areas are needed and that the concerns outlined in the report are applicable to other underserved areas as well. Your Reference Committee recommends adoption of the report's recommendations.

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

RECOMMENDATION:

Resolution 412 be adopted.

HOD ACTION: Resolution 412 adopted.

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)

Your Reference Committee heard supportive testimony on Resolution 412. Testimony provided noted the negative impact that nuisance ordinances can have, penalizing individuals for needing help for their safety. It was noted that this is a particular concern for people experiencing domestic violence. Therefore, your Reference Committee recommends that Resolution 412 be adopted.

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

RECOMMENDATION:

Resolution 415 be adopted.

HOD ACTION: Resolution 415 referred for decision.

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)

Your Reference Committee heard overwhelming testimony in support of forming an obesity task force. It was noted that 42 percent of Americans have obesity, with 330,000 Americans dying annually from obesity-related causes. Disparities exist in access to care for patients with obesity, and weight bias in clinical settings needs to be addressed. A member of the Board of Trustees testified that it would be better to defer strategy-related decisions to the Board and implementation decisions to Senior Management as opposed to creating a task force. Given the favorable testimony specifically regarding the creation of a task force, your Reference Committee recommends that Resolution 415 be adopted and will defer to the newly created task force to determine its scope relative to the proposed amendments regarding prevention and treatment.

(5) RESOLUTION 417 – TOBACCO CONTROL

RECOMMENDATION:

Resolution 417 be adopted.

HOD ACTION: Resolution 417 adopted.

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 (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 (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 (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)

Your Reference Committee heard limited testimony that was supportive of this amendment to AMA policy. Therefore, your Reference Committee recommends that Resolution 417 be adopted.

(6) RESOLUTION 418 – LUNG CANCER SCREENING AWARENESS

RECOMMENDATION:

Resolution 418 be adopted.

HOD ACTION: Resolution 418 adopted.

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)

Your Reference Committee heard testimony in support of this resolution and the role of lung cancer screening in promoting public health given that lung cancer is the leading cause of cancer death. Your Reference Committee recommends that Resolution 418 be adopted.

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

RECOMMENDATION:

Resolution 421 be adopted.

HOD ACTION: Resolution 421 adopted.

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)

Your Reference Committee heard testimony in support of Resolution 421. It was noted that preventing HPV-related cancers, particularly within populations such as men who have sex with men and HIV-infected patient population, is essential. It was also noted that the U.S. Preventive Services Task Force should be encouraged to conduct an evidence-based review and establish screening guidelines for anal cancer. Amendments were proffered noting various cancers associated with HPV and the need for education on HPV vaccination. Your Reference Committee noted that the intent of the resolution was to focus on anal cancers and the offered amendments would broaden the scope. Therefore, your Reference Committee recommends that Resolution 421 be adopted.

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

RECOMMENDATION:

Resolution 424 be adopted.

HOD ACTION: Resolution 424 adopted.

RESOLVED, That our American Medical Association amend policy H-135.938, “Global Climate Change and Human Health,” by addition to read as follows: Our AMA: 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 was supportive, noting that environmental factors are causing detrimental effects on human health. Encouraging physicians to assess for environmental factors could help improve health outcomes. Therefore, your Reference Committee recommends adoption.

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

RECOMMENDATION:

Resolution 427 be adopted.

HOD ACTION: Resolution 427 adopted.

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)

Your Reference Committee heard limited, but supportive testimony on this resolution. It was noted that pictorial warnings are ten times more effective at raising awareness than written warnings and would be beneficial for people with low literacy. Therefore, your Reference Committee recommends that Resolution 427 be adopted.

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

RECOMMENDATION:

Resolution 428 be adopted.

HOD ACTION: Resolution 428 adopted.

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 D~~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 (~~HDD~~) 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)

Your Reference Committee heard testimony in support of broadening the range of disabilities listed in current AMA policy. It was noted that improving the quality of education in medical schools for those with disabilities is critical. Therefore, your Reference Committee recommends that Resolution 428 be adopted.

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

RECOMMENDATION:

Resolution 429 be adopted.

HOD ACTION: Resolution 429 adopted.

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)

Your Reference Committee heard limited testimony in favor of this resolution, noting that seventy percent of kids’ nutrition is now derived from ultra-processed food. It was also noted that advertising heavily informs children’s food knowledge, preferences, and consumption patterns that can lead to excess calorie intake. Therefore, your Reference Committee recommends that Resolution 429 be adopted.

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

RECOMMENDATION:

Resolution 432 be adopted.

HOD ACTION: Resolution 432 adopted.

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)

Testimony presented was strongly supportive of this resolution, noting that there is a growing body of research demonstrating a strong link between social isolation and loneliness and adverse health outcomes. The Surgeon General of the United States has noted that loneliness is a public health concern and is the root cause of a number of epidemics. It was also noted that recognizing loneliness as a public health issue is the best next step in combating loneliness. Your Reference Committee agrees and recommends adoption as amended.

(13) RESOLUTION 433 – SUPPORT FOR DEMOCRACY

RECOMMENDATION:

Resolution 433 be adopted.

HOD ACTION: Resolution 433 adopted.

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)

Your Reference Committee heard testimony in support of this resolution, noting the importance of having policy in place to speak out in favor of democracy should civil unrest occur in the future. Therefore, your Reference Committee recommends that Resolution 433 be adopted.

(14) RESOLUTION 434 – SUPPORT FOR PEDIATRIC SIBLINGS OF CHRONICALLY ILL CHILDREN

RECOMMENDATION:

Resolution 434 be adopted.

HOD ACTION: Resolution 434 adopted.

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 was supportive, stating that it is important to ensure support and resources are provided to family members and siblings of chronically ill pediatric patients, a subset of the population with nuances that deserve to be addressed. Interventions exist that have demonstrated positive outcomes for the children who participated, including improvement in emotional, physical, and self-esteem functioning. Therefore, your Reference Committee recommends adoption.

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

RECOMMENDATION:

Resolution 438 be adopted.

HOD ACTION: Resolution 438 adopted.

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 on this resolution 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. Therefore, your Reference Committee recommends adoption.

(16) 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

RECOMMENDATION:

Resolution 439 be adopted.

HOD ACTION: Resolution 439 adopted.

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 was supportive of Resolution 439, noting the increases in nitrogen oxides 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 economically disadvantaged populations. Some concerns were raised about the power grid in some communities not being able to support a move to electric appliances. Your Reference Committee notes that this resolution does not mandate a transition to electric stoves, but calls for advocacy for innovative programs to assist with mitigation to encourage the transition from gas stoves to electric stoves. Therefore, your Reference Committee recommends adoption.

(17) RESOLUTION 442 – OPPOSING THE CENSORSHIP OF SEXUALITY
AND GENDER IDENTITY DISCUSSIONS IN PUBLIC SCHOOLS

RECOMMENDATION:

Resolution 442 be adopted.

HOD ACTION: Resolution 442 adopted.

RESOLVED, That our AMA opposes censorship of LGBTQIA+ topics and opposes any policies that limit discussion or restrict mention of sexuality, sexual orientation, and gender identity in schools or educational curricula; and be it further

RESOLVED, That our AMA will support policies that ensure an inclusive, well-rounded educational environment free from censorship of discussions surrounding sexual orientation, sexuality, and gender identity in public schools.

Your Reference Committee heard testimony that was in support of this resolution. It was noted that children are marginalized and shamed and are at increased risk of dying by suicide due to bullying based on sexual orientation and gender identity. Therefore, your Reference Committee recommends that Resolution 442 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

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

RECOMMENDATION A:

That the first resolve of Resolution 401 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association ~~review the support the Environmental Protection Agency's guidelines proposal, under the Clean Air Act to for monitoring regulate the air quality for heavy metals and other air toxins which is emitted from smokestacks.~~ The risk of dispersion through air and soil should be taking into consideration, particularly for the risks to citizens people living downwind of smokestacks (Directive to Take Action); and be it further

RECOMMENDATION B:

That the second resolve of Resolution 401 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA ~~urge the EPA to develop a report based on a review of the EPA's finalize updated mercury, cadmium, and air toxic regulations~~ guidelines for monitoring air quality emitted from power plants and other industrial sources, smokestacks ensuring that recommendations to protect the public's health are enforceable ~~included in the report.~~ (Directive to Take Action)

RECOMMENDATION C:

Resolution 401 be adopted as amended.

HOD ACTION: Resolution 401 adopted as amended.

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 heard testimony in support of this resolution. It was stated that industrial impacts on the environment have repeatedly been proven to predispose or worsen certain health conditions and that regulation can improve health. It was also noted better air quality will improve child health outcomes. Amendments were provided to strengthen the resolution and specifically address enforcement. Your Reference Committee agrees with these suggestions, which help clarify the EPA's role, and recommends that Resolution 401 be adopted as amended.

(19) RESOLUTION 403 – ADDRESSING MATERNAL DISCRIMINATION AND SUPPORT FOR FLEXIBLE FAMILY LEAVE

RECOMMENDATION A:

That the first resolve of Resolution 403 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association encourage key stakeholders to implement policies and programs that help protect against ~~maternal~~ parental discrimination and promote work-life integration for physician parents, which should encompass prenatal parental care, equal parental leave for birthing and non-birthing parents, and flexibility for childcare (Directive to Take Action)

RECOMMENDATION B:

Resolution 403 be adopted as amended.

RECOMMENDATION C:

That the title of Resolution 403 be changed to read as follows:

ADDRESSING PARENTAL DISCRIMINATION AND SUPPORT FOR FLEXIBLE FAMILY LEAVE

HOD ACTION: Resolution 403 adopted as amended with a change in title.

ADDRESSING PARENTAL 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)

Your Reference Committee heard overwhelming testimony in support of addressing parental discrimination, with amendments proffered to make the language more inclusive of a broader range of parental roles. This is a pressing issue for a significant portion of physicians who do not have access to paid leave and who are forced to choose between their career and their family, which has been a particular concern during the COVID-19 pandemic. Parental 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. Therefore, your Reference Committee recommends that Resolution 403 be adopted as amended.

(20) RESOLUTION 404 – WEAPONS IN CORRECTIONAL HEALTHCARE SETTINGS

RECOMMENDATION A:

That the second resolve of Resolution 404 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA ~~study work with appropriate stakeholders and~~ to make evidence-based recommendations regarding the presence of weapons in correctional healthcare facilities. (Directive to Take Action)

RECOMMENDATION B:

Resolution 404 be adopted as amended.

HOD ACTION: Resolution 404 adopted as amended.

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)

Your Reference Committee heard testimony in support of Resolution 404. Testimony noted that new policies require correctional staff, including physicians, to carry less-lethal weapons such as pepper spray and rapid rotation batons; and such policy interferes with the physician-patient relationship. It was also noted that physicians must have a choice in whether they carry weapons. Testimony was presented against referral for study due to the lack of data available on the presence of weapons in correctional health care facilities. Your Reference Committee agreed with this sentiment noting that it is best to work with appropriate stakeholders who understand the risks and benefits of physicians carrying weapons in correctional facilities. Therefore, your Reference Committee recommends Resolution 404 be adopted as amended.

(21) RESOLUTION 405 – UNIVERSAL CHILDCARE AND PRESCHOOL

RECOMMENDATION A:

Resolution 405 be amended by addition to read as follows:

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

RECOMMENDATION B:

Resolution 405 be adopted as amended.

HOD ACTION: Resolution 405 adopted.

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

Your Reference Committee heard overwhelming testimony in support of this resolution, emphasizing the importance of high-quality care and its ability to close the academic achievement gap, as well as providing economic benefits to parents able to engage in the labor force. 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. An amendment was suggested to add "child-directed and play-based" childcare and preschool, which is a type of early childhood education where children are given the autonomy to choose activities based on their current interests. Your Reference Committee agrees with this addition and therefore, recommends that Resolution 405 be adopted as amended.

(22) RESOLUTION 406 – COVID-19 PREVENTIVE MEASURES FOR CORRECTIONAL FACILITIES: AMA POLICY POSITION

RECOMMENDATION A:

That the first resolve of Resolution 406 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association advocate for all employees working in a correctional facility or detention center to be up to date with vaccinations against COVID-19, unless there is a valid medical contraindication/~~religious exception~~ (Directive to Take Action)

RECOMMENDATION B:

That the second resolve of Resolution 406 be amended by addition to read as follows:

RESOLVED, That our AMA advocate for all employees working in a correctional facility or detention center, not up to date with vaccination for COVID-19 to be COVID rapid tested each time they enter a correctional facility or detention center, as consistent with Centers for Disease Control and Prevention (CDC) or local public health guidelines (Directive to Take Action); and be it further

RECOMMENDATION C:

That the third resolve of Resolution 406 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA advocate for correctional facility or detention center policies that require non-employed, non-residents (e.g. visitors, contractors, etc.) to either show evidence of being up to date for COVID-19 vaccines or show proof of a negative COVID test completed within 24 hours prior to each when they enter entry into a correctional facility or detention center as consistent with CDC or local public health guidelines, at no cost to the visitor; (Directive to Take Action); and be it further

RECOMMENDATION D:

That the fourth resolve of Resolution 406 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA advocate that all people inside a correctional facility or detention center 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 CDC Centers for Disease Control and Prevention (Directive to Take Action); and be it further

RECOMMENDATION E:

That the fifth Resolve of Resolution 406 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA advocate that correctional facilities or detention centers be able to request and receive all necessary funding for ~~the~~

~~above endemic~~ COVID-19 vaccination and testing, according to CDC or local public health guidelines. (Directive to Take Action)

RECOMMENDATION F:

Resolution 406 be adopted as amended.

RECOMMENDATION G:

That the title of Resolution 406 be changed to read as follows:

COVID-19 PREVENTIVE MEASURES FOR CORRECTIONAL
FACILITIES AND DETENTION CENTERS

HOD ACTION: Resolution 406 adopted as amended with a change in title.

COVID-19 PREVENTIVE MEASURES FOR CORRECTIONAL
FACILITIES AND DETENTION-CENTERS

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)

Your Reference Committee heard testimony in support of Resolution 406. It was noted aggregate settings may house persons at increased risk for disease morbidity and mortality from COVID-19 illness. An amendment was proffered to remove the mention of religious exemptions noting that it is contradictory to existing AMA policy. Another amendment suggested adding detention centers, in addition to correctional facilities. Your Reference Committee agreed with these suggested amendments. Testimony raised concern about required testing of visitors, which may increase inequities and make it more difficult for families to visit their loved ones. Therefore, your Reference Committee recommends Resolution 406 be adopted as amended. The title has been changed to reflect the inclusion of detention centers.

(23) RESOLUTION 407 – STUDY OF BEST PRACTICES FOR ACUTE CARE
OF PATIENTS IN THE CUSTODY OF LAW ENFORCEMENT OR
CORRECTIONS

RECOMMENDATION A:

Resolution 407 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association study best practices for interactions between hospitals, other acute care facilities, 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~~ clinicians 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)

RECOMMENDATION B:

Resolution 407 be adopted as amended.

HOD ACTION: Resolution 407 adopted as amended.

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)

Your Reference Committee heard testimony in support of Resolution 407. 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 physicians have few guidelines. One amendment proffered noted that the scope of this resolution should include other acute care facilities. Your Reference Committee agreed with this amendment. Therefore, your Reference Committee recommends that Resolution 407 be adopted as amended.

(24) RESOLUTION 408 – SUPPORTING INCREASED RESEARCH ON IMPLEMENTATION OF NONVIOLENT DE-ESCALATION TRAINING AND MENTAL ILLNESS AWARENESS IN LAW ENFORCEMENT

RECOMMENDATION A:

The first resolve of Resolution 408 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association support increased research on non-violent de-escalation tactics for law enforcement encounters with ~~the mentally ill~~ people who have mental illness and/or developmental disabilities. (New HOD Policy)

RECOMMENDATION B:

Resolution 408 be adopted as amended.

RECOMMENDATION C:

That the title of Resolution 408 be changed to read as follows:

SUPPORTING INCREASED RESEARCH ON IMPLEMENTATION OF NONVIOLENT DE-ESCALATION TRAINING FOR LAW ENFORCEMENT

HOD ACTION: Resolution 408 adopted as amended with a change in title.

SUPPORTING INCREASED RESEARCH ON IMPLEMENTATION
OF NONVIOLENT DE-ESCALATION TRAINING FOR LAW
ENFORCEMENT

RESOLVED, That our American Medical Association support increased research on non-violent 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)

Your Reference Committee heard testimony in support of this resolution. 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 de-escalate situations involving individuals in a state of psychiatric crisis. An amendment suggested updating and broadening the language to be inclusive of people with developmental disabilities. Your Reference agrees with this suggestion and recommends that Resolution 408 be adopted as amended.

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

RECOMMENDATION A:

Resolution 410 be amended by addition and deletion to read as follows:

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

RECOMMENDATION B:

Resolution 410 be adopted as amended.

HOD ACTION: Resolution 410 adopted as amended.

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)

Your Reference Committee heard testimony in support of this resolution. It was stated that education programs on the prodromal symptoms of schizophrenia could be integrated into existing trainings for school staff. It was also suggested that “early” be deleted as it’s repetitive of “prodromal.” Therefore, your Reference Committee recommends that Resolution 410 be adopted as amended.

(26) RESOLUTION 411 – ANONYMOUS PRESCRIBING OPTION FOR EXPEDITED PARTNER THERAPY

RECOMMENDATION A:

Resolution 411 be amended by addition and deletion to read as follows:

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

RECOMMENDATION B:

Resolution 411 be adopted as amended.

RECOMMENDATION C:

That the title of Resolution 411 be changed to read as follows:

PRESCRIBING OPTION FOR EXPEDITED PARTNER THERAPY

HOD ACTION: Resolution 411 adopted as amended with a change in title.

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)

Your Reference Committee heard testimony supportive of Resolution 411. Testimony noted that many partners might not be treated for STIs despite exposure through a partner and expedited partner therapy (EPT) is one method to alleviate that barrier. Some testimony stated that referral was appropriate to better understand the nuances involved in the implementation of anonymous prescribing for expedited partner therapy. Your Reference Committee noted that anonymous prescribing is state-based and is therefore not broadly applicable. It was also noted that anonymous prescribing can have unintended consequences such as allergic reactions and adverse drug to drug interactions if physicians do not have the appropriate medical history of a patient in which medication is prescribed for. Your Reference Committee agreed to strike out the word anonymous to address this concern and keep it in alignment with current AMA policy supporting EPT, which does not reference anonymous prescribing. Therefore, your Reference Committee recommends that Resolution 411 be adopted as amended.

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

RECOMMENDATION A:

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 additionally s~~ Supports the concept of a complementary family life and sexuality education in the home, when possible, as well as developmentally appropriate sexuality education programming in the schools at all levels, at local option and direction;
- (2) Urges schools at all education levels to implement comprehensive, developmentally appropriate sexuality education programs that: (a) are

based on rigorous, peer reviewed science; (b) incorporate sexual violence prevention; (c) show promise for delaying the onset of sexual activity and a reduction in sexual behavior that puts adolescents at risk for contracting human immunodeficiency virus (HIV) and other sexually transmitted diseases and for becoming pregnant; (d) include an integrated strategy for making condoms ~~dental dams,~~ and other effective 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)

RECOMMENDATION B:

Resolution 413 be adopted as amended.

HOD ACTION: Resolution 413 adopted as amended.

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 additionally~~ Supports the concept of a ~~complementary~~ family life and sexuality education program in the schools at all levels, at local option and direction;
- (2) Urges schools at all education levels to implement comprehensive, developmentally appropriate sexuality education programs that: (a) are based on rigorous, peer reviewed science; (b) incorporate sexual violence prevention; (c) show promise for delaying the onset of sexual activity and a reduction in sexual behavior that puts adolescents at risk for contracting human immunodeficiency virus (HIV) and other sexually transmitted diseases and for becoming pregnant; (d) include an integrated strategy for making condoms dental dams, and other barrier protection methods available to students and for providing both factual information and skill-building related to reproductive biology, sexual abstinence, sexual responsibility, contraceptives including condoms, alternatives in birth control, and other issues aimed at prevention of pregnancy and sexual transmission of diseases; (e) utilize classroom teachers and other professionals who have shown an aptitude for working with young people and who have received special training that includes addressing the needs of LGBTQ+ gay, lesbian, and bisexual youth; (f) appropriately and comprehensively address the sexual behavior of all people, inclusive of sexual and gender minorities; (g) include ample involvement of parents, health professionals, and other concerned members of the community in the development of the program; (h) are part of an overall health education program; and (i) include culturally competent materials that are language-appropriate for Limited English Proficiency (LEP) pupils;
- (3) Continues to monitor future research findings related to emerging initiatives that include abstinence-only, school-based sexuality education, and consent communication to prevent dating violence while promoting healthy relationships, and school-based condom availability programs that address sexually transmitted diseases and pregnancy prevention for young people and report back to the House of Delegates as appropriate;
- (4) Will work with the United States Surgeon General to design programs that address communities of color and youth in high risk situations within the context of a comprehensive school health education program;
- (5) Opposes the sole use of abstinence-only education, as defined by the 1996 Temporary Assistance to Needy Families Act (P.L. 104-193), within school systems;
- (6) Endorses comprehensive family life education in lieu of abstinence-only education, unless research shows abstinence-only education to be superior in preventing negative health outcomes;
- (7) Supports federal funding of comprehensive sex education programs that stress the importance of ~~abstinence in~~ preventing unwanted teenage pregnancy and sexually transmitted infections via comprehensive education, and also teach about including contraceptive choices, ~~abstinence, and~~ safer sex, and opposes federal funding of community-based programs that do not show evidence-based benefits; and
- (8) Extends its support of comprehensive family-life education to community-based programs promoting abstinence as the best method to prevent teenage pregnancy and sexually-transmitted diseases while also discussing the roles of condoms and birth control, as endorsed for school systems in this policy;
- (9) Supports the development of sexual education curriculum that integrates dating violence prevention through lessons on healthy relationships, sexual health, and conversations about consent; and
- (10) Encourages physicians and all interested parties to ~~conduct research and~~ develop best-practice, evidence-based, guidelines for sexual education curricula that are developmentally appropriate as well as medically, factually, and technically accurate. (Modify Current HOD Policy)

Your Reference Committee heard testimony in support of Resolution 413. An amendment was offered to remove dental dams noting that they are not a scientifically proven method of barrier protection. Another amendment was proffered to consider that sex education from family life might not be the primary method of education. It was noted that some family lives are not ideal for talking about sexual education due to certain educational, cultural, religious backgrounds, or other circumstances. Your Reference Committee considered these amendments and amended the policy to recognize the role of sexuality education in the home, when possible. We believe this language is more

inclusive of varying home dynamics. Therefore, your Reference Committee recommends that Resolution 413 be adopted as amended.

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

RECOMMENDATION A:

Resolution 414 be amended by the addition of a resolve to read as follows:

RESOLVED, that our AMA make available existing educational resources from federal agencies and other stakeholders related to the needs of housing-insecure individuals.

RECOMMENDATION B:

Resolution 414 be adopted as amended.

RECOMMENDATION C:

That the title of Resolution 410 be changed to read as follows:

IMPROVEMENT OF CARE AND RESOURCE ALLOCATION FOR HOUSING-INSECURE PERSONS IN THE GLOBAL PANDEMIC

HOD ACTION: Resolution 414 adopted as amended with a change in title.

IMPROVEMENT OF CARE AND RESOURCE ALLOCATION FOR HOUSING-INSECURE 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 testimony presented on Resolution 414 was supportive. Access to safe and affordable housing is a social determinant of health. Testimony noted that housing insecurity is a broader term than homelessness. It was recognized that housing insecurity creates significant barriers to accessing health care treatment and preventive services and puts people at greater risk for worse health outcomes. A number of edits were suggested. Your Reference Committee thought that some were outside of the scope of this resolution, such as screening for latent tuberculosis infection. However, your Reference Committee agrees that it would be helpful to make existing educational resources on this issue available from federal agencies and other stakeholders. Your Reference Committee also recommends a change in title for consistency. Therefore, your Reference Committee recommends that Resolution 414 be adopted as amended.

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

RECOMMENDATION A:

That the second resolve of Resolution 422 be amended by addition to read as follows:

RESOLVED, That our AMA recognizes that gerrymandering which disenfranchises individuals/communities as a partisan effort that functions in part to limits 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

RECOMMENDATION B:

That Resolution 422 be adopted as amended.

HOD ACTION: Resolution 422 adopted as amended.

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)

Your Reference Committee heard testimony in favor of acknowledging voting as a social determinant of health. It was noted that this is a timely issue given the upcoming elections. Gerrymandering may or may not be legal depending on the circumstances under which it may exist. If gerrymandering is beyond partisan and begins to disenfranchise individuals/communities, then it negatively impacts health outcomes and is therefore a social determinant of health. Your Reference Committee amended the language in the second resolve clause to reflect this. Therefore, your Reference Committee recommends that Resolution 422 be adopted as amended.

(30) RESOLUTION 425 – MENTAL HEALTH CRISIS

RECOMMENDATION A:

That the first resolve of Resolution 425 be amended by addition and deletion to read as follows:

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~~ inequities 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)

RECOMMENDATION B:

Resolution 425 be adopted as amended.

HOD ACTION: Resolution 425 adopted as amended.

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)

Your Reference Committee heard limited testimony in support of Resolution 425. It was noted that the COVID-19 pandemic has exacerbated our nation's mental health crisis and action is needed. It was also suggested that the word "disparities" be replaced with "inequities." Your Reference Committee agrees and recommends that Resolution 425 be adopted as amended.

(31) RESOLUTION 431 – PROTECTIONS FOR INCARCERATED MOTHERS AND INFANTS IN THE PERINATAL PERIOD

RECOMMENDATION A:

That the first resolve of Resolution 431 be amended by addition to read as follows:

RESOLVED, That our American Medical Association encourage data collection on pregnancy and other reproductive health outcomes of incarcerated people and 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

RECOMMENDATION B:

That the third resolve of Resolution 431 be amended by deletion to read as follows:

RESOLVED, That our AMA oppose the ~~immediate~~ separation of infants from incarcerated pregnant individuals post-partum; (Directive to Take Action) and be it further

RECOMMENDATION C:

That the fifth resolve of Resolution 431 be amended by addition to read as follows:

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 directly and/or privately pump and safely 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)

RECOMMENDATION D:

Resolution 431 be adopted as amended.

HOD ACTION: Resolution 431 adopted as amended.

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)

Your Reference Committee heard testimony in support of Resolution 431. It was noted 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. Amendments were proffered noting that people who are incarcerated should have access to direct breastfeeding and access to privately pump. Another amendment offered noted that data collection on the pregnancy and reproductive health outcomes of incarcerated people is needed. Your Reference Committee agreed with these amendments. Therefore, your Reference Committee recommends that Resolution 431 be adopted as amended.

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

RECOMMENDATION A:

That the first resolve of Resolution 436 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association support the inclusion of ~~gun~~ firearm-related violence and suicide epidemiology, as well as ~~and~~ evidence-based firearm-related injury prevention education in ~~medical school curricula~~ undergraduate and graduate medical education training programs, where appropriate (Directive to Take Action)

RECOMMENDATION B:

That Resolution 436 be adopted as amended.

HOD ACTION: Resolution 436 adopted as amended.

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:

Firearm Safety Counseling in Physician-Led Health Care Teams, H-145.976

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 was supportive of this resolution, noting that firearm violence is a largely preventable public health crisis and 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. One amendment suggested that firearm-related injury prevention and firearm suicide education be added to appropriate medical education training. Your Reference Committee agrees with these amendments and recommends that Resolution 436 be adopted as amended.

(33) RESOLUTION 440 – ADDRESSING SOCIAL DETERMINANTS OF HEALTH THROUGH HEALTH IT

RECOMMENDATION A:

Resolution 440 be amended by the addition of a third resolve to read as follows:

RESOLVED, That our AMA advocate for adequate standards and capabilities for electronic health records to effectively tag and protect sensitive data before it can be shared or reshared (Directive to Take Action); and be it further

RECOMMENDATION B:

Resolution 440 be amended by the addition of a fourth resolve to read as follows:

RESOLVED, That our AMA support ongoing monitoring and data collection regarding unintended harm to patients from sharing information on social determinants of health and social risk (Directive to Take Action).

RECOMMENDATION C:

Resolution 440 be adopted as amended.

HOD ACTION: Resolution 440 adopted as amended.

RESOLVED, That our American Medical Association advocate for data interoperability between physicians' practices, public health, vaccine registries, community-based organizations, and other related social care organizations to promote coordination across the spectrum of care, while maintaining appropriate patient privacy (Directive to Take Action); and be it further

RESOLVED, That the AMA adopt the position that electronic health records should integrate and display information on social determinants of health and social risk so that such information is actionable by physicians to intervene and mitigate the impacts of social factors on health outcomes (Directive to Take Action)

Testimony on Resolution 440 was supportive. It was noted that data interoperability is needed to promote care coordination, while protecting patient privacy. An amendment was offered, noting support for the idea, but concern for potential unintended consequences such as in a pediatric setting where parents of a child are separated or divorced and data should not be shared with one parent about the other parent's health. Your Reference Committee agrees that these amendments are important and therefore recommends that Resolution 440 be adopted as amended.

(34) RESOLUTION 441 – ADDRESSING ADVERSE EFFECTS OF ACTIVE SHOOTER DRILLS ON CHILDREN'S HEALTH

RECOMMENDATION A:

That the first resolve of Resolution 441 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA support that any school system conducting active-shooter or live-crisis drills does so in an evidence-based and all school systems conduct evidence-based active shooter drills in a trauma-informed manner that

- a. is cognizant of children's physical and mental wellness,
- b. considers prior experiences that might affect children's response to a simulation,
- c. avoids creating additional traumatic experiences for children, and
- d. provides support for students who may be adversely affected; and be it further

RECOMMENDATION B:

That the second resolve of Resolution 441 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA work with relevant stakeholders to raise awareness of ways to conduct active-shooter or live-crisis drills that are safe for children and developmentally age-appropriate.

RECOMMENDATION C:

That Resolution 441 be amended by the addition of a third resolve to read as follows:

RESOLVED, That our AMA advocate for research into the impact of live-crisis exercises and drills on the physical and mental health and well-being of children including the goals, efficacy, and potential unintended consequences of crisis-preparedness activities involving children (Directive to Take Action);

RECOMMENDATION D:

Resolution 441 be adopted as amended.

RECOMMENDATION E:

That the title of Resolution 441 be changed to read as follows:

ADDRESSING ADVERSE EFFECTS OF ACTIVE- SHOOTER AND LIVE-CRISIS DRILLS ON CHILDREN'S HEALTH

HOD ACTION: Resolution 441 adopted as amended with a change in title.

ADDRESSING ADVERSE EFFECTS OF ACTIVE- SHOOTER AND
LIVE-CRISIS DRILLS ON CHILDREN'S HEALTH

RESOLVED, That our AMA support that all school systems conduct evidence-based active shooter drills in a trauma-informed manner that

- a. is cognizant of children's physical and mental wellness,
- b. considers prior experiences that might affect children's response to a simulation,
- c. avoids creating additional traumatic experiences for children, and
- d. provides support for students who may be adversely affected; and be it further

RESOLVED, That our AMA work with relevant stakeholders to raise awareness of ways to conduct active shooter drills that are safe for children and age-appropriate.

Your Reference Committee heard testimony in support of Resolution 441. It was noted that there are unintended consequences of active-shooter and live-crisis drills and best practices are needed to ensure these drills do not cause psychological harm for children. Traumatic events (including sexual abuse, domestic violence, elder abuse, and combat trauma) are associated with long-term physical and psychological effects. One amendment offered noted that ways to conduct active-shooter drills should be developmentally-appropriate instead of age-appropriate. Another amendment called for a study of the impact of these drills on the well-being of children. Your Reference Committee agrees with these amendments. Therefore, your Reference Committee recommends that Resolution 441 be adopted as amended. The title was changed to reflect the inclusion of live-crisis drills.

(35) RESOLUTION 443 – ADDRESSING THE LONGITUDINAL
HEALTHCARE NEEDS OF AMERICAN INDIAN CHILDREN IN
FOSTER CARE

RECOMMENDATION A:

That the first resolve of Resolution 443 be amended by addition and deletion to read as follows:

RESOLVED, The AMA recognizes the Indian Child Welfare Act of 1978 as ~~a the gold standard model~~ in American Indian and Alaska Native child welfare legislation;

RECOMMENDATION B:

Resolution 443 be adopted as amended.

HOD ACTION: Resolution 443 adopted as amended.

RESOLVED, The AMA recognizes the Indian Child Welfare Act of 1978 as the gold standard in child welfare legislation; and be it further

RESOLVED, The AMA supports federal legislation preventing the removal of American Indian and Alaska Native children from their homes by public and private agencies without cause; and be it further

RESOLVED, The AMA will work with local and state medical societies and other relevant stakeholders to support legislation preventing the removal of American Indian and Alaska Native children from their homes by public and private agencies without cause; and be it further

RESOLVED, The AMA supports state and federal funding opportunities for American Indian and Alaska Native child welfare systems.

Your Reference Committee heard testimony in support of Resolution 443. The foundational principles of the tribal welfare systems are of great importance in order for children to maintain their cultural identity. Furthermore, it was stated that disruption from family, culture and community is traumatizing for children. The United States Supreme Court is currently reviewing a Fifth Circuit Court of Appeals' decision, in a case challenging the constitutionality of the Indian Child Welfare Act (ICWA), so we recognize this resolution is timely. However, your Reference Committee was uncomfortable with the term "gold standard" in reference to the ICWA and instead suggests referring to it as a model in child welfare legislation. Your Reference Committee recommends that Resolution 443 be adopted as amended.

RECOMMENDED FOR ADOPTION IN LIEU OF

- (36) RESOLUTION 420 – DECLARING CLIMATE CHANGE A PUBLIC HEALTH CRISIS
RESOLUTION 430 – LONGITUDINAL CAPACITY-BUILDING TO ADDRESS CLIMATE ACTION AND JUSTICE

RECOMMENDATION:

Alternate Resolution 420 be adopted lieu of Resolution 420 and Resolution 430.

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 aimed at carbon neutrality by 2050, and (3) support rapid implementation and incentivization of clean energy solutions and significant investments in climate resilience through a climate justice lens (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)

HOD ACTION: Alternate Resolution 420 adopted in lieu of Resolution 420 and Resolution 430.

Resolution 420

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)

Resolution 430

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)

Your Reference Committee heard testimony in strong support of Resolutions 420 and 430. Testimony noted that this is the “fight of our lives” and there is no better place to invest resources. The Council on Science and Public Health noted several activities the AMA is already engaged in to address the climate crisis and efforts to achieve decarbonization of the health sector. The Board noted that task forces are not necessarily the best approach or most effective mechanism for prompt action and ask for flexibility to accomplish the goal. Your Reference Committee believes that calling on the AMA to develop a strategic plan around climate change, with consideration for a task force, is the best approach to accomplish the intended goal and therefore recommends adoption of Alternate Resolution 420.

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

RECOMMENDATION:

That Alternate Resolution 423 be adopted in lieu of Resolution 423.

RESOLVED, That our AMA: (1) utilize their existing communications channels to educate the physician community and the public on the new 9-8-8 National Suicide Prevention Lifeline program and (2) work with the Federation and other stakeholders to advocate for adequate federal and state funding for the 9-8-8 system, and (3) collaborate with the Substance Abuse and Mental Health Services Administration and the 9-8-8 partner community to strengthen suicide prevention and mental health crisis services.

HOD ACTION: Alternate Resolution 423 adopted in lieu of Resolution 423.

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 was in strong support of this resolution. It was recognized that the 9-8-8 program will depend on awareness of its existence as well as funding of the program. It was noted that to date only a handful of state have provided the needed funding. Amendments, which were supported by the authors, called for the AMA to advocate for federal and state funding for the 9-8-8 program as well as to collaborate with SAMHSA and the broader 9-8-8 partner community. Your Reference Committee agrees with these suggestions and recommends Alternate Resolution 423 be adopted.

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

RECOMMENDATION:

That Policies H-135.946, “Protective NAAQS Standard for Fine Particulate Matter (PM 2.5)” and D-135.978, “978 Protective NAAQS Standard for Particulate Matter (PM 2.5 & PM 10)” be reaffirmed in lieu of Resolution 437.

HOD ACTION: That Policies H-135.946, “Protective NAAQS Standard for Fine Particulate Matter (PM 2.5)” and D-135.978, “978 Protective NAAQS Standard for Particulate Matter (PM 2.5 & PM 10)” reaffirmed in lieu of Resolution 437.

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 was supportive of Resolution 437, stating that deaths attributable to air pollution would be much reduced with more stringent 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. However, the Council on Science and Public Health noted that existing policy already establishes protective National Ambient Air Quality Standards (NAAQS) for fine particulate matter and directs the AMA to review the proposal and offer comments. It was noted that the proposed resolution was vague compared to existing policy. Your Reference Committee agrees and therefore, recommends reaffirmation of existing policy in lieu of Resolution 437.

Policies recommended for reaffirmation:

H-135.946 Protective NAAQS Standard for Fine Particulate Matter (PM 2.5)

Our AMA supports more stringent air quality standards for particulate matter. We specifically request a NAAQS that provides improved protection for our patients which includes:

- 12 µg/m³ for the average annual standard
- 25 µg/m³ for the 24-hour standard
- 99th percentile used for compliance determination.

D-135.978 Protective NAAQS Standard for Particulate Matter (PM 2.5 & PM 10)

At such time as a new EPA Proposed Rule on National Ambient Air Quality Standards for Particulate Matter is published, our AMA will review the proposal and be prepared to offer its support for comments developed by the American Thoracic Society and its sister organizations.

RECOMMENDED FOR REFERRAL

(39) BOARD OF TRUSTEES REPORT 15 – ADDRESSING PUBLIC HEALTH DISINFORMATION

RECOMMENDATION:

That the Board of Trustees Report 15 be referred.

HOD ACTION: Board of Trustees Report 15 adopted.

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)

2. That Policies D-440.914, “Addressing Public Health Disinformation Disseminated by Health Professionals,” D-440.915, “Medical and Public Health Misinformation in the Age of Social Media,” and H-460.978, “Communication Among the Research Community, the Media and the Public” be reaffirmed (Reaffirm HOD Policy).

Testimony on Board of Trustees Report 15 was mixed. The report proposed a broad strategy to address the public health crisis of health-related disinformation spread by health professionals. Legitimate concerns were raised particularly around the proposed definition of “disinformation” included in the report, which specifically includes the intent to cause harm. It was noted that disinformation and misinformation are harmful, whether or not there is intent to cause harm, but the ramifications of applying one versus the other may be criminal in nature. Therefore, your Reference Committee recommends that this report be referred to the board for additional study and clarification, particularly around the definitions.

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

RECOMMENDATION:

Resolution 416 be referred.

HOD ACTION: Resolution 416 referred.

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)

Your Reference Committee heard mixed testimony of Resolution 416. There was supportive testimony of the first resolve clause 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. Most testimony in opposition stated that the second resolve clause needs further study to understand its efficacy and therefore supported referral. Your Reference Committee agreed with this testimony noting that it is unknown if current de-escalation training is evidence-based, and this issue is too complex and should be studied. Therefore, your Reference Committee recommends that Resolution 416 be referred.

RECOMMENDED FOR NOT ADOPTION

(41) RESOLUTION 402 – SUPPORT FOR IMPAIRMENT RESEARCH

RECOMMENDATION:

Resolution 402 not be adopted.

HOD ACTION: Resolution 402 not adopted.

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)

Your Reference Committee heard significant testimony on the complexity of this issue. It was recommended that impairment evaluations be handled by specialists in that field rather than physicians. Concerns surrounding liability were also highlighted. The Council on Science and Public Health questioned the broad scope of the study. Given these concerns, your Reference Committee recommends that Resolution 402 not be adopted.

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

RECOMMENDATION:

That Resolution 435 be not adopted.

HOD ACTION: Resolution 435 referred.

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:

The Clinical Utility of Measuring ~~Body Mass Index~~ Weight, Adiposity, and Waist Circumference in the Diagnosis and Management of Adult Overweight and Obesity, H-440.866

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)

Your Reference Committee heard substantial testimony in opposition to the removal of Body Mass Index (BMI) as a standard measure in clinical practice. While it is acknowledged that BMI is an imperfect measure whose racist derivation justifies the resolution's intent, it was noted that without a better measure to replace it, removing BMI would have unintended consequences and adverse impacts on patients' health care given the widespread use of BMI in many formulas. This is a complex issue. As such, your Reference Committee recommends referring it to the proposed obesity task force to address, recommending they take on all of the issues identified in the resolution, including, but not limited to, psychiatric, metabolic, and other conditions. Therefore, your Reference Committee recommends that Resolution 435 be not adopted.

REPORT OF REFERENCE COMMITTEE E

Your reference committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Council on Science and Public Health Report 3 - Correcting Policy H-120.958
2. Resolution 509 - Regulation and Control of Self-Service Labs
3. Resolution 510 - Evidence-Based Deferral Periods for MSM Corneas and Tissue Donors
4. Resolution 519 - Advanced Research Projects Agency for Health (ARPA-H)
5. Resolution 522 - Encouraging Research of Testosterone and Pharmacological Therapies for Post-Menopausal Individuals with Decreased Libido

RECOMMENDED FOR ADOPTION AS AMENDED

6. Resolution 501 - Marketing Guardrails for the “Over-Medicalization” of Cannabis Use
7. Resolution 502 - Ensuring Correct Drug Dispensing
8. Resolution 504 - Scientific Studies Which Support Legislative Agendas
9. Resolution 505 - CBD Oil Use and the Marketing of CBD Oil
10. Resolution 506 - Drug Manufacturing Safety
11. Resolution 512 - Scheduling and Banning the Sale of Tianeptine in the United States
12. Resolution 513 - Education for Patients on Opiate Replacement Therapy
13. Resolution 514 - Oppose Petition to the DEA and FDA on Gabapentin
14. Resolution 515 - Reducing Polypharmacy as a Significant Contributor to Senior Morbidity
15. Resolution 520 - Addressing Informal Milk Sharing
16. Resolution 521 - Encouraging Brain and Other Tissue Donation for Research and Educational Purposes
17. Resolution 524 - Increasing Access to Traumatic Brain Injury Resources in Primary Care Settings
18. Resolution 525 – Reforming the FDA Accelerated Approval Process
19. Resolution 526 – Adoption of Accessible Medical Diagnostic Equipment Standards

RECOMMENDED FOR ADOPTION IN LIEU OF

20. Resolution 503 - Pharmacy Benefit Managers and Drug Shortages
21. Resolution 508 - Supplemental Resources for Inflight Medical Kit
22. Resolution 511 - Over the Counter (OTC) Hormonal Birth Control
23. Resolution 516 - Oppose “Mild Hyperbaric” Facilities from Delivering Unsupported Clinical Treatments
- Resolution 517 - Safeguard the Public from Widespread Unsafe Use of “Mild Hyperbaric Oxygen Therapy”

RECOMMENDED FOR REFERRAL

24. Resolution 523 - Improving Research Standards, Approval Processes, and Post-Market Surveillance Standards for Medical Devices

Resolutions handled via the reaffirmation consent calendar:

- Resolution 507 - Federal Initiative to Treat Cannabis Dependence
-

For the purposes of clarity, items marked with double underline or ~~double strikethrough~~ are highlighted in yellow.

RECOMMENDED FOR ADOPTION

(1) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 3 – CORRECTING
POLICY H-120.958

RECOMMENDATION:

Recommendation in Council on Science and Public Health Report 2 be adopted,
and the rest of the report filed.

HOD ACTION: Recommendation in Council on Science and Public Health
Report 2 adopted, and the rest of the report filed.

1. That Policy H 120.958, “Supporting Safe Medical Products as a Priority Public Health Initiative,” be amended by addition and deletion to read as follows:

Our AMA will: (1) work through the United States Adopted Names (USAN) Council to adopt methodology to help prevent “look alike-sound alike” errors in giving new drugs generic names; (2) continue participation in efforts to advance the science of safety in the medication use process, including work with on the National Coordinating Council for Medication Error Reporting and Prevention; (3) support the FDA’s Medwatch program by working to improve physicians’ knowledge and awareness of the program and encouraging proper reporting of adverse events; (4) vigorously work to support the Drug Supply Chain and Security Act (DSCSA, Public Law 113-54), including provisions on product identification and verification, data sharing, detection and response, and encourage efforts to create and expeditiously implement a national coding system for prescription medicine packaging in an effort to improve patient safety; (5) participate in the work of the Healthy People 2030 initiative in the area of safe medical products especially as it relates to existing AMA policy and ~~(5) seek opportunities to work collaboratively with other stakeholders to provide information to individual physicians and state medical societies on the need for public health infrastructure and local consortiums to work on problems related to medical product safety.~~

Your Reference Committee heard limited testimony in support of CSAPH Report 3. Testimony noted that the policy changes contained within CSAPH Report 3 have previously been approved by HOD and the report seeks to rectify a drafting error. Therefore, your Reference Committee recommends CSAPH Report 3 be adopted.

(2) RESOLUTION 509 – REGULATION AND CONTROL OF SELF-SERVICE
LABS

RECOMMENDATION:

Resolution 509 be adopted.

HOD ACTION: Resolution 509 adopted.

RESOLVED, That our American Medical Association study issues with patient-directed self-service testing, including the accreditation and licensing of laboratories that sell self-ordered tests and physician liability related to non-physician-ordered tests. (Directive to Take Action)

Your Reference Committee heard unanimously supportive testimony. Testimony described concerns regarding physician liability and burden associated with handling results from self-ordered tests, as well as potential for patient harm. Therefore, your Reference Committee recommends adoption as written.

(3) RESOLUTION 510 – EVIDENCE-BASED DEFERRAL PERIODS FOR MSM
CORNEAS AND TISSUE DONORS

RECOMMENDATION:

Resolution 510 be adopted.

HOD ACTION: Resolution 510 adopted

RESOLVED, That our American Medical Association amend current policy H-50.973, “Blood Donor Deferral Criteria,” by addition and deletion as follows:

Blood and Tissue Donor Deferral Criteria

Our AMA: (1) supports the use of rational, scientifically-based ~~blood and tissue donation~~ deferral periods for donation of blood, corneas, and other tissues that are fairly and consistently applied to donors according to their individual risk; (2) opposes all policies on deferral of blood and tissue donations that are not based on evidence; (3) supports a blood and tissue donation deferral period for those determined to be at risk for transmission of HIV that is representative of current HIV testing technology; and (4) supports research into individual risk assessment criteria for blood and tissue donation (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA continue to lobby the United States Food and Drug Administration to use modern medical knowledge to revise its decades-old deferral criteria for MSM donors of corneas and other tissues. (Directive to Take Action)

Testimony for this resolution was supportive. Several speakers noted that our AMA supports evidence-based deferrals for other forms of donation and supported the idea of bringing outdated policy more in line with modern science. Speakers also noted the importance of corneal donations on reversing blindness and emphasized the low risk of HIV transmission within corneal donations. Therefore, your Reference Committee recommends that Resolution 510 be adopted.

(4) RESOLUTION 519 – ADVANCED RESEARCH PROJECTS AGENCY FOR HEALTH (ARPA-H)

RECOMMENDATION:

Resolution 519 be adopted.

HOD ACTION: Resolution 519 adopted.

RESOLVED, That our American Medical Association urge Congress and the Administration to ensure that while providing adequate funding for the promising research conducted at Advanced Research Projects Agency for Health (ARPA-H), it also provides robust annual baseline increases in appropriations for other research agencies, centers, and institutes, including, but not limited to, the NIH and NCI. (Directive to Take Action)

Testimony for Resolution 519 was supportive. The testimony noted that while ARPA-H funding is important, it will only be successful when combined with robust funding for the existing research agencies. They also described the need for an entity (similar to the Defense Advanced Research Projects Agency) that could identify innovation and build solutions to further support the health care field. Therefore, your Reference Committee recommends that Resolution 519 be adopted.

(5) RESOLUTION 522 – ENCOURAGING RESEARCH OF TESTOSTERONE AND PHARMACOLOGICAL THERAPIES FOR POST-MENOPAUSAL INDIVIDUALS WITH DECREASED LIBIDO

RECOMMENDATION:

Resolution 522 be adopted.

HOD ACTION: Resolution 522 adopted.

RESOLVED, That our AMA encourage expansion of research on the use of testosterone therapy and other pharmacological interventions in treatment of decreased libido in postmenopausal individuals. (Directive to Take Action)

Your Reference Committee heard testimony in support of Resolution 522. It was noted that research is still needed to understand the use of testosterone treatment in women. Testimony also noted that most of the testosterone treatments used have been approved in men and current literature is insufficient in addressing the possible benefits and harms in women. An amendment offered asked for our AMA to work with the FDA on approval of existing medications that treat decreased libido, but there was a lack of clarity as to which medications were considered and are dependent upon the research proposed. Your Reference Committee also stated that our AMA should focus on promoting research that will inform physicians about these treatments. Therefore, your Reference Committee recommends that Resolution 522 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

(6) RESOLUTION 501 – MARKETING GUARDRAILS FOR THE “OVER-MEDICALIZATION” OF CANNABIS USE

RECOMMENDATION A:

That Resolution 501 be amended by addition of a second resolve to read as follows:

RESOLVED, That our AMA generate a formal letter for use by state medical societies requesting more direct oversight by state government of the marketing of cannabis. (Directive to Take Action)

RECOMMENDATION B:

That Resolution 501 be amended by addition of a third resolve to read as follows:

RESOLVED, That our AMA study marketing practices of cannabis, cannabis products and cannabis paraphernalia that influence vulnerable populations, such as children or pregnant people. (Directive to Take Action)

RECOMMENDATION C:

That existing Policy H-95.936, “Cannabis Warnings for Pregnant and Breastfeeding Women” be reaffirmed.

RECOMMENDATION D:

That Resolution 501 be adopted as amended.

HOD ACTION: Resolution 501 adopted as amended.

RESOLVED, That our American Medical Association send a formal letter to the Food and Drug Administration and Federal Trade Commission requesting more direct oversight of the marketing of cannabis for medical use. (Directive to Take Action)

Testimony for Resolution 501 was unanimously supportive. Several individuals and delegations, particularly from states which have more permissive cannabis laws, noted the difficulty of dealing with the perception of cannabis for medical use. A significant portion of testimony focused on the complicated status of cannabis regulation, including whether the FDA or FTC had the regulatory authority to achieve the goals of the proposed resolution. Other speakers noted that our AMA’s Cannabis Task Force is currently active in this space and may be a useful resource for clarifying some uncertainties within the legal landscape around cannabis. Testimony was focused on the need for further research on this topic, especially around marketing to children, pregnant women, and other vulnerable populations. One speaker noted that the responsibility for these falls to each state and called for coordination among state medical societies. Your Reference Committee agrees that the marketing of cannabis for medical use is of concern, especially regarding vulnerable populations, and suggests further research be conducted to better understand the current practices. Therefore, your Reference Committee additionally suggests reaffirmation of H-95.936 (Cannabis Warnings for Pregnant and Breastfeeding Women) and to adopt Resolution 501 as amended.

(7) RESOLUTION 502 – ENSURING CORRECT DRUG DISPENSING

RECOMMENDATION A:

Resolution 502 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association ~~request that work with the United States Food and Drug Administration, work with the pharmaceutical and pharmacy industries, state boards of pharmacy, patient advocacy groups, and standards-setting organizations to facilitate the ability to evaluate the feasibility of pharmacies to ensure that~~ including a color photo of a prescribed medication and information about its dosage with is attached to the sales receipt to ensure that the drug dispensed is that which has been prescribed. (Directive to Take Action)

RECOMMENDATION B:

Resolution 502 be adopted as amended.

HOD ACTION: Resolution 502 adopted as amended.

RESOLVED, That our American Medical Association request that the United States Food and Drug Administration work with the pharmaceutical and pharmacy industries to facilitate the ability of pharmacies to ensure that a color photo of a prescribed medication and its dosage is attached to the sales receipt to ensure that the drug dispensed is that which has been prescribed. (Directive to Take Action)

Testimony on Resolution 502 was largely supportive of the effort to reduce prescription errors. Some questioned the economics of the approach proposed, including concerns that prescription drug prices could be impacted, and if color photos would be a cost-effective measure. They also added that many insurance companies may require filling of substitutes rather than what the patient discussed with their physician, which would reduce the patient's ability to catch dispensing errors without visual aids. Some speakers did not want to put the burden on patients to confirm the correct medication was dispensed and were not clear on how this would work for medications other than pills/tablets (ie, creams). Additionally, it was noted that it is not solely the FDA's decision to facilitate the addition of photos on sales receipts. Your Reference Committee agrees that a photo could reduce errors but recognizes there are additional decision makers that would need to be included in discussions. Therefore, your Reference Committee supports Resolution 502 with amendments specifically facilitating a discussion with the FDA, state boards, pharmacists, and other stakeholder groups.

(8) RESOLUTION 504 – SCIENTIFIC STUDIES WHICH SUPPORT LEGISLATIVE AGENDAS

RECOMMENDATION A:

Resolution 504 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association continue and expand its efforts to work with allied groups, health care policy influencers such as think tanks, and entities that can produce high quality scientific evidence, to help generate support for data to inform our the AMA's key advocacy goals. (Directive to Take Action)

RECOMMENDATION B:

Resolution 504 be adopted as amended.

HOD ACTION: Resolution 504 adopted as amended.

RESOLVED, That our American Medical Association continue and expand its efforts to work with allied groups, health care policy influencers such as think tanks, and entities that can produce high quality scientific evidence, to help generate support for the AMA's key advocacy goals. (Directive to Take Action)

Your Reference Committee heard limited testimony on Resolution 504. One amendment was proffered to strengthen the language by ensuring the generation of data to inform our AMA's advocacy goals. Your Reference Committee agreed with this amendment, noting that it is in alignment with our AMA's previous policy on evidence-based goals. Therefore, your Reference Committee recommends that Resolution 504 be adopted as amended.

(9) RESOLUTION 505 – CBD OIL USE AND THE MARKETING OF CBD OIL

RECOMMENDATION A:

That the second resolve of Resolution 505 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA support legislation and regulatory actions at the federal and state level to prohibit companies from selling CBD products if they make any unproven health and therapeutic claims, ~~and to require companies to include a Food and Drug Administration approved warning on CBD product labels.~~ (New HOD Policy)

RECOMMENDATION B:

That Resolution 505 be adopted as amended.

HOD ACTION: Resolution 505 adopted as amended.

RESOLVED, That our American Medical Association support banning the advertising of cannabidiol (CBD) as a component of marijuana in places that children frequent (New HOD Policy); and be it further

RESOLVED, That our AMA support legislation to prohibit companies from selling CBD products if they make any unproven health and therapeutic claims, and to require companies to include a Food and Drug Administration-approved warning on CBD product labels. (New HOD Policy)

Testimony was roundly supportive, with minimal opposition. Testimony noted the similarities between the practices observed in advertisements targeting children and other forms of medical misinformation. Testimony noted a lack of evidence supporting CBD products with the exception of one FDA-approved CBD medication for narrow indications. Supportive speakers noted that CBD myth-debunking is a time-consuming activity for physicians, and that marketing that could influence children is particularly concerning. Testimony relayed from the FDA noted that CBD oil is not regulated as a dietary supplement because it is excluded from the dietary supplement definition. Following consideration of testimony and discussion of the complex regulatory environment related to CBD products, your Reference Committee recommends amended language to the second resolve clause to support legislative or regulatory actions at the federal and state level to prohibit companies from selling CBD products that make unproven medical claims. Your Reference Committee recommends that Resolution 505 be adopted as amended.

(10) RESOLUTION 506 – DRUG MANUFACTURING SAFETY

RECOMMENDATION A:

That the first resolve of Resolution 506 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association support efforts to ensure that the U.S. Food and Drug Administration (FDA) resumes inspections of

~~safety testing~~ for all drug manufacturing facilities on a frequent and rigorous basis, as done in the past (Directive to Take Action); and be it further

RECOMMENDATION B:

That the second resolve of Resolution 506 be amended by addition to read as follows:

RESOLVED, That our AMA call for the FDA to: (a) assure ~~reaffirm~~ the safety of the manufacture of drugs ~~and, drug ingredients and precursors;~~ (b) work proactively with industry to prevent or minimize drug shortages; (c) work with industry to oversee the adequacy of product volume in the pipeline. (Directive to Take Action)

RECOMMENDATION C:

That Resolution 506 be adopted as amended.

HOD ACTION: Resolution 506 adopted as amended.

RESOLVED, That our American Medical Association support efforts to ensure that the U.S. Food and Drug Administration (FDA) resumes safety testing for all drug manufacturing facilities on a frequent and rigorous basis, as done in the past (Directive to Take Action); and be it further

RESOLVED, That our AMA call for the FDA to reaffirm the safety of the manufacture of drugs and the adequacy of volume in the pipeline. (Directive to Take Action)

In-person testimony was unanimously supportive. The FDA offered amendments modifying the language about “safety testing” and adding language to the second resolve regarding working proactively to prevent and minimize drug shortages. An additional amendment was offered to broaden the scope of the resolution beyond pharmaceuticals to include chemical substrates. Therefore, your Reference Committee recommends the adoption of this resolution as amended.

(11) RESOLUTION 512 – SCHEDULING AND BANNING THE SALE OF TIANEPTINE IN THE UNITED STATES

RECOMMENDATION A:

That the first resolve of Resolution 512 be deleted.

RECOMMENDATION B:

That the second resolve of Resolution 512 be amended by addition to read as follows:

RESOLVED, That our AMA advocate to ban the sale of Tianeptine directly to the public in the absence of research into the safety and efficacy of the substance. (Directive to Take Action)

RECOMMENDATION C:

That Resolution 512 be adopted as amended.

RECOMMENDATION D:

That the title of Resolution 512 be changed to read as follows:

BANNING THE SALE OF TIANEPTINE TO THE PUBLIC IN THE UNITED STATES

HOD ACTION: Resolution 512 be adopted as amended with a change in title.

BANNING THE SALE OF TIANEPTINE TO THE PUBLIC IN THE UNITED STATES

RESOLVED, That our American Medical Association advocate to schedule Tianeptine as Schedule II whilst supporting research into the safety and efficacy of the substance (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate to ban the sale of Tianeptine directly to the public. (Directive to Take Action)

Testimony was supportive of Resolution 512. Speakers clarified that tianeptine could not be scheduled unless it is approved by the FDA for medical use. The authors of the resolution stated that there are various technical aspects to scheduling a drug but supported efforts by the Reference Committee to take action to remove this drug from public sales as it is easily made available and regularly abused, especially by children. Your Reference Committee agrees with the concern regarding tianeptine. Therefore, your Reference Committee recommends adoption of Resolution 512 as amended with a change in title.

(12) RESOLUTION 513 – EDUCATION FOR PATIENTS ON OPIATE REPLACEMENT THERAPY

RECOMMENDATION A:

That Resolution 513 be amended by addition and deletion to read as follows:

5. Our AMA implement an education program for patients with substance use disorder on opiate replacement therapy and their family/caregivers to increase understanding of the increased risk of adverse outcomes associated with having a substance use disorder and their increased risk of death with concurrent opiate maintenance therapy and the onset of a serious respiratory illness such as COVID-19, SARS-CoV-2. (Modify Current HOD Policy)

RECOMMENDATION B:

That Resolution 513 be adopted as amended.

HOD ACTION: Resolution 513 adopted as amended.

RESOLVED, That our American Medical Association amend Policy D-95.987, “Prevention of Drug-Related Overdose,” by addition to read as follows:

1. Our AMA: (a) recognizes the great burden that 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 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; (c) encourages the education of health care workers and people who use drugs 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 a drug-related overdose; and (b) encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for 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 a SUD and their friends/families that address harm reduction measures.

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 for harm reduction from drug use, including but not limited to drug contamination testing and injection drug preparation, use, and disposal supplies.

5. Our AMA implement an education program for patients on opiate replacement therapy and their family/caregivers to increase understanding of their increased risk of death with concurrent opiate maintenance therapy and the onset of a serious respiratory illness such as SARS-CoV-2. (Modify Current HOD Policy)

Your Reference Committee heard mixed testimony on Resolution 513. There was testimony noting that this resolution could give the impression that medication for an opioid use disorder (MOUD) increases the risk of death with a concurrent respiratory illness (such as COVID-19), when in fact, an individual with an untreated substance use disorder is at higher risk, and such statements may discourage individuals from seeking beneficial MOUD. Opposition noted that the language in this resolution should be updated to use less stigmatizing terminology of MOUD rather than opioid replacement therapy. Amendments were proffered to support education on the increased risk of adverse outcomes associated with having SUD and respiratory illness. Your Reference Committee agreed with these amendments, noting that the amended language is in alignment with the less stigmatizing language in current AMA policy. Your Reference Committee acknowledges that the original resolution title contains outdated language but that this resolution modifies already titled policy, and as such it will not be contained in the policy database. Therefore, your Reference Committee recommends that Resolution 513 be adopted as amended.

(13) RESOLUTION 514 – OPPOSE PETITION TO THE DEA AND FDA ON GABAPENTIN

RECOMMENDATION A:

That Resolution 514 be amended by addition of a third resolve to read as follows:

RESOLVED, That our American Medical Association study the off-label use and potential risks and benefits of gabapentin to the general population as well as to those individuals with substance use disorders.

RECOMMENDATION B:

That Resolution 514 be adopted as amended.

RECOMMENDATION C:

That the title of Resolution 514 be changed:

OPPOSING SCHEDULING OF GABAPENTIN

HOD ACTION: Resolution 514 adopted as amended with a change in title.

OPPOSING SCHEDULING OF GABAPENTIN

RESOLVED, our American Medical Association actively oppose the placement of (a) gabapentin (2-[1-(aminomethyl) cyclohexyl] acetic acid), including its salts, and all products containing gabapentin (including the brand name products Gralise and Neurontin) and (b) gabapentin enacarbil (1-[[[(1RS)-1-[(2-methylpropanoyl)oxy]ethoxy] carbonyl]amino]methyl] cyclohexyl] acetic acid), including its salts, (including the brand name product Horizant) into schedule V of the Controlled Substances Act; and be it further

RESOLVED, our American Medical Association submit a timely letter to the Commissioner of Food and Drug for the proceedings assigned docket number FDA-2022-P-0149 in opposition to placement of gabapentin and gabapentin enacarbil into the schedule V of the Controlled Substance Act.

Your Reference Committee heard a great deal of testimony in support of Resolution 514, which opposes the scheduling of gabapentin and its salts. Speakers testified that some states have already classified gabapentin as a Schedule V substance, which limits prescriptions to 30 days or less, but some testified that this did not notably reduce access in a state with Schedule V status. Others noted that gabapentin is one of the only non-opioid pain therapies available to clinicians. Testimony highlighted the number of clinical settings in which gabapentin has been used safely and is a critical tool for physicians in their practice. Many testifying in support noted the clinical value of gabapentin for treating both chronic and acute pain and reducing the dose of opioids. Supporters expressed that scheduling gabapentin would create unnecessary barriers for patients. Some testimony also noted the benefits of having gabapentin appear in Prescription Drug Monitoring Programs, however substances can appear in a PDMP without being scheduled. An amendment was proffered for an additional resolve calling for a study of off-label use and the risks and benefits in the general population and among those with substance use disorders. Therefore, your Reference Committee agrees with the proposed amendment and recommends adoption of Resolution 514 as amended.

(14) RESOLUTION 515 – REDUCING POLYPHARMACY AS A SIGNIFICANT CONTRIBUTOR TO SENIOR MORBIDITY

RECOMMENDATION A:

That the third resolve of Resolution 515 be amended by deletion to read as follows:

RESOLVED, That our AMA work with other stakeholders and EHR vendors to address the continuing problem of inaccuracies in medication reconciliation and propagation of such inaccuracies in electronic health records, ~~and to include non-prescription medicines in medication compatibility screens.~~ (Directive to Take Action)

RECOMMENDATION B:

That Resolution 515 be amended by addition of a fourth resolve to read as follows:

RESOLVED, That our AMA work with other stakeholders and EHR vendors to include non-prescription medicines and supplements in medication lists and compatibility screens. (Directive to Take Action)

RECOMMENDATION C:

That Resolution 515 be adopted as amended.

HOD ACTION: Resolution 515 adopted as amended.

RESOLVED, That our American Medical Association work with other organizations e.g., AARP, other medical specialty societies, PhRMA, and pharmacists to educate patients about the significant effects of all medications and most supplements, and to encourage physicians to teach patients to bring all medications and supplements or accurate, updated lists including current dosage to each encounter (Directive to Take Action); and be it further

RESOLVED, That our AMA along with other appropriate organizations encourage physicians and ancillary staff if available to initiate discussions with patients on improving their medical care through the use of only the minimal number of medications (including prescribed or over-the-counter, including vitamins and supplements) needed to optimize their health (Directive to Take Action); and be it further

RESOLVED, That our AMA work with other stakeholders and EHR vendors to address the continuing problem of inaccuracies in medication reconciliation and propagation of such inaccuracies in electronic health records, and to include non-prescription medicines in medication compatibility screens. (Directive to Take Action)

Your Reference Committee heard testimony largely in support of the effort to reduce the problem of polypharmacy. Several speakers spoke to the problems faced by the senior population when dealing with multiple prescriptions all with unique dosing regimens, often prescribed by more than one physician. In addition, several speakers noted the added complexity from over-the-counter herbs and supplements which are often not considered in the traditional polypharmacy discussion. Much of the testimony was particularly supportive of the third resolve, calling for improved electronic health record tools to help manage this problem. Amendments were offered to split a resolve for increased clarity. Your Reference Committee therefore recommends Resolution 515 for adoption with amendments.

(15) RESOLUTION 520 – ADDRESSING INFORMAL MILK SHARING

RECOMMENDATION A:

That the first resolve of Resolution 520 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA encourage ~~discourage~~ the practice of breast informal milk sharing, and work with the appropriate stakeholders to develop standards that promote safe and equitable access ~~when said practice does not rise to health and safety standards comparable to those of milk banks, including but not limited to screening of donors and/or milk pasteurization;~~ (New HOD Policy)

RECOMMENDATION B:

That the second resolve of Resolution 520 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA encourage breast milk donation to regulated human milk banks instead of via informal means; ~~(Directive to Take Action)~~ the education of patients about the potential risks of breast milk sharing when acceptable health and safety standards are not met (New HOD Policy) and be it further

RECOMMENDATION C:

That the third resolve of Resolution 520 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA supports further research into the status of breast milk donation in the U.S. and how rates of donation for regulated human milk banks may be improved. (New HOD Policy)

RECOMMENDATION D:

Resolution 520 be adopted as amended.

RECOMMENDATION E:

That the title of Resolution 520 be changed to read as follows:

BREAST MILK SHARING

HOD ACTION: Resolution 520 adopted as amended with a change in title.

BREAST MILK SHARING

RESOLVED, That our AMA discourage the practice of informal milk sharing when said practice does not rise to health and safety standards comparable to those of milk banks, including but not limited to screening of donors and/or milk pasteurization; (New HOD Policy) and be it further

RESOLVED, That our AMA encourage breast milk donation to regulated human milk banks instead of via informal means; (Directive to Take Action) and be it further

RESOLVED, That our AMA supports further research into the status of milk donation in the U.S. and how rates of donation for regulated human milk banks may be improved. (New HOD Policy)

Your Reference Committee heard mixed testimony on Resolution 520. Testimony noted that this resolution is backdropped by an ongoing infant formula shortage. Testimony in support noted that during the formula shortage, parents may be more susceptible to predatory actors or turn to questionably sourced milk. Some argued that at a time in which parents are struggling to find formula and feed their infants, our AMA should be offering solutions. Additional testimony noted that milk procured from milk banks is often prohibitively expensive and risks deepening health inequity for those that cannot afford it. Your Reference Committee considered several amendments to address the concerns and preserves the intent of the resolution. Therefore, your Reference Committee recommends that Resolution 520 be adopted as amended.

(16) RESOLUTION 521 – ENCOURAGING BRAIN AND OTHER TISSUE DONATION FOR RESEARCH AND EDUCATIONAL PURPOSES

RECOMMENDATION A:

That the first resolve of Resolution 521 be amended by deletion to read as follows:

RESOLVED, That our AMA support the production and distribution of educational materials regarding the importance of ~~postmortem~~ tissue donation for the purposes of medical research and education; (Directive to Take Action) and be it further

RECOMMENDATION B:

That the second resolve of Resolution 521 be amended by addition to read as follows:

RESOLVED, That our AMA encourage the inclusion of additional information and informed consent options for brain and other tissue donation for research purposes on appropriate donor documents; (Directive to Take Action) and be it further

RECOMMENDATION C:

That the fourth resolve of Resolution 521 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA encourage efforts to facilitate recovery, transportation and storage of ~~postmortem~~ tissue, including brain tissue, for research and education purposes. (Directive to Take Action)

RECOMMENDATION D:

That Resolution 521 be adopted as amended.

HOD ACTION: Resolution 521 adopted as amended.

RESOLVED, That our AMA support the production and distribution of educational materials regarding the importance of postmortem tissue donation for the purposes of medical research and education; (Directive to Take Action) and be it further

RESOLVED, That our AMA encourage the inclusion of additional information and consent options for brain and other tissue donation for research purposes on appropriate donor documents; (Directive to Take Action) and be it further

RESOLVED, That our AMA encourage all persons to consider consenting to tissue donation including brain tissue for research purposes; (Directive to Take Action) and be it further

RESOLVED, That our AMA encourage efforts to facilitate recovery of postmortem tissue including brain tissue for research and education purposes. (Directive to Take Action)

Your Reference Committee heard mixed testimony mostly in support of Resolution 521. It was noted that the use of brain and other tissues helps advance scientific studies. Some testimony stated that there is a lack of infrastructure to ensure appropriate distribution and storage of donated tissue and noted that the costs for this infrastructure should be considered. Testimony also noted that the resolution should be inclusive of all tissues, including tissue used for transplantation. Your Reference Committee agreed with this inclusion and amended the language to remove the mention of postmortem tissue. Therefore, your Reference Committee recommends that Resolution 521 be adopted as amended.

(17) RESOLUTION 524 – INCREASING ACCESS TO TRAUMATIC BRAIN INJURY RESOURCES IN PRIMARY CARE SETTINGS

RECOMMENDATION A:

That the second resolve of Resolution 524 be amended by addition to read as follows:

RESOLVED, That our AMA supports increased access to currently available traumatic brain injury resources in primary care settings which advocate for early intervention, encourage follow-up retention of patients for post-injury rehabilitation, and improved patient quality of life. (New HOD Policy)

RECOMMENDATION B:

That Resolution 524 be amended by addition of a third resolve to read as follows:

RESOLVED, That our AMA work with relevant stakeholders to develop and distribute evidence-based guidelines for traumatic brain injury care in primary care settings.

RECOMMENDATION C:

That Resolution 524 be adopted as amended.

HOD ACTION: Resolution 524 adopted as amended.

RESOLVED, That our AMA recognize disparities in the care for traumatic brain injuries, and acknowledge non-athletic traumatic brain injuries as a significant cause of morbidity and mortality, particularly for ethnic minorities and victims of domestic violence; (New HOD Policy) and be it further

RESOLVED, That our AMA supports increased access to traumatic brain injury resources in primary care settings which advocate for early intervention, encourage follow-up retention of patients for post-injury rehabilitation, and improved patient quality of life. (New HOD Policy)

Your Reference Committee heard mixed testimony. All speakers agreed that resources should be disseminated to primary care providers (PCP), especially given the increasing number of non-athletic patients being seen within PCP offices. This includes those in rural settings, survivors of domestic abuse, patients with long-term TBI, and those in minoritized populations. Some testimony expressed concern that they were unaware of any available evidence-based resources, which led to your Reference Committee recommending an additional resolve to address this gap. Speakers in support of this resolution were able to identify several current resources that are available for dissemination, which were confirmed by your Reference Committee. Your Reference Committee also recognizes the limited data in this area and supports working with stakeholders to develop additional evidence-based guidelines. Therefore, your Reference Committee recommends Resolution 524 be adopted with amendments.

(18) RESOLUTION 525 – REFORMING THE FDA ACCELERATED APPROVAL PROCESS

RECOMMENDATION A:

That the first resolve of Resolution 525 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA supports mechanisms to address issues in the Food & Drug Administration (FDA)'s Accelerated Approval process, including but not limited to: efforts to ameliorate delays in post-marketing confirmatory study timelines and, the creation of expiration dates for accelerated approvals, protocols for the withdrawal of approvals when post-marketing studies fail, justifications for the use of surrogate endpoints used to demonstrate clinical benefit, and special considerations for certain diseases; and be it further

RECOMMENDATION B:

That Resolution 525 be adopted as amended.

HOD ACTION: That Resolution 525 adopted as amended.

RESOLVED, Our AMA supports mechanisms to address issues in the Food & Drug Administration (FDA)'s Accelerated Approval process, including but not limited to: efforts to ameliorate delays in post-marketing confirmatory study timelines, the creation of expiration dates for accelerated approvals, protocols for the withdrawal of approvals when post-marketing studies fail, justifications for the use of surrogate endpoints used to demonstrate clinical benefit, and special considerations for certain diseases; and be it further

RESOLVED, Our AMA will support specific solutions to issues in the FDA's Accelerated Approval process if backed by evidence that such solutions would not adversely impact the likelihood of investment in novel drug development.

Your Reference Committee heard mixed testimony regarding this resolution. An amendment to the first resolve clause was suggested striking certain phrases that could be overly prescriptive, which was generally supported. Speakers also noted that federal rulemaking will be underway prior to the next AMA Interim meeting, so there is an urgent timeline to adopt a resolution if our AMA wishes to engage in advocacy on this issue. Therefore, your Reference Committee recommends adopting Resolution 525 as amended.

(19) RESOLUTION 526 – ADOPTION OF ACCESSIBLE MEDICAL DIAGNOSTIC EQUIPMENT STANDARDS

RECOMMENDATION A:

Resolution 526 be amended by addition and deletion to read as follows:

That our American Medical Association support ~~the enforcement of evidence-based~~ federal accessibility standards for medical diagnostic equipment, as well as grants, tax incentives and deductions that help physicians implement these standards.

RECOMMENDATION B:

Resolution 526 be adopted as amended.

HOD ACTION: 526 adopted as amended.

RESOLVED, That our AMA support the enforcement of proposed federal accessibility standards for medical diagnostic equipment, as well as tax incentives and deductions that help physicians implement these standards.

Your Reference Committee heard mixed testimony on Resolution 526. Speakers expressed the need for diagnostic medical care to be accessible. Speakers expressed concerns regarding resultant costs to physician practices, and that language supporting enforcement of standards could be detrimental. An amendment was proffered striking the “enforcement” terminology in favor of evidence-based federal accessibility standards and suggesting the addition of grants as an additional means to help physicians implement accessibility standards. Your Reference Committee recommends this resolution be adopted as amended.

RECOMMENDED FOR ADOPTION IN LIEU OF

(20) RESOLUTION 503 – PHARMACY BENEFIT MANAGERS AND DRUG SHORTAGES

RECOMMENDATION:

That Alternate Resolution 503 be adopted in lieu of Resolution 503.

RESOLVED, That our American Medical Association amend current Policy H-100.956, “National Drug Shortages” by addition to read as follows:

5. The Council on Science and Public Health shall continue to evaluate the drug shortage issue, including the impact of group purchasing organizations and pharmacy benefit managers on drug shortages, and report back at least annually to the House of Delegates on progress made in addressing drug shortages.

6. Our AMA urges continued analysis of the root causes of drug shortages that includes consideration of federal actions, evaluation of manufacturer, Group Purchasing Organization (GPO), pharmacy benefit managers, and distributor practices, contracting practices by market participants on competition, access to drugs, pricing, and analysis of economic drivers.

HOD ACTION: Alternate Resolution 503 adopted in lieu of Resolution 503.

RESOLVED, That our American Medical Association conduct a study which will investigate the role pharmacy benefit managers play in drug shortages. (Directive to Take Action)

Your Reference Committee heard testimony mostly in support of Resolution 503. It was noted that it has been a long-standing interest of our AMA to monitor both drug shortages and the oversight of pharmacy benefit managers, because drug shortages are a public health crisis that negatively impacts patient care. The Council on Science and Public Health testified they report on drug shortages yearly and can include the role of PBMs in their I-22 report. Your Reference Committee noted that studying the role of PBMs is necessary and should be included in CSAPH annual reports and supported amending existing AMA policy D-110.987 in lieu of Resolution 503 to reflect this. Therefore, your Reference Committee recommends that Alternate Resolution 503 be adopted.

National Drug Shortages H-100.956

1. Our AMA considers drug shortages to be an urgent public health crisis, and recent shortages have had a dramatic and negative impact on the delivery and safety of appropriate health care to patients.
2. Our AMA supports recommendations that have been developed by multiple stakeholders to improve manufacturing quality systems, identify efficiencies in regulatory review that can mitigate drug shortages, and explore measures designed to drive greater investment in production capacity for products that are in short supply, and will work in a collaborative fashion with these and other stakeholders to implement these recommendations in an urgent fashion.
3. Our AMA supports authorizing the Secretary of the U.S. Department of Health and Human Services (DHHS) to expedite facility inspections and the review of manufacturing changes, drug applications and supplements that would help mitigate or prevent a drug shortage.
4. Our AMA will advocate that the US Food and Drug Administration (FDA) and/or Congress require drug manufacturers to establish a plan for continuity of supply of vital and life-sustaining medications and vaccines to avoid production shortages whenever possible. This plan should include establishing the necessary resiliency and redundancy in manufacturing capability to minimize disruptions of supplies in foreseeable circumstances including the possibility of a disaster affecting a plant.
5. The Council on Science and Public Health shall continue to evaluate the drug shortage issue, including the impact of group purchasing organizations on drug shortages, and report back at least annually to the House of Delegates on progress made in addressing drug shortages.

6. Our AMA urges continued analysis of the root causes of drug shortages that includes consideration of federal actions, evaluation of manufacturer, Group Purchasing Organization (GPO), and distributor practices, contracting practices by market participants on competition, access to drugs, pricing, and analysis of economic drivers.
7. Our AMA urges regulatory relief designed to improve the availability of prescription drugs by ensuring that such products are not removed from the market due to compliance issues unless such removal is clearly required for significant and obvious safety reasons.
8. Our AMA supports the view that wholesalers should routinely institute an allocation system that attempts to fairly distribute drugs in short supply based on remaining inventory and considering the customer's purchase history.
9. Our AMA will collaborate with medical specialty society partners and other stakeholders in identifying and supporting legislative remedies to allow for more reasonable and sustainable payment rates for prescription drugs.
10. Our AMA urges that during the evaluation of potential mergers and acquisitions involving pharmaceutical manufacturers, the Federal Trade Commission consult with the FDA to determine whether such an activity has the potential to worsen drug shortages.
11. Our AMA urges the FDA to require manufacturers to provide greater transparency regarding the pharmaceutical product supply chain, including production locations of drugs, and provide more detailed information regarding the causes and anticipated duration of drug shortages.
12. Our AMA supports the collection and standardization of pharmaceutical supply chain data in order to determine the data indicators to identify potential supply chain issues, such as drug shortages.
13. Our AMA encourages global implementation of guidelines related to pharmaceutical product supply chains, quality systems, and management of product lifecycles, as well as expansion of global reporting requirements for indicators of drug shortages.
14. Our AMA urges drug manufacturers to accelerate the adoption of advanced manufacturing technologies such as continuous pharmaceutical manufacturing.
15. Our AMA supports the concept of creating a rating system to provide information about the quality management maturity, resiliency and redundancy, and shortage mitigation plans, of pharmaceutical manufacturing facilities to increase visibility and transparency and provide incentive to manufacturers. Additionally, our AMA encourages GPOs and purchasers to contractually require manufacturers to disclose their quality rating, when available, on product labeling.
16. Our AMA encourages electronic health records (EHR) vendors to make changes to their systems to ease the burden of making drug product changes.
17. Our AMA urges the FDA to evaluate and provide current information regarding the quality of outsourcer compounding facilities.
18. Our AMA urges DHHS and the U.S. Department of Homeland Security (DHS) to examine and consider drug shortages as a national security initiative and include vital drug production sites in the critical infrastructure plan.

(21) **RESOLUTION 508 – SUPPLEMENTAL RESOURCES FOR INFLIGHT MEDICAL KIT**

RECOMMENDATION:

That Alternate Resolution 508 be adopted in lieu of Resolution 508.

RESOLVED, That our American Medical Association amend current policy H-45.981, "Improvement in US Airlines Aircraft Emergency Kits," by addition to read as follows:

1. Our AMA urges federal action to require all US air carriers to report data on in-flight medical emergencies, specific uses of in-flight medical kits and emergency lifesaving devices, and unscheduled diversions due to in-flight medical emergencies; this action should further require the Federal Aviation Administration to work with the airline industry and appropriate medical specialty societies to periodically review data on the incidence and outcomes of

in-flight medical emergencies and issue recommendations regarding the contents of in-flight medical kits and the use of emergency lifesaving devices aboard commercial aircraft.

2. Our AMA will: (a) support the addition of naloxone to the airline medical kit; (b) encourage airlines to voluntarily include naloxone in their airline medical kits; and (c) encourage the addition of naloxone to the emergency medical kits of all US airlines (14CFR Appendix A to Part 121 - First Aid Kits and Emergency Medical Kits).

3. That our American Medical Association advocate for U.S. passenger airlines to carry standard pulse oximeters, automated blood pressure cuffs and blood glucose monitoring devices in their emergency medical kits.

HOD ACTION: That Alternate Resolution 508 adopted in lieu of Resolution 508.

RESOLVED, That our American Medical Association amend current policy H-45.981, "Improvement in US Airlines Aircraft Emergency Kits," by addition to read as follows:

1. Our AMA urges federal action to require all US air carriers to report data on in-flight medical emergencies, specific uses of in-flight medical kits and emergency lifesaving devices, and unscheduled diversions due to in-flight medical emergencies; this action should further require the Federal Aviation Administration to work with the airline industry and appropriate medical specialty societies to periodically review data on the incidence and outcomes of in-flight medical emergencies and issue recommendations regarding the contents of in-flight medical kits and the use of emergency lifesaving devices aboard commercial aircraft.

2. Our AMA will: (a) support the addition of naloxone, epinephrine auto injector and glucagon to the airline medical kit; (b) encourage airlines to voluntarily include naloxone, epinephrine auto injector and glucagon in their airline medical kits; and (c) encourage the addition of naloxone, epinephrine auto injector and glucagon to the emergency medical kits of all US airlines (14CFR Appendix A to Part 121 - First Aid Kits and Emergency Medical Kits).

3. That our American Medical Association advocate for U.S. passenger airlines to carry standard pulse oximeters, automated blood pressure cuffs and blood glucose monitoring devices in their emergency medical kits.

RESOLVED, That our American Medical Association advocate for U.S. passenger airlines to carry standard pulse oximeters, automated blood pressure cuffs and blood glucose monitoring devices in their emergency medical kits.
(Directive to Take Action)

Speakers emphasized the need to provide proper medical care for all patients which requires additional diagnostic equipment within inflight medical kits. Several speakers commented on the difficulty of taking blood pressure with a manual blood pressure device and a stethoscope given the noise level within an airplane, but additional equipment should be functioning and regularly maintained. The Reference Committee was reminded that there are many other factors the FAA considers when adding supplies to an airplane (ie, weight, size, training for crew). One speaker added, however, that the proposed resolution may be streamlined by amending existing policy (Improvement in US Airlines Aircraft Emergency Kits H-45.981) rather than creating a new standalone policy. Your Reference

Committee recommends amendments to H-45.981 to include an automated blood pressure device, pulse oximeter, and glucometer in addition to current AMA policy within inflight medical kits in lieu of Resolution 508.

- (22) RESOLUTION 511 – OVER THE COUNTER (OTC) HORMONAL BIRTH CONTROL
RESOLUTION 518 – OVER-THE-COUNTER ACCESS TO ORAL CONTRACEPTIVES

RECOMMENDATION:

Alternate Resolution 518 be adopted in lieu of Resolutions 511 and 518.

OVER-THE-COUNTER HORMONAL CONTRACEPTIVES

RESOLVED, That our American Medical Association amends policy D-75.995, “Over-the-Counter Access to Oral Contraceptives,” by addition and deletion to read as follows:

Our AMA:

1. Encourages ~~manufacturers of oral contraceptives to submit the required application and supporting evidence to the US Food and Drug Administration for the Agency to consider approving to approve a switch in status from prescription to over-the-counter for such products~~ oral contraceptives, without age restriction.
2. Encourages the continued study of issues relevant to over-the-counter access for oral contraceptives.
3. Will work with expert stakeholders to advocate for the availability of hormonal contraception as an over-the-counter medication. (Modify Current HOD Policy)

HOD ACTION: Alternate Resolution 518 adopted in lieu of Resolutions 511 and 518.

Resolution 511

RESOLVED, That our American Medical Association recommend elimination of the requirement for a physician’s prescription to purchase birth control pills (BCP) and over the counter (OTC) hormonal contraceptives and allow OTC purchase (New HOD Policy); and be it further

RESOLVED, That our AMA advocate for the revocation of Food and Drug Administration and/or Congressional regulations requiring a prescription for OTC hormonal BCP. (Directive to Take Action)

Resolution 518

RESOLVED, That our American Medical Association amends policy D-75.995, “Over-the-Counter Access to Oral Contraceptives,” by addition and deletion to read as follows:

Our AMA:

1. Encourages ~~manufacturers of oral contraceptives to submit the required application and supporting evidence to the US Food and Drug Administration for the Agency to consider approving a~~ to swiftly review and approve a switch in status from prescription to over-the-counter for such products oral contraceptives, without age restriction.
2. Encourages the continued study of issues relevant to over-the-counter access for oral contraceptives.

3. Will work with expert stakeholders to advocate for the availability of hormonal contraception as an over-the-counter medication. (Modify Current HOD Policy)

Your Reference Committee heard mostly supportive testimony on Resolutions 511 and 518. Testimony noted that the current political landscape is becoming increasingly restrictive of reproductive health, making access to OTC contraception imperative. Concern was noted that there are potential health risks for providing access to OTC contraception but stated that the benefits outweigh the potential harms. Testimony was supportive of adopting the language outlined in Resolution 518 and your Reference Committee agreed with this. Testimony also highlighted overwhelming support for the inclusion of access to OTC contraception without an age restriction; having an age requirement might limit access for people who do not have identification. Therefore, your Reference Committee recommends that Alternate Resolution 518 be adopted in lieu of Resolutions 511 and 518.

- (23) RESOLUTION 516 – OPPOSE “MILD HYPERBARIC” FACILITIES FROM DELIVERING SUPPORTED CLINICAL TREATMENTS
RESOLUTION 517 – SAFEGUARD THE PUBLIC FROM WIDESPREAD UNSAFE USE OF “MILD HYPERBARIC OXYGEN THERAPY”

RECOMMENDATION:

That Alternate Resolution 516 be adopted in lieu of Resolutions 516 and 517.

OPPOSE UNSAFE USE OF “MILD HYPERBARIC THERAPY”

RESOLVED, That our American Medical Association oppose the operation of “mild hyperbaric facilities” unless and until effective treatments can be delivered in safely in facilities with appropriately trained staff including physician supervision and prescription and only when the intervention has scientific support or rationale. (New HOD Policy); and be it further

RESOLVED, That our AMA work with the U.S. Food and Drug Administration and other regulatory bodies to close facilities offering “mild hyperbaric therapy” until and unless they adopt and adhere to all established safety regulations, adhere to the established principles of the practice of hyperbaric oxygen under the prescription and oversight of a licensed and trained physician, and ensure that staff are appropriately trained and adherent to applicable safety regulations. (Directive to Take Action)

HOD ACTION: That Alternate Resolution 516 adopted in lieu of Resolutions 516 and 517.

Resolution 516

RESOLVED, That our American Medical Association oppose the operation of “mild hyperbaric facilities” unless and until effective treatments can be delivered in safe facilities with appropriately trained staff including physician supervision and prescription and only when the intervention has scientific support or rationale. (New HOD Policy)

Resolution 517

RESOLVED, That our American Medical Association oppose the operation of unsafe “Mild Hyperbaric Facilities” (New HOD Policy); and be it further

RESOLVED, That our AMA work with the U.S. Food and Drug Administration and other regulatory bodies to close these facilities until and unless they adopt and adhere to all established safety regulations, adhere to the established principles of the practice of hyperbaric oxygen under the prescription and oversight of a licensed and trained physician, and ensure that staff are appropriately trained and adherent to applicable safety regulations. (Directive to Take Action)

Testimony was unanimously supportive of these resolutions. Testimony noted several safety concerns of these facilities, such as inappropriate targeting of vulnerable populations, inappropriate dosing and delaying patients seeking proper treatment. As such, your Reference Committee recommends the alternate resolution be adopted in lieu of Resolutions 516 and 517.

RECOMMENDED FOR REFERRAL

(24) RESOLUTION 523 – IMPROVING RESEARCH STANDARDS, APPROVAL PROCESSES, AND POST-MARKET SURVEILLANCE STANDARDS FOR MEDICAL DEVICES

RECOMMENDATION:

Resolution 523 be referred.

HOD ACTION: Resolution 523 referred.

RESOLVED, That our AMA support improvements to the Food and Drug Administration 510(k) exception to ensure the safety and efficacy of medical devices to: (a) make more stringent guidelines for which devices can qualify for the 510(k) exceptions; (b) mandate all 510(k) devices demonstrate equivalent or improved safety and effectiveness compared to market devices for the same clinical purpose; (Directive to Take Action) and be it further

RESOLVED, That our AMA support stronger post-market surveillance requirements of medical devices, including but not limited to (a): conditional approval of devices until sufficient post-market surveillance data determining device safety can be collected, followed by confirmatory trials, and (b) a publicly available summary of medical devices approved under expedited programs along with associated clinical trial data and list of reported adverse events; (Directive to Take Action) and be it further

RESOLVED, That our AMA amend policy H-100.992 to include medical devices by addition as follows:

FDA, H-100.992

1. Our AMA reaffirms its support for the principles that:

(a) an FDA decision to approve a new drug or medical device, to withdraw a drug or medical device's approval, or to change the indications for use of a drug or medical device must be based on sound scientific and medical evidence derived from controlled trials, real-world data (RWD) fit for regulatory purpose, and/or postmarket incident reports as provided by statute;

(b) this evidence should be evaluated by the FDA, in consultation with its Advisory Committees and expert extramural advisory bodies; and

(c) any risk/benefit analysis or relative safety or efficacy judgments should not be grounds for limiting access to or indications for use of a drug or medical device unless the weight of the evidence from clinical trials, RWD fit for regulatory purpose, and post market reports shows that the drug or medical device is unsafe and/or ineffective for its labeled indications. (Modify Current HOD Policy)

Members testified that while supporting the underlying principles of reforming 510(k) medical device approval pathways to support patient safety, they felt that the language in the proffered resolution could be improved. Speakers voiced concern regarding the complexity of this issue. Some speakers noted the potential for significant resultant costs that could be passed on to patients or physicians and noted that conditionally approved devices might be subject to less insurance coverage. An additional speaker questioned what is meant by “more stringent.” Testimony was given that non-autonomous artificial intelligence software should be considered a medical device. Testimony also noted that all types of medical devices (examples provided included sunglasses, vision charts and splints) are not equivalent, and it may not be appropriate to apply the same requirements for safety and efficacy across the board. A speaker expressed concern regarding the potential negative impact that this resolution could have on smaller physician-owned medical device companies. Multiple speakers suggested referral of this resolution. Your Reference Committee agrees that this is an important issue but has a high level of complexity and recommends this resolution for referral.

REPORT OF REFERENCE COMMITTEE F

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Board of Trustees Report 4 - AMA 2023 Dues
2. Compensation Committee Report - Report of the House of Delegates Committee on the Compensation of the Officers
3. Resolution 607 - AMA Urges Health and Life Insurers to Divest of Investments of Fossil Fuels
4. Resolution 615 - Anti-Harassment Training

RECOMMENDED FOR ADOPTION IN LIEU OF

5. Resolution 624 - Creation of United Nations “Dr. Saul Hertz Theranostic Nuclear Medicine” International Day
Resolution 604 - UN International Radionuclide Therapy Day Recognition

RECOMMENDED FOR ADOPTION WITH CHANGE IN TITLE

6. Resolution 603 - September 11th as a National Holiday

RECOMMENDED FOR ADOPTION AS AMENDED

7. Board of Trustees Report 16 - Language Proficiency Data of Physicians in the AMA Masterfile
8. Board of Trustees Report 20 - Delegate Apportionment and Pending Members
Resolution 618: Extending the Delegate Apportionment Freeze During COVID-19 Pandemic
9. Council on Constitution and Bylaws / Council on Long Range Planning and Development Report 1 - Joint Council Sunset Review of 2012 House Policies
10. Resolution 601 - Development of Resources on End-of-Life Care
11. Resolution 602 - Report on the Preservation of Independent Medical Practice
12. Resolution 610 - Making AMA Meetings Accessible
13. Resolution 611 - Continuing Equity Education
14. Resolution 612 - Identifying Strategies for Accurate Disclosure and Reporting of Racial and Ethnic Data Across the Medical Education Continuum and Physician Workforce
15. Resolution 614 - Allowing Virtual Interviews on Non-Holiday Weekends for Candidates for AMA Office
16. Resolution 616 - Medical Student, Resident/Fellow, and Physician Voting in Federal, State and Local Elections
17. Resolution 617 - Study a Need-Based Scholarship to Encourage Medical Student Participation in the AMA
18. Resolution 621 - Establishing a Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care is Banned or Restricted

RECOMMENDED FOR REFERRAL

19. Resolution 605 - Fulfilling Medicine's Social Contract with Humanity in the Face of the Climate Health Crisis
20. Resolution 608 - Transparency of Resolution Fiscal Notes
21. Resolution 609 - Surveillance Management System for Organized Medicine Policies and Reports
22. Resolution 619 - Focus and Priority for the AMA House of Delegates
23. Resolution 622 - HOD Modernization
24. Resolution 625 - AMA Funding of Political Candidates who Oppose Research-Backed Firearm Regulations

RECOMMENDED FOR REFERRAL FOR DECISION

25. Resolution 606 - Financial Impact and Fiscal Transparency of the American Medical Association Current Procedural Terminology® System

RECOMMENDED FOR NOT ADOPTION

26. Board of Trustees Report 11 - Procedure for Altering the Size or Composition of Section Governing Councils
27. Resolution 613 - Timing of Board Report on Resolution 605 from N-21 Regarding a Permanent Resolution Committee
28. Resolution 623 - Virtual Attendance at AMA Meetings

RECOMMENDED FOR FILING

29. Board of Trustees Report 1 - Annual Report

RECOMMENDED FOR ADOPTION

(1) BOARD OF TRUSTEES REPORT 4 - AMA 2023 DUES

RECOMMENDATION:

Recommendation in Board of Trustees Report 4 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendation in Board of Trustees Report 4 adopted and the remainder of the Report filed.

The Board of Trustees recommends no change to the dues levels for 2023, that the following be adopted and that the remainder of this report be filed:

Regular Members	\$420
Physicians in Their Fourth Year of Practice	\$315
Physicians in Their Third Year of Practice	\$210
Physicians in Their Second Year of Practice	\$105
Physicians in Their First Year of Practice	\$60
Physicians in Military Service	\$280
Semi-Retired Physicians	\$210
Fully Retired Physicians	\$84
Physicians in Residency Training	\$45
Medical Students	\$20

(Directive to Take Action)

Board of Trustees Report 4 recommends no changes to our AMA membership dues levels for 2023.

Beyond the introduction of Board of Trustees Report 4, your Reference Committee received no further testimony.

(2) COMPENSATION COMMITTEE REPORT - REPORT OF THE HOUSE OF DELEGATES COMMITTEE ON THE COMPENSATION OF THE OFFICERS

RECOMMENDATION:

Recommendations in the Report of the House of Delegates Committee on the Compensation of the Officers be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendations in the Report of the House of Delegates Committee on the Compensation of the Officers adopted and the remainder of the Report filed.

1. That there be no changes to the Officers' compensation for the period beginning July 1, 2022 through June 30, 2023. (Directive to Take Action.)
2. That the travel policy and the Board travel and expense standing rules be amended by addition, shown with underscores as follows:

Transportation

- a. Air: AMA policy on reimbursement for domestic air travel for members of the Board is that the AMA will reimburse for coach fare only. The Presidents (President, Immediate Past President and President Elect) will each have access to an individual \$5000 term allowance (July 1 to June 30) and all other Officers will each have access to \$2500 term allowance (July 1 to June 30) to use for upgrades as each deems appropriate, typically

when traveling on an airline with non-preferred status. The unused portion of the allowance is not subject to carry forward or use by any other Officer and remains the property of the AMA. In rare instances it is recognized that short notice assignments may require up to first class travel because of the lack of availability of coach seating, and this will be authorized when necessary by the Board Chair, prior to travel. Business Class airfare is authorized for foreign travel on AMA business. (Also see Rule IV –Invitations, B—Foreign, for policy on foreign travel). (Directive to Take Action)

3. That the remainder of the report be filed.

Your Reference Committee received testimony in support of the report. The Compensation Committee testified that there are no changes to the Officers' compensation for July 1, 2022 through June 30, 2023.

Your Reference Committee recommends that the recommendations in the Compensation Committee be adopted, and the remainder be filed.

(3) RESOLUTION 607 - AMA URGES HEALTH AND LIFE INSURERS TO DIVEST FROM INVESTMENTS IN FOSSIL FUELS

RECOMMENDATION:

Resolution 607 be adopted.

HOD ACTION: Resolution 607 adopted.

RESOLVED, That our American Medical Association declare that climate change is an urgent public health emergency, and calls upon all governments, organizations, and individuals to work to avert catastrophe (New HOD Policy); and be it further

RESOLVED, That our AMA urge all health and life insurance companies, including those that provide insurance for medical, dental, and long-term care, to work in a timely, incremental, and fiscally responsible manner to end all financial investments or relationships (divestment) with companies that generate the majority of their income from the exploration for, production of, transportation of, or sale of fossil fuels (New HOD Policy); and be it further

RESOLVED, That our AMA send letters to the nineteen largest health or life insurance companies in the United States to inform them of AMA policies concerned with climate change and with fossil fuel divestments, and urging these companies to divest. (Directive to Take Action)

Your Reference Committee heard overwhelming support for Resolution 607 indicating that the resolution builds on the strong precedent of existing AMA policy as it pertains to the tobacco industry, which “specifically calls on all life and health insurance companies and HMOs to divest of any tobacco holdings” (H-500.975). It is further believed that the intent of Resolution 607 is a logical extension of AMA policy directing the organization and all associated corporations to “end all financial investments or relationships (divestment) with companies that generate the majority of their income from the exploration for, production of, transportation of, or sale of fossil fuels” (D-135.969).

(4) RESOLUTION 615 - ANTI-HARASSMENT TRAINING

RECOMMENDATION:

Resolution 615 be adopted.

HOD ACTION: Resolution 615 adopted.

RESOLVED, That our AMA require all members elected and appointed to national and regional AMA leadership positions to complete AMA Code of Conduct and anti-harassment training, with continued evaluation of the training for effectiveness in reducing harassment within the AMA (Directive to Take Action); and be it further

RESOLVED, That our AMA work with the Women Physicians Section, American Medical Women's Association, GLMA: Health Professionals Advancing LGBTQ Equality, and other stakeholders to identify an appropriate, evidence-based anti-harassment and sexual harassment prevention training to administer to leadership. (Directive to Take Action)

Testimony was supportive of this resolution. Online testimony posits that failing to mitigate sexual and other forms of harassment could result in a disproportionate number of women leaders to be driven away from the organization.

Your Reference Committee recommends that Resolution 615 be adopted.

RECOMMENDED FOR ADOPTION IN LIEU OF

- (5) RESOLUTION 624 - CREATION OF UNITED NATIONS "DR. SAUL HERTZ THERANOSTIC NUCLEAR MEDICINE" INTERNATIONAL DAY
RESOLUTION 604 - UN INTERNATIONAL RADIONUCLIDE THERAPY DAY RECOGNITION

RECOMMENDATION:

Resolution 624 be adopted in lieu of Resolution 604.

HOD ACTION: Resolution 624 adopted in lieu of Resolution 604.

Resolution 624

RESOLVED, That our American Medical Association advocate and participate with the United States Mission to the United Nations to create and introduce a United Nations General Assembly Resolution for the creation of a new United Nations International Day of recognition, marking March 31 as: "Dr. Saul Hertz Theranostic Nuclear Medicine Day," commemorating the day the first patient was treated with therapeutic radionuclide therapy on that day in 1941, marking the advent of theranostic medicine (Directive to Take Action).

Resolution 604

RESOLVED, That our American Medical Association support the efforts of the American College of Nuclear Medicine to create and introduce a United Nations General Assembly (UNGA) Resolution for the creation of a new International Day of recognition with the suggested name of "International Radionuclide Therapy Day." (Directive to Take Action)

Resolution 604 and 624 both emphasize the importance of named days. Testimony was supportive and explains how named days can educate the public on issues of concern and celebrate achievements of humanity. Your Reference Committee is aware that the two resolutions differ, one recognizes a diagnostic tool while the other recognizes a drug therapy; however, the author of Resolution 604 accepts that adoption of Resolution 624 would achieve the goal of highlighting scientific achievements to the public.

Your Reference Committee recommends that Resolution 624 be adopted in lieu of Resolution 604.

ADOPT WITH CHANGE IN TITLE

(6) RESOLUTION 603 - SEPTEMBER 11TH AS A NATIONAL HOLIDAY

RECOMMENDATION A:

Resolution 603 be adopted.

RECOMMENDATION B:

The title of Resolution 603 be changed to read as follows:

SEPTEMBER 11TH AS AN ANNUAL DAY OF OBSERVANCE

HOD ACTION: Resolution 603 adopted with a change in title to read:

SEPTEMBER 11TH AS AN ANNUAL DAY OF OBSERVANCE

RESOLVED, That our American Medical Association support and recognize September 11th as an annual day of observance to remember and recognize all who died and who continue to suffer health consequences from the events of 9/11, to honor first- and all responders from around the country, and to recognize and forever remind us of the unity our country experienced on 9/11/01 and the months that followed. (New HOD Policy)

Your Reference Committee heard limited yet favorable testimony in support of this resolution. However, your Reference Committee wishes to proffer an amendment to the title to make it more consistent with the language in the Resolve clause. Therefore, your Reference Committee recommends that Resolution 603 be adopted with a change in title.

RECOMMENDED FOR ADOPTION AS AMENDED

(7) BOARD OF TRUSTEES REPORT 16 - LANGUAGE PROFICIENCY DATA OF PHYSICIANS IN THE AMA MASTERFILE

RECOMMENDATION A:

Recommendation in Board of Trustees Report 16 be amended by addition of a second recommendation to read as follows:

In the event a national standard for the collection of self-reported language is identified, our AMA Masterfile will include this proficiency in the data file.

RECOMMENDATION B:

Recommendation in Board of Trustees Report 16 be adopted as amended and the remainder of the Report be filed.

HOD ACTION: Recommendation in Board of Trustees Report 16 adopted as amended and the remainder of the Report filed.

In lieu of Resolution 613-A-19, it is recommended that our AMA continue its work with other industry stakeholders to identify best practices, including adoption of a national standard, for the collection of self-reported language proficiency and the remainder of this report be filed.

According to testimony, this is a complex issue that requires collaboration with stakeholders. Those who testified were generally supportive of the report, but expressed that once a national standard is established, our AMA should include collection of the data.

Your Reference Committee recommends that the Board Report be adopted as amended and the remainder filed.

(8) BOARD OF TRUSTEES REPORT 20 - DELEGATE APPORTIONMENT AND PENDING MEMBERS
RESOLUTION 618 - EXTENDING THE DELEGATE APPORTIONMENT FREEZE DURING COVID-19 PANDEMIC

RECOMMENDATION A:

Recommendation 3, in Board of Trustees Report 20 be amended by addition and deletion to read as follows:

3. That delegates be apportioned to constituent societies for 2023 with each society getting the greatest of the following numbers:
 - The number of delegates apportioned at the rate of 1 per 1000, or fraction thereof, AMA members;
 - The number of delegates apportioned for 2022 so long as that figure is not greater than 2 more than the number apportioned at the rate of 1 per 1000, or fraction thereof, AMA members; or
 - For societies that would lose more than five delegates from their 2022 apportionment, the number of delegates, apportioned at the rate of 1 per 1000, or fraction thereof, AMA members, the number of delegates apportioned for 2022 plus 5. (Directive to Take Action)

RECOMMENDATION B:

Recommendations in Board of Trustees Report 20 be adopted as amended in lieu of Resolution 618 and the remainder of the Report filed.

HOD ACTION: Recommendation 1 in Board of Trustees Report 20 referred for decision. Recommendations 2, 4, 5, and 6 in Board of Trustees Report 20 referred. Recommendation 3 in Board of Trustees Report 20 adopted as amended in lieu of Resolution 618 and the remainder of the Report filed.

Board of Trustees Report 20

Your Board of Trustees recommends that the following recommendations be adopted and the remainder of the report be filed.

1. That pending members no longer be considered in apportioning delegates in the House of Delegates. (Directive to Take Action)
2. That delegate apportionment for 2023 for constituent societies be based on official 2022 year-end AMA membership data as recorded by the AMA. (Directive to Take Action)
3. That delegates be apportioned to constituent societies for 2023 with each society getting the greatest of the following numbers:
 - The number of delegates apportioned at the rate of 1 per 1000, or fraction thereof, AMA members;
 - The number of delegates apportioned for 2022 so long as that figure is not greater than 2 more than the number apportioned at the rate of 1 per 1000, or fraction thereof, AMA members; or
 - For societies that would lose more than five delegates from their 2022 apportionment, the number of delegates apportioned for 2022 plus 5. (Directive to Take Action)
4. That delegate apportionment for 2024 be based on then current bylaws. (Directive to Take Action)
5. That the Council on Constitution and Bylaws prepare bylaws amendments to implement these recommendations, with the report to be considered no later than the November 2022 meeting of the House of Delegates. (Directive to Take Action)
6. That Policy G-600.016, "Data Used to Apportion Delegates," be rescinded. (Rescind HOD Policy)

Resolution 618

RESOLVED, That our American Medical Association extend the current delegate apportionment freeze for losing a delegate from a state medical or specialty society until the end of 2023. (Directive to Take Action)

Your Reference Committee received testimony indicating that membership has been difficult to maintain during the COVID-19 pandemic and recruitment has been a challenge. Additionally, it was noted that most individuals and organizations scaled back on expenses at the onset and are not quick to re-instate past spending patterns in a more challenging economic environment.

Board of Trustees Report 20 comes in response to an apportionment pilot that was adopted earlier by our AMA House of Delegates as a means for delegations to maintain stability in representation; however, few members of the Federation benefited. Subsequently, an apportionment freeze was adopted by our AMA House of Delegates and an extension of that freeze is proposed by Resolution 618.

Your Reference Committee believes the tiered system of implementing potential delegate reductions gradually, as proposed in Board of Trustees Report 20, is preferable to further extending an apportionment freeze that will result

in some delegations facing sudden, steep declines in representation if membership cannot be turned around in short order.

- (9) COUNCIL ON CONSTITUTION AND BYLAWS / COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT REPORT 1 - JOINT COUNCIL SUNSET REVIEW OF 2012 HOUSE POLICIES

RECOMMENDATION A:

Recommendation in Council on Constitution and Bylaws / Council on Long Range Planning and Development Report 1 be amended by addition to read as follows:

That the House of Delegates policies that are listed in the Appendix to this report be acted upon in the manner indicated, with the exception of Policy G-635.053 and Policy D-350.996, which should be retained, and the remainder of this report be filed.

RECOMMENDATION B:

Council on Constitution and Bylaws / Council on Long Range Planning and Development Report 1 be adopted as amended.

HOD ACTION: Council on Constitution and Bylaws / Council on Long Range Planning and Development Report 1 adopted as amended.

The Councils on Constitution and Bylaws and Long Range Planning and Development recommend that the House of Delegates policies that are listed in the appendix to this report be acted upon in the manner indicated and the remainder of this report be filed.

Limited testimony noted that an issue cited in the online forum had been resolved and agreed that AMA Policy D-225.990 should be sunset as initially recommended.

Commentary in the Online Forum called for AMA Policy G-635.053 and D-350.996 to be retained because they are still relevant. Your Reference Committee concurs and recommends that the Joint Council Sunset Review of 2012 House Policies be adopted as amended.

- (10) RESOLUTION 601 - DEVELOPMENT OF RESOURCES ON END-OF-LIFE CARE

RECOMMENDATION A:

The first resolve of Resolution 601 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association, in conjunction with interested stakeholders, will provide develop educational resources for medical students, physicians, allied health professionals, and patients, and their families on end-of-life care, (Directive to Take Action); ~~and be it further~~

RECOMMENDATION B:

That the second resolve of Resolution 601 be deleted:

~~RESOLVED, That our AMA work with all stakeholders to develop proper quality metrics to evaluate and improve palliative and hospice care. (Directive to Take Action)~~

RECOMMENDATION C:

Resolution 601 be adopted as amended.

HOD ACTION: Resolution 601 adopted as amended.

RESOLVED, That our American Medical Association develop educational resources for physicians, allied health professionals and patients on end-of-life care (Directive to Take Action); and be it further

RESOLVED, That our AMA work with all stakeholders to develop proper quality metrics to evaluate and improve palliative and hospice care. (Directive to Take Action)

Testimony was supportive of providing resources to facilitate decision making on end-of-life care as many physicians indicated that they did not have access to resources that will support them in making informed decisions that would help their patients. Testimony noted it was imperative that this information be made available to patients and their families as well.

Additional testimony noted that the American Academy of Hospice and Palliative Medicine has access to existing resources, which is available for dissemination to interested stakeholders.

Your Reference Committee believes that amending the first resolve clause would strengthen the overall resolution. Further, the second resolve clause was deleted because the AMA does not have the appropriate expertise to develop quality metrics, which historically resides with the specialty societies.

(11) RESOLUTION 602 - REPORT ON THE PRESERVATION OF INDEPENDENT MEDICAL PRACTICE

RECOMMENDATION A:

Resolution 602 be amended by addition to read as follows:

RESOLVED, That our American Medical Association issue a report in collaboration with the Private Practice Physicians Section at least every two years communicating their efforts to support independent medical practices.

RECOMMENDATION B:

Resolution 602 be adopted as amended.

HOD ACTION: Resolution 602 adopted as amended.

RESOLVED, That our American Medical Association issue a report every two years communicating their efforts to support independent medical practices. (Directive to Take Action)

There was a plethora of supportive testimony, including consulting with internal experts. Testimony addressed the importance of the resolution for protecting the viability of independent physician practice and the prevention of large corporations from absorbing small practices.

(12) RESOLUTION 610 - MAKING AMA MEETINGS ACCESSIBLE

RECOMMENDATION A:

That the second resolve of Resolution 610 be deleted:

~~RESOLVED, That our AMA investigate ways of allowing meaningful participation in all meetings of the AMA by members who are limited in their ability to physically attend meetings (Directive to Take Action); and be it further~~

RECOMMENDATION B:

Resolution 610 be adopted as amended.

HOD ACTION: The first, third and fourth resolves of Resolution 610 adopted as amended. The second resolve in Resolution 610 referred.

RESOLVED, That all future American Medical Association meetings be structured to provide accommodations for members and invited attendees who are able to physically attend, but who need assistance in order to meaningfully participate (Directive to Take Action); and be it further

RESOLVED, That our AMA investigate ways of allowing meaningful participation in all meetings of the AMA by members who are limited in their ability to physically attend meetings (Directive to Take Action); and be it further

RESOLVED, That our AMA revisit our criteria for selection of hotels and other venues ~~for the HOD~~ in order to facilitate maximum participation by members and invited attendees with disabilities (Directive to Take Action); and be it further

RESOLVED, That our AMA report back to the HOD by no later than the 2023 Annual Meeting with a plan on how to maximize ~~HOD~~ meeting participation for members and invited attendees with disabilities. (Directive to Take Action)

Overwhelmingly supportive testimony was received in favor of Resolution 610. Clarification on the resolution intent was offered during testimony, noting that the scope relates to accommodations to support individuals with physical disabilities.

Your Reference Committee believes that the first, third and fourth resolves support finding ways to allow meaningful participation in all AMA meetings and implicitly addresses the second resolve. Therefore, your Reference Committee believes that the deletion of the second resolve is appropriate because it was accomplished through the other Resolve clauses.

(13) RESOLUTION 611 - CONTINUING EQUITY EDUCATION

RECOMMENDATION A:

Resolution 611 be amended by addition and deletion to read as follows:

~~RESOLVED, That our American Medical Association including its Center for Health Equity, host health equity sessions periodically establish an Open Forum on Health Equity, to be held annually at a House of Delegates Meeting, for members to directly engage in educational discourse and strengthen organizational capacity to advance and operationalize equity. (Directive to Take Action); and be it further~~

RESOLVED, That our American Medical Association establish an Open Forum on Health Equity, to be held at least annually at a House of Delegates Meeting,

for members to directly engage in educational discourse and strengthen organizational capacity to advance and operationalize equity. (Directive to Take Action)

RECOMMENDATION B:

Resolution 611 be amended by addition of a new second resolve to read as follows:

~~RESOLVED, That our American Medical Association reassess its periodic health equity sessions in three years. (Directive to Take Action)~~

RECOMMENDATION C:

Resolution 611 be adopted as amended.

HOD ACTION: Resolution 611 adopted as amended.

RESOLVED, That our American Medical Association establish an Open Forum on Health Equity, to be held at least annually at a House of Delegates Meeting, for members to directly engage in educational discourse and strengthen organizational capacity to advance and operationalize equity. (Directive to Take Action)

Your Reference Committee heard supportive testimony acknowledging the importance of prioritizing equity through forums, education sessions, and other programming. Testimony supported changing the frequency of educational opportunities to each House of Delegates meeting, noting that it will increase education and awareness of the effects of bias, prejudice, and racism in medicine.

During testimony, it was mentioned that a call for education sessions is made prior to each House of Delegates meeting. For the June 2022 meeting, the Center for Health Equity opted to host education sessions in lieu of an open forum. Format and timing of educational sessions at the House of Delegates is at the discretion of the Speakers in consultation with subject matter experts. In addition, the proffered language allows for the potential of additional sessions offered online, asynchronous to the House of Delegates meeting, or even at other AMA sponsored meetings.

Therefore, your Reference Committee recommends that Resolution 611 be adopted as amended.

(14) RESOLUTION 612 - IDENTIFYING STRATEGIES FOR ACCURATE DISCLOSURE AND REPORTING OF RACIAL AND ETHNIC DATA ACROSS THE MEDICAL EDUCATION CONTINUUM AND PHYSICIAN WORKFORCE

RECOMMENDATION A:

That the second resolve of Resolution 612 be amended by addition and deletion read as follows:

RESOLVED, That our AMA report demographic physician workforce data in ~~mutually exclusive~~ categories of race and ethnicity whereby Latino, Hispanic, and ~~Other Spanish ethnicity and Middle Eastern North African ethnicity~~ other identified ethnicities are categories, irrespective of race (Directive to Take Action); and be if further

RECOMMENDATION B:

Resolution 612 be adopted as amended.

HOD ACTION: Resolution 612 adopted as amended.

RESOLVED, That our American Medical Association adopt racial and ethnic demographic data collection practices that allow self-identification of designation of one or more racial categories (Directive to Take Action); and be it further

RESOLVED, That our AMA report demographic physician workforce data in mutually exclusive categories of race and ethnicity whereby Latino, Hispanic, and Other Spanish ethnicity and Middle Eastern North African ethnicity are categories, irrespective of race (Directive to Take Action); and be it further

RESOLVED, That our AMA adopt racial and ethnic physician workforce demographic data reporting practices that permit disaggregation of individuals who have chosen multiple categories of race so as to distinguish each category of individuals' demographics as alone or in combination with any other racial and ethnic category (Directive to Take Action); and be it further

RESOLVED, That our AMA collaborate with AAMC, ACGME, AACOM, AOA, NBME, NBOME, NRMP, FSBM, CMSS, ABMS, HRSA, OMB, NIH, ECFMG, and all other appropriate stakeholders, including minority physician organizations, and relevant federal agencies to develop standardized processes and identify strategies to improve the accurate collection, disclosure and reporting of racial and ethnic data across the medical education continuum and physician workforce. (Directive to Take Action)

Testimony was supportive of the resolution and the proposed amendment. Testimony from one of the authors suggested an amendment to Resolve 2 because, as written, the Resolve negates existing AMA Policy D-350.979, "Disaggregation of Demographic Data for Individuals of Middle Eastern and North African Descent." The recommended amendment resolves this conflict.

Your Reference Committee agrees with the amendment brought forth by the Minority Affairs Section and adoption of the resolution as amended.

(15) RESOLUTION 614 - ALLOWING VIRTUAL INTERVIEWS ON NON-HOLIDAY WEEKENDS FOR CANDIDATES FOR AMA OFFICE

RECOMMENDATION A:

Resolution 614 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA amend policy G-610.020, "Rules for AMA Elections," by addition and deletion to read as follows:

Interviews may be conducted only during a 4-7 day window designated by the Speaker beginning on the Thursday evening of a non-holiday weekend at least two weeks but not more than 4 weeks prior to the scheduled Opening Session of the House of Delegates meeting at which elections will take place ~~and must be concluded by that following Sunday (four days later)~~. (Modify Current HOD Policy)

RECOMMENDATION B:

Resolution 614 be adopted as amended.

HOD ACTION: Resolution 614 adopted as amended.

RESOLVED, That our AMA amend policy G-610.020, "Rules for AMA Elections," by addition and deletion to read as follows:

Interviews may be conducted only during a window designated by the Speaker beginning on the Thursday evening of a non-holiday weekend at least two weeks but not more than 4 weeks prior to the scheduled Opening Session of the House of Delegates meeting at which elections will take place and must be concluded by that following Sunday ~~(four days later)~~. (Modify Current HOD Policy)

Your Reference Committee heard unanimous testimony articulating concerns with hosting candidate interviews over holiday weekends. Additionally, your Reference Committee heard mixed testimony about the merits of both virtual and in-person candidate interviews.

Your AMA Speaker offered a point of clarification by noting the implementation of AMA Policy G-610.020 entails conducting a two-year pilot on virtual interviews. However, the timing of these interviews over the Memorial Day weekend was the result of an amendment proffered during House of Delegates deliberations.

Additional testimony indicated that the timing of the interviews should be left to the discretion of the Speaker and your Reference Committee concurs. Therefore, it is recommended that Resolution 614 be adopted as amended.

(16) RESOLUTION 616 - MEDICAL STUDENT, RESIDENT/FELLOW, AND PHYSICIAN VOTING IN FEDERAL, STATE AND LOCAL ELECTIONS

RECOMMENDATION A:

That the first resolve of Resolution 616 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA study the rate of voter turnout in physicians, residents, fellows, and medical students in federal, and state ~~and local~~ elections without regard to political party affiliation or voting record, as a step towards understanding political participation in the medical community (Directive to Take Action); ~~and be it further~~

RECOMMENDATION B:

That the second resolve of Resolution 616 be deleted:

~~RESOLVED, That our AMA will work with appropriate stakeholders to guarantee a full day off on Election Days at medical schools. (Directive to Take Action)~~

RECOMMENDATION C:

Resolution 616 be adopted as amended.

RECOMMENDATION D:

The title of Resolution 616 be changed to read as follows:

MEDICAL COMMUNITY VOTING IN FEDERAL AND STATE ELECTIONS

HOD ACTION: Resolution 616 adopted as amended with the addition of a new second resolve to read as follows:

RESOLVED, That our AMA will work with appropriate stakeholders to ensure that medical students, residents, fellows and physicians are allowed time to vote without penalty on Election Days. (Directive to Take Action)

RESOLVED, That our AMA study the rate of voter turnout in physicians, residents, fellows, and medical students in federal, state, and local elections without regard to political party affiliation or voting record, as a step towards understanding political participation in the medical community (Directive to Take Action); and be it further

RESOLVED, That our AMA will work with appropriate stakeholders to guarantee a full day off on Election Days at medical schools. (Directive to Take Action)

Testimony was mixed in response to Resolution 616. Those in support of the resolution explained the barriers medical students face when trying to vote; barriers include, geographic, timing, and logistical challenges, and allowing a day off would enable students to vote. Those in opposition feel that including local level elections and guaranteeing a full day off for every election would not be feasible.

Your Reference Committee noted that every state offers no excuse absentee ballots as an alternative to in-person voting.

(17) RESOLUTION 617 - STUDY A NEED-BASED SCHOLARSHIP TO ENCOURAGE MEDICAL STUDENT PARTICIPATION IN THE AMA

RECOMMENDATION A:

Resolution 617 be amended by addition and deletion to read as follows:

~~RESOLVED, That our American Medical Association study explore mechanisms to mitigate costs for all participants associated with medical student participation at national, in person AMA conferences. (Directive to Take Action)~~

RESOLVED, That our American Medical Association study explore mechanisms to mitigate costs incurred by ~~associated with~~ medical students, residents and fellows participation who participate ~~for associated with medical student participation~~ at national, in person AMA conferences. (Directive to Take Action)

RECOMMENDATION B:

Resolution 617 be adopted as amended.

RECOMMENDATION C:

The title of Resolution 617 be changed to read as follows:

STUDY OF MECHANISMS TO MITIGATE THE COST OF MEDICAL STUDENT, RESIDENT AND FELLOW PARTICIPATION IN THE AMA

HOD ACTION: Resolution 617 be adopted as amended with a change in title:

STUDY OF MECHANISMS TO MITIGATE THE COST OF MEDICAL STUDENT, RESIDENT AND FELLOW PARTICIPATION IN THE AMA

RESOLVED, That our American Medical Association explore mechanisms to mitigate costs associated with medical student participation at national, in-person AMA conferences. (Directive to Take Action)

Your Reference Committee received testimony indicating that as we emerge from the COVID-19 pandemic, many states and medical specialty societies are indicating budgets will not be returning to pre-pandemic funding levels due

to increased financial pressures; therefore, our AMA should study methods for maintaining engagement across the Federation of Medicine.

Your Reference Committee agrees with the testimony received that funding concerns are not unique to just medical students and supports broadening the scope of Resolution 617.

(18) RESOLUTION 621 - ESTABLISHING A TASK FORCE TO PRESERVE THE PATIENT-PHYSICIAN RELATIONSHIP WHEN EVIDENCE-BASED, APPROPRIATE CARE IS BANNED OR RESTRICTED

RECOMMENDATION A:

That the first resolve of Resolution 621 be amended by addition, to read as follows:

RESOLVED, That our American Medical Association convene a task force of appropriate AMA councils and interested state and medical specialty societies, in conjunction with the AMA Center for Health Equity, and in consultation with relevant organizations, practices, government bodies, and impacted communities for the purpose of preserving the patient-physician relationship. (Directive to Take Action); and be it further

RECOMMENDATION B:

That the second resolve of Resolution 621 be amended by addition, to read as follows:

RESOLVED, That this task force, which will serve at the direction of our AMA Board of Trustees, will inform the Board to help guide organized medicine's response to bans and restrictions on abortion, prepare for widespread criminalization of other evidence-based care, implement relevant AMA policies, and identify and create implementation-focused practice and advocacy resources on issues including but not limited to:

- a. Health equity impact, including monitoring and evaluating the consequences of abortion bans and restrictions for public health and the physician workforce and including making actionable recommendations to mitigate harm, with a focus on the disproportionate impact on under-resourced, marginalized, and minoritized communities,
- b. Practice management, including developing recommendations and educational materials for addressing reimbursement, uncompensated care, interstate licensure, and provision of care, including telehealth and care provided across state lines;
- c. Training, including collaborating with interested medical schools, residency and fellowship programs, academic centers, and clinicians to mitigate radically diminished training opportunities;
- d. Privacy protections, including best practice support for maintaining medical records privacy and confidentiality, including under HIPAA, for strengthening physician, patient, and clinic security measures, and countering law enforcement reporting requirements;

- e. Patient triage and care coordination, including identifying and publicizing resources for physicians and patients to connect with referrals, practical support, and legal assistance;
- f. Coordinating implementation of pertinent AMA policies, including any actions to protect against civil, criminal, and professional liability and retaliation, including criminalizing and penalizing physicians for referring patients to the care they need; and
- g. Anticipation and preparation, including assessing information and resource gaps and creating a blueprint for preventing or mitigating bans on other appropriate health care, such as gender affirming care, contraceptive care, sterilization, infertility care, and management of ectopic pregnancy and spontaneous pregnancy loss and pregnancy complications. (Directive to Take Action)

RECOMMENDATION B:

Resolution 621 be adopted as amended.

HOD ACTION: Resolution 621 adopted as amended.

RESOLVED, That our American Medical Association convene a task force of appropriate AMA councils and interested state and medical specialty societies, in conjunction with the AMA Center for Health Equity, and in consultation with relevant organizations, practices, government bodies, and impacted communities (Directive to Take Action); and be it further

RESOLVED, That this task force guide organized medicine's response to bans and restrictions on abortion, prepare for widespread criminalization of other evidence-based care, implement relevant AMA policies, and identify and create implementation-focused practice and advocacy resources on issues including but not limited to:

- a) Health equity impact, including monitoring and evaluating the consequences of abortion bans and restrictions for public health and the physician workforce and including making actionable recommendations to mitigate harm, with a focus on the disproportionate impact on under-resourced, marginalized, and minoritized communities,
- b) Practice management, including developing recommendations and educational materials for addressing reimbursement, uncompensated care, interstate licensure, and provision of care, including telehealth and care provided across state lines;
- c) Training, including collaborating with interested medical schools, residency and fellowship programs, academic centers, and clinicians to mitigate radically diminished training opportunities;
- d) Privacy protections, including best practice support for maintaining medical records privacy and confidentiality, including under HIPAA, for strengthening physician, patient, and clinic security measures, and countering law enforcement reporting requirements;
- e) Patient triage and care coordination, including identifying and publicizing resources for physicians and patients to connect with referrals, practical support, and legal assistance;
- f) Coordinating implementation of pertinent AMA policies, including any actions to protect against civil, criminal, and professional liability and retaliation, including criminalizing and penalizing physicians for referring patients to the care they need; and
- g) Anticipation and preparation, including assessing information and resource gaps and creating a blueprint for preventing or mitigating bans on other appropriate health care, such as gender affirming care,

contraceptive care, sterilization, infertility care, and management of ectopic pregnancy and spontaneous pregnancy loss and pregnancy complications. (Directive to Take Action)

Your Reference Committee heard uniformly supportive testimony for Resolution 621. Testimony highlighted that mounting restrictions associated with reproductive health threaten the patient-physician relationship. Unintended consequences of these bans include restricted patient access to care, exacerbation of health inequities, and worsened health outcomes.

Your Reference Committee proffered an amendment to the first resolve clarifying the scope of this taskforce. Additionally, your Reference Committee noted that implementation of the second resolve could present a conflict with AMA Bylaws B-5.3, Duties and Privileges:

B-5.3 Duties and Privileges.

5.3.2 Planning. Serve as the principal planning agent for the AMA.

The proffered amendment makes it clear that the Board will retain its strategic planning role to guide our AMA.

RECOMMENDED FOR REFERRAL

(19) RESOLUTION 605 - FULFILLING MEDICINE'S SOCIAL CONTRACT WITH HUMANITY IN THE FACE OF THE CLIMATE HEALTH CRISIS

RECOMMENDATION:

Resolution 605 be referred.

HOD ACTION: Resolution 605 referred.

RESOLVED, That our American Medical Association reaffirm Policy H-135.949, "Support of Clean Air and Reduction in Power Plant Emissions," (Reaffirm HOD Policy); and be it further

RESOLVED, That our AMA establish a climate crisis campaign that will distribute evidence-based information on the relationship between climate change and human health, determine high-yield advocacy and leadership opportunities for physicians, and centralize our AMA's efforts towards environmental justice and an equitable transition to a net-zero carbon society by 2050. (Directive to Take Action)

Your Reference Committee received testimony indicating that our AMA Council on Science and Public (CSAPH) is crafting a report for submission at the 2022 Interim Meeting; consequently, your Reference Committee believes referral will allow CSAPH to consider the concerns outlined in Resolution 605 and will elicit an expedient response that also ensures alignment with our AMA's overall strategy in this area.

(20) RESOLUTION 608 - TRANSPARENCY OF RESOLUTION FISCAL NOTES

RECOMMENDATION:

Resolution 608 be referred.

HOD ACTION: Resolution 608 referred.

RESOLVED, That our American Medical Association amend current policy G-600.061, "Guidelines for Drafting a Resolution or Report," by addition and deletion to read as follows:

(d) A fiscal note setting forth the estimated resource implications (expense increase, expense reduction, or change in revenue) of ~~the any proposed policy, program, study or directive to take action~~ shall be generated and published by AMA staff in consultation with the sponsor, prior to its acceptance as business of the AMA House of Delegates. Estimated changes in expenses will include direct outlays by the AMA as well as the value of the time of AMA's elected leaders and staff. A succinct description of the assumptions used to estimate the resource implications must be included in the AMA House of Delegates Handbook to justify each fiscal note. ~~When the resolution or report is estimated to have a resource implication of \$50,000 or more, the AMA shall publish and distribute a document explaining the major financial components or cost centers (such as travel, consulting fees, meeting costs, or mailing).~~ No resolution or report that proposes ~~policies, programs, studies~~ or actions that require financial support by the AMA shall be considered without a fiscal note that meets the criteria set forth in this policy. (Modify Current HOD Policy)

Your Reference Committee heard mixed testimony on Resolution 608. Testimony noted that standardizing the fiscal note process will be beneficial for both the resolution author and the House of Delegates.

It was stated that a process for developing fiscal notes was previously established through current AMA policy. Additionally, a concern was raised the proposed process could hinder the timely generation of fiscal notes for emergency resolutions.

Due to issues raised during testimony, your Reference Committee believes that an exploration of all concerns related to fiscal note development is merited and recommends referral.

(21) RESOLUTION 609 - SURVEILLANCE MANAGEMENT SYSTEM FOR ORGANIZED MEDICINE POLICIES AND REPORTS

RECOMMENDATION:

Resolution 609 be referred.

HOD ACTION: Resolution 609 referred.

RESOLVED, That our American Medical Association develop a prioritization matrix across both global and reference committee specific areas of interest (Directive to Take Action); and be it further

RESOLVED, That our AMA develop a web-based surveillance management system, with pre-defined primary and/or secondary metrics, for resolutions and reports passed by their respective governance body (Directive to Take Action); and be it further

RESOLVED, That our AMA share previously approved metrics and results from the surveillance management system at intervals deemed most appropriate to the state and local membership of organized medicine, including where and when appropriate to their patients. (Directive to Take Action)

Your Reference Committee heard mixed testimony in response to Resolution 609.

Our AMA Board of Trustees testified that the intent of Resolution 609 is currently being carried out and the requested information is available on our AMA website. However, testimony reflected that finding the status of an item can be time consuming as one navigates our AMA website.

Your Reference Committee agrees with the testimony indicating that Resolution 609 be referred so our AMA can investigate and report back on various improvements (i.e., more visibility on the website, push notifications to authors, etc.) being undertaken given the concerns raised by our House of Delegates.

(22) RESOLUTION 619 - FOCUS AND PRIORITY FOR THE AMA HOUSE OF DELEGATES

RECOMMENDATION:

Resolution 619 be referred.

HOD ACTION: Resolution 619 referred.

RESOLVED, That the Resolutions Committee be formed as a standing committee of the house, the purpose of which is to review and prioritize all submitted resolutions to be acted upon at the annual and interim meetings of the AMA House of Delegates (Directive to Take Action); and be it further

RESOLVED, That the membership of the Resolutions Committee be composed of one Medical Student Section (MSS) member, one Resident and Fellow Section (RFS) member, and one Young Physicians Section (YPS) member, all appointed by the speakers through nominations of the MSS, RFS, and YPS respectively; six regional members appointed by the speakers through nominations from the regional caucuses, six specialty members appointed by the speakers through nominations from the specialty caucuses, three section members appointed by the speakers through nominations from sections other than the MSS, RFS, and YPS, and one past president appointed by the speakers (Directive to Take Action) and be it further

RESOLVED, That the members of the Resolutions Committee serve staggered two-year terms except for the past president and the MSS and RFS members, who shall serve a one-year term (Directive to Take Action); and be it further

RESOLVED, That members of the Resolutions Committee cannot serve more than four years consecutively (Directive to Take Action); and be it further

RESOLVED, That if a Resolutions Committee member is unable or unwilling to complete his or her term, the speakers will replace that member with someone from a similar member group in consultation with that group the next year, and the new member will complete the unfulfilled term (Directive to Take Action); and be it further

RESOLVED, That each member of the Resolutions Committee confidentially rank resolutions using a 0-to-5 scale (0 – not a priority to 5 – top priority) based on scope (the number of physicians affected), urgency (the urgency of the resolution and the impact of not acting), appropriateness (whether AMA is the appropriate organization to lead on the issue), efficacy (whether an AMA stance would have a positive impact), history (whether the resolution has been submitted previously and not accepted), and existing policy (whether an AMA policy already effectively covers the issue). Resolutions would not have to meet all of these parameters nor would these parameters have to be considered equally (Directive to Take Action); and be it further

RESOLVED, That the composite (or average) score of all members of the Resolutions Committee be used to numerically rank the proposed resolutions. No resolution with a composite average score of less than 2 would be recommended for consideration. The Resolutions Committee would further determine the cutoff score above which resolutions would be considered by the house based on the available time for reference committee and house discussion, and the list of resolutions ranked available for consideration would be titled “Resolutions Recommended to be Heard by the HOD” (Directive to Take Action); and be it further

RESOLVED, That the Resolutions Committee also make recommendations on all resolutions submitted recommending reaffirmation of established AMA policy and create a list titled “Resolutions Recommended for Reaffirmation,” with both lists presented to the house for acceptance (Directive to Take Action); and be it further

RESOLVED, That the membership of the Resolutions Committee be published on the AMA website with a notice that the appointed members should not be contacted, lobbied, or coerced; any such activity must be reported to the AMA Grievance Committee for investigation; and should the alleged violations be valid, disciplinary action of the offending person will follow (Directive to Take Action); and be it further

RESOLVED, That the bylaws be amended to add the Resolution Committee as a standing Committee with the defined charge, composition, and functions as defined above for all AMA HOD meetings effective Interim 2022. (Directive to Take Action)

Many who testified in opposition to Resolution 619 noted that this topic is currently under study with the pending Board of Trustees report back on Resolution 605 (N-21), “Formalization of the Resolution Committee as a Standing Committee of the American Medical Association House of Delegates.” Further, opposing testimony expressed concern that establishing a Resolution Committee compromises the democratic process and could result in diminished ability for minority voices to be heard, disenfranchisement with the policy process, and potential loss of membership.

Testimony in support of Resolution 619 indicated that establishing a Resolutions Committee would promote efficiency and contribute to process improvements in policy making.

Your Reference Committee believes the complexity of this issue warrants further exploration and recommends referral to inform the pending Board of Trustees report.

(23) RESOLUTION 622 - HOD MODERNIZATION

RECOMMENDATION:

Resolution 622 be referred.

HOD ACTION: Resolution 622 referred.

RESOLVED, That our AMA immediately convene a task force [The House of Delegates (HOD) Modernization Task Force] representing HOD stakeholders, including representatives from all AMA Sections, charged with analyzing lessons learned from virtual meetings of our HOD to determine how future in-person meetings may be

updated to improve the efficiency and effectiveness of the HOD, while making efforts to maintain the central tenets of our House, including equity, democracy, protecting minority voices, and recognizing the importance of in-person deliberations. (Directive to Take Action); and be it further

RESOLVED, That the Speakers issue updates on the HOD Modernization Task Force progress and recommendations beginning at the 2022 Interim Meeting of the AMA House of Delegates and each meeting thereafter until the Task Force has completed its work (Directive to Take Action)

Minimal testimony was received in response to Resolution 622. However, your Reference Committee recognizes the objective of the resolution relates to an ongoing topic and believes a Board of Trustees report on the nuances of a hybrid environment would serve to inform the decision of our AMA House of Delegates.

(24) RESOLUTION 625 - AMA FUNDING OF POLITICAL CANDIDATES WHO
OPPOSE RESEARCH-BACKED FIREARM REGULATIONS

RECOMMENDATION:

Resolution 625 be referred.

HOD ACTION: Resolution 625 adopted as amended with a change in title:

POLITICAL ACTION COMMITTEES AND CONTRIBUTIONS

RESOLVED, That our AMA amend policy G-640.020 as follows:

G-640.020 – POLITICAL ACTION COMMITTEES AND CONTRIBUTIONS

Our AMA: (1) Believes that better-informed and more active citizens will result in better legislators, better government, and better health care; (2) Encourages AMA members to participate personally in the campaign of their choice and strongly supports physician/family leadership in the campaign process; (3) Opposes legislative initiatives that improperly limit individual and collective participation in the democratic process; (4) Supports AMPAC's policy to adhere to a no Rigid Litmus Test policy in its assessment and support of political candidates; (5) Encourages AMPAC to continue to consider the legislative agenda of our AMA and the recommendations of state medical PACs in its decisions; (6) Urges members of the House to reaffirm their commitment to the growth of AMPAC and the state medical PACs; (7) Will continue to work through its constituent societies to achieve a 100 percent rate of contribution to AMPAC by members; ~~and~~ (8) Calls upon all candidates for public office to refuse contributions from tobacco companies and their subsidiaries; and (9) Calls upon all candidates for public office to refuse contributions from any organization that opposes evidence-based public health measures to reduce firearm violence.

Testimony heard on Resolution 625 indicated that gun violence is a long-standing issue that remains prevalent in our society, and even more so considering recent events across our country. Despite already having AMA policy recognizing gun violence as a public health crisis, testimony indicated that additional actions need to be taken. One recommended action is to address funding of political candidates who oppose research-backed firearm regulations.

Additional testimony from a member of AMPAC indicated support for the spirit of Resolution 625, but clarification and research is needed to better understand this issue.

REFERRED FOR DECISION

- (25) RESOLUTION 606 - FINANCIAL IMPACT AND FISCAL
TRANSPARENCY OF THE AMERICAN MEDICAL ASSOCIATION
CURRENT PROCEDURAL TERMINOLOGY® SYSTEM

RECOMMENDATION:

Resolution 606 be referred for decision.

HOD ACTION: Resolution 606 referred for decision.

RESOLVED, That our American Medical Association survey physicians about and study the impact of the 2021 CPT® Evaluation and Management coding reform on physicians, among all specialties, in private and employed practices and report the findings and any recommendations at the November 2022 meeting of the House of Delegates. (Directive to Take Action)

Your Reference Committee heard testimony indicating that our AMA has partnered with the University of California San Francisco Center for Clinical Informatics and Improvement Research to study the impact of the 2021 E&M coding and documentation changes on physicians. A concurrent study is measuring documentation time and physician burnout among physicians in an academic medical center Epic system client.

While support for referral was heard, some indicated a desire for a report back on the findings. Our Board of Trustees indicated that our AMA is working to get the studies published in a peer reviewed journal.

RECOMMEND FOR NOT ADOPTION

(26) BOARD OF TRUSTEES REPORT 11 - PROCEDURE FOR ALTERING THE SIZE OR COMPOSITION OF SECTION GOVERNING COUNCILS

RECOMMENDATION:

Recommendations in Board of Trustees Report 11 not be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendations in Board of Trustees Report 11 not adopted and the remainder of the Report be filed.

Your Board of Trustees recommends that the following recommendations be adopted and that the remainder of this report be filed:

1. That AMA Bylaws be amended to include the size and core composition (chair cycle, delegate/alternate delegate) of each section governing council. (Modify Bylaws)
2. That the Council on Long Range Planning and Development develop criteria for reviewing requests to alter the size or core composition (chair cycle, delegate/alternate delegate) of section governing councils. (Directive to Take Action)
3. That the Council on Long Range Planning and Development be assigned responsibility for reviewing and making recommendations to the House of Delegates as to the disposition of any request to alter the size or core composition (chair cycle, delegate/alternate delegate) of a section governing council. (Modify Bylaws)

There was overwhelming testimony in opposition to Board of Trustees Report 11. Testimony indicated that the House of Delegates should not provide input on the operations and composition of the Sections as it could be incompatible with the fiduciary responsibilities of the Board of Trustees. Further, concern was expressed that the AMA Sections were created to represent the interests of groups that are not otherwise well-represented in the House of Delegates. Accordingly, the leadership of the respective sections were better positioned to identify the objectives and concerns along with potential solutions. Testimony supported updating the section's Internal Operating Procedures as a mechanism for codifying necessary changes to the size or composition of a section.

It was noted that the AMA Bylaws were changed in the past to simplify Sections' operations; therefore, to adopt this complexity would be a step backward. Additionally, it was also noted that the proposed process for altering the size or composition of a Section's Governing Council would create an administrative burden for both the House of Delegates and the Sections, at a time when the House of Delegates is working on ways to better manage increasing items of business.

In light of the testimony presented, your Reference Committee recommends that Board of Trustees Report not be adopted.

(27) RESOLUTION 613 - TIMING OF BOARD REPORT ON RESOLUTION 605 FROM N-21 REGARDING A PERMANENT RESOLUTION COMMITTEE

RECOMMENDATION:

Resolution 613 not be adopted.

HOD ACTION: Resolution 613 not adopted.

RESOLVED, That the Report of the Board of Trustees regarding Resolution 605 from N-21 be presented to the American Medical Association House of Delegates with recommendation(s) for the House of Delegates to be voted upon at the 2022 Interim Meeting. (Directive to Take Action)

Testimony was opposed to Resolution 613 and indicated that when referring an item to the Board of Trustees, sufficient time needs to be allowed for our Board of Trustees to respond with the highest quality report possible.

(28) RESOLUTION 623 - VIRTUAL ATTENDANCE AT AMA MEETINGS

RECOMMENDATION:

Resolution 623 not be adopted.

HOD ACTION: Resolution 623 not adopted.

RESOLVED, That our American Medical Association expand the format of Section meetings to include official participation via virtual, as well as in-person, attendance at Section Meetings, with procedures to include voting as well as testimony and educational presentations, and ensure equity and full access to meaningful interaction of those accredited but not physically present starting at the Interim 2022 Meeting (Directive to Take Action); and be it further

RESOLVED, That our AMA study the experience of Sections that include virtual participation in business meetings with voting privileges, with the goal of expanding House of Delegates meetings to include virtual participation with those privileges as an option to in-person attendance at its meeting and reference committees, and report back to the HOD by Interim 2023 (Directive to Take Action).

Testimony was largely in opposition. According to testimony, actions of the Sections should be determined by their respective Governing Councils, not by the House of Delegates. Another piece of testimony explained that the Sections exist to protect minority voices and treating them differently than the House of Delegates would be inequitable. A possible unintended consequence of Resolution 623 discussed in testimony was the potential for physicians and students to be defunded for travel by their respective societies/delegations.

Based on abundant testimony in opposition, your reference committee recommends for Resolution 623 be not adopted.

RECOMMENDED FOR FILING

(29) BOARD OF TRUSTEES REPORT 1 - ANNUAL REPORT

RECOMMENDATION:

Board of Trustees Report 1 be filed.

HOD ACTION: Board of Trustees Report 1 filed.

The Consolidated Financial Statements for the years ended December 31, 2021 and 2020 and the Independent Auditor's report have been included in a separate booklet, titled "2021 Annual Report." This booklet is included in the Handbook mailing to members of the House of Delegates and will be discussed at the Reference Committee F hearing.

Beyond the introduction of Board of Trustees Report 1, your reference committee received no further testimony.

Your reference committee recommends that the Board of Trustees Report 1 be filed.

REPORT OF REFERENCE COMMITTEE G

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Council on Medical Service Report 1 –Sunset Review of 2012 House Policies
2. Resolution 705 – Fifteen Month Lab Standing Orders
3. Resolution 732 – Advocacy of Private Practice Options for Healthcare Operations in Large Corporations

RECOMMENDED FOR ADOPTION AS AMENDED

4. Board of Trustees Report 18 – Addressing Inflammatory and Untruthful Online Ratings
5. Council on Medical Service Report 2 – Prospective Payment Model Best Practices for Independent Private Practice
6. Council on Medical Service Report 5 – Poverty-Level Wages and Health
7. Resolution 702 – Health System Consolidation
8. Resolution 723 – Physician Burnout
9. Resolution 724 – Ensuring Medical Practice Viability through Reallocation of Insurance Savings during the COVID-19 Pandemic
10. Resolution 726 – Payment for the Cost of Electronic Prescription of Controlled Substances and Compensation for Time Spent Engaging State Prescription Monitoring Programs
11. Resolution 727 – Utilization Review, Medical Necessity Determination, Prior Authorization Decisions
12. Resolution 729 – Protecting Physicians Wellbeing on Board Certification Applications
13. Resolution 731 – Prior Authorization Patient Autonomy

RECOMMENDED FOR ADOPTION IN LIEU OF

14. Resolution 701 – Appeals and Denials – CPT Codes for Fair Compensation
Resolution 710 – Prior Authorization – CPT Codes for Fair Compensation
15. Resolution 716 – Discharge Summary Reform
16. Resolution 728 – Maintaining an Open and Equitable Hospital Work Environment for Specialists
Resolution 730 – Maintaining an Open and Equitable Hospital Work Environment for Specialists

RECOMMENDED FOR REFERRAL

17. Resolution 721 – Amend AMA Policy H-215.981, “Corporate Practice of Medicine”

RECOMMENDED FOR NOT ADOPTION

18. Resolution 703 – Mandating Reporting of All Antipsychotic Drug Use in Nursing Home Residents
19. Resolution 708 – Physician Burnout is an OSHA Issue
20. Resolution 717 – Expanding the AMA’s Study on the Economic Impact of COVID-19

RECOMMENDED FOR ADOPTION

(1) COUNCIL ON MEDICAL SERVICE REPORT 1 - SUNSET REVIEW OF 2012 HOUSE POLICIES

RECOMMENDATION:

That the Recommendations in Council on Medical Service Report 1 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Service Report 1 adopted and the remainder of the report filed.

The Council on Medical Service recommends that the House of Delegates policies that are listed in the appendix to this report be acted upon in the manner indicated and the remainder of this report be filed.

Your Reference Committee heard testimony that was unanimously supportive of Council on Medical Service Report 1. We recommend the Recommendations in Council on Medical Service Report 1 be adopted and the remainder of the report be filed.

(2) RESOLUTION 705 - FIFTEEN MONTH LAB STANDING ORDERS

RECOMMENDATION:

That Resolution 705 be adopted.

HOD ACTION: Resolution 705 adopted.

RESOLVED, That our American Medical Association advocate the Centers for Medicare and Medicaid Services to allow standing laboratory orders to be active for fifteen (15) months. (Directive to Take Action)

Your Reference Committee heard limited testimony mostly in support of Resolution 705 as it expands upon the AMA's work to ease administrative burden. Testimony indicated that allowing standing laboratory orders to be active for fifteen months – rather than six – will help physicians, their patients, and staff. We agree that this would give physicians the choice and flexibility to extend their laboratory orders, if appropriate. We further note that testimony was not heard regarding the proposed fifteen-month time period compared other time periods. Therefore, your Reference Committee recommends that Resolution 705 be adopted.

(3) RESOLUTION 732 - ADVOCACY OF PRIVATE PRACTICE OPTIONS FOR HEALTHCARE OPERATIONS IN LARGE CORPORATIONS

RECOMMENDATION:

That Resolution 732 be adopted.

HOD ACTION: Resolution 732 adopted.

RESOLVED, That our American Medical Association study the best method to create pilot programs which advance the advocacy of private practice and small business medicine within the rapidly growing area of internal healthcare within Fortune 500 corporations in American with a report back at Annual 2023 (Directive to Take Action); and be it further

RESOLVED, That our AMA use proposals for the advocacy of small business medicine and private practice models in healthcare as a pilot project in the development of advocacy programs within major leading corporations like Amazon and Walmart which are currently entering the healthcare service market with internalized models of

healthcare in the complete absence of more diverse private practice (small business) options (Directive to Take Action); and be it further

RESOLVED, That our AMA prioritize advocacy efforts that emphasize small private practice utilization within the investment and business efforts of Fortune 500 corporations that are currently seeking to enter into the healthcare industry. (Directive to Take Action).

Your Reference Committee heard limited testimony unanimously in support of Resolution 732. Testimony expressed concern regarding the extremely fragile nature of the private practice environment and the intrusion of large corporations into this health care space. It was stated that the AMA should support small business medicine and private practice models through the study of pilot programs within the rapidly growing area of internal healthcare within Fortune 500 corporations. Therefore, your Reference Committee recommends that Resolution 732 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

(4) BOARD OF TRUSTEES REPORT 18 - ADDRESSING INFLAMMATORY AND UNTRUTHFUL ONLINE RATINGS

RECOMMENDATION A:

That the first Recommendation of Board of Trustees Report 18 be amended by addition and deletion as follows:

That our American Medical Association: (1) encourages physicians to take an active role in managing their online reputation in ways that can help them improve practice efficiency and patient care; (2) encourages physician practices and health care organizations to establish policies and procedures to address negative online complaints directly with patients that do not run afoul of federal and state privacy laws; ~~and~~ (3) will develop and publish educational material to help guide physicians and their practices in managing their online reputation, including recommendations for responding to negative patient reviews and clarification about how federal privacy laws apply to online reviews; and (4) will work with appropriate stakeholders to (a) consider an outlet for physicians to share their experiences and (b) potentially consider a mechanism for recourse for physicians whose practices have been affected by negative online reviews, consistent with federal and state privacy laws (Directive to Take Action).

RECOMMENDATION B:

That Board of Trustees Report 18 be adopted as amended and the remainder of the report be filed.

HOD ACTION: First Recommendation of Board of Trustees Report 18 be adopted as amended and remainder of report filed.

The Board of Trustees recommends that the following recommendation be adopted in lieu of Resolution 702-Jun-21 and the remainder of the report be filed:

That our American Medical Association: (1) encourages physicians to take an active role in managing their online reputation in ways that can help them improve practice efficiency and patient care; (2) encourages physician practices and health care organizations to establish policies and procedures to address negative online complaints directly with patients that do not run afoul of federal and state privacy laws; and (3) will develop and publish educational material to help guide physicians and their practices in managing their online reputation, including recommendations for responding to negative patient reviews and clarification about how federal privacy laws apply to online reviews (Directive to Take Action).

Your Reference Committee heard testimony in support of Board of Trustees Report 18. There was concern that as written the directives did not go far enough to address physicians' experiences with navigating how to handle untruthful online reviews. We provide an amendment that addresses this, to encourage the AMA to work with appropriate stakeholders to find an outlet for physicians to share their experiences and potentially develop a mechanism for recourse for physicians whose practices have been affected by negative online reviews. We note that our amended language could encompass the potential to develop a forum or hotline as mentioned in testimony without being overly restrictive. We recommend that Board of Trustees Report 18 be adopted as amended and the remainder of the report be filed.

(5) COUNCIL ON MEDICAL SERVICE REPORT 2 - PROSPECTIVE
PAYMENT MODEL BEST PRACTICES FOR INDEPENDENT PRIVATE
PRACTICE

RECOMMENDATION A:

That Council on Medical Service Report 2 be amended by addition of a new Recommendation 3 (with remaining recommendations renumbered appropriately) to read as follows:

3. That our AMA identify financially viable prospective payment models and develop educational opportunities for physicians to learn and collaborate on best practices for such payment models for independent private physician practice, including but not limited to independent private practice. (Directive to Take Action)

RECOMMENDATION B:

That Recommendations in Council on Medical Service Report 2 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Service Report 2 adopted as amended and remainder of report filed.

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 122-J-21, and the remainder of the report be filed:

1. That our American Medical Association (AMA) support the consideration of prospective payment elements in the development of payment and delivery reform that are consistent with AMA principles. (New HOD Policy)
2. That our AMA support the following principles to support physicians who choose to participate in prospective payment models:
 - a. The AMA, state medical associations, and national medical specialty societies should be encouraged to continue to provide guidance and support infrastructure that allows independent physicians to join with other physicians in clinically integrated networks, independent of any hospital system.
 - b. Prospective payment model compensation should incentivize specialty and primary care collegiality among independently practicing physicians.
 - c. Prospective payment models should take into consideration clinical data, where appropriate, in addition to claims data.
 - d. Governance within the model must be physician-led and autonomous.
 - e. Physician practices should be encouraged to work with field advisors on patient attributions and a balanced mix of payers.
 - f. Quality metrics used in the model should be clinically meaningful and developed with physician input.
 - g. Administrative burdens, such as those related to prior authorization, should be reduced for participating physicians. (New HOD Policy)
3. That our AMA reaffirm Policies H-165.844 and H-385.926, which support pluralism and the freedom of physician enterprise. (Reaffirm HOD Policy)
4. That our AMA reaffirm Policy H-385.907, which supports fair and accurate risk adjustment.
5. That our AMA reaffirm Policies H-385.913, D-478.972, D-478.995, H-478.984, H-479.980, D-480.965, H-480.946, D-480.969, and H-285.957, which collectively address the concerns raised in Resolution 122-I-21. (Reaffirm HOD Policy)

Your Reference Committee heard mixed testimony on this report, which responded to referred Resolution 122-J-21. The sponsor of the original resolution expressed dissatisfaction with the direction of the Council report and requested consideration of an amendment for a new Recommendation similar to Resolution 122-J-21. Supportive testimony noted the timeliness and need for the principles outlined in the report. The Council emphasized the wealth of AMA policy and advocacy related to best practices for prospective payment models as outlined in its report, and strongly urged adoption of its recommendations.

Your Reference Committee appreciates both perspectives and offers its amendment as a potential compromise. The recommended new amendment is consistent with the AMA policy and resources outlined in the report as well as the goals of the sponsor of Resolution 122-J-21. Your Reference Committee heard other amendments and believes they are unnecessary with the addition of the new Recommendation 3.

(6) COUNCIL ON MEDICAL SERVICE REPORT 5 - POVERTY-LEVEL WAGES AND HEALTH

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the second Recommendation of Council on Medical Service Report 5 be amended by addition and deletion to read as follows:

2. That our AMA advocate for ~~affirm that~~ federal, state, and/or local policies regarding minimum wage that should include plans for adjusting the minimum wage level in the future to and an explanation of how these adjustments can keep pace with inflation (New HOD Policy).

RECOMMENDATION B:

That Recommendation 3 in Council on Medical Service Report 5 be amended by deletion to read as follows:

3. That our AMA affirm that federal, state, and/or local policies regarding minimum wage should be consistent with the AMA's commitment to speak against policies that create greater health inequities and be a voice for ~~our most~~ vulnerable populations who will suffer the most under such policies, further widening the gaps that exist in health and wellness in our nation. (New HOD Policy)

RECOMMENDATION C:

That Recommendation 6 in Council on Medical Service Report 5 be amended by deletion addition to read as follows:

~~6. That our AMA affirm that federal, state, and/or local policies regarding minimum wage should include an estimate of the policy's impact on factors including, but not limited to:~~
~~a. Unemployment and/or reduction in hours;~~
~~b. First-time job seekers;~~
~~c. Qualification for public assistance (e.g., food, housing, transportation, childcare, health care, etc.);~~
~~d. Working conditions;~~
~~e. Health equity, with specific focus on gender, and both minoritized and marginalized communities;~~
~~f. Income equity;~~
~~g. Local small business viability, including independent physician practices; and~~
~~h. Educational and/or training opportunities. (New HOD Policy)~~

RECOMMENDATION D:

That the Recommendations in Council on Medical Service Report 5 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Service Report 5 adopted as amended and remainder of report filed.

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 203-N-21 and that the remainder of the report be filed:

1. That our American Medical Association (AMA) affirm that poverty is detrimental to health. (New HOD Policy)
2. That our AMA affirm that federal, state, and/or local policies regarding minimum wage should include plans for adjusting the minimum wage level in the future and an explanation of how these adjustments can keep pace with inflation. (New HOD Policy)
3. That our AMA affirm that federal, state, and/or local policies regarding minimum wage should be consistent with the AMA's commitment to speak against policies that create greater health inequities and be a voice for our most vulnerable populations who will suffer the most under such policies, further widening the gaps that exist in health and wellness in our nation. (New HOD Policy)
4. That our AMA affirm that federal, state, and/or local policies regarding minimum wage should be consistent with the AMA's principle that the highest attainable standard of health, in all its dimensions, is a basic human right and that optimizing the social determinants of health is an ethical obligation of a civil society. (New HOD Policy)
5. That our AMA affirm that federal, state, and/or local policies regarding minimum wage should include an explanation of how variations in geographical cost of living have been considered. (New HOD Policy)
6. That our AMA affirm that federal, state, and/or local policies regarding minimum wage should include an estimate of the policy's impact on factors including:
 - a. Unemployment and/or reduction in hours;
 - b. First-time job seekers;
 - c. Qualification for public assistance (e.g., food, housing, transportation, childcare, health care, etc.);
 - d. Working conditions;
 - e. Health equity, with specific focus on gender and minoritized and marginalized communities;
 - f. Income equity;
 - g. Local small business viability, including independent physician practices; and
 - h. Educational and/or training opportunities. (New HOD Policy)
7. That our AMA reaffirm Policy D-440.922, which states that the AMA will enhance advocacy and support for programs and initiatives that strengthen public health systems to address health inequities and the social determinants of health. (Reaffirm HOD Policy)
8. That our AMA reaffirm Policy H-165.822, which 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. (Reaffirm HOD Policy)

Your Reference Committee heard testimony that was supportive of Council on Medical Service Report 5. There were several amendments offered, and we believe the language we provide here encompasses all of these changes. By adding "but not limited to" we ensure that all present and future issues are included in Recommendation 6. Your Reference Committee appreciates the language used by the Council in crafting their recommendations. The use of "affirmation" allows for flexibility in the future, which is important in addressing the nuanced issue of inflation and minimum wage. Finally, we heard testimony regarding the use of "vulnerable" in Recommendation 3. Our goal was to align the language with the recommendations in AMA's Guide to Language, Narratives, and Concepts, however, we ultimately found that use of the word "vulnerable" was redundant, so we recommend striking this language from the recommendation. Your Reference Committee recommends that the Recommendations in Council on Medical Service Report 5 be adopted as amended and the remainder of the report be filed.

(7) RESOLUTION 702 - HEALTH SYSTEM CONSOLIDATION

RECOMMENDATION A:

That Resolution 702 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association 1) ~~undertake an annual report assessing~~ study nationwide health system and hospital consolidation in order to assist policymakers and the federal government in assessing healthcare consolidation for the benefit of patients and physicians who face an existential threat from healthcare consolidation; and 2) regularly review and report back on these issues to keep the House of Delegates apprised on relevant changes that may impact the practice of medicine, with the first report no later than A-23.
(Directive to Take Action)

RECOMMENDATION B:

That Resolution 702 be adopted as amended.

HOD ACTION: Resolution 702 adopted as amended.

RESOLVED, That our American Medical Association undertake an annual report assessing nationwide health system and hospital consolidation in order to assist policymakers and the federal government in assessing healthcare consolidation for the benefit of patients and physicians who face an existential threat from healthcare consolidation.
(Directive to Take Action)

Your Reference Committee heard testimony that was supportive of Resolution 702. Testimony from the Council on Medical Service underscored the importance of monitoring this issue regularly, but recommended an updated timeline, as an annual report may be too frequent to yield new results. We recommend an amendment to address this and recommend Resolution 702 be adopted as amended.

(8) RESOLUTION 723 - PHYSICIAN BURNOUT

RECOMMENDATION A:

That the first resolve of Resolution 723 be amended by addition and deletion as follows:

~~RESOLVED, That our American Medical Association will work with the Centers for Medicare and Medicaid Services and The Joint Commission to assure that clinician, including physician, wellbeing is a component of standards for hospital certification (Directive to Take Action); and be it further~~

RESOLVED, That our AMA work with Centers for Medicare and Medicaid Services (CMS), The Joint Commission, and other accrediting bodies and interested stakeholders to add an institutional focus on physician wellbeing as an accreditation standard for hospitals, focusing on system-wide interventions that do not add additional burden to physicians (Directive to Take Action); and be it further

RECOMMENDATION B:

That the second resolve of Resolution 723 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA work with hospitals and other stakeholders to determine areas of focus on ~~clinician~~ physician wellbeing, to include the removal of intrusive questions regarding ~~clinician~~ physician physical or mental health or related treatments on initial or renewal hospital credentialing applications (Directive to Take Action).

RECOMMENDATION C:

That Resolution 723 be adopted as amended.

HOD ACTION: Resolution 723 adopted as amended.

RESOLVED, That our American Medical Association will work with the Centers for Medicare and Medicaid Services and The Joint Commission to assure that clinician, including physician, wellbeing is a component of standards for hospital certification (Directive to Take Action); and be it further

RESOLVED, That our AMA work with hospitals and other stakeholders to determine areas of focus on clinician wellbeing, to include the removal of intrusive questions regarding clinician physical or mental health or related treatments on initial or renewal hospital credentialing applications (Directive to Take Action).

Your Reference Committee heard extensive testimony on Resolution 723. Testimony was generally supportive of this resolution, and there were two separate amendments that proffered substitute language for the first resolve clause. Your Reference Committee saw merit in each of the proposed amendments and combined them for a new first resolve clause. These amendments were considered friendly by the original author of the resolution. Your Reference Committee also recommends amending the second resolve to change “clinician” to “physician” to keep the language consistent between the two clauses. We recommend Resolution 723 be adopted as amended.

(9) RESOLUTION 724 - ENSURING MEDICAL PRACTICE VIABILITY THROUGH REALLOCATION OF INSURANCE SAVINGS DURING THE COVID-19 PANDEMIC

RECOMMENDATION A:

That Policies H-180.975 and D-405.988 be reaffirmed in lieu of the first resolve of Resolution 724.

RECOMMENDATION B:

That the fourth resolve of Resolution 724 be deleted:

~~RESOLVED, That our AMA urge health plans to offer practices per-patient per-month fees for innovative practice models to improve practice sustainability.~~

RECOMMENDATION C:

That Resolution 724 be adopted as amended.

RECOMMENDATION D:

That the title of Resolution 724 be changed to read as follows:

REALLOCATION OF INSURANCE SAVINGS DURING THE COVID-19 PANDEMIC

HOD ACTION: Resolution 724 adopted as amended with a change in title.

REALLOCATION OF INSURANCE SAVINGS DURING THE COVID-19 PANDEMIC

RESOLVED, That our American Medical Association continue to advocate for and educate members about practice viability issues; and be it further

RESOLVED, That our AMA work with private payers to encourage them to pass along savings generated during the pandemic to patients; and be it further

RESOLVED, That our AMA advocate that all plans follow medical loss ratio requirements and, as appropriate and with particular mindfulness of the public health emergency, issue rebates to patients; and be it further

RESOLVED, That our AMA urge health plans to offer practices per-patient-per-month fees for innovative practice models to improve practice sustainability.

Your Reference Committee heard mixed testimony on Resolution 724. There was testimony that supported Reaffirmation of the resolution; however, we found the second and third resolve clauses to be novel, and only recommend reaffirmation of Policy H-180.975 and D-405.988 in lieu of the first resolve clause. There was general opposition to the fourth resolve clause, as it only applies to physicians in certain practice models and may not reflect best practices. We also recommend updating the title of Resolution 724 to align with the amended language. Your Reference Committee recommends Resolution 724 be adopted as amended.

(10) RESOLUTION 726 - PAYMENT FOR THE COST OF ELECTRONIC PRESCRIPTION OF CONTROLLED SUBSTANCES AND COMPENSATION FOR TIME SPENT ENGAGING STATE PRESCRIPTION MONITORING PROGRAMS

RECOMMENDATION A:

That the first resolve clause of Resolution 726 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association advocate for appropriate physician ~~payment incentives through the resource-based relative value scale~~ to cover the expense of technology required to electronically prescribe controlled substances (Directive to Take Action); and be it further

RECOMMENDATION B:

That the second resolve clause of Resolution 726 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA advocate for appropriate physician ~~payment incentives~~ to cover the extra time and expense to query state prescription monitoring programs as required by law. (Directive to Take Action)

RECOMMENDATION C:

That Resolution 726 be adopted as amended.

HOD ACTION: Resolution 726 adopted as amended.

RESOLVED, That our American Medical Association advocate for appropriate physician payment through the resource-based relative value scale to cover the expense of technology required to electronically prescribe controlled substances (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for appropriate physician payment to cover the extra time and expense to query state prescription monitoring programs as required by law (Directive to Take Action).

Your Reference Committee heard mixed testimony on Resolution 726. One delegation speaking in opposition of the Resolution called for an amendment, expressing concerns that it is inappropriate to pursue payment for e-prescribing and prescription monitoring technologies through the resource-based relative value scale. Speaking in support of the Resolution, the Council on Medical Service introduced an amendment addressing this concern and establishing policy that physicians be compensated for e-prescribing of controlled substances and prescription monitoring technologies through incentive programs.

One individual commented that the second resolve clause is redundant as prescription drug monitoring queries may be included in evaluation and management coding. Recognizing that evaluation and management billing only addresses time spent on the day of the visit and understanding that queries may occur on a day other than when the visit occurs, your Reference Committee recommends retaining this clause.

(11) RESOLUTION 727 - UTILIZATION REVIEW, MEDICAL NECESSITY DETERMINATION, PRIOR AUTHORIZATION DECISIONS

RECOMMENDATION A:

That the first resolve clause of Resolution 727 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association advocate for implementation of a federal version of a prior authorization Texas' "gold card" law (~~House Bill 3459~~), which aims to curb onerous prior authorization practices by many state-regulated health insurers and health maintenance organizations (Directive to Take Action); and be it further

RECOMMENDATION B:

That the second resolve clause of Resolution 727 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA ~~House of Delegates~~ advocate adopt a similar policy to Texas's "gold card" law (House Bill 3459) that health plans should offer physicians at least one physician-driven, clinically-based alternative to prior authorization, including a "gold-card" or "preferred provider program." (New HOD Policy) (Directive to Take Action); and be it further

RECOMMENDATION C:

That the third resolve clause of Resolution 727 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA ~~request that the~~ Council on Ethical and Judicial Affairs ~~devise~~ review current ethical opinions similar to the Texas Medical Association ~~TMA~~ Board of Councilors' opinions regarding medical necessity determination and utilization review.

RECOMMENDATION D:

That Resolution 727 be adopted as amended.

HOD ACTION: Resolution 727 adopted as amended.

RESOLVED, That our American Medical Association advocate for implementation of a federal version of Texas' "gold card" law (House Bill 3459), which aims to curb onerous prior authorization practices by many state-regulated health insurers and health maintenance organizations; and be it further

RESOLVED, That our AMA adopt a similar policy to Texas' "gold card" law (House Bill 3459); and be it further

RESOLVED, That our AMA Council on Ethical and Judicial Affairs devise ethical opinions similar to the TMA Board of Councilors' opinions regarding medical necessity determination and utilization review.

Your Reference Committee heard testimony that was generally supportive of Resolution 727. Those speaking in favor stated that the Resolution is responsive to the increasing and excessive use of prior authorization programs by health plans, presents practical safeguards against physician burnout while promoting care access, and will be helpful for state delegations. Supporting the Resolution, the Council on Medical Service (CMS) proposed amendments to make the policy more broadly applicable, while retaining the spirit of the ask. Acting in support of multiple avenues for prior authorization reform, your Reference Committee adopts the amendments proposed by CMS, which eliminate references to a specific state program and highlight relevant principles.

One delegation in opposition to this Resolution supported the first two Resolve clauses but raised concerns about whether involvement of the Council on Ethical and Judicial Affairs (CEJA) is necessary. Your Committee notes that while the House of Delegates may not direct the Council on Ethical and Judicial Affairs (CEJA) to issue an opinion, it may request that CEJA review existing opinions and determine if further action is necessary.

The Reference Committee reviewed the TMA opinions which are as follows:

1. Medical Necessity Determination: (a) the determination of medical necessity is the practice of medicine, it is not a benefit determination; (b) whether or not a proposed treatment is medically necessary should be decided in a manner consistent with generally accepted standards of medical practice that a prudent physician would provide to a patient for the purposes of preventing, diagnosing or treating an illness, injury, disease or its symptoms. This is true even if the physician making the medical necessity determination is making those decisions on behalf of a managed care organization; (c) a physician must not permit financial mechanisms to interfere with his/her determination as to whether a treatment is medically necessary.
2. Utilization Review: The physician who performs utilization review is obligated to review the request for treatment with the same standard of care as would be required by the profession in the community in which the patient is being treated and that review should be considered the practice of medicine. (Directive to Take Action).

Therefore, your Reference Committee recommends requesting CEJA review this and other relevant current opinions. We recommend Resolution 727 be adopted as amended.

(12) RESOLUTION 729 - PROTECTING PHYSICIAN WELLBEING ON BOARD CERTIFIED APPLICATIONS

RECOMMENDATION A:

That the first resolve of Resolution 729 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association work with ~~the American Board of Medical Specialties (ABMS), the American Osteopathic Association (AOA), and the National Board of Physicians and Surgeons (NBPS) and their constituent boards~~ physician board certifying organizations to assure that physicians wellbeing is a primary concern (Directive to Take Action); and be it further

RECOMMENDATION B:

That the second resolve of Resolution 729 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA advocate that the ~~ABMS, AOA, and NBPS constituent boards~~² focus of physician board certifying organizations on physician wellbeing be demonstrated by the removal of intrusive questions regarding physician physical or mental health (including substance misuse) or related treatments on board certification applications (Directive to Take Action); and be it further

RECOMMENDATION C:

That the third resolve of Resolution 729 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA advocate that any questions on ~~ABMS, AOA, and NBPS constituent~~ physician board certifying applications related to physician health be limited to only inquiries about current impairment (Directive to Take Action).

RECOMMENDATION D:

That Resolution 729 be adopted as amended.

RECOMMENDATION E:

That the title of Resolution 729 be changed to read as follows:

PROTECTING PHYSICIAN WELLBEING ON APPLICATIONS FOR
BOARD CERTIFICATION

HOD ACTION: Resolution 729 adopted as amended with a change in title.

PROTECTING PHYSICIAN WELLBEING ON APPLICATIONS FOR BOARD
CERTIFICATION

RESOLVED, That our American Medical Association work with the American Board of Medical Specialties (ABMS), the American Osteopathic Association (AOA), and the National Board of Physicians and Surgeons (NBPS) and their constituent boards to assure that physicians wellbeing is a primary concern (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate that the ABMS, AOA, and NBPS constituent boards' focus on physician wellbeing be demonstrated by the removal of intrusive questions regarding physician physical or mental health (including substance misuse) or related treatments on board certification applications (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate that any questions on ABMS, AOA, and NBPS constituent board certification applications related to physician health be limited to only inquiries about current impairment (Directive to Take Action).

Your Reference Committee heard limited, supportive testimony for Resolution 729 and appreciation for all the work being done by the AMA on the issue of physician burnout. A friendly amendment was offered with broader language as there was concern that the specific listing of organizations would potentially exclude other legitimate physician credentialing bodies now and/or in the future. The Council on Medical Education expressed strong

agreement with the amended language. Testimony also specifically expressed support for the third resolve clause which advocates limiting physician health inquiries to current impairment. Accordingly, your Reference Committee recommends that Resolution 729 be adopted as amended.

(13) RESOLUTION 731 - PRIOR AUTHORIZATION - PATIENT AUTONOMY

RECOMMENDATION A:

That Resolution 731 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association will advocate that patients and physicians should be given access to an electronic prior authorization system by their health plans with the ability to monitor the electronic prior authorization process in any model legislation and as a basis for ~~all~~ advocacy for prior authorization reforms (Directive to Take Action).

RECOMMENDATION B:

That Resolution 731 be adopted as amended.

HOD ACTION: Resolution 731 adopted as amended.

RESOLVED, That our American Medical Association will advocate that patients should be given access to an electronic prior authorization system by their health plans with the ability to monitor the electronic prior authorization process in any model legislation and as a basis for all advocacy for prior authorization reforms (Directive to Take Action).

Your Reference Committee heard ample testimony in support of this Resolution. One delegation proposed an amendment to state that physicians also have access to an electronic prior authorization system, which received support. We offer a clarifying amendment to strike “all.” Your Reference Committee recommends Resolution 731 be adopted as amended.

RECOMMENDED FOR ADOPTION IN LIEU OF

- (14) RESOLUTION 701 - APPEALS AND DENIALS – CPT CODES FOR FAIR COMPENSATION
RESOLUTION 710 – PRIOR AUTHORIZATION – CPT CODES FOR FAIR COMPENSATION

RECOMMENDATION:

That Alternate Resolution 701 be adopted in lieu of Resolutions 701 and 710.

RESOLUTION 701 – FAIR REIMBURSEMENT FOR ADMINISTRATIVE BURDENS

RESOLVED, That our American Medical Association will continue its strong state and federal legislative advocacy efforts to promote legislation that streamlines the prior authorization process and reduces the overall volume of prior authorizations for physician practices (Directive to Take Action); and be it further

RESOLVED, That our AMA will continue partnering with patient advocacy groups in prior authorization reform efforts to reduce patient harms, including care delays, treatment abandonment, and negative clinical outcomes (Directive to Take Action); and be it further

RESOLVED, That our AMA will oppose inappropriate payer policies and procedures that deny or delay medically necessary drugs and medical services (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for fair reimbursement of established and future CPT codes for administrative burdens related to (a) the prior authorization process or (b) appeals or denials of services (visits, tests, procedures, medications, devices, and claims), whether pre- or post-service denials (Directive to Take Action).

HOD ACTION: Alternate Resolution 701 adopted in lieu of Resolutions 701 and 710.

Resolution 701

RESOLVED, That our American Medical Association support the creation of CPT codes for consideration by the CPT® Editorial Panel to provide adequate compensation for administrative work involved in successfully appealing denials of services (visits, tests, procedures, medications, devices, and claims), whether pre- or post-service denials, that reflect the actual time expended by physicians and healthcare practices to advocate on behalf of patients, appeal denials, and to comply with insurer and legal requirements and that compensate physicians fully for the time, effort, and legal risks inherent in such work (Directive to Take Action); and be it further

RESOLVED, That our AMA support the creation of CPT codes for consideration by the CPT Editorial Panel for primary, secondary, and tertiary appeals to independent review organizations (IROs), state and federal regulators, and ERISA plan appeals, including codes for appeals, reconsiderations, and other forms of appeals of adverse determination (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for fair compensation based on CPT codes for appeal of denied services in any model legislation and as a basis for all advocacy for prior authorization reforms. (Directive to Take Action)

Resolution 710

RESOLVED, That our American Medical Association include in any model legislation and as basis for all advocacy, fair compensation based on CPT codes for appeal of wrongfully denied services, including those for prior

authorization reforms and that CPT codes must fully reflect the aggregated time and effort expended by physician practices (Directive to Take Action); and be it further

RESOLVED, That our AMA evaluate and propose a CPT code for consideration by the CPT® Editorial Panel to account for administrative work involved in prior authorizations that reflects the actual time expended by physician practices to advocate on behalf of patients and to comply with insurer requirements (Directive to Take Action); and be it further

RESOLVED, That our AMA evaluate and propose a CPT code for consideration by the CPT® Editorial Panel to account for administrative work that reflects the actual time expended by physician practices and their billing vendors involved in successfully appealing wrongful pre- and post-service denials. (Directive to Take Action)

Testimony on Resolutions 701 and 710 was robust and mixed.

Speakers in favor of the proposed Resolutions cited the appreciable time and cost burden faced by physician practices as a result of improper claim denials and the prior authorization process. Testimony noted that prior authorization is a key contributor to physician burnout, and supporters recommended that AMA address these prior authorization burdens from multiple angles, including compensating physicians for the time and effort spent on such administrative work through novel CPT codes.

Speakers offered testimony in opposition to the Resolutions and offered four main arguments. First, the CPT Editorial Panel Chair and others noted that the CPT Editorial Panel is the only proper forum for the development of CPT codes, and it is inappropriate for the HOD to advocate for such codes (H-70.919). Second, multiple speakers indicated that existing HOD policy (H-385.951) addresses this issue. Third, the Board of Trustees and the Council on Medical Service (CMS) noted that advocacy for compensation for prior authorization could undermine AMA's ongoing prior authorization reform advocacy efforts. Fourth, CMS cited practical challenges acknowledged in prior CMS reports—for example, the existence of a CPT code does not guarantee payment. The Council on Legislation proposed substitute language that reinforces AMA's prior authorization reform advocacy, coalition building efforts, and commitment to oppose payer practices that stand in the way of medically necessary care.

Your Reference Committee appreciates the extensive debate on this issue. Your Reference Committee recognizes AMA's active involvement in advocacy efforts to reform prior authorization and acknowledges recent state and federal legislative momentum in this area. Your Committee also recognizes that existing AMA policy could more effectively promote fair reimbursement for work related to prior authorization. Specifically, current AMA policy does not call for advocacy to promote reimbursement for administrative work using existing CPT codes. Hearing the ample testimony, your Reference Committee attempts to incorporate all considerations within the amended language and recommends Alternate Resolution 701 be adopted in lieu of Resolution 701 and Resolution 710.

(15) RESOLUTION 716 - DISCHARGE SUMMARY REFORM

RECOMMENDATION:

That Alternate Resolution 716 be adopted in lieu of Resolution 716.

RESOLVED, That our AMA coordinate with interested stakeholders to develop a model discharge summary that 1) is concise but informational; 2) promotes excellent and safe patient care; and 3) improves coordinated discharge planning (Directive to Take Action).

HOD ACTION: Alternate Resolution 716 adopted in lieu of Resolution 716.

RESOLVED, That our American Medical Association coordinate with the American Hospital Association with input from the Centers for Medicare and Medicaid Services and other professional organizations as appropriate to revive the concise discharge summary that existed prior to electronic medical records for the sake of much improved patient care and safety (Directive to Take Action); and be it further

RESOLVED, That our AMA internally develop a model hospital discharge summary in such a manner as to be concise but informational, include to promote excellent, safe patient care and improve coordinated discharge planning. This model use shall be promoted to our AMA and federation of medicine colleagues. (Directive to Take Action)

Your Reference Committee heard testimony that was generally supportive of Resolution 716. We proffer a substitute resolution that combines the language of both original resolve clauses and makes the resolution more actionable. We chose not to include the amendment proffered during testimony in regards to artificial intelligence and health IT, as we believe these stakeholders are encompassed in the new language we provide. Keeping this language broad will allow for flexibility as action on this issue develops over time. Your Reference Committee recommends that Alternate Resolution 716 be adopted in lieu of Resolution 716.

- (16) RESOLUTION 728 - MAINTAINING AN OPEN AND EQUITABLE HOSPITAL WORK ENVIRONMENT FOR SPECIALISTS
RESOLUTION 730 – MAINTAINING AN OPEN AND EQUITABLE HOSPITAL WORK ENVIRONMENT FOR SPECIALISTS

RECOMMENDATION:

That Alternate Resolution 728 be adopted in lieu of Resolutions 728 and 730.

RESOLUTION 728 – MAINTAINING AN OPEN AND EQUITABLE HOSPITAL WORK ENVIRONMENT

RESOLVED, That our AMA support equal promotion of and access to inpatient consults for credentialed and privileged community/independent specialty physicians on par with hospital-employed specialty physicians (New HOD Policy); and be it further

RESOLVED, That our AMA advocate that hospitals that employ specialty physicians also equitably support having community/independent specialty physicians, if credentialed, be available for observation, inpatient, and emergency department consultation coverage and that the parties negotiate mutually satisfactory payment terms and service agreements for such service to enable physician and patient choice.

~~RESOLVED, That our AMA advocate that hospitals support having community/independent and employed specialty physicians, if credentialed, available for observation, inpatient, and emergency department coverage thus ensuring that physician referrals and consults be based on physician and patient choice (Directive to Take Action).~~

HOD ACTION: Alternate Resolution 728 adopted in lieu of Resolutions 728 and 730.

Resolution 728

RESOLVED, That our American Medical Association take the position that there should be equal visibility of and access to inpatient consults for credentialed and privileged community /independent specialty physicians as well as for hospital-employed specialty physicians (New HOD Policy); and be it further

RESOLVED, That our AMA advocate that hospitals engage community/independent specialty physicians available on the medical staff for observation, inpatient, and emergency department coverage and that the parties negotiate mutually satisfactory payment terms and service agreements for such service (Directive to Take Action).

Resolution 730

RESOLVED, That our American Medical Association support equal promotion of, and access to inpatient consults for, credentialed and privileged community /independent specialty physicians on par with hospital-employed specialty physicians (New HOD Policy); and be it further

RESOLVED, That our AMA advocate that hospitals support having community/independent and employed specialty physicians if credentialed available for observation, inpatient, and emergency department coverage thus ensuring that physician referrals and consults be based on physician and patient choice (Directive to Take Action).

Your Reference Committee heard generally supportive testimony on Resolutions 728 and 730 acknowledging that the trend toward specialty hospitalists has marginalized community/independent specialists in the inpatient setting and constrained access to inpatient hospital consultations by independent physicians. Concerns were raised about closed referral status in regard to access to care, equity and not-for-profit status, as well as the impact of teaching institutions on community care. Testimony also expressed preference for the language in the second resolve of Resolution 730. The Council on Medical Service noted existing policy H-230.951, Economic Discrimination in the Hospital Practice Setting, that opposes policies that limit a physician's access to hospital services based on the number and type of referrals made, the number of procedures performed, the use of any and all hospital services or employment affiliation; and recognizes that physician onboarding, credentialing and peer review should not be tied in a discriminatory manner to hospital employment status. The authors stated that the urgency of this issue is increasing despite our existing policy. Your Reference Committee concurs and recommends that Alternate Resolution 728 be adopted in lieu of Resolutions 728 and Resolution 730.

RECOMMENDED FOR REFERRAL

- (17) RESOLUTION 721 - AMEND AMA POLICY H-215.981, "CORPORATE PRACTICE OF MEDICINE"

RECOMMENDATION:

That Resolution 721 be referred.

HOD ACTION: Resolution 721 referred.

RESOLVED, That our American Medical Association amend policy H-215.981, "Corporate Practice of Medicine," by addition to read as follows:

4. Our AMA acknowledges that the corporate practice of medicine has led to the erosion of the physician-patient relationship, erosion of physician-driven care and created a conflict of interest between profit and training the next generation of physicians. (Modify Current HOD Policy)

Your Reference Committee heard testimony that was supportive of the spirit of this resolution, but overwhelmingly supported referral. We concur as we believe this needs to be studied further to examine the impact on all practice types. For these reasons, your Reference Committee recommends Resolution 721 be referred.

RECOMMENDED FOR NOT ADOPTION

(18) RESOLUTION 703 - MANDATING REPORTING OF ALL ANTIPSYCHOTIC DRUG USE IN NURSING HOME RESIDENTS

RECOMMENDATION:

That Resolution 703 not be adopted.

HOD ACTION: Resolution 703 not adopted.

RESOLVED, That American Medical Association Policy D-120.951, "Appropriate Use of Antipsychotic Medications in Nursing Home Patients," be amended by addition and deletion to read as follows:

Our AMA will: (1) meet with the Centers for Medicare & Medicaid Services (CMS) for a determination that acknowledges that antipsychotics can be an appropriate treatment for dementia-related psychosis if non-pharmacologic approaches have failed and will ask CMS to cease and desist in issuing citations or financial penalties for medically necessary and appropriate use of antipsychotics for the treatment of dementia-related psychosis; ~~and~~ (2) ask CMS to discontinue the use of antipsychotic medication as a factor contributing to the Nursing Home Compare rankings, unless the data utilized is limited to medically inappropriate administration of these medications; and (3) require the reporting of all antipsychotic drugs used and the diagnoses for which they are prescribed. (Modify Current HOD Policy)

Your Reference Committee heard testimony that was mixed, but generally opposed to Resolution 703. There was concern that the amendment proffered to existing policy by the authors of this resolution did not address the crux of this issue, which is the ability of physicians to use correct diagnosis codes. There was also concern about unintended consequences and that this may adversely affect institutions and add administrative burdens to physicians. In addition, there was a lack of clarity on who the reporting body will be and how this will be utilized. For these reasons, we recommend that Resolution 703 not be adopted.

(19) RESOLUTION 708 - PHYSICIAN BURNOUT IS AN OSHA ISSUE

RECOMMENDATION:

That Resolution 708 not be adopted.

HOD ACTION: Resolution 708 not adopted.

RESOLVED, That our American Medical Association seek legislation/regulation to add physician burnout as a Repetitive Strain (Stress) Injury and subject to Occupational Safety and Health Administration (OSHA) oversight. (Directive to Take Action)

Your Reference Committee heard testimony that was generally opposed to Resolution 708. There was unanimous support for addressing physician burnout, but there was concern about inviting Occupational Safety and Health Administration (OSHA) oversight into physician practices as the solution. There was testimony provided by the United States Public Health Service on behalf of the Centers for Disease Control and Prevention to highlight that physician burnout does not fit into the current definition of repetitive stress/strain injury under OSHA regulations, as that category is defined as injuries "to the musculoskeletal and nervous systems that may be caused by repetitive tasks, forceful exertions, vibrations, mechanical compression, or sustained or awkward positions." The United States Public Health Service also recommended this may be more appropriate under the General Duty Clause instead. There were several recommendations for reaffirmation, but given that the AMA does not have specific policy on OSHA oversight, we didn't feel this was appropriate. Furthermore, as Addressing Physician Burnout is included as a pillar in the AMA's Rescue Plan for America's Doctors, your Reference Committee believes that the issue of physician burnout will continue to be a top priority for the AMA. Due to concerns raised during testimony regarding OSHA oversight generally and the specific focus of this resolution on OSHA, we recommend that Resolution 708 not be adopted.

(20) RESOLUTION 717 - EXPANDING THE AMA'S STUDY ON THE ECONOMIC IMPACT OF COVID-19

RECOMMENDATION:

That Resolution 717 not be adopted.

HOD ACTION: Resolution 717 not adopted.

RESOLVED, That our American Medical Association work with relevant organizations and stakeholders to study the economic impact and long-term recovery of the COVID-19 pandemic on healthcare institutions in order to identify and better understand which groups of physicians, patients and organizations may have been disproportionately affected by the financial burdens of the COVID-19 pandemic (Directive to Take Action); and be it further

RESOLVED, That our AMA work with relevant organizations and stakeholders to study the overall economic impact of office closures, cancellations of elective surgeries and interruptions in patient care, as well as the economic impact of utilizing telemedicine for an increasing percentage of patient care. (Directive to Take Action)

In-person testimony on Resolution 717 was limited to the author and the Council on Medical Service. There was limited online testimony in support of the resolution. Testimony from the authors emphasized the need to be proactive with the lessons learned from the COVID-19 pandemic. The Council appreciated the intent and provided compelling testimony in person and online that the AMA's Advocacy unit has been tracking and reporting on changes in the health care sector since the start of the pandemic.

Ongoing AMA work was summarized by the Council on Medical Service and includes:

- (1) a COVID-19 impact survey administered to physicians in July and August of 2020 (COVID-19 Financial Impact on Physician Practices. 2020.);
- (2) analysis and continued monitoring of changes in Medicare physician spending (Changes in Medicare Physician Spending During the COVID-19 Pandemic. American Medical Association Policy Research Perspectives, 2021);
- (3) analysis and continued monitoring of changes in National Health Expenditures estimates from the Centers for Medicare & Medicaid Services;
- (4) analysis and continued monitoring of changes in consumer spending for health care and physician services from the Bureau of Economic Analysis;
- (5) analysis and continued monitoring of changes in employment in health care and physician offices from the Bureau of Labor Statistics; and
- (6) general monitoring of the Economics, Health Services Research and trade literature for studies on the impacts of COVID-19.

The Council further noted that the studies called for in the Resolve clauses are wide-ranging and that it is difficult to isolate the impact of COVID-19 from other changes occurring in health care and the economy. For these reasons, your Reference Committee concurs that the AMA has addressed and continues to monitor the economic impact and long-term recovery of the COVID-19 pandemic on healthcare and recommends that Resolution 717 not be adopted.