

**MEMORIAL RESOLUTIONS  
ADOPTED UNANIMOUSLY**

**Joseph M. Heyman, MD**

Introduced by the New England Delegation

Whereas, Joseph M. Heyman, MD, passed away on February 12, 2022; and

Whereas, Dr. Heyman obtained his medical degree from the State University of New York, Downtown Medical Center in Brooklyn. He then served three years in the U.S. Public Health Service, two of which were spent on the Navajo Indian Reservation in Shiprock, New Mexico; and

Whereas, Dr. Heyman completed a residency in obstetrics and gynecology at Sinai Hospital in Baltimore, Maryland; and

Whereas, Dr. Heyman practiced medicine for 41 years in Massachusetts, first with Women's Health Care in Newburyport and later in a solo practice in Amesbury. At Ana Jacques Hospital he served terms on the Board of Trustees and as President of the medical staff; and

Whereas, Dr. Heyman was a member of the Massachusetts Medical Society and the Essex North District Medical Society for nearly 50 years, president of the Massachusetts Medical Society from 1996 to 1997, was the first speaker of the MMS House of Delegates (HOD) in 1993 at the first HOD meeting in Mechanics Hall, Worcester, and served for over 40 years on the former council and now HOD; and

Whereas, Dr. Heyman was known as the "father of our House of Delegates," leading the transition from a council of a few to a more representative grassroots governing body; and

Whereas, Dr. Heyman served organized medicine in many other leadership roles, including the Chair of the Board of Trustees at the American Medical Association and Chair of the Associate Members in the World Medical Association, and contributed his talents, wise perspectives, and love for the Society on countless MMS committees including, most recently, Information Technology, Bylaws, Nominations, Global Health, and governance working groups, just to name a few, and was actively engaged in governance work even weeks before he died; and

Whereas, The MMS created the Joseph M. Heyman, MD Award for Outstanding Contributions to Organized Medicine and honored Dr. Heyman as the inaugural recipient of the award; and

Whereas, Dr. Heyman is survived by his beloved wife, Laurie Heyman of West Newbury, MA; his daughter, Eve Heyman Tuminaro with her husband, Dave, and their children, Sierra and MacKenzie, of Oak Bluffs, MA; his son, Todd Heyman with his wife, Suzy, and their, children Autumn and Meadow, of Hartland, VT; his two nieces, Zeka Glucs, and her husband, Dave, and Caroline Kuspa all of Santa Cruz, CA; and touched the lives of so many family members, friends, colleagues, and patients, leaving this world a better place and living on in the hearts of so many; therefore be it

RESOLVED, That our American Medical Association note with great sadness the passing of Joseph M. Heyman, MD, with recognition and thanks for his many contributions to our Association; and be it further

RESOLVED, That expressions of condolence be forwarded to the Heyman family, along with a copy of this memorial resolution.

**Joseph M. Heyman, MD**

Introduced by the Private Practice Physicians Section

Whereas, After a long and distinguished career in obstetrics and gynecology, Joseph “Joe” M. Heyman, MD, passed away on February 12, 2022, at age 79; and

Whereas, Dr. Heyman was highly regarded by his colleagues, patients, friends, and family not only as a careful, kind, and caring physician, but also a leader in healthcare, a staunch patient advocate, and a pioneer in digital health; and

Whereas, Dr. Heyman’s career was marked by a passion for development of medical policy and action on patient rights, expanded access to healthcare, increased racial and ethnic diversity in medical institutions and organizations, and an enthusiastic adapter of new technologies, both in and outside of the practice of medicine; and

Whereas, After having received his undergraduate degree from City College of New York and his MD from the State University of New York, Downstate Medical Center, Dr. Heyman completed his residency in obstetrics and gynecology at Sinai Hospital in Baltimore, Maryland; and

Whereas, Dr. Heyman’s career was marked by public service, including serving three years in the U.S. Public Health Service, two of which were spent on the Navajo Nation in Shiprock, New Mexico; and

Whereas, He continued his career in Massachusetts, practicing medicine for 41 years with Women’s Health Care in Newburyport and in solo practice in Amesbury; and

Whereas, Dr. Heyman was a leader in many of the settings where he worked, including serving terms on the Board of Trustees and as President of the medical staff at Anna Jaques Hospital in Newburyport and as Founder of the Whittier IPA non-profit physician organization in Merrimack Valley; and

Whereas, He continued to establish himself as a leader in organized medicine, including serving as President of the Massachusetts Medical Society, Chair of the Associate Members in the World Medical Association, and as Chair of the Board of Trustees at our American Medical Association; and

Whereas, That Dr. Heyman’s staunch advocacy for and joy in solo practice was a formative element in the creation of the Private Practice Physician Caucus and, later, the Private Practice Physician Section and that as such is he regarded by the PPPS as a founding father of the Section; and

Whereas, Dr. Heyman has been recognized for his efforts to improve racial and ethnic diversity in the practice of medicine with the creation by the AMA of the Joe Heyman, MD Fund, which provides financial support for medical students of color in financial need; and

Whereas, Beyond the practice of medicine, Dr. Heyman is remembered for his delight in irony, his gift of storytelling, his skill in bringing people together, and his passion for space exploration, science, art, and jazz music; and

Whereas, Dr. Heyman was a loving and devoted husband to his wife, Laurie, father to daughter Eve Heyman Tuminaro with her husband Dave, and son Todd with his wife Suzy, and grandfather to Sierra, MacKenzie, Autumn, and Meadow, and uncle to nieces Zeka and Caroline; therefore be it

RESOLVED, That our American Medical Association acknowledge with deep gratitude and sincere appreciation the lifelong work performed by Joseph Heyman, MD, in service of the practice of medicine; and be it further

RESOLVED, That our AMA extend its heartfelt condolences to the family of Joseph Heyman, MD, and adopt this resolution as an expression of deepest respect for our colleague and dear friend and our grief at his passing.

**William B. Monnig, MD**

Introduced by Kentucky

Whereas, Our American Medical Association House of Delegates holds in highest regards individuals who better our profession by going above and beyond their daily duties to become beacons of light whose work touched the lives of others in profound and indelible ways; and

Whereas, William B. Monnig, MD, whom we all know as “Bill” is remembered as one of the nicest persons whose enthusiasm was contagious to all with a big heart and that quick smile; and

Whereas, Dr. Monnig has been attending our American Medical Association meetings since 1982 (39 years) when he participated in the first meeting of the Organized Medical Staff Section (then known as the Hospital Medical Staff Section) and has done so until the time of his passing; and

Whereas, Dr. Monnig served as Chair of the Organized Medical Staff Section from 2002 to 2006; and

Whereas, Dr. Monnig has served our American Medical Association House of Delegates as an Alternate Delegate from 1995 until the present; and

Whereas, Bill will be missed by all whose lives he touched; and

Whereas, Bill’s life is woven in the lives of Kathy Robinson; his long-time girlfriend, his sons Aaron and Tom, his siblings Carol, Mike, and Dan, and his grandchildren Lucy, William, Liesl, and Sydney; therefore be it

RESOLVED, That our American Medical Association House of Delegates recognize the outstanding contributions made by William B. Monnig, MD, to the medical profession; and be it further

RESOLVED, That our AMA House of Delegates, individually and collectively, hereby extend their most profound sympathy upon the passing of William B. Monnig, MD, March 27, 2022 and extend heartfelt condolences to his family and his esteemed colleagues. and be it further

RESOLVED, That a copy of this resolution be recorded in the proceedings of this House and be forwarded to Dr. Monnig’s family.

**Preston J. Phillips, MD**

Introduced by Oklahoma and American Academy of Orthopaedic Surgeons

Whereas, It is with the deepest sadness that we mourn the unbearable loss of Preston J. Phillips, MD, FAAOS, in a senseless act of violence that occurred in his clinic on June 1, 2022 in Tulsa, Oklahoma; and

Whereas, Dr. Phillips, an esteemed orthopaedic surgeon and treasured colleague, graduated from Harvard Medical School in 1990, completed residency in orthopaedic surgery at Yale New Haven Hospital, and further trained at Beth Israel Deaconess Medical Center and Boston Children’s Hospital in 1986 and 1996; and

Whereas, Dr. Phillips earned advanced degrees in organic chemistry and pharmacology, as well as theology from Emory University; and

Whereas, Dr. Phillips, who focused on spine surgery and joint reconstruction at Saint Francis Health System in Oklahoma, was a member of American Medical Association, American Academy of Orthopaedic Surgeons, J. Robert Gladden Orthopaedic Society, Oklahoma State Medical Association and Tulsa County Medical Society; and

Whereas, Dr. Phillips was a volunteer for Project TCMS, the Tulsa County Medical Society’s program to provide specialty health services to low-income, uninsured residents of Tulsa County; and

Whereas, St. Francis President and Chief Executive Officer Cliff Robertson, MD, described Dr. Phillips as “... a consummate gentleman, a man we should all strive to emulate,” and a physician, “who [spent] every minute with the

patient that they need... [and] one of those doctors that was cut from the cloth of four decades ago in terms of how he felt about people and how he felt about his calling;" and

Whereas, Dr. Phillips led medical mission trips with the nonprofit Light in the World Development Foundation, aiding in the effort to ensure that African children had access to healthcare, education, and clean water; therefore be it

RESOLVED, That our American Medical Association acknowledge, with profound gratitude and sincere appreciation, the lifelong commitment to the practice of medicine demonstrated by Dr. Preston J. Phillips; and be it further

RESOLVED, That our American Medical Association extend its heartfelt condolences to the family of Dr. Preston J. Phillips and adopt this resolution as an expression of deepest respect for a colleague and dear friend and our immense grief at his passing, and further present them with a copy of this memorial resolution.

## RESOLUTIONS

Note: Testimony on each item is summarized in the reference committee reports. Items considered on the reaffirmation calendar do not appear in the reference committee reports and were handled as part of the Committee on Rules and Credentials Supplementary Report on Saturday, June 11. The following resolutions were dealt with on the reaffirmation calendar: 102, 104, 105, 106, 107, 112, 115, 126, 128, 204, 206, 214, 235, 244, 303, 311, 312, 313, 318, 320, 409, 419, 426, 507, 620, 704, 706, 707, 709, 711, 712, 713, 714, 715, 718, 719, 720, 722, and 725.

Alternate resolutions are considered to have been introduced by the reference committee.

### REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION & BYLAWS

#### 1. INCREASING PUBLIC UMBILICAL CORD BLOOD DONATIONS IN TRANSPLANT CENTERS

**Introduced by Young Physicians Section**

*Reference committee hearing: see report of Reference Committee on Amendments to Constitution & Bylaws.*

**HOD ACTION: RESOLVE 1 REFERRED  
SECOND AND THIRD RESOLVES ADOPTED AS FOLLOWS**  
*See Policy H-370.956*

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; and be it further

RESOLVED, That our AMA encourage the availability of altruistic cord blood donations in all states; and be it further

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

#### 2. OPPOSITION TO DISCRIMINATORY TREATMENT OF HAITIAN ASYLUM SEEKERS

**Introduced by New York**

*Reference committee hearing: see report of Reference Committee on Amendments to Constitution & Bylaws.*

**HOD ACTION: ADOPTED**  
*See Policy H-350.951*

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.

#### 3. GENDER EQUITY AND FEMALE PHYSICIAN WORK PATTERNS DURING THE PANDEMIC

**Introduced by Women Physicians Section**

*Reference committee hearing: see report of Reference Committee on Amendments to Constitution & Bylaws.*

**HOD ACTION: ADOPTED**  
*See Policy D-65.983*

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; and be it further

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

#### **4. ENCOURAGING LGBTQ+ REPRESENTATION IN MEDICINE** **Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee on Amendments to Constitution & Bylaws.*

**HOD ACTION:     ADOPTED**  
**TITLE CHANGED**  
*See Policy D-200.972*

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

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

#### **5. SUPPORTING THE STUDY OF REPARATIONS AS A MEANS TO REDUCE RACIAL INEQUALITIES** **Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee on Amendments to Constitution & Bylaws.*

**HOD ACTION:     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; 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; and be it further

RESOLVED, That our AMA support federal legislation that facilitates the study of reparations.

#### **6. COMBATING NATURAL HAIR AND CULTURAL HEADWEAR DISCRIMINATION IN MEDICINE AND MEDICAL PROFESSIONALISM** **Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee on Amendments to Constitution & Bylaws.*

**HOD ACTION:     ADOPTED AS FOLLOWS**  
*See Policy H-65.949*

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; and be it further

RESOLVED, That our AMA oppose discrimination against individuals based on their hair or cultural headwear in health care settings; 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; 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; and be it further

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.

## **7. EQUAL ACCESS TO ADOPTION FOR THE LGBTQ COMMUNITY**

### **Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee on Amendments to Constitution & Bylaws.*

**HOD ACTION:      ADOPTED**  
*See Policy D-60.964*

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; 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.

## **8. STUDENT-CENTERED APPROACHES FOR REFORMING SCHOOL DISCIPLINARY POLICIES**

### **Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee on Amendments to Constitution & Bylaws.*

**HOD ACTION:      ADOPTED AS FOLLOWS**  
*See Policies H-60.900 and D-60.964*

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; and be it further

RESOLVED, That our AMA support the consultation with school-based mental health professionals in the student discipline process.

**9. PRIVACY PROTECTION AND PREVENTION OF FURTHER TRAUMA FOR VICTIMS OF  
DISTRIBUTION OF INTIMATE VIDEOS AND IMAGES WITHOUT CONSENT  
Introduced by Illinois**

*Reference committee hearing: see report of Reference Committee on Amendments to Constitution & Bylaws.*

**HOD ACTION: ADOPTED**

*See Policies H-515.967a and D-515.975*

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:

H-515.967, "Protection of the Privacy of Sexual Assault Victims"

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 broadcast 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.

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.

**10. IMPROVING THE HEALTH AND SAFETY OF INDIVIDUALS WHO OFFER SEX IN  
RETURN FOR MONEY, GOODS OR OTHER CONSIDERATIONS  
Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee on Amendments to Constitution & Bylaws.*

**HOD ACTION: ADOPTED AS FOLLOWS  
TITLE CHANGED**

*See Policy H-65.948*

RESOLVED, That our American Medical Association recognize the adverse health outcomes of criminalizing individuals who offer sex in return for money, goods, or other considerations; and be it further

RESOLVED, That our AMA: 1) support legislation that decriminalizes individuals who offer sex in return for money, goods, or other consideration; 2) oppose legislation that decriminalizes the purchase of sex services as well as ownership and operation of brothels 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; 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.

**11. EVALUATING SCIENTIFIC JOURNAL ARTICLES FOR RACIAL AND ETHNIC BIAS  
Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee on Amendments to Constitution & Bylaws.*

**HOD ACTION: ADOPTED AS FOLLOWS**

*See Policy H-460.885*

RESOLVED, That our American Medical Association support major journal publishers issuing guidelines for interpreting research which defines race and ethnicity by outdated means; 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.

**12. EXPANDING THE DEFINITION OF IATROGENIC INFERTILITY TO  
INCLUDE GENDER AFFIRMING INTERVENTIONS  
Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee on Amendments to Constitution & Bylaws.*

**HOD ACTION:      ADOPTED AS FOLLOWS**  
*See Policies H-185.950 and H-185.990*

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

H-185.990, “Infertility and Fertility Preservation Insurance Coverage”

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 be it further

RESOLVED, That our AMA reaffirm Policy H-185.950.

**13. RECOGNITION OF NATIONAL ANTI-LYNCHING LEGISLATION AS  
PUBLIC HEALTH INITIATIVE  
Introduced by Resident and Fellow Section**

*Reference committee hearing: see report of Reference Committee on Amendments to Constitution & Bylaws.*

**HOD ACTION:      ADOPTED AS FOLLOWS**  
*See Policies H-65.952, H-65.965, and D-65.985*

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

RESOLVED, That 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, 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; and be it further

RESOLVED, That our AMA reaffirm Policy H-65.952, “Racism as a Public Health Threat.”

**14. HEALTHCARE EQUITY THROUGH INFORMED CONSENT AND A COLLABORATIVE  
HEALTHCARE MODEL FOR THE GENDER DIVERSE POPULATION**

*Reference committee hearing: see report of Reference Committee on Amendments to Constitution & Bylaws.*

**HOD ACTION:      ALTERNATE RESOLUTION 14 ADOPTED**  
*See Policy H-140.824*

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; and be it further

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.

**15. INCREASING MENTAL HEALTH SCREENINGS BY REFUGEE RESETTLEMENT AGENCIES  
AND IMPROVING MENTAL HEALTH OUTCOMES FOR REFUGEE WOMEN**  
**Introduced by Women Physicians Section**

*Reference committee hearing: see report of Reference Committee on Amendments to Constitution & Bylaws.*

**HOD ACTION:      ADOPTED AS FOLLOWS**  
*See Policy D-345.982*

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 brief, accessible, clinically validated, culturally sensitive, and patient centered mental health screening tools for refugee and migrant populations; and be it further

RESOLVED, That our AMA advocate for increased funding for more research on evidence-based 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; and be it further

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; and be it further

RESOLVED, That our AMA advocate for and encourage culturally responsive mental health counseling specifically.

**16. ADDRESSING AND BANNING NONCONSENSUAL MEDICAL PROCEDURES  
AMONG MIGRANT WOMEN AT THE BORDER**  
**Introduced by Women Physicians Section**

*Reference committee hearing: see report of Reference Committee on Amendments to Constitution & Bylaws.*

**HOD ACTION:      ADOPTED AS FOLLOWS**  
**TITLE CHANGED**  
*See Policy D-350.978*

RESOLVED, That our American Medical Association condemn the performance of nonconsensual, invasive medical procedures; and be it further

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); and be it further

RESOLVED, That our AMA advocate for safer medical practices and protections for migrant women.

**17. HUMANITARIAN AND MEDICAL AID SUPPORT TO UKRAINE**  
**Introduced by International Medical Graduate Section**

*Reference committee hearing: see report of Reference Committee on Amendments to Constitution & Bylaws.*

**HOD ACTION: ADOPTED AS FOLLOWS**  
*See Policy D-65.984*

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; and be it further

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, pregnant women, and the elderly; 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 broad protective factors (e.g., financial, employment, housing, and food stability) that can improve adjustment and outcomes for war-affected people, particularly when applied to vulnerable categories of people.

**18. HARDSHIP FOR INTERNATIONAL MEDICAL GRADUATES FROM RUSSIA AND BELARUS**  
**Introduced by International Medical Graduate Section**

*Reference committee hearing: see report of Reference Committee on Amendments to Constitution & Bylaws.*

**HOD ACTION: ADOPTED**  
*See Policy D-255.975*

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.

**19. HARDSHIP FOR INTERNATIONAL MEDICAL GRADUATES FROM UKRAINE**  
**Introduced by International Medical Graduate Section**

*Reference committee hearing: see report of Reference Committee on Amendments to Constitution & Bylaws.*

**HOD ACTION: ADOPTED**  
*See Policy D-255.974*

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.

**20. COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS GUIDELINES FOR  
TREATING UNVACCINATED INDIVIDUALS  
Introduced by International Medical Graduate Section**

*Reference committee hearing: see report of Reference Committee on Amendments to Constitution & Bylaws.*

**HOD ACTION: 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.

**21. NATIONAL CANCER RESEARCH PATIENT IDENTIFIER  
Introduced by Mississippi**

*Reference committee hearing: see report of Reference Committee on Amendments to Constitution & Bylaws.*

**HOD ACTION: 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); 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.

**22. ORGAN TRANSPLANT EQUITY FOR PERSONS WITH DISABILITIES  
Introduced by Pennsylvania**

*Reference committee hearing: see report of Reference Committee on Amendments to Constitution & Bylaws.*

**HOD ACTION: ADOPTED AS FOLLOWS**  
*See Policy D-370.980*

RESOLVED, That our American Medical Association support equitable inclusion of people with Intellectual and Developmental Disabilities (IDD) in eligibility for transplant surgery; and be it further

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; 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; 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.

**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  
Introduced by Oregon**

*Reference committee hearing: see report of Reference Committee on Amendments to Constitution & Bylaws.*

**HOD ACTION: ADOPTED AS FOLLOWS**  
*See Policy D-280.982*

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; and be it further

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.

**24. PHARMACEUTICAL EQUITY FOR PEDIATRIC POPULATIONS  
Introduced by Michigan**

*Reference committee hearing: see report of Reference Committee on Amendments to Constitution & Bylaws.*

**HOD ACTION: ADOPTED**  
*See Policy H-100.987*

RESOLVED, That our American Medical Association amend Policy H-100.987, "Insufficient Testing of Pharmaceutical Agents in Children," by addition to read as follows:

H-100.987, "Insufficient Testing of Pharmaceutical Agents in Children"

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.

**25. USE OF SOCIAL MEDIA FOR PRODUCT PROMOTION AND COMPENSATION  
Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee on Amendments to Constitution & Bylaws.*

**HOD ACTION: 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.

**26. ESTABLISHING ETHICAL PRINCIPLES FOR PHYSICIANS INVOLVED IN  
PRIVATE EQUITY OWNED PRACTICES  
Introduced by Integrated Physician Practice Section**

*Reference committee hearing: see report of Reference Committee on Amendments to Constitution & Bylaws.*

**HOD ACTION:      ADOPTED**  
*See Policy D-140.951*

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.

**27. PROTECTING ACCESS TO ABORTION AND REPRODUCTIVE HEALTHCARE  
Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee on Amendments to Constitution & Bylaws.*

**HOD ACTION:      ADOPTED AS FOLLOWS**  
*See Policies H-5.980 and H-100.948*

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:

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

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.

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

H-5.980, “Oppose the Criminalization of Self-~~Managed-Induced~~ Abortion”

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.

**28. PRESERVING ACCESS TO REPRODUCTIVE HEALTH SERVICES**

**Introduced by Resident and Fellow Section, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, American Society for Reproductive Medicine, Minority Affairs Section, International Medical Graduates Section**

*Reference committee hearing: see report of Reference Committee on Amendments to Constitution & Bylaws.*

**HOD ACTION:      ADOPTED**  
*See Policy D-5.999*

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.

**REFERENCE COMMITTEE A****101. FERTILITY PRESERVATION BENEFITS FOR ACTIVE-DUTY MILITARY PERSONNEL**

**Introduced by Young Physicians Section**

*Reference committee hearing: see report of Reference Committee A.*

**HOD ACTION:      ADOPTED AS FOLLOWS**  
*See Policy H-510.984*

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; and be it further

RESOLVED, That our AMA work with interested organizations to encourage TRICARE to cover gamete preservation for active-duty military personnel and activated reservist military personnel.

**102. BUNDLING PHYSICIAN FEES WITH HOSPITAL FEES**  
**Introduced by New York**

*Considered on reaffirmation calendar.*

**HOD ACTION: POLICY D-390.961 REAFFIRMED**  
**IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association oppose bundling of physician payments with hospital payments, unless the physician has agreed to such an arrangement in advance.

**103. COBRA FOR COLLEGE STUDENTS**  
**Introduced by New York**

*Reference committee hearing: see report of Reference Committee A.*

**HOD ACTION: 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.

**104. CONSUMER OPERATED AND ORIENTED PLANS (CO-OPS) AS A  
PUBLIC OPTION FOR HEALTH CARE FINANCING**  
**Introduced by New York**

*Considered on reaffirmation calendar.*

**HOD ACTION: POLICIES H-165.823 AND H-165.838 REAFFIRMED**  
**IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association study options to improve the performance of Consumer Operated and Oriented Plans (CO-OPs) as a potential public option to improve competition in the health insurance marketplace and to improve the value of health care to patients; and be it further

RESOLVED, That our AMA work with the National Alliance of State Health Co-Ops to request that Congress and the US Department of Health and Human Services reestablish funding for new health insurance co-operatives.

**105. HEALTH INSURANCE THAT FAIRLY COMPENSATES PHYSICIANS**  
**Introduced by New York**

*Considered on reaffirmation calendar.*

**HOD ACTION: POLICIES H-390.849, H-400.957, AND D-405.988 REAFFIRMED**  
**IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED. That our American Medical Association advocate for insurance plans to adequately compensate physicians so that they are able to remain in practice independent of hospital employment.

**106. HOSPICE RECERTIFICATION FOR NON-CANCER DIAGNOSIS**  
**Introduced by New York**

*Considered on reaffirmation calendar.*

**HOD ACTION: POLICY H-85.955 REAFFIRMED**  
**IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association request that the Centers for Medicare & Medicaid Services allow automatic reinstatement for hospice if a patient survives for more than 6 months with a non-cancer diagnosis and that prognosis remains terminal.

**107. MEDICAID TAX BENEFITS**  
**Introduced by New York**

*Considered on reaffirmation calendar.*

**HOD ACTION: POLICIES H-160.969, H-180.965, AND H-290.982 REAFFIRMED**  
**IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association advocate for legislation that would allow physicians who take care of Medicaid or uninsured patients to receive some financial benefit through a tax deduction such as (a) a reduced rate of overall taxation or (b) the ability to use the unpaid charges for such patients as a tax deduction.

**108. PAYMENT FOR PHYSICIAN-PURCHASED MEDICATIONS AND**  
**DIAGNOSTIC IMAGING AGENTS**

*Reference committee hearing: see report of Reference Committee A.*

**HOD ACTION: ALTERNATE RESOLUTION 108 ADOPTED**  
*See Policy D-110.985*

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.

**109. STUDY OF INCENTIVES TO ENCOURAGE EFFICIENT USE OF EMERGENCY DEPARTMENTS**  
**Introduced by New York**

*Reference committee hearing: see report of Reference Committee A.*

**HOD ACTION: ADOPTED AS FOLLOWS**  
**TITLE CHANGED**  
*See Policy D-130.959*

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 condition instead of hospital emergency departments.

**110. PRIVATE PAYOR PAYMENT INTEGRITY**  
**Introduced by New York**

*Reference committee hearing: see report of Reference Committee A.*

**HOD ACTION:      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; 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.

**111. BUNDLED PAYMENTS AND MEDICALLY NECESSARY CARE**  
**Introduced by American Academy of Physical Medicine and Rehabilitation, Ohio**

*Reference committee hearing: see report of Reference Committee A.*

**HOD ACTION:      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; 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; and be it further

RESOLVED, That our AMA advocate that functional improvement be a key target outcome for bundled payments.

**112. SUPPORT FOR EASY ENROLLMENT FEDERAL LEGISLATION**  
**Introduced by Maryland**

*Considered on reaffirmation calendar.*

**HOD ACTION:      POLICY H-165.823 REAFFIRMED**  
**IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association advocate for the federal legislation known as the Easy Enrollment in Health Care Act to allow Americans to receive health care information and enroll in healthcare coverage through their federal tax returns.

**113. INCREASING PATIENT ACCESS TO HEARING, DENTAL AND VISION SERVICES**

*Reference committee hearing: see report of Reference Committee A.*

**HOD ACTION: ALTERNATE RESOLUTION 113 ADOPTED  
IN LIEU OF RESOLUTIONS 113, 114, AND 119  
ADDITIONAL PROPOSED RESOLVE REFERRED**  
*See Policy D-185.972*

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; 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; 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; 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.

[Editor's note: The following proposed amendment, which would replace the first paragraph with the second, was referred.]

RESOLVED, That our AMA study the impacts of covering vision, hearing, and dental benefits under the Medicare program.

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.

**114. ORAL HEALTHCARE IS HEALTHCARE**  
**Introduced by Senior Physicians Section**

**Resolution 114 was considered with Resolutions 113 and 119.**  
**See Resolution 113.**

RESOLVED, That our American Medical Association reaffirm that dental and oral health are integral components of basic health care and maintenance regardless of age; 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; 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; 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.

**115. SUPPORT FOR UNIVERSAL INTERNET ACCESS**  
**Introduced by Illinois**

*Considered on reaffirmation calendar.*

**HOD ACTION:      POLICIES H-478.980, H-480.937, AND D-480.963 REAFFIRMED  
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association recognize that internet access is a social determinant of health; and be it further

RESOLVED, That our AMA support universal access to broadband home internet; and be it further

RESOLVED, That our AMA advocate for legislation to reduce barriers and increase access to broadband internet, including federal, state, and local funding of broadband internet to reduce price, the establishment of automatic applications for recipients of Medicaid or other assistance programs, and increasing the number of devices and streams covered per household.

**116. REIMBURSEMENT OF SCHOOL-BASED HEALTH CENTERS**  
**Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee A.*

**HOD ACTION:      ADOPTED AS FOLLOWS**  
*See Policy H-60.921*

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:

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

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 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 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.

**117. SUPPORTING TRANSPORTATION TO HEALTHY GROCERY DESTINATIONS**

*Reference committee hearing: see report of Reference Committee A.*

**HOD ACTION:      ALTERNATE RESOLUTION 117 ADOPTED**  
*See Policy H-150.925*

RESOLVED, That our American Medical Association 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

**118. CAPS ON INSULIN CO-PAYMENTS FOR PATIENTS WITH INSURANCE**  
**Introduced by Medical Student Section, The Endocrine Society**

*Reference committee hearing: see report of Reference Committee A.*

**HOD ACTION: ADOPTED AS FOLLOWS**  
*See Policy H-110.984*

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

H-110.984, “Insulin Affordability”

Our AMA will: (1) encourage the Federal Trade Commission (FTC) and the Department of Justice to 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 ultimate expenses incurred by insured patients for prescribed insulin.

**119. MEDICARE COVERAGE OF DENTAL, VISION, AND HEARING SERVICES**  
**Introduced by Medical Student Section**

**Resolution 119 was considered with Resolutions 113 and 114.**  
**See Resolution 113.**

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; and be it further

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

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

H-185.929, “Hearing Aid Coverage”

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.

**120. EXPANDING COVERAGE FOR AND ACCESS TO PULMONARY REHABILITATION**

*Reference committee hearing: see report of Reference Committee A.*

**HOD ACTION: ALTERNATE RESOLUTION 120 ADOPTED**  
*See Policy D-185.975*

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.

**121. INCREASE FUNDING, RESEARCH AND EDUCATION FOR POST-INTENSIVE CARE SYNDROME**  
**Introduced by Society of Critical Care Medicine**

*Reference committee hearing: see report of Reference Committee A.*

**HOD ACTION: ADOPTED**  
*See Policy D-70.943*

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); 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.

**122. PROVIDING EDUCATIONAL RESOURCES ON MEDICAID EXPANSION**  
**Introduced by Michigan**

*Reference committee hearing: see report of Reference Committee A.*

**HOD ACTION: ADOPTED AS FOLLOWS**  
**TITLE CHANGED**  
*See Policies H-165.823, H 290.965, and D-290.979*

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; and be it further

RESOLVED, That our AMA 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.

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

*Reference committee hearing: see report of Reference Committee A.*

**HOD ACTION: ALTERNATE RESOLUTION 123 ADOPTED**  
*See Policy D-185.973*

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.

**124. TO REQUIRE INSURANCE COMPANIES MAKE THE “COVERAGE YEAR” AND THE “DEDUCTIBLE YEAR” SIMULTANEOUS FOR THEIR POLICIES****Introduced by Illinois***Reference committee hearing: see report of Reference Committee A.***HOD ACTION: POLICY H-180.955 REAFFIRMED  
IN LIEU OF FOLLOWING RESOLUTION**

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.

**125. EDUCATION, FOREWARNING AND DISCLOSURE REGARDING CONSEQUENCES  
OF CHANGING MEDICARE PLANS****Introduced by Senior Physicians Section***Reference committee hearing: see report of Reference Committee A.***HOD ACTION: ADOPTED**  
*See Policy H-330.870*

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.

**126. PROVIDING RECOMMENDED VACCINES UNDER MEDICARE PARTS B AND C****Introduced by Idaho***Considered on reaffirmation calendar.***HOD ACTION: POLICIES H-440.860, H-440.875, AND D-440.981 REAFFIRMED  
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association support the expansion of coverage of all Advisory Committee for Immunization Practices (ACIP) recommended immunizations for routine use as a covered benefit by all public and private health plans; and be it further

RESOLVED, That our AMA advocate to the Centers for Medicare and Medicaid Services (CMS), and Congress if necessary, for expanded coverage of all ACIP recommended immunizations for routine use to be a covered benefit without patient cost under Medicare parts B and C for Medicare beneficiaries.

## 127. CONTINUITY OF CARE UPON RELEASE FROM CORRECTIONAL SYSTEMS

### Introduced by Michigan

*Reference committee hearing: see report of Reference Committee A.*

**HOD ACTION:      ADOPTED AS FOLLOWS**  
*See Policy H-430.986*

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; (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; 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.

**128. IMPROVING ACCESS TO VACCINATIONS FOR PATIENTS**  
**Introduced by Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont**

*Considered on reaffirmation calendar.*

**HOD ACTION:      POLICIES H-440.860, H-440.875, AND D-440.981 REAFFIRMED  
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association encourage all payors, including the Centers for Medicare and Medicaid Services, to fully cover the cost of product, handling and administration, without cost sharing, all vaccines recommended by the Centers for Disease Control and Prevention, at patient's preferred site of care including when administered in the physician office.

**REFERENCE COMMITTEE B**

**201. THE IMPACT OF MIDLEVEL PROVIDERS ON MEDICAL EDUCATION**  
**Introduced by Resident and Fellow Section**

*Reference committee hearing: see report of Reference Committee B.*

**HOD ACTION:      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; 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; 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; 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.

**202. AMA POSITION ON ALL PAYER DATABASE CREATION**  
**Introduced by New York**

*Reference committee hearing: see report of Reference Committee B.*

**HOD ACTION:      POLICY H-225.964 REAFFIRMED  
IN LIEU OF FOLLOWING RESOLUTION**

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.

**203. BAN THE GAY/TRANS (LGBTQ+) PANIC DEFENSE**

**Introduced by New York, GLMA - Health Professionals Advancing LGBTQ Equality, American Psychiatric Association, American Academy of Child and Adolescent Psychiatry, American Association of Geriatric Psychiatry, American Academy of Psychiatry and Law, Medical Student Section, Minority Affairs Section**

*Reference committee hearing: see report of Reference Committee B.*

**HOD ACTION: ADOPTED AS FOLLOWS**

*See Policy D-65.986*

RESOLVED, That our American Medical Association support federal legislation banning the use of the so-called “gay or trans (LGBTQ+) panic” defense in homicide, manslaughter, physical or sexual assault cases; and be it further

RESOLVED, That our AMA develop 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 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; and be it further

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

**204. INSURANCE CLAIMS DATA**

**Introduced by New York**

*Considered on reaffirmation calendar.*

**HOD ACTION: POLICY H-315.962 REAFFIRMED  
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association seek legislation and regulation to promote open sharing of de-identified health insurance claims data.

**205. INSURERS AND VERTICAL INTEGRATION**

**Introduced by New York**

*Reference committee hearing: see report of Reference Committee B.*

**HOD ACTION: 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.

**206. MEDICARE ADVANTAGE PLAN MANDATES**

**Introduced by New York**

*Considered on reaffirmation calendar.*

**HOD ACTION: POLICY H-285.905 REAFFIRMED  
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association advocate for federal legislation to ensure that no person should be mandated to change from traditional Medicare to Medicare Advantage plans.

**207. PHYSICIAN TAX FAIRNESS**  
**Introduced by New York**

*Reference committee hearing: see report of Reference Committee B.*

**HOD ACTION: 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.

**208. REGULATION OF HOMEMADE FIREARMS**  
**Introduced by New York**

*Reference committee hearing: see report of Reference Committee B.*

**HOD ACTION: ADOPTED AS FOLLOWS**  
**TITLE CHANGED**  
*See Policy H-145.967*

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

**209. SUPPORTING COLLECTION OF DATA ON MEDICAL REPATRIATION**  
**Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee B.*

**HOD ACTION: ADOPTED AS FOLLOWS**  
*See Policy H-250.985*

RESOLVED, That our AMA denounce the practice of forced medical repatriation.

**210. REDUCING THE PREVALENCE OF SEXUAL ASSAULT BY TESTING**  
**SEXUAL ASSAULT EVIDENCE KITS**  
**Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee B.*

**HOD ACTION: ADOPTED AS FOLLOWS**  
*See Policy H-80.999*

RESOLVED, That our American Medical Association amend Policy H-80.999, “Sexual Assault 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 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.

## 211. REPEAL OR MODIFICATION OF THE MEDICARE APPROPRIATE USE CRITERIA (AUC) PROGRAM

*Reference committee hearing: see report of Reference Committee B.*

### HOD ACTION: ALTERNATE RESOLUTION 211 ADOPTED

*See Policy H-320.940*

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.

## 212. MEDICATION FOR OPIOID USE DISORDER IN PHYSICIAN HEALTH PROGRAMS Introduced by Michigan

*Reference committee hearing: see report of Reference Committee B.*

### HOD ACTION: ADOPTED AS FOLLOWS

*See Policies H-95.913 and D-405.990*

RESOLVED, That our American Medical Association reaffirm Policy H-95.913, "Discrimination Against Physicians in Treatment with Medication for Opioid Use Disorders"; 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 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.

### **213. RESENTENCING FOR INDIVIDUALS CONVICTED OF MARIJUANA-BASED OFFENSES** **Introduced by Michigan**

**Resolution 213 was considered with Board of Trustees Report 17.**

**See Board of Trustees Report 17, which was adopted in lieu of 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; 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.

### **214. ELIMINATING UNFUNDED OR UNPROVEN MANDATES AND REGULATIONS** **Introduced by Ohio**

*Considered on reaffirmation calendar.*

#### **HOD ACTION: POLICY H-320.940 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association advocate for policies that allow for physician judgment and documented medical decision-making to supersede government regulation--including the utilization of Augmented Intelligence--in instances of disputes in patient care; and be it further

RESOLVED, That our AMA advocate for policies that require “proof of concept,” in the form of independently demonstrated quality improvement, prior to the implementation of any government, insurance company or other third-party mandate or regulation on patient care and the physician-patient relationship; and be it further

RESOLVED, That our AMA advocate for policies requiring government, insurance company or other third-party entities to fully fund any mandates or regulations imposed on patient care and the physician-patient relationship.

**215. TRANSFORMING PROFESSIONAL LICENSURE TO THE 21ST CENTURY**  
**Introduced by American College of Cardiology, American Society of Echocardiography, American Society of Nuclear Cardiology, Heart Rhythm Society, Society for Cardiovascular Angiography and Interventions, Society of Cardiovascular Computed Tomography**

*Reference committee hearing: see report of Reference Committee B.*

**HOD ACTION: POLICIES D-275.994, D-275.996, AND D-480.960 REAFFIRMED  
 IN LIEU OF FOLLOWING RESOLUTION**

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; 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; and be it further

RESOLVED, That our AMA report back on these recommendations by the 2022 Interim Meeting.

**216. ADVOCATING FOR THE ELIMINATION OF HEPATITIS C TREATMENT RESTRICTIONS**  
**Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee B.*

**HOD ACTION: ADOPTED AS FOLLOWS**  
*See Policy H-440.845*

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:

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

Our AMA will: (1) encourage the adoption of birth-year-based universal screening of all adults ~~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 payers; (54) support programs aimed at training physicians ~~providers~~ in the screening, 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.

**217. PRESERVING THE PRACTICE OF MEDICINE**  
**Introduced by Resident and Fellow Section**

*Reference committee hearing: see report of Reference Committee B.*

**HOD ACTION: TWO RESOLVES ADOPTED AS FOLLOWS**  
**IN LIEU OF FOURTH RESOLVE OF RESOLUTION 251**  
**FIVE RESOLVES REFERRED FOR DECISION**  
*See Policy H-405.950*

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; and be it further

RESOLVED, That our AMA support whistleblower protections for physicians who report unsafe care provided by non-physicians to the appropriate regulatory board.

[Editor's note: The following resolves were referred for decision.]

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; 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; and be it further

RESOLVED, That our AMA study the impact scope-of practice advocacy by physicians has had on physician employment and termination; 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; 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.

**218. EXPEDITED IMMIGRANT GREEN CARD VISA FOR J-1 VISA WAIVER**  
**PHYSICIANS SERVING IN UNDERSERVED AREAS**  
**Introduced by American Association of Physicians of Indian Origin**

*Reference committee hearing: see report of Reference Committee B.*

**HOD ACTION: ADOPTED AS FOLLOWS**  
**IN LIEU OF RESOLUTION 229**  
*See Policy D-255.976*

RESOLVED, That our American Medical Association advocate that 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, and be exempt from the per country limitation of H-1B visa to green card conversion.

**219. DUE PROCESS AND INDEPENDENT CONTRACTORS**  
**Introduced by American College of Emergency Physicians**

*Reference committee hearing: see report of Reference Committee B.*

**HOD ACTION:      ADOPTED**  
*See Policy D-405.975*

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.

**220. VITAL NATURE OF BOARD-CERTIFIED PHYSICIANS IN AEROSPACE MEDICINE**  
**Introduced by Aerospace Medical Association**

*Reference committee hearing: see report of Reference Committee B.*

**HOD ACTION:      ADOPTED AS FOLLOWS**  
*See Policy H-405.949*

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; and be it further

RESOLVED, That our AMA support 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 the safety, health, and well-being of aircrew, support personnel and the flying public.

**Resolution 221 was withdrawn.**

**222. TO STUDY THE COST AND QUALITY IMPACT OF NON-PHYSICIAN PROVIDER  
EMPLOYMENT IN THE UNITED STATES OF AMERICA**  
**Introduced by Mississippi, Florida, Arizona, Texas, New Jersey, California**

*Reference committee hearing: see report of Reference Committee B.*

**HOD ACTION:      ADOPTED AS FOLLOWS**  
**TITLE CHANGED**  
*See Policy D-200.973*

RESOLVED, That our American Medical Association encourage and support studies to determine the cost and quality impact of non-physician unsupervised practice on all patients; and be it further

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.

**223. NATIONAL SHORTAGES OF LIDOCAINE, SALINE PREPARATION,  
AND IODINATED CONTRAST MEDIA**

**Introduced by American Academy of Dermatology, American Society for Dermatologic Surgery Association, American Society of Dermatopathology, American College of Mohs Surgery, Society for Investigative Dermatology, American Society of Ophthalmic Plastic and Reconstructive Surgery, Louisiana, South Carolina, Missouri, Arizona, International Society of Hair Restoration Surgery, Iowa, Texas, Florida, Mississippi, Kansas, American Academy of Otolaryngology- Head and Neck Surgery, American Association of Neurological Surgeons, Congress of Neurological Surgeons, American College of Rheumatology**

*Reference committee hearing: see report of Reference Committee B.*

**HOD ACTION:      ADOPTED AS FOLLOWS  
                         TITLE CHANGED  
                         See Policy D-120.925**

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

**224. HPSA AND MUA DESIGNATION FOR SNFs  
Introduced by AMDA – The Society for Post-Acute and Long-Term Care Medicine**

*Reference committee hearing: see report of Reference Committee B.*

**HOD ACTION:      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.

**225. PUBLIC LISTING OF MEDICAL DIRECTORS FOR NURSING FACILITIES  
Introduced by AMDA – The Society for Post-Acute and Long-Term Care Medicine**

*Reference committee hearing: see report of Reference Committee B.*

**HOD ACTION:      ADOPTED  
                         See Policy D-360.992**

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.

**226. COVERAGE FOR CLINICAL TRIAL ANCILLARY COSTS  
Introduced by Association for Clinical Oncology**

*Reference committee hearing: see report of Reference Committee B.*

**HOD ACTION:      ADOPTED  
                         See Policy H-460.965**

RESOLVED, That our American Medical Association 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; 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.

## **227. SUPPORTING IMPROVEMENTS TO PATIENT DATA PRIVACY**

**Introduced by Louisiana**

*Reference committee hearing: see report of Reference Committee B.*

### **HOD ACTION: ADOPTED AS FOLLOWS**

*See Policy D-315.968*

RESOLVED, That our American Medical Association strengthen patient data privacy protections by advocating for legislation that reflects the AMA's Privacy Principles with particular focus on mobile health apps and other digital health tools.

## **228. EXPANDED CHILD TAX CREDIT**

**Introduced by Michigan**

**Resolution 228 was considered with Resolution 247.**

**See Resolution 247, which was adopted in lieu of 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.

## **229. EXPEDITED IMMIGRANT GREEN CARD FOR J-1 VISA WAIVER PHYSICIANS SERVING IN UNDERSERVED AREAS**

**Introduced by Michigan**

**Resolution 229 was considered with Resolution 218.**

**See Resolution 218, which was adopted in lieu of 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.

## **230. ADVANCING THE ROLE OF OUTDOOR RECREATION IN PUBLIC HEALTH**

**Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee B.*

### **HOD ACTION: ADOPTED AS FOLLOWS**

*See Policy H-440.804*

RESOLVED, That our American Medical Association support the creation and maintenance of existing public lands and outdoor spaces for the purposes of outdoor recreation and support continued research on the clinical uses of outdoor recreation therapy.

**231. AMENDING POLICY H-155.955: INCREASING ACCESSIBILITY TO INCONTINENCE PRODUCTS TO INCLUDE DIAPER TAX EXEMPTION**  
**Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee B.*

**HOD ACTION: ADOPTED AS FOLLOWS**  
*See Policy H-155.955*

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

H-155.955, “Increasing Accessibility to Incontinence Products”

Our AMA supports increased access to ~~affordable~~ incontinence products for children and adults, including the removal of sales tax and ensuring eligibility of these products as medical expenses for Health Savings Accounts (HSAs), Health Reimbursement Arrangements (HRAs), and Flexible Spending Accounts (FSAs).

**232. EXPANSION OF EPINEPHRINE ENTITY STOCKING LEGISLATION**  
**Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee B.*

**HOD ACTION: ADOPTED AS FOLLOWS**  
*See Policy H-115.966*

RESOLVED, That our American Medical Association support the adoption of state laws that allow state-authorized entities to permit the storage of auto-injectable epinephrine for use in case of anaphylaxis.

**233. SUPPORT FOR WARNING LABELS ON FIREARM AMMUNITION PACKAGING**  
**Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee B.*

**HOD ACTION: ADOPTED**  
*See Policy H-145.968*

RESOLVED, That our American Medical Association 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, 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.

**234. UPDATING POLICY ON IMMIGRATION LAWS, RULES, LEGISLATION, AND HEALTH DISPARITIES**  
**Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee B.*

**HOD ACTION: POLICIES H-60.906, H-65.960, H-80.993, H-350.955, D-255.980, AND D-255.991 REAFFIRMED**  
**IN LIEU OF FOLLOWING RESOLUTION**

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

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

**235. IMPROVING THE VETERANS HEALTH ADMINISTRATION REFERRALS FOR  
VETERANS FOR CARE OUTSIDE THE VA SYSTEM**  
**Introduced by Ohio**

*Considered on reaffirmation calendar.*

**HOD ACTION:      POLICIES H-510.983 AND H-510.985 REAFFIRMED  
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association advocate for reform of the veterans' health administration to provide timely and complete payment for veterans' care received outside the VA system and accurate and efficient management of travel reimbursement for that care.

**236. OUT-OF-NETWORK CARE**  
**Introduced by Ohio**

*Reference committee hearing: see report of Reference Committee B.*

**HOD ACTION:      ADOPTED AS FOLLOWS**  
*See Policy H-285.904*

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 minimum coverage standard.~~

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

**237. PRESCRIPTION DRUG DISPENSING POLICIES**  
**Introduced by Ohio**

*Reference committee hearing: see report of Reference Committee B.*

**HOD ACTION:      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; and be it further

RESOLVED, That our AMA create model state legislation that would restrict dispensing medication quantities greater than prescribed; and be it further

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

**238. COVID-19 ECONOMIC INJURY DISASTER LOAN (EIDL) FORGIVENESS  
FOR PHYSICIAN GROUPS OF FIVE OR FEWER PHYSICIANS**

*Reference committee hearing: see report of Reference Committee B.*

**HOD ACTION: ALTERNATE RESOLUTION 238 ADOPTED**  
*See Policy D-385.948*

RESOLVED, That our American Medical Association advocate at the federal level for debt-relief or loan forgiveness for independent physician practices facing COVID-related financial jeopardy.

**239. VIRTUAL SERVICES WHEN PATIENTS ARE AWAY FROM THEIR MEDICAL HOME  
Introduced by Idaho**

*Reference committee hearing: see report of Reference Committee B.*

**HOD ACTION: POLICIES H-480.946, H-480.969, D-480.963, AND D-480.969 REAFFIRMED  
IN LIEU OF FOLLOWING RESOLUTION**

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; 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.

**240. PHYSICIAN PAYMENT REFORM & EQUITY (PPR & E)**

*Reference committee hearing: see report of Reference Committee B.*

**HOD ACTION: ALTERNATE RESOLUTION 240 ADOPTED  
IN LIEU OF RESOLUTIONS 240, 242, 243, AND 253**  
*See Policies H-390.849, D-390.922, and D-390.946*

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.

#### **241. UNMATCHED GRADUATE PHYSICIAN WORKFORCE**

**Introduced by Missouri**

*Reference committee hearing: see report of Reference Committee B.*

##### **HOD ACTION: 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; 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; 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; 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.

#### **242. PUBLIC AWARENESS AND ADVOCACY CAMPAIGN TO REFORM THE MEDICARE PHYSICIAN PAYMENT SYSTEM**

**Introduced by American Association of Neurological Surgeons, Congress of Neurological Surgeons, American Academy of Dermatology, American Academy of Facial Plastic and Reconstructive Surgery, American Academy of Otolaryngology-Head and Neck Surgery, American Academy of Physical Medicine and Rehabilitation, American College of Surgeons, American Gastroenterological Association, American Orthopaedic Foot & Ankle Society, American Society for Dermatologic Surgery, American Society for Gastrointestinal Endoscopy; American Society for Surgery of the Hand, American Society of Cataract and Refractive Surgery, American Society of Echocardiography, American Society of Interventional Pain Physicians, International Society for the Advancement of Spine Surgery, North American Spine Society, California, Florida, Texas, American Academy of Ophthalmology, American College of Radiology, American Society of Anesthesiologists, American Society of Plastic Surgeons, Spine Intervention Society, South Carolina**

**Resolution 242 was considered with Resolutions 240, 243, and 253.**

**See Resolution 240, which was adopted in lieu of Resolutions 242, 243, and 253.**

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.

**243. APPROPRIATE PHYSICIAN PAYMENT FOR OFFICE-BASED SERVICES****Introduced by Ohio****Resolution 243 was considered with Resolutions 240, 242, and 253.****See Resolution 240, which was adopted in lieu of Resolutions 242, 243, and 253.**

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.

**244. PROHIBIT REVERSAL OF PRIOR AUTHORIZATION****Introduced by Ohio***Considered on reaffirmation calendar.***HOD ACTION: POLICIES H-320.961 AND D-320.995 REAFFIRMED  
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That once the physician's office has received prior authorization for testing, a procedure, or a medication, the insurance company should not be permitted to refuse payment for that test or procedure or medication unless the patient is no longer insured by that company at the time the test or procedure is done or the medication is given; and be it further

RESOLVED, That a health insuring corporation or utilization review organization that authorizes a proposed admission, treatment, or health care service by a participating provider based upon the complete and accurate submission of all necessary information relative to an eligible enrollee should not retroactively deny this authorization if the provider renders the health care service in good faith and pursuant to the authorization and all of the terms and conditions of the provider's contract with the health insuring corporation, and be it further

RESOLVED, That our American Medical Association seek federal legislation/rules to prohibit denial of payment by a Medicare Advantage plan for a previously prior approved medication, procedure, or test unless the patient is no longer insured by that company at the time of service; and be it further

RESOLVED, That our AMA redistribute its model legislation on retrospective denial of payment to all state societies, especially those who have not already passed such legislation.

**245. DEFINITION AND ENCOURAGEMENT OF THE APPROPRIATE USE  
OF THE WORD "PHYSICIAN"****Introduced by Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont****Resolution 245 was considered with Resolution 249.****See Resolution 249, which was adopted in lieu of 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."

**246. FURTHER ACTION TO RESPOND TO THE GUN VIOLENCE PUBLIC HEALTH CRISIS****Introduced by Medical Student Section***Reference committee hearing: see report of Reference Committee B.***HOD ACTION: REFERRED FOR REPORT AT I-22**

RESOLVED, Our American Medical Association 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.

**247. RECOGNIZING CHILD POVERTY AND THE RACIAL WEALTH GAP AS PUBLIC HEALTH ISSUES AND EXTENDING THE CHILD TAX CREDIT FOR FAMILIES IN NEED****Introduced by Medical Student Section***Reference committee hearing: see report of Reference Committee B.***HOD ACTION: ADOPTED AS FOLLOWS  
IN LIEU OF RESOLUTION 228  
TITLE CHANGED  
See Policy D-60.965**

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 and other evidence-based cash assistance programs to alleviate child poverty, ameliorate the racial wealth gap, and advance health equity for families in need.

**248. PROMOTING PROPER OVERSIGHT AND REIMBURSEMENT FOR SPECIALTY PHYSICIAN EXTENDERS AND NON-PHYSICIAN PRACTITIONERS****Introduced by Organized Medical Staff Section***Reference committee hearing: see report of Reference Committee B.***HOD ACTION: REFERRED**

RESOLVED, That our American Medical Association work with state medical boards to improve oversight and coordination of the work done with physician extenders and non-physician practitioners; 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; 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.

**249. CLARIFICATION OF HEALTHCARE PHYSICIAN IDENTIFICATION:  
CONSUMER TRUTH & TRANSPARENCY  
Introduced by Organized Medical Staff Section**

*Reference committee hearing: see report of Reference Committee B.*

**HOD ACTION: ADOPTED AS FOLLOWS  
IN LIEU OF RESOLUTION 245  
See Policy D-405.974**

RESOLVED, That our American Medical Association advocate for legislation that would establish clear legal definitions for use of words or terms “physician,” “surgeon,” “medical doctor,” “doctor of osteopathy,” “MD,” “DO,” or any other allopathic or osteopathic medical specialist; 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, and board licensure 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., -ologist) that can mislead the public.

**250. OPPOSITION TO CRIMINALIZATION OF PHYSICIANS’ MEDICAL PRACTICE  
Introduced by Organized Medical Staff Section**

*Reference committee hearing: see report of Reference Committee B.*

**HOD ACTION: POLICIES H-160.946, H-160.954, H-270.959, AND D-125.997 REAFFIRMED  
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association affirm 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; and be it further

RESOLVED, That our AMA oppose 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.

**251. PHYSICIAN MEDICAL LICENSE USE IN CLINICAL SUPERVISION  
Introduced by Organized Medical Staff Section**

*Reference committee hearing: see report of Reference Committee B. See Resolution 217.*

**HOD ACTION: RESOLVES ONE TO THREE REFERRED FOR DECISION  
RESOLUTION 217 ADOPTED IN LIEU OF RESOLVE FOUR**

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; and be it further

RESOLVED, That our AMA oppose mandatory physician supervision of non-physician practitioners as a condition for physician employment; 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; 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

## **252. THE CRIMINALIZATION OF HEALTH CARE DECISION MAKING AND PRACTICE**

### **Introduced by Resident and Fellow Section**

*Reference committee hearing: see report of Reference Committee B.*

#### **HOD ACTION: POLICIES H-160.946 AND H-160.954 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION**

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:

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

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; 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.

## **253. PHYSICIAN PAYMENT REFORM AND EQUITY**

### **Introduced by Private Practice Physicians Section**

**Resolution 253 was considered with Resolutions 240, 242, and 243.  
See Resolution 240, which was adopted in lieu of Resolutions 242, 243, and 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”; and be it further

RESOLVED, That our AMA place Physician Payment Reform & Equity as the advocacy priority of our organization; 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; 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; 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.

**254. STAKEHOLDER ENGAGEMENT IN MEDICARE ADMINISTRATIVE  
CONTRACTOR POLICY PROCESSES  
Introduced by Private Practice Physicians Section**

*Reference committee hearing: see report of Reference Committee B.*

**HOD ACTION:      ADOPTED AS FOLLOWS**  
*See Policy D-330.897*

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; and be it further

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 LCAs that could have the effect of restricting coverage or access from being adopted 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; and be it further

RESOLVED, That our AMA work with specialty and state medical societies and other interested stakeholders to identify LCAs that potentially restrict coverage or access and that were issued without the MACs providing opportunities for stakeholder input, public data, decision criteria, and evidentiary review, and advocate that CMS require MACs to revise the policies taking any such proposed changes through an appropriate stakeholder engagement, public data, and evidentiary review.

**REFERENCE COMMITTEE C**

**301. MEDICAL EDUCATION DEBT CANCELLATION IN THE FACE OF A PHYSICIAN  
SHORTAGE DURING THE COVID-19 PANDEMIC  
Introduced by New York**

*Reference committee hearing: see report of Reference Committee C.*

**HOD ACTION:      ADOPTED AS FOLLOWS**  
*See Policy D-305.951*

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.

**302. RESIDENT AND FELLOW ACCESS TO FERTILITY PRESERVATION**  
**Introduced by Resident and Fellow Section**

*Reference committee hearing: see report of Reference Committee C.*

**HOD ACTION: ADOPTED AS FOLLOWS**  
*See Policy H-310.902*

RESOLVED, That our AMA encourage insurance coverage for fertility preservation and infertility treatment within health insurance benefits for residents and fellows offered through graduate medical education programs; 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 but not limited to, the need to attend medical visits to complete the gamete preservation process and to administer medications in a time-sensitive fashion.

**303. FATIGUE MITIGATION RESPITE FOR FACULTY AND RESIDENTS**  
**Introduced by Women Physicians Section**

*Considered on reaffirmation calendar.*

**HOD ACTION: POLICIES H-15.958, H-135.932, H-310.907, AND H-310.912 REAFFIRMED  
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association make available resources to institutions and physicians that support self-care and fatigue mitigation, help protect physician health and well-being, and model appropriate health promoting behaviors; and be it further

RESOLVED, That our AMA advocate for policies that support fatigue mitigation programs, which include, but are not limited to, quiet places to rest and funding for alternative transport including return to work for vehicle recovery at a later time for all medical staff who feel unsafe driving due to fatigue after working.

**304. ORGANIZATIONAL ACCOUNTABILITY TO RESIDENT AND FELLOW TRAINEES**  
**Introduced by Resident and Fellow Section**

*Reference committee hearing: see report of Reference Committee C.*

**HOD ACTION: 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.

**305. REDUCING OVERALL FEES AND MAKING COSTS FOR LICENSING,  
EXAM FEES, APPLICATION FEES, ETC., EQUITABLE FOR IMGs**  
**Introduced by Resident and Fellow Section**

*Reference committee hearing: see report of Reference Committee C.*

**HOD ACTION:      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; 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.

**306. CREATING A MORE ACCURATE ACCOUNTING OF MEDICAL  
EDUCATION FINANCIAL COSTS**  
**Introduced by Illinois, American Society of Anesthesiologists**

*Reference committee hearing: see report of Reference Committee C.*

**HOD ACTION:      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.

**307. PARENTAL LEAVE AND PLANNING RESOURCES FOR MEDICAL STUDENTS**  
**Introduced by Illinois**

*Reference committee hearing: see report of Reference Committee C.*

**HOD ACTION:      ADOPTED AS FOLLOWS**  
*See Policies H-405.960 and D-295.308*

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; and be it further

RESOLVED, That AMA Policy H-405.960 be amended by addition 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; and be it further

RESOLVED, That our AMA work with key stakeholders to advocate that parties involved in medical training (including but not limited to residency programs, administration, fellowships, away rotations, physician evaluators, and research opportunities) do not discriminate against students who take family/parental leave; and be it further

RESOLVED, That Policy H-405.960(14) be reaffirmed.

**308. UNIVERSITY LAND GRANT STATUS IN MEDICAL SCHOOL ADMISSIONS**  
**Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee C.*

**HOD ACTION:      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; 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:

H-350.981, “AMA Support of American Indian Health Career Opportunities”

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.

**309. DECREASING BIAS IN EVALUATIONS OF MEDICAL STUDENT PERFORMANCE**  
**Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee C.*

**HOD ACTION:      FIRST RESOLVE ADOPTED AS FOLLOWS**  
**SECOND RESOLVE REFERRED**  
*See Policy D-295.307*

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.

[Editor's note: The following resolve was referred.]

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

**310. SUPPORT FOR STANDARDIZED INTERPRETER TRAINING**  
**Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee C.*

**HOD ACTION:      ADOPTED**  
*See Policies H-160.924 and D-300.976*

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; 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"; 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.

**311. DISCONTINUE STATE LICENSURE REQUIREMENT FOR COMLEX LEVEL 2 PE**  
**Introduced by Illinois**

*Considered on reaffirmation calendar.*

**HOD ACTION:      POLICY D-275.950 REAFFIRMED**  
**IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association advocate to remove COMLEX Level 2 PE as a requirement for state medical licensure for graduates of accredited U.S. and Canadian osteopathic medical schools, and encourage state medical societies to do the same for their state licensure bodies.

**312. REDUCE FINANCIAL BURDEN TO MEDICAL STUDENTS OF**  
**MEDICAL LICENSURE EXAMINATIONS**  
**Introduced by Illinois**

*Considered on reaffirmation calendar.*

**HOD ACTION:      POLICIES H-305.925 AND D-295.939 REAFFIRMED**  
**IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association advocate for medical licensure examinations and related study, practice examinations, and examination preparatory materials released by the National Board of Medical Examiners and the National Board of Osteopathic Medical Examiners to be available at a cost that does not exceed the reasonable cost of providing the examination and examination preparatory materials.

**313. DECREASING MEDICAL STUDENT DEBT AND INCREASING TRANSPARENCY  
IN COST OF MEDICAL SCHOOL ATTENDANCE**  
**Introduced by Illinois, American Society of Anesthesiologists**

*Considered on reaffirmation calendar.*

**HOD ACTION: POLICIES H-305.925 AND H-305.988 REAFFIRMED  
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association work with Congress and related bodies to make it a priority to reduce the costs of medical school tuition incurred by graduates of U.S. medical schools, without sacrificing current educational quality; and be it further

RESOLVED, That our AMA encourage the written transparent disclosure by U.S. medical schools of the overall cost of attendance, including but not limited to, cost of living; educational materials not provided by the school, such as exam preparatory materials from outside companies; examination fees; interview and residency application costs; and other related costs incurred by students over the duration of their education; and be it further

RESOLVED, That our AMA encourage the written transparent disclosure of all scholarships provided by an institution, including disclosure of allocation criteria and duration; and be it further

RESOLVED, That our AMA encourage U.S. medical schools to provide written, transparent information about how medical school tuition dollars are allocated across the medical school budget.

**314. SUPPORT FOR INSTITUTIONAL POLICIES FOR PERSONAL DAYS FOR  
UNDERGRADUATE MEDICAL STUDENTS**  
**Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee C.*

**HOD ACTION: REFERRED**

RESOLVED, That our American Medical Association encourage medical schools to accept flexible uses for excused absences from clinical clerkships; 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.

**315. MODIFYING FINANCIAL ASSISTANCE ELIGIBILITY CRITERIA FOR  
MEDICAL SCHOOL APPLICANTS**  
**Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee C.*

**HOD ACTION: ADOPTED AS FOLLOWS  
TITLE CHANGED  
See Policy D-305.950**

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.

**316. PROVIDING TRANSPARENT AND ACCURATE DATA REGARDING STUDENTS  
AND FACULTY AT MEDICAL SCHOOLS**  
**Introduced by Illinois**

*Reference committee hearing: see report of Reference Committee C.*

**HOD ACTION:     ADOPTED**  
*See Policy D-295.306*

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.

**317. MEDICAL STUDENT, RESIDENT AND FELLOW SUICIDE REPORTING**  
**Introduced by Illinois**

**Resolution 317 was considered with Resolution 326.**  
**See Resolution 326, which was adopted in lieu of Resolution 317.**

RESOLVED, That our American Medical Association amend Policy D-345.983 by addition to read 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. (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.

**318. CME FOR PRECEPTORSHIP**  
**Introduced by Oklahoma**

*Considered on reaffirmation calendar.*

**HOD ACTION:     POLICIES H-300.977 AND H-300.988 REAFFIRMED**  
**IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association study formulating a plan, in collaboration with other interested bodies, to award AMA Category 1 credits to physicians who serve as preceptors and teach medical students, residents, fellows, and other allied health professional students training in Liaison Committee on Medical Education/Accreditation Council for Graduate Medical Education accredited institutions; and be it further

RESOLVED, That our AMA devise a method of converting those credits awarded by other organizations into AMA recognized credits for the purpose of CME.

**319. SENIOR LIVING COMMUNITY TRAINING FOR MEDICAL STUDENTS AND RESIDENTS**  
**Introduced by AMDA – The Society for Post-Acute and Long-Term Care Medicine**

*Reference committee hearing: see report of Reference Committee C.*

**HOD ACTION: ADOPTED AS FOLLOWS**  
*See Policy D-295.305*

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.

**320. TUITION COST TRANSPARENCY**  
**Introduced by Michigan**

*Considered on reaffirmation calendar.*

**HOD ACTION: POLICIES H-305.925 AND H-305.988 REAFFIRMED**  
**IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association collaborate with organizations such as the Association of American Medical Colleges in creating transparency in tuition costs of undergraduate medical education institutions; and be it further

RESOLVED, That our AMA work with other national organizations to improve the affordability of medical education.

**321. IMPROVING AND STANDARDIZING PREGNANCY AND LACTATION**  
**ACCOMMODATIONS FOR MEDICAL BOARD EXAMINATIONS**  
**Introduced by Michigan**

*Reference committee hearing: see report of Reference Committee C.*

**HOD ACTION: ADOPTED AS FOLLOWS**  
*See Policy H-275.915*

RESOLVED, That our American Medical Association support and advocate for the implementation of a minimum of 60 minutes of additional, scheduled break time for all test takers who are pregnant and/or lactating during all medical licensure and certification examinations; 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 any medical licensure or certification examination's pre-approved list of Personal Item Exemptions (PIEs) permitted in the secure testing area for all test takers who are pregnant and/or lactating.

### 322. STANDARDS IN CULTURAL HUMILITY TRAINING WITHIN MEDICAL EDUCATION Introduced by Michigan

*Reference committee hearing: see report of Reference Committee C.*

**HOD ACTION: ADOPTED**  
*See Policy H-295.897*

RESOLVED, That our AMA amend Policy H-295.897, “Enhancing the Cultural Competence of Physicians,” by addition to read as follows:

H-295.897, “Enhancing the Cultural Competence of Physicians”

1. Our AMA continues to inform medical schools and residency program directors about activities and resources related to assisting physicians in providing culturally competent care to patients throughout their life span and encourage them to include the topic of culturally effective health care in their curricula.
2. Our AMA continues to support research into the need for and effectiveness of training in cultural competence 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.

### 323. CULTURAL LEAVE FOR AMERICAN INDIAN TRAINEES Introduced by Medical Student Section

*Reference committee hearing: see report of Reference Committee C.*

**HOD ACTION: ADOPTED AS FOLLOWS**  
*See Policies H-310.923 and H-350.957*

RESOLVED, That our American Medical Association amend Policy H-310.923, Eliminating Religious Discrimination from Residency Programs, by addition and deletion to read as follows:

H-310.923, “Eliminating Religious and Cultural Discrimination from Residency and Fellowship Programs and Medical Schools”

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, 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; and be it further

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.

**324. ACCREDITATION STANDARDS TO ADDRESS SEXUAL HARASSMENT IN  
MEDICAL TRAINING PROGRAMS**  
**Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee C.*

**HOD ACTION:     ADOPTED AS FOLLOWS**  
**TITLE CHANGED**  
*See Policy D-295.304*

RESOLVED, That our American Medical Association encourage 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; and be it further

RESOLVED, That our AMA encourage 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.

**325. SINGLE LICENSING EXAM SERIES FOR OSTEOPATHIC AND  
ALLOPATHIC MEDICAL STUDENTS**  
**Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee C.*

**HOD ACTION:     ADOPTED AS FOLLOWS**  
*See Policy D-275.947*

RESOLVED, That our American Medical Association 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.

**326. STANDARDIZED WELLNESS INITIATIVE REPORTING**  
**Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee C.*

**HOD ACTION:     ADOPTED AS FOLLOWS**  
**IN LIEU OF RESOLUTION 317**  
*See Policy D-345.983*

RESOLVED, That our American Medical Association amend D-345.983, "Study of Medical Student, Resident, and Physician Suicide," by addition to read 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 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.

**327. LEADERSHIP TRAINING MUST BECOME AN INTEGRAL PART OF MEDICAL EDUCATION**  
**Introduced by New Jersey**

*Reference committee hearing: see report of Reference Committee C.*

**HOD ACTION: ADOPTED AS FOLLOWS**  
*See Policy D-295.316*

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 be it further

RESOLVED, That our AMA expand efforts to promote the tenets of health systems science to prepare trainees for leadership roles and address prevalent challenges in the practice of medicine and public health.

**328. INCREASING TRANSPARENCY OF THE RESIDENT PHYSICIAN APPLICATION PROCESS**  
**Introduced by Ohio**

*Reference committee hearing: see report of Reference Committee C.*

**HOD ACTION: ADOPTED AS FOLLOWS**  
*See Policy D-310.977*

RESOLVED, That our American Medical Association work with appropriate stakeholders to study options for improving transparency in the resident application process.

**329. USE OF THE TERMS “RESIDENCY” AND “FELLOWSHIP” BY HEALTH PROFESSIONS OUTSIDE OF MEDICINE**  
**Introduced by Texas**

**Resolution 329 was considered with Council on Medical Education Report 4.**  
**See Council on Medical Education Report 4, which was adopted in lieu of 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.

**REFERENCE COMMITTEE D**

**401. AIR QUALITY AND THE PROTECTION OF CITIZEN HEALTH**  
**Introduced by New York**

*Reference committee hearing: see report of Reference Committee D.*

**HOD ACTION: ADOPTED AS FOLLOWS**  
*See Policy H-135.949*

RESOLVED, That our American Medical Association support the Environmental Protection Agency’s proposal, under the Clean Air Act to regulate air quality for heavy metals and other air toxins emitted from smokestacks. The

risk of dispersion through air and soil should be considered, particularly for people living downwind of smokestacks; and be it further

RESOLVED, That our AMA urge the EPA to finalize updated mercury, cadmium, and air toxic regulations for monitoring air quality emitted from power plants and other industrial sources, ensuring that recommendations to protect the public's health are enforceable.

**402. SUPPORT FOR IMPAIRMENT RESEARCH**  
**Introduced by New York**

*Reference committee hearing: see report of Reference Committee D.*

**HOD ACTION: 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.

**403. ADDRESSING PARENTAL DISCRIMINATION AND SUPPORT FOR FLEXIBLE FAMILY LEAVE**  
**Introduced by Women Physicians Section**

*Reference committee hearing: see report of Reference Committee D.*

**HOD ACTION: ADOPTED AS FOLLOWS**  
**TITLE CHANGED**  
*See Policy H-405.954*

RESOLVED, That our American Medical Association encourage key stakeholders to implement policies and programs that help protect against 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; 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.

**404. WEAPONS IN CORRECTIONAL HEALTHCARE SETTINGS**  
**Introduced by American Academy of Child and Adolescent Psychiatry, American Academy of Psychiatry and the Law, American Association for Geriatric Psychiatry, American Psychiatric Association**

*Reference committee hearing: see report of Reference Committee D.*

**HOD ACTION: ADOPTED AS FOLLOWS**  
*See Policy H-215.977*

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; and be it further

RESOLVED, That our AMA work with appropriate stakeholders to make evidence-based recommendations regarding the presence of weapons in correctional healthcare facilities.

**405. UNIVERSAL CHILDCARE AND PRESCHOOL**  
**Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee D.*

**HOD ACTION: ADOPTED**  
*See Policy H-60.917*

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

**406. COVID-19 PREVENTIVE MEASURES FOR CORRECTIONAL FACILITIES  
AND DETENTION CENTERS**  
**Introduced by American Association of Public Health Physicians**

*Reference committee hearing: see report of Reference Committee D.*

**HOD ACTION: ADOPTED AS FOLLOWS**  
**TITLE CHANGED**  
*See Policy H-430.979*

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; and be it further

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; and be it further

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 when they enter a correctional facility or detention center as consistent with CDC or local public health guidelines, at no cost to the visitor; and be it further

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 6 foot distance from anyone else if local transmission rate is above low risk as determined by the CDC; and be it further

RESOLVED, That our AMA advocate that correctional facilities or detention centers be able to request and receive all necessary funding for COVID-19 vaccination and testing, according to CDC or local public health guidelines.

**407. STUDY OF BEST PRACTICES FOR ACUTE CARE OF PATIENTS IN THE CUSTODY  
OF LAW ENFORCEMENT OR CORRECTIONS**  
**Introduced by American Thoracic Society**

*Reference committee hearing: see report of Reference Committee D.*

**HOD ACTION: ADOPTED AS FOLLOWS**  
*See Policy D-430.993*

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 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.

**408. SUPPORTING INCREASED RESEARCH ON IMPLEMENTATION OF NONVIOLENT  
DE-ESCALATION TRAINING FOR LAW ENFORCEMENT**

**Introduced by Illinois**

*Reference committee hearing: see report of Reference Committee D.*

**HOD ACTION:      ADOPTED AS FOLLOWS  
                         TITLE CHANGED  
                         See Policy H-345.972**

RESOLVED, That our American Medical Association support increased research on non-violent de-escalation tactics for law enforcement encounters with people who have mental illness and/or developmental disabilities; and be it further

RESOLVED, That our AMA support research of fatal encounters with law enforcement and the prevention thereof.

**409. INCREASING HPV VACCINATION RATES IN RURAL COMMUNITIES**

**Introduced by Illinois**

*Considered on reaffirmation calendar.*

**HOD ACTION:      POLICY H-440.872 REAFFIRMED  
                         IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association advocate for increased HPV vaccination access and education in rural communities.

**410. INCREASING EDUCATION FOR SCHOOL STAFF TO RECOGNIZE PRODROMAL  
SYMPTOMS OF SCHIZOPHRENIA IN TEENS AND YOUNG ADULTS  
TO INCREASE EARLY INTERVENTION**

**Introduced by Illinois**

*Reference committee hearing: see report of Reference Committee D.*

**HOD ACTION:      ADOPTED AS FOLLOWS  
                         See Policy D-345.979**

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 staff to recognize prodromal symptoms of schizophrenia to increase early intervention.

**411. PRESCRIBING OPTION FOR EXPEDITED PARTNER THERAPY**  
**Introduced by Michigan, Oregon**

*Reference committee hearing: see report of Reference Committee D.*

**HOD ACTION:     ADOPTED AS FOLLOWS**  
**TITLE CHANGED**  
*See Policy D-440.968*

RESOLVED, That our American Medical Association work with electronic medical record vendors to create a prescribing option for the purpose of expedited partner therapy.

**412. ADVOCATING FOR THE AMENDMENT OF CHRONIC NUISANCE ORDINANCES**  
**Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee D.*

**HOD ACTION:     ADOPTED**  
*See Policy D-270.985*

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; 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.

**413. EXPANSION ON COMPREHENSIVE SEXUAL HEALTH EDUCATION**  
**Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee D.*

**HOD ACTION:     ADOPTED AS FOLLOWS**  
*See Policy H-170.968*

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:

H-170.968, "Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools"

(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~~ 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 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.

**414. IMPROVEMENT OF CARE AND RESOURCE ALLOCATION FOR HOUSING-INSECURE  
PERSONS IN THE GLOBAL PANDEMIC  
Introduced by Resident and Fellow Section**

*Reference committee hearing: see report of Reference Committee D.*

**HOD ACTION:      ADOPTED AS FOLLOWS  
TITLE CHANGED**

*See Policies H-160.903, H-160.978, and H-345.975*

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; 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; and be it further

RESOLVED, that our AMA make available existing educational resources from federal agencies and other stakeholders related to the needs of housing-insecure individuals; 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”; 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.”

**415. CREATION OF AN OBESITY TASK FORCE**

**Introduced by Obesity Medicine Association, Colorado, Arizona, California, Illinois, New Jersey, Texas, American Association of Clinical Endocrinology, Endocrine Society, American Society for Metabolic and Bariatric Surgery**

*Reference committee hearing: see report of Reference Committee D.*

**HOD ACTION: 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; 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.

**416. SCHOOL RESOURCE OFFICER VIOLENCE DE-ESCALATION  
TRAINING AND CERTIFICATION**

**Introduced by Oklahoma**

*Reference committee hearing: see report of Reference Committee D.*

**HOD ACTION: REFERRED**

RESOLVED, That our American Medical Association highly recommend mandatory conflict de-escalation training for all school resource officers; 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.

**417. TOBACCO CONTROL**

**Introduced by Oklahoma**

*Reference committee hearing: see report of Reference Committee D.*

**HOD ACTION: ADOPTED**  
*See Policy H-490.913*

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.

#### **418. LUNG CANCER SCREENING AWARENESS** **Introduced by Oklahoma**

*Reference committee hearing: see report of Reference Committee D.*

**HOD ACTION:      ADOPTED**  
*See Policy H-185.936*

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.

**419. ADVOCATING FOR THE UTILIZATION OF POLICE AND MENTAL HEALTH CARE  
CO-RESPONSE TEAMS FOR 911 MENTAL HEALTH EMERGENCY CALLS  
Introduced by Illinois**

*Considered on reaffirmation calendar.*

**HOD ACTION: POLICY H-345.972 REAFFIRMED  
IN LIEU OF FOLLOWING RESOLUTION**

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

**420. DECLARING CLIMATE CHANGE A PUBLIC HEALTH CRISIS**

*Reference committee hearing: see report of Reference Committee D.*

**HOD ACTION: ALTERNATE RESOLUTION 420 ADOPTED  
IN LIEU OF RESOLUTIONS 420 AND 430  
See Policy D-135.966**

RESOLVED, That our American Medical Association declare climate change a public health crisis that threatens the health and well-being of all individuals; 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; 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.

**421. SCREENING FOR HPV-RELATED ANAL CANCER  
Introduced by Pennsylvania**

*Reference committee hearing: see report of Reference Committee D.*

**HOD ACTION: ADOPTED  
See Policy H-460.913**

RESOLVED, That our American Medical Association support advocacy efforts to implement screening for anal cancer for high-risk populations; 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.

**422. VOTING AS A SOCIAL DETERMINANT OF HEALTH**  
**Introduced by Minority Affairs Section, National Medical Association**

*Reference committee hearing: see report of Reference Committee D.*

**HOD ACTION:      ADOPTED AS FOLLOWS**  
*See Policy H-440.805*

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; and be it further

RESOLVED, That our AMA recognizes that gerrymandering which disenfranchises individuals/communities limits access to health care, including but not limited to the expansion of comprehensive medical insurance coverage, and negatively impacts health outcomes; 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.

**423 AWARENESS CAMPAIGN FOR 988 NATIONAL SUICIDE PREVENTION LIFELINE**

*Reference committee hearing: see report of Reference Committee D.*

**HOD ACTION:      ALTERNATE RESOLUTION 423 ADOPTED**  
*See Policy D-345.974*

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.

**424. PHYSICIAN INTERVENTIONS ADDRESSING ENVIRONMENTAL HEALTH AND JUSTICE**  
**Introduced by Maryland**

*Reference committee hearing: see report of Reference Committee D.*

**HOD ACTION:      ADOPTED**  
*See Policy H-135.938*

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.

#### **425. MENTAL HEALTH CRISIS**

**Introduced by Melissa Garretson, MD, and Samantha Rosman, MD, MPH, Delegates**

*Reference committee hearing: see report of Reference Committee D.*

**HOD ACTION: ADOPTED AS FOLLOWS**

*See Policies H-345.984, D-345.972, and D-345.994*

RESOLVED, That our American Medical Association work expeditiously 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 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.

#### **426. MENTAL HEALTH FIRST AID TRAINING**

**Introduced by Michigan**

*Considered on reaffirmation calendar.*

**HOD ACTION: POLICIES H-345.984 AND D-345.994 REAFFIRMED  
IN LIEU OF FOLLOWING RESOLUTION**

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; and be it further

RESOLVED, That our AMA reaffirm AMA Policy D-345.994 and H-345.984.

**427. PICTORIAL HEALTH WARNINGS ON ALCOHOLIC BEVERAGES**  
**Introduced by Michigan**

*Reference committee hearing: see report of Reference Committee D.*

**HOD ACTION:     ADOPTED**  
*See Policy H-30.940*

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:

H-30.940, “AMA Policy Consolidation: Labeling Advertising, and Promotion of Alcoholic Beverages”

(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.; and be it further

RESOLVED, That our AMA advocate for the implementation of pictorial health warnings on alcoholic beverages.

**428. AMENDING H-90.968 TO EXPAND POLICY ON MEDICAL CARE OF  
PERSONS WITH DISABILITIES**

**Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee D.*

**HOD ACTION: ADOPTED**

*See Policy H-90.968*

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 Policy 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:

H-90.968, “Medical Care of Persons with ~~Developmental~~ Disabilities”

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

**429. INCREASING AWARENESS AND REDUCING CONSUMPTION OF FOOD AND DRINK  
OF POOR NUTRITIONAL QUALITY  
Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee D.*

**HOD ACTION: ADOPTED**  
*See Policy H-150.927*

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; 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.

#### **430. LONGITUDINAL CAPACITY-BUILDING TO ADDRESS CLIMATE ACTION AND JUSTICE**

**Introduced by Medical Student Section**

**Resolution 430 was considered with Resolution 420.**

**See Resolution 420, which was adopted in lieu of 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.

#### **431. PROTECTIONS FOR INCARCERATED MOTHERS AND INFANTS IN THE PERINATAL PERIOD**

**Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee D.*

##### **HOD ACTION: ADOPTED AS FOLLOWS**

*See Policies H-420.948 and H-430.990*

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; 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; and be it further

RESOLVED, That our AMA oppose the separation of infants from incarcerated, pregnant individuals post-partum; 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; and be it further

RESOLVED, That our AMA amend Policy H-430.990 by addition to read as follows:

H-430.990, “Bonding Programs for Women Prisoners and their Newborn Children”

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.

#### **432. RECOGNIZING LONELINESS AS A PUBLIC HEALTH ISSUE**

##### **Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee D.*

**HOD ACTION:     ADOPTED**  
*See Policy D-440.913*

RESOLVED, That our American Medical Association release a statement identifying loneliness as a public health issue with consequences for physical and mental health; and be it further

RESOLVED, That our AMA support evidence-based efforts to combat loneliness.

#### **433. SUPPORT FOR DEMOCRACY**

##### **Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee D.*

**HOD ACTION:     ADOPTED**  
*See Policy H-65.947*

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; and be it further

RESOLVED, That our AMA strongly oppose attempts to subvert the democratic process; 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.

#### **434. SUPPORT FOR PEDIATRIC SIBLINGS OF CHRONICALLY ILL CHILDREN**

##### **Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee D.*

**HOD ACTION:     ADOPTED**  
*See Policy H-60.899*

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.

**435. SUPPORT REMOVAL OF BMI AS A STANDARD MEASURE IN MEDICINE AND RECOGNIZING CULTURALLY-DIVERSE AND VARIED PRESENTATIONS OF EATING DISORDERS**  
**Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee D.*

**HOD ACTION: 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; 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; 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:

H-440.866, “The Clinical Utility of Measuring ~~Body Mass Index~~ Weight, Adiposity, and Waist Circumference in the Diagnosis and Management of Adult Overweight and Obesity”

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/m<sup>2</sup>~~;
- (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.; 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.

**436. TRAINING AND REIMBURSEMENT FOR FIREARM SAFETY COUNSELING**  
**Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee D.*

**HOD ACTION: ADOPTED AS FOLLOWS**  
*See Policy H-145.976*

RESOLVED, That our American Medical Association support the inclusion of firearm-related violence and suicide epidemiology, as well as evidence-based firearm-related injury prevention education in undergraduate and graduate medical education training programs, where appropriate; 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:

H-145.976, “Firearm Safety Counseling in Physician-Led Health Care Teams”

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.

#### **437. AIR POLLUTION AND COVID: A CALL TO TIGHTEN REGULATORY STANDARDS FOR PARTICULATE MATTER**

*Reference committee hearing: see report of Reference Committee D.*

**HOD ACTION: ALTERNATE RESOLUTION 437 ADOPTED**

*See Policies H-135.946 and D-135.978*

RESOLVED, That Policies H-135.946, “Protective NAAQS Standard for Fine Particulate Matter (PM 2.5)” and D-135.978, “Protective NAAQS Standard for Particulate Matter (PM 2.5 & PM 10)” be reaffirmed.

#### **438. INFORMING PHYSICIANS, HEALTH CARE PROVIDERS, AND THE PUBLIC OF THE HEALTH DANGERS OF FOSSIL FUEL-DERIVED HYDROGEN**

**Introduced by Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont**

*Reference committee hearing: see report of Reference Committee D.*

**HOD ACTION: ADOPTED**

*See Policy D-135.965*

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); 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; 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.

**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**

**Introduced by Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont**

*Reference committee hearing: see report of Reference Committee D.*

**HOD ACTION: ADOPTED**  
*See Policy D-135.964*

RESOLVED, That our American Medical Association recognize the association between the use of gas stoves, indoor nitrogen dioxide levels and asthma; 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; 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.

**440. ADDRESSING SOCIAL DETERMINANTS OF HEALTH THROUGH HEALTH IT  
Introduced by Integrated Physician Practice Section**

*Reference committee hearing: see report of Reference Committee D.*

**HOD ACTION: ADOPTED AS FOLLOWS**  
*See Policy H-160.896*

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; 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; and be it further

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

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.

**441. ADDRESSING ADVERSE EFFECTS OF ACTIVE- SHOOTER AND LIVE-CRISIS  
DRILLS ON CHILDREN'S HEALTH  
Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee D.*

**HOD ACTION:      ADOPTED AS FOLLOWS  
TITLE CHANGED  
See Policy D-145.993**

RESOLVED, That our American Medical Association support that any school system conducting active-shooter or live-crisis drills does so in an evidence-based and 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 or live crisis drills that are safe for children and developmentally appropriate; and be it further

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.

**442. OPPOSING THE CENSORSHIP OF SEXUALITY AND GENDER  
IDENTITY DISCUSSIONS IN PUBLIC SCHOOLS  
Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee D.*

**HOD ACTION:      ADOPTED  
See Policy H-60.898**

RESOLVED, That our American Medical Association oppose 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 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.

**443. ADDRESSING THE LONGITUDINAL HEALTHCARE NEEDS OF  
AMERICAN INDIAN CHILDREN IN FOSTER CARE  
Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee D.*

**HOD ACTION:      ADOPTED AS FOLLOWS  
See Policy D-350.977**

RESOLVED, The AMA recognize the Indian Child Welfare Act of 1978 as a model in American Indian and Alaska Native child welfare legislation; and be it further

RESOLVED, The AMA support 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 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 support state and federal funding opportunities for American Indian and Alaska Native child welfare systems.

## REFERENCE COMMITTEE E

### **501. MARKETING GUARDRAILS FOR THE “OVER-MEDICALIZATION” OF CANNABIS USE** **Introduced by Young Physicians Section**

*Reference committee hearing: see report of Reference Committee E.*

**HOD ACTION: ADOPTED AS FOLLOWS**  
*See Policies H-95.936 and D-95.958*

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; and be it further

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; and be it further

RESOLVED, That our AMA study marketing practices of cannabis, cannabis products and cannabis paraphernalia that influence vulnerable populations, such as children or pregnant people; and be it further

RESOLVED, That Policy H-95.936, “Cannabis Warnings for Pregnant and Breastfeeding Women,” be reaffirmed.

### **502. ENSURING CORRECT DRUG DISPENSING** **Introduced by New York**

*Reference committee hearing: see report of Reference Committee E.*

**HOD ACTION: ADOPTED AS FOLLOWS**  
*See Policy D-120.926*

RESOLVED, That our American Medical Association work with the United States Food and Drug Administration, the pharmaceutical and pharmacy industries, state boards of pharmacy, patient advocacy groups, and standards-setting organizations to evaluate the feasibility of pharmacies including a color photo of a prescribed medication and information about its dosage with the sales receipt to ensure that the drug dispensed is that which has been prescribed.

**503. PHARMACY BENEFIT MANAGERS AND DRUG SHORTAGES**

*Reference committee hearing: see report of Reference Committee E.*

**HOD ACTION: ALTERNATE RESOLUTION 503 ADOPTED**

*See Policy H-100.956*

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.

**504. SCIENTIFIC STUDIES WHICH SUPPORT LEGISLATIVE AGENDAS**

**Introduced by New York**

*Reference committee hearing: see report of Reference Committee E.*

**HOD ACTION: ADOPTED AS FOLLOWS**

*See Policy D-460.964*

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 data to inform our AMA’s key advocacy goals.

**505. CBD OIL USE AND THE MARKETING OF CBD OIL**

**Introduced by Illinois**

*Reference committee hearing: see report of Reference Committee E.*

**HOD ACTION: ADOPTED AS FOLLOWS**

*See Policy H-95.911*

RESOLVED, That our American Medical Association support banning the advertising of cannabidiol (CBD) as a component of marijuana in places that children frequent; and be it further

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.

**506. DRUG MANUFACTURING SAFETY**  
**Introduced by Illinois**

*Reference committee hearing: see report of Reference Committee E.*

**HOD ACTION:      ADOPTED AS FOLLOWS**  
*See Policy H-100.945*

RESOLVED, That our American Medical Association support efforts to ensure that the U.S. Food and Drug Administration (FDA) resumes inspections of all drug manufacturing facilities on a frequent and rigorous basis, as done in the past; and be it further

RESOLVED, That our AMA call for the FDA to: (a) assure the safety of the manufacture of drugs, 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 in the pipeline.

**507. FEDERAL INITIATIVE TO TREAT CANNABIS DEPENDENCE**  
**Introduced by Illinois**

*Considered on reaffirmation calendar.*

**HOD ACTION:      POLICIES H-95.923 AND H-95.952 REAFFIRMED**  
**IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association urge the National Institutes of Health to award appropriate incentive grants to universities, pharmaceutical companies and other capable entities to develop treatment options for cannabis dependence; and that the cost of these grants be financed by taxes on those who profit from selling cannabis.

**508. SUPPLEMENTAL RESOURCES FOR INFLIGHT MEDICAL KIT**

*Reference committee hearing: see report of Reference Committee E.*

**HOD ACTION:      ALTERNATE RESOLUTION 508 ADOPTED**  
*See Policy H-45.981*

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, 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.

**509. REGULATION AND CONTROL OF SELF-SERVICE LABS**  
**Introduced by Illinois**

*Reference committee hearing: see report of Reference Committee E.*

**HOD ACTION: ADOPTED**  
*See Policy D-260.992*

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.

**510. EVIDENCE-BASED DEFERRAL PERIODS FOR MSM CORNEAS AND TISSUE DONORS**  
**Introduced by Colorado, American Academy of Ophthalmology, GLMA: Health Professionals Advancing LGBTQ Equality, Society of Critical Care Medicine, American Society of Transplant Surgeons, American Society of Cataract and Refractive Surgery, California**

*Reference committee hearing: see report of Reference Committee E.*

**HOD ACTION: ADOPTED**  
*See Policy H-50.973*

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; 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.

**511. OVER THE COUNTER (OTC) HORMONAL BIRTH CONTROL**  
**Introduced by Illinois**

**Resolution 511 was considered with Resolution 518.**  
**See Resolution 518, which was adopted in lieu of 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; 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.

**512. BANNING THE SALE OF TIANEPTINE TO THE PUBLIC IN THE UNITED STATES**  
**Introduced by Mississippi**

*Reference committee hearing: see report of Reference Committee E.*

**HOD ACTION:**     **ADOPTED AS FOLLOWS**  
                          **TITLE CHANGED**  
                          *See Policy D-95.957*

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.

**513. EDUCATION FOR PATIENTS ON OPIATE REPLACEMENT THERAPY**  
**Introduced by Oklahoma**

*Reference committee hearing: see report of Reference Committee E.*

**HOD ACTION:**     **ADOPTED AS FOLLOWS**  
                          *See Policy D-95.987*

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 with substance use disorder and their family/caregivers to increase understanding of the increased risk of adverse outcomes associated with having a substance use disorder and a serious respiratory illness such as SARS-CoV-2.

**514. OPPOSING SCHEDULING OF GABAPENTIN**  
**Introduced by Oklahoma**

*Reference committee hearing: see report of Reference Committee E.*

**HOD ACTION:**     **ADOPTED AS FOLLOWS**  
                          **TITLE CHANGED**  
                          *See Policy D-120.927*

RESOLVED, That 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, That our AMA submit a timely letter to the Commissioner of the U.S. Food and Drug Administration 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; and be it further

RESOLVED, That our AMA 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.

#### **515. REDUCING POLYPHARMACY AS A SIGNIFICANT CONTRIBUTOR TO SENIOR MORBIDITY** **Introduced by Senior Physicians Section**

*Reference committee hearing: see report of Reference Committee E.*

**HOD ACTION: ADOPTED AS FOLLOWS**  
*See Policy D-120.928*

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; 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; 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 be it further

RESOLVED, That our AMA work with other stakeholders and EHR vendors to include non-prescription medicines and supplements in medication lists and compatibility screens.

#### **516. OPPOSE UNSAFE USE OF “MILD HYPERBARIC THERAPY”**

*Reference committee hearing: see report of Reference Committee E.*

**HOD ACTION: ALTERNATE RESOLUTION 516 ADOPTED  
IN LIEU OF RESOLUTIONS 516 AND 517**  
*See Policy D-270.986*

RESOLVED, That our American Medical Association oppose the operation of “mild hyperbaric facilities” unless and until effective treatments can be delivered safely in facilities with appropriately trained staff including physician supervision and prescription and only when the intervention has scientific support or rationale; 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.

**517. SAFEGUARD THE PUBLIC FROM WIDESPREAD UNSAFE USE OF  
“MILD HYPERBARIC OXYGEN THERAPY”**

**Introduced by Undersea and Hyperbaric Medical Society**

**Resolution 517 was considered with Resolution 516.**

**See Resolution 516, which was adopted in lieu of Resolution 517.**

RESOLVED, That our American Medical Association oppose the operation of unsafe “Mild Hyperbaric Facilities”; 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.

**518. OVER-THE-COUNTER HORMONAL CONTRACEPTIVES**

*Reference committee hearing: see report of Reference Committee E.*

**HOD ACTION:      ALTERNATE RESOLUTION 518 ADOPTED  
IN LIEU OF RESOLUTIONS 511 AND 518**

*See Policy D-75.995*

RESOLVED, That our American Medical Association amend 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.

**519. ADVANCED RESEARCH PROJECTS AGENCY FOR HEALTH (ARPA-H)  
Introduced by Association for Clinical Oncology, American College of Rheumatology**

*Reference committee hearing: see report of Reference Committee E.*

**HOD ACTION:      ADOPTED**

*See Policy H-460.888*

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.

**520. BREAST MILK SHARING**  
**Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee E.*

**HOD ACTION:     ADOPTED AS FOLLOWS**  
**TITLE CHANGED**  
*See Policy H-245.966*

RESOLVED, That our American Medical Association encourage the practice of breast milk sharing, and work with the appropriate stakeholders to develop standards that promote safe and equitable access; and be it further

RESOLVED, That our AMA encourage the education of patients about the potential risks of breast milk sharing when acceptable health and safety standards are not met; and be it further

RESOLVED, That our AMA support further research into the status of breast milk donation in the U.S. and how rates of donation may be improved.

**521. ENCOURAGING BRAIN AND OTHER TISSUE DONATION FOR RESEARCH  
AND EDUCATIONAL PURPOSES**  
**Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee E.*

**HOD ACTION:     ADOPTED AS FOLLOWS**  
*See Policy H-460.887*

RESOLVED, That our American Medical Association support the production and distribution of educational materials regarding the importance of tissue donation for the purposes of medical research and education; and be it further

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; and be it further

RESOLVED, That our AMA encourage all persons to consider consenting to tissue donation including brain tissue for research purposes; and be it further

RESOLVED, That our AMA encourage efforts to facilitate recovery, transportation, and storage of tissue including brain tissue for research and education purposes.

**522. ENCOURAGING RESEARCH OF TESTOSTERONE AND PHARMACOLOGICAL THERAPIES  
FOR POST-MENOPAUSAL INDIVIDUALS WITH DECREASED LIBIDO**  
**Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee E.*

**HOD ACTION:     ADOPTED**  
*See Policy H-460.886*

RESOLVED, That our American Medical Association encourage expansion of research on the use of testosterone therapy and other pharmacological interventions in treatment of decreased libido in postmenopausal individuals.

**523. IMPROVING RESEARCH STANDARDS, APPROVAL PROCESSES, AND POST-MARKET  
SURVEILLANCE STANDARDS FOR MEDICAL DEVICES**  
**Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee E.*

**HOD ACTION:      REFERRED**

RESOLVED, That our American Medical Association 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; 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; and be it further

RESOLVED, That our AMA amend Policy H-100.992 to include medical devices by addition to read as follows:

H-100.992, “FDA”

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.

**524. INCREASING ACCESS TO TRAUMATIC BRAIN INJURY RESOURCES  
IN PRIMARY CARE SETTINGS**  
**Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee E.*

**HOD ACTION:      ADOPTED AS FOLLOWS**  
*See Policy D-10.990*

RESOLVED, That our American Medical Association 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; and be it further

RESOLVED, That our AMA support 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; and be it further

RESOLVED, That our AMA work with relevant stakeholders to develop and distribute evidence-based guidelines for traumatic brain injury care in primary care settings.

**525. REFORMING THE FDA ACCELERATED APPROVAL PROCESS**  
**Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee E.*

**HOD ACTION: ADOPTED AS FOLLOWS**  
*See Policy H-100.944*

RESOLVED, Our American Medical Association support 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 protocols for the withdrawal of approvals when post-marketing studies fail; and be it further

RESOLVED, That our AMA 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.

**526. ADOPTION OF ACCESSIBLE MEDICAL DIAGNOSTIC EQUIPMENT STANDARDS**  
**Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee E.*

**HOD ACTION: ADOPTED AS FOLLOWS**  
*See Policy H-90.965*

RESOLVED, That our American Medical Association support evidence-based federal accessibility standards for medical diagnostic equipment, as well as grants, tax incentives, and deductions that help physicians implement these standards.

**REFERENCE COMMITTEE F**

**601. DEVELOPMENT OF RESOURCES ON END OF LIFE CARE**  
**Introduced by New York**

*Reference committee hearing: see report of Reference Committee F.*

**HOD ACTION: ADOPTED AS FOLLOWS**  
*See Policy H-85.956*

RESOLVED, That our American Medical Association, in conjunction with interested stakeholders, will provide educational resources for medical students, physicians, allied health professionals, patients, and their families on end-of-life care.

**602. REPORT ON THE PRESERVATION OF INDEPENDENT MEDICAL PRACTICE**  
**Introduced by New York**

*Reference committee hearing: see report of Reference Committee F.*

**HOD ACTION: ADOPTED AS FOLLOWS**  
*See Policy D-405.988*

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.

**603. SEPTEMBER 11<sup>TH</sup> AS AN ANNUAL DAY OF OBSERVANCE**  
**Introduced by New York**

*Reference committee hearing: see report of Reference Committee F.*

**HOD ACTION:     ADOPTED**  
**TITLE CHANGED**  
*See Policy H-445.983*

RESOLVED, That our American Medical Association support and recognize September 11<sup>th</sup> 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.

**604. UN INTERNATIONAL RADIONUCLIDE THERAPY DAY RECOGNITION**  
**Introduced by New York**

**Resolution 604 was considered with Resolutions 624.**  
**See Resolution 624, which was adopted in lieu of 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.”

**605. FULFILLING MEDICINE’S SOCIAL CONTRACT WITH HUMANITY IN THE FACE**  
**OF THE CLIMATE HEALTH CRISIS**  
**Introduced by Resident and Fellow Section**

*Reference committee hearing: see report of Reference Committee F.*

**HOD ACTION:     REFERRED**

RESOLVED, That our American Medical Association reaffirm Policy H-135.949, “Support of Clean Air and Reduction in Power Plant Emissions,”; 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.

**606. FINANCIAL IMPACT AND FISCAL TRANSPARENCY OF THE AMERICAN MEDICAL**  
**ASSOCIATION CURRENT PROCEDURAL TERMINOLOGY® SYSTEM**  
**Introduced by Michigan**

*Reference committee hearing: see report of Reference Committee F.*

**HOD ACTION:     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.

**607. AMA URGES HEALTH AND LIFE INSURERS OF DIVEST FROM  
INVESTMENTS IN FOSSIL FUELS**

**Introduced by American Association of Public Health Physicians**

*Reference committee hearing: see report of Reference Committee F.*

**HOD ACTION: ADOPTED**  
*See Policy H-135.921*

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; 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; 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.

**608. TRANSPARENCY OF RESOLUTION FISCAL NOTES**

**Introduced by Resident and Fellow Section**

*Reference committee hearing: see report of Reference Committee F.*

**HOD ACTION: 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.~~

**609. SURVEILLANCE MANAGEMENT SYSTEM FOR ORGANIZED  
MEDICINE POLICIES AND REPORTS**

**Introduced by Georgia**

*Reference committee hearing: see report of Reference Committee F.*

**HOD ACTION: REFERRED**

RESOLVED, That our American Medical Association develop a prioritization matrix across both global and reference committee specific areas of interest; 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; 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.

**610. MAKING AMA MEETINGS ACCESSIBLE**  
**Introduced by Senior Physicians Section**

*Reference committee hearing: see report of Reference Committee F.*

**HOD ACTION:      ADOPTED AS FOLLOWS**  
**ADDITIONAL RESOLVE REFERRED**  
*See Policy G-630.140*

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; and be it further

RESOLVED, That our AMA revisit our criteria for selection of hotels and other venues in order to facilitate maximum participation by members and invited attendees with disabilities; 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.

[Editor's note: The following resolve from Resolution 610 was referred.]

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.

**611. CONTINUING EQUITY EDUCATION**  
**Introduced by Minority Affairs Section, National Medical Association**

*Reference committee hearing: see report of Reference Committee F.*

**HOD ACTION:      ADOPTED AS FOLLOWS**  
*See Policy G-600.960*

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.

**612. IDENTIFYING STRATEGIES FOR ACCURATE DISCLOSURE AND REPORTING  
OF RACIAL AND ETHNIC DATA ACROSS THE MEDICAL EDUCATION  
CONTINUUM AND PHYSICIAN WORKFORCE**  
**Introduced by Minority Affairs Section, National Medical Association**

*Reference committee hearing: see report of Reference Committee F.*

**HOD ACTION: ADOPTED AS FOLLOWS**  
*See Policy D-630.972*

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; and be it further

RESOLVED, That our AMA report demographic physician workforce data in categories of race and ethnicity whereby Latino, Hispanic, and other identified ethnicities are categories, irrespective of race; 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; 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.

**613. TIMING OF BOARD REPORT ON RESOLUTION 605 FROM N-21 REGARDING  
A PERMANENT RESOLUTION COMMITTEE**  
**Introduced by California**

*Reference committee hearing: see report of Reference Committee F.*

**HOD ACTION: 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.

**614. ALLOWING VIRTUAL INTERVIEWS ON NON-HOLIDAY WEEKENDS FOR  
CANDIDATES FOR AMA OFFICE**  
**Introduced by Albert L. Hsu, MD, Delegate**

*Reference committee hearing: see report of Reference Committee F.*

**HOD ACTION: ADOPTED AS FOLLOWS**  
*See Policy G-610.020*

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 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 Sunday (four days later).~~

**615. ANTI-HARASSMENT TRAINING**  
**Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee F.*

**HOD ACTION:     ADOPTED**  
*See Policy D-65.989*

RESOLVED, That our American Medical Association 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; and be it further

RESOLVED, That our AMA work with the Women Physician 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.

**616. MEDICAL COMMUNITY VOTING IN FEDERAL AND STATE ELECTIONS**  
**Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee F.*

**HOD ACTION:     ADOPTED AS FOLLOWS**  
**TITLE CHANGED**  
*See Policy D-65.982*

RESOLVED, That our American Medical Association study the rate of voter turnout in physicians, residents, fellows, and medical students in federal and state elections without regard to political party affiliation or voting record, as a step towards understanding political participation in the medical community; and be it further

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.

**617. STUDY OF MECHANISMS TO MITIGATE THE COST OF MEDICAL STUDENT, RESIDENT  
AND FELLOW PARTICIPATION IN THE AMA**  
**Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee F.*

**HOD ACTION:     ADOPTED AS FOLLOWS**  
**TITLE CHANGED**  
*See Policy G-615.103*

RESOLVED, That our American Medical Association study mechanisms to mitigate costs incurred by medical students, residents and fellows who participate at national, in-person AMA conferences.

**618. EXTENDING THE DELEGATE APPORTIONMENT FREEZE DURING COVID-19 PANDEMIC**  
**Introduced by Oklahoma**

**Resolution 618 was considered with Board of Trustees Report 20.**

**See Board of Trustees Report 20, the third recommendation of which was adopted in lieu of 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.

**619. FOCUS AND PRIORITY FOR THE AMA HOUSE OF DELEGATES**  
**Introduced by Texas, South Carolina, Florida, Mississippi, New Jersey, Pennsylvania**

*Reference committee hearing: see report of Reference Committee F.*

**HOD ACTION:      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; 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; 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; and be it further

RESOLVED, That members of the Resolutions Committee cannot serve more than four years consecutively; 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; 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; 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”; 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; 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; 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.

**620. REVIEW OF HEALTH INSURANCE COMPANIES AND THEIR  
SUBSIDIARIES' BUSINESS PRACTICES**  
**Introduced by Ohio**

*Considered on reaffirmation calendar.*

**HOD ACTION: POLICY D-385.949 REAFFIRMED  
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association conduct a review of the business practices of health insurance companies in order to identify potential fraudulent and unfair activities.

**621. ESTABLISHING A TASK FORCE TO PRESERVE THE PATIENT-PHYSICIAN RELATIONSHIP  
WHEN EVIDENCE-BASED, APPROPRIATE CARE IS BANNED OR RESTRICTED**  
**Introduced by American College of Obstetricians and Gynecologists**

*Reference committee hearing: see report of Reference Committee F.*

**HOD ACTION: ADOPTED AS FOLLOWS**  
*See Policy G-605.009*

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; and be it further

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.

**622. HOD MODERNIZATION**  
**Introduced by Young Physicians Section**

*Reference committee hearing: see report of Reference Committee F.*

**HOD ACTION:      REFERRED**

RESOLVED, That our American Medical Association 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; 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.

**623. VIRTUAL ATTENDANCE AT AMA MEETINGS**  
**Introduced by Organized Medical Staff Section**

*Reference committee hearing: see report of Reference Committee F.*

**HOD ACTION:      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; 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.

**624. CREATION OF UNITED NATIONS “DR. SAUL HERTZ THERANOSTIC  
NUCLEAR MEDICINE” INTERNATIONAL DAY**  
**Introduced by Organized Medical Staff Section**

*Reference committee hearing: see report of Reference Committee F.*

**HOD ACTION:      ADOPTED**  
**IN LIEU OF RESOLUTION 604**  
*See Policy D-445.996*

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.

**625. POLITICAL ACTION COMMITTEES AND CONTRIBUTIONS**  
**Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee F.*

**HOD ACTION:      ADOPTED AS FOLLOWS**  
**TITLE CHANGED**  
*See Policy G-640.020*

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.

**REFERENCE COMMITTEE G**

**701. FAIR REIMBURSEMENT FOR ADMINISTRATIVE BURDENS**

*Reference committee hearing: see report of Reference Committee G.*

**HOD ACTION:      ALTERNATE RESOLUTION 701 ADOPTED**  
**IN LIEU OF RESOLUTIONS 701 AND 710**  
*See Policy D-320.978*

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; 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; 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; 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.

**702. HEALTH SYSTEM CONSOLIDATION**  
**Introduced by Private Practice Physician Section**

*Reference committee hearing: see report of Reference Committee G.*

**HOD ACTION:      ADOPTED AS FOLLOWS**  
*See Policy D-215.984*

RESOLVED, That our American Medical Association 1) 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.

**703. MANDATING REPORTING OF ALL ANTIPSYCHOTIC DRUG USE IN  
NURSING HOME RESIDENTS**  
**Introduced by Maryland, Mississippi**

*Reference committee hearing: see report of Reference Committee G.*

**HOD ACTION:      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) ask CMS to require the reporting of all antipsychotic drugs used and the diagnoses for which they are prescribed.

**704. EMPLOYED PHYSICIAN CONTRACTS**  
**Introduced by New York**

*Considered on reaffirmation calendar.*

**HOD ACTION:      POLICIES H-225.942, H-225.950, AND D-230.985 REAFFIRMED  
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association advocate in support of all employed physicians receiving all rights and due process protections afforded all other members of the medical staff.

**705. FIFTEEN MONTH LAB STANDING ORDERS**  
**Introduced by New York**

*Reference committee hearing: see report of Reference Committee G.*

**HOD ACTION:     ADOPTED**  
*See Policy D-260.991*

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.

**706. GOVERNMENT IMPOSED VOLUME REQUIREMENTS FOR CREDENTIALING**  
**Introduced by New York**

*Considered on reaffirmation calendar.*

**HOD ACTION:     POLICIES H-230.953 AND H-230.954 REAFFIRMED**  
**IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association create guidelines and standards for evaluation of government-imposed volume requirements for credentialing that would include at least the following considerations:

- (a) the evidence for that volume requirement;
- (b) how many current practitioners meet that volume requirement;
- (c) how difficult it would be to meet that volume requirement;
- (d) the consequences to that practitioner of not meeting that volume requirement;
- (e) the consequences to the hospital and the community of losing the services of the practitioners who can't meet that volume requirement; and
- (f) whether volumes of similar procedures could also reasonably be used to satisfy such a requirement.

**707. INSURANCE COVERAGE FOR SCALP COOLING (COLD CAP) THERAPY**  
**Introduced by New York**

*Considered on reaffirmation calendar.*

**HOD ACTION:     POLICIES H-155.960, H-185.964, H-285.998, H-320.942, H-320.995,**  
**AND D-185.979 REAFFIRMED**  
**IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association advocate for and seek through legislation and/or regulation, universal insurance coverage for Scalp Cooling (Cold Cap) Therapy; and be it further

RESOLVED, That our AMA work with consumer and advocacy groups to challenge insurers on medical necessity denials for Scalp Cooling (Cold Cap) Therapy and encourage appeals to independent third-party reviewers.

**708. PHYSICIAN BURNOUT IS AN OSHA ISSUE**  
**Introduced by New York**

*Reference committee hearing: see report of Reference Committee G.*

**HOD ACTION:     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.

**709. PHYSICIAN WELL-BEING AS AN INDICATOR OF HEALTH SYSTEM QUALITY****Introduced by New York***Considered on reaffirmation calendar.***HOD ACTION: POLICY D-310.968 REAFFIRMED  
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association support policies that acknowledge physician well-being is both a driver and an indicator of hospital and health system quality; and be it further

RESOLVED, That our AMA promote dialogue between key stakeholders (physician groups, health-system decision makers, payers, and the general public) about the components needed in such a quality-indicator system to best measure physician and organizational wellness; and be it further

RESOLVED, That our AMA (with appropriate resources) develop the expertise to be available to assist in the implementations of effective interventions in situations of suboptimal physician wellness.

**710. PRIOR AUTHORIZATION – CPT CODES FOR FAIR COMPENSATION****Introduced by New York**

**Resolution 710 was considered with Resolution 701.  
See Resolution 701, which was adopted in lieu of Resolution 710.**

RESOLVED, That our American Medical Association include in any model legislation and as a 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; 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; 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

**711. REDUCING PRIOR AUTHORIZATION BURDEN****Introduced by New York***Considered on reaffirmation calendar.***HOD ACTION: POLICIES H-320.939, H-320.968, H-385.951, D-125.992,  
AND D-330.910 REAFFIRMED  
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association seek regulation or legislation that:

- restricts insurance companies from requiring prior authorizations for generic medications;
- contains disincentives for insurers demanding unnecessary prior authorizations, including payments to physicians' practices for inappropriate prior authorizations;
- requires payment be made to the physician practice for services related to prior authorization when those services do not coincide with a visit; and
- ensures a requirement for an independent external review organization to review disputes involving prior authorizations and require insurer payments be made to the practice when the review organization agrees with the physician practice.

**712. THE QUADRUPLE AIM – PROMOTING IMPROVEMENT IN THE PHYSICIAN  
EXPERIENCE OF PROVIDING CARE  
Introduced by New York**

*Considered on reaffirmation calendar.*

**HOD ACTION: POLICIES H-405.955 AND H-480.939 REAFFIRMED  
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That to the Triple Aim which was established by Dr. Berwick and the Institute of Healthcare Improvement, our American Medical Association adopt a fourth goal: namely the goal of improving physicians' experience in providing care.

**713. ENFORCEMENT OF ADMINISTRATIVE SIMPLIFICATION REQUIREMENTS - CMS  
Introduced by Private Practice Physician Section**

*Considered on reaffirmation calendar.*

**HOD ACTION: POLICIES D-190.970, D-190.974, D-190.989, AND D-315.992 REAFFIRMED  
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association take the position that the failure by the National Standards Group at the Centers for Medicare and Medicaid Services Office of Burden Reduction to effectively enforce the HIPAA administrative simplification requirements as required by the law and its failure to impose financial penalties for non-compliance by health plans is clearly unacceptable; and be it further

RESOLVED, That our AMA take the position that the National Standards Group at the Centers for Medicare and Medicaid Services Office of Burden Reduction practices of closing complaints without further investigation and ignoring overwhelming evidence that contradicts health plan assertions is also unacceptable; and be it further

RESOLVED, That our AMA advocate for enhanced enforcement of the HIPAA Administrative Simplification requirements for health plans.

**714. PRIOR AUTHORIZATION REFORM FOR SPECIALTY MEDICATIONS  
Introduced by Organized Medical Staff Section**

*Considered on reaffirmation calendar.*

**HOD ACTION: POLICIES H-125.977, H-320.939, H-320.968, H-385.951,  
AND D-320.982 REAFFIRMED  
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association encourage Congress and the President to issue a moratorium on the specialty medicine prior authorization process for one year to allow further study; and be it further

RESOLVED, That our AMA work with other stakeholders to encourage pharmaceutical companies and other entities that offer assistance programs to increase eligibility for their assistance programs.

**715. PRIOR AUTHORIZATION – CPT CODES FOR FAIR COMPENSATION**  
**Introduced by Private Practice Physician Section**

*Considered on reaffirmation calendar.*

**HOD ACTION: POLICIES H-320.939, H-320.968, H-385.951, AND D-320.982 REAFFIRMED  
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association support the creation of CPT codes to provide adequate compensation for administrative work involved in prior authorizations, including pre-certifications and prior notifications, that reflects the actual time expended by physicians and healthcare practices to advocate on behalf of patients and to comply with insurer requirements and that compensates physicians fully for the time, effort, and legal risks inherent in such work; and be it further

RESOLVED, That our AMA advocate for CPT codes to be developed for prior authorizations to fully reflect the aggregated time and effort involved in prior authorization, including multiple contracts, wait time on the phone, chat, or other platforms preferred by payers or their agents, among other costs to physician practice; and be it further

RESOLVED, That our AMA advocate for fair compensation based on CPT codes for prior authorization in any model legislation and as a basis for all advocacy for prior authorization reforms

**716. DISCHARGE SUMMARY REFORM**

*Reference committee hearing: see report of Reference Committee G.*

**HOD ACTION: ALTERNATE RESOLUTION 716 ADOPTED**  
*See Policy D-160.913*

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

**717. EXPANDING THE AMA’S STUDY ON THE ECONOMIC IMPACT OF COVID-19**  
**Introduced by Resident and Fellow Section**

*Reference committee hearing: see report of Reference Committee G.*

**HOD ACTION: 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; 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.

**718. DEGRADATION OF MEDICAL RECORDS****Introduced by Illinois***Considered on reaffirmation calendar.*

**HOD ACTION: POLICIES D-478.966, D-478.975, AND D-478.996 REAFFIRMED  
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association publish available data about the amount of time physicians spend on data entry versus direct patient care, in order to inform patients, insurers, and prospective primary care physicians about the real expectations of the medical profession.

**719. SYSTEM WIDE PRIOR AND POST-AUTHORIZATION DELAYS AND  
EFFECTS ON PATIENT CARE ACCESS****Introduced by Ohio***Considered on reaffirmation calendar.*

**HOD ACTION: POLICIES H-190.978, H-320.939, D-190.974, D-320.979,  
AND D-320.982 REAFFIRMED  
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association encourage and advocate health care insurers and Medicare/Medicaid Products to ensure that the systems of communication for prior authorization include: live personnel access, simplification of website navigation, immediate response with confirmation number of submission and an expedient decision for authorizations.

**720. MITIGATING THE NEGATIVE IMPACT OF STEP THERAPY POLICIES AND NONMEDICAL  
SWITCHING OF PRESCRIPTION DRUGS ON PATIENT SAFETY****Introduced by Illinois***Considered on reaffirmation calendar.*

**HOD ACTION: POLICIES H-320.937, H-320.939, H-320.941, D-320.981,  
AND D-320.984 REAFFIRMED  
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association adopt policy supporting the recommendations of the American College of Physicians with respect to insurance step therapy and nonmedical drug switching policies, including:

- All step therapy and medication switching policies should aim to minimize care disruption, harm, side effects and risks to the patient.
- All step therapy and nonmedical drug switching policies should be designed with patients at the center, while accounting for unique needs and preferences.
- All step therapy and nonmedical drug switching protocols should be designed with input from frontline physicians and community pharmacists; feature transparent, minimally burdensome processes that consider the expertise of a patient's physician; and include a timely appeals process.
- Data concerning the effectiveness and potential adverse consequences of step therapy and nonmedical drug switching programs should be made transparent to the public and studies by policymakers. Alternative strategies to address the rising cost of prescription drugs that do not inhibit patient access to medications should be explored.

**721. AMEND AMA POLICY H-215.981, “CORPORATE PRACTICE OF MEDICINE”  
Introduced by Resident and Fellow Section**

*Reference committee hearing: see report of Reference Committee G.*

**HOD ACTION: 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.

**722. ELIMINATING CLAIMS DATA FOR MEASURING PHYSICIAN AND HOSPITAL QUALITY  
Introduced by Oklahoma**

*Considered on reaffirmation calendar.*

**HOD ACTION: POLICIES H-406.988, H-450.927, H-450.947, AND H-450.966 REAFFIRMED  
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association collaborate with the Centers for Medicare and Medicaid Services (CMS) and other appropriate stakeholders to ensure physician and hospital quality measures are based on the delivery of care in accordance with established best practices; and be it further

RESOLVED, That our AMA collaborate with CMS and other stakeholders to eliminate the use of claims data for measuring physician and hospital quality.

**723. PHYSICIAN BURNOUT  
Introduced by American Medical Women’s Association**

*Reference committee hearing: see report of Reference Committee G.*

**HOD ACTION: ADOPTED AS FOLLOWS  
*See Policy D-405.972***

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; and be it further

RESOLVED, That our AMA work with hospitals and other stakeholders to determine areas of focus on physician wellbeing, to include the removal of intrusive questions regarding physician physical or mental health or related treatments on initial or renewal hospital credentialing applications.

**724. REALLOCATION OF INSURANCE SAVINGS DURING THE COVID-19 PANDEMIC**  
**Introduced by Texas**

*Reference committee hearing: see report of Reference Committee G.*

**HOD ACTION: ADOPTED AS FOLLOWS**  
**TITLE CHANGED**  
*See Policies H-180.975, D-180.978, and D-405.988*

RESOLVED, That Policies H-180.975 and D-405.988 be reaffirmed; 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.

**725. COMPENSATION TO PHYSICIANS FOR AUTHORIZATIONS AND PREAUTHORIZATIONS**  
**Introduced by Texas**

*Considered on reaffirmation calendar.*

**HOD ACTION: POLICIES H-285.998, H-320.938, H-320.939, H-320.945, H-320.968,**  
**H-320.982, H-385.951, D-180.984, D-185.977, D-320.979, D-320.980,**  
**D-320.982, AND D-320.988 REAFFIRMED**  
**IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That the American Medical Association support legislation that requires insurance and managed care companies, including companies managing governmental insurance plans (“payers”), to compensate physicians for the time physicians and their staff spend on authorization and preauthorization procedures. Such legislation is recommended to include the following: Compensation shall be paid in full by payers to physicians without deductible, coinsurance, or copayment billable to patients; thus, patients will not bear the burden for such processes imposed by payers. Physicians shall bill payers for time spent by physicians and their staff in performing such tasks at a rate commensurate with that of the most highly trained professionals. Payers shall pay physicians promptly upon receiving such a bill with significant interest penalties assessed for delay in payment. Billable services for authorization and preauthorization include, but are not limited to, time spent filling out forms, making telephone calls (including time spent negotiating phone trees and hold time), documenting in the patient’s medical record, communicating with the patient, altering treatment plans (such as changing medications to comply with formularies), printing, copying, and faxing.

**726. PAYMENT FOR THE COST OF ELECTRONIC PRESCRIPTION OF CONTROLLED**  
**SUBSTANCES AND COMPENSATION FOR TIME SPENT ENGAGING STATE**  
**PRESCRIPTION MONITORING PROGRAMS**  
**Introduced by Texas**

*Reference committee hearing: see report of Reference Committee G.*

**HOD ACTION: ADOPTED AS FOLLOWS**  
*See Policy D-385.947*

RESOLVED, That our American Medical Association advocate for appropriate physician incentives to cover the expense of technology required to electronically prescribe controlled substances; and be it further

RESOLVED, That our AMA advocate for appropriate physician incentives to cover the extra time and expense to query state prescription monitoring programs as required by law.

**727. UTILIZATION REVIEW, MEDICAL NECESSITY DETERMINATION,  
PRIOR AUTHORIZATION DECISIONS  
Introduced by Texas**

*Reference committee hearing: see report of Reference Committee G.*

**HOD ACTION:      ADOPTED AS FOLLOWS**  
*See Policy D-320.977*

RESOLVED, That the American Medical Association advocate for implementation of a federal version of a prior authorization “gold card” law, 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 advocate 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”; and be it further

RESOLVED, That our AMA request that the Council on Ethical and Judicial Affairs review current ethical opinions similar to the Texas Medical Association Board of Councilors’ opinions regarding medical necessity determination and utilization review.

**728. MAINTAINING AN OPEN AND EQUITABLE HOSPITAL WORK ENVIRONMENT**

*Reference committee hearing: see report of Reference Committee G.*

**HOD ACTION:      ALTERNATE RESOLUTION 728 ADOPTED  
IN LIEU OF RESOLUTIONS 728 AND 730**  
*See Policy D-230.983*

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; 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.

**729. PROTECTING PHYSICIAN WELLBEING ON APPLICATIONS FOR BOARD CERTIFICATION  
Introduced by Organized Medical Staff Section**

*Reference committee hearing: see report of Reference Committee G.*

**HOD ACTION:      ADOPTED AS FOLLOWS  
TITLE CHANGED**  
*See Policy D-275.946*

RESOLVED, That our American Medical Association work with physician board certifying organizations to assure that physician wellbeing is a primary concern; and be it further

RESOLVED, That our AMA advocate that the 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; and be it further

RESOLVED, That our AMA advocate that any questions on physician board certifying applications related to physician health be limited to only inquiries about current impairment.

**730. MAINTAINING AN OPEN AND EQUITABLE HOSPITAL WORK  
ENVIRONMENT FOR SPECIALISTS**

**Introduced by Private Practice Physicians Section**

**Resolution 730 was considered with Resolution 728.  
See Resolution 728, which was adopted in lieu of 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; and be it further

RESOLVED, That our AMA advocate that hospitals support having community/independent and employed specialty physicians if credentialled available for observation, inpatient, and emergency department coverage thus ensuring that physician referrals and consults be based on physician and patient choice.

**731. PRIOR AUTHORIZATION – PATIENT AUTONOMY**  
**Introduced by Private Practice Physicians Section**

*Reference committee hearing: see report of Reference Committee G.*

**HOD ACTION:     ADOPTED AS FOLLOWS**  
*See Policy D-478.958*

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 advocacy for prior authorization reforms.

**732. ADVOCACY OF PRIVATE PRACTICE OPTIONS FOR HEALTHCARE  
OPERATIONS IN LARGE CORPORATIONS**  
**Introduced by Private Practice Physicians Section**

*Reference committee hearing: see report of Reference Committee G.*

**HOD ACTION:     ADOPTED**  
*See Policy D-160.912*

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; 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; 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.