

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: Late 1001
(A-22)

Introduced by: Society for Cardiovascular Angiography and Interventions

Subject: National Emergency Cardiac Care Resolution – The Need for STEMI, OHCA and Shock Centers of Excellence

Referred to: Reference Committee D

1 Whereas, Cardiovascular disease is the number one cause of death for men and women in the
2 United States¹; and

4 Whereas, The acute coronary syndromes (ACS) of ST-elevation myocardial infarction (STEMI),
5 Non ST-elevation myocardial infarction (NSTEMI) and unstable angina pectoris (USAP) are
6 major causes of death and disability; and

8 Whereas, Survival for uncomplicated STEMI patients has dramatically improved over the last
9 6 decades with the implementation of systems of care, survival for STEMI with cardiogenic
10 shock (CS) is unacceptably high approaching 40% except in specialized STEMI/Shock Centers
11 where extraordinary care teams are available²; and

13 Whereas, Out-of-hospital cardiac arrest (OHCA) is the fifth most common cause of death in the
14 United States, accounting for more deaths than colon cancer, breast cancer, prostate cancer,
15 influenza, pneumonia, HIV, firearms and house fires combined^{3,4,5}; and

17 Whereas, Specialized systems of care for OHCA, STEMI and STEMI with CS have shown
18 markedly improved survival for these catastrophic illnesses⁶; therefore be it

20 RESOLVED, That our American Medical Association encourage individual states to
21 standardized specialized care for STEMI, OHCA and Cardiogenic Shock to centers of
22 excellence and, where feasible, ensure immediate transportation to an Emergency Cardiac
23 Care Center of Excellence. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 05/20/22

REFERENCES

1. Virani SS, Alonso A, Aparicio HJ, et.al. Heart disease and Stroke Statistics – 2021 Update. *Circulation*. 2021;143:e1-e490
2. Basir MB, Kapur NK, Patel K, et.al. Improved outcomes associated with the use of shock protocols: Updates from the National Cardiogenic Shock Initiative. *Catheter Cardiovasc Inter*. 2019;93:1173-1183.
3. Yannopoulos D, Bartos JA, Raveendran G, et.al. Coronary artery disease in patients with Out-of-Hospital refractory ventricular fibrillation cardiac arrest. *J Am Coll Cardiol*. 2017;70:1109-17.
4. American Heart Association Facts, A Race against the Clock, Out of Hospital Cardiac Arrest. www.heart.org/policyfactsheets.
5. Meaney PA, Bobrow BJ, Mancini ME, et. al. Cardiopulmonary resuscitation Quality: Improving outcomes both inside and outside the hospital: A consensus Statement from the AHA. *Circulation*. 2013;128:417-435.
6. Van Diepen S, Alpert NM, Henry TD, et. al. Contemporary management of cardiogenic shock. A scientific statement from the AHA. *Circulation*. 2017;136:e232-e268.

REFERRAL CHANGES AND OTHER REVISIONS

June 2022 Annual Meeting

WITHDRAWN RESOLUTIONS

- Resolution 221 – Strategies to Mitigate Racial and Ethnic Disparities in Maternal and Fetal Morbidity and Mortality at the Grassroots Level

RESOLUTIONS WITH ADDITIONAL SPONSORS*

- Resolution 113 - Prevention of Hearing Loss-Associated-Cognitive-Impairment through Earlier Recognition and Remediation (Senior Physicians Section, American Academy of Neurology)
- Resolution 242 - Public Awareness and Advocacy Campaign to Reform the Medicare Physician Payment System (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 411 – Anonymous Prescribing Option for Expedited Partner Therapy (Michigan, Oregon)
- Resolution 415 - Creation of an Obesity Task Force (Obesity Medicine Association, Colorado, Arizona, California, Illinois, New Jersey, Texas, American Association of Clinical Endocrinology, Endocrine Society, American Society for Metabolic and Bariatric Surgery)
- Resolution 420 - Declaring Climate Change a Public Health Crisis (California, American College of Physicians, Maine, Massachusetts, Oregon, Washington, Minnesota, American Medical Women's Association, Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont, American Association of Public Health Physicians)
- Resolution 519 - Advanced Research Projects Agency for Health (ARPA-H) (Association for Clinical Oncology, American College of Rheumatology)

* Additional sponsors underlined.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Supplementary Report of Committee on Rules and Credentials (A-22)

Presented by: Deepak Kumar, MD, Chair

Saturday, June 11, 2022

1 Mister Speaker, Members of the House of Delegates:

2 (1) LATE RESOLUTION(S)

3 The Committee on Rules and Credentials met Thursday, June 2, to discuss Late Resolution 1001.
4 The sponsor of the late resolutions met with the committee to consider late resolutions and was
5 given the opportunity to present for the committee's consideration the reason the resolution could
6 not be submitted in a timely fashion and the urgency of consideration by the House of Delegates at
7 this meeting.

8 Recommended not be accepted:

- Late 1001 - The Need for STEMI, OHCA and Shock Centers of Excellence

9 (2) REAFFIRMATION RESOLUTIONS

10 The Speakers asked the Committee on Rules and Credentials to review the recommendations for
11 placing resolutions introduced at this meeting of the House of Delegates on the Reaffirmation
12 Calendar. Reaffirmation of existing policy means that the policies reaffirmed remain active policies
13 within the AMA policy database and therefore are part of the body of policy that can be used in
14 setting the AMA's agenda. It also resets the sunset clock, so such policies will remain viable for 10
15 years from the date of reaffirmation. The Committee recommends that current policy be reaffirmed
16 in lieu of the following resolutions (current policy and AMA activities are listed in the Appendix to
17 this report):

- Resolution 101 – Fertility Preservation Benefits for Active-Duty Military Personnel
- Resolution 102 – Bundling Physician Fees with Hospital Fees
- Resolution 104 – Consumer Operated and Oriented Plans (CO-OPs) as a Public Option for
18 Health Care Financing
- Resolution 105 – Health Insurance that Fairly Compensates Physicians
- Resolution 106 – Hospice Recertification for Non-Cancer Diagnosis
- Resolution 107 – Medicaid Tax Benefits
- Resolution 109 – Piloting the Use of Financial Incentives to Reduce Unnecessary
19 Emergency Room Visits
- Resolution 112 – Support for Easy Enrollment Federal Legislation
- Resolution 113 – Prevention of Hearing Loss-Associated-Cognitive-Impairment through
20 Earlier Recognition and Remediation
- Resolution 114 – Oral Healthcare Is Healthcare
- Resolution 115 – Support for Universal Internet Access
- Resolution 116 – Reimbursement of School-Based Health Centers
- Resolution 117 – Expanding Medicaid Transportation to Include Healthy Grocery
21 Destinations
- Resolution 118 – Caps on Insulin Co-Payments for Patients with Insurance

- 1 • Resolution 122 – Medicaid Expansion
- 2 • Resolution 126 – Providing Recommended Vaccines Under Medicare Parts B And C
- 3 • Resolution 128 – Improving Access to Vaccinations for Patients
- 4 • Resolution 204 – Insurance Claims Data
- 5 • Resolution 206 – Medicare Advantage Plan Mandates
- 6 • Resolution 208 – Prohibit Ghost Guns
- 7 • Resolution 214 – Eliminating Unfunded or Unproven Mandates and Regulations
- 8 • Resolution 215 – Transforming Professional Licensure to the 21st Century
- 9 • Resolution 220 – Vital Nature of Board-Certified Physicians in Aerospace Medicine
- 10 • Resolution 235 – Improving the Veterans Health Administration Referrals for Veterans for Care outside the VA System
- 11 • Resolution 244 – Prohibit Reversal of Prior Authorization
- 12 • Resolution 245 – Definition and Encouragement of the Appropriate Use of the Word "Physician"
- 13 • Resolution 302 – Resident and Fellow Access to Fertility Preservation
- 14 • Resolution 303 – Fatigue Mitigation Respite for Faculty and Residents
- 15 • Resolution 305 – Reducing Overall Fees and Making Costs for Licensing, Exam Fees, Application Fees, etc., Equitable for IMGS
- 16 • Resolution 311 – Discontinue State Licensure Requirement for COMLEX Level 2 PE
- 17 • Resolution 312 – Reduce Financial Burden to Medical Students of Medical Licensure Examinations
- 18 • Resolution 313 – Decreasing Medical Student Debt and Increasing Transparency in Cost of Medical School Attendance
- 19 • Resolution 318 – CME for Preceptorship
- 20 • Resolution 320 – Tuition Cost Transparency
- 21 • Resolution 324 – Sexual Harassment Accreditation Standards for Medical Training Programs
- 22 • Resolution 325 – Single Licensing Exam Series for Osteopathic and Allopathic Medical Students
- 23 • Resolution 403 - Addressing Maternal Discrimination and Support for Flexible Family Leave
- 24 • Resolution 409 – Increasing HPV Vaccination Rates in Rural Communities
- 25 • Resolution 419 – Advocating for the Utilization of Police and Mental Health Care Co-Response Teams for 911 Mental Health Emergency Calls
- 26 • Resolution 426 – Mental Health First Aid Training
- 27 • Resolution 503 – Pharmacy Benefit Managers and Drug Shortages
- 28 • Resolution 507 – Federal Initiative to Treat Cannabis Dependence
- 29 • Resolution 510 – Evidence-Based Deferral Periods for MSM Corneas and Tissue Donors
- 30 • Resolution 519 – Advanced Research Projects Agency for Health (ARPA-H)
- 31 • Resolution 522 – Encouraging Research of Testosterone and Pharmacological Therapies for Post-Menopausal Individuals with Decreased Libido
- 32 • Resolution 524 – Increasing Access to Traumatic Brain Injury Resources in Primary Care Settings
- 33 • Resolution 617 – Study a Need-Based Scholarship to Encourage Medical Student Participation in the AMA
- 34 • Resolution 620 – Review of Health Insurance Companies and Their Subsidiaries' Business Practices
- 35 • Resolution 701 – Appeals and Denials – CPT Codes for Fair Compensation
- 36 • Resolution 702 – Health System Consolidation
- 37 • Resolution 704 – Employed Physician Contracts
- 38 • Resolution 706 – Government Imposed Volume Requirements for Credentialing
- 39 • Resolution 707 – Insurance Coverage for Scalp Cooling (Cold Cap) Therapy

- 1 • Resolution 708 – Physician Burnout is an OSHA Issue
- 2 • Resolution 709 – Physician Well-Being as an Indicator of Health System Quality
- 3 • Resolution 710 – Prior Authorization – CPT Codes for Fair Compensation
- 4 • Resolution 711 – Reducing Prior Authorization Burden
- 5 • Resolution 712 – The Quadruple Aim – Promoting Improvement in the Physician
- 6 Experience Providing Care
- 7 • Resolution 713 – Enforcement of Administrative Simplification Requirements – CMS
- 8 • Resolution 714 – Prior Authorization Reform for Specialty Medications
- 9 • Resolution 715 – Prior Authorization – CPT Codes for Fair Compensation
- 10 • Resolution 718 – Degradation of Medical Records
- 11 • Resolution 719 – System Wide Prior and Post-Authorization Delays and Effects on Patient
- 12 Care
- 13 • Resolution 720 – Mitigating the Negative Impact of Step Therapy Policies and Nonmedical
- 14 Switching of Prescription Drugs on Patient Safety
- 15 • Resolution 722 – Eliminating Claims Data for Measuring Physician and Hospital Quality
- 16 • Resolution 723 – Physician Burnout
- 17 • Resolution 725 – Compensation to Physicians for Authorizations and Preauthorizations

19 Mister Speaker, this concludes the Supplementary Report of the Committee on Rules and
20 Credentials. I would like to thank Patricia L. Austin, MD; Mary Ann Contogiannis, MD; Shane
21 Hopkins, MD; Thomas G. Peters, MD; Donald J. Swikert, MD; and Thomas Vidic, MD; and on
22 behalf of the committee those who appeared before the committee.

Patricia L. Austin, MD
California

Donald J. Swikert, MD
Kentucky

Mary Ann Contogiannis, MD
North Carolina

Thomas Vidic, MD*
Indiana

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American Society for Radiation Oncology

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* Alternate Delegate

APPENDIX – RESOLUTIONS RECOMMENDED FOR REAFFIRMATION OF CURRENT POLICY IN LIEU OF THE RESOLUTIONS WITH REAFFIRMED POLICY AND AMA ACTIVITIES

Resolution 101 – Fertility Preservation Benefits for Active-Duty Military Personnel

- Right for Gamete Preservation Therapies H-185.922
- Reproductive Health Insurance Coverage H-185.926
- Infertility and Fertility Preservation Insurance Coverage H-185.990
- Infertility Benefits for Veterans H-510.984

Resolution 102 – Bundling Physician Fees with Hospital Fees

- Medicare Physician Payment Reform D-390.961

Resolution 104 – Consumer Operated and Oriented Plans (CO-OPs) as a Public Option for Health Care Financing

- Options to Maximize Coverage under the AMA Proposal for Reform H-165.823
- Health System Reform Legislation H-165.838

Resolution 105 – Health Insurance that Fairly Compensates Physicians

- Physician Payment Reform H-390.849
- Medicare Reimbursement of Office-Based Procedures H-400.957
- The Preservation of the Private Practice of Medicine D-405.988

Resolution 106 – Hospice Recertification for Non-Cancer Diagnosis

- Hospice Care H-85.955

Resolution 107 – Medicaid Tax Benefits

- Tax Deduction for Care Provided to the Indigent H-160.969
- Income Tax Credits or Deductions as Compensation for Treating Medically Uninsured or Underinsured H-180.965
- Transforming Medicaid and Long-Term Care and Improving Access to Care for the Uninsured H-290.982

Resolution 109 – Piloting the Use of Financial Incentives to Reduce Unnecessary Emergency Room Visits

- Strategies to Address Rising Health Care Costs H-155.960
- Addressing Financial Incentives to Shop for Lower-Cost Health Care H-185.920

Resolution 112 – Support for Easy Enrollment Federal Legislation

- Options to Maximize Coverage under the AMA Proposal for Reform H-165.823

Resolution 113 – Prevention of Hearing Loss-Associated-Cognitive-Impairment through Earlier Recognition and Remediation

- Hearing Aid Coverage H-185.929

Resolution 114 – Oral Healthcare Is Healthcare

- Importance of Oral Health in Patient Care D-160.925
- Medicare Coverage for Dental Services H-330.872

Resolution 115 – Support for Universal Internet Access

- COVID-19 Emergency and Expanded Telemedicine Regulations D-480.963
- Increasing Access to Broadband Internet to Reduce Health Disparities H-478.980
- Addressing Equity in Telehealth H-480.937

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Resolution 116 – Reimbursement of School-Based Health Centers

- School-Based and School-Linked Health Centers H-60.921
- Adolescent Health H-60.981
- Increasing Coverage for Children H-165.877

Resolution 117 – Expanding Medicaid Transportation to Include Healthy Grocery Destinations

- Health Plan Initiatives Addressing Social Determinants of Health H-165.822

Resolution 118 – Caps on Insulin Co-Payments for Patients with Insurance

- Strategies to Address Rising Health Care Costs H-155.960
- Incorporating Value into Pharmaceutical Pricing H-110.986
- Cost Sharing Arrangements for Prescription Drugs H-110.990
- Non-Formulary Medications and the Medicare Part D Coverage Gap H-125.977

Resolution 122 – Medicaid Expansion

- Medicaid Expansion D-290.979
- Options to Maximize Coverage Under the AMA Proposal for Reform H-165.823

Resolution 126 – Providing Recommended Vaccines Under Medicare Parts B And C

- Financing of Adult Vaccines: Recommendations for Action H-440.860
- Assuring Access to ACIP/AAFP/AAP-Recommended Vaccines H-440.875
- Appropriate Reimbursements and Carve-outs for Vaccines D-440.981

Resolution 128 – Improving Access to Vaccinations for Patients

- Financing of Adult Vaccines: Recommendations for Action H-440.860
- Assuring Access to ACIP/AAFP/AAP-Recommended Vaccines H-440.875
- Appropriate Reimbursements and Carve-outs for Vaccines D-440.981

Resolution 204 – Insurance Claims Data

- Research Handling of De-Identified Patient Information, H-315.962

Resolution 206 – Medicare Advantage Plan Mandates

- Ending Medicare Advantage Auto-Enrollment, H-285.905

Resolution 208 – Prohibit Ghost Guns

- Firearm Availability, H-145.996
- Control of Non-Detectable Firearms, H-145.994

Resolution 214 – Eliminating Unfunded or Unproven Mandates and Regulations

- Medicare's Appropriate Use Criteria Program, H-320.940

Resolution 215 – Transforming Professional Licensure to the 21st Century

- Facilitating Credentialing for State Licensure, D-275.994
- Creation of AMA Data Bank on Interstate Practice of Medicine, D-275.996
- Licensure and Telehealth, D-480.960

Resolution 220 – Vital Nature of Board-Certified Physicians in Aerospace Medicine

- In-flight Medical Emergencies, H-45.978
- Air Travel Safety, H-45.979
- Need for Active Medical Board Oversight of Medical Scope-of-Practice Activities by Mid-Level Practitioners, H-270.958
- Support for Physician Led, Team Based Care, D-35.985

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- Scopes of Practice of Physician Extenders, H-35.973
- Models/Guidelines for Medical Health Care Teams, H-160.906
- Principles Guiding AMA Policy Regarding Supervision of Medical Care Delivered by Advanced Practice Nurses in Integrated Practice, H-360.987

Resolution 235 – Improving the Veterans Health Administration Referrals for Veterans for Care Outside the VA System

- Access to Health Care for Veterans, H-510.985
- Expansion of US Veterans' Health Care Choices, H-510.983

Resolution 244 – Prohibit Reversal of Prior Authorization

- Preauthorization for Payment of Services, H-320.961
- Physicians Experiences with Retrospective Denial of Payment and Down-Coding by Managed Care Plans, D-320.995

Resolution 245 – Definition and Encouragement of the Appropriate Use of the Word "Physician"

- Definition and Use of the Term Physician, H-405.951
- Definition of a Physician, H-405.969
- Truth in Advertising, H-405.964
- Truth in Corporate Advertising: Using Professional Degrees in Advertising Listings, H-405.967

Resolution 302 – Resident and Fellow Access to Fertility Preservation

- Policies for Parental, Family and Medical Necessity Leave, H-405.960
- Infertility and Fertility Preservation Insurance Coverage, H-185.990
- Disclosure of Risk to Fertility with Gonadotoxic Treatment, H-425.967
- Reproductive Health Insurance Coverage, H-185.926
- Residents and Fellows' Bill of Rights, H-310.912

Resolution 303 – Fatigue Mitigation Respite for Faculty and Residents

- Resident/Fellow Clinical and Educational Work Hours, H-310.907
- Fatigue, Sleep Disorders, and Motor Vehicle Crashes, H-15.958
- Light Pollution: Adverse Health Effects of Nighttime Lighting, H-135.932
- Residents and Fellows' Bill of Rights, H-310.912

Resolution 305 – Reducing Overall Fees and Making Costs for Licensing, Exam Fees, Application Fees, etc., Equitable for IMGS

- National Resident Matching Program Reform, D-310.977
- Abolish Discrimination in Licensure of IMGS, H-255.966

Resolution 311 – Discontinue State Licensure Requirement for COMLEX Level 2 PE

- Retirement of the National Board of Medical Examiners Step 2 Clinical Skills Exam for US Medical Graduates: Call for Expedited Action by the American Medical Association, D-275.950

Resolution 312 – Reduce Financial Burden to Medical Students of Medical Licensure Examinations

- Independent Regulation of Physician Licensing Exams, D-295.939 (2)
- Principles of and Actions to Address Medical Education Costs and Student Debt, H-305.925 (1, 2, 12, 16)

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Resolution 313 – Decreasing Medical Student Debt and Increasing Transparency in Cost of Medical School Attendance

- Principles of and Actions to Address Medical Education Costs and Student Debt, H-305.925 (1, 10, 11, 12, 15, 16, 17, 18)
- Cost and Financing of Medical Education and Availability of First-Year Residency Positions, H-305.988 (1-7)

Resolution 318 – CME for Preceptorship

- Revisions to the Physician's Recognition Award, H-300.977
- Restoring Integrity to Continuing Medical Education, H-300.988

Resolution 320 – Tuition Cost Transparency

- Principles of and Actions to Address Medical Education Costs and Student Debt, H-305.925
- Cost and Financing of Medical Education and Availability of First Year Residency Positions, H-305.988

Resolution 324 – Sexual Harassment Accreditation Standards for Medical Training Programs

- Teacher-Learner Relationship In Medical Education, H-295.955

Resolution 325 – Single Licensing Exam Series for Osteopathic and Allopathic Medical Students

- Proposed Single Examination for Licensure, H-275.962

Resolution 403 – Addressing Maternal Discrimination and Support for Flexible Family Leave

- Principles for Advancing Gender Equity in Medicine H-65.961
- Policies for Parental, Family and Medical Necessity Leave H-405.960

Resolution 409 – Increasing HPV Vaccination Rates in Rural Communities

- HPV Vaccine and Cervical Cancer Prevention Worldwide H-440.872

Resolution 419 – Advocating for the Utilization of Police and Mental Health Care Co-Response Teams for 911 Mental Health Emergency Calls

- Mental Health Crisis Interventions H-345.972

Resolution 426 – Mental Health First Aid Training

- Awareness, Diagnosis and Treatment of Depression and other Mental Illnesses H-345.984
- Increasing Detection of Mental Illness and Encouraging Education D-345.994

Resolution 503 – Pharmacy Benefit Managers and Drug Shortages

- National Drug Shortages, H-100.956

Resolution 507 – Federal Initiative to Treat Cannabis Dependence

- Cannabis and Cannabinoid Research, H-95.952
- Taxes on Cannabis Products, H-95.923

Resolution 510 – Evidence-Based Deferral Periods for MSM Corneas and Tissue Donors

- Blood Donor Deferral Criteria, H-50.973

Resolution 519 – Advanced Research Projects Agency for Health (ARPA-H)

- Funding of Biomedical, Translational, and Clinical Research, H-460.926
- Importance of Clinical Research, H-460.930
- Support of Biomedical Research, H-460.998

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Resolution 522 – Encouraging Research of Testosterone and Pharmacological Therapies for Post-Menopausal Individuals with Decreased Libido

- Compounded Hormone Therapy Preparations, D-120.969
- Sex and Gender Differences in Medical Research, H-525.988

Resolution 524 – Increasing Access to Traumatic Brain Injury Resources in Primary Care Settings

- Reduction of Sports-Related Injury and Concussion, H-470.954
- Physician Involvement in State Regulations of Motor Vehicle Operation and/or Firearm Use by Individuals with Cognitive Deficits Due to Traumatic Brain Surgery, H-10.960
- Racial and Ethnic Disparities in Health Care, H-350.974

Resolution 617 – Study a Need-Based Scholarship to Encourage Medical Student Participation in the AMA

- AMA Support for Medical Students D-615.981
- Supporting Women and Underrepresenting Minorities in Overcoming Barriers to Positions of Medical Leadership and Competitive Specialties D-200.975

Resolution 620 – Review of Health Insurance Companies and Their Subsidiaries' Business Practices

- Insurance Industry Behaviors D-385.949

Resolution 701 – Appeals and Denials – CPT Codes for Fair Compensation

- Remuneration for Physician Services H-385.951
- Approaches to Increase Payer Accountability H-320.968
- Prior Authorization and Utilization Management Reform H-320.939
- Prior Authorization Reform D-320.982

Resolution 702 – Health System Consolidation

- Hospital Consolidation H-215.960

Resolution 704 – Employed Physician Contracts

- Promoting the AMA Model Medical Staff Code of Conduct and its Application to Employed Physicians D-230.985
- Physician and Medical Staff Member Bill of Rights H-225.942
- AMA Principles for Physician Employment H-225.950

Resolution 706 – Government Imposed Volume Requirements for Credentialing

- Reentry into Physician Practice H-230.953
- Privileging Physicians with Low Volume Hospital Activity H-230.954

Resolution 707 – Insurance Coverage for Scalp Cooling (Cold Cap) Therapy

- Strategies to Address Rising Health Care Costs H-155.960
- Aligning Clinical and Financial Incentives for High-Value Care D-185.979
- Medical Necessity and Utilization Review H-320.942
- Managed Care H-285.998
- Medical Necessity Determinations H-320.995
- Status Report on the Uninsured H-185.964

Resolution 708 – Physician Burnout is an OSHA Issue

- Physician and Medical Student Burnout D-310.968
- Programs on Managing Stress and Burnout H-405.957
- Physician Health Programs H-405.961

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Resolution 709 – Physician Well-Being as an Indicator of Health System Quality

- Physician and Medical Student Burnout D-310.968

Resolution 710 – Prior Authorization – CPT Codes for Fair Compensation

- Remuneration for Physician Services H-385.951
- Approaches to Increase Payer Accountability H-320.968
- Prior Authorization and Utilization Management Reform H-320.939
- Prior Authorization Reform D-320.982

Resolution 711 – Reducing Prior Authorization Burden

- Remuneration for Physician Services H-385.951
- Approaches to Increase Payer Accountability H-320.968
- Prior Authorization and Utilization Management Reform H-320.939
- Opposition to Prescription Prior Approval D-125.992
- Prescription Drug Plans and Patient Access D-330.910

Resolution 712 – The Quadruple Aim – Promoting Improvement in the Physician Experience Providing Care

- Support for the Quadruple Aim H-405.955
- Augmented Intelligence in Healthcare H-480.939

Resolution 713 – Enforcement of Administrative Simplification Requirements – CMS

- Administrative Simplification in the Physician Practice D-190.974
- Police, Payer and Government Access to Patient Health Information D-315.992
- HIPAA Law and Regulations D-190.989
- CMS Administrative Requirements D-190.970

Resolution 714 – Prior Authorization Reform for Specialty Medications

- Remuneration for Physician Services H-385.951
- Approaches to Increase Payer Accountability H-320.968
- Prior Authorization and Utilization Management Reform H-320.939
- Prior Authorization Reform D-320.982
- Non-Formulary Medications and the Medicare Part D Coverage Gap H-125.977

Resolution 715 – Prior Authorization – CPT Codes for Fair Compensation

- Remuneration for Physician Services H-385.951
- Approaches to Increase Payer Accountability H-320.968
- Prior Authorization and Utilization Management Reform H-320.939
- Prior Authorization Reform D-320.982

Resolution 718 – Degradation of Medical Records

- Understanding and Correcting Imbalances in Physician Work Attributable to Electronic Health Records D-478.966
- Maintenance Payments for Electronic Health Records D-478.975
- Information Technology Standards and Costs D-478.996

Resolution 719 – System Wide Prior and Post-Authorization Delays and Effects on Patient Care

- Promoting Electronic Data Interchange H-190.978
- Administrative Simplification in the Physician Practice D-190.974
- Prior Authorization and Utilization Management Reform H-320.939
- Prior Authorization Reform D-320.982
- Processing Prior Authorization Decisions D-320.979

APPENDIX – RESOLUTIONS RECOMMENDED FOR REAFFIRMATION OF CURRENT POLICY IN LIEU OF THE RESOLUTIONS WITH REAFFIRMED POLICY AND AMA ACTIVITIES

Resolution 720 – Mitigating the Negative Impact of Step Therapy Policies and Nonmedical Switching of Prescription Drugs on Patient Safety

- Step Therapy D-320.981
- Step Therapy H-320.937
- Medicare Advantage Step Therapy D-320.984
- Eliminate Fail First Policy in Addiction Treatment H-320.941
- Prior Authorization and Utilization Management Reform H-320.939

Resolution 722 – Eliminating Claims Data for Measuring Physician and Hospital Quality

- Claims Based Data as a Flawed Quality of Care Measure H-406.988
- Quality Management H-450.966
- Development of Quality Measures with Appropriate Exclusions and Review Processes H-450.927
- Pay-for-Performance Principles and Guidelines H-450.947

Resolution 723 – Physician Burnout

- Physician and Medical Student Burnout D-310.968
- Programs on Managing Stress and Burnout H-405.957
- Physician Health Programs H-405.961

Resolution 725 – Compensation to Physicians for Authorizations and Preauthorizations

- Payer Measures for Private and Public Health Insurance D-180.984
- Strengthening the Accountability of Health Care Reviewers D-185.977
- Managed Care H-285.998
- Prior Authorization Relief in Medicare Advantage Plans H-320.938
- Prior Authorization and Utilization Management Reform H-320.939
- Abuse of Preauthorization Procedures H-320.945
- Approaches to Increase Payer Accountability H-320.968
- Processing Prior Authorization Decisions D-320.979
- Require Payers to Share Prior Authorization Cost Burden D-320.980
- Payer Accountability H-320.982
- Prior Authorization Reform D-320.982
- Preauthorization D-320.988
- Renumeration for Physician Services H-385.951

SUMMARY OF FISCAL NOTES (JUNE 2022 ANNUAL MEETING)

BOT Report(s)

- 01 Annual Report: Informational report
- 02 New Specialty Organizations Representation in the House of Delegates: Minimal
- 03 2021 Grants and Donations: Informational report
- 04 AMA 2023 Dues: Minimal
- 05 Update on Corporate Relationships: Informational report
- 06 Redefining AMA's Position on ACA and Healthcare Reform: Informational report
- 07 AMA Performance, Activities and Status in 2021: Informational report
- 08 Annual Update on Activities and Progress in Tobacco Control: March 2021 through February 2022: Informational report
- 09 Council on Legislation Sunset Review of 2012 House Policies: Minimal
- 10 American Medical Association Center for Health Equity Annual Report: Informational report
- 11 Procedure for Altering the Size or Composition of Section Governing Councils: Modest
- 12 Disaggregation of Demographic Data for Individuals of Middle Eastern and North African (MENA) Descent: Informational report
- 13 Use of Psychiatric Advance Directives: Minimal
- 14 Amendment to Truth and Transparency in Pregnancy Counseling Centers, H-420.954: Minimal
- 15 Addressing Public Health Disinformation: \$100,000
- 16 Language Proficiency Data of Physicians in the AMA Masterfile: Minimal
- 17 Expungement, Destruction, and Sealing of Criminal Records for Legal Offenses Related to Cannabis Use or Possession: Modest
- 18 Addressing Inflammatory and Untruthful Online Ratings: Minimal
- 19 Demographic Report of the House of Delegates and AMA Membership: Informational report
- 20 Delegate Apportionment and Pending Members: Modest
- 21 Opposition to Requirements for Gender-Based Treatments for Athletes: Minimal
- 22# Nonconsensual Audio/Video Recording at Medical Encounters: None
- 23# Specialty Society Representation in the House of Delegates: Minimal

CC&B Report(s)

- 01 Clarification to the Bylaws: Delegate Representation: Minimal

CEJA Opinion(s)

- 01 Amendment to E-1.1.6, Quality: Informational Report
- 02 Amendment to E-1.2.11, Ethical Innovation in Medical Practice: Informational Report
- 03 Amendment to E-11.1.2, Physician Stewardship of Health Care Resources: Informational Report
- 04 Amendment to E-11.2.1, Professionalism in Health Care Systems: Informational Report

CEJA Report(s)

- 01 Short-Term Medical Service Trips: Minimal
- 02 Amendment to Opinion 10.8, Collaborative Care: Minimal
- 03 Amendment to E-9.3.2, Physician Responsibilities to Colleagues with Illness, Disability or Impairment: Minimal
- 04 CEJA's Sunset Review of 2012 House Policies: Minimal
- 05 Pandemic Ethics and the Duty of Care (D-130.960): Informational Report
- 06 Judicial Function of the Council on Ethical and Judicial Affairs - Annual Report: Informational Report

SUMMARY OF FISCAL NOTES (JUNE 2022 ANNUAL MEETING)

CME Report(s)

- 01 Council on Medical Education Sunset Review of 2012 House Policies: Minimal
- 02 An Update on Continuing Board Certification: Modest
- 03 Onsite and Subsidized Childcare for Medical Students, Residents and Fellows: Modest
- 04 Protection of Terms Describing Physician Education and Practice: Modest
- 05 Education, Training and Credentialing of Non-Physician Health Care Providers and Their Impact on Physician Education and Training: Minimal
- 06 Clinical Applications of Pathology and Laboratory Medicine for Medical Students, Residents and Fellows: Modest

CMS Report(s)

- 01 Council on Medical Service Sunset Review of 2012 House Policies: Minimal
- 02 Prospective Payment Model Best Practices for Independent Private Practice: Minimal
- 03 Preventing Coverage Losses After the Public Health Emergency Ends: Minimal
- 04 Parameters of Medicare Drug Price Negotiation: Minimal
- 05 Poverty-Level Wages and Health: Minimal

CSAPH Report(s)

- 01 Council on Science and Public Health Sunset Review of 2012 HOD Policies: Minimal
- 02 Transformation of Rural Community Public Health Systems: Modest
- 03 Correcting Policy H-120.958: Minimal

HOD Comm on Compensation of the Officers

01* Report of the House of Delegates Committee on the Compensation of the Officers: Estimated cost for July 1 2022 - June 30 2022 is a maximum of \$52,000.

Joint Report(s)

CCB/CLRPD 01 Joint Council Sunset Review of 2012 House Policies: Minimal

Report of the Speakers

- 01 Recommendations for Policy Reconciliation: Informational Report

Resolution(s)

- 001 Increasing Public Umbilical Cord Blood-Donations in Transplant Centers: Modest
- 002 Opposition to Discriminatory Treatment of Haitian Asylum Seekers: Minimal
- 003 Gender Equity and Female Physician Work Patterns During the Pandemic: Minimal
- 004 Recognizing LGBTQ+ Individuals as Underrepresented in Medicine: Modest
- 005 Supporting the Study of Reparations as a Means to Reduce Racial Inequalities: Estimated cost to implement this resolution is \$110,000. Estimate includes current and new staff (new complement positions or use of contract labor) costs.
- 006 Combating Natural Hair and Cultural Headwear Discrimination in Medicine and Medical Professionalism: Minimal
- 007 Equal Access for Adoption in the LGBTQ Community: Minimal
- 008 Student-Centered Approaches for Reforming School Disciplinary Policies: Minimal
- 009 Privacy Protection and Prevention of Further Trauma for Victims of Distribution of Intimate Videos and Images Without Consent: Minimal
- 010 Improving the Health and Safety of Sex Workers: Minimal
- 011 Evaluating Scientific Journal Articles for Racial and Ethic Bias: Minimal
- 012 Expanding the Definition of Iatrogenic Infertility to Include Gender Affirming Interventions: Minimal

SUMMARY OF FISCAL NOTES (JUNE 2022 ANNUAL MEETING)

Resolution(s)

- 013 Recognition of National Anti-Lynching Legislation as a Public Health Initiative: Minimal
- 014* Healthcare Equity Through Informed Consent and a Collaborative Healthcare Model for the Gender Diverse Population: Minimal
- 015* Increasing Mental Health Screenings by Refugee Resettlement Agencies and Improving Mental Health Outcomes for Refugee Women: Modest
- 016* Addressing and Banning Unjust and Invasive Medical Procedures Among Migrant Women at the Border: Modest
- 017* Humanitarian and Medical Aid Support to Ukraine: Modest
- 018* Hardship for International Medical Graduates from Russia and Belarus: Modest
- 019* Hardship for International Medical Graduates from Ukraine: Modest
- 020* Council on Ethical and Judicial Affairs Guidelines for Treating Unvaccinated Individuals: Modest
- 021* National Cancer Research Patient Identifier: Modest
- 022* Organ Transplant Equity for Persons with Disabilities: Modest
- 023* 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: Modest
- 024* Pharmaceutical Equity for Pediatric Populations: Minimal
- 025* Use of Social Media for Product Promotion and Compensation: Modest
- 026# Establishing Ethical Principles for Physicians Involved in Private Equity Owned Practices: Modest
- 027# Protecting Access to Abortion and Reproductive Healthcare: Minimal
- 028# Preserving Access to Reproductive Health Services: Modest
- 101 Fertility Preservation Benefits for Active-Duty Military Personnel: Modest
- 102 Bundling Physician Fees with Hospital Fees: Minimal
- 103 COBRA for College Students: Modest
- 104 Consumer Operated and Oriented Plans (CO-OPs) as a Public Option for Health Care Financing: Modest
- 105 Health Insurance that Fairly Compensates Physicians: Modest
- 106 Hospice Recertification for Non-Cancer Diagnosis: Modest
- 107 Medicaid Tax Benefits: Modest
- 108 Payment for Regadenoson (Lexiscan): Modest
- 109 Piloting the Use of Financial Incentives to Reduce Unnecessary Emergency Room Visits: Modest
- 110 Private Payor Payment Integrity: Modest
- 111 Bundled Payments and Medically Necessary Care: Modest
- 112 Support for Easy Enrollment Federal Legislation: Modest
- 113 Prevention of Hearing Loss-Associated-Cognitive-Impairment Through Earlier Recognition and Remediation: Modest
- 114 Oral Healthcare IS Healthcare: Modest
- 115 Support for Universal Internet Access: Modest
- 116 Reimbursement of School-Based Health Centers: Minimal
- 117 Expanding Medicaid Transportation to Include Healthy Grocery Destinations: Modest
- 118 Caps on Insulin Co-Payments for Patients with Insurance: Minimal
- 119 Medicare Coverage of Dental, Vision and Hearing Services: Minimal
- 120 Expanding Coverage for and Access to Pulmonary Rehabilitation: Modest
- 121 Increase Funding, Research and Education for Post-Intensive Care Syndrome: Modest
- 122 Medicaid Expansion: Modest
- 123 Advocating for All Payer Coverage of Cosmetic Treatment for Survivors of Domestic Abuse and Intimate Partner Violence: Modest

SUMMARY OF FISCAL NOTES (JUNE 2022 ANNUAL MEETING)

Resolution(s)

- 124 To Require Insurance Companies Make the "Coverage Year" and the "Deductible Year" Simultaneous for Their Policies: Modest
- 125 Education, Forewarning and Disclosure Regarding Consequences of Changing Medicare Plans: Minimal
- 126* Providing Recommended Vaccines Under Medicare Parts B and C: Modest
- 127* Continuity of Care Upon Release from Correctional Systems: Minimal
- 128# Improving Access to Vaccinations for Patients: Modest
- 201 The Impact of Midlevel Providers on Medical Education: Estimated cost of \$50K to hire outside consultants to conduct research and analysis.
- 202 AMA Position on All Payer Database Creation: Modest
- 203 Ban the Gay/Trans (LGBTQ+) Panic Defense: Modest
- 204 Insurance Claims Data: Modest
- 205 Insurers and Vertical Integration: Modest
- 206 Medicare Advantage Plan Mandates: Modest
- 207 Physician Tax Fairness: Modest
- 208 Prohibit Ghost Guns: Minimal
- 209 Supporting Collection of Data on Medical Repatriation: Modest
- 210 Reducing the Prevalence of Sexual Assault by Testing Sexual Assault Evidence Kits: Modest
- 211 Repeal or Modification of the Medicare Appropriate Use Criteria (AUC) Program: Modest
- 212 Medication for Opioid Use Disorder in Physician Health Programs: Modest
- 213 Resentencing for Individuals Convicted of Marijuana-Based Offenses: Minimal
- 214 Eliminating Unfunded or Unproven Mandates and Regulations: Modest
- 215 Transforming Professional Licensure to the 21st Century: Modest
- 216 Advocating for the Elimination of Hepatitis C Treatment Restrictions: Modest
- 217 Preserving the Practice of Medicine: \$462,000 to conduct research and analysis in house (\$77,000), and hire outside consultants to conduct research, analysis, surveys and analysis of results (\$385,000).
- 218 Expedited Immigrant Green Card Visa for J-1 Visa Waiver Physicians Serving in Underserved Areas: Modest
- 219 Due Process and Independent Contractors: Modest
- 220 Vital Nature of Board-Certified Physicians in Aerospace Medicine: Modest
- 221* WITHDRAWN: N/A
- 222* To Study the Economic Impact of Mid-Level Provider Employment in the United States of America: Modest
- 223* National Drug Shortages of Lidocaine and Saline Preparations: Modest
- 224* HPSA and MUA Designation for SNFs: Modest
- 225* Public Listing of Medical Directors for Nursing Facilities: Modest
- 226* Coverage for Clinical Trial Ancillary Costs: Modest
- 227* Supporting Improvements to Patient Data Privacy: Minimal
- 228* Expanded Child Tax Credit: Modest
- 229* Expedited Immigrant Green Card for J-1 Visa Waiver Physicians Serving in Underserved Areas: Modest
- 230* Advancing the Role of Outdoor Recreation in Public Health: Modest
- 231* Amending Policy H-155.955, "Increasing Accessibility to Incontinence Products to Include Diaper Tax Exemption": Minimal
- 232* Expansion of Epinephrine Entity Stocking Legislation: Modest
- 233* Support for Warning Labels on Firearm Ammunition Packaging: Modest
- 234* Updating Policy on Immigration Laws, Rules, Legislation, and Health Disparities: Modest

SUMMARY OF FISCAL NOTES (JUNE 2022 ANNUAL MEETING)

Resolution(s)

- 235* Improving the Veterans Health Administration Referrals for Veterans for Care Outside the VA System: Modest
- 236* Out-of-Network Care: Minimal
- 237* Prescription Drug Dispensing Policies: Modest
- 238* COVID-19 Economic Injury Disaster Loan (EIDL) Forgiveness for Physician Groups of Five or Fewer Physicians: Modest
- 239* Virtual Services When Patients Are Away From Their Medical Home: Modest
- 240* Physician Payment Reform and Equity: Estimated cost to implement resolution is \$320K which includes staff time, professional fees and printing and production costs.
- 241* Unmatched Graduate Physician Workforce: Modest
- 242* Public Awareness and Advocacy Campaign to Reform the Medicare Physician Payment System: Est btwn \$1M - \$25M to conduct a public awareness camp (incl. paid ads, social and earned media, patient and phys grassroots) to prevent/mitigate further Medicare payment cuts and lay the groundwork to pass fed legislation. Incl prof. fees and promotion
- 243* Appropriate Physician Payment for Office-Based Services: Modest
- 244* Prohibit Reversal of Prior Authorization: Modest
- 245# Definition and Encouragement of the Appropriate Use of the Word "Physician": Estimated cost of \$257,000 to develop and implement a sustained and wide reaching PR campaign includes professional fees, promotion and staff costs.
- 246# Further Action to Respond to the Gun Violence Public Health Crisis: \$50,000
- 247# Recognizing Child Poverty and the Racial Wealth Gap as Public Health Issues and Extending the Child Tax Credit for Low-Income Families: Modest
- 248# Promoting Proper Oversight and Reimbursement for Specialty Physician Extenders and Non-Physician Practitioners: Modest
- 249# Clarification of Healthcare Physician Identification: Consumer Truth & Transparency: Modest
- 250# Opposition to Criminalization of Physicians' Medical Practice: Modest
- 251# Physician Medical License Use in Clinical Supervision: Modest
- 252# The Criminalization of Health Care Decision Making and Practice: Modest
- 253# Physician Payment Reform & Equity: Estimated cost to implement resolution is \$320K. Similar to Resolution 240.
- 254# Stakeholder Engagement in Medicare Administrative Contractor Policy Processes: Minimal
- 301 Medical Education Debt Cancellation in the Face of a Physician Shortage During the COVID-19 Pandemic: Modest
- 302 Resident and Fellow Access to Fertility Preservation: Minimal
- 303 Fatigue Mitigation Respite for Faculty and Residents: Minimal
- 304 Organizational Accountability to Resident and Fellow Trainees: Modest
- 305 Reducing Overall Fees and Making Costs for Licensing Exam Fees, Application Fees, Etc., Equitable for IMGs: Minimal
- 306 Creating a More Accurate Accounting of Medical Education Financial Costs: Modest
- 307 Parental Leave and Planning Resources for Medical Students: Minimal
- 308 University Land Grant Status in Medical School Admissions: Modest
- 309 Decreasing Bias in Evaluations of Medical Student Performance: Modest
- 310 Support for Standardized Interpreter Training: Moderate
- 311 Discontinue State Licensure Requirement for COMLEX Level 2 PE: Minimal
- 312 Reduce Financial Burden to Medical Students of Medical Licensure Examinations: Minimal
- 313 Decreasing Medical Student Debt and Increasing Transparency in Cost of Medical School Attendance: Modest
- 314 Support for Institutional Policies for Personal Days for Undergraduate Medical Students: Minimal
- 315 Modifying Eligibility Criteria for the Association of American Medical Colleges' Financial Assistance Program: Minimal
- 316 Providing Transparent and Accurate Data Regarding Students and Faculty at Medical Schools: Minimal
- 317 Medical Student, Resident and Fellow Suicide Reporting: Moderate
- 318* CME for Preceptorship: Minimal

SUMMARY OF FISCAL NOTES (JUNE 2022 ANNUAL MEETING)

Resolution(s)

- 319* Senior Living Community Training for Medical Students and Residents: Minimal
- 320* Tuition Cost Transparency: Modest
- 321* Improving and Standardizing Pregnancy and Lactation Accommodations for Medical Board Examinations: Minimal
- 322* Standards in Cultural Humility Training Within Medical Education: Minimal
- 323* Cultural Leave for American Indian Trainees: Modest
- 324* Sexual Harassment Accreditation Standards for Medical Training Programs: Minimal
- 325* Single Licensing Exam Series for Osteopathic and Allopathic Medical Students: Minimal
- 326* Standardized Wellness Initiative Reporting: Minimal
- 327* Leadership Training Must Become an Integral Part of Medical Education: Minimal
- 328* Increasing Transparency of the Resident Physician Application Process: Minimal
- 329* Use of the Terms "Residency" and "Fellowship" by Health Professionals Outside of Medicine: Modest
- 401 Air Quality and the Protection of Citizen Health: Modest
- 402 Support for Impairment Research: Modest
- 403 Addressing Maternal Discrimination and Support for Flexible Family Leave: Minimal
- 404 Weapons in Correctional Healthcare Facilities: Modest
- 405 Universal Childcare and Preschool: Moderate
- 406 COVID-19 Preventive Measures for Correctional Facilities: AMA Policy Position: Modest
- 407 Study of Best Practices for Acute Care of Patients in the Custody of the Law: Modest
- 408 Supporting Increased Research on Implementation of Nonviolent De-escalation Training and Mental Illness Awareness in Law Enforcement: Minimal
- 409 Increasing HPV Vaccination Rates in Rural Communities: Modest
- 410 Increasing Education for School Staff to Recognize Prodromal Symptoms of Schizophrenia in Teens and Young Adults to Increase Early Intervention: Modest
- 411 Anonymous Prescribing Option for Expedited Partner Therapy: Modest
- 412 Advocating for the Amendment of Chronic Nuisance Ordinances: Modest
- 413 Expansion on Comprehensive Sexual Health Education: Minimal
- 414 Improvement of Care and Resource Allocation for Homeless Persons in the Global Pandemic: Modest
- 415 Creation of an Obesity Task Force: Moderate
- 416 School Resource Officer Violence De-Escalation Training and Certification: Modest
- 417 Tobacco Control: Minimal
- 418 Lung Cancer Screening Awareness: Moderate
- 419 Advocating for the Utilization of Police and Mental Health Care Co-Response Teams for 911 Mental Health Emergency Calls: Minimal
- 420* Declaring Climate Change a Public Health Crisis: Modest
- 421* Screening for HPV-Related Anal Cancer: Minimal
- 422* Voting as a Social Determinant of Health: Modest
- 423* Awareness Campaign for 988 National Suicide Prevention Lifeline: Modest
- 424* Physician Interventions Addressing Environmental Health and Justice: Minimal
- 425* Mental Health Crisis: Modest
- 426* Mental Health First Aid Training: Modest
- 427* Pictorial Health Warnings on Alcoholic Beverages: Modest
- 428* Amending H-90.968 to Expand Policy on Medical Care of Persons with Disabilities: Moderate
- 429* Increasing Awareness and Reducing Consumption of Food and Drink of Poor Nutritional Quality: Modest

SUMMARY OF FISCAL NOTES (JUNE 2022 ANNUAL MEETING)

Resolution(s)

- 430* Longitudinal Capacity Building to Address Climate Action and Justice: Modest
- 431* Protections for Incarcerated Mothers and Infants in the Perinatal Period: Modest
- 432* Recognizing Loneliness as a Public Health Issue: Modest
- 433* Support for Democracy: Modest
- 434* Support for Pediatric Siblings of Chronically Ill Children: Modest
- 435* Support Removal of BMI as a Standard Measure in Medicine and Recognizing Culturally-Diverse and Varied Presentations of Eating Disorders: Modest
- 436* Training and Reimbursement for Firearm Safety Counseling: Modest
- 437# Air Pollution and COVID: A Call to Tighten Regulatory Standards for Particulate Matter: Modest
- 438# Informing Physicians, Health Care Providers, and the Public of the Health Dangers of Fossil-Fuel Derived Hydrogen: Modest
- 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: Modest
- 440# Addressing Social Determinants of Health Through Health IT: Modest
- 441# Addressing Adverse Effects of Active Shooter Drills on Children's Health: Minimal
- 442# Opposing the Censorship of Sexuality and Gender Identity Discussions in Public Schools: Minimum
- 443# Addressing the Longitudinal Healthcare Needs of American Indian Children in Foster Care: Modest
- 501 Marketing Guardrails for the "Over-Medicalization" of Cannabis Use: Minimal
- 502 Ensuring Correct Drug Dispensing: Minimal
- 503 Pharmacy Benefit Managers and Drug Shortages: Modest
- 504 Scientific Studies Which Support Legislative Agendas: Minimal
- 505 CBD Oil Use and the Marketing of CBD Oil: Minimal
- 506 Drug Manufacturing Safety: Modest
- 507 Federal Initiative to Treat Cannabis Dependence: Modest
- 508 Supplemental Resources for Inflight Medical Kit: Modest
- 509 Regulation and Control of Self-Service Labs: Modest
- 510 Evidence-Based Deferral Periods for MSM Cornea and Tissue Donors: Minimal
- 511 Over the Counter (OTC) Hormonal Birth Control: Modest
- 512 Scheduling and Banning the Sale of Tianepentine in the United States: Modest
- 513 Education for Patients on Opiate Replacement Therapy: Est. cost is \$72K per year for educ prog for patients on opioid replacement therapy and their caregivers. Includes professional fees, printing, production and staff costs.
- 514 Oppose Petition to the DEA and FDA on Gabapentin: Modest
- 515 Reducing Polypharmacy as a Significant Contributor to Senior Morbidity: Est. cost is \$76K per year which includes travel, meetings, professional fees (devel ed materials), promotion and staff costs.
- 516* Oppose "Mild Hyperbaric" Facilities from Delivering Unsupported Clinical Treatments: Minimal
- 517* Safeguard the Public from Widespread Unsafe Use of "Mild Hyperbaric Oxygen Therapy": Modest
- 518* Over-the-Counter Access to Oral Contraceptives: Minimal
- 519* ARPA-H Advanced Research Projects Agency for Health: Modest
- 520* Addressing Informal Milk Sharing: Modest
- 521* Encouraging Brain and Other Tissue Donation for Research and Educational Purposes: Modest
- 522* Encouraging Research of Testosterone and Pharmacological Therapies for Post-Menopausal Individuals with Decreased Libido: Modest
- 523* Improving Research Standards, Approval Processes, and Post-Market Surveillance Standards for Medical Devices: Modest
- 524* Increasing Access to Traumatic Brain Injury Resources in Primary Care Settings: Minimal

SUMMARY OF FISCAL NOTES (JUNE 2022 ANNUAL MEETING)

Resolution(s)

- 525# Reforming the FDA Accelerated Approval Process: Modest
- 526# Adoption of Accessible Medical Diagnostic Equipment Standards: Minimal
- 601 Development of Resources on End-of-Life Care: Modest
- 602 Report on the Preservation of Independent Medical Practice: Modest
- 603 September 11th as a National Holiday: Minimal
- 604 UN International Radionuclide Therapy Day Recognition: Minimal
- 605 Fulfilling Medicine's Social Contract with Humanity in the Face of the Climate Health Crisis: \$2M to est a crisis campaign to dist evidence based info on the relationship btwn climate change & human health, determine high yield adv and leadership opps for physicians, centralize effort towards environ justice and an equitable transition to net zero carbon society
- 606 Financial Impact and Fiscal Transparency of the American Medical Association Current Procedural Terminology System: Modest
- 607 AMA Urges Health and Life Insurers to Divest of Investments of Fossil Fuels: Modest
- 608 Transparency of Resolution Fiscal Notes: Estimated cost of \$5,810 annually based on the average volume of HOD business during in-person meetings over the three-year period 2017-2019.
- 609 Surveillance Management System for Organized Medicine Policies and Reports: Modest
- 610 Making AMA Meetings Accessible: Modest
- 611* Continuing Equity Education: Modest (\$1K-\$5K) however, honoraria and/or speakers' fees may result in significantly larger and variable annual cost.
- 612* Identifying Strategies for Accurate Disclosure and Reporting of Racial and Ethnic Data Across the Medical Education Continuum and Physician Workforce: Pending
- 613* Timing of Board Report on Resolution 605 from N-21 Regarding a Permanent Resolution Committee: Minimal
- 614* Allowing Virtual Interviews on Non-Holiday Weekends for Candidates for AMA Office: Minimal
- 615* Anti-Harassment Training: Est cost approx. \$60K-\$65K to create 3 targeted eLearning modules. Incl end to end content design & devel costs to start from scratch, subj matter expert honorariams and staff time
- 616* Medical Student, Resident/Fellow, and Physician Voting in Federal, State and Local Elections: Modest
- 617* Study a Need-Based Scholarship to Encourage Medical Student Participation in the AMA: Modest
- 618* Extending the Delegate Apportionment Freeze During COVID-19 Pandemic: Minimal
- 619* Focus and Priority for the AMA House of Delegates: Minimal fiscal note assuming the Resolution Committee does not convene in person
- 620* Review of Health Insurance Companies and Their Subsidiaries' Business Practices: Est to cost approx \$300K annually derived from outsourcing to local counsels around the country.
- 621# Establishing A Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted: Est. cost of \$30K (incl. travel, meetings and staff costs) to convene a task force to guide organized medicine's response on key healthcare matters that should remain within the purview of the patient-physician relationship.
- 622# HOD Modernization: Estimated cost of \$30K to implement resolution.
- 623# Virtual Attendance at AMA Meetings: Indeterminate. The cost of prod hybrid sections mtgs will be impacted by the added costs for virtual platform vendor, subj to negotiation, and potential offset in savings
- 624# Creation of United Nations "Dr. Saul Hertz Theranostic Nuclear Medicine" International Day: Minimal
- 625# AMA Funding of Political Candidates Who Opposed Research-Backed Firearm Regulations: Minimal
- 701 Appeals and Denial - CPT Codes for Fair Compensation: Minimal
- 702 Health System Consolidation: Modest
- 703 Mandatory Reporting of All Antipsychotic Drug Use in Nursing Home Residents: Minimal
- 704 Employed Physician Contracts: Minimal
- 705 Fifteen Month Lab Standing Orders: Modest
- 706 Government Imposed Volume Requirements for Credentialing: Modest
- 707 Insurance Coverage for Scalp Cooling (Cold Cap) Therapy: Modest

SUMMARY OF FISCAL NOTES (JUNE 2022 ANNUAL MEETING)

Resolution(s)

- 708 Physician Burnout is an OSHA Issue: Modest
- 709 Physician Well-Being as an Indicator of Health System Quality: Minimal
- 710 Prior Authorization - CPT Codes for Fair Compensation: Minimal
- 711 Reducing Prior Authorization Burden: Modest
- 712 The Quadruple Aim - Promoting Improvement in the Physician Experience of Providing Care: Minimal
- 713 Enforcement of Administrative Simplification Requirements: Modest
- 714 Prior Authorization Reform for Specialty Medications: Modest
- 715 Prior Authorization - CPT Codes for Fair Compensation: Modest
- 716 Discharge Summary Reform: Moderate
- 717 Expanding the AMA's Study on the Economic Impact of COVID-19: Modest
- 718 Degradation of Medical Records: Minimal
- 719 System Wide Prior and Post-Authorization Delays and Effects on Patient Care Access: Modest
- 720 Mitigating the Negative Impact of Step Therapy Policies and Nonmedical Switching of Prescription Drugs on Patient Safety: Minimal
- 721 Amend AMA Policy H-215.981 Corporate Practice of Medicine: Minimal
- 722 Eliminating Claims Data for Measuring Physician and Hospital Quality: Modest
- 723* Physician Burnout: Minimal
- 724* Ensuring Medical Practice Viability Through Reallocation of Insurance Savings During the COVID-19 Pandemic: Modest
- 725* Compensation to Physicians for Authorizations and Preauthorizations: Modest
- 726* Payment for the Cost of Electronic Prescription of Controlled Substances and Compensation for Time Spent Engaging State Prescription Monitoring Programs: Modest
- 727* Utilization Review, Medical Necessity Determination, Prior Authorization Decisions: Modest
- 728# Maintaining an Open and Equitable Hospital Work Environment for Specialists: Minimal
- 729# Protecting Physician Wellbeing on Board Certification Applications: Modest
- 730# Maintaining an Open and Equitable Hospital Work Environment for Specialists: Minimal
- 731# Prior Authorization-Patient Autonomy: Modest
- 732# Advocacy of Private Practice Options for Healthcare Operations in Large Corporations: Indeterminate. Depends on nature of pilot program.

SUMMARY OF FISCAL NOTES (JUNE 2022 ANNUAL MEETING)

*** Contained in the Handbook Addendum**

Contained in the Saturday Tote

Minimal - less than \$1,000

Modest - between \$1,000 - \$5,000

Moderate - between \$5,000 - \$10,000

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

JUNE 2022 ANNUAL MEETING

ORDER OF BUSINESS - SECOND SESSION

Saturday, June 11, 2022
12:30 pm

1. Report of the Rules and Credentials Committee - Deepak Kumar, MD

2. Presentation, Correction and Adoption of Minutes of the November 2021 Special Meeting

3. Acceptance of Business

Reports of the Board of Trustees - Bobby Mukkamala, MD, Chair

- 01 Annual Report (F)
- 02 New Specialty Organizations Representation in the House of Delegates (Amendments to C&B)
- 03 2021 Grants and Donations (Info. Report)
- 04 AMA 2023 Dues (F)
- 05 Update on Corporate Relationships (Info. Report)
- 06 Redefining AMA's Position on ACA and Healthcare Reform (Info. Report)
- 07 AMA Performance, Activities and Status in 2021 (Info. Report)
- 08 Annual Update on Activities and Progress in Tobacco Control: March 2021 through February 2022 (Info. Report)
- 09 Council on Legislation Sunset Review of 2012 House Policies (B)
- 10 American Medical Association Center for Health Equity Annual Report (Info. Report)
- 11 Procedure for Altering the Size or Composition of Section Governing Councils (F)
- 12 Disaggregation of Demographic Data for Individuals of Middle Eastern and North African (MENA) Descent (Info. Report)
- 13 Use of Psychiatric Advance Directives (Amendments to C&B)
- 14 Amendment to Truth and Transparency in Pregnancy Counseling Centers, H-420.954 (Amendments to C&B)
- 15 Addressing Public Health Disinformation (D)
- 16 Language Proficiency Data of Physicians in the AMA Masterfile (F)
- 17 Expungement, Destruction, and Sealing of Criminal Records for Legal Offenses Related to Cannabis Use or Possession (B)
- 18 Addressing Inflammatory and Untruthful Online Ratings (G)
- 19 Demographic Report of the House of Delegates and AMA Membership (Info. Report)
- 20 Delegate Apportionment and Pending Members (F)
- 21 Opposition to Requirements for Gender-Based Treatments for Athletes (Amendments to C&B)
- 22# Nonconsensual Audio/Video Recording at Medical Encounters (Amendments to C&B)
- 23# Specialty Society Representation in the House of Delegates (Amendments to C&B)

Reports of the Council on Constitution and Bylaws - Pino D. Colone, MD, Chair

- 01 Clarification to the Bylaws: Delegate Representation (Amendments to C&B)

Reports of the Council on Ethical and Judicial Affairs - Alexander M. Rosenau, MD, Chair

- 01 Short-Term Medical Service Trips (Amendments to C&B)
- 02 Amendment to Opinion 10.8, Collaborative Care (Amendments to C&B)
- 03 Amendment to E-9.3.2, Physician Responsibilities to Colleagues with Illness, Disability or Impairment (Amendments to C&B)
- 04 CEJA's Sunset Review of 2012 House Policies (Amendments to C&B)
- 05 Pandemic Ethics and the Duty of Care (D-130.960) (Info. Report)

06 Judicial Function of the Council on Ethical and Judicial Affairs - Annual Report (Info. Report)

Opinion(s) of the Council on Ethical and Judicial Affairs - Alexander M. Rosenau, MD, Chair

01 Amendment to E-1.1.6, Quality (Info. Report)

02 Amendment to E-1.2.11, Ethical Innovation in Medical Practice (Info. Report)

03 Amendment to E-11.1.2, Physician Stewardship of Health Care Resources (Info. Report)

04 Amendment to E-11.2.1, Professionalism in Health Care Systems (Info. Report)

Reports of the Council on Medical Education - Niranjan V. Rao, MD, Chair

01 Council on Medical Education Sunset Review of 2012 House Policies (C)

02 An Update on Continuing Board Certification (C)

03 Onsite and Subsidized Childcare for Medical Students, Residents and Fellows (C)

04 Protection of Terms Describing Physician Education and Practice (C)

05 Education, Training and Credentialing of Non-Physician Health Care Providers and Their Impact on Physician Education and Training (C)

06 Clinical Applications of Pathology and Laboratory Medicine for Medical Students, Residents and Fellows (C)

Reports of the Council on Medical Service - Asa C. Lockhart, MD, Chair

01 Council on Medical Service Sunset Review of 2012 House Policies (G)

02 Prospective Payment Model Best Practices for Independent Private Practice (G)

03 Preventing Coverage Losses After the Public Health Emergency Ends (A)

04 Parameters of Medicare Drug Price Negotiation (A)

05 Poverty-Level Wages and Health (G)

Reports of the Council on Science and Public Health - Alexander Ding, MD, Chair

01 Council on Science and Public Health Sunset Review of 2012 HOD Policies (D)

02 Transformation of Rural Community Public Health Systems (D)

03 Correcting Policy H-120.958 (E)

Report of the HOD Committee on Compensation of the Officers - Steven Tolber, MD, Chair

01* Report of the House of Delegates Committee on the Compensation of the Officers (F)

Joint Report(s)

CCB/CLRPD 01 Joint Council Sunset Review of 2012 House Policies (F)

Report of the Speakers - Bruce A. Scott, MD, Speaker; Lisa Bohman Egbert, MD, Vice Speaker

01 Recommendations for Policy Reconciliation (Info. Report)

-- EXTRACTION OF INFORMATIONAL REPORTS --

Memorial Resolutions

Resolutions

001 Increasing Public Umbilical Cord Blood-Donations in Transplant Centers (Amendments to C&B)

002 Opposition to Discriminatory Treatment of Haitian Asylum Seekers (Amendments to C&B)

003 Gender Equity and Female Physician Work Patterns During the Pandemic (Amendments to C&B)

004 Recognizing LGBTQ+ Individuals as Underrepresented in Medicine (Amendments to C&B)

005 Supporting the Study of Reparations as a Means to Reduce Racial Inequalities (Amendments to C&B)

006 Combating Natural Hair and Cultural Headwear Discrimination in Medicine and Medical Professionalism (Amendments to C&B)

007 Equal Access for Adoption in the LGBTQ Community (Amendments to C&B)

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009 Privacy Protection and Prevention of Further Trauma for Victims of Distribution of Intimate Videos and Images Without Consent (Amendments to C&B)

010 Improving the Health and Safety of Sex Workers (Amendments to C&B)

011 Evaluating Scientific Journal Articles for Racial and Ethnic Bias (Amendments to C&B)

- 012 Expanding the Definition of Iatrogenic Infertility to Include Gender Affirming Interventions (Amendments to C&B)
- 013 Recognition of National Anti-Lynching Legislation as a Public Health Initiative (Amendments to C&B)
- 014* Healthcare Equity Through Informed Consent and a Collaborative Healthcare Model for the Gender Diverse Population (Amendments to C&B)
- 015* Increasing Mental Health Screenings by Refugee Resettlement Agencies and Improving Mental Health Outcomes for Refugee Women (Amendments to C&B)
- 016* Addressing and Banning Unjust and Invasive Medical Procedures Among Migrant Women at the Border (Amendments to C&B)
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- 019* Hardship for International Medical Graduates from Ukraine (Amendments to C&B)
- 020* Council on Ethical and Judicial Affairs Guidelines for Treating Unvaccinated Individuals (Amendments to C&B)
- 021* National Cancer Research Patient Identifier (Amendments to C&B)
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- 024* Pharmaceutical Equity for Pediatric Populations (Amendments to C&B)
- 025* Use of Social Media for Product Promotion and Compensation (Amendments to C&B)
- 026# Establishing Ethical Principles for Physicians Involved in Private Equity Owned Practices (Amendments to C&B)
- 027# Protecting Access to Abortion and Reproductive Healthcare (Amendments to C&B)
- 028# Preserving Access to Reproductive Health Services (Amendments to C&B)
- 101 Fertility Preservation Benefits for Active-Duty Military Personnel (A)
- 102 Bundling Physician Fees with Hospital Fees (A)
- 103 COBRA for College Students (A)
- 104 Consumer Operated and Oriented Plans (CO-OPs) as a Public Option for Health Care Financing (A)
- 105 Health Insurance that Fairly Compensates Physicians (A)
- 106 Hospice Recertification for Non-Cancer Diagnosis (A)
- 107 Medicaid Tax Benefits (A)
- 108 Payment for Regadenoson (Lexiscan) (A)
- 109 Piloting the Use of Financial Incentives to Reduce Unnecessary Emergency Room Visits (A)
- 110 Private Payor Payment Integrity (A)
- 111 Bundled Payments and Medically Necessary Care (A)
- 112 Support for Easy Enrollment Federal Legislation (A)
- 113 Prevention of Hearing Loss-Associated-Cognitive-Impairment Through Earlier Recognition and Remediation (A)
- 114 Oral Healthcare IS Healthcare (A)
- 115 Support for Universal Internet Access (A)
- 116 Reimbursement of School-Based Health Centers (A)
- 117 Expanding Medicaid Transportation to Include Healthy Grocery Destinations (A)
- 118 Caps on Insulin Co-Payments for Patients with Insurance (A)
- 119 Medicare Coverage of Dental, Vision and Hearing Services (A)
- 120 Expanding Coverage for and Access to Pulmonary Rehabilitation (A)
- 121 Increase Funding, Research and Education for Post-Intensive Care Syndrome (A)
- 122 Medicaid Expansion (A)
- 123 Advocating for All Payer Coverage of Cosmetic Treatment for Survivors of Domestic Abuse and Intimate Partner Violence (A)

- 124 To Require Insurance Companies Make the "Coverage Year" and the "Deductible Year" Simultaneous for Their Policies (A)
- 125 Education, Forewarning and Disclosure Regarding Consequences of Changing Medicare Plans (A)
- 126* Providing Recommended Vaccines Under Medicare Parts B and C (A)
- 127* Continuity of Care Upon Release from Correctional Systems (A)
- 128# Improving Access to Vaccinations for Patients (A)
- 201 The Impact of Midlevel Providers on Medical Education (B)
- 202 AMA Position on All Payer Database Creation (B)
- 203 Ban the Gay/Trans (LGBTQ+) Panic Defense (B)
- 204 Insurance Claims Data (B)
- 205 Insurers and Vertical Integration (B)
- 206 Medicare Advantage Plan Mandates (B)
- 207 Physician Tax Fairness (B)
- 208 Prohibit Ghost Guns (B)
- 209 Supporting Collection of Data on Medical Repatriation (B)
- 210 Reducing the Prevalence of Sexual Assault by Testing Sexual Assault Evidence Kits (B)
- 211 Repeal or Modification of the Medicare Appropriate Use Criteria (AUC) Program (B)
- 212 Medication for Opioid Use Disorder in Physician Health Programs (B)
- 213 Resentencing for Individuals Convicted of Marijuana-Based Offenses (B)
- 214 Eliminating Unfunded or Unproven Mandates and Regulations (B)
- 215 Transforming Professional Licensure to the 21st Century (B)
- 216 Advocating for the Elimination of Hepatitis C Treatment Restrictions (B)
- 217 Preserving the Practice of Medicine (B)
- 218 Expedited Immigrant Green Card Visa for J-1 Visa Waiver Physicians Serving in Underserved Areas (B)
- 219 Due Process and Independent Contractors (B)
- 220 Vital Nature of Board-Certified Physicians in Aerospace Medicine (B)
- 221* WITHDRAWN (B)
- 222* To Study the Economic Impact of Mid-Level Provider Employment in the United States of America (B)
- 223* National Drug Shortages of Lidocaine and Saline Preparations (B)
- 224* HPSA and MUA Designation for SNFs (B)
- 225* Public Listing of Medical Directors for Nursing Facilities (B)
- 226* Coverage for Clinical Trial Ancillary Costs (B)
- 227* Supporting Improvements to Patient Data Privacy (B)
- 228* Expanded Child Tax Credit (B)
- 229* Expedited Immigrant Green Card for J-1 Visa Waiver Physicians Serving in Underserved Areas (B)
- 230* Advancing the Role of Outdoor Recreation in Public Health (B)
- 231* Amending Policy H-155.955, "Increasing Accessibility to Incontinence Products to Include Diaper Tax Exemption" (B)
- 232* Expansion of Epinephrine Entity Stocking Legislation (B)
- 233* Support for Warning Labels on Firearm Ammunition Packaging (B)
- 234* Updating Policy on Immigration Laws, Rules, Legislation, and Health Disparities (B)
- 235* Improving the Veterans Health Administration Referrals for Veterans for Care Outside the VA System (B)
- 236* Out-of-Network Care (B)
- 237* Prescription Drug Dispensing Policies (B)
- 238* COVID-19 Economic Injury Disaster Loan (EIDL) Forgiveness for Physician Groups of Five or Fewer Physicians (B)
- 239* Virtual Services When Patients Are Away From Their Medical Home (B)
- 240* Physician Payment Reform and Equity (B)
- 241* Unmatched Graduate Physician Workforce (B)

- 242* Public Awareness and Advocacy Campaign to Reform the Medicare Physician Payment System (B)
- 243* Appropriate Physician Payment for Office-Based Services (B)
- 244* Prohibit Reversal of Prior Authorization (B)
- 245# Definition and Encouragement of the Appropriate Use of the Word "Physician" (B)
- 246# Further Action to Respond to the Gun Violence Public Health Crisis (B)
- 247# Recognizing Child Poverty and the Racial Wealth Gap as Public Health Issues and Extending the Child Tax Credit for Low-Income Families (B)
- 248# Promoting Proper Oversight and Reimbursement for Specialty Physician Extenders and Non-Physician Practitioners (B)
- 249# Clarification of Healthcare Physician Identification: Consumer Truth & Transparency (B)
- 250# Opposition to Criminalization of Physicians' Medical Practice (B)
- 251# Physician Medical License Use in Clinical Supervision (B)
- 252# The Criminalization of Health Care Decision Making and Practice (B)
- 253# Physician Payment Reform & Equity (B)
- 254# Stakeholder Engagement in Medicare Administrative Contractor Policy Processes (B)
- 301 Medical Education Debt Cancellation in the Face of a Physician Shortage During the COVID-19 Pandemic (C)
- 302 Resident and Fellow Access to Fertility Preservation (C)
- 303 Fatigue Mitigation Respite for Faculty and Residents (C)
- 304 Organizational Accountability to Resident and Fellow Trainees (C)
- 305 Reducing Overall Fees and Making Costs for Licensing Exam Fees, Application Fees, Etc., Equitable for IMGs (C)
- 306 Creating a More Accurate Accounting of Medical Education Financial Costs (C)
- 307 Parental Leave and Planning Resources for Medical Students (C)
- 308 University Land Grant Status in Medical School Admissions (C)
- 309 Decreasing Bias in Evaluations of Medical Student Performance (C)
- 310 Support for Standardized Interpreter Training (C)
- 311 Discontinue State Licensure Requirement for COMLEX Level 2 PE (C)
- 312 Reduce Financial Burden to Medical Students of Medical Licensure Examinations (C)
- 313 Decreasing Medical Student Debt and Increasing Transparency in Cost of Medical School Attendance (C)
- 314 Support for Institutional Policies for Personal Days for Undergraduate Medical Students (C)
- 315 Modifying Eligibility Criteria for the Association of American Medical Colleges' Financial Assistance Program (C)
- 316 Providing Transparent and Accurate Data Regarding Students and Faculty at Medical Schools (C)
- 317 Medical Student, Resident and Fellow Suicide Reporting (C)
- 318* CME for Preceptorship (C)
- 319* Senior Living Community Training for Medical Students and Residents (C)
- 320* Tuition Cost Transparency (C)
- 321* Improving and Standardizing Pregnancy and Lactation Accommodations for Medical Board Examinations (C)
- 322* Standards in Cultural Humility Training Within Medical Education (C)
- 323* Cultural Leave for American Indian Trainees (C)
- 324* Sexual Harassment Accreditation Standards for Medical Training Programs (C)
- 325* Single Licensing Exam Series for Osteopathic and Allopathic Medical Students (C)
- 326* Standardized Wellness Initiative Reporting (C)
- 327* Leadership Training Must Become an Integral Part of Medical Education (C)
- 328* Increasing Transparency of the Resident Physician Application Process (C)
- 329* Use of the Terms "Residency" and "Fellowship" by Health Professionals Outside of Medicine (C)
- 401 Air Quality and the Protection of Citizen Health (D)
- 402 Support for Impairment Research (D)

- 403 Addressing Maternal Discrimination and Support for Flexible Family Leave (D)
- 404 Weapons in Correctional Healthcare Facilities (D)
- 405 Universal Childcare and Preschool (D)
- 406 COVID-19 Preventive Measures for Correctional Facilities: AMA Policy Position (D)
- 407 Study of Best Practices for Acute Care of Patients in the Custody of the Law (D)
- 408 Supporting Increased Research on Implementation of Nonviolent De-escalation Training and Mental Illness Awareness in Law Enforcement (D)
- 409 Increasing HPV Vaccination Rates in Rural Communities (D)
- 410 Increasing Education for School Staff to Recognize Prodromal Symptoms of Schizophrenia in Teens and Young Adults to Increase Early Intervention (D)
- 411 Anonymous Prescribing Option for Expedited Partner Therapy (D)
- 412 Advocating for the Amendment of Chronic Nuisance Ordinances (D)
- 413 Expansion on Comprehensive Sexual Health Education (D)
- 414 Improvement of Care and Resource Allocation for Homeless Persons in the Global Pandemic (D)
- 415 Creation of an Obesity Task Force (D)
- 416 School Resource Officer Violence De-Escalation Training and Certification (D)
- 417 Tobacco Control (D)
- 418 Lung Cancer Screening Awareness (D)
- 419 Advocating for the Utilization of Police and Mental Health Care Co-Response Teams for 911 Mental Health Emergency Calls (D)
- 420* Declaring Climate Change a Public Health Crisis (D)
- 421* Screening for HPV-Related Anal Cancer (D)
- 422* Voting as a Social Determinant of Health (D)
- 423* Awareness Campaign for 988 National Suicide Prevention Lifeline (D)
- 424* Physician Interventions Addressing Environmental Health and Justice (D)
- 425* Mental Health Crisis (D)
- 426* Mental Health First Aid Training (D)
- 427* Pictorial Health Warnings on Alcoholic Beverages (D)
- 428* Amending H-90.968 to Expand Policy on Medical Care of Persons with Disabilities (D)
- 429* Increasing Awareness and Reducing Consumption of Food and Drink of Poor Nutritional Quality (D)
- 430* Longitudinal Capacity Building to Address Climate Action and Justice (D)
- 431* Protections for Incarcerated Mothers and Infants in the Perinatal Period (D)
- 432* Recognizing Loneliness as a Public Health Issue (D)
- 433* Support for Democracy (D)
- 434* Support for Pediatric Siblings of Chronically Ill Children (D)
- 435* Support Removal of BMI as a Standard Measure in Medicine and Recognizing Culturally-Diverse and Varied Presentations of Eating Disorders (D)
- 436* Training and Reimbursement for Firearm Safety Counseling (D)
- 437# Air Pollution and COVID: A Call to Tighten Regulatory Standards for Particulate Matter (D)
- 438# Informing Physicians, Health Care Providers, and the Public of the Health Dangers of Fossil-Fuel Derived Hydrogen (D)
- 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 (D)
- 440# Addressing Social Determinants of Health Through Health IT (D)
- 441# Addressing Adverse Effects of Active Shooter Drills on Children's Health (D)
- 442# Opposing the Censorship of Sexuality and Gender Identity Discussions in Public Schools (D)
- 443# Addressing the Longitudinal Healthcare Needs of American Indian Children in Foster Care (D)
- 501 Marketing Guardrails for the "Over-Medicalization" of Cannabis Use (E)
- 502 Ensuring Correct Drug Dispensing (E)
- 503 Pharmacy Benefit Managers and Drug Shortages (E)

- 504 Scientific Studies Which Support Legislative Agendas (E)
- 505 CBD Oil Use and the Marketing of CBD Oil (E)
- 506 Drug Manufacturing Safety (E)
- 507 Federal Initiative to Treat Cannabis Dependence (E)
- 508 Supplemental Resources for Inflight Medical Kit (E)
- 509 Regulation and Control of Self-Service Labs (E)
- 510 Evidence-Based Deferral Periods for MSM Cornea and Tissue Donors (E)
- 511 Over the Counter (OTC) Hormonal Birth Control (E)
- 512 Scheduling and Banning the Sale of Tianeptine in the United States (E)
- 513 Education for Patients on Opiate Replacement Therapy (E)
- 514 Oppose Petition to the DEA and FDA on Gabapentin (E)
- 515 Reducing Polypharmacy as a Significant Contributor to Senior Morbidity (E)
- 516* Oppose "Mild Hyperbaric" Facilities from Delivering Unsupported Clinical Treatments (E)
- 517* Safeguard the Public from Widespread Unsafe Use of "Mild Hyperbaric Oxygen Therapy" (E)
- 518* Over-the-Counter Access to Oral Contraceptives (E)
- 519* ARPA-H Advanced Research Projects Agency for Health (E)
- 520* Addressing Informal Milk Sharing (E)
- 521* Encouraging Brain and Other Tissue Donation for Research and Educational Purposes (E)
- 522* Encouraging Research of Testosterone and Pharmacological Therapies for Post-Menopausal Individuals with Decreased Libido (E)
- 523* Improving Research Standards, Approval Processes, and Post-Market Surveillance Standards for Medical Devices (E)
- 524* Increasing Access to Traumatic Brain Injury Resources in Primary Care Settings (E)
- 525# Reforming the FDA Accelerated Approval Process (E)
- 526# Adoption of Accessible Medical Diagnostic Equipment Standards (E)
- 601 Development of Resources on End-of-Life Care (F)
- 602 Report on the Preservation of Independent Medical Practice (F)
- 603 September 11th as a National Holiday (F)
- 604 UN International Radionuclide Therapy Day Recognition (F)
- 605 Fulfilling Medicine's Social Contract with Humanity in the Face of the Climate Health Crisis (F)
- 606 Financial Impact and Fiscal Transparency of the American Medical Association Current Procedural Terminology System (F)
- 607 AMA Urges Health and Life Insurers to Divest of Investments of Fossil Fuels (F)
- 608 Transparency of Resolution Fiscal Notes (F)
- 609 Surveillance Management System for Organized Medicine Policies and Reports (F)
- 610 Making AMA Meetings Accessible (F)
- 611* Continuing Equity Education (F)
- 612* Identifying Strategies for Accurate Disclosure and Reporting of Racial and Ethnic Data Across the Medical Education Continuum and Physician Workforce (F)
- 613* Timing of Board Report on Resolution 605 from N-21 Regarding a Permanent Resolution Committee (F)
- 614* Allowing Virtual Interviews on Non-Holiday Weekends for Candidates for AMA Office (F)
- 615* Anti-Harassment Training (F)
- 616* Medical Student, Resident/Fellow, and Physician Voting in Federal, State and Local Elections (F)
- 617* Study a Need-Based Scholarship to Encourage Medical Student Participation in the AMA (F)
- 618* Extending the Delegate Apportionment Freeze During COVID-19 Pandemic (F)
- 619* Focus and Priority for the AMA House of Delegates (F)
- 620* Review of Health Insurance Companies and Their Subsidiaries' Business Practices (F)
- 621# Establishing A Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted (F)
- 622# HOD Modernization (F)

- 623# Virtual Attendance at AMA Meetings (F)
- 624# Creation of United Nations "Dr. Saul Hertz Theranostic Nuclear Medicine" International Day (F)
- 625# AMA Funding of Political Candidates Who Opposed Research-Backed Firearm Regulations (F)
- 701 Appeals and Denial - CPT Codes for Fair Compensation (G)
- 702 Health System Consolidation (G)
- 703 Mandatory Reporting of All Antipsychotic Drug Use in Nursing Home Residents (G)
- 704 Employed Physician Contracts (G)
- 705 Fifteen Month Lab Standing Orders (G)
- 706 Government Imposed Volume Requirements for Credentialing (G)
- 707 Insurance Coverage for Scalp Cooling (Cold Cap) Therapy (G)
- 708 Physician Burnout is an OSHA Issue (G)
- 709 Physician Well-Being as an Indicator of Health System Quality (G)
- 710 Prior Authorization - CPT Codes for Fair Compensation (G)
- 711 Reducing Prior Authorization Burden (G)
- 712 The Quadruple Aim - Promoting Improvement in the Physician Experience of Providing Care (G)
- 713 Enforcement of Administrative Simplification Requirements (G)
- 714 Prior Authorization Reform for Specialty Medications (G)
- 715 Prior Authorization - CPT Codes for Fair Compensation (G)
- 716 Discharge Summary Reform (G)
- 717 Expanding the AMA's Study on the Economic Impact of COVID-19 (G)
- 718 Degradation of Medical Records (G)
- 719 System Wide Prior and Post-Authorization Delays and Effects on Patient Care Access (G)
- 720 Mitigating the Negative Impact of Step Therapy Policies and Nonmedical Switching of Prescription Drugs on Patient Safety (G)
- 721 Amend AMA Policy H-215.981 Corporate Practice of Medicine (G)
- 722 Eliminating Claims Data for Measuring Physician and Hospital Quality (G)
- 723* Physician Burnout (G)
- 724* Ensuring Medical Practice Viability Through Reallocation of Insurance Savings During the COVID-19 Pandemic (G)
- 725* Compensation to Physicians for Authorizations and Preauthorizations (G)
- 726* Payment for the Cost of Electronic Prescription of Controlled Substances and Compensation for Time Spent Engaging State Prescription Monitoring Programs (G)
- 727* Utilization Review, Medical Necessity Determination, Prior Authorization Decisions (G)
- 728# Maintaining an Open and Equitable Hospital Work Environment for Specialists (G)
- 729# Protecting Physician Wellbeing on Board Certification Applications (G)
- 730# Maintaining an Open and Equitable Hospital Work Environment for Specialists (G)
- 731# Prior Authorization-Patient Autonomy (G)
- 732# Advocacy of Private Practice Options for Healthcare Operations in Large Corporations (G)

4. Report of the Committee on Rules and Credentials - Deepak Kumar, MD, Chair

- Late Resolutions

5. Unfinished Business and Announcements - Bruce A. Scott, MD

* contained in the Handbook Addendum

contained in the Saturday Tote

ORDER OF BUSINESS

Reference Committee on Amendments to Constitution and Bylaws (A-22)
Nicole Riddle, MD, Chair

June 11, 2022
1:00pm – 5:30pm, Crystal B/C
[Zoom Meeting Link](#) (view only)

1. Board of Trustees Report 02 - New Specialty Organizations Representation in the House of Delegates
2. Board of Trustees Report 13 - Use of Psychiatric Advance Directives
3. Board of Trustees Report 14 - Amendment to Truth and Transparency in Pregnancy Counseling Centers, H-420.954
4. Board of Trustees Report 21 - Opposition to Requirements for Gender-Based Treatments for Athletes
5. Board of Trustees Report 22 - Nonconsensual Audio/Video Recording at Medical Encounters, Resolution 007-June-21
6. Board of Trustees Report 23 - Specialty Society Representation in the House of Delegates - Five-Year Review
7. Council on Constitution and Bylaws Report 1 - Clarification to the Bylaws Delegate Representation
8. Council on Ethical and Judicial Affairs Report 1 - Short-Term Medical Service Trips
9. Council on Ethical and Judicial Affairs Report 2 - Amendment to Opinion 10.8, Collaborative Care
10. Council on Ethical and Judicial Affairs Report 3 - Amendment to E-9.3.2, Physician Responsibilities to Colleagues with Illness, Disability or Impairment
11. Council on Ethical and Judicial Affairs Report 4 - CEJA's Sunset Review of 2012 House Policies
12. Resolution 001 - Increasing Public Umbilical Cord Blood-Donations in Transplant Centers

Note: During the reference committee hearing, supplemental material may be sent to Scott.Schweikart@ama-assn.org. Supplemental material includes items that have been referenced in testimony such as alternative wording, proposed amendments, and supporting documents. AMENDMENTS MUST BE EMAILED. This email address is NOT intended as a means to provide testimony, which should only be presented in on the Online Member Forum or orally to the committee. This address is only operational for the duration of the reference committee hearing.

Participants with technical issues should email HODMeetingSupport@ama-assn.org (please include a phone number); someone will contact you back as soon as possible to assist. For urgent issues during the meeting, the HOD Hotline: 800-337-1599, will be available for assistance. Please note that unless there is a widespread technical difficulty, proceedings will continue.

13. Resolution 002 - Opposition to Discriminatory Treatment of Haitian Asylum Seekers
14. Resolution 003 – Gender Equity and Female Physician Work Patterns During the Pandemic
15. Resolution 004 – Recognizing LGBTQ+ Individuals as Underrepresented in Medicine
16. Resolution 005 – Supporting the Study of Reparations as a Means to Reduce Racial Inequalities
17. Resolution 006 – Combating Natural Hair and Cultural Headwear Discrimination in Medicine and Medical Professionalism
18. Resolution 007 – Equal Access for Adoption in the LGBTQ Community
19. Resolution 008 – Student-Centered Approaches for Reforming School Disciplinary Policies
20. Resolution 009 – Privacy Protection and Prevention of Further Trauma for Victims of Distribution of Intimate Videos and Images Without Consent
21. Resolution 010 – Improving the Health and Safety of Sex Workers
22. Resolution 011 – Evaluating Scientific Journal Articles for Racial and Ethnic Bias
23. Resolution 012 – Expanding the Definition of Iatrogenic Infertility to Include Gender Affirming Interventions
24. Resolution 013 – Recognition of National Anti-Lynching Legislation as a Public Health Initiative
25. Resolution 014 - Healthcare Equity Through Informed Consent and a Collaborative Healthcare Model for the Gender Diverse Population
26. Resolution 015 – Increasing Mental Health Screenings by Refugee Resettlement Agencies and Improving Mental Health Outcomes for Refugee Women
27. Resolution 016 – Addressing and Banning Unjust and Invasive Medical Procedures Among Migrant Women at the Border
28. Resolution 017- Humanitarian and Medical Aid Support to Ukraine
29. Resolution 018 – Hardship for International Medical Graduates from Russia and Belarus

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30. Resolution 019 – Hardship for International Medical Graduates from Ukraine
31. Resolution 020 – Council on Ethical and Judicial Affairs Guidelines for Treating Unvaccinated Individuals
32. Resolution 021 – National Cancer Research Patient Identifier
33. Resolution 022 – Organ Transplant Equity for Persons with Disabilities
34. Resolution 023 – 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
35. Resolution 024 – Pharmaceutical Equity for Pediatric Populations
36. Resolution 025 – Use of Social Media for Product Promotion and Compensation
37. Resolution 026 - Establishing Ethical Principles for Physicians Involved in Private Equity Owned Practices
38. Resolution 027 - Protecting Access to Abortion and Reproductive Healthcare
39. Resolution 028 - Preserving Access to Reproductive Health Services

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ORDER OF BUSINESS

Reference Committee B (Annual 2022 Meeting)

John Flores, MD, Chair

June 11, 2022

Zoom Link

<https://zoom.us/j/93152370412>

1. BOT 09 – Council on Legislation Sunset Review of 2012 House Policies
2. BOT 17 – Expungement, Destruction, and Sealing of Criminal Records for Legal Offenses Related to Cannabis Use or Possession
 - 213 – Resentencing for Individuals Convicted of Marijuana-Based Offenses
3. 201 – The Impact of Midlevel Providers on Medical Education
4. 202 – AMA Position on All Payer Database Creation
5. 203 – Ban the Gay/Trans (LGBTQ+) Panic Defense
6. 204 – *Insurance Claims Data*
7. 205 – Insurers and Vertical Integration
8. 206 – *Medicare Advantage Plan Mandates*
9. 207 – Physician Tax Fairness
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15. 212 – Medication for Opioid Use Disorder in Physician Health Programs
16. 215 – *Transforming Professional Licensure to the 21st Century*
17. 216 – Advocating for the Elimination of Hepatitis C Treatment Restrictions
18. 217 – Preserving the Practice of Medicine
19. 218 – Expedited Immigrant Green Card Visa for J-1 Visa Waiver Physicians Serving in Underserved Areas
 - 229 – Expedited Immigrant Green Card for J-1 Visa Waiver Physicians Serving in Underserved Areas
20. 219 – Due Process and Independent Contractors
21. 220 – *Vital Nature of Board-Certified Physicians in Aerospace Medicine*
22. 222 – To Study the Economic Impact of Mid-Level Provider Employment in the United States of America
23. 223 – National Drug Shortages of Lidocaine and Saline Preparations
24. 224 – HPSA and MUA Designation for SNFs
25. 225 – Public Listing of Medical Directors for Nursing Facilities
26. 226 – Coverage for Clinical Trial Ancillary Costs
27. 227 – Supporting Improvements to Patient Data Privacy
28. 228 – Expanded Child Tax Credit
 - 247 – Recognizing Child Poverty and the Racial Wealth Gap as Public Health Issues and Extending the Child Tax Credit for Low-Income Families
29. 230 – Advancing the Role of Outdoor Recreation in Public Health
30. 231 – Amending Policy H-155.955, "Increasing Accessibility to Incontinence Products to Include Diaper Tax Exemption"
31. 232 – Expansion of Epinephrine Entity Stocking Legislation

- 32. 233 – Support for Warning Labels on Firearm Ammunition Packaging
- 33. 234 – Updating Policy on Immigration Laws, Rules, Legislation, and Health Disparities
- 34. 235 – *Improving the Veterans Health Administration Referrals for Veterans for Care Outside the VA System*
- 35. 236 – Out-of-Network Care
- 36. 237 – Prescription Drug Dispensing Policies
- 37. 238 – COVID-19 Economic Injury Disaster Loan (EIDL) Forgiveness for Physician Groups of Five or Fewer Physicians
- 38. 239 – Virtual Services When Patients Are Away From Their Medical Home
- 39. 240 – Physician Payment Reform and Equity
 - 242 – Public Awareness and Advocacy Campaign to Reform the Medicare Physician Payment System
 - 243 – Appropriate Physician Payment for Office-Based Services
- 40. 253 – Physician Payment Reform & Equity
- 41. 241 – Unmatched Graduate Physician Workforce
- 42. 244 – *Prohibit Reversal of Prior Authorization*
- 43. 245 – *Definition and Encouragement of the Appropriate Use of the Word "Physician"*
- 44. 246 – Further Action to Respond to the Gun Violence Public Health Crisis
- 45. 248 – Promoting Proper Oversight and Reimbursement for Specialty Physician Extenders and Non Physician Practitioners
- 46. 249 – Clarification of Healthcare Physician Identification: Consumer Truth & Transparency
- 47. 250 – Opposition to Criminalization of Physicians' Medical Practice
- 48. 251 – Physician Medical License Use in Clinical Supervision
- 49. 254 – The Criminalization of Health Care Decision Making and Practice

During the reference committee hearing, supplemental material may be sent to alexis.pierce@ama-assn.org. Supplemental material includes items that have been referenced in testimony such as alternative wording, proposed amendments, and supporting documents. This email address is NOT intended as a means to provide testimony, which should only be presented in on the Online Member Forum or orally to the committee. This address is only operational for the duration of the reference committee hearing.

Participants with technical issues should email HODMeetingSupport@ama-assn.org (please include a phone number); someone will contact you back as soon as possible to assist. For urgent issues during the meeting, the HOD Hotline: 800-337-1599, will be available for assistance. Please note that unless there is a widespread technical difficulty, proceedings will continue.

ORDER OF BUSINESS

Reference Committee C (2022 Annual Meeting)
David T. Walsworth, MD, Chair

Saturday, June 11, 2022
1 – 5:30 pm CST

Regency Ballrooms C/D
Zoom link below (view only)

1. Council on Medical Education Report 1 – Council on Medical Education Sunset Review of 2012 House Policies
2. Council on Medical Education Report 4 – Protection of Terms Describing Physician Education and Practice (Resolution 305-J-21, Alternate Resolve 2)
Resolution 329 – Use of the Terms "Residency" and "Fellowship" by Health Professionals Outside of Medicine
3. Council on Medical Education Report 5 – Education, Training, and Credentialing of Non-Physician Health Care Providers and Their Impact on Physician Education and Training (Resolution 305-J-21, Resolve 8)
4. Resolution 304 – Accountable Organizations to Resident and Fellow Trainees
5. Resolution 328 – Increasing Transparency of the Resident Physician Application Process
6. Resolution 301 – Medical Education Debt Cancellation in the Face of a Physician Shortage During the COVID-19 Pandemic
7. Resolution 306 – Creating a More Accurate Accounting of Medical Education Financial Costs
8. *Resolution 313 – Decreasing Medical Student Debt and Increasing Transparency in Cost of Medical School Attendance*
9. *Resolution 320 – Tuition Cost Transparency*
10. *Resolution 312 – Reduce Financial Burden to Medical Students of Medical Licensure Examinations*
11. *Resolution 305 – Reducing Overall Fees and Making Costs for Licensing, Exam Fees, Application Fees, etc., Equitable for IMGS*
12. *Resolution 311 – Discontinue State Licensure Requirement for COMLEX Level 2 PE*
13. *Resolution 325 – Single Licensing Exam Series for Osteopathic and Allopathic Medical Students*
14. Resolution 321 – Improving and Standardizing Pregnancy and Lactation Accommodations for Medical Board Examinations
15. Council on Medical Education Report 3 – Onsite and Subsidized Childcare for Medical Students, Residents and Fellows (Resolution 304-J-21, Resolve 3)
16. Resolution 314 – Support for Institutional Policies for Personal Days for Undergraduate Medical Students

17. Resolution 307 – Parental Leave and Planning Resources for Medical Students
18. *Resolution 302 – Resident and Fellow Access to Fertility Preservation*
19. *Resolution 303 – Fatigue Mitigation Respite for Faculty and Residents*
20. Resolution 326 – Standardized Wellness Initiative Reporting
Resolution 317 – Medical Student, Resident and Fellow Suicide Reporting
21. Resolution 308 – University Land Grant Status in Medical School Admissions
22. Resolution 323 – Cultural Leave for American Indian Territories
23. Resolution 322 – Standards in Cultural Humility Training Within Medical Education
24. Resolution 309 – Decreasing Bias in Evaluations of Medical Student Performance
25. Resolution 316 – Providing Transparent and Accurate Data Regarding Students and Faculty at Medical Schools
26. Resolution 310 – Support for Standardized Interpreter Training
27. Resolution 315 – Modifying Eligibility Criteria for the Association of American Medical Colleges' Financial Assistance Program
28. Council on Medical Education Report 2 – An Update on Continuing Board Certification
29. Council on Medical Education Report 6 – Clinical Applications of Pathology and Laboratory Medicine for Medical Students, Residents and Fellows
30. *Resolution 318 – CME for Preceptorship*
31. Resolution 319 – Senior Living Community Training for Medical Students and Residents
32. *Resolution 324 – Sexual Harassment Accreditation Standards for Medical Training Programs*
33. Resolution 327 – Leadership Training Must Become an Integral Part of Medical Education

Items in *italics* were placed on the Reaffirmation Consent Calendar. At the beginning of this hearing, the chair will identify those items that were not extracted and therefore will not be discussed in this hearing.

Amendments and supplemental material for Reference Committee C **must** be sent to meded@ama-assn.org.

Links to related information:

- Zoom link to hearing (view only webinar) <https://zoom.us/j/94829800676>
- Handbook and addendum <https://www.ama-assn.org/system/files/a22-handbook-ref-cmte-c-addendum.pdf>
- Online members forum <https://www.ama-assn.org/forums/house-delegates/ref-comm-c>
- Preliminary document of online testimony <https://www.ama-assn.org/system/files/a22-ref-cmte-c-preliminary-doc.pdf>

For technical assistance, contact HODMeetingSupport@ama-assn.org or 800-337-1599.

ORDER OF BUSINESS

Reference Committee D (June 2022 Meeting)
Ankush Kumar Bansal, MD, Chair

June 11, 2022
1 – 5:30 pm CT

Riverside East
Zoom link below (view only)

1. Board of Trustees Report 15 – Addressing Public Health Disinformation
2. Council on Science and Public Health Report 1 – Sunset Review of 2012 House Policies
3. Council on Science and Public Health Report 2 – Transformation of Rural Community Public Health Systems
4. Resolution 413 – Expansion on Comprehensive Sexual Health Education
5. *Resolution 409 – Increasing HPV Vaccination Rates in Rural Communities*
6. Resolution 421 – Screening for HPV-Related Anal Cancer
7. Resolution 411 – Anonymous Prescribing Option for Expedited Partner Therapy
8. Resolution 406 – COVID-19 Preventive Measures for Correctional Facilities: AMA Policy Position
9. Resolution 404 – Weapons in Correctional Healthcare Settings
10. Resolution 407 – Study of Best Practices for Acute Care of Patients in the Custody of Law Enforcement or Corrections
11. Resolution 431 – Protections for Incarcerated Mothers and Infants in the Perinatal Period
12. Resolution 416 – School Resource Officer Violence De-Escalation Training and Certification
13. Resolution 441 – Addressing Adverse Effects of Active Shooter Drills on Children's Health
14. Resolution 436 – Training and Reimbursement for Firearm Safety Counseling
15. Resolution 408 – Supporting Increased Research on Implementation of Nonviolent De-escalation Training and Mental Illness Awareness in Law Enforcement
Resolution 419 – Advocating for the Utilization of Police and Mental Health Care Co-Response Teams for 911 Mental Health Emergency Calls
16. Resolution 423 – Awareness Campaign for 988 National Suicide Prevention Lifeline
Resolution 425 – Mental Health Crisis
17. *Resolution 426 – Mental Health First Aid Training*
18. Resolution 410 – Increasing Education for School Staff to Recognize Prodromal Symptoms of Schizophrenia in Teens and Young Adults to Increase Early Intervention
19. Resolution 442 – Opposing the Censorship of Sexuality and Gender Identity Discussions in Public Schools

Items in *italics* were placed on the Reaffirmation Consent Calendar. At the beginning of this hearing, the chair will identify those items that were not extracted and therefore will not be discussed in this hearing

Zoom link to hearing (view only webinar) <https://zoom.us/j/96449541183>

During the reference committee hearing, supplemental material may be sent to ReferenceCommitteeD@gmail.com. Supplemental material includes items that have been referenced in testimony such as alternative wording, proposed amendments, and supporting documents. This email address is NOT intended as a means to provide testimony, which should be only be presented in on the Online Forum or orally to the committee. This address is only operational for the duration of the reference committee hearing.

20. Resolution 443 – Addressing the Longitudinal Healthcare Needs of American Indian Children in Foster Care
21. Resolution 432 – Recognizing Loneliness as a Public Health Issue
22. Resolution 401 – Air Quality and the Protection of Citizen Health
Resolution 437 – Air Pollution and COVID: A Call to Tighten Regulatory Standards for Particulate Matter
23. Resolution 420 – Declaring Climate Change a Public Health Crisis
Resolution 430 – Longitudinal Capacity-Building to Address Climate Action and Justice
24. Resolution 438 – Informing Physicians, Health Care Providers, and the Public of the Health Dangers of Fossil-Fuel Derived Hydrogen
25. Resolution 439 – Informing Physicians, Health Care Providers, and the Public that Cooking with a Gas Stove Increases Household Air Pollution and the Risk of Childhood Asthma
26. Resolution 424 – Physician Interventions Addressing Environmental Health and Justice
27. Resolution 440 - Addressing Social Determinants of Health Through Health IT
28. Resolution 434 – Support for Pediatric Siblings of Chronically Ill Children
29. Resolution 428 – Amending H-90.968 to Expand Policy on Medical Care of Persons with Disabilities
30. Resolution 402 – Support for Impairment Research
31. *Resolution 403 – Addressing Maternal Discrimination and Support for Flexible Family Leave*
32. Resolution 405 – Universal Childcare and Preschool
33. Resolution 412 – Advocating for the Amendment of Chronic Nuisance Ordinances
34. Resolution 414 – Improvement of Care and Resource Allocation for Homeless Persons in the Global Pandemic
35. Resolution 422 – Voting as a Social Determinant of Health
36. Resolution 433 – Support for Democracy
37. Resolution 418 – Lung Cancer Screening Awareness
38. Resolution 417 – Tobacco Control
39. Resolution 427 – Pictorial Health Warnings on Alcoholic Beverages
40. Resolution 415 – Creation of an Obesity Task Force
41. Resolution 435 – Support Removal of BMI as a Standard Measure in Medicine and Recognizing Culturally-Diverse and Varied Presentations of Eating Disorders
42. Resolution 429 – Increasing Awareness and Reducing Consumption of Food and Drink of Poor Nutritional Quality
43. Late 1001 – National Emergency Cardiac Care Resolution – The Need for STEMI, OHCA and Shock Centers of Excellence

Items in *italics* were placed on the Reaffirmation Consent Calendar. At the beginning of this hearing, the chair will identify those items that were not extracted and therefore will not be discussed in this hearing

Zoom link to hearing (view only webinar) <https://zoom.us/j/96449541183>

During the reference committee hearing, supplemental material may be sent to ReferenceCommitteeD@gmail.com. Supplemental material includes items that have been referenced in testimony such as alternative wording, proposed amendments, and supporting documents. This email address is NOT intended as a means to provide testimony, which should be only be presented in on the Online Forum or orally to the committee. This address is only operational for the duration of the reference committee hearing.

ORDER OF BUSINESS

Reference Committee F (A-22)
David J. Bensema, MD, Chair

June 11, 2022
Grand Ballroom

Hyatt Regency Chicago
Chicago

FINANCIAL

1. Board of Trustees Report 1 - Annual Report
2. Board of Trustees Report 4 - AMA 2023 Dues
3. Compensation Committee Report - Report of the House of Delegates Committee on the Compensation of the Officers

MEMBERSHIP

4. Board of Trustees Report 16 - Language Proficiency Data of Physicians in the AMA Masterfile
5. Resolution 612 - Identifying Strategies for Accurate Disclosure and Reporting of Racial and Ethnic Data Across the Medical Education Continuum and Physician Workforce

GOVERNANCE

6. Board of Trustees Report 11 - Procedure for Altering the Size or Composition of Section Governing Councils
7. Resolution 615 - Anti-Harassment Training
8. Resolution 621 - Establish a Task Force to Preserve the Patient-Physician Relationship when Evidence-based, Appropriate Care is Banned or Restricted

HOUSE OF DELEGATES

9. Board of Trustees Report 20 - Delegate Apportionment and Pending Members
10. Resolution 618 - Extending the Delegate Apportionment Freeze During COVID-19 Pandemic
11. Council on Constitution and Bylaws / Council on Long Range Planning and Development Report 1 - Joint Council Sunset Review of 2012 House Policies
12. Resolution 608 - Transparency of Resolution Fiscal Notes
13. Resolution 609 - Surveillance Management System for Organized Medicine Policies and Reports
14. Resolution 611 - Continuing Equity Education
15. Resolution 614 - Allowing Virtual Interviews on Non-Holiday Weekends for Candidates for AMA Office

Note: Items in italics were originally placed on the reaffirmation consent calendar, were recommended against consideration, or were late items. At the beginning of the reference committee hearing, the chair will identify those items that will not be discussed in the hearing, and these items will NOT be considered by the reference committee.

Throughout the reference committee hearing, supplemental materials should be sent to referencecommitteef@gmail.com. Supplemental material includes items that have been referenced in testimony such as alternative wording, proposed amendments, supporting documents, and the like. This email address is not intended as a means to provide testimony, which should be presented orally to the committee, and will only accept supplemental material for the duration of the reference committee hearing.

This Reference Committee F hearing will be broadcast as a view only webinar at <https://zoom.us/j/98461190469>.

16. *Resolution 617 - Study a Need-Based Scholarship to Encourage Medical Student Participation in the AMA*
17. Resolution 610 - Making AMA Meetings Accessible
18. Resolution 622 - HOD Modernization
19. Resolution 623 – Virtual Attendance at AMA Meetings
20. Resolution 613 - Timing of Board Report on Resolution 605 from N-21 Regarding a Permanent Resolution Committee
21. Resolution 619 - Focus and Priority for the AMA House of Delegates

MEDICAL PRACTICE

22. Resolution 601 - Development of Resources on End-of-Life Care
23. Resolution 602 - Report on the Preservation of Independent Medical Practice
24. Resolution 606 - Financial Impact and Fiscal Transparency of the American Medical Association Current Procedural Terminology® System
25. *Resolution 620 - Review of Health Insurance Companies and Their Subsidiaries' Business Practices*

ENVIRONMENTAL

26. Resolution 605 - Fulfilling Medicine's Social Contract with Humanity in the Face of the Climate Health Crisis
27. Resolution 607 - AMA Urges Health and Life Insurers to Divest of Investments of Fossil Fuels

MISCELLANEOUS

28. Resolution 603 - September 11th as a National Holiday
29. Resolution 604 - UN International Radionuclide Therapy Day Recognition
30. Resolution 624 - Creation of United Nations "Dr. Saul Hertz Theranostic Nuclear Medicine" International Day
31. Resolution 616 - Medical Student, Resident/Fellow, and Physician Voting in Federal, State and Local Elections
32. Resolution 625 - AMA Funding of Political Candidates who Oppose Research-Backed Firearm Regulations

ORDER OF BUSINESS

Reference Committee G (A-22)
Brandi Ring, MD, Chair

June 11, 2022
Grand Hall I/J

Hyatt Regency Chicago
Chicago, IL

1. Board of Trustees Report 18 – Addressing Inflammatory and Untruthful Online Ratings
2. Council on Medical Service Report 1 – Council on Medical Service Sunset Review of 2012 Policies
3. Council on Medical Service Report 2 – Prospective Payment Model Best Practices for Independent Private Practice
4. Council on Medical Service Report 5 – Poverty-Level Wages and Health
5. *Resolution 701 – Appeals and Denials – CPT Codes for Fair Compensation*
Resolution 710 – Appeals and Denials – CPT Codes for Fair Compensation
Resolution 715 – Prior Authorization – CPT Codes for Fair Compensation
Resolution 725 – Compensation to Physicians for Authorizations and Preauthorizations
6. *Resolution 702 – Health System Consolidation*
7. Resolution 703 – Mandating Reporting of All Antipsychotic Drug Use in Nursing Home Residents
8. *Resolution 704 – Employed Physicians Contracts*
9. Resolution 705 – Fifteen Month Lab Standing Orders
10. *Resolution 706 – Government Imposed Volume Requirements for Credentialing*
11. *Resolution 707 – Insurance Coverage for Scalp Cooling (Cold Cap) Therapy*
12. *Resolution 708 – Physician Burnout is an OSHA Issue*
13. *Resolution 709 – Physician Well-Being as an Indicator of Health System Quality*
14. *Resolution 711 – Reducing Prior Authorization Burden*
Resolution 714 – Prior Authorization Reform for Specialty Medications

Amendments and supplemental materials MUST be sent to RefComG2022@gmail.com. Please include the Resolution or Report number in the subject line. Do not send testimony to this email address. This address is only operational for the duration of the Reference Committee G hearing.

Note: Items in italics were originally placed on the reaffirmation consent calendar or were late items. At the beginning of the reference committee hearing, the chair will identify those items that will not be discussed in the hearing, and these items will not be considered by the reference committee.

A Zoom webinar link is provided here <https://zoom.us/j/94817746394>. This link is view-only. Testimony cannot be accepted via Zoom.

Resolution 719 – System-Wide Prior and Post-Authorization Delays and Effects on Patient Care Access

15. *Resolution 712 – The Quadruple Aim – Promoting Improvement in the Physician Experience Providing Care*
16. *Resolution 713 – Enforcement of Administrative Simplification Requirements – CMS*
17. Resolution 716 – Discharge Summary Reform
18. Resolution 717 – Expanding the AMA’s Study on the Economic Impact of COVID-19
19. *Resolution 718 – Degradation of Medical Records*
20. *Resolution 720 – Mitigating the Negative Impact of Step Therapy Policies and Nonmedical Switching of Prescription Drugs on Patient Safety*
21. Resolution 721 – Amend AMA Policy H-215.981, “Corporate Practice of Medicine”
22. *Resolution 722 – Eliminating Claims Data for Measuring Physician and Hospital Quality*
23. *Resolution 723 – Physician Burnout*
24. Resolution 724 – Ensuring Medical Practice Viability through Reallocation of Insurance Savings during the COVID-19 Pandemic
25. Resolution 726 – Payment for the Cost of Electronic Prescription of Controlled Substances and Compensation for Time Spent Engaging State Prescription Monitoring Programs
26. Resolution 727 – Utilization Review, Medical Necessity Determination, Prior Authorization Decisions
27. Resolution 728 – Maintaining an Open and Equitable Hospital Work Environment for Specialists
Resolution 730 – Maintaining an Open and Equitable Hospital Work Environment for Specialists
28. Resolution 729 – Protecting Physicians Wellbeing on Board Certification Applications

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29. Resolution 731 – Prior Authorization Patient Autonomy
30. Resolution 732 – Advocacy of Private Practice Options for Healthcare Operations in Large Corporations

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Reference Committee on Amendments to Constitution and Bylaws

BOT Report(s)

- 02 New Specialty Organizations Representation in the House of Delegates
- 13 Use of Psychiatric Advance Directives
- 14 Amendment to Truth and Transparency in Pregnancy Counseling Centers, H-420.954
- 21 Opposition to Requirements for Gender-Based Treatments for Athletes
- 22# Nonconsensual Audio/Video Recording at Medical Encounters
- 23# Specialty Society Representation in the House of Delegates

CC&B Report(s)

- 01 Clarification to the Bylaws: Delegate Representation

CEJA Report(s)

- 01 Short-Term Medical Service Trips
- 02 Amendment to Opinion 10.8, Collaborative Care
- 03 Amendment to E-9.3.2, Physician Responsibilities to Colleagues with Illness, Disability or Impairment
- 04 CEJA's Sunset Review of 2012 House Policies

Resolution(s)

- 001 Increasing Public Umbilical Cord Blood-Donations in Transplant Centers
- 002 Opposition to Discriminatory Treatment of Haitian Asylum Seekers
- 003 Gender Equity and Female Physician Work Patterns During the Pandemic
- 004 Recognizing LGBTQ+ Individuals as Underrepresented in Medicine
- 005 Supporting the Study of Reparations as a Means to Reduce Racial Inequalities
- 006 Combating Natural Hair and Cultural Headwear Discrimination in Medicine and Medical Professionalism
- 007 Equal Access for Adoption in the LGBTQ Community
- 008 Student-Centered Approaches for Reforming School Disciplinary Policies
- 009 Privacy Protection and Prevention of Further Trauma for Victims of Distribution of Intimate Videos and Images Without Consent
- 010 Improving the Health and Safety of Sex Workers
- 011 Evaluating Scientific Journal Articles for Racial and Ethnic Bias
- 012 Expanding the Definition of Iatrogenic Infertility to Include Gender Affirming Interventions
- 013 Recognition of National Anti-Lynching Legislation as a Public Health Initiative
- 014* Healthcare Equity Through Informed Consent and a Collaborative Healthcare Model for the Gender Diverse Population
- 015* Increasing Mental Health Screenings by Refugee Resettlement Agencies and Improving Mental Health Outcomes for Refugee Women
- 016* Addressing and Banning Unjust and Invasive Medical Procedures Among Migrant Women at the Border
- 017* Humanitarian and Medical Aid Support to Ukraine
- 018* Hardship for International Medical Graduates from Russia and Belarus
- 019* Hardship for International Medical Graduates from Ukraine
- 020* Council on Ethical and Judicial Affairs Guidelines for Treating Unvaccinated Individuals
- 021* National Cancer Research Patient Identifier
- 022* Organ Transplant Equity for Persons with Disabilities
- 023* 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
- 024* Pharmaceutical Equity for Pediatric Populations

* contained in the Handbook Addendum

contained in the Saturday Tote

Reference Committee on Amendments to Constitution and Bylaws

Resolution(s)

- 025* Use of Social Media for Product Promotion and Compensation
- 026# Establishing Ethical Principles for Physicians Involved in Private Equity Owned Practices
- 027# Protecting Access to Abortion and Reproductive Healthcare
- 028# Preserving Access to Reproductive Health Services

** contained in the Handbook Addendum*

contained in the Saturday Tote

Reference Committee A

CMS Report(s)

- 03 Preventing Coverage Losses After the Public Health Emergency Ends
- 04 Parameters of Medicare Drug Price Negotiation

Resolution(s)

- 101 Fertility Preservation Benefits for Active-Duty Military Personnel
- 102 Bundling Physician Fees with Hospital Fees
- 103 COBRA for College Students
- 104 Consumer Operated and Oriented Plans (CO-OPs) as a Public Option for Health Care Financing
- 105 Health Insurance that Fairly Compensates Physicians
- 106 Hospice Recertification for Non-Cancer Diagnosis
- 107 Medicaid Tax Benefits
- 108 Payment for Regadenoson (Lexiscan)
- 109 Piloting the Use of Financial Incentives to Reduce Unnecessary Emergency Room Visits
- 110 Private Payor Payment Integrity
- 111 Bundled Payments and Medically Necessary Care
- 112 Support for Easy Enrollment Federal Legislation
- 113 Prevention of Hearing Loss-Associated-Cognitive-Impairment Through Earlier Recognition and Remediation
- 114 Oral Healthcare IS Healthcare
- 115 Support for Universal Internet Access
- 116 Reimbursement of School-Based Health Centers
- 117 Expanding Medicaid Transportation to Include Healthy Grocery Destinations
- 118 Caps on Insulin Co-Payments for Patients with Insurance
- 119 Medicare Coverage of Dental, Vision and Hearing Services
- 120 Expanding Coverage for and Access to Pulmonary Rehabilitation
- 121 Increase Funding, Research and Education for Post-Intensive Care Syndrome
- 122 Medicaid Expansion
- 123 Advocating for All Payer Coverage of Cosmetic Treatment for Survivors of Domestic Abuse and Intimate Partner Violence
- 124 To Require Insurance Companies Make the "Coverage Year" and the "Deductible Year" Simultaneous for Their Policies
- 125 Education, Forewarning and Disclosure Regarding Consequences of Changing Medicare Plans
- 126* Providing Recommended Vaccines Under Medicare Parts B and C
- 127* Continuity of Care Upon Release from Correctional Systems
- 128# Improving Access to Vaccinations for Patients

* contained in the Handbook Addendum

contained in the Saturday Tote

Reference Committee B

BOT Report(s)

- 09 Council on Legislation Sunset Review of 2012 House Policies
- 17 Expungement, Destruction, and Sealing of Criminal Records for Legal Offenses Related to Cannabis Use or Possession

Resolution(s)

- 201 The Impact of Midlevel Providers on Medical Education
- 202 AMA Position on All Payer Database Creation
- 203 Ban the Gay/Trans (LGBTQ+) Panic Defense
- 204 Insurance Claims Data
- 205 Insurers and Vertical Integration
- 206 Medicare Advantage Plan Mandates
- 207 Physician Tax Fairness
- 208 Prohibit Ghost Guns
- 209 Supporting Collection of Data on Medical Repatriation
- 210 Reducing the Prevalence of Sexual Assault by Testing Sexual Assault Evidence Kits
- 211 Repeal or Modification of the Medicare Appropriate Use Criteria (AUC) Program
- 212 Medication for Opioid Use Disorder in Physician Health Programs
- 213 Resentencing for Individuals Convicted of Marijuana-Based Offenses
- 214 Eliminating Unfunded or Unproven Mandates and Regulations
- 215 Transforming Professional Licensure to the 21st Century
- 216 Advocating for the Elimination of Hepatitis C Treatment Restrictions
- 217 Preserving the Practice of Medicine
- 218 Expedited Immigrant Green Card Visa for J-1 Visa Waiver Physicians Serving in Underserved Areas
- 219 Due Process and Independent Contractors
- 220 Vital Nature of Board-Certified Physicians in Aerospace Medicine
- 221* WITHDRAWN
- 222* To Study the Economic Impact of Mid-Level Provider Employment in the United States of America
- 223* National Drug Shortages of Lidocaine and Saline Preparations
- 224* HPSA and MUA Designation for SNFs
- 225* Public Listing of Medical Directors for Nursing Facilities
- 226* Coverage for Clinical Trial Ancillary Costs
- 227* Supporting Improvements to Patient Data Privacy
- 228* Expanded Child Tax Credit
- 229* Expedited Immigrant Green Card for J-1 Visa Waiver Physicians Serving in Underserved Areas
- 230* Advancing the Role of Outdoor Recreation in Public Health
- 231* Amending Policy H-155.955, "Increasing Accessibility to Incontinence Products to Include Diaper Tax Exemption"
- 232* Expansion of Epinephrine Entity Stocking Legislation
- 233* Support for Warning Labels on Firearm Ammunition Packaging
- 234* Updating Policy on Immigration Laws, Rules, Legislation, and Health Disparities
- 235* Improving the Veterans Health Administration Referrals for Veterans for Care Outside the VA System
- 236* Out-of-Network Care
- 237* Prescription Drug Dispensing Policies

* contained in the Handbook Addendum

contained in the Saturday Tote

Reference Committee B

Resolution(s)

- 238* COVID-19 Economic Injury Disaster Loan (EIDL) Forgiveness for Physician Groups of Five or Fewer Physicians
- 239* Virtual Services When Patients Are Away From Their Medical Home
- 240* Physician Payment Reform and Equity
- 241* Unmatched Graduate Physician Workforce
- 242* Public Awareness and Advocacy Campaign to Reform the Medicare Physician Payment System
- 243* Appropriate Physician Payment for Office-Based Services
- 244* Prohibit Reversal of Prior Authorization
- 245# Definition and Encouragement of the Appropriate Use of the Word "Physician"
- 246# Further Action to Respond to the Gun Violence Public Health Crisis
- 247# Recognizing Child Poverty and the Racial Wealth Gap as Public Health Issues and Extending the Child Tax Credit for Low-Income Families
- 248# Promoting Proper Oversight and Reimbursement for Specialty Physician Extenders and Non-Physician Practitioners
- 249# Clarification of Healthcare Physician Identification: Consumer Truth & Transparency
- 250# Opposition to Criminalization of Physicians' Medical Practice
- 251# Physician Medical License Use in Clinical Supervision
- 252# The Criminalization of Health Care Decision Making and Practice
- 253# Physician Payment Reform & Equity
- 254# Stakeholder Engagement in Medicare Administrative Contractor Policy Processes

* contained in the Handbook Addendum

contained in the Saturday Tote

Reference Committee C

CME Report(s)

- 01 Council on Medical Education Sunset Review of 2012 House Policies
- 02 An Update on Continuing Board Certification
- 03 Onsite and Subsidized Childcare for Medical Students, Residents and Fellows
- 04 Protection of Terms Describing Physician Education and Practice
- 05 Education, Training and Credentialing of Non-Physician Health Care Providers and Their Impact on Physician Education and Training
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- 238* COVID-19 Economic Injury Disaster Loan (EIDL) Forgiveness for Physician Groups of Five or Fewer Physicians
- 329* Use of the Terms "Residency" and "Fellowship" by Health Professionals Outside of Medicine
- 619* Focus and Priority for the AMA House of Delegates
- 724* Ensuring Medical Practice Viability Through Reallocation of Insurance Savings During the COVID-19 Pandemic
- 725* Compensation to Physicians for Authorizations and Preauthorizations
- 726* Payment for the Cost of Electronic Prescription of Controlled Substances and Compensation for Time Spent Engaging State Prescription Monitoring Programs
- 727* Utilization Review, Medical Necessity Determination, Prior Authorization Decisions

UNDERSEA AND HYPERBARIC MEDICAL SOCIETY

- 516* Oppose "Mild Hyperbaric" Facilities from Delivering Unsupported Clinical Treatments
- 517* Safeguard the Public from Widespread Unsafe Use of "Mild Hyperbaric Oxygen Therapy"

WEHRI, DELEGATE

- 240* Physician Payment Reform and Equity

WOMEN PHYSICIANS SECTION

- 003 Gender Equity and Female Physician Work Patterns During the Pandemic
- 014* Healthcare Equity Through Informed Consent and a Collaborative Healthcare Model for the Gender Diverse Population
- 015* Increasing Mental Health Screenings by Refugee Resettlement Agencies and Improving Mental Health Outcomes for Refugee Women
- 016* Addressing and Banning Unjust and Invasive Medical Procedures Among Migrant Women at the Border
- 221* WITHDRAWN
- 303 Fatigue Mitigation Respite for Faculty and Residents
- 403 Addressing Maternal Discrimination and Support for Flexible Family Leave

YOUNG PHYSICIANS SECTION

- 001 Increasing Public Umbilical Cord Blood-Donations in Transplant Centers
- 101 Fertility Preservation Benefits for Active-Duty Military Personnel
- 501 Marketing Guardrails for the "Over-Medicalization" of Cannabis Use
- 622# HOD Modernization

* contained in the Handbook Addendum

contained in the Saturday Tote

Report of the AMPAC Board of Directors

Presented by: Stephen Imbeau, MD
 Chair

On behalf of the AMPAC Board of Directors, I am pleased to present this report to the House of Delegates regarding our activities this election cycle. Over the past two years, the COVID-19 pandemic has continually stressed the already struggling health care system in our country leading to unprecedented pressure on physician practices and their patients. As the country slowly turns the corner on the pandemic, these stressors still pose a massive challenge to our health care system. Issues like time consuming prior authorizations, loss of expanded telehealth coverage and looming cuts to physician Medicare payments remain as major roadblocks to how physicians provide quality care for their patients. The hardships faced by the medical community these past two years have only strengthened our commitment to our mission - to provide physicians with opportunities to support candidates for federal office who have demonstrated their support for organized medicine through a willingness to work with physicians to strengthen our ability to care for America's patients. In addition, we continue to help physician advocates grow their abilities through our political education programs, which include intensive training sessions that provide them with all the tools necessary to successfully take the next step and work on campaigns or run for office themselves.

AMPAC Membership Fundraising

Thank you to the House of Delegate members who have given to AMPAC in 2022, especially those at the Capitol Club levels. Your support during this midterm election year provides the necessary resources so the AMA can carry out its advocacy mission while helping AMPAC elect medicine-friendly candidates to federal office.

This year, AMPAC has begun pulling out of the haze of pandemic fundraising and into a positive transition period of growth for AMPAC membership across many areas. AMPAC has raised a combined total \$1,284,877 in hard and corporate funds for the 2022 election cycle. AMPAC's hard dollar receipts are up by 18 percent over last year and corporate receipts are up 45 percent. Additionally, AMPAC's Capitol Club continues to show solid growth over the last several months with a 5 percent increase in membership with 533 members and this growth is expected to continue during this meeting.

Each year AMPAC strives to hit 100 percent AMPAC participation within AMA's House of Delegates. AMPAC ended 2021 with only 55 percent HOD participation and currently participation stands at 38 percent which is well below where AMPAC should be during an important election year. There are many HOD members who have not physically attended an AMA meeting due to the pandemic, and as the leaders in the House of Medicine we strongly encourage members in their HOD leadership role to invest in AMPAC by stopping by AMPAC's Booth which is located in the foyer outside the Grand Ballroom during this meeting or by visiting <https://www.ampaconline.org/>

Finally, all current 2022 Capitol Club members are invited to attend a Capitol Club event on Tuesday, June 14 at 12 p.m. with special guest Mara Liasson, a well-respected political correspondent for NPR and Fox News contributor. There will be safety measures in place during this event such as additional tables spaced out with fewer seats at each table as a precaution to protect attendees so they can participate safely in the event in addition to the AMA's Health & Safety Masking policy which will be utilized as well.

We can only be as effective as we are united in our efforts to support our own advocacy mission and we hope to count on the support of HOD members during this meeting to boost overall AMPAC HOD participation

Political Action

The 2022 electoral landscape has come into better focus since the first of the year and the political season is well underway. All states have approved new Congressional maps ahead of midterm elections now less than six months away and AMPAC is keeping step as a key player to ensure medicine's interests stay at the forefront of the national debate. In February, the AMPAC Board completed its Congressional Review Committee budgeting process. Since then, staff have been working diligently with the AMA government affairs unit as well as partners in state medical societies to identify the best opportunities for AMPAC to support those champions of medicine and other members of Congress in key positions to advance the issues most critical to physicians and their patients. As of the writing of this report, AMPAC has invested over half a million dollars in the 2022 elections and expects activities will intensify as November fast approaches. While uncertainty remains for some states and congressional districts, early AMPAC contributions to U.S. House and Senate incumbents most important to advancing medicine's agenda, including lawmakers in leadership roles and/or on key legislative committees, are helping move the needle on issues such as telemedicine, prior authorization and MACRA. In other races where congressional district boundaries are still unclear or the field of candidates remains unsettled, AMPAC waits for the dust to settle but remains vigilant and ready to take advantage of opportunities to assist friends of medicine.

Political Education Programs

Over the course of two weekends in March, physicians, medical students, and physician spouses from across the country took part in the 2022 Candidate Workshop held virtually due to the ongoing COVID-19 pandemic. During the program, nineteen participants heard from a bipartisan group of political experts on a wide range of topics including: the importance of a disciplined campaign plan and messaging, the secrets of effective fundraising, what kinds of advertising may be right for your campaign, how to leverage the media as well as how to build an effective campaign team and grassroots organization. U.S. Representative Mariannette Miller-Meeks, MD (R, IA-2), a former program graduate, was the keynote speaker and AMPAC is happy to report that the virtual program received high marks from participants, a few of whom have since announced their run for public office this cycle.

After two years of hosting the political education programs virtually, AMPAC is excited to announce that the 2022 Campaign School is scheduled to be held in-person September 29 – October 2 at the AMA offices in Washington, DC. The Campaign School is renowned for its use of a simulated campaign for the U.S. House of Representatives, complete with demographics, voting statistics and detailed candidate biographies. During the three-day program participants will be placed into campaign teams and with a hands-on approach, our team of political experts will walk them through the simulated campaign and will apply what they learn in real-time exercises on strategy, vote targeting, social media, paid advertising, and public speaking. Insider tactics will be taught by experts on both sides of the political spectrum. The in-person program will follow all AMA safety protocols to ensure the safety of participants and staff. As always, the political education programs remain a member benefit with registration fees heavily discounted for AMA members. Registration will open soon on AMPAConline.org.

Conclusion

On behalf of the AMPAC Board of Directors, I would like to thank all members of the House of Delegates who support AMPAC and the work we do. Your continued involvement in political and grassroots activities ensures organized medicine a powerful voice in Washington, DC.

AMERICAN MEDICAL ASSOCIATION House of Delegates

Memorial Resolution

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.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Memorial Resolution

Joseph M. Heyman, MD

Introduced by the Private Practice Physician 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.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Memorial Resolution

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, M.D 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.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Memorial Resolution

Preston J. Phillips, MD, FAAOS

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.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 22-A-22

Subject: Nonconsensual Audio/Video Recording at Medical Encounters
(Resolution 007-June-21)

Presented by: Bobby Mukkamala, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Resolution 007-June-21, “Nonconsensual Audio/Video Recording at Medical Encounters,” sponsored by
2 the Virginia, New Jersey, District of Columbia, and Maryland Delegations along with the America
3 Association of Clinical Urologists and the American Urological Association, was referred by the House
4 of Delegates. Resolution 007 asks our AMA to:

5
6 [E]ncourage that any audio or video recording made during a medical encounter should require both
7 physician and patient notification and consent.
8

9 NONCONSENSUAL RECORDING AND STATE RECORDING LAWS

10
11 Recording patient-physician encounters without the consent of one of the parties is of long-standing
12 concern both ethically and legally and such nonconsensual recording has received increased attention in
13 recent years. New technology—such as smartphones—has made recordings easier and “more
14 commonplace” [1]. Recording an interaction with their physician can offer benefits for patients. For
15 example, it can provide a convenient way to recall and better understand their information or to share
16 information more accurately with caregivers [2]. However, from the physician’s perspective recordings
17 also raise concerns “about the ownership of recordings and the potential for these to be used as a basis for
18 legal claims or complaints” [1]. Hence, many physicians worry that covert recordings could breach trust
19 and harm the patient-physician relationship and have looked to the law for protection. Laws in the United
20 States regarding recordings are “complex” and “vary at the state level” [1]. Some state laws require only
21 one party to a conversation to give consent to record a conversation, while some require all parties to
22 consent [1]. “All parties” jurisdictions are in the minority: only 11 states require all parties to a
23 conversation consent to recording in order for such recording to be lawful [3].
24

25 The use of virtual medical scribes, who are not physically present with the patient and physician, creates a
26 context in which similar concerns may arise since scribes have remote audio or audiovisual access to the
27 patient-physician interaction [4,5]. There is a relative paucity of data regarding patient perceptions or
28 concerns in this area, but little to suggest that patients object to or are distrustful of virtual scribes [6],
29 despite early concerns [7], as long as they are aware their visit is being observed or recorded remotely.
30 Physicians are not uniformly required to notify patients that they use virtual scribes or obtain patient
31 consent, but patient advocacy organizations encourage patients to discuss privacy concerns with their
32 physician [8]. Guidelines established by the Joint Commission in 2011 require that virtual scribes
33 employed by JC-accredited entities “meet all requirements of information management, HIPAA,
34 HITECH, confidentiality and patient rights standards just as any other hospital personnel” [9]. Emerging
35 augmented intelligence (AI) enabled scribe services (“digital scribes”) that utilize deep learning protocols
36 and natural language processing to capture information for the medical record raise similar concerns, and
37 are subject to similar responsibilities with respect to the security and confidentiality of personal health
38 information [10].

1 AMA HOUSE POLICY AND ADVOCACY EFFORTS
2

3 At its 2018 meeting, the House of Delegates adopted Resolution 232-A-18, “Recording Law Reform,”
4 which called on AMA to “draft model state legislation requiring consent of all parties to the recording of
5 a patient-physician conversation.” Resolution 232, sponsored by the Oklahoma Delegation, noted in its
6 rationale that “[r]ecording in a public part of a doctor’s office could violate other patients’ privacy while
7 making a recording in secret could both lead to a fundamental breach in the trust relationship between the
8 health professional and the patient.”
9

10 This resolution was implemented by amending existing AMA Policy [H-315.983](#), “Patient Privacy and
11 Confidentiality,” to incorporate the language adopted by the HOD as a new provision of policy. In 2019,
12 AMA Advocacy staff prepared model legislation in the “Patient-Physician Encounter Recording Reform
13 Act,” which mandates consent of all parties to any recording of a communication between a physician and
14 patient [Appendix I]. The model act states that it shall be unlawful for a person to:

15 1. Obtain or attempt to obtain the whole or any part of a conversation, telecommunication, or other
16 oral communication between a physician and patient by means of any device, contrivance,
17 machine or apparatus, whether electrical, mechanical, manual or otherwise, if:
18
19 a. a patient-physician relationship has been established between the patient and physician, and
20 b. not all participants in the conversation have given consent to being recorded.

24 AMA ETHICS POLICY
25

26 The AMA *Code of Medical Ethics* provides guidance on recording patient-physician interactions in two
27 specific contexts: for purposes of educating health care professionals ([Opinion 3.1.3](#), “Audio or Visual
28 Recording Patients for Education in Health Care”) and for purposes of public education ([Opinion E-3.1.4](#),
29 “Audio or Visual Recording of Patients for Public Education”). This guidance notes that in neither case is
30 recording intended to benefit the patient and underscores the importance of protecting patient privacy and
31 of obtaining informed consent from the patient (or surrogate) for any recording. Guidance further
32 observes that recording creates a permanent record of personal patient information and may in some
33 instances be considered part of the medical record and subject to laws governing medical records.
34

35 Guidance elsewhere in the *Code* emphasizes the importance of trust in patient-physician relationships and
36 the need for candor between patient and physician ([Opinions 1.1.1](#), “Patient-Physician Relationship,” and
37 [1.1.4](#), “Patient Responsibilities,” respectively).

39 CONCLUSION
40

41 Like Resolution 232-A-18, Resolution 7-June-21 seeks to address concern that recording patient-
42 physician interactions, while potentially beneficial, also carries risks and may undermine the trust
43 essential to patient-physician relationships. They share the conviction that all parties should be aware
44 when recording is taking place and should consent to being recorded. Existing policy in [H-315.983](#) and
45 guidance in the *Code of Medical Ethics* address these issues and fulfill the intent of Resolution 7-June-21.

1 RECOMMENDATION

2

3 In consideration of the foregoing, your Board of Trustees recommends that Policy H-315.983, "Patient

4 Privacy and Confidentiality," be reaffirmed in lieu of Resolution 7-June-21 and the remainder of this

5 report be filed.

Fiscal Note: None

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1

2

3 **IN THE GENERAL ASSEMBLY STATE OF** _____

4

5 **Patient-Physician Encounter Recording Reform Act**

6

7 Be it enacted by the People of the State of _____, represented in the General Assembly:

8 **Section 1. Title.** This act shall be known as and may be cited as the "Patient-Physician Encounter
9 Recording Reform" Act.

10 **Section 2. Purpose.** The Legislature hereby finds and declares that:

11 1. The practice of medicine, and its embodiment in the clinical encounter between a patient
12 and a physician, is fundamentally a moral activity that arises from the imperative to care
13 for patients and to alleviate suffering;

14 2. The relationship that arises between a patient and a physician is based on trust, and is
15 intimate and sacred;

16 3. Physicians have an ethical obligation under the *AMA Code of Medical Ethics* to inform the
17 patient about audio or visual recording of the patient and obtain consent prior to the
18 recording;

19 4. Patients have no such obligation to obtain consent from the physician prior to recording;

20 5. Secret recordings of physician encounters by patients could lead to a fundamental breach in
21 the trust relationship between the physician and the patient;

22 6. Open communication about a patient's intent to record a conversation is essential to
23 preserve trust.

24 **Section 3. Prohibitions.** Except as otherwise provided in [reference state wiretapping
25 laws], it shall be unlawful for a person to:

1. Obtain or attempt to obtain the whole or any part of a conversation,
2 telecommunication, or other oral communication between a physician and patient
3 by means of any device, contrivance, machine or apparatus, whether electrical,
4 mechanical, manual or otherwise, if
 - 5 a. a patient-physician relationship has been established between the patient
6 and physician, and
 - 7 b. not all participants in the conversation have given consent to being
8 recorded;
- 9 2. Obtain the whole or any part of a conversation, telecommunication, or other oral
10 communication between a physician and patient from any person, while knowing
11 or having good reason to believe that the conversation, telecommunication or other
12 oral communication was initially obtained in a manner prohibited by this section;
- 13 3. Use or attempt to use, or divulge to others, any conversation, telecommunication or
14 other oral communication obtained by any means prohibited by this section.

15 **Section 4. Remedies.** Any person whose conversation, telecommunication or oral
16 communication is intercepted, disclosed, or used in violation of Section 3 shall have a civil
17 cause of action against any person who intercepts, discloses, or uses, or procures any other
18 person to intercept, disclose or use such communications, to enjoin a violation of Section 3
19 and be entitled to recover from any such person:

20 1. actual damages; and

21 2. reasonable attorney's fees and other litigation costs reasonably incurred.

22 **Section 5. Effective.** This Act shall become effective immediately upon being enacted into law.

1 **Section 6. Severability.** If any provision of this Act is held by a court to be invalid, such
2 invalidity shall not affect the remaining provisions of this Act, and to this end the provisions of this
3 Act are hereby declared severable.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 23-A-22

Subject: Specialty Society Representation in the House of Delegates -
Five-Year Review

Presented by: Bobby Mukkamala, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 The Board of Trustees (BOT) has completed its review of the specialty organizations seated in the
2 House of Delegates (HOD) scheduled to submit information and materials for the 2022 American
3 Medical Association (AMA) Annual Meeting in compliance with the five-year review process
4 established by the House of Delegates in Policy G-600.020, "Summary of Guidelines for
5 Admission to the House of Delegates for Specialty Societies," and AMA Bylaw 8.5, "Periodic
6 Review Process."

7
8 Organizations are required to demonstrate continuing compliance with the guidelines established
9 for representation in the HOD. Compliance with the five responsibilities of professional interest
10 medical associations and national medical specialty organizations is also required as set out in
11 AMA Bylaw 8.2, "Responsibilities of National Medical Specialty Societies and Professional
12 Interest Medical Associations."

13
14 The following organizations were reviewed for the 2022 Annual Meeting:

15
16 Academy of Physicians in Clinical Research
17 American Society for Reproductive Medicine
18 American Society of General Surgeons
19 American Society of Hematology
20 American Society of Transplant Surgeons
21 American Thoracic Society
22 College of American Pathologists
23 Congress of Neurological Surgeons
24 Eye and Contact Lens Association
25 International College of Surgeons – US Section
26 International Society of Hair Restoration Surgery
27 Society for Cardiovascular Angiography and Interventions
28 Society for Investigative Dermatology
29 United States and Canadian Academy of Pathology

30
31 Each organization was required to submit materials demonstrating compliance with the guidelines
32 and requirements along with appropriate membership information. A summary of each group's
33 membership data is attached to this report (Exhibit A). A summary of the guidelines for specialty
34 society representation in the AMA HOD (Exhibit B), the five responsibilities of national medical
35 specialty organizations and professional medical interest associations represented in the HOD
36 (Exhibit C), and the AMA Bylaws pertaining to the five-year review process (Exhibit D) are also
37 attached.

1 The materials submitted by the Academy of Physicians in Clinical Research, American Society for
2 Reproductive Medicine, American Thoracic Society, College of American Pathologists, Congress
3 of Neurological Surgeons, International College of Surgeons – US Section, Society for
4 Cardiovascular Angiography and Interventions, and the Society for Investigative Dermatology,
5 indicate the organizations meet all guidelines and are in compliance with the five-year review
6 requirements of specialty organizations represented in the HOD.

7
8 The materials submitted by American Society of General Surgeons, American Society of
9 Hematology, American Society of Transplant Surgeons, International Society of Hair Restoration
10 Surgery and United States and Canadian Academy of Pathology, indicate the organizations did not
11 meet all guidelines and are not in compliance with the five-year review requirements of specialty
12 organizations represented in the HOD.

13
14 The Eye and Contact Lens Association did not submit materials for the review but did submit a
15 letter ending the organizations involvement with the AMA.

16
17 RECOMMENDATIONS

18
19 The Board of Trustees recommends that the following be adopted, and the remainder of this report
20 be filed:

21
22 1. That the Academy of Physicians in Clinical Research, American Society for Reproductive
23 Medicine, American Thoracic Society, College of American Pathologists, Congress of
24 Neurological Surgeons, International College of Surgeons – US Section, Society for
25 Cardiovascular Angiography and Interventions, and the Society for Investigative
26 Dermatology, retain representation in the AMA House of Delegates. (Directive to Take
27 Action)

28
29 2. Having failed to meet the requirements for continued representation in the AMA House of
30 Delegates as set forth in AMA Bylaw B-8.5, the American Society of General Surgeons,
31 American Society of Hematology, American Society of Transplant Surgeons, International
32 Society of Hair Restoration Surgery and United States and Canadian Academy of
33 Pathology be placed on probation and be given one-year to work with AMA membership
34 staff to increase their AMA membership. (Directive to Take Action)

35
36 3. Having failed to meet the requirements for continued representation in the AMA House of
37 Delegates as set forth in AMA Bylaw B-8.5 the Eye and Contact Lens Association not
38 retain representation in the House of Delegates. (Directive to Take Action)

Fiscal Note: Less than \$500

APPENDIX***Exhibit A - Summary Membership Information***

Organization	AMA Membership of Organization's Total Eligible Membership
Academy of Physicians in Clinical Research	146 of 413 (35%)
American Society for Reproductive Medicine	487 of 2,073 (23%)
American Society of General Surgeons	15 of 39 (38%)
American Society of Hematology	963 of 6,741 (14%)
American Society of Transplant Surgeons	138 of 799 (17%)
American Thoracic Society	1,304 of 7,205 (18%)
College of American Pathologists	2,887 of 14,297 (20%)
Congress of Neurological Surgeons	773 of 3,682 (20%)
Eye and Contact Lens Association	No Data
International College of Surgeons – US Section	169 of 488 (35%)
International Society of Hair Restoration Surgery	82 of 237 (35%)
Society for Cardiovascular Angiography and Interventions	745 of 3,240 (23%)
Society for Investigative Dermatology	226 of 785 (29%)
United States and Canadian Academy of Pathology	777 of 4,490 (17%)

Exhibit B - Summary of Guidelines for Admission to the House of Delegates for Specialty Societies (Policy G-600.020)

Policy G-600.020

1. The organization must not be in conflict with the Constitution and Bylaws of the American Medical Association with regard to discrimination in membership.
2. The organization must:
 - (a) represent a field of medicine that has recognized scientific validity;
 - (b) not have board certification as its primary focus; and
 - (c) not require membership in the specialty organization as a requisite for board certification.
3. The organization must meet one of the following criteria:
 - (a) a specialty organization must demonstrate that it has 1,000 or more AMA members; or
 - (b) a specialty organization must demonstrate that it has a minimum of 100 AMA members and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA; or
 - (c) a specialty organization must demonstrate that it was represented in the House of Delegates at the 1990 Annual Meeting and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA.
4. The organization must be established and stable; therefore, it must have been in existence for at least five years prior to submitting its application.
5. Physicians should comprise the majority of the voting membership of the organization.
6. The organization must have a voluntary membership and must report as members only those who are current in payment of dues, have full voting privileges, and are eligible to hold office.
7. The organization must be active within its field of medicine and hold at least one meeting of its members per year.
8. The organization must be national in scope. It must not restrict its membership geographically and must have members from a majority of the states.
9. The organization must submit a resolution or other official statement to show that the request is approved by the governing body of the organization.
10. If international, the organization must have a US branch or chapter, and this chapter must be reviewed in terms of all of the above guidelines.

Exhibit C

8.2 Responsibilities of National Medical Specialty Societies and Professional Interest

Medical Associations. Each national medical specialty society and professional interest medical association represented in the House of Delegates shall have the following responsibilities:

- 8.2.1** To cooperate with the AMA in increasing its AMA membership.
- 8.2.2** To keep its delegate(s) to the House of Delegates fully informed on the policy positions of the society or association so that the delegates can properly represent the society or association in the House of Delegates.
- 8.2.3** To require its delegate(s) to report to the society on the actions taken by the House of Delegates at each meeting.
- 8.2.4** To disseminate to its membership information as to the actions taken by the House of Delegates at each meeting.
- 8.2.5** To provide information and data to the AMA when requested.

Exhibit D – AMA Bylaws on Specialty Society Periodic Review

8 - Representation of National Medical Specialty Societies and Professional Interest Medical Associations in the House of Delegates

8.5 Periodic Review Process. Each specialty society and professional interest medical association represented in the House of Delegates must reconfirm its qualifications for representation by demonstrating every 5 years that it continues to meet the current guidelines required for granting representation in the House of Delegates, and that it has complied with the responsibilities imposed under Bylaw 8.2. The SSS may determine and recommend that societies currently classified as specialty societies be reclassified as professional interest medical associations. Each specialty society and professional interest medical association represented in the House of Delegates must submit the information and data required by the SSS to conduct the review process. This information and data shall include a description of how the specialty society or the professional interest medical association has discharged the responsibilities required under Bylaw 8.2.

- 8.5.1** If a specialty society or a professional interest medical association fails or refuses to provide the information and data requested by the SSS for the review process, so that the SSS is unable to conduct the review process, the SSS shall so report to the House of Delegates through the Board of Trustees. In response to such report, the House of Delegates may terminate the representation of the specialty society or the professional interest medical association in the House of Delegates by majority vote of delegates present and voting, or may take such other action as it deems appropriate.
- 8.5.2** If the SSS report of the review process finds the specialty society or the professional interest medical association to be in noncompliance with the current guidelines for representation in the House of Delegates or the responsibilities under Bylaw 8.2, the specialty society or the professional interest medical association will have a grace period of one year to bring itself into compliance.
- 8.5.3** Another review of the specialty society's or the professional interest medical association's compliance with the current guidelines for representation in the House of Delegates and the responsibilities under Bylaw 8.2 will then be conducted, and the SSS will submit a report to the House of Delegates through the Board of Trustees at the end of the one-year grace period.
 - 8.5.3.1** If the specialty society or the professional interest medical association is then found to be in compliance with the current guidelines for representation in the House of Delegates and the responsibilities under Bylaw 8.2, the specialty society or the professional interest medical association will continue to be represented in the House of Delegates and the current review process is completed.
 - 8.5.3.2** If the specialty society or the professional interest medical association is then found to be in noncompliance with the current guidelines for representation in the House of Delegates, or the responsibilities under Bylaw 8.2, the House may take one of the following actions:

8.5.3.2.1 The House of Delegates may continue the representation of the specialty society or the professional interest medical association in the House of Delegates, in which case the result will be the same as in Bylaw 8.5.3.1.

8.5.3.2.2 The House of Delegates may terminate the representation of the specialty society or the professional interest medical association in the House of Delegates. The specialty society or the professional interest medical association shall remain a member of the SSS, pursuant to the provisions of the Standing Rules of the SSS. The specialty society or the professional interest medical association may apply for reinstatement in the House of Delegates, through the SSS, when it believes it can comply with all of the current guidelines for representation in the House of Delegates.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 026
(A-22)

Introduced by: Integrated Physician Practice Section

Subject: Establishing Ethical Principles for Physicians Involved in Private Equity Owned Practices

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 WHEREAS, Private equity firms, either independently or through Practice Management
2 Companies (PMCs), have identified healthcare as an opportunity for investment with a
3 significant potential for financial return; and
4
5 WHEREAS, The operational success of a physician practice can be difficult under current payer
6 and regulatory constraints; and
7
8 WHEREAS, The Covid-19 pandemic has further stressed the fragile nature of practice and has
9 expanded investment and contracting strategies that a private equity and PMC may be able to
10 provide¹; and
11
12 WHEREAS, The potential for private equity funded PMCs to manage the operations of a
13 physician practice to maximize payment and utilization while minimizing expenses can increase
14 healthcare costs and may not improve care or outcomes²; and
15
16 WHEREAS, The potential for private equity/PMC-owned settings to make short-term profitability
17 a priority can result in lower quality of care and higher Medicare costs³; and
18
19 WHEREAS, revenue enhancements sought in private equity arrangements can be achieved in a
20 variety of ways, some of which include either lowering physician reimbursement, cutting practice
21 support costs, and/or increasing the number of procedures performed per patient⁴; and
22
23 WHEREAS, If a particular specialty in a geographic area is significantly controlled by a private
24 equity firm, participation with all payers, especially public payers, may be limited and reduce
25 access to care and choice of physician, especially for those patients with complex and costly
26 conditions⁵, and

¹ Appelbaum, E & Batt, R. Private Equity Buyouts in Healthcare: Who wins, who loses? Institute for New Economic Thinking. Published online on March 25, 2020. <https://www.ineteconomics.org/perspectives/blog/private-equity-buyouts-in-healthcare-who-wins-who-loses>

² LaForgia, A., Bond, AM, Braut RT, et al. Association of physician management companies and private equity investment with commercial health care prices paid to anesthesia practitioners. *JAMA Intern Med*. Published online February 28, 2022. <https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2789280>?

³ Jung, H., Casalino, L., Unruh, M., & Tyler Braun, R. Private equity ownership of nursing homes linked to lower quality of care, higher Medicare costs. Weill Cornell Medicine Office of External Affairs. Published online November 19, 2021. <https://news.weill.cornell.edu/news/2021/11/private-equity-ownership-of-nursing-homes-linked-to-lower-quality-of-care-higher>

⁴ Crosson, F.J. Physician management companies—Should we care? *JAMA Internal Med*. Published online February 28, 2022. <https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2789285>?

⁵ Resnick, J.S. Dermatology practice consolidation fueled by private equity investment: Potential consequences for the specialty and patients. *JAMA Dermatol*. Published online January, 2018. <https://jamanetwork.com/journals/jamadermatology/article-abstract/2664345>?

1 WHEREAS, The primacy of the care and welfare of a patient needs to be valued and preserved
2 and should not be secondary to a financial interest, otherwise the potential to undermine patient
3 trust in a physician's professional judgment and motives can lead to untoward, negative
4 consequences; and
5
6 WHEREAS, AMA Policy H-160.891, Corporate Investors, addresses the relationship of and
7 professional considerations around private equity investment or ownership in physician practice
8 but does not adequately address the professional ethical considerations of the patient-physician
9 relationship in these settings; therefore, be it
10
11 RESOLVED, That our American Medical Association study and clarify the ethical challenges
12 and considerations regarding physician professionalism raised by the advent and expansion of
13 private equity ownership or management of physician practices and report back on the status of
14 any ethical dimensions inherent in these arrangements, including consideration of the need for
15 ethical guidelines as appropriate. Such a study should evaluate the impact of private equity
16 ownership, including but not limited to the effect on the professional responsibilities and ethical
17 priorities for physician practices (Directive to Take Action).
18

Fiscal Note: Modest - between \$1,000 - \$5,000

Date received: 06/10/22

RELEVANT AMA POLICY

Corporate Investors (H-160.891)

1. Our AMA encourages physicians who are contemplating corporate investor partnerships to consider the following guidelines:
 - a. Physicians should consider how the practice's current mission, vision, and long-term goals align with those of the corporate investor.
 - b. Due diligence should be conducted that includes, at minimum, review of the corporate investor's business model, strategic plan, leadership and governance, and culture.
 - c. External legal, accounting and/or business counsels should be obtained to advise during the exploration and negotiation of corporate investor transactions.
 - d. Retaining negotiators to advocate for best interests of the practice and its employees should be considered.
 - e. Physicians should consider whether and how corporate investor partnerships may require physicians to cede varying degrees of control over practice decision-making and day-to-day management.
 - f. Physicians should consider the potential impact of corporate investor partnerships on physician and practice employee satisfaction and future physician recruitment.
 - g. Physicians should have a clear understanding of compensation agreements, mechanisms for conflict resolution, processes for exiting corporate investor partnerships, and application of restrictive covenants.
 - h. Physicians should consider corporate investor processes for medical staff representation on the board of directors and medical staff leadership selection.
 - i. Physicians should retain responsibility for clinical governance, patient welfare and outcomes, physician clinical autonomy, and physician due process under corporate investor partnerships.
2. Our AMA supports improved transparency regarding corporate investment in physician practices and subsequent changes in health care prices.
3. Our AMA encourages national medical specialty societies to research and develop tools and resources on the impact of corporate investor partnerships on patients and the physicians in practicing in that specialty.
4. Our AMA supports consideration of options for gathering information on the impact of private equity and corporate investors on the practice of medicine.

Citation: CMS Rep. 11, A-19

Health Plan and Fiscal Intermediary Insolvency Protection Measures (H-285.928)

(1) It is the policy of the AMA that health plans should be legally responsible to pay directly for physician services in the event of an insolvency of fiscal intermediaries like groups, independent practice associations, and physician practice management companies. (2) Our AMA continues to advocate at the state level for protective measures for patients and physicians who are adversely affected by health insurers and their fiscal intermediaries that declare insolvency, to include: (a) actuarially sound capitation rates and administrative costs; (b) submission of timely financial information by health plans to independent practice associations and medical groups; and (c) the establishment of financial and monetary standards for health plans, as well as for independent practice associations, and groups that assume financial risk unrelated to direct provision of patient care.

Citation: Res. 717, I-99; Reaffirmed: Res. 711, A-03; Reaffirmed: CMS Rep. 4, A-13

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 027
(A-22)

Introduced by: Medical Student Section

Subject: Protecting Access to Abortion and Reproductive Healthcare

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, Research on abortion often uses gendered language such as “women” or “woman” to
2 describe patients; however, the authors of this resolution recognize that individuals of all gender
3 identities have abortions; and
4
5 Whereas, Abortion is one of the most common medical procedures globally, as 29% of all
6 pregnancies worldwide end in induced abortion and 24% of women in the United States aged
7 15 to 44 will have an abortion by age 45^{1,2}; and
8
9 Whereas, The United Nations’ (UN) Humans Rights Committee (HRC) and American Public
10 Health Association (APHA) have expressed that abortion is necessary to ensuring the right to
11 life for women and girls due to its role in prevention of maternal morbidity and mortality^{3,4}; and
12
13 Whereas, In 2021, the Supreme Court heard oral arguments in *Dobbs v. Jackson’s Women’s*
14 *Health Organization*, a case that challenges the constitutionality of a Mississippi law which
15 would ban abortion at 15 weeks, allowing the court the opportunity to overturn *Roe v. Wade* and
16 subsequently enacting legislation in 21 states that would ban abortion access^{5,6}; and
17
18 Whereas, If *Roe v. Wade* was overturned, patients seeking to terminate a pregnancy would
19 have to drive an average of 97 miles further to reach the closest clinic⁷; and
20
21 Whereas, The World Health Organization (WHO) and the Center for Reproductive Rights
22 recognize that restrictive abortion laws do not decrease abortion; rather, they lead to a higher
23 number of unsafe or illegal abortions, endangering women’s health and leading to significant
24 maternal morbidity and mortality^{6,8}; and
25
26 Whereas, Medication abortion with mifepristone, one of just two U.S. Food and Drug
27 Administration (FDA) approved drugs to manage abortion and early miscarriage, comprises
28 54% of all abortions in the United States as of 2020 and has a 20-year record of safety and
29 efficacy⁹⁻¹¹; and
30
31 Whereas, Providers can safely provide medication abortion without routine physical examination
32 and instead through patient interviews via telehealth, laboratory testing, and
33 ultrasonography^{10,12}; and
34
35 Whereas, In response to the COVID-19 pandemic, in December 2021, the FDA amended
36 mifepristone’s Risk Evaluation and Mitigation Strategy (REMS) by removing the in-person
37 dispensing requirement, adding a requirement that pharmacies which dispense mifepristone
38 must be certified, and maintaining the prescriber certification and Patient Agreement Form
39 requirements; when mifepristone is made accessible, adverse events and complications, as well

1 as rates of abortion, remain unchanged and can reduce the demand for induced abortion in the
2 second trimester¹³⁻¹⁶; and
3
4 Whereas, Although clinicians who provide abortions in the United States are subject to
5 evidence-based federal regulations, 23 states have imposed Targeted Regulation of Abortion
6 Providers (TRAP) laws, which target abortion clinics with the primary purpose of limiting access
7 to abortion, not ensuring patient safety; these laws extend to physicians' offices where abortions
8 are performed, including sites where only medication abortion is administered¹⁷; and
9
10 Whereas, When patients face barriers to abortion healthcare such as long travel distances to
11 clinics and high costs, 10-28% attempt to self-manage their abortions, with 38-52% using herbs,
12 supplements, or vitamins, 18-20% using misoprostol and/or mifepristone, 19-29% using other
13 medications, and 18-19% inflicting abdominal or other physical trauma¹⁸⁻²⁰; and
14
15 Whereas, A 2013 study by Paltrow and Flavin found that in criminal cases where pregnancy
16 was a necessary factor leading to deprivation of her physical liberty, such as arrest, detention,
17 or forced medical intervention, 85% of African American women were subjected to felony
18 charges, compared to 71% of white women, and were also significantly more likely to be
19 reported to authorities by hospital staff, indicating that the burden of abortion criminalization is
20 more likely to fall on women of color²¹; and
21
22 Whereas, Arkansas, Kentucky, Mississippi, Alabama, and South Carolina have redefined
23 "personhood" in the context of existing state statutes for the explicit purpose of expanding the
24 scope of criminal liability for serious offenses such as homicide, feticide, aggravated assault,
25 and domestic violence, resulting in increased arrests, prosecutions, and prison sentences for
26 people who have abortions²²; and
27
28 Whereas, Various laws have passed which criminalize clinicians who provide abortions, such as
29 Senate Bill (SB) 8 in Texas allowing private citizens to sue clinicians who provide abortions and
30 anyone who helps a patient obtain an abortion; in Oklahoma, under SB 612, anyone convicted
31 of performing an abortion can face up to 10 years in prison and a \$100,000 fine²³⁻²⁵; and
32
33 Whereas, Some states have passed bills designating it a felony for a doctor to perform an
34 abortion, including in Alabama, where House Bill (HB) 314 defines a fetus as a legal person "for
35 homicide purposes" and compares abortion to the Holocaust and other genocides²⁶; and
36
37 Whereas, Other bills, which were introduced but not passed, signal hostility towards clinicians
38 who perform abortions: Ohio HB 565 and Texas HB 896 would subject patients, medical
39 professionals, and others implicated in abortion attainment, to criminalization, jail time, and the
40 death penalty^{27,28}; and
41
42 Whereas, Criminalizing abortion care and counseling is an interference of patient-provider
43 shared decision-making as denounced by the American College of Obstetricians and
44 Gynecologists (ACOG)²⁹; and
45
46 Whereas, Significant racial and ethnic disparities exist surrounding abortion access, and these
47 disparities are exacerbated by restrictive state abortion laws^{30,31}; and
48
49 Whereas, Under the AMA policy 4.2.7, "Code of Medical Ethics Opinion", physicians are not
50 prohibited from performing an abortion in accordance with good medical practice and under
51 circumstances that do not violate the law; however, the principle does not guarantee access to
52 either medication abortion or abortion procedures; and
53

1 Whereas, Our AMA has condemned the criminalization of clinicians who provide abortion and
2 the practice of safe medicine in public correspondence with legislators, and existing policy H-
3 160.946, "The Criminalization of Health Care Decision Making," opposes criminalization of
4 health care decision-making, without explicitly protecting abortion care and counseling^{32,33}; and
5

6 Whereas, Our AMA opposes the criminalization of self-induced abortion in existing policy H-
7 5.980; however, the AMA has no policy opposing laws which criminalize and impose penalties
8 on patients who access abortions in general; therefore be it
9

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

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

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

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

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

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

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 06/10/2022

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RELEVANT AMA POLICY

4.2.7 Abortion

The Principles of Medical Ethics of the AMA do not prohibit a physician from performing an abortion in accordance with good medical practice and under circumstances that do not

violate the law.

AMA Principles of Medical Ethics: III,IV; Issued 2016

Ending the Risk Evaluation and Mitigation Strategy (REMS) Policy on Mifepristone (Mifeprex) H-100.948

Our AMA will support efforts urging the Food and Drug Administration to lift the Risk Evaluation and Mitigation Strategy on mifepristone.

Res. 504, A-18

Support for Access to Preventive and Reproductive Health Services H-425.969

Our AMA supports access to preventive and reproductive health services for all patients and opposes legislative and regulatory actions that utilize federal or state health care funding mechanisms to deny established and accepted medical care to any segment of the population.

Sub. Res. 224, I-15; Reaffirmation: I-17

Violence Against Medical Facilities and Health Care Practitioners and Their Families H-5.997

The AMA supports the right of access to medical care and opposes (1) violence and all acts of intimidation directed against physicians and other health care providers and their families and (2) violence directed against medical facilities, including abortion clinics and family planning centers, as an infringement of the individual's right of access to the services of such centers.

Res. 82, I-84; Reaffirmed by CLRPD Rep. 3 - I-94; Res. 422, A-95; Reaffirmation I-99;

Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed: CSAPH Rep. 01, A-19

Policy on Abortion H-5.990

The issue of support of or opposition to abortion is a matter for members of the AMA to decide individually, based on personal values or beliefs. The AMA will take no action which may be construed as an attempt to alter or influence the personal views of individual physicians regarding abortion procedures.

Res. 158, A-90; Reaffirmed by Sub. Res. 208, I-96; Reaffirmed by BOT Rep. 26, A-97;

Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: Res. 1, A-09; Reaffirmed: CEJA Rep. 03, A-19

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

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

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

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

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

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

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

Res. 523, A-06; Appended: Res. 706, A-13

1.1.3 Patient Rights

The health and well-being of patients depends on a collaborative effort between patient and physician in a mutually respectful alliance. Patients contribute to this alliance when they fulfill responsibilities they have, to seek care and to be candid with their physicians, for example.

Physicians can best contribute to a mutually respectful alliance with patients by serving as their patients' advocates and by respecting patients' rights. These include the right:

- (a) To courtesy, respect, dignity, and timely, responsive attention to his or her needs.
- (b) To receive information from their physicians and to have opportunity to discuss the benefits, risks, and costs of appropriate treatment alternatives, including the risks, benefits and costs of forgoing treatment. Patients should be able to expect that their physicians will provide guidance about what they consider the optimal course of action for the patient based on the physician's objective professional judgment.
- (c) To ask questions about their health status or recommended treatment when they do not fully understand what has been described and to have their questions answered.
- (d) To make decisions about the care the physician recommends and to have those decisions respected. A patient who has decision-making capacity may accept or refuse any recommended medical intervention.
- (e) To have the physician and other staff respect the patient's privacy and confidentiality.
- (f) To obtain copies or summaries of their medical records.
- (g) To obtain a second opinion.
- (h) To be advised of any conflicts of interest their physician may have in respect to their care.
- (i) To continuity of care. Patients should be able to expect that their physician will cooperate in coordinating medically indicated care with other health care professionals, and that the physician will not discontinue treating them when further treatment is medically indicated without giving them sufficient notice and reasonable assistance in making alternative arrangements for care.

AMA Principles of Medical Ethics: I, IV, V, VIII, IX; Issued 2016

The Criminalization of Health Care Decision Making H-160.946

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

Sub. Res. 202, A-95; Reaffirmed: Res. 227, I-98; Reaffirmed: BOT Rep. 2, A-07; Reaffirmation A-09; Reaffirmation: I-12

Medical Training and Termination of Pregnancy H-295.923

1. Our AMA supports the education of medical students, residents and young physicians about

the need for physicians who provide termination of pregnancy services, the medical and public health importance of access to safe termination of pregnancy, and the medical, ethical, legal and psychological principles associated with termination of pregnancy.

2. Our AMA supports the availability of abortion education and exposure to procedures for termination of pregnancy, including medication abortions, for medical students and resident/fellow physicians and opposes efforts to interfere with or restrict the availability of this education and training.

3. Our AMA encourages the Accreditation Council for Graduate Medical Education to consistently enforce compliance with the standardization of abortion training opportunities as per the requirements set forth by the Review Committee for Obstetrics and Gynecology and the American College of Obstetricians and Gynecologists' recommendations.

Res. 315, I-94; Reaffirmed: CME Rep. 2, A-04; Modified: CME Rep. 2, A-14; Modified: CME Rep. 1, A-15; Appended: Res. 957, I-17; Modified: Res. 309, I-21

Preserving the Doctor-Patient Relationship H-100.971

The AMA and interested physicians will continue to work with the Food and Drug Administration to prevent the unnecessary intrusion of the government and other regulatory bodies into the doctor-patient relationship, especially as it concerns the prescription of medication.

Sub. Res. 510, I-95; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15

Government Interference in Patient Counseling H-373.995

1. Our AMA vigorously and actively defends the physician-patient-family relationship and actively opposes state and/or federal efforts to interfere in the content of communication in clinical care delivery between clinicians and patients.

2. Our AMA strongly condemns any interference by government or other third parties that compromise a physician's ability to use his or her medical judgment as to the information or treatment that is in the best interest of their patients.

3. Our AMA supports litigation that may be necessary to block the implementation of newly enacted state and/or federal laws that restrict the privacy of physician-patient-family relationships and/or that violate the First Amendment rights of physicians in their practice of the art and science of medicine.

4. Our AMA opposes any government regulation or legislative action on the content of the individual clinical encounter between a patient and physician without a compelling and evidence-based benefit to the patient, a substantial public health justification, or both.

5. Our AMA will educate lawmakers and industry experts on the following principles endorsed by the American College of Physicians which should be considered when creating new health care policy that may impact the patient-physician relationship or what occurs during the patient-physician encounter:

A. Is the content and information or care consistent with the best available medical evidence on clinical effectiveness and appropriateness and professional standards of care?

B. Is the proposed law or regulation necessary to achieve public health objectives that directly affect the health of the individual patient, as well as population health, as supported by scientific evidence, and if so, are there no other reasonable ways to achieve the same objectives?

C. Could the presumed basis for a governmental role be better addressed through advisory clinical guidelines developed by professional societies?

D. Does the content and information or care allow for flexibility based on individual patient circumstances and on the most appropriate time, setting and means of delivering such

information or care?

E. Is the proposed law or regulation required to achieve a public policy goal - such as protecting public health or encouraging access to needed medical care - without preventing physicians from addressing the healthcare needs of individual patients during specific clinical encounters based on the patient's own circumstances, and with minimal interference to patient-physician relationships?

F. Does the content and information to be provided facilitate shared decision-making between patients and their physicians, based on the best medical evidence, the physician's knowledge and clinical judgment, and patient values (beliefs and preferences), or would it undermine shared decision-making by specifying content that is forced upon patients and physicians without regard to the best medical evidence, the physician's clinical judgment and the patient's wishes?

G. Is there a process for appeal to accommodate individual patients' circumstances?

6. Our AMA strongly opposes any attempt by local, state, or federal government to interfere with a physician's right to free speech as a means to improve the health and wellness of patients across the United States.

Res. 201, A-11; Reaffirmation: I-12; Appended: Res. 717, A-13; Reaffirmed in lieu of Res. 5, I-13; Appended: Res. 234, A-15; Reaffirmation: A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 028
(A-22)

Introduced by: RFS, AAP, ACOG, ASRM, MAS, IMGS

Subject: Preserving Access to Reproductive Health Services

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, “Reproductive health services” were defined in the U.S. Code through the *Freedom of*
2 *Access to Clinic Entrances Act of 1994* to be, “reproductive health services provided in a
3 hospital, clinic, physician’s office, or other facility, and includes medical, surgical, counselling or
4 referral services relating to the human reproductive system, including services relating to
5 pregnancy or the termination of a pregnancy,” which include, but are not limited to, prenatal
6 care, childbirth, postpartum care, contraception, emergency contraception, sterilization, abortion
7 care, miscarriage management, adoption, and fertility treatments;^{1,2} therefore be it

8
9 Whereas, In 1973, the U.S. Supreme Court decision in *Roe v. Wade* created the federal legal
10 precedent that the 14th Amendment of the U.S. Constitution protects a pregnant person’s liberty
11 to choose to have an abortion without excessive government restriction;³ and

12
13 Whereas, Subsequent U.S. Supreme Court decisions in *Planned Parenthood v. Casey* (1992)
14 and *Whole Woman’s Health v. Hellerstedt* (2016) have upheld the right to abortion and limited
15 the government’s ability to place restrictions on access that present an “undue burden” to
16 patients;^{4,5} and

17
18 Whereas, If *Roe* is overturned: (1) “trigger laws” in thirteen states would make abortion
19 immediately illegal and nine states would revert to pre-*Roe* statutes that ban all abortions, (2)
20 several states are developing, or have passed laws, that would limit, ban, or criminalize
21 physicians practicing within their scope of practice or would compel physicians to report on their
22 patients, with penalties as severe as “the death penalty or life without the possibility of parole,
23 and (3) the average distance required to travel for an abortion would increase from 35 miles to
24 279 miles;^{6,7,8} and

25
26 Whereas, Despite laws prohibiting the criminalization of pregnant persons, there have been
27 criminal charges and convictions against pregnant individuals suffering miscarriages or self-
28 managed abortions, and new legislation currently being forwarded to charge pregnant people
29 with homicide for terminating a pregnancy;⁹⁻¹³ and

30
31 Whereas, Several laws nationwide have criminalized or severely curtailed parts of routine
32 reproductive healthcare, including the appropriate management of life-threatening and non-
33 viable ectopic pregnancies, as was the case in recently defeated legislation in the Missouri
34 House of Representatives (HOUSE BILL NO. 2810);¹⁴ and

35
36 Whereas, Restrictive abortion laws and policies, such as Medicaid funding restrictions,
37 mandatory parental involvement, mandatory counseling, mandatory waiting period, and two-visit
38 laws have been associated with higher infant mortality rates, higher incidence of pre-term and
39 low birth weight births, decreased utilization of women’s preventative health screenings
40 (including mammograms and pap smears), increased rates of sexually-transmitted infections

1 (specifically gonorrhea and chlamydia), and, most notably, overall increased rates of
2 abortions;¹⁵⁻¹⁸ and

3
4 Whereas, In recent years, despite protections outlined by *Roe* and subsequent cases, several
5 states have passed laws imposing limitations on abortion access, culminating in *Dobbs v.*
6 *Jackson Women's Health Organization*, which heard oral arguments in the U.S. Supreme Court
7 starting December 1, 2021, and represents the most significant challenge to reproductive rights
8 to date;^{19,20} and

9
10 Whereas, On May 2, 2022, a leaked draft opinion from the U.S. Supreme Court revealed a plan
11 to broadly reverse the constitutional right to abortion originally defined by *Roe* that, if finalized,
12 would have wide-ranging implications for access to reproductive health care;²¹ and

13
14 Whereas, The AMA has come out strongly to defend reproductive rights through amicus briefs,
15 viewpoints, and statements on several recent challenges to reproductive rights and related
16 medical practice, including *United States v. Texas* and *Dobbs*, including stating that, "access to
17 abortion remains vital for pregnant patients' overall health and well-being," and, "abortion is a
18 safe, common, and essential component of health care,"²²⁻²⁶ and

19
20 Whereas, On May 5, 2022, in response to the leaked draft opinion for the *Dobbs* case, the
21 President of the AMA released a statement condemning the severe intrusion into the physician-
22 patient relationship, and stated that "we strongly urge the Court to reject the premise of the draft
23 opinion and affirm precedent that allows patients to receive the critical reproductive health care
24 that they need;"²⁶ and

25
26 Whereas, Current AMA policy supports reproductive rights and the ability for physicians to
27 practice and be appropriately reimbursed in this field without state interference, but contains
28 inconsistencies requiring clarification and revision; and therefore be it

29
30 RESOLVED, That our AMA:

- 31 (1) Recognizes that healthcare, including reproductive health services like contraception
32 and abortion, is a human right;
- 33 (2) Opposes limitations on access to evidence-based reproductive health services, including
34 fertility treatments, contraception, and abortion;
- 35 (3) Will work with interested state medical societies and medical specialty societies to
36 vigorously advocate for broad, equitable access to reproductive health services,
37 including fertility treatments, contraception, and abortion;
- 38 (4) Supports shared decision-making between patients and their physicians regarding
39 reproductive healthcare;
- 40 (5) Opposes any effort to undermine the basic medical principle that clinical assessments,
41 such as viability of the pregnancy and safety of the pregnant person, are determinations
42 to be made only by healthcare professionals with their patients;
- 43 (6) Opposes the imposition of criminal and civil penalties or other retaliatory efforts against
44 patients, patient advocates, physicians, other healthcare workers, and health systems
45 for receiving, assisting in, referring patients to, or providing reproductive health services;
- 46 (7) Will advocate for legal protections for patients who cross state lines to receive
47 reproductive health services, including contraception and abortion, or who receive
48 medications for contraception and abortion from across state lines, and legal protections
49 for those that provide, support, or refer patients to these services;
- 50 (8) Will review the AMA policy compendium and recommend policies which should be
51 amended or rescinded to reflect these core values, with report back at I-22; and be it
52 further

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 06/10/22

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Relevant AMA Policy:

H-5.980 Oppose the Criminalization of Self-Induced Abortion

Our AMA: (1) opposes the criminalization of self-induced abortion 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 abortion.

H-5.982 Late-Term Pregnancy Termination Techniques

(1) The term 'partial birth abortion' is not a medical term. The AMA will use the term "intact dilatation and extraction"(or intact D&X) to refer to a specific procedure comprised of the following elements: deliberate dilatation of the cervix, usually over a sequence of days; instrumental or manual conversion of the fetus to a footling breech; breech extraction of the body excepting the head; and partial evacuation of the intracranial contents of the fetus to effect vaginal delivery of a dead but otherwise intact fetus. This procedure is distinct from dilatation and evacuation (D&E) procedures more commonly used to induce abortion after the first trimester. Because 'partial birth abortion' is not a medical term it will not be used by the AMA.

(2) According to the scientific literature, there does not appear to be any identified situation in which intact D&X is the only appropriate procedure to induce abortion, and ethical concerns have been raised about intact D&X. The AMA recommends that the procedure not be used unless alternative procedures pose materially greater risk to the woman. The physician must, however, retain the discretion to make that judgment, acting within standards of good medical practice and in the best interest of the patient.

(3) The viability of the fetus and the time when viability is achieved may vary with each pregnancy. In the second-trimester when viability may be in question, it is the physician who should determine the viability of a specific fetus, using the latest available diagnostic technology.

(4) In recognition of the constitutional principles regarding the right to an abortion articulated by the Supreme Court in *Roe v. Wade*, and in keeping with the science and values of medicine, the AMA recommends that abortions not be performed in the third trimester except in cases of serious fetal anomalies incompatible with life. Although third-trimester abortions can be performed to preserve the life or health of the mother, they are, in fact, generally not necessary for those purposes. Except in extraordinary circumstances, maternal health factors which demand termination of the pregnancy can be accommodated without sacrifice of the fetus, and the near certainty of the independent viability of the fetus argues for ending the pregnancy by appropriate delivery.

H-5.983 Pregnancy Termination

The AMA adopted the position that pregnancy termination be performed only by appropriately trained physicians (MD or DO).

H-5.985 Fetal Tissue Research

The AMA supports the use of fetal tissue obtained from induced abortion for scientific research.

H-5.988 Accurate Reporting on AMA Abortion Policy

Our AMA HOD cautions members of the Board of Trustees, Councils, employees and members of the House of Delegates to precisely state current AMA policy on abortion and related issues in an effort to minimize public misperception of AMA policy and urges that our AMA continue efforts to refute misstatements and misquotes by the media with reference to AMA abortion policy.

H-5.989 Freedom of Communication Between Physicians and Patients

It is the policy of the AMA: (1) to strongly condemn any interference by the government or other third parties that causes a physician to compromise his or her medical judgment as to what information or treatment is in the best interest of the patient;

(2) working with other organizations as appropriate, to vigorously pursue legislative relief from regulations or statutes that prevent physicians from freely discussing with or providing information to patients about medical care and procedures or which interfere with the physician-patient relationship;

(3) to communicate to HHS its continued opposition to any regulation that proposes restrictions on physician-patient communications; and

(4) to inform the American public as to the dangers inherent in regulations or statutes restricting communication between physicians and their patients.

H-5.990 Policy on Abortion

The issue of support of or opposition to abortion is a matter for members of the AMA to decide individually, based on personal values or beliefs. The AMA will take no action which may be construed as an attempt to alter or influence the personal views of individual physicians regarding abortion procedures.

H-5.993 Right to Privacy in Termination of Pregnancy

The AMA reaffirms existing policy that (1) abortion is a medical procedure and should be performed only by a duly licensed physician in conformance with standards of good medical practice and the laws of the state; and (2) no physician or other professional personnel shall be required to perform an act violative of good medical judgment or personally held moral principles. In these circumstances good medical practice requires only that the physician or other professional withdraw from the case so long as the withdrawal is consistent with good medical practice. The AMA further supports the position that the early termination of pregnancy is a medical matter between the patient and the physician, subject to the physician's clinical judgment, the patient's informed consent, and the availability of appropriate facilities.

H-5.995 Abortion

Our AMA reaffirms that: (1) abortion is a medical procedure and should be performed only by a duly licensed physician and surgeon in conformance with standards of good medical practice and the Medical Practice Act of his state; and (2) no physician or other professional personnel shall be required to perform an act violative of good medical judgment. Neither physician, hospital, nor hospital personnel shall be required to perform any act violative of personally held moral principles. In these circumstances, good medical practice requires only that the physician or other professional withdraw from the case, so long as the withdrawal is consistent with good medical practice.

H-5.997 Violence Against Medical Facilities and Health Care Practitioners and Their Families

The AMA supports the right of access to medical care and opposes (1) violence and all acts of intimidation directed against physicians and other health care providers and their families and (2) violence directed against medical facilities, including abortion clinics and family planning centers, as an infringement of the individual's right of access to the services of such centers.

H-5.998 Public Funding of Abortion Services

The AMA reaffirms its opposition to legislative proposals that utilize federal or state health care funding mechanisms to deny established and accepted medical care to any segment of the population.

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

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

H-75.987 Reducing Unintended Pregnancy

Our AMA: (1) urges health care professionals to provide care for women of reproductive age, to assist them in planning for pregnancy and support age-appropriate education in esteem building, decision-making and family life in an effort to introduce the concept of planning for childbearing in the educational process; (2) supports reducing unintended pregnancies as a national goal; and (3) supports the training of all primary care physicians and relevant allied health professionals in the area of preconception counseling, including the recognition of long-acting reversible contraceptives as efficacious and economical forms of contraception.

D-75.997 Access to Emergency Contraception

1. Our AMA will: (a) intensify efforts to improve awareness and understanding about the availability of emergency contraception in the general public; and (b) support and monitor the application process of manufacturers filing for over-the-counter approval of emergency contraception pills with the Food and Drug Administration (FDA).
2. Our AMA: (a) will work in collaboration with other stakeholders (such as American College of Obstetricians and Gynecologists, American Academy of Pediatrics, and American College of Preventive

Medicine) to communicate with the National Association of Chain Drug Stores and the National Community Pharmacists Association, and request that pharmacies utilize their web site or other means to signify whether they stock and dispense emergency contraception, and if not, where it can be obtained in their region, either with or without a prescription; and (b) urges that established emergency contraception regimens be approved for over-the-counter access to women of reproductive age, as recommended by the relevant medical specialty societies and the US Food and Drug Administration's own expert panel.

H-100.948 Ending the Risk Evaluation and Mitigation Strategy (REMS) Policy on Mifepristone (Mifeprex)

Our AMA will support efforts urging the Food and Drug Administration to lift the Risk Evaluation and Mitigation Strategy on mifepristone.

H-185.937 Reproductive Parity

Our AMA supports legislation and policies that require any health insurance products offering maternity services to include all choices in the management of reproductive medical care.

H-295.923 Medical Training and Termination of Pregnancy

1. Our AMA supports the education of medical students, residents and young physicians about the need for physicians who provide termination of pregnancy services, the medical and public health importance of access to safe termination of pregnancy, and the medical, ethical, legal and psychological principles associated with termination of pregnancy.
2. Our AMA supports the availability of abortion education and exposure to procedures for termination of pregnancy, including medication abortions, for medical students and resident/fellow physicians and opposes efforts to interfere with or restrict the availability of this education and training.
3. Our AMA encourages the Accreditation Council for Graduate Medical Education to consistently enforce compliance with the standardization of abortion training opportunities as per the requirements set forth by the Review Committee for Obstetrics and Gynecology and the American College of Obstetricians and Gynecologists' recommendations.

D-310.954 Training in Reproductive Health Topics as a Requirement for Accreditation of Family Residencies

Our AMA: (1) will work with the Accreditation Council for Graduate Medical Education to protect patient access to important reproductive health services by advocating for all family medicine residencies to provide comprehensive women's health including training in contraceptive counseling, family planning, and counseling for unintended pregnancy; and (2) encourages the ACGME to ensure greater clarity when making revisions to the educational requirements and expectations of family medicine residents in comprehensive women's health topics.

H-425.969 Support for Access to Preventive and Reproductive Health Services

Our AMA supports access to preventive and reproductive health services for all patients and opposes legislative and regulatory actions that utilize federal or state health care funding mechanisms to deny established and accepted medical care to any segment of the population.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 128
(A-22)

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

Subject: Improving Access to Vaccinations for Patients

Referred to: Reference Committee A

1 Whereas, Over the past two years a new shingles vaccine, Shingrix, has become available.
2 However, that vaccine is only reimbursed under Medicare Part D, which does not pay for office-
3 based treatment. It remains unclear why that decision was made as the previous shingles
4 vaccine, Zostavax, was covered in an office-based practice (Medicare Part B); and
5
6 Whereas, Medicare does cover other vaccines (influenza, both pneumococcal vaccines and Td)
7 in the office; and
8
9 Whereas, Commercial insurers in Massachusetts, unlike Medicare, cover this vaccine in an
10 office-based practice as they do with other vaccines; and
11
12 Whereas, This policy of the Centers for Medicaid and Medicare Services (not to cover in-office
13 administration of the Shingrix vaccine) encourages our patients to forego the convenience of
14 having their vaccine while being present for an office visit. They must travel to the pharmacy to
15 obtain the vaccine; and
16
17 Whereas, It is generally acknowledged that patients are much more likely to accept a treatment
18 as part of a meeting with their health care provider than if they have to make a separate trip to
19 access the treatment, such that deferring the vaccination lessens the likelihood that the patient
20 will receive it; and
21
22 Whereas, It is important to improve our patients access to this vaccine; therefore be it
23
24 RESOLVED, That our American Medical Association encourage all payors, including the
25 Centers for Medicare and Medicaid Services, to fully cover the cost of product, handling and
26 administration, without cost sharing, all vaccines recommended by the Centers for Disease
27 Control and Prevention, at patient's preferred site of care including when administered in the
28 physician office. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 05/18/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 245
(A-22)

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

Subject: Definition and Encouragement of the Appropriate Use of the Word "Physician"

Referred to: Reference Committee B

1 Whereas, American Medical Association policy H-405.951 defines a physician as having a
2 Doctor of Medicine or Doctor of Osteopathic Medicine, advocates for the definition of physician
3 to be as above, and encourages physicians to insist on being identified as such and to use such
4 a term rather than provider;¹ and
5
6 Whereas, The American Academy of Pediatrics (AAP) has a policy in its publications and
7 conferences to cease using the term "provider" to describe board-certified pediatricians. The
8 AAP also encourages fellows and the media to use the term "pediatrician," "doctor," or
9 "physician," instead of "provider" when describing board-certified pediatricians;² and
10
11 Whereas, The American Academy of Family Physicians has a position that the term "provider"
12 implies uniformity of expertise and knowledge among health care professionals, and this
13 terminology implies an interchangeability that is inappropriate and erroneous. The term
14 "provider" is of bureaucratic origin and has no significance beyond regulators and insurers. The
15 implication is that patients can expect to receive the same level of care from any "provider";³
16 and
17
18 Whereas, The term "provider" makes no reference to professional values, suggesting these
19 values are not important. It has been noted that using the "provider" designation for health
20 professionals' risks deprofessionalizing them. Physicians, nurses, nurse practitioners, and
21 physician assistants value their specific professional identities and are proud to be referred to as
22 such and respected for the professional values they connote⁴; and
23
24 Whereas, Under federal regulations, a "health care provider" is defined as a doctor of medicine
25 or osteopathy, podiatrist, dentist, chiropractor, clinical psychologist, optometrist, nurse
26 practitioner, nurse-midwife, or a clinical social worker... or a Christian Science practitioner;⁵ and
27
28 Whereas, Physician burnout is a well-acknowledged problem in medicine. Jordan Cohen, MD,
29 in his farewell address as president of the Association of American Medical Colleges noted that:
30 "One of the biggest contributors to burnout is the high level of stress inherent in our job,
31 combined with the lack of control over many aspects of our work. Not being in control of how we
32 are addressed is the most basic of all issues that is 'low hanging fruit' to fix.;"⁶ therefore be it

¹ Ref: <https://policysearch.ama-assn.org/policyfinder/search/Definition%20and%20Use%20of%20the%20Term%20Physician%20H-405.951/relevant/1/>

² American Academy of Pediatrics, 2019 Annual Leadership Forum, Resolution #53 Calling Pediatricians "Doctors" Instead of "Providers"

³ <https://www.aafp.org/about/policies/all/provider-term-position.html>

⁴ <https://jamanetwork.com/journals/jama/fullarticle/2506307>

⁵ <https://hr.berkeley.edu/node/3777>

⁶ Jordan J. Cohen, MD. AAMC Presidential Farewell Address, July 2006.

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

Fiscal Note: Estimated cost of \$250,000 to implement resolution.

Received: 05/18/22

RELEVANT AMA POLICY

Definition and Use of the Term Physician H-405.951

Our AMA:

1. Affirms that the term physician be limited to those people who have a Doctor of Medicine, Doctor of Osteopathic Medicine, or a recognized equivalent physician degree and who would be eligible for an Accreditation Council for Graduate Medical Education (ACGME) residency.
2. Will, in conjunction with the Federation, aggressively advocate for the definition of physician to be limited as defined above:
 - a. In any federal or state law or regulation including the Social Security Act or any other law or regulation that defines physician;
 - b. To any federal and state legislature or agency including the Department of Health and Human Services, Federal Aviation Administration, the Department of Transportation, or any other federal or state agency that defines physician; and
 - c. To any accrediting body or deeming authority including the Joint Commission, Health Facilities Accreditation Program, or any other potential body or authority that defines physician.
3. Urges all physicians to insist on being identified as a physician, to sign only those professional or medical documents identifying them as physicians, and to not let the term physician be used by any other organization or person involved in health care.
4. Ensure that all references to physicians by government, payers, and other health care entities involving contracts, advertising, agreements, published descriptions, and other communications at all times distinguish between physician, as defined above, and non-physicians and to discontinue the use of the term provider.
5. Policy requires any individual who has direct patient contact and presents to the patient as a doctor, and who is not a physician, as defined above, must specifically and simultaneously declare themselves a non-physician and define the nature of their doctorate degree.
6. Will review and revise its own publications as necessary to conform with the House of Delegates' policies on physician identification and physician reference and will refrain from any definition of physicians as providers that is not otherwise covered by existing Journal of the American Medical Association (JAMA) Editorial Governance Plan, which protects the editorial independence of JAMA.
7. Actively supports the Scope of Practice Partnership in the Truth in Advertising campaign

Citation: Res. 214, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 246
(A-22)

Introduced by: Medical Student Section

Subject: Further Action to Respond to the Gun Violence Public Health Crisis

Referred to: Reference Committee B

1 Whereas, Gun violence is a major public health crisis in the US that only continues to worsen
2 every year, with the CDC most recently reporting 45,222 gun deaths in 2020—the most on
3 record at the time, a 14% increase from 2019, a 25% increase from 2015, and a 43%
4 increase from 2010¹⁻³; and

5 Whereas, The CDC reported that gun-related injuries were one of the five leading causes of
6 death for people aged 1-44 in the US in 2020, and a May 2022 letter in *The New England*
7 *Journal of Medicine* suggests that based on 2020 CDC data, gun-related injuries may have
8 surpassed motor vehicle crashes to now become the leading cause of death for children and
9 young adults aged 1-19³⁻⁴; and

10 Whereas, Based on 2020 data, the CDC reported that over 40% of gun deaths were
11 homicides (19,384 deaths, or 79% of all homicides) and over 50% of gun deaths were
12 suicides (24,292 deaths, or 53% of all suicides), accounting for 124 deaths a day;³ and
13 Whereas, The Gun Violence Archive, an independent data research group that tracks various
14 types of gun-related incidents, uses a statistical threshold to define a mass shooting as one
15 where four or more people are shot and reported 692 in 2021 and 610 in 2020⁵⁻⁶; and

16 Whereas, National Public Radio reported that 246 mass shootings took place in the first five
17 months of 2022 according to the Gun Violence Archive, and that 27 school shootings took
18 place in this same period according to Education Week, compared to 34 school shootings in
19 all of 2021⁶⁻⁷; and

20 Whereas, On May 14, 2022, 10 people were killed and 3 injured in a racist mass shooting at
21 a supermarket in Buffalo, New York⁸; and

22 Whereas, On May 15, 2022, 1 person was killed and 5 injured in a politically motivated mass
23 shooting at a congregation of the Irvine Taiwanese Presbyterian Church in Laguna Woods,
24 California⁹; and

25 Whereas, On May 24, 2022, 21 people, including 19 children and 2 teachers, were killed and
26 18 injured at Robb Elementary School in Uvalde, Texas, the second deadliest school
27 shooting on record, ten years after 26 people were killed in Sandy Hook Elementary
28 shooting¹⁰; and

29 Whereas, On June 1, 2022, two physicians, a patient, and another healthcare worker were
30 killed and several injured in a mass shooting at the St. Francis Hospital in Tulsa, Oklahoma¹¹;
31 and

1 Whereas, Advocacy to address the gun violence public health crisis is crucial to support
2 racial justice and health equity, as CDC data shows that Black, American Indian and Alaska
3 Native, and Hispanic people are disproportionately affected by gun homicides compared to
4 white individuals¹²; and

5
6 Whereas, Multiple countries, including the United Kingdom, New Zealand, Norway, and
7 Australia, quickly introduced and adopted successful national legislation to ban semi-
8 automatic and automatic weapons after just a single mass shooting¹³; and

9
10 Whereas, Many community gun violence interventions have demonstrated success as cost-
11 effective investments to prevent gun injuries, trauma, and deaths¹⁴⁻²⁶; and

12
13 Whereas, In 2020, our AMA announced a partnership with West Side United to invest \$6
14 million in community infrastructure programs in Chicago's west side neighborhoods to
15 address issues relating to health inequities and economic vitality based on community needs,
16 including affordable housing, access to healthy foods, financing local business projects, and
17 supporting job creation efforts and educational programs²⁷; and

18
19 Whereas, In 2016, in the wake of the Pulse Orlando mass shooting where 49 were killed and
20 53 injured, our AMA declared gun violence as a public health crisis "requiring a
21 comprehensive public health response and solution"²⁸; and

22
23 Whereas, In the past several years, our AMA has convened multiple task forces to address
24 major public health issues, including the AMA Health Equity Task Force (which led to the
25 creation of the AMA Center for Health Equity) and the AMA Opioid Task Force, which
26 included more than 25 other stakeholders, generated progress reports, recommended
27 evidence-based policies to legislators and regulators, and was succeeded by the ongoing the
28 AMA Substance Use and Pain Care Task Force²⁹⁻³²; and

29
30 Whereas, Our AMA has adopted numerous policies over the past several decades to reduce
31 gun trauma, injury and death, including H-145.996, H-145.975, H-145.997, D-145.996, H-
32 145.983, H-145.978, H-145.984, H-145.979, H-145.985, H-145.990, H-145.992, H-145.993,
33 H-145.999, and H-515.971, but as this crisis continues to escalate, our advocacy could
34 benefit from unified efforts to collaborate and partner with stakeholders to bolster our efforts
35 and navigate the difficult US landscape on gun violence³³; and

36
37 Whereas, Because of the difficulties the US has faced in addressing gun deaths and injuries,
38 now is the time to produce actionable recommendations for the AMA to be a leader in
39 responding to the gun violence public health crisis; therefore, be it

40
41 RESOLVED, Our American Medical Association convene a task force for the purposes of
42 working with advocacy groups and other relevant stakeholders to advocate for federal, state,
43 and local efforts to end the gun violence public health crisis; identifying and supporting
44 evidence-based community interventions to prevent gun injury, trauma, and death;
45 monitoring federal, state, and local legislation, regulation, and litigation relating to gun
46 violence; and reporting annually to the House of Delegates on the AMA's efforts to reduce
47 gun violence. (Directive to Take Action)

Fiscal Note: Estimated cost to implement resolution is \$50K.

Received: 06/10/2022

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RELEVANT AMA POLICY

Prevention of Firearm Accidents in Children H-145.990

Our AMA (1) supports increasing efforts to reduce pediatric firearm morbidity and mortality by encouraging its members to (a) inquire as to the presence of household firearms as a part of childproofing the home; (b) educate patients to the dangers of firearms to children; (c) encourage patients to educate their children and neighbors as to the dangers of firearms; and (d) routinely remind patients to obtain firearm safety locks, to store firearms under lock and key, and to store ammunition separately from firearms; (2) encourages state medical societies to work with other organizations to increase public education about firearm safety; (3) encourages organized medical staffs and other physician organizations, including state and local medical societies, to recommend programs for teaching firearm safety to children; and (4) supports enactment of Child Access Prevention laws that are consistent with AMA policy.

Res. 165, I-89; Reaffirmed: Sunset Report and Appended: Sub. Res. 401, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmation A-13; Reaffirmed: CSAPH Rep. 04, A-18; Reaffirmation: I-18; Modified: BOT Rep. 11, I-18

Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care H-145.975

1. Our AMA supports: a) federal and state research on firearm-related injuries and deaths; b) increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to inform state and federal health policy; c) encouraging physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety; d) the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes; e) encouraging local projects to facilitate the low-cost distribution of gun locks in homes; f) encouraging physicians to become involved in local firearm safety classes as a means of promoting injury prevention and the public health; and g) encouraging CME providers to consider, as appropriate, inclusion of presentations about the prevention of gun violence in national, state, and local continuing medical education programs.
2. Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of mental illness and concurrent substance use disorders, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior.
3. Our AMA (a) recognizes the role of firearms in suicides, (b) encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling, and (c) encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide.

Sub. Res. 221, A-13; Appended: Res. 416, A-14; Reaffirmed: Res. 426, A-16; Reaffirmed: BOT Rep. 28, A-18; Reaffirmation: A-18; Modified: CSAPH Rep. 04, A-18; Reaffirmation: I-18;

Reaffirmed: CSAPH Rep. 3, A-21

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

1. Our AMA: (a) will oppose any restrictions on physicians' and other members of the physician-led health care team's ability to inquire and talk about firearm safety issues and risks with their patients; (b) will oppose any law restricting physicians' and other members of the physician-led health care team's discussions with patients and their families about firearms as an intrusion into medical privacy; and (c) encourages dissemination of educational materials related to firearm safety to be used in undergraduate medical education.
2. Our AMA will work with appropriate stakeholders to develop state-specific guidance for physicians on how to counsel patients to reduce their risk for firearm-related injury or death, including guidance on when and how to ask sensitive questions about firearm ownership, access, and use, and clarification on the circumstances under which physicians are permitted or may be required to disclose the content of such conversations to family members, law enforcement, or other third parties.

Res. 219, I-11; Reaffirmation A-13; Modified: Res. 903, I-13; Appended: Res. 419, A-17;
Reaffirmed: CSAPH Rep. 04, A-18; Reaffirmed: CSAPH Rep. 3, I-21

Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997

1. Our AMA recognizes that uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and deaths.

Therefore, the AMA:

- (A) encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms;
- (B) urges that government agencies, the CDC in particular, enlarge their efforts in the study of firearm-related injuries and in the development of ways and means of reducing such injuries and deaths;
- (C) urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns;
- (D) urges the Congress to support recent legislative efforts to ban the manufacture and importation of nonmetallic, not readily detectable weapons, which also resemble toy guns; (5) encourages the improvement or modification of firearms so as to make them as safe as humanly possible;
- (E) encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms;
- (F) urges that a significant portion of any funds recovered from firearms manufacturers and dealers through legal proceedings be used for gun safety education and gun-violence prevention; and
- (G) strongly urges US legislators to fund further research into the epidemiology of risks related to gun violence on a national level.

2. Our AMA will advocate for firearm safety features, including but not limited to mechanical or smart technology, to reduce accidental discharge of a firearm or misappropriation of the weapon by a non-registered user; and support legislation and regulation to standardize the use of these firearm safety features on weapons sold for non-military and non-police officer use within the U.S.; with the aim of establishing manufacturer liability for the absence of safety features on newly manufactured firearms.

CSA Rep. A, I-87; Reaffirmed: BOT Rep. I-93-50; Appended: Res. 403, I-99; Reaffirmation A-07; Reaffirmation A-13; Appended: Res. 921, I-13; Reaffirmed: CSAPH Rep. 04, A-18; Reaffirmation: A-18; Reaffirmation: I-18; Appended: Res. 405, A-19

Firearms and High-Risk Individuals H-145.972

Our AMA supports: (1) the establishment of laws allowing family members, intimate partners,

household members, and law enforcement personnel to petition a court for the removal of a firearm when there is a high or imminent risk for violence; (2) prohibiting persons who are under domestic violence restraining orders, convicted of misdemeanor domestic violence crimes or stalking, from possessing or purchasing firearms; (3) expanding domestic violence restraining orders to include dating partners; (4) requiring states to have protocols or processes in place for requiring the removal of firearms by prohibited persons; (5) requiring domestic violence restraining orders and gun violence restraining orders to be entered into the National Instant Criminal Background Check System; and (6) efforts to ensure the public is aware of the existence of laws that allow for the removal of firearms from high-risk individuals. CSAPH Rep. 04, A-18; Reaffirmed: BOT Rep. 11, I-18; Reaffirmed: CSAPH Rep. 3, I-21

Firearm Availability H-145.996

1. Our AMA: (a) advocates a waiting period and background check for all firearm purchasers; (b) encourages legislation that enforces a waiting period and background check for all firearm purchasers; and (c) urges legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic, ceramics, or other non-metallic materials that cannot be detected by airport and weapon detection devices.
2. Our AMA supports requiring the licensing/permitting of firearms-owners and purchasers, including the completion of a required safety course, and registration of all firearms.
3. Our AMA supports “gun violence restraining orders” for individuals arrested or convicted of domestic violence or stalking, and supports extreme risk protection orders, commonly known as “red-flag” laws, for individuals who have demonstrated significant signs of potential violence. In supporting restraining orders and “red-flag” laws, we also support the importance of due process so that individuals can petition for their rights to be restored.

Res. 140, I-87; Reaffirmed: BOT Rep. 8, I-93; Reaffirmed: BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Modified: BOT Rep. 12, A-16; Appended: Res. 433, A-18; Reaffirmation: I-18; Modified: BOT Rep. 11, I-18

Ban on Handguns and Automatic Repeating Weapons H-145.985

It is the policy of the AMA to:

- (1) Support interventions pertaining to firearm control, especially those that occur early in the life of the weapon (e.g., at the time of manufacture or importation, as opposed to those involving possession or use). Such interventions should include but not be limited to:
 - (a) mandatory inclusion of safety devices on all firearms, whether manufactured or imported into the United States, including built-in locks, loading indicators, safety locks on triggers, and increases in the minimum pressure required to pull triggers;
 - (b) bans on the possession and use of firearms and ammunition by unsupervised youths under the age of 21;
 - (c) bans of sales of firearms and ammunition from licensed and unlicensed dealers to those under the age of 21 (excluding certain categories of individuals, such as military and law enforcement personnel);
 - (d) the imposition of significant licensing fees for firearms dealers;
 - (e) the imposition of federal and state surtaxes on manufacturers, dealers and purchasers of handguns and semiautomatic repeating weapons along with the ammunition used in such firearms, with the attending revenue earmarked as additional revenue for health and law enforcement activities that are directly related to the prevention and control of violence in U.S. society; and
 - (f) mandatory destruction of any weapons obtained in local buy-back programs.
- (2) Support legislation outlawing the Black Talon and other similarly constructed bullets.
- (3) Support the right of local jurisdictions to enact firearm regulations that are stricter than those that exist in state statutes and encourage state and local medical societies to evaluate and support local efforts to enact useful controls.

(4) Oppose “concealed carry reciprocity” federal legislation that would require all states to recognize concealed carry firearm permits granted by other states and that would allow citizens with concealed gun carry permits in one state to carry guns across state lines into states that have stricter laws.

(5) Support the concept of gun buyback programs as well as research to determine the effectiveness of the programs in reducing firearm injuries and deaths.

BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmation A-14; Appended: Res. 427, A-18; Reaffirmation: A-18; Modified: Res. 244, A-18

Data on Firearm Deaths and Injuries H-145.984

The AMA supports legislation or regulatory action that: (1) requires questions in the National Health Interview Survey about firearm related injury as was done prior to 1972; (2) mandates that the Centers for Disease Control and Prevention develop a national firearm fatality reporting system; and (3) expands activities to begin tracking by the National Electronic Injury Surveillance System.

Res. 811, I-94; Reaffirmed: CSA Rep. 6, A-04; Reaffirmation A-13

Control of Non-Detectable Firearms H-145.994

Our AMA supports a ban on the (1) manufacture, importation, and sale of any firearm which cannot be detected by ordinary airport screening devices, including 3D printed firearms and (2) production and distribution of 3D firearm digital blueprints.

Sub. Res. 79, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CSAPH Rep. 01, A-18; Modified: BOT Rep. 11, I-18

Epidemiology of Firearm Injuries D-145.999

Our AMA will: (1) strongly urge the Administration and Congress to encourage the Centers for Disease Control and Prevention to conduct an epidemiological analysis of the data of firearm-related injuries and deaths; and (2) urge Congress to provide sufficient resources to enable the CDC to collect and analyze firearm-related injury data and report to Congress and the nation via a broadly disseminated document, so that physicians and other health care providers, law enforcement and society at large may be able to prevent injury, death and the other costs to society resulting from firearms.

Res. 424, A-03; Reaffirmation A-13; Modified: CSAPH Rep. 1, A-13; Reaffirmation: A-18

Firearm Related Injury and Death: Adopt a Call to Action H-145.973

Our AMA endorses the specific recommendations made by an interdisciplinary, inter-professional group of leaders from the American Academy of Family Physicians, American Academy of Pediatrics, American College of Emergency Physicians, American College of Obstetricians and Gynecologists, American College of Physicians, American College of Surgeons, American Psychiatric Association, American Public Health Association, and the American Bar Association in the publication "Firearm-Related Injury and Death in the United States: A Call to Action From 8 Health Professional Organizations and the American Bar Association," which is aimed at reducing the health and public health consequences of firearms and lobby for their adoption.

Res. 214, I-16

Preventing Firearm-Related Injury and Morbidity in Youth D-145.996

Our American Medical Association will identify and support the distribution of firearm safety materials that are appropriate for the clinical setting.

Res. 216, A-15

Gun Safety H-145.978

Our AMA: (1) recommends and promotes the use of trigger locks and locked gun cabinets as

safety precautions; and (2) endorses standards for firearm construction reducing the likelihood of accidental discharge when a gun is dropped and that standardized drop tests be developed. Removing Restrictions on Federal Funding for Firearm Violence Research D-145.994

Our AMA will provide an informational report on recent and current organizational actions taken on our existing AMA policies (e.g. H-145.997) regarding removing the restrictions on federal funding for firearms violence research, with additional recommendations on any ongoing or proposed upcoming actions.

Res. 425, I-98; Reaffirmed: Res. 409, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmation A-13

AMA Campaign to Reduce Firearm Deaths H-145.988

The AMA supports educating the public regarding methods to reduce death and injury due to keeping guns, ammunition and other explosives in the home.

Res. 410, A-93; Reaffirmed: CLRPD Rep. 5, A-03; Reaffirmation A-13; Modified: CSAPH Rep. 1, A-13

Guns in Hospitals H-215.977

1. The policy of the AMA is to encourage hospitals to incorporate, within their security policies, specific provisions on the presence of firearms in the hospital. The AMA believes the following points merit attention:

A. Given that security needs stem from local conditions, firearm policies must be developed with the cooperation and collaboration of the medical staff, the hospital security staff, the hospital administration, other hospital staff representatives, legal counsel, and local law enforcement officials. Consultation with outside experts, including state and federal law enforcement agencies, or patient advocates may be warranted.

B. The development of these policies should begin with a careful needs assessment that addresses past issues as well as future needs.

C. Policies should, at minimum, address the following issues: a means of identification for all staff and visitors; restrictions on access to the hospital or units within the hospital, including the means of ingress and egress; changes in the physical layout of the facility that would improve security; the possible use of metal detectors; the use of monitoring equipment such as closed circuit television; the development of an emergency signaling system; signage for the facility regarding the possession of weapons; procedures to be followed when a weapon is discovered; and the means for securing or controlling weapons that may be brought into the facility, particularly those considered contraband but also those carried in by law enforcement personnel.

D. Once policies are developed, training should be provided to all members of the staff, with the level and type of training being related to the perceived risks of various units within the facility. Training to recognize and defuse potentially violent situations should be included.

E. Policies should undergo periodic reassessment and evaluation.

F. Firearm policies should incorporate a clear protocol for situations in which weapons are brought into the hospital.

2. Our AMA will advocate that hospitals and other healthcare delivery settings limit guns and conducted electrical weapons in units where patients suffering from mental illness are present
BOT Rep. 23, I-94; Reaffirmation I-03; Reaffirmed: CSA Rep. 6, A-04; Reaffirmed: CSAPH Rep. 2, I-10; Appended: Res. 426, A-16

Gun Regulation H-145.999

Our AMA supports stricter enforcement of present federal and state gun legislation and the imposition of mandated penalties by the judiciary for crimes committed with the use of a firearm, including the illegal possession of a firearm.

Sub. Res. 31, I-81; Reaffirmed: CLRPD Rep. F, I-91; Amended: BOT Rep. I-93-50; Reaffirmed:

Res. 409, A-00; Reaffirmation A-07; Reaffirmed: BOT Rep. 22, A-17; Modified: Res. 401, A-17;
Reaffirmation: I-18

Physician Involvement in State Regulations of Motor Vehicle Operation and/or Firearm Use by Individuals with Cognitive Deficits Due to Traumatic Brain Surgery H-10.960

Our AMA encourages the National Institutes of Health and other funders to expand research on cognitive impairment, including traumatic brain injury (TBI), as a risk factor for harm to self or others that may impact driving and/or firearm ownership, and the role of the physicians in policy advocacy and counseling patients so as to decrease the risk of morbidity and mortality.

CSAPH Rep. 3, I-21

Waiting Period Before Gun Purchase H-145.992

The AMA supports legislation calling for a waiting period of at least one week before purchasing any form of firearm in the U.S.

Res. 171, A-89; Reaffirmed: BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmation A-07; Reaffirmed: BOT Rep. 22, A-17; Reaffirmation: A-18

Physicians and the Public Health Issues of Gun Safety D-145.997

Our AMA will request that the US Surgeon General develop a report and campaign aimed at reducing gun-related injuries and deaths.

Res. 410, A-13

Use of Conducted Electrical Devices by Law Enforcement Agencies H-145.977

Our AMA: (1) recommends that law enforcement departments and agencies should have in place specific guidelines, rigorous training, and an accountability system for the use of conducted electrical devices (CEDs) that is modeled after available national guidelines; (2) encourages additional independent research involving actual field deployment of CEDs to better understand the risks and benefits under conditions of actual use. Federal, state, and local agencies should accurately report and analyze the parameters of CED use in field applications; and (3) policy is that law enforcement departments and agencies have a standardized protocol developed with the input of the medical community for the evaluation, management and post-exposure monitoring of subjects exposed to CEDs.

CSAPH Rep. 6, A-09 Modified: Res. 501, A-14

Restriction of Assault Weapons H-145.993

Our AMA supports appropriate legislation that would restrict the sale and private ownership of inexpensive handguns commonly referred to as "Saturday night specials," and large clip, high-rate-of-fire automatic and semi-automatic firearms, or any weapon that is modified or redesigned to operate as a large clip, high-rate-of-fire automatic or semi-automatic weapon and ban the sale and ownership to the public of all assault-type weapons, bump stocks and related devices, high capacity magazines and armor piercing bullets.

Sub. Res. 264, A-89; Reaffirmed: BOT Rep. 50, I-93; Amended: Res. 215, I-94; Reaffirmed: CSA Rep. 6, A-04; Reaffirmation A-07; Reaffirmed: BOT Rep. 22, A-17; Modified: Res. 433, A-18; Reaffirmation: A-18

Waiting Periods for Firearm Purchases H-145.991

The AMA supports using its influence in matters of health to effect passage of legislation in the Congress of the U.S. mandating a national waiting period that allows for a police background and positive identification check for anyone who wants to purchase a handgun from a gun dealer anywhere in our country.

Sub. Res. 34, I-89; Reaffirmed: BOT Rep. 8, I-93; Reaffirmed: BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmation A-07; Reaffirmed: BOT Rep. 22, A-17; Modified: Res. 401, A-

17; Reaffirmation: A-18; Reaffirmation: I-18

Prevention of Ocular Injuries from BB and Air Guns H-145.982

The AMA encourages businesses that sell BB and air guns to make appropriate and safe protective eye wear available and encourages its use to their customers and to distribute educational materials on the safe use of non-powder guns.

Res. 416, I-96; Reaffirmed: CSAPH Rep. 3, A-06; Reaffirmed: CSAPH Rep. 01, A-16

Violence Prevention H-145.970

Our AMA: (1) encourages the enactment of state laws requiring the reporting of all classes of prohibited individuals, as defined by state and federal law, to the National Instant Criminal Background Check System (NICS); (2) supports federal funding to provide grants to states to improve NICS reporting; and (3) encourages states to automate the reporting of relevant information to NICS to improve the quality and timeliness of the data.

BOT Rep. 11, I-18; Reaffirmed: CSAPH Rep. 3, I-21

Prevention of Unintentional Shooting Deaths Among Children H-145.979

Our AMA supports legislation at the federal and state levels making gun owners legally responsible for injury or death caused by a child gaining unsupervised access to a gun, unless it can be shown that reasonable measures to prevent child access to the gun were taken by the gun owner, and that the specifics, including the nature of "reasonable measures," be determined by the individual constituencies affected by the law.

Res. 204, I-98 Reaffirmed: BOT Rep. 23, A-09; Reaffirmed: CSAPH Rep. 01, A-19

School Violence H-145.983

Our AMA: (1) encourages states to adopt legislation enabling schools to limit and control the possession and storage of weapons or potential weapons on school property; (2) advocates for schools to remain gun-free zones except for school-sanctioned activities and professional law enforcement officers; and (3) opposes requirements or incentives of teachers to carry weapons.

Sub. Res. 402, I-95; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15;

Appended: Res. 402, A-18

Gun Violence as a Public Health Crisis D-145.995

Our AMA: (1) will immediately make a public statement that gun violence represents a public health crisis which requires a comprehensive public health response and solution; and (2) will actively lobby Congress to lift the gun violence research ban.

Res. 1011, A-16; Reaffirmation: A-18; Reaffirmation: I-18

Development and Implementation of Recommendations for Responsible Media Coverage of Mass Shootings H-145.971

Our AMA encourages the Centers for Disease Control and Prevention, in collaboration with other public and private organizations, to develop recommendations and/or best practices for media coverage of mass shootings, including informed discussion of the limited data on the relationship between mental illness and gun violence, recognizing the potential for exacerbating stigma against individuals with mental illness.

Res. 212, I-18; Modified: Res. 934, I-19

Safety of Nonpowder (Gas-Loaded/Spring-Loaded) Guns H-145.989

It is the policy of the AMA to encourage the development of appropriate educational materials designed to enhance physician and general public awareness of the safe use of as well as the dangers inherent in the unsafe use of nonpowder (gas-loaded/spring-loaded) guns.

Res. 423, I-91; Modified: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11; Reaffirmed:

CSAPH Rep. 1, A-21

Less-Lethal Weapons and Crowd Control H-145.969

Our AMA: (1) supports prohibiting the use of rubber bullets, including rubber or plastic-coated metal bullets and those with composites of metal and plastic, by law enforcement for the purposes of crowd control and management in the United States; (2) supports prohibiting the use of chemical irritants and kinetic impact projectiles to control crowds that do not pose an immediate threat; (3) recommends that law enforcement agencies have in place specific guidelines, rigorous training, and an accountability system, including the collection and reporting of data on injuries, for the use of kinetic impact projectiles and chemical irritants; (4) encourages guidelines on the use of kinetic impact projectiles and chemical irritants to include considerations such as the proximity of non-violent individuals and bystanders; for kinetic impact projectiles, a safe shooting distance and avoidance of vital organs (head, neck, chest, and abdomen), and for all less-lethal weapons, the issuance of a warning followed by sufficient time for compliance with the order prior to discharge; (5) recommends that law enforcement personnel use appropriate de-escalation techniques to minimize the risk of violence in crowd control and provide transparency about less-lethal weapons in use and the criteria for their use; and (6) encourages relevant stakeholders including, but not limited to manufacturers and government agencies to develop and test crowd-control techniques which pose a more limited risk of physical harm.

BOT Rep. 10, A-21; Reaffirmed: BOT Rep. 2, I-21

Ban Realistic Toy Guns H-145.995

The AMA supports (1) working with civic groups and other interested parties to ban the production, sale, and distribution of realistic toy guns; and (2) taking a public stand on banning realistic toy guns by various public appeal methods.

Sub. Res. 140, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CSAPH Rep. 01, A-18

Increasing Toy Gun Safety H-145.974

Our American Medical Association (1) encourages toy gun manufacturers to take further steps beyond the addition of an orange tip on the gun to reduce the similarity of toy guns with real guns, and (2) encourages parents to increase their awareness of toy gun ownership risks.

Res. 406, A-15

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 247
(A-22)

Introduced by: Medical Student Section

Subject: Recognizing Child Poverty and the Racial Wealth Gap as Public Health Issues and Extending the Child Tax Credit for Low-Income Families

Referred to: Reference Committee B

1 Whereas, Rates of child poverty in the United States grew from 14.4% in 2019 to 16.1% in
2 2020, with a disproportionate impact among Black, Indigenous, and Latinx families, widening
3 the racial wealth gap¹⁻²; and

4 Whereas, Child poverty is causally linked with negative health outcomes during and beyond
5 childhood, including developmental delays or permanent deficits, chronic diseases, and
6 mental health conditions³⁻⁶; and

7 Whereas, In response to the adverse economic impact of the COVID-19 pandemic, the
8 American Rescue Plan Act (ARPA) temporarily increased the federal Child Tax Credit (CTC)
9 for 2021 (up to \$3,600 per child <6 years old and \$3,000 per child from 6-17 years old,
10 compared to the previous amount of up to \$2,000 per child ≤16 years old, with refunds limited
11 to \$1,400 per child)⁷; and

12 Whereas, As of 2021, 91% of low-income families (household income <\$35,000) spent
13 monthly CTC payments on fundamental necessities (food, clothing, shelter, utilities,
14 healthcare) or education⁸⁻⁹; and

15 Whereas, ARPA made the 2021 CTC fully refundable, allowing the lowest-income families to
16 receive the maximum credit even if their incomes were too low to owe federal income tax¹⁰;
17 and

18 Whereas, Under pre-ARPA law, approximately three-quarters of white and Asian children
19 were eligible for the full CTC compared to only about half of Black and Hispanic children, but
20 these racial gaps would be closed by full refundability¹¹; and

21 Whereas, Full refundability is crucial to ensuring widespread access to the CTC, with experts
22 estimating that extension of full refundability could reduce child poverty by 40% nationally
23 (from 14.2% to 8.4%) and have pronounced benefits among Black children¹²; and

24 Whereas, A report by the U.S. Congressional Joint Economic Committee on the economic
25 impact of an expanded CTC predicted long-term benefits for families and communities by
26 boosting both families' current incomes and children's future earnings, and, in turn, the
27 economy's future economic potential¹³; and

28 Whereas, The novel monthly payment model of the CTC from July-December 2021 (as
29 opposed to the previous model of a yearly lump sum) reduced income volatility and food
30 insecurity,¹⁴ including a 25% decline in food insufficiency among low-income families¹⁵⁻¹⁶; and

31

1 Whereas, The monthly CTC could improve short- and long-term health by allowing low-
2 income families to seek care at the time it is needed, rather than delaying care until tax time
3 when funds are received¹⁷; and

4
5 Whereas, Other models of cash assistance, such as universal basic income (UBI) and the
6 expanded Earned Income Tax Credit of 2021, have been associated with improved health
7 outcomes, including decreased rates of low birth weight, childhood obesity, smoking, injuries,
8 behavioral problems, psychiatric conditions, and hospitalizations¹⁸⁻²⁵; and

9
10 Whereas, Reducing child poverty through an extension of the CTC could improve adult
11 health, reduce total lifetime health care expenditure, and improve health equity²⁶⁻²⁷; and

12
13 Whereas, Our AMA has signaled its commitment to racial health equity and reducing the
14 racial health gap, which is inherently tied to the racial wealth gap (H-65.952, H-65.960, H-
15 165.822)²⁸⁻²⁹; and

16
17 Whereas, Our AMA has no policy calling attention to child poverty and the racial wealth gap
18 as a public health issue, nor have we advocated for the CTC as a potential solution,³⁰⁻³²
19 although one report from the AMA Council on Medical Service has acknowledged the
20 importance of the CTC for minimizing financial hardship for families during the pandemic³³;
21 and

22
23 Whereas, Congress recently debated an expansion of the 2021 CTC, which expired in
24 December 2021 but is widely supported by President Biden, Democrat legislators, and the
25 public, representing a monumental opportunity to advocate for legislation that supports
26 economic mobility and asset building—both of which are critical to breaking the cycle of
27 poverty and economic hardship for families and are associated with positive health
28 outcomes^{6,34-36}; and

29
30 Whereas, This window of advocacy could close before our AMA Interim 2022 meeting if
31 Democrat legislators lose their majority in the U.S. House of Representatives in the upcoming
32 midterm elections, warranting immediate forwarding to the AMA House of Delegates; and

33
34 Whereas, Another six months without the expanded CTC, particularly during this time of
35 economic instability due to the COVID-19 pandemic and geopolitical unrest, is another six
36 months where millions of children, particularly in low-income families of color, will experience
37 poverty (and its negative health effects) that could be reduced by half with an expanded
38 CTC^{13,27}; therefore, be it

39
40 RESOLVED, That our AMA recognize child poverty as a public health issue and a crucial
41 social determinant of health across the life course; and be it further

42
43 RESOLVED, That our AMA recognize that the disproportionate concentration of child poverty
44 and generational wealth gaps experienced by Black, American Indian or Alaska Native, and
45 Hispanic families are a consequence of structural racism and a barrier to achieving racial
46 health equity; and be it further

47
48 RESOLVED, That our AMA advocate for fully refundable expanded child tax credit payments
49 and other evidence-based cash assistance programs to alleviate child poverty, ameliorate the
50 racial wealth gap, and advance health equity for low-income U.S. residents.

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 06/10/2022

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RELEVANT AMA POLICY

Universal Basic Income Pilot Studies D-440.916

Our AMA will: (1) actively monitor universal basic income pilot studies that intend to measure participant health outcomes and access to care; and (2) encourage universal basic income pilot studies to measure health outcomes and access to care for patients to increase data on the health effects of these programs.

CMS Rep. 3, A-21

Poverty Screening as a Clinical Tool for Improving Health Outcomes H-160.909

Our AMA encourages screening for social and economic risk factors in order to improve care plans and direct patients to appropriate resources.

Res. 404, A-13; Reaffirmed: BOT Rep. 39, A-18

Racism as a Public Health Threat H-65.952

1. Our AMA acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health care delivery have caused and continue to cause harm to marginalized communities and society as a whole.
2. Our AMA recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care.
5. Our AMA: (a) supports the development of policy to combat racism and its effects; and (b) encourages governmental agencies and nongovernmental organizations to increase funding for research into the epidemiology of risks and damages related to racism and how to prevent or repair them.

Res. 5, I-20

Increasing Coverage for Children H-165.877

Our AMA: (3) places particular emphasis on advocating policies and proposals designed to expand the extent of health expense coverage protection for presently uninsured children; (10) advocates consideration by Congress, and encourages consideration by states, of other sources of financing premium subsidies for children's private coverage.

Sub. Res. 208, A-97; CMS Rep. 7, A-97; Reaffirmation A-99; Reaffirmed: CMS Rep. 5, I-99; Reaffirmed: Res. 238 and Reaffirmation A-00; Reaffirmation A-02Reaffirmation A-05; Consolidated: CMS Rep. 7, I-05; Reaffirmation A-07; Reaffirmation A-08; Modified: Speakers Rep. 2, I-14; Reaffirmed: CMS Rep. 01, A-18

Health Plan Initiatives Addressing Social Determinants of Health H-165.822

Our AMA:

1. recognizing that social determinants of health encompass more than health care, encourages new and continued partnerships among all levels of government, the private sector, philanthropic organizations, and community- and faith-based organizations to address non-medical, yet critical health needs and the underlying social determinants of health;
2. supports continued efforts by public and private health plans to address social determinants of health in health insurance benefit designs;
3. encourages public and private health plans to examine implicit bias and the role of racism and social determinants of health, including through such mechanisms as professional development and other training;
4. supports mechanisms, including the establishment of incentives, to improve the acquisition of data related to social determinants of health, while minimizing burdens on patients and physicians;
5. supports research to determine how best to integrate and finance non-medical services as part of health insurance benefit design, and the impact of covering non-medical benefits on health care and societal costs; and
6. encourages coverage pilots to test the impacts of addressing certain non-medical, yet critical health needs, for which sufficient data and evidence are not available, on health outcomes and health care costs.

CMS Rep. 7, I-20; Reaffirmed: CMS Rep. 5, I-21

Expanding Access to Screening Tools for Social Determinants of Health/Social Determinants of Health in Payment Models H-160.896

Our AMA supports payment reform policy proposals that incentivize screening for social determinants of health and referral to community support systems.

BOT Rep. 39, A-18; Reaffirmed: CMS Rep. 10, A-19

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

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

Res. 021, A-19

Alternative Payment Models and Vulnerable Populations D-385.952

Our AMA: (1) supports alternative payment models (APMs) that link quality measures and payments to outcomes specific to vulnerable and high-risk populations and reductions in health care disparities; (2) will continue to encourage the development and implementation of physician-focused APMs that provide services to improve the health of vulnerable and high-risk populations; and (3) will continue to advocate for appropriate risk adjustment of performance results based on clinical and social determinants of health to avoid penalizing physicians whose performance and aggregated data are impacted by factors outside of the physician's control.

CMS Rep. 10, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 248
(A-22)

Introduced by: Organized Medical Staff Section

Subject: Promoting Proper Oversight and Reimbursement for Specialty Physician Extenders and Non-Physician Practitioners

Referred to: Reference Committee B

1 Whereas, Physician extenders and non-physician practitioners, such as nurse practitioners and
2 physician assistants have far less training than physicians; and
3
4 Whereas, Physician extenders and non-physician practitioners specifically lack specialty training
5 as part of their education or maintenance of certification and as such should not be considered
6 to be meant to be practicing as specialists without appropriate oversight; and
7
8 Whereas, Despite differences in training relative to physicians, in some states extenders and
9 non-physician practitioners are permitted to practice a wide variety of specialty medicine
10 independently, including intrathecal pain management, fluoroscopy, surgery, biopsies,
11 endocrinology, dermatology, anesthesiology, ophthalmology, and orthopedics; and
12
13 Whereas, Because physician extenders and non-physician practitioners can change practices
14 every year, a quality standard for their work cannot be truly established; and
15
16 Whereas, In some states that allow physician extenders and non-physician practitioners to
17 practice independently, their oversight boards have no specific training in overseeing specialty
18 care in which their members are in practice; and
19
20 Whereas, Physician assistants, nurse practitioners, and other extenders have been pushing in
21 several states for greater independence in their practices and, in many cases, seeing that
22 independence granted while board standards are kept at the lowest level; and
23
24 Whereas, Current Medicare reimbursement for physician extenders and non-physician
25 practitioners pays 85 percent of the physician rate when practicing beyond primary care,
26 including specialties like pain management, anesthesiology, orthopedics, ophthalmology,
27 dermatology, ENT, endocrinology, and urology despite thousands of fewer hours of training,
28 markedly less academic rigor, and dramatically fewer costs to achieve academic training than
29 all Board Certified Physicians; and
30
31 Whereas, The original goal of physician extenders and non-physician practitioners was never to
32 see patients independently but to contribute instead to overall continuity of care; and
33
34 Whereas, real world evidence from Hattiesburg Clinic to redesign the clinic's care model over 15
35 years to expand care teams found that placing non-physician practitioners in independent
36 panels was more expensive than care delivered by physicians¹; therefore be it

¹ Batson, B.N, Crosby, S.N., & Fitzpatrick, J.M. (2022). Targeting value-based care with physician-led care teams. *Journal of the Mississippi State Medical Association*. 63, 1. P. 19-21.
<https://ejournal.msmaonline.com/publication/?m=63060&i=735364&p=22&ver=html5>

1
2 RESOLVED, That our American Medical Association work with state medical boards to improve
3 oversight and coordination of the work done with physician extenders and non-physician
4 practitioners (Directive to Take Action); and be it further
5
6 RESOLVED, That our AMA adopt the position that Boards of Medical Examiners or its
7 equivalent in each state should have oversight of cases involving specialty care as boards with
8 oversight over physician extenders and non-physician practitioners do not have the training to
9 oversee specialty care (New HOD Policy); and be it further
10
11 RESOLVED, That our AMA adopt the position that in each state the Board of Medical
12 Examiners or its equivalent should have oversight over physician extenders and non-physician
13 practitioners if billing independently or in independent practice as their respective oversights
14 boards do not have experience providing accurate oversight for specialty care (New HOD
15 Policy).

Fiscal Note: Modest - between \$1,000 - \$5,000

Date received: 06/10/22

RELEVANT AMA POLICY

Physician and Nonphysician Licensure and Scope of Practice (D-160.995)

1. Our AMA will: (a) continue to support the activities of the Advocacy Resource Center in providing advice and assistance to specialty and state medical societies concerning scope of practice issues to include the collection, summarization and wide dissemination of data on the training and the scope of practice of physicians (MDs and DOs) and nonphysician groups and that our AMA make these issues a legislative/advocacy priority; (b) endorse current and future funding of research to identify the most cost effective, high-quality methods to deliver care to patients, including methods of multidisciplinary care; and (c) review and report to the House of Delegates on a periodic basis on such data that may become available in the future on the quality of care provided by physician and nonphysician groups.
2. Our AMA will: (a) continue to work with relevant stakeholders to recognize physician training and education and patient safety concerns, and produce advocacy tools and materials for state level advocates to use in scope of practice discussions with legislatures, including but not limited to infographics, interactive maps, scientific overviews, geographic comparisons, and educational experience; (b) advocate for the inclusion of non-physician scope of practice characteristics in various analyses of practice location attributes and desirability; (c) advocate for the inclusion of scope of practice expansion into measurements of physician well-being; and (d) study the impact of scope of practice expansion on medical student choice of specialty.
3. Our AMA will consider all available legal, regulatory, and legislative options to oppose state board decisions that increase non-physician health care provider scope of practice beyond legislative statute or regulation.

Citation: CME Rep. 1, I-00; Reaffirmed: CME Rep. 2, A-10; Modified: CCB/CLRPD Rep. 2, A-14; Appended: Res. 251, A-18; Appended: Res. 222, I-19

Need for Active Medical Board Oversight of Medical Scope-of-Practice Activities by Mid Level Practitioners (H-270.958)

1. It is AMA policy that state medical boards shall have authority to regulate the practice of medicine by all persons within a state notwithstanding claims to the contrary by

nonphysician practitioner state regulatory boards or other such entities.

2. Our AMA will work with interested Federation partners: (a) in pursuing legislation that requires all health care practitioners to disclose the license under which they are practicing and, therefore, prevent deceptive practices such as nonphysician healthcare practitioners presenting themselves as physicians or "doctors"; (b) on a campaign to identify and have elected or appointed to state medical boards physicians (MDs or DOs) who are committed to asserting and exercising the state medical board's full authority to regulate the practice of medicine by all persons within a state notwithstanding efforts by nonphysician practitioner state regulatory boards or other such entities that seek to unilaterally redefine their scope of practice into areas that are true medical practice.

Citation: BOT Action in response to referred for decision Res. 902, I-06; Reaffirmed: BOT Rep. 06, A-16

10.2 Physician Employment by a Nonphysician Supervisee

Physicians' relationships with midlevel practitioners must be based on mutual respect and trust as well as their shared commitment to patient well-being. Health care professionals recognize that clinical tasks should be shared and delegated in keeping with each practitioner's training, expertise, and scope of practice. Given their comprehensive training and broad scope of practice, physicians have a professional responsibility for the quality of overall care that patients receive, even when aspects of that care are delivered by nonphysician clinicians.

Accepting employment to supervise a nonphysician employer's clinical practice can create ethical dilemmas for physicians. If maintaining an employment relationship with a midlevel practitioner contributes significantly to the physician's livelihood, the personal and financial influence that employer status confers creates an inherent conflict for a physician who is simultaneously an employee and a clinical supervisor of his or her employer.

Physicians who are simultaneously employees and clinical supervisors of nonphysician practitioners must:

- (a) Give precedence to their ethical obligation to act in the patient's best interest.
- (b) Exercise independent professional judgment, even if that puts the physician at odds with the employer-supervisee.

AMA Principles of Medical Ethics: II, VI, VIII

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.

Citation: Issued: 2016

Scopes of Practice of Physician Extenders (H-35.973)

Our AMA supports the formulation of clearer definitions of the scope of practice of physician extenders to include direct appropriate physician supervision and recommended guidelines for physician supervision to ensure quality patient care.

Citation: Res. 213, A-02; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed: BOT Rep. 7, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 249
(A-22)

Introduced by: Organized Medical Staff Section

Subject: Clarification of Healthcare Physician Identification: Consumer Truth & Transparency

Referred to: Reference Committee B

1 Whereas, The American Medical Association supports a role for non-physicians healthcare
2 practitioners within the framework of patient centered, physician-led healthcare, non-physician
3 provider contributions to the delivery of care should not be confused or considered equivalent to
4 those of a licensed physician; and
5
6 Whereas, Patients are entitled to clarity and transparency regarding the qualifications and
7 limitations of those providing their healthcare; and
8
9 Whereas, Many physicians are reporting misappropriation on their titles by the use of
10 professional terms, titles, or other descriptors by non-physician providers, such as by the
11 addition of the specialty-specific “-ologist” nomenclature (“anesthesiologist,” “dermatologist,”
12 “cardiologist,” etc.), addition of the word “surgeon,” or substitution of the word “associate” for
13 “assistant,” thus describing themselves as “nurse anesthesiologists,” “aesthetic surgeons,”
14 “nurse dermatologists,” “optometric surgeons” or “physician associates,” etc., and by using such
15 terms in personal, practice, marketing, and public communications; and
16
17 Whereas, Current regulations, such as those requiring the use of nametags and identification
18 badges are important but insufficient to properly identify the title and training of an individual’s
19 healthcare provider; and
20
21 Whereas, Title misappropriation and deceptive advertising is a nationwide problem, requiring
22 statutory, regulatory, and judicial action: recently, the New Hampshire Supreme Court upheld
23 the new Hampshire Board of Medicine ruling that healthcare professionals using the term
24 “anesthesiologist” must be licensed physicians, and only licensed MDs and Dos who are fully
25 trained in anesthesiology will be allowed to call themselves “anesthesiologists;” and
26
27 Whereas, Consumer “Truth-in-Advertising” laws are helping to safeguard patients in Texas,
28 where the Texas Association of Nurse Anesthetists, in response to the American Association of
29 Nurse Anesthetists (AANA) name change to the American Association of Nurse
30 Anesthesiologists (AANA), notified its members of the AANA title change approval of the “nurse
31 anesthesiologist” term and cautioned such Texas members that any nomenclature comparing
32 nurses to physicians that misleads patients could result in disciplinary or legal action; and
33
34 Whereas, Washington, DC law describes prohibited representations (DC CODE §3-1210.03),
35 stating that “unless authorized to practice medicine under this chapter, a person shall not use or
36 imply the use of the words or terms ‘physician,’ ‘surgeon,’ ‘medical doctor,’ ‘doctor of
37 osteopathy,’ ‘M.D.,’ ‘anesthesiologist,’ ‘cardiologist,’ ‘dermatologist,’ … or any similar title or
38 description of services with the intent to represent that the person practices medicine;” therefore
39 be it

1 RESOLVED, That our American Medical Association advocate for legislation that would
2 establish clear legal definitions for use of words or terms "physician," "surgeon," "medical
3 doctor," "doctor of osteopathy," "M.D." , "D.O., or any other allopathic or osteopathic medical
4 specialist (Directive to Take Action); and be it further
5

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

Fiscal Note: Modest - between \$1,000 - \$5,000

Date received: 06/10/22

RELEVANT AMA POLICY

Definition and Use of the Term Physician (H-405.951)

Our AMA:

1. Affirms that the term physician be limited to those people who have a Doctor of Medicine, Doctor of Osteopathic Medicine, or a recognized equivalent physician degree and who would be eligible for an Accreditation Council for Graduate Medical Education (ACGME) residency.
2. Will, in conjunction with the Federation, aggressively advocate for the definition of physician to be limited as defined above:
 - a. In any federal or state law or regulation including the Social Security Act or any other law or regulation that defines physician;
 - b. To any federal and state legislature or agency including the Department of Health and Human Services, Federal Aviation Administration, the Department of Transportation, or any other federal or state agency that defines physician; and
 - c. To any accrediting body or deeming authority including the Joint Commission, Health Facilities Accreditation Program, or any other potential body or authority that defines physician.
3. Urges all physicians to insist on being identified as a physician, to sign only those professional or medical documents identifying them as physicians, and to not let the term physician be used by any other organization or person involved in health care.
4. Ensure that all references to physicians by government, payers, and other health care entities involving contracts, advertising, agreements, published descriptions, and other communications at all times distinguish between physician, as defined above, and non-physicians and to discontinue the use of the term provider.
5. Policy requires any individual who has direct patient contact and presents to the patient as a doctor, and who is not a physician, as defined above, must specifically and simultaneously declare themselves a non-physician and define the nature of their doctorate degree.
6. Will review and revise its own publications as necessary to conform with the House of Delegates' policies on physician identification and physician reference and will refrain from any definition of physicians as providers that is not otherwise covered by existing Journal of the American Medical Association (JAMA) Editorial Governance Plan, which protects the editorial independence of JAMA.
7. Actively supports the Scope of Practice Partnership in the Truth in Advertising campaign

Citation: Res. 214, A-19

Definition of a Physician (H-405.951)

1. The AMA affirms that a physician is an individual who has received a "Doctor of Medicine" or a "Doctor of Osteopathic Medicine" degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine.
2. AMA policy requires anyone in a hospital environment who has direct contact with a patient who presents himself or herself to the patient as a "doctor," and who is not a "physician" according to the AMA definition above, must specifically and simultaneously declare themselves a "non-physician" and define the nature of their doctorate degree.
3. Our AMA actively supports the Scope of Practice Partnership in the Truth in Advertising campaign.

Citation: CME Rep. 4, A-94; Reaffirmed by Sub Res. 712, I-94; Reaffirmed and Modified: CME Rep. 2, A-04 Res. 846, I-08; Reaffirmed in lieu of Res 235, A-09; Reaffirmed: Res. 821, I-09; Appended: BOT Rep. 9, I-09; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed: A-13; Reaffirmed: A-15; Reaffirmed in lieu of: Res. 225, A-17; Reaffirmed: Res. 228, A-19

Communications and Collaboration with the Federation (G-620.021)

Our AMA: (1) when confronted with attempts by non-physicians to expand scope of practice via state legislation, shall work at the invitation of its component societies to develop strategies to most effectively promote and protect the best interest of our patients; (2) shall continue to work with national medical specialty societies to assist them in working with and coordinating activities with state medical associations and that the AMA, when requested by either a state medical association or a national specialty society, provide a mechanism to attempt to resolve any dispute between such organizations; (3) shall become actively involved in lobbying and/or communicating with state officials at the request of the state medical associations. (4) Prior to placing targeted advertising, our AMA will contact the relevant state medical associations and/or specialty societies for the purpose of enhancing communication about AMA's planned activities.

Citation: CME Rep. 4, A-94; Reaffirmed by Sub Res. 712, I-94; Reaffirmed and Modified: CME Rep. 2, A-04 Res. 846, I-08; Reaffirmed in lieu of Res 235, A-09; Reaffirmed: Res. 821, I-09; Appended: BOT Rep. 9, I-09; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed: A-13; Reaffirmed: A-15; Reaffirmed in lieu of: Res. 225, A-17; Reaffirmed: Res. 228, A-19

Physician Practice Drift (H-410.951)

Our AMA will: (1) continue to work with interested state and national medical specialty societies to advance truth in advertising legislation, and (2) continue to monitor legislative and regulatory activity related to physician practice drift.

Citation: BOT Rep. 5, A-13

Truth in Advertising (H-405.964)

1. AMA policy is that any published lists of "Best Physicians" should include a full disclosure of the selection criteria, including direct or indirect financial arrangements.
2. Our AMA opposes any misappropriation of medical specialties' titles and work with state medical societies to advocate for states and administrative agencies overseeing nonphysician providers to authorize only the use of titles and descriptors that align with the nonphysician providers' state issued licenses.

Citation: Sub. Res. 9, A-02; Reaffirmed: CCB/CLRPD Rep. 4, A-12; Appended: Res. 228, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 250
(A-22)

Introduced by: Organized Medical Staff Section

Subject: Opposition to Criminalization of Physicians' Medical Practice

Referred to: Reference Committee B

1 Whereas, Physicians have a professional and ethical obligation to act in the best interest of their
2 patients by following evidence-based practices; and
3
4 Whereas, Physicians act in the best interest of their patients' access to needed medical
5 services; and
6
7 Whereas, The physician-patient relationship relies on a physician's ability to use their medical
8 judgement as to the information or treatment that is in the best interest of a patient; and
9
10 Whereas, Our AMA takes all reasonable and necessary steps to ensure that its members can
11 exercise medical decision-making and treatment in good faith; and
12
13 Whereas, Federal and state laws should not criminalize physicians for practicing within the
14 accepted standard of medical care and within the scope of training for their specialty; and
15
16 Whereas, Government or other third parties that seek to criminalize a physician's ability to use
17 their professional medical judgment as to the treatment that is in the best interest of a patient
18 compromise the trusted nature of the physician-patient relationship; therefore be it
19
20 RESOLVED, That our American Medical Association affirm that government and other third-
21 party interference in evidence-based medical care compromises the physician-patient
22 relationship and may undermine the provision of quality healthcare (Directive to Take Action);
23 and be it further
24
25 RESOLVED, That our AMA oppose any government regulation or legislative action which would
26 criminalize physicians for providing evidence-based medical care within the accepted standard
27 of care according to the scope of a physician's training and professional judgment. (New HOD
28 Policy)

Fiscal Note: Modest - between \$1,000 - \$5,000

Date received: 06/10/22

RELEVANT AMA POLICY

Patient-Physician Relationships (1.1.1)

The practice of medicine, and its embodiment in the clinical encounter between a patient and a physician, is fundamentally a moral activity that arises from the imperative to care for patients and to alleviate suffering. The relationship between a patient and a physician is based on trust, which gives rise to physicians' ethical responsibility to place patients' welfare above the physician's own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for their patients' welfare.

A patient-physician relationship exists when a physician serves a patient's medical needs. Generally, the relationship is entered into by mutual consent between physician and patient (or surrogate).

However, in certain circumstances a limited patient-physician relationship may be created without the patient's (or surrogate's) explicit agreement. Such circumstances include:

- (a) When a physician provides emergency care or provides care at the request of the patient's treating physician. In these circumstances, the patient's (or surrogate's) agreement to the relationship is implicit.
- (b) When a physician provides medically appropriate care for a prisoner under court order, in keeping with ethics guidance on court-initiated treatment.
- (c) When a physician examines a patient in the context of an independent medical examination, in keeping with ethics guidance. In such situations, a limited patient-physician relationship exists.

AMA Principles of Medical Ethics: I,II,IV,VIII

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.

Citation: Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 251
(A-22)

Introduced by: Organized Medical Staff Section

Subject: Physician Medical License Use in Clinical Supervision

Referred to: Reference Committee B

1 Whereas, Physicians, as leaders of the healthcare team, often clinically supervise other team
2 members including non-physician practitioners; and
3
4 Whereas, Patients are often not explicitly informed regarding the qualifications of the person
5 treating them when seeking medical care; and
6
7 Whereas, Physicians are being required or at times coerced as a condition of employment to
8 supervise non-physician practitioners either directly or indirectly; and
9
10 Whereas, Physicians are being asked to "supervise," in name only, unreasonably high numbers
11 of non-physician practitioners, exposing the physicians to liability risk; and
12
13 Whereas, There have been reported instances of physicians' medical licenses being used,
14 unbeknownst to the physician, to document "supervision" of non-physician practitioners and
15 instances where the non-physician practitioners do not even know the identity of their
16 documented "supervising" physician; and
17
18 Whereas, Physicians must retain the ability to advocate in good faith for the safety and clinical
19 care of their patients without concern for negative personal consequences; therefore be it
20
21 RESOLVED, That our American Medical Association work with relevant regulatory agencies to
22 ensure physicians receive written notification when their license is being used to document
23 "supervision" of non-physician practitioners (Directive to Take Action); and be it further
24
25 RESOLVED, That our AMA oppose mandatory physician supervision of non-physician
26 practitioners as a condition for physician employment (New HOD Policy); and be it further
27
28 RESOLVED, That our AMA advocate for the right of physicians to deny participation in
29 "supervision" of any non-physician practitioner with whom they have concerns for patient safety
30 and/or clinical care (Directive to Take Action); and be it further
31
32 RESOLVED, That our AMA advocate that physicians be able to report unsafe care provided by
33 non-physician practitioners to the appropriate regulatory board with whistleblower protections for
34 the physician and their employment (Directive to Take Action).

Fiscal Note: Modest - between \$1,000 - \$5,000

Date received: 06/10/22

RELEVANT AMA POLICY

Practicing Medicine by Non-Physicians (H-160.949)

Our AMA: (1) urges all people, including physicians and patients, to consider the consequences of any health care plan that places any patient care at risk by substitution of a non-physician in the diagnosis, treatment, education, direction and medical procedures where clear-cut documentation of assured quality has not been carried out, and where such alters the traditional pattern of practice in which the physician directs and supervises the care given; (2) continues to work with constituent societies to educate the public regarding the differences in the scopes of practice and education of physicians and non-physician health care workers; (3) continues to actively oppose legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision; (4) continues to encourage state medical societies to oppose state legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision; (5) through legislative and regulatory efforts, vigorously support and advocate for the requirement of appropriate physician supervision of non-physician clinical staff in all areas of medicine; and (6) opposes special licensing pathways for "assistant physicians" (i.e., those who are not currently enrolled in an Accreditation Council for Graduate Medical Education training program, or have not completed at least one year of accredited graduate medical education in the U.S). Citation: Res. 317, I-94; Modified: Res. 501, A-97; Appended: Res. 321, I-98; Reaffirmed: A-99; Appended: Res. 240, Reaffirmed: Res. 708 and reaffirmation, A-00; Reaffirmed: CME Rep. 1, I-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: Res. 208, I-10; Reaffirmed: Res. 334, A-11; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed: Res. 107, A-14; Appended: Res. 342, A-14; Modified: CME Rep. 2, A-21

Support for Physician Led, Team Based Care (D-35.985)

Our AMA:

1. Reaffirms, will proactively advance at the federal and state level, and will encourage state and national medical specialty societies to promote policies H-35.970, H-35.973, H-35.974, H-35.988, H-35.989, H-35.992, H-35.993, H-160.919, H-160.929, H-160.947, H-160.949, H-160.950, H-360.987, H 405.969 and D-35.988.
2. Will identify and review available data to analyze the effects on patients' access to care in the opt-out states (states whose governor has opted out of the federal Medicare physician supervision requirements for anesthesia services) to determine whether there has been any increased access to care in those states.
3. Will identify and review available data to analyze the type and complexity of care provided by all non-physician providers, including CRNAs in the opt-out states (states whose governor has opted out of the federal Medicare physician supervision requirements for anesthesia services), compared to the type and complexity of care provided by physicians and/or the anesthesia care team.
4. Will advocate to policymakers, insurers and other groups, as appropriate, that they should consider the available data to best determine how non-physicians can serve as a complement to address the nation's primary care workforce needs.
5. Will continue to recognize non-physician providers as valuable components of the physician-led health care team.
6. Will continue to advocate that physicians are best qualified by their education and training to lead the health care team.

7. Will call upon the Robert Wood Johnson Foundation to publicly announce that the report entitled, "Common Ground: An Agreement between Nurse and Physician Leaders on Interprofessional Collaboration for the Future of Patient Care" was premature; was not released officially; was not signed; and was not adopted by the participants.

Citation: BOT Rep. 9, I-11; Reaffirmed: CMS Rep. 1, A-12; Reaffirmed: CMS Rep. 07, A-17; Reaffirmed: CMS Rep. 10, A-19; Reaffirmed: CMS Rep. 6, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 252
(A-22)

Introduced by: Resident and Fellow Section

Subject: The Criminalization of Health Care Decision Making and Practice

Referred to: Reference Committee B

1 Whereas, Former Tennessee nurse RaDonda Vaught was found guilty of criminally negligent
2 homicide following a self-reported unintentional medical error that resulted in a patient's death¹;
3 and

5 Whereas, "the AMA seeks to contain the burden of medical malpractice, liability against
6 physicians by opposing legal arguments that would expand such liability"²; and

8 Whereas, "the AMA has a longstanding history of opposing the criminalization of health care
9 decision making"³; and

11 Whereas, Many states restrict punitive damages, as is the example in the Maryland supreme
12 court case of Owens-Illinois, Inc. v. Zenobia⁴ which determined that punitive damages could not
13 be awarded unless a plaintiff is able to show that there was malice on the part of the wrongdoer
14 and again reaffirmed in 2017 in the case of Rockman v. Union Carbide Corp.⁵ which limited
15 punitive damages to intentional errors; therefore be it

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

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

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

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

1 RESOLVED, That our AMA study the ramifications of trying all health care decision-making,
2 practice, malpractice, and medical error cases in health courts instead of criminal courts
3 (Directive to Take Action); and be it further
4
5 RESOLVED, That our AMA reaffirm policies H-120.921, H-160.954, H-375.984, H-375.997, and
6 H-435.950. (Reaffirm HOD Policy)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 06/10/22

References:

1. Former nurse found guilty in accidental injection death of 75-year-old patient. Originally published 2022. Accessed 04/18/2022 at <[Nurse RaDonda Vaught convicted of 2 felonies for fatal medical error : Shots - Health News : NPR](#)>.
2. Ho v. Frye, 880 N.E.2d 1192 (Ind. 2008). [Ho v. Frye, 880 N.E.2d 1192 \(Ind. 2008\) \(ama-assn.org\)](#)
3. United States v. Wood, 207 F.3d 1222 (10th Cir. 2000). [United States v. Wood, 207 F.3d 1222 \(10th Cir. 2000\) \(ama-assn.org\)](#).
4. Owens-Illinois, Inc. v. Zenobia, 601 A.2d 633 (Md. 1992)
5. *Rockman v. Union Carbide Corp.*, 266 F. Supp. 3d 839 (D. Md. 2017)

RELEVANT AMA POLICY:

The Criminalization of Health Care Decision Making H-160.946

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

Citation: Sub. Res. 202, A-95; Reaffirmed: Res. 227, I-98; Reaffirmed: BOT Rep. 2, A-07; Reaffirmation A-09; Reaffirmation: I-12

Criminalization of Medical Judgment H-160.954

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

Citation: Sub. Res. 223, I-93; Reaffirmed: Res. 227, I-98; Reaffirmed: Res. 237, A-99; Reaffirmed and Appended: Sub. Res. 215, I-99; Reaffirmation A-09; Reaffirmed: CEJA Rep. 8, A-09; Reaffirmation: I-12; Modified: Sub. Res. 716, A-13; Reaffirmed in lieu of Res. 605, I-13

Opposition to Criminalizing Health Care Decisions D-160.999

Whether definitely stated or not, it is the position of the AMA that all conditions or principles adopted by the Association concerning the position of the medical profession, in any form of medical practice, are set forth primarily in order to maintain such standards as are essential to the maintenance of the best medical care and the protection of the health of all members of the community.

Citation: 1934 Annual Session; Reaffirmed: CLRPD Rep. B, A-87 Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmed: CLRPD Rep. 2, A-06; Reaffirmed: CEJA Rep. 03, A-16

Medication Errors H-120.965

The AMA reaffirms its long-standing supportive efforts to curtail the problems of medication errors; and encourages physicians to add a brief notation of purpose (e.g., for cough, for constipation) on prescriptions, where appropriate, to avoid confusion on the part of either the pharmacists or the patients.

Citation: Res. 515, I-95; Reaffirmed: CSA Rep. 8, A-05; Modified: CSAPH Rep. 1, A-15

Medication (Drug) Errors in Hospitals H-120.968

(1) Our AMA encourages individual physicians to minimize medication errors by adhering to the following guidelines when prescribing medications:

- (a) Physicians should stay abreast of the current state of knowledge regarding optimal prescribing through literature review, use of consultations with other physicians and pharmacists, participation in continuing medical education programs, and other means.
- (b) Physicians should evaluate the patient's total status and review all existing drug therapy before prescribing new or additional medications (e.g., to ascertain possible antagonistic drug interactions).
- (c) Physicians should evaluate and optimize patient response to drug therapy by appropriately monitoring clinical signs and symptoms and relevant laboratory data; follow-up and periodically reevaluate the need for continued drug therapy.
- (d) Physicians should be familiar with the hospital's medication-ordering system, including the formulary system; the drug use review (DUR) program; allowable delegation of authority; procedures to alert nurses and others to new drug orders that need to be processed; standard medication administration times; and approved abbreviations.
- (e) Written drug or prescription orders (including signatures) should be legible. Physicians with poor handwriting should print or type medication orders if direct order entry capabilities for computerized systems are unavailable.
- (f) Medication orders should be complete and should include patient name; drug name (generic drug name or trademarked name if a specific product is required); route and site of administration; dosage form (if applicable); dose; strength; quantity; frequency of administration; and prescriber's name. In some cases, a dilution, rate, and time of administration should be specified. Physicians should review all drug orders for accuracy and legibility immediately after they have prescribed them.
- (g) Medication orders should be clear and unambiguous. Physicians should: (i) write out instructions rather than use nonstandard or ambiguous abbreviations (e.g., write "daily" rather than "qd" which could be misinterpreted as "qid" or "od"); (ii) not use vague instructions, such as "take as directed"; (iii) specify exact dosage strengths (such as milligrams) rather than dosage form units (such as one vial) (an exception would be combination products, for which the number of dosage form units should be specified); (iv) prescribe by standard nomenclature, using the United States Adopted Names (USAN)-approved generic drug name, official name, or trademarked name (if a specific product is required) and avoid locally coined names, chemical names, unestablished abbreviated drug names (e.g., AZT), acronyms, and apothecary or chemical symbols; (v) always use a leading "0" to precede a decimal expression of less than one (e.g., 0.5 ml), but never use a terminal "0" (e.g., 5.0 ml); (vi) avoid the use of decimals when possible (e.g., prescribe 500 mg instead of 0.5 g); (vii) spell out the word "units" rather than writing "u"; (viii) and use the metric system. Instructions with respect to "hold" orders for medications should be clear.
- (h) Verbal medication orders should be reserved only for those situations in which it is impossible or impractical for the prescriber to write the order or enter it in a computer. Verbal orders should be dictated slowly, clearly, and articulately to avoid confusion. The order should be read back to the prescriber by the recipient (e.g., nurse, pharmacist); when read back, the recipient should spell the drug name and avoid abbreviations when repeating the directions. A written copy of the verbal order should be placed in the patient's medical record and later confirmed by the prescriber in accordance with applicable state regulations and hospital policies.

(2) Our AMA encourages the hospital medical staff to take a leadership role in their hospital, and in collaboration with pharmacy, nursing, administration, and others, to develop and improve organizational systems for monitoring, reviewing, and reporting medication errors and, after identification, to eliminate their cause and prevent their recurrence.

Citation: BOT Rep. 11, A-94; Reaffirmed by Sub. Res. 508, I-94; Reaffirmed and Modified: CSA Rep. 6, A-04; Reaffirmed: CSAPH Rep. 1, A-14

Health Court Principles H-435.951

Citation: BOT Rep. 15, A-07; Reaffirmed: BOT Rep. 22, A-17

Safe and Efficient E-Prescribing H-120.921

Our AMA encourages health care stakeholders to improve electronic prescribing practices in meaningful ways that will result in increased patient safety, reduced medication error, improved care quality, and

reduced administrative burden associated with e-prescribing processes and requirements. Specifically, the AMA encourages:

- A. E-prescribing system implementation teams to conduct an annual audit to evaluate the number, frequency and user acknowledgment/dismissal patterns of e-prescribing system alerts and provide an audit report to the software vendors for their consideration in future releases.
- B. Health care organizations and implementation teams to improve prescriber end-user training and on-going education.
- C. Implementation teams to prioritize the adoption of features like structured and codified Sig formats that can help address quality issues, allowing for free text when necessary.
- D. Implementation teams to enable functionality of pharmacy directories and preferred pharmacy options.
- E. Organizational leadership to encourage the practice of inputting a patient's preferred pharmacy at registration, and re-confirming it upon check-in at all subsequent visits.
- F. Implementation teams to establish interoperability between the e-prescribing system and the EHR to allow prescribers to easily confirm continued need for e-prescription refills and to allow for ready access to pharmacy choice and selection during the refill process.
- G. Implementation teams to enhance EHR and e-prescribing system functions to require residents assign an authorizing attending physician when required by state law.
- H. Organizational leadership to implement e-prescribing systems that feature more robust clinical decision support, and ensure prescriber preferences are tested and seriously considered in implementation decisions.
- i. Organizational leadership to designate e-prescribing as the default prescription method.
- J. The DEA to allow for lower-cost, high-performing biometric devices (e.g., fingerprint readers on laptop computers and mobile phones) to be leveraged in two-factor authentication.
- K. States to allow integration of PDMP data into EHR systems.
- L. Health insurers, pharmacies and e-prescribing software vendors to enable real-time benefit check applications that enable more up to date prescription coverage information and allow notification when a patient changes health plans or a health insurer has changed a pharmacy's network status.
- M. Functionality supporting the electronic transfer and cancellation of prescriptions.

Citation: BOT Rep. 20, A-19

Apologizing to Patients H-435.950

AMA policy is that any statements by physicians of apology, confessions of regret, or admission of errors to patients and/or their families regarding less than anticipated clinical outcomes be subsequently inadmissible in court and will seek to incorporate such policy into medical liability reform legislation.

Citation: Res. 217, A-07; Reaffirmation A-08; Reaffirmed: BOT Rep. 09, A-18

Participation in Peer Review H-375.984

Our AMA affirms that it is the ethical duty of a physician to share truthfully quality care information regarding a colleague when requested by an authorized credentialing body, so long as the information that is shared with the credentialing body is protected by statute or regulation as confidential peer review information. Quality of care and patient safety are the goals of peer review. Peer review should address the prevention of medical errors and appropriate system changes.

Citation: Sub. Res. 93, A-88; Reaffirmed: Sunset Report, I-98; Amended: BOT Action in response to referred for decision BOT Rep. 23, A-05; Reaffirmed: BOT Rep. 13, I-11; Reaffirmed: CEJA Rep. 1, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 253
(A-22)

Introduced by: Private Practice Physicians Section

Subject: Physician Payment Reform and Equity

Referred to: Reference Committee B

1 Whereas, Physicians in independent practice are running small businesses and employ tens of
2 thousands of American workers; and

4 Whereas, According to the Medicare Economic Index, the cost of running a medical practice
5 increased 39 percent from 2001 to 2021; and

7 Whereas, The U.S. economy has entered a new inflationary cycle and the cost of retaining staff
8 for a physician's office continues to increase with inflation; and

10 Whereas, According to data from the Medicare Trustees, Medicare physician pay has increased
11 just 11 percent over the last 20 years while Medicare hospital payments increased by 60
12 percent from 2011 to 2021; and

14 Whereas, Adjusted for inflation, Medicare physician pay declined 20 percent from 2011 to 2021,
15 which hospital payment far surpassed inflation in this period; and

17 Whereas, Cost/price pressures have reduced the number of independent practice physicians
18 and have threatened the viability of independent medical practice; and

20 Whereas, The loss of the private practice of medicine will have a profound impact on the
21 availability of high-quality, cost-effective medical care for many patients across the nation; and

23 Whereas, Improved payments for physician work will aid all physicians, both independent and
24 employed, as increased payment for physician services will also improve the value of RVUs that
25 our employed physician colleagues depend on for their compensation; and

27 Whereas, Our AMA has long had policy on improving payments for physician work, but it has
28 little to show in terms of concrete actions and results to accomplish said policy; therefore be it

30 RESOLVED, That our American Medical Association define Physician Payment Reform and
31 Equity (PPR & E) as "improvement in physician payment be Medicare and other third-party
32 payers so that physician reimbursement covers current office practice expenses at rates that
33 are fair and equitable, and that said equity include annual updates in payment rates" (New HOD
34 Policy); and be it further

36 RESOLVED, That our AMA place Physician Payment Reform & Equity as the advocacy priority
37 of our organization (Directive to Take Action); and be it further

39 RESOLVED, That our AMA use multiple resources, including but not limited to elective,
40 legislative, regulatory, and lobbying efforts, to advocate for an immediate increase in Medicare

1 physician payments to help cover the expense of office practices (Directive to Take Action); and
2 be it further

3
4 RESOLVED, That our AMA advocate for a statutory annual update in such payments that would
5 equal or exceed the Medicare Economic Index or the Consumer Price Index, whichever is most
6 advantageous in covering the continuously inflating costs of running an office practice (Directive
7 to Take Action); and be it further

8
9 RESOLVED, That our AMA establish a Task Force appointed by the Board of Trustees to
10 outline a specific set of steps that are needed to accomplish the goals of Physician Payment
11 Reform & Equity and report back to the HOD at each subsequent Annual meeting regarding
12 their progress on meeting the goals of Physician Payment Reform & Equity (PPR&E) until
13 PPR&E is accomplished. (Directive to Take Action)

Fiscal Note: Estimated cost to implement this resolution is \$317K.

Date received: 06/10/22

RELEVANT AMA POLICY

Payment for Physicians Services (H-385.989)

Our AMA: (1) supports a pluralistic approach to third party payment methodology under fee-for-service, and does not support a preference for "usual and customary or reasonable" (UCR) or any other specific payment methodology; (2) affirms the following four principles: (a) Physicians have the right to establish their fees at a level which they believe fairly reflects the costs of providing a service and the value of their professional judgment. (b) Physicians should continue to volunteer fee information to patients, to discuss fees in advance of service where feasible, to expand the practice of accepting any third party allowances as payment in full in cases of financial hardship, and to communicate voluntarily to their patients their willingness to make appropriate arrangements in cases of financial need. (c) Physicians should have the right to choose the basic mechanism of payment for their services, and specifically to choose whether or not to participate in a particular insurance plan or method of payment, and to accept or decline a third party allowance as payment in full for a service. (d) All methods of physician payment should incorporate mechanisms to foster increased cost-awareness by both providers and recipients of service; and (3) supports modification of current legal restrictions, so as to allow meaningful involvement by physician groups in: (a) negotiations on behalf of those physicians who do not choose to accept third party allowances as full payment, so that the amount of such allowances can be more equitably determined; (b) establishing additional limits on the amount or the rate of increase in charge-related payment levels when appropriate; and (c) professional fee review for the protection of the public.

Citation: CMS Rep. A, A-84; Reaffirmed: CLRPD Rep. 3, I-94; Reaffirmed: Sub. Res. 716, A-00; Reaffirmed: A-02; Reaffirmed: A-07; Reaffirmed in lieu of Res. 127, A-10; Reaffirmed: I-13; Reaffirmed: A-15

Physician Payment Reform (H-390.849)

1. Our AMA will advocate for the development and adoption of physician payment reforms that adhere to the following principles:
 - a) promote improved patient access to high-quality, cost-effective care;
 - b) be designed with input from the physician community;
 - c) ensure that physicians have an appropriate level of decision-making authority over bonus or shared-savings distributions;
 - d) not require budget neutrality within Medicare Part B;
 - e) be based on payment rates that are sufficient to cover the full cost of sustainable medical

practice;

- f) ensure reasonable implementation timeframes, with adequate support available to assist physicians with the implementation process;
- g) make participation options available for varying practice sizes, patient mixes, specialties, and locales;
- h) use adequate risk adjustment methodologies;
- i) incorporate incentives large enough to merit additional investments by physicians;
- j) provide patients with information and incentives to encourage appropriate utilization of medical care, including the use of preventive services and self-management protocols;
- k) provide a mechanism to ensure that budget baselines are reevaluated at regular intervals and are reflective of trends in service utilization;
- l) attribution processes should emphasize voluntary agreements between patients and physicians, minimize the use of algorithms or formulas, provide attribution information to physicians in a timely manner, and include formal mechanisms to allow physicians to verify and correct attribution data as necessary; and
- m) include ongoing evaluation processes to monitor the success of the reforms in achieving the goals of improving patient care and increasing the value of health care services.

2. Our AMA opposes bundling of payments in ways that limit care or otherwise interfere with a physician's ability to provide high quality care to patients.

3. Our AMA supports payment methodologies that redistribute Medicare payments among providers based on outcomes, quality and risk-adjustment measures only if measures are scientifically valid, verifiable, accurate, and based on current data.

4. Our AMA will continue to monitor health care delivery and physician payment reform activities and provide resources to help physicians understand and participate in these initiatives.

5. Our AMA supports the development of a public-private partnership for the purpose of validating statistical models used for risk adjustment.

Citation: CMS Rep. 6, A-09; Reaffirmed: A-10; Appended: Res. 829, I-10; Appended: CMS Rep. 1, A-11; Appended: CMS Rep. 4, A-11; Reaffirmed in lieu of Res. 119, A-12; Reaffirmed in lieu of Res. 122, A-12; Modified: CMS Rep. 6, A-13, Raffirmed: I-15; Reaffirmed: A-16; Reaffirmed in lieu of Res. 712, A-17; Reaffirmed: BOT Action in response to referred for decision: Res. 237, I-17; Reaffirmed: A-19; Reaffirmed: BOT Action in response to referred for decision Res. 111, A-19; Reaffirmed: BOT action in response to referred for decision Res. 132, A-19; Reaffirmed: Res. 212, I-21.

Remuneration for Physician Services (H-385.951)

1. Our AMA actively supports payment to physicians by contractors and third party payers for physician time and efforts in providing case management and supervisory services, including but not limited to coordination of care and office staff time spent to comply with third party payer protocols.

2. It is AMA policy that insurers pay physicians fair compensation for work associated with prior authorizations, including pre-certifications and prior notifications, that reflects the actual time expended by physicians to comply with insurer requirements and that compensates physicians fully for the legal risks inherent in such work.

3. Our AMA urges insurers to adhere to the AMA's Health Insurer Code of Conduct Principles including specifically that requirements imposed on physicians to obtain prior authorizations, including pre-certifications and prior notifications, must be minimized and streamlined and health insurers must maintain sufficient staff to respond promptly.

Citation: Sub. Res. 814, A-96; Reaffirmed: A-02; Reaffirmed: I-08; Reaffirmed: I-09; Appended: Sub. Res. 126, A-10; Reaffirmed in lieu of: Res. 719, A-11; Reaffirmed in lieu of: Res. 721, A-11; Reaffirmed: A-11; Reaffirmed in lieu of Res. 822, I-11; Reaffirmed in lieu of: Res. 711, A-14; Reaffirmed: Res. 811, I-19

Cuts in Medicare and Medicaid Reimbursement (H-330.932)

Our AMA: (1) continues to oppose payment cuts in the Medicare and Medicaid budgets that may reduce patient access to care and undermine the quality of care provided to patients; (2) supports the concept that the Medicare and Medicaid budgets need to expand adequately to adjust for factors such as cost of living, the growing size of the Medicare population, and the cost of new technology; (3) aggressively encourages CMS to affirm the patient's and the physician's constitutional right to privately contract for medical services; (4) if the reimbursement is not improved, the AMA declares the Medicare reimbursement unworkable and intolerable, and seek immediate legislation to allow the physician to balance bill the patient according to their usual and customary fee; and (5) supports a mandatory annual "cost-of-living" or COLA increase in Medicaid, Medicare, and other appropriate health care reimbursement programs, in addition to other needed payment increases.

Citation: Sub Res. 101, A-97; Reaffirmed: A-99 and Reaffirmed: Res. 127, A-99; Reaffirmed: A-00; Reaffirmed: I-00; Reaffirmed: BOT Action in response to referred for decision Res. 215, I-00; Reaffirmed: A-01; Reaffirmed and Appended: Res. 113, A-02; Reaffirmed: A-05; Reaffirmed in lieu of Res. 210, A-13; Reaffirmed: Res. 212, I-21

Payment for Copying Medical Records (H-335.980)

It is the policy of the AMA to seek legislation under which Medicare will be required to reimburse physicians and hospitals for the reasonable cost of copying medical records which are required for the purpose of postpayment audit. A reasonable charge will be paid by the patient or requesting entity for each copy (in any form) of the medical record provided.

Citation: Res. 161, I-90; Appended by Res. 819, A-98; Reaffirmed: A-08; Reaffirmed in lieu of Res. 710, A-14

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 254
(A-22)

Introduced by: Private Practice Physicians Section

Subject: Stakeholder Engagement in Medicare Administrative Contractor Policy Processes

Referred to: Reference Committee B

1 Whereas, Carrier Advisory Committees (CACs) and other stakeholders have played an
2 important role in review of policy changes put forth by Medicare Administrative Contractors
3 (MACs); and

4
5 Whereas, The Local Coverage Determination (LCD) process historically has considered
6 comment and input for a Carrier Advisory Committee and, in most cases, LCDs require a 45-
7 day comment period; and

8
9 Whereas, Our AMA has strong policy in support of robust MAC processes for transparency and
10 stakeholder engagement, including engagement of CACs, in reviewing Local Coverage
11 Determinations and in support of local Medicare CACs in their role as policy advisors; and

12
13 Whereas, The 21st Century Cures Act included provisions intended to modernize and strengthen
14 the LCD review process and ensure transparency and stakeholder engagement in MACs'
15 decision making processes and the Medicare Program Integrity Manual Chapter 13 finalized
16 requirements of the LCD modernization process; and

17
18 Whereas, The 21st Century Cures Act and related regulations demonstrate the intent of
19 Congress and the Centers for Medicare and Medicaid Services (CMS) to ensure processes for
20 meaningful stakeholder review and input for substantive policy changes; and

21
22 Whereas, Some MACs have used Local Coverage Articles (LCAs) to unilaterally issue policy
23 changes that might have the effect of restricting coverage or access, without an attached,
24 supportive LCD, arguing they are only providing billing instructions when changes could
25 reasonable be expected to have the effect of restricting coverage. In most cases LCAs are
26 coupled with LCDs or a National Coverage Determination (NCD) and the LCA only provides
27 such additional coding/billing or other information as may be needed to implement the coverage
28 policy determined in the LCD or NCD; and

29
30 Whereas, MACs issuing changes in coverage policy through LCAs without issuing a proposed
31 LCD are circumventing the notice-and-comment period required of LCDs and other substantive
32 rulemaking, bypassing the stakeholder engagement and transparency in decision making that
33 was intended by Congress; and

34
35 Whereas, By issuing LCAs without associated LCDs these MACs are denying stakeholders a
36 meaningful opportunity to review data and decision-making criteria and to provide feedback on
37 proposed changes in coverage policy and are bypassing consultation with healthcare
38 professional experts and professional societies; and

1 Whereas, The evidentiary requirements of LCDs are not required in an LCA and LCAs
2 unilaterally issued without LCDs lack transparency and do not allow stakeholders to review data
3 or decision criteria or to submit formal requests for reconsideration of the coverage policy; and
4

5 Whereas, These actions by MACs are counter to and not in the spirit of the transparency and
6 increased stakeholder engagement and review intended by Congress in revising the LCD
7 process by way of the 21st Century Cures Act, nor of CMS' improvements to the LCD process
8 following stakeholder feedback to its Request for Information in the CY 2018 Physician Fee
9 Schedule; and

10 Whereas, The significant changes to LCD procedures stemming from the 21st Century Cures
11 Act also allow MACs to change their engagement with traditional CACs and CACs are no longer
12 being engaged by MACs to function in their roles in reviewing and commenting on proposed
13 policy changes and therefore no longer have a meaningful function; therefore be it

14
15 RESOLVED, That our American Medical Association opposes Medicare Administrative
16 Contractors (MACs) using Local Coverage Articles (LCAs) that could have the effect of
17 restricting coverage or access without providing data and evidentiary review or without issuing
18 associated Local Coverage Determinations (LCDs) and following required stakeholder
19 processes (New HOD Policy); and be it further

20
21 RESOLVED, That our AMA advocate and work with the Centers for Medicare and Medicaid
22 Services (CMS) to ensure no LCAs that could have the effect of restricting coverage or access
23 are issued by MACs without the MAC providing public data, decision criteria, and evidentiary
24 review and allowing comment, or without an associated LCD and the required LCD stakeholder
25 review and input process, through the modernization requirement of the 21st Century Cures Act
26 (Directive to Take Action); and be it further

27
28 RESOLVED, That our AMA advocate to CMS that the agency immediately invalidate any LCAs
29 that are identified as potentially restricting coverage or access and that were issued without the
30 MACs providing public data, decision criteria, and evidentiary review, or that were issued
31 without an associated LCD and the required stakeholder processes, and that CMS require
32 MACs to restart those processes taking any such proposed changes through CLDs and
33 associated requirements for stakeholder engagement, public data, and evidentiary review
34 (Directive to Take Action); and be it further

35
36 RESOLVED, That our AMA advocate that Congress and the Department of Health and Human
37 Services consider clarifying language that reinstates a role for local Carrier Advisory
38 Committees in review processes going forward, addressing unintended outcomes of changes in
39 the 21st Century Cures Act that allowed local CACs to be left without a voice or purpose
40 (Directive to Take Action).

Fiscal Note: Minimal - less than \$1,000

Date received: 06/10/22

RELEVANT AMA POLICY

Improving the Local Coverage Determination Process D-330.908

1. Our AMA will advocate through legislative and/or regulatory efforts as follows: A. When Medicare Administrative Contractors (MACs) propose new or revised Local Coverage Determinations (LCDs) said Contractors must: (1) Ensure that Carrier Advisory Committee meeting minutes are recorded and posted to the Contractor's website; and (2) Disclose the rationale for the LCD, including the evidence upon which it is based when releasing an approved LCD; B. That the Centers for Medicare and Medicaid Services adopt a new LCD reconsideration process that allows for an independent review of a MAC's payment policies by a third-party, with appropriate medical and specialty expertise, empowered to make recommendations to the Secretary of Health and Human Services that said policies should be withdrawn or revised; and C. That MACs shall be prohibited from adopting another MAC's LCD without first undertaking a full and independent review of the underlying science and necessity of such LCD in their jurisdiction.
2. Our AMA will work with interested state medical and national specialty societies to develop model legislation or regulations requiring commercial insurance companies, state Medicaid agencies, or third party payers to: A. Publish all edits that are to be used in their claims processing in a manner that is freely accessible and downloadable to physicians; and B. Participate in a transparent process that allows for review, challenge, and deletion of unfair edits.

Citation: Res. 807, I-15

Support for Maintaining the Medicare Carrier Advisory Committee and Carrier Medical Director D-330.974

Our AMA will: (1) continue its efforts in urging the Centers for Medicare and Medicaid Services (CMS) management to retain and support local Medicare Carrier Advisory Committees and Medical Directors in their role as policy advisers; and (2) urge the CMS to seek input from the AMA and all interested medical societies before proposing any further changes to the Medicare Carrier Advisory Committee (CAC) framework or to the roles and responsibilities of carrier medical directors.

Citation: Res. 121, I-01; Reaffirmed: CMS Rep. 5, A-10; Reaffirmed: CMS Rep. 01, A-20

Changes to the Medical Profession Resulting from Medicare Administrative Contracting Reforms H-390.851

1. Our AMA will review and monitor the impacts of Medicare Administrative Contracting reforms with periodic reports to the House of Delegates, to include at a minimum: (a) growth, nature and outcomes of actions against physicians by Payment Safeguard Contractors, Zone Program Integrity Contractors, and Recovery Audit Contractors; (b) changes in structure and/or function of Contractor Advisory Committees; and (c) changes in access to Medicare Administrative Contractor Medical Directors and other Medicare Administrative Contractor personnel.
2. All information gathered by our AMA regarding the impact of Medicare administrative contracting reforms will be shared in a timely manner with all state and national medical specialty societies.

Citation: Res. 710, I-07; Modified: CMS Rep. 01, A-17

Uniformity of Operations of Medicare Administrative Contractors H-390.921

It is the policy of the AMA (1) to use its influence and resources to bring about uniformity of business policies and procedures among the Medicare Administrative Contractors, and (2) to investigate and monitor the differing policies and procedures among the Medicare Administrative Contractors with respect to physician reimbursement.

Citation: Res. 154, A-90; Reaffirmed: Sunset Report, I-00; Modified: CMS Rep. 6, A-10; Reaffirmed: CMS Rep. 4, I-15

Medicare Part B Contractor Changes D-335.984

1. Our AMA will: (a) register a formal public complaint to the Centers for Medicare & Medicaid Services (CMS) about the need to accept physician input as part of future contract decisions; (b) ask CMS to require that the local Medicare Administrative Contractor and clearinghouse quickly rectify problems, including having more prompt and effective communication with providers; and (c) advocate for legislation or agency policy changes that provide additional resources to be allocated to the Centers for Medicare and Medicaid Services for the specific purpose of enhancing Part B contractor customer service and accountability in billing and enrollment matters.
2. If CMS and the local Medicare Administrative Contractor and clearinghouse fail to effectively address the problems physicians are facing, our AMA will notify elected officials and the public of these failures and the need for redress.

Citation: Res. 218, I-08; Reaffirmed: CMS Rep. 01, A-18

Physician Input in MAC Contracting Process D-330.943

1. Our AMA will work with other interested members of the Federation to develop mechanisms with the Centers for Medicare and Medicaid Services that meaningful input from physicians and physician associations may be received and appropriately considered in the Medicare Administrative Contractor contracting processes, both those now underway and those in the future, including input on specific potential contract bidders.
2. Our AMA: (a) encourages the Federation to continue to report problems with Medicare Administrative Contractors (MACs), or other Medicare contractors, to the AMA; (b) will advocate that the Centers for Medicare and Medicaid Services (CMS) ensure that MACs are adequately staffed to handle enrollment, claims review, appeals and other functions in a timely and accurate manner; (c) will advocate that CMS increase training of MAC personnel to ensure they can respond efficiently and effectively to provider inquiries; (d) will advocate that CMS provide sufficient time between announcement and implementation of policy changes to allow contractors to thoroughly understand and adequately prepare to communicate with physicians and other providers about the changes; (e) will urge CMS to publish on its Web site the list of performance standards against which MACs are measured, and a report of each MAC's rating on those performance standards; (f) encourages state medical societies to educate their members regarding MAC performance standards, and to actively petition CMS regarding underperforming MACs; and (g) will advocate that the Centers for Medicare and Medicaid Services impose monetary penalties on MACs that fail to process and pay claims in a timely manner.

Citation: Res. 714, I-05; Appended: CMS Rep. 5, A-10; Reaffirmed: CMS Rep. 01, A-20

Review of Self-Administered Drug List Alterations Under Medicare Part B D-335.983

Our AMA will seek regulatory or legislative changes to require that any alterations to Self-Administered Drug lists made by Medicare Administrative Contractors shall be subject to Carrier Advisory Committee review and advisement.

Citation: Res. 811, I-13

Parity of Payment for Administering Biologic Medications H-330.883

Our AMA supports and encourages interested national medical specialty societies and other stakeholders to submit a request to Medicare for a national coverage determination directing Medicare Administrative Contractors to consider all biologics as complex injections or infusions.

Citation: CMS Rep. 4, I-15

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 437
(A-22)

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

Subject: Air Pollution and COVID: A Call to Tighten Regulatory Standards for Particulate Matter

Referred to: Reference Committee D

1 Whereas, The Environmental Protection Agency (EPA) is in the process of reviewing the current
2 National Ambient Air Quality Standards (NAAQS) for fine particulate matter (particles with a
3 diameter of $\leq 2.5 \mu\text{m}$ [PM_{2.5}]) — that is, levels not exceeding an annual average of 12 μg per
4 cubic meter and a 24-hour average of 35 μg per cubic meter; and
5

6 Whereas, The current EPA guidelines are not sufficient to protect public health, since exposure to
7 ambient PM_{2.5} at the current accepted EPA levels is estimated to be responsible for tens of
8 thousands of premature deaths in the United States each year¹; and
9

10 Whereas, Current AMA policy calls for more stringent standards than are currently followed by the
11 EPA as noted in the policy summary below; and
12

13 Whereas, Air pollution is known to correlate with numerous other adverse health outcomes also,
14 including heart disease, stroke, asthma, COPD, and neurodegenerative disorders; and air
15 pollution disproportionately affects vulnerable populations and communities of color¹; and
16

17 Whereas, Results suggest that exposure to traffic-related air pollution is associated with
18 dementia, via both direct neural damage as well as indirect pathways related to diabetes and
19 metabolic dysfunction; and
20

21 Whereas, Nearly all deaths attributable to air pollution in the contiguous United States are
22 associated with ambient air pollution concentrations below the current EPA standards, a finding
23 that both reflects past success and suggests that more stringent PM_{2.5} air quality standards may
24 further reduce the national death toll associated with air pollution; and
25

26 Whereas, Vulnerable populations and communities of color are most at risk for negative health
27 impacts from particulate air pollution owing to their location near emission sources or to
28 demographic or clinical characteristics (e.g., age or disease status) that increase their
29 susceptibility¹; and
30

31 Whereas, Despite many improvements since passage of the Clean Air Act in 1970, according to a
32 report from the National Bureau of Economic Research, “After declining by 24.2% from 2009 to
33 2016, annual average fine particulate matter (PM_{2.5}) in the United States in counties with
34 monitors increased by 5.5% between 2016 and 2018;” and
35

36 Whereas, Former members of the EPA Clean Air Scientific Advisory Committee on Particulate
37 Matter (which was dissolved on October 10, 2018), who now make up the nongovernmental

1 Independent Particulate Matter Review Panel, unequivocally and unanimously concluded that the
2 current PM2.5 standards do not adequately protect public health¹; and
3
4 Whereas, A recent health impact assessment modeling a 40% reduction in PM2.5 exposure
5 estimated a drop in mortality by > 100,000 among adults in the Continental United States; and
6
7 Whereas, Increased mortality due to COVID-19 has been shown in studies at Harvard and in the
8 Netherlands to be associated with air pollution: an increase of 1ug/m3 of PM 2.5 was shown to be
9 associated with an 8% increase in the COVID-19 death rate in the US, and a 16% increase in the
10 death rate due to COVID-19 in the Netherlands; and
11
12 Whereas, Indoor air pollution in the COVID-19 era has demonstrated unequivocally to be a
13 much greater source of viral transmission than outdoor pollution by CDC, EPA and other
14 agencies, recently resulting in recommended improvements in ventilation and air filtering¹; and
15
16 Whereas, COVID-19 has also disproportionately affected vulnerable populations and communities
17 of color where there has been a higher burden of disease and higher mortality; therefore be it
18
19 RESOLVED, That our American Medical Association advocate for stronger federal particulate
20 matter air quality standards than currently in place and improved enforcement that will better
21 protect the public's health. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 05/18/22

References

Link that is most pertinent: <https://www.epa.gov/pm-pollution/national-ambient-air-quality-standards-naaqs-pm>

¹ Independent Particulate Matter Review Panel NEJM Sounding Board "The Need for a Tighter Particulate-Matter Air-Quality Standard" NEJM 383;7 August 13, 2020.

² Paul KC, Haan M, Yu Y, et al. Traffic-Related Air Pollution and Incident Dementia: Direct and Indirect Pathways Through Metabolic Dysfunction. *J Alzheimers Dis.* 2020;76(4):1477-1491. doi:10.3233/JAD-200320

³ Bowe B, Xie Y, Yan Y, Al-Aly Z. Burden of Cause-Specific Mortality Associated With PM2.5 Air Pollution in the United States. *JAMA Netw Open.* 2019 Nov 1;2(11):e1915834. doi: 10.1001/jamanetworkopen.2019.15834. PMID: 31747037; PMCID: PMC6902821.

⁴ NBER WORKING PAPER SERIES, "RECENT INCREASES IN AIR POLLUTION: EVIDENCE AND IMPLICATIONS FOR MORTALITY," K Clay et al. <http://www.nber.org/papers/w26381>

⁵ Vodonos A, Schwartz J. Estimation of excess mortality due to long-term exposure to PM_{2.5} in continental United States using a high-spatiotemporal resolution model. *Environ Res.* 2021 May;196:110904. doi: 10.1016/j.envres.2021.110904. Epub 2021 Feb 23. PMID: 33636186.

⁶ Wu X, Nethery RC, Sabath BM, Braun D, Dominici F (2020) Exposure to air pollution and COVID-19 mortality in the United States: a nationwide cross-sectional study. *medRxiv*3

⁷ IM Cole et al "Air Pollution and COVID-19 in Dutch Municipalities, *Envir Resource Econ* Aug 4 2020 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7399597/#CR25>

⁸ Health Equity considerations and racial and ethnic minority groups. <https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/race-ethnicity.html>

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 438
(A-22)

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

Subject: Informing Physicians, Health Care Providers, and the Public of the Health Dangers of Fossil-Fuel Derived Hydrogen

Referred to: Reference Committee D

1 Whereas, Fossil fuel derived hydrogen (H₂) on a lifecycle basis produces more carbon dioxide
2 (CO₂) pollution than methane, despite being portrayed as a “carbon-free” fuel because it does
3 not produce CO₂ at the point of combustion¹; and
4
5 Whereas, Increasing the use of hydrogen as an energy source is being promoted as a way to
6 reduce carbon emissions (“decarbonize”) and combat climate change;^{2 3} and
7
8 Whereas, The majority (96%) of hydrogen is currently derived from fossil fuels (mostly methane
9 from natural gas),⁴ generating high greenhouse gas (GHG) emissions from both the CO₂
10 emitted in producing hydrogen and the upstream methane leaking into the atmosphere during
11 drilling, production, storage, and transport of natural gas used in producing hydrogen;⁵ and
12
13 Whereas, Current fossil fuel-derived hydrogen production is responsible for CO₂ emissions of
14 around 830 million tons of CO₂ per year, equivalent to the annual CO₂ emissions of the United
15 Kingdom and Indonesia combined;⁶ and
16
17 Whereas, Burning blends of hydrogen and methane releases substantially more NOX than
18 burning methane gas alone, therefore increasing indoor and outdoor air pollution; burning 100%
19 hydrogen emits six times more NO_x than burning natural gas;⁷ and
20
21 Whereas, Capturing and storing the CO₂ generated from fossil fuel derived hydrogen is not
22 currently a viable option because carbon capture is an energy intensive process and
23 commercial-scale, long-term storage of very large quantities of CO₂ has not yet been proven to
24 be feasible;^{8 9 10} and

¹ Howarth, RW, Jacobson, MZ. How green is blue hydrogen? *Energy Sci Eng*. 2021; 00: 1– 12. DOI:[10.1002/ese3.956](https://doi.org/10.1002/ese3.956)

² IEA (2019), The Future of Hydrogen, IEA, Paris <https://www.iea.org/reports/the-future-of-hydrogen>

³ Howarth, RW, Jacobson, MZ. How green is blue hydrogen? *Energy Sci Eng*. 2021; 00: 1– 12. DOI:[10.1002/ese3.956](https://doi.org/10.1002/ese3.956)

⁴ International Energy Agency. The Future of Hydrogen, 2019. <https://www.iea.org/reports/the-future-of-hydrogen> Accessed 11/9/21.

⁵ Howarth, RW, Jacobson, MZ. How green is blue hydrogen? *Energy Sci Eng*. 2021; 00: 1– 12. DOI:[10.1002/ese3.956](https://doi.org/10.1002/ese3.956)

⁶ IEA (2019), The Future of Hydrogen, IEA, Paris <https://www.iea.org/reports/the-future-of-hydrogen>

⁷ Cellek Mehmet Salih & Ali Pınarbaşı, Investigations on Performance and Emission Characteristics of an Industrial Low Swirl Burner While Burning Natural Gas, Methane, Hydrogen Enriched Natural Gas and Hydrogen as Fuels, 43 Int'l J. of Hydrogen Energy 1994-1207. (Jan. 11, 2018), <https://www.sciencedirect.com/science/article/abs/pii/S0360319917319791> .

⁸ Howarth, RW, Jacobson, MZ. How green is blue hydrogen? *Energy Sci Eng*. 2021; 00: 1– 12. DOI:[10.1002/ese3.956](https://doi.org/10.1002/ese3.956)

⁹ Schlissel D, Wamsted D, Suzanne Mattei S, Mawji O. Reality Check on CO₂ Emissions Capture at Hydrogen-From-Gas Plants; Carbon Capture Essential to Blue Hydrogen Production Has Been Unreliable. Institute for Energy Economics and Financial Analysis. February 2022. http://iefa.org/wp-content/uploads/2022/02/Reality-Check-on-CO2-Emissions-Capture-at-Hydrogen-From-Gas-Plants_February-2022.pdf

¹⁰ Longden T, Beck FJ, Jotzo F, Andrews R, MoPrasad M. 'Clean' hydrogen? – Comparing the emissions and costs of fossil fuel versus renewable electricity-based hydrogen. *Applied Energy*. 2022;306 Part B: . <https://doi.org/10.1016/j.apenergy.2021.118145>

1 Whereas, Supporters of natural gas for use in buildings are proposing blending fossil fuel
2 derived hydrogen with natural gas to reduce CO₂ emissions despite significant risks to human
3 health and safety;¹¹ ¹² ¹³ and
4
5 Whereas, Hydrogen ignites more easily and is more explosive than methane,¹⁴ burns at a
6 higher temperature,¹⁵ and blends of hydrogen and methane cannot be burned safely in current
7 gas appliances that have not been retrofitted to handle hydrogen¹⁶; and
8
9 Whereas, Burning blends of hydrogen and methane releases substantially more NO_X than
10 burning methane gas alone, therefore increasing indoor and outdoor air pollution; burning 100%
11 hydrogen emits six times more NO_X than burning natural gas;¹⁷ and
12
13 Whereas, According to the Environmental Protection Agency (EPA), exposures to high
14 concentrations of nitrogen dioxide (NO₂) can irritate airways in the human respiratory system
15 and contribute to the development of or exacerbate respiratory diseases, particularly asthma¹⁸
16 ¹⁹, with increased risks for emergency department visits and hospital admissions;²⁰ and
17
18 Whereas, 48% of households have natural gas appliances²¹ and current natural gas appliances
19 were not built with technology to reduce the NO_X produced by burning hydrogen;²² and
20
21 Whereas, Blending hydrogen in US natural gas infrastructure could cause increased hydrogen
22 and methane leakage because hydrogen is particularly corrosive to bare steel and cast iron
23 pipes; 28 states have cast iron pipes in their gas infrastructure;²³ there are more than 40,000
24 miles of bare steel natural gas pipes;²⁴ and

¹¹ Boston Gas Company d/b/a National Grid, Exhibit NG-FOH-1 1, Hydrogen Implementation Plan, D.P.U. 20-120, November 13, 2020
<https://fileservice.eea.comacloud.net/FileService.Api/file/FileRoom/12873346>

¹² Southern California Gas Company. SoCalGas Among First in the Nation to Test Hydrogen Blending in Real-World Infrastructure and Appliances in Closed Loop System. September 30, 2021. <https://www.prnewswire.com/news-releases/socalgas-among-first-in-the-nation-to-test-hydrogen-blending-in-real-world-infrastructure-and-appliances-in-closed-loop-system-301389186.html>

¹³ St. John J. Green Hydrogen in Natural Gas Pipelines: Decarbonization Solution or Pipe Dream? Green Tech Media Nov 30, 2020 <https://www.greentechmedia.com/articles/read/green-hydrogen-in-natural-gas-pipelines-decarbonization-solution-or-pipe-dream>

¹⁴ James Purtill. What is green hydrogen, how is it made and will it be the fuel of the future? <https://www.abc.net.au/news/science/2021-01-23/green-hydrogen-renewable-energy-climate-emissions-explainer/13081872>

¹⁵ Menzies M. Hydrogen: The Burning Question. The Chemical Engineer, 2019 <https://www.thechemicalengineer.com/features/hydrogen-the-burning-question/>

¹⁶ NATURALHY. Using the Existing Natural Gas System for Hydrogen https://www.fwg-gross-bieberau.de/fileadmin/user_upload/Erneuerbare_Energie/Naturalhy_Brochure.pdf

¹⁷ Cellek Mehmet Salih & Ali Pinarbaşı, Investigations on Performance and Emission Characteristics of an Industrial Low Swirl Burner While Burning Natural Gas, Methane, Hydrogen Enriched Natural Gas and Hydrogen as Fuels, 43 Int'l J. of Hydrogen Energy 1994-1207. (Jan. 11, 2018), <https://www.sciencedirect.com/science/article/pii/S0360319917319791>

¹⁸ Sharma H, Hansel N, Matsui E, Diette G, Eggleston P, Breysse P. Indoor environmental influences on children's asthma. *Pediatr Clin North Am.* 2007;54:103-120. <https://doi.org/10.1016/j.pcl.2006.11.007>

¹⁹ Guarneri M, Balmes JR. Outdoor air pollution and asthma. *Lancet.* 2014;383(9928):1581-92.

²⁰ Environmental Protection Agency. Nitrogen Dioxide (NO₂) Pollution. <https://www.epa.gov/no2-pollution/basic-information-about-no2> Accessed April 8, 2019.

²¹ Lebel ED, Finnegan CJ, Ouyang Z, Jackson RB. Methane and NO_X Emissions from Natural Gas Stoves, Cooktops, and Ovens in Residential Homes. *Environ. Sci. Technol.* January 27, 2022. <https://doi.org/10.1021/acs.est.1c04707>

²² Personal communications with Association of Home Appliances Manufacturers (AHAM).

²³ Pipeline and Hazardous Materials Safety Administration (PHMSA). Pipeline Replacement Background. March 17, 2020, <https://www.phmsa.dot.gov/data-and-statistics/pipeline-replacement/pipeline-replacement-background>, accessed 01/14/22

²⁴ PHMSA, Bare Steel Inventory, March 16, 2020. <https://www.phmsa.dot.gov/data-and-statistics/pipeline-replacement/bare-steel-inventory> accessed 01/14/22

1 Whereas, Methane, over a 20-year period, is about an 80 times more potent global warming
2 agent than CO₂;²⁵ 30 to 45% of global warming is attributed to methane; and atmospheric
3 methane has increased dramatically in the last decade;^{26 27} and
4
5 Whereas, The White House Office of Domestic Climate Policy and the Global Methane Pledge
6 have called for reducing overall methane emissions by 30% below 2020 levels by 2030, in part
7 because reducing methane in the atmosphere is one of the best ways to limit global warming;²⁸
8^{29 30} and
9
10 Whereas, The oil and gas sector is the largest industrial source of methane emissions in the
11 United States, responsible for approximately 30% of total methane emissions;³¹ and
12
13 Whereas, Increasing the production of fossil fuel-derived hydrogen to blend with methane in the
14 natural gas infrastructure will increase the demand for and the production of methane and,
15 thereby, increase methane emissions and worsen the climate crisis;³² and
16
17 Whereas, The Intergovernmental Panel on Climate Change (IPCC) Working Group noted that
18 "Stabilizing the climate will require strong, rapid, and sustained reductions in greenhouse gas
19 emissions, and reaching net zero CO₂ emissions. Limiting other greenhouse gases and air
20 pollutants, especially methane, could have benefits both for health and the climate,"³³ and
21
22 Whereas, In an unprecedented joint editorial, 200 health and medical journals, including the
23 *New England Journal of Medicine*, urged world leaders to cut heat-trapping emissions to avoid
24 "catastrophic harm to health that will be impossible to reverse,"³⁴ and
25
26 Whereas, More than 100 leading public health groups, including the American Medical
27 Association and the American Academy of Pediatrics; Center for Climate, Health, and the
28 Global Environment; and the Harvard T.H. Chan School of Public Health agree that the climate
29 crisis is a health emergency;³⁵ and
30
31 Whereas, Ongoing dependence on fossil fuels contributes to the climate crisis which
32 disproportionately affects low income communities and communities of color; therefore be it

²⁵ Anthropogenic and Natural Radiative Forcing, Chapter 8

https://www.ipcc.ch/site/assets/uploads/2018/02/WG1AR5_Chapter08_FINAL.pdf

²⁶ United Nations Environment Programme and Climate and Clean Air Coalition (2021). Global Methane Assessment: Benefits and Costs of Mitigating Methane Emissions. Nairobi: United Nations Environment Programme. ISBN: 978-92-807-3854-4

²⁷ IPCC, 2021: Summary for Policymakers. In: Climate Change 2021: The Physical Science Basis. Contribution of Working Group I to the Sixth Assessment Report of the Intergovernmental Panel on Climate Change. Cambridge University Press. In Press.

²⁸ White House Office of Domestic Climate Policy. U.S. Methane Emissions Reduction Action Plan. November 2021.

<https://www.whitehouse.gov/wp-content/uploads/2021/11/US-Methane-Emissions-Reduction-Action-Plan-1.pdf>

²⁹ Global Methane Pledge <https://www.globalmethanepledge.org>

³⁰ United Nations Environment Programme and Climate and Clean Air Coalition (2021). Global Methane Assessment: Benefits and Costs of Mitigating Methane Emissions. Nairobi: United Nations Environment Programme. ISBN: 978-92-807-3854-4

³¹ EPA. Inventory of U.S. Greenhouse Gas Emissions and Sinks: 1990-2019 (Apr. 2021).
<https://www.epa.gov/ghgemissions/inventory-usgreenhouse-gas-emissions-and-sinks-1990-2019>.

³² Howarth, RW, Jacobson, MZ. How green is blue hydrogen? Energy Sci Eng. 2021; 00: 1– 12. doi:[10.1002/ese3.956](https://doi.org/10.1002/ese3.956)

³³ IPCC report: 'Code red' for human driven global heating, warns UN chief, August 9, 2021

<https://news.un.org/en/story/2021/08/1097362>

³⁴ Atwoli L, Baqui AH, Benfield T, et al. Call for Emergency Action to Limit Global Temperature Increases, Restore Biodiversity, and Protect Health. N Engl J Med. 2021 Sep 5. DOI: 10.1056/NEJMMe2113200. Online ahead of print.
<https://www.nejm.org/doi/10.1056/NEJMMe2113200>

³⁵ U.S. Call to Action On Climate, Health and Equity: A Policy Action Agenda. List of signatures.
<https://climatehealthaction.org/cta/climate-health-equity-policy/> Accessed 12/28/19.

1 RESOLVED, That our American Medical Association recognize the health, safety, and climate
2 risks of current methods of producing fossil fuel-derived hydrogen and the dangers of adding
3 hydrogen to natural gas (HP) (New HOD Policy); and be it further
4
5 RESOLVED, That our AMA educate its members, and, to the extent possible, health care
6 professionals and the public, about the health, safety, and climate risks of current methods of
7 producing fossil fuel-derived hydrogen and the dangers of adding hydrogen to natural gas
8 (Directive to Take Action); and be it further
9
10 RESOLVED, That our AMA advocate to appropriate government agencies such as the EPA and
11 the Department of Energy, and federal legislative bodies, regarding the health, safety and
12 climate risks of current methods of producing fossil fuel derived hydrogen and the dangers of
13 adding hydrogen to natural gas. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 05/18/22

RELEVANT AMA POLICY

Global Climate Change and Human Health H-135.938

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.

Citation: CSAPH Rep. 3, I-08; Reaffirmation A-14; Reaffirmed: CSAPH Rep. 04, A-19; Reaffirmation: I-19

EPA and Green House Gas Regulation H-135.934

1. Our AMA supports the Environmental Protection Agency's authority to promulgate rules to regulate and control green house gas emissions in the United States.
2. Our AMA: (a) strongly supports evidence-based environmental statutes and regulations intended to regulate air and water pollution and to reduce greenhouse gas emissions; and (b) will advocate that environmental health regulations should only be modified or rescinded with scientific justification.

Citation: Res. 925, I-10; Reaffirmed in lieu of Res. 526, A-12; Reaffirmed: Res. 421, A-14;
Appended: Res. 523, A-17

Climate Change Education Across the Medical Education Continuum H-135.919

Our AMA: (1) supports teaching on climate change in undergraduate, graduate, and continuing medical education such that trainees and practicing physicians acquire a basic knowledge of the science of climate change, can describe the risks that climate change poses to human health, and counsel patients on how to protect themselves from the health risks posed by climate change; (2) will make available a prototype presentation and lecture notes on the intersection of climate change and health for use in undergraduate, graduate, and continuing medical education; and (3) will communicate this policy to the appropriate accrediting organizations such as the Commission on Osteopathic College Accreditation and the Liaison Committee on Medical Education.

Citation: Res. 302, A-19

Stewardship of the Environment H-135.973

The AMA: (1) encourages physicians to be spokespersons for environmental stewardship, including the discussion of these issues when appropriate with patients; (2) encourages the medical community to cooperate in reducing or recycling waste; (3) encourages physicians and the rest of the medical community to dispose of its medical waste in a safe and properly prescribed manner; (4) supports enhancing the role of physicians and other scientists in environmental education; (5) endorses legislation such as the National Environmental Education Act to increase public understanding of environmental degradation and its prevention; (6) encourages research efforts at ascertaining the physiological and psychological effects of abrupt as well as chronic environmental changes; (7) encourages international exchange of information relating to environmental degradation and the adverse human health effects resulting from environmental degradation; (8) encourages and helps support physicians who participate actively in international planning and development conventions associated with improving the environment; (9) encourages educational programs for worldwide family planning and control of population growth; (10) encourages research and development programs for safer, more effective, and less expensive means of preventing unwanted pregnancy; (11) encourages programs to prevent or reduce the human and environmental health impact from global climate change and environmental degradation; (12) encourages economic development programs for all nations that will be sustainable and yet nondestructive to the environment; (13) encourages physicians and environmental scientists in the United States to continue to incorporate concerns for human health into current environmental research and public policy initiatives; (14) encourages physician educators in medical schools, residency programs, and continuing medical education sessions to devote more attention to environmental health issues; (15) will strengthen its liaison with appropriate environmental health agencies, including the National Institute of Environmental Health Sciences (NIEHS); (16) encourages expanded funding for environmental research by the federal government; and (17) encourages family planning through national and international support.

Citation: CSA Rep. G, I-89; Amended: CLRPD Rep. D, I-92; Amended: CSA Rep. 8, A-03; Reaffirmed in lieu of Res. 417, A-04; Reaffirmed in lieu of Res. 402, A-10; Reaffirmation I-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 439
(A-22)

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

Subject: Informing Physicians, Health Care Providers, and the Public That Cooking with a Gas Stove Increases Household Air Pollution and the Risk of Childhood Asthma

Referred to: Reference Committee D

1 Whereas, In the United States, more than 11.5 million people with asthma, including nearly 3
2 million children, report having had one or more asthma attacks in 2015¹; and

4 Whereas, Household air pollution is a major health problem. Worldwide, it is responsible for
5 more than three million deaths a year,² and indoor air pollution is strongly linked to asthma;³
6 and

8 Whereas, Household and outdoor air pollution are social determinants of health and associated
9 with an increased risk of asthma;^{4,5} and air pollution contributes to health disparities in asthma;⁶
10 and

12 Whereas, According to the United States Environmental Protection Agency (EPA), a growing
13 body of scientific evidence indicates that, even in large cities, indoor air can be more polluted
14 than the outdoor air;⁷ and

16 Whereas, Burning natural gas creates nitrogen dioxide (NO₂), particulate matter (PM_{2.5}), carbon
17 monoxide (CO), and other byproducts that contribute to air pollution;⁸ and

19 Whereas, Nitrogen dioxide levels are significantly higher in homes with gas stoves than homes
20 with electric stoves;^{9,10} and

¹ Zahrani HS, Bailey CM, Damon SA, Garbe PL, Breysse PN. Vital Signs: Asthma in Children – United States, 2001-2016. MMWR Morb Mortal Wkly Rep 2018;67:149-155. DOI: <http://dx.doi.org/10.15585/mmwr.mm6705e1>

² The World Health Organization. Household air pollution and health. <https://www.who.int/news-room/fact-sheets/detail/household-air-pollution-and-health>. Published May 8, 2018. Accessed October 5, 2019.

³ Breysse PN, Diette GB, Matsui EC, Butz AM, Hansel NN, McCormack MC. Indoor air pollution and asthma in children. *Proc Am Thorac Soc*. 2010;7(2):102-106. doi:10.1513/pats.200908-083RM.

⁴ Sharma H, Hansel N, Matsui E, Diette G, Eggleston P, Breysse P. Indoor environmental influences on children's asthma. *Pediatr Clin North Am*. 2007;54:103-120. <https://doi.org/10.1016/j.pcl.2006.11.007>.

⁵ Guarneri M, Balmes JR. Outdoor air pollution and asthma. *Lancet*. 2014;383(9928):1581-92.

⁶ Forno E, Celedón JC. Health disparities in asthma. *Am J Respir Crit Care Med*. 2012;185(10):1033-1035. doi:10.1164/rccm.201202-0350ED.

⁷ Environmental Protection Agency. The inside story: A guide to indoor air quality. <https://www.epa.gov/indoor-air-quality-iaq/inside-story-guide-indoor-air-quality>. Accessed April 8, 2019.

⁸ Environmental Protection Agency. Natural gas combustion. www3.epa.gov/ttn/chief/ap42/ch01/final/c01s04.pdf. Accessed February 14, 2019.

⁹ Belanger K, Gent JF, Triche EW, Bracken MB, Leaderer BP. Association of indoor nitrogen dioxide exposure with respiratory symptoms in children with asthma. *Am J Respir Crit Care Med*. 2006;173(3):297-303. doi:10.1164/rccm.200408-1123OC.

¹⁰ Mullen NA, Li J, Russell, ML, Spears, M, Less, BD, Singer BC. Results of the California Health Homes Indoor Air Quality Study of 2011-2013: impact of natural gas appliances on air pollutant concentrations. *Indoor Air*. 2016;26: 231-245. <https://doi.org/10.1111/ina.12190>.

1 Whereas, In a simulation of homes where gas cooking stoves are used without exhaust
2 ventilation hoods, indoor NO₂ levels exceed outdoor air quality standards in 41%–70% of
3 homes;¹¹ and
4
5 Whereas, The burning of natural gas in stoves releases nitrogen oxides (NO_x) into indoor air
6 and is an important source of household air pollution in the United States;¹² and
7
8 Whereas, According to the EPA, “Breathing air with a high concentration of NO₂ can irritate
9 airways in the human respiratory system. Such exposures over short periods can aggravate
10 respiratory diseases, particularly asthma, leading to respiratory symptoms (such as coughing,
11 wheezing or difficulty breathing), hospital admissions and visits to emergency rooms. Longer
12 exposures to elevated concentrations of NO₂ may contribute to the development of asthma and
13 potentially increase susceptibility to respiratory infections. People with asthma, as well as
14 children and the elderly are generally at greater risk for the health effects of NO_{2”};¹³ and
15
16 Whereas, The World Health Organization recognized the associations between cooking with
17 gas stoves, indoor NO₂ levels, and asthma in their 2010 guidelines for indoor air quality;¹⁴ and
18
19 Whereas, Children living in a home with a gas cooking stove have a 42% increased risk of
20 current asthma and a 24% increased lifetime risk of asthma according to a meta-analysis;¹⁵ and
21
22 Whereas, A year-long, prospective study of NO₂ exposure in 1,342 children with active asthma
23 in Massachusetts and Connecticut found a dose-response relationship between the amount of
24 NO₂ exposure and risk of asthma severity. Every five-fold increase in NO₂ exposure above 6
25 parts per billion (ppb) was associated with a dose-dependent increase in the risk of asthma
26 severity, wheeze, and rescue medication use;¹⁶ and
27
28 Whereas, About one-third of households in the United States cook with gas stoves;¹⁷ and
29
30 Whereas, In homes with gas cooking stoves, children whose parents reported never using
31 exhaust fans, or who did not have them available had lower lung function and higher adjusted
32 odds of asthma 1.56 (1.03, 2.32), wheeze, 1.66 (1.16, 2.38), and bronchitis 1.66 (1.05–2.70)
33 compared to children in homes where parents reported using exhaust fans;¹⁸ and
34
35 Whereas, In a randomized study comparing replacing gas stoves with electric stoves, using a
36 free-standing high efficiency particulate air (HEPA) filters and installing above-stove hoods with
37 exhaust fans were effective in reducing NO₂ levels;¹⁹ and

¹¹ Logue JM, Klepeis NE, Lobscheid AB, Singer BC. Pollutant exposures from natural gas cooking burners: A simulation-based assessment for Southern California. *Environ Health Perspect*. 2014;122:43–50. <https://dx.doi.org/10.1289/ehp.1306673>.

¹² Environmental Protection Agency. Nitrogen dioxide's impact on indoor air quality. <https://www.epa.gov/indoor-air-quality-iaq/nitrogen-dioxides-impact-indoor-air-quality>. Accessed October 12, 2019.

¹³ Environmental Protection Agency. Nitrogen dioxide (NO₂) pollution. <https://www.epa.gov/no2-pollution/basic-information-about-no2>. Accessed April 8, 2019.

¹⁴ Jarvis DJ, Adamkiewicz G, Heroux ME, et al. Nitrogen dioxide. WHO Guidelines for Indoor Air Quality: Selected Pollutants. Geneva: World Health Organization; 2010. <https://www.ncbi.nlm.nih.gov/books/NBK138707/>.

¹⁵ Lin W, Brunekreef B, Gehring, U. Meta-analysis of the effects of indoor nitrogen dioxide and gas cooking on asthma and wheeze in children. *Int J Epidemiol*. 2013;42:1724–1737. doi:10.1093/ije/dyt150.

¹⁶ Belanger K, Holford TR, Gent JF, Hill ME, Kezik JM, Leaderer BP. Household levels of nitrogen dioxide and pediatric asthma severity. *Epidemiology*. 2013;24(2):320–330. doi:10.1097/EDE.0b013e318280e2ac.

¹⁷ US Department of Housing and Urban Development and US Census Bureau, American Housing Survey for the United States. www.census.gov/prod/2011pubs/h150-09.pdf. Published 2009. Accessed February 13, 2019.

¹⁸ Kile ML, Coker ES, Smit E, Sudakin D, Molitor J, Harding AK. A cross-sectional study of the association between ventilation of gas stoves and chronic respiratory illness in U.S. children enrolled in NHANESIII. *Environ. Health*. 2014;13:71. doi:10.1186/1476-069X-13-71.

¹⁹ Paulin LM, Diette GB, Scott M, McCormack MC, Matsui EC, Curtin-Brosnan J, Williams DL, Kidd-Taylor A, Shea M, Breysse P, Hanse NN. Home interventions are effective at decreasing indoor nitrogen dioxide concentrations. *Indoor Air*. 2014;24:416–424. doi:[10.1111/ina.12085](https://doi.org/10.1111/ina.12085)

1 Whereas, Informal questioning found that many parents, health professionals, local health
2 departments, local boards of health, and others did not know about the association between
3 cooking with gas stoves and increased risk of asthma;²⁰ and
4
5 Whereas, Parents, public health staff, building inspectors, teachers, and many others should
6 know about this association so that they can help protect children from household air pollution
7 produced by gas stoves and reduce the risk of asthma; therefore be it
8
9 RESOLVED, That our American Medical Association recognize the association between the
10 use of gas stoves, indoor nitrogen dioxide levels and asthma (New HOD Policy); and be it
11 further
12
13 RESOLVED, That our AMA inform its members and, to the extent possible, health care
14 providers, the public, and relevant organizations that use of a gas stove increases household
15 air pollution and the risk of childhood asthma and asthma severity; which can be mitigated by
16 reducing the use of the gas cooking stove, using adequate ventilation, and/or using an
17 appropriate air filter (Directive to Take Action); and be it further
18
19 RESOLVED, That our AMA advocate for innovative programs to assist with mitigation of cost
20 to encourage the transition from gas stoves to electric stoves in an equitable manner.
21 (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 05/18/22

²⁰ Personal communication from T. Stephen Jones and Andee Krasner April 4, 2019.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 440
(A-22)

Introduced by: Integrated Physician Practice Section

Subject: Addressing Social Determinants of Health through Health IT

Referred to: Reference Committee D

1 WHEREAS, Social determinants of health (SDOH) are widely acknowledged to be a driver of
2 health outcome; and

4 WHEREAS, There is existing AMA policy on data collection on SDOH while minimizing impact
5 on patients and physicians (H-165.822); and

7 WHEREAS, There is existing AMA policy on interoperability and data exchange (D-478.972),
8 though it is limited to interoperability between physician practices and healthcare organizations;
9 and

11 WHEREAS, Data collection and coordination of care will continue to rely heavily on electronic
12 health records (EHRs); therefore be it

14 RESOLVED, That our American Medical Association advocate for data interoperability between
15 physicians' practices, public health, vaccine registries, community-based organizations, and
16 other related social care organizations to promote coordination across the spectrum of care,
17 while maintaining appropriate patient privacy (Directive to Take Action); and be it further

19 RESOLVED, That the AMA adopt the position that electronic health records should integrate
20 and display information on social determinants of health and social risk so that such information
21 is actionable by physicians to intervene and mitigate the impacts of social factors on health
22 outcomes (Directive to Take Action).

Fiscal Note: Modest - between \$1,000 - \$5,000

Date received: 06/10/22

RELEVANT AMA POLICY

Health Plan Initiatives Addressing Social Determinants of Health (H-165.822)

Our AMA:

1. recognizing that social determinants of health encompass more than health care, encourages new and continued partnerships among all levels of government, the private sector, philanthropic organizations, and community- and faith-based organizations to address non-medical, yet critical health needs and the underlying social determinants of health;
2. supports continued efforts by public and private health plans to address social determinants of health in health insurance benefit designs;
3. encourages public and private health plans to examine implicit bias and the role of racism and social determinants of health, including through such mechanisms as professional development and other training;
4. supports mechanisms, including the establishment of incentives, to improve the acquisition of data related to social determinants of health, while minimizing burdens on patients and physicians;
5. supports research to determine how best to integrate and finance non-medical services as part of health insurance benefit design, and the impact of covering non-medical benefits on health care and societal costs; and
6. encourages coverage pilots to test the impacts of addressing certain non-medical, yet critical health needs, for which sufficient data and evidence are not available, on health outcomes and health care costs.

Citation: CMS Report 7, I-20; Reaffirmed: CMS Rep. 5, I-21

EHR Interoperability (D-478.972)

Our AMA:

- (1) will enhance efforts to accelerate development and adoption of universal, enforceable electronic health record (EHR) interoperability standards for all vendors before the implementation of penalties associated with the Medicare Incentive Based Payment System;
- (2) supports and encourages Congress to introduce legislation to eliminate unjustified information blocking and excessive costs which prevent data exchange;
- (3) will develop model state legislation to eliminate pricing barriers to EHR interfaces and connections to Health Information Exchanges;
- (4) will continue efforts to promote interoperability of EHRs and clinical registries;
- (5) will seek ways to facilitate physician choice in selecting or migrating between EHR systems that are independent from hospital or health system mandates;
- (6) will seek exemptions from Meaningful Use penalties due to the lack of interoperability or decertified EHRs and seek suspension of all Meaningful Use penalties by insurers, both public and private;
- (7) will continue to take a leadership role in developing proactive and practical approaches to promote interoperability at the point of care;
- (8) will seek legislation or regulation to require the Office of the National Coordinator for Health Information Technology to establish regulations that require universal and standard interoperability protocols for electronic health record (EHR) vendors to follow during EHR data transition to reduce common barriers that prevent physicians from changing EHR vendors, including high cost, time, and risk of losing patient data; and
- (9) will review and advocate for the implementation of appropriate recommendations from the "Consensus Statement: Feature and Function Recommendations to Optimize Clinician Usability of Direct Interoperability to Enhance Patient Care," a physician-directed set of

recommendations, to EHR vendors and relevant federal offices such as, but not limited to, the Office of the National Coordinator, and the Centers for Medicare and Medicaid Services.

Citation: Sub. Res. 212, I-15; Reaffirmed: BOT Rep. 03, I-16; Reaffirmed: Res. 221, I-16; Reaffirmed in lieu of: Res. 243, A-17; Reaffirmed: CMS Rep. 10, A-17; Appended: BOT Rep. 45, A-18; Reaffirmed: BOT Rep. 19, A-18; Appended: Res. 202, A-18; Appended: Res. 226, I-18; Reaffirmed: A-19; Reaffirmed: CMS Rep. 7, I-20

Interoperability of Medical Devices (H-480.953)

Our AMA believes that intercommunication and interoperability of electronic medical devices could lead to important advances in patient safety and patient care, and that the standards and protocols to allow such seamless intercommunication should be developed fully with these advances in mind. Our AMA also recognizes that, as in all technological advances, interoperability poses safety and medico-legal challenges as well. The development of standards and production of interoperable equipment protocols should strike the proper balance to achieve optimum patient safety, efficiency, and outcome benefit while preserving incentives to ensure continuing innovation.

Citation: Res. 519; Reaffirmed: I-15; Reaffirmed: BOT Rep. 05, I-16

The Precision Medicine Initiative (D-460.968)

1. Our AMA will work with the Precision Medicine Initiative (PMI) to gather input from physicians to assist in the planning stages of the initiative and to improve awareness and willingness to recruit patients as participants.
2. Our AMA encourages the PMI to develop resources that will assist physicians in understanding the goals of the PMI, how to recruit and enroll patients, and how to best use the research results generated by it.
3. Our AMA continues to advocate for improvements to electronic health record systems that will enable interoperability and access while not creating additional burdens and usability challenges for physicians.

Citation: CSAPH Rep. 03, A-16; Reaffirmed: BOT Rep. 45, A-18

Principles for Hospital Sponsored Electronic Health Records (D-478.973)

1. Our AMA will promote electronic health record (EHR) interoperability, data portability, and health IT data exchange testing as a priority of the Office of the National Coordinator for Health Information Technology (ONC).
2. Our AMA will work with EHR vendors to promote transparency of actual costs of EHR implementation, maintenance and interface production.
3. Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) and ONC to identify barriers and potential solutions to data blocking to allow hospitals and physicians greater choice when purchasing, donating, subsidizing, or migrating to new EHRs.
4. Our AMA will advocate that sponsoring institutions providing EHRs to physician practices provide data access and portability to affected physicians if they withdraw support of EHR sponsorship.

Citation: BOT Rep. 1, I-15; Reaffirmed: BOT Rep. 45, A-18; Reaffirmed: BOT Rep. 19, A-18

Integration of Mobile Health Applications and Devices into Practice (H-480.943)

1. Our AMA supports the establishment of coverage, payment and financial incentive mechanisms to support the use of mobile health applications (mHealth apps) and associated devices, trackers and sensors by patients, physicians and other providers that: (a) support the establishment or continuation of a valid patient-physician relationship; (b) have a high-quality clinical evidence base to support their use in order to ensure mHealth app safety and effectiveness; (c) follow evidence-based practice guidelines, especially those developed and produced by national medical specialty societies and based on systematic reviews, to ensure

patient safety, quality of care and positive health outcomes; (d) support care delivery that is patient-centered, promotes care coordination and facilitates team-based communication; (e) support data portability and interoperability in order to promote care coordination through medical home and accountable care models; (f) abide by state licensure laws and state medical practice laws and requirements in the state in which the patient receives services facilitated by the app; (g) require that physicians and other health practitioners delivering services through the app be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state's medical board; and (h) ensure that the delivery of any services via the app be consistent with state scope of practice laws.

2. Our AMA supports that mHealth apps and associated devices, trackers and sensors must abide by applicable laws addressing the privacy and security of patients' medical information.

3. Our AMA encourages the mobile app industry and other relevant stakeholders to conduct industry-wide outreach and provide necessary educational materials to patients to promote increased awareness of the varying levels of privacy and security of their information and data afforded by mHealth apps, and how their information and data can potentially be collected and used.

4. Our AMA encourages the mHealth app community to work with the AMA, national medical specialty societies, and other interested physician groups to develop app transparency principles, including the provision of a standard privacy notice to patients if apps collect, store and/or transmit protected health information.

5. Our AMA encourages physicians to consult with qualified legal counsel if unsure of whether an mHealth app meets Health Insurance Portability and Accountability Act standards and also inquire about any applicable state privacy and security laws.

6. Our AMA encourages physicians to alert patients to the potential privacy and security risks of any mHealth apps that he or she prescribes or recommends, and document the patient's understanding of such risks.

7. Our AMA supports further development of research and evidence regarding the impact that mHealth apps have on quality, costs, patient safety and patient privacy.

8. Our AMA encourages national medical specialty societies to develop guidelines for the integration of mHealth apps and associated devices into care delivery.

Citation: CMS Rep. 06, I-16; Reaffirmed: A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 441
(A-22)

Introduced by: Medical Student Section

Subject: Addressing Adverse Effects of Active Shooter Drills on Children's Health

Referred to: Reference Committee D

1 Whereas, Active shooter drills are an updated version of lockdown drills that are employed by
2 school systems to prepare students and educators for a possible active shooting scenario^{1,2};
3 and
4

5 Whereas, Following the Columbine shooting and subsequent mass shootings, schools began to
6 face an added responsibility to prevent school shooting fatalities, and many began implementing
7 active-shooter drills to signal their commitment to risk management to parents and
8 communities²⁻⁴; and
9

10 Whereas, Ninety-five percent of schools conducted drills for emergency procedures including
11 lockdowns, evacuations, and shelter-in-place procedures by 2015-2016⁵; and
12

13 Whereas, At least 40 states require school-based drills for active shooter scenarios, but state
14 laws leave the composition of the drill open to interpretation by school administrators¹; and
15

16 Whereas, Active shooter preparation drills have increased in number following a change in
17 stance by the Department of Education in 2012 which called for "options-based" approaches for
18 its active-shooter response recommendations⁶; and
19

20 Whereas, An "options-based" approach encourages schools to tailor their prevention activities
21 to both educators and students and provides them with training to respond appropriately in the
22 event of an active shooter scenario⁶; and
23

24 Whereas, Limited research exists that demonstrates a significant difference between lockdown
25 drills and multi-option approaches in preparation for an active shooter event⁴; and
26

27 Whereas, The advent of this new approach has resulted in a new industry driven by providing a
28 variety of techniques that school systems can employ during a practice drill, including playing
29 911 recordings from prior shootings, using rubber bullets, masked "shooters", and fake blood^{6,7};
30 and
31

32 Whereas, Despite the lack of research on the efficacy of active shooter drills, school districts
33 continue to pay tens of thousands of dollars to for-profit third-party companies allowing them to
34 enter the school environment and facilitate the active shooter drills^{1,4,8}; and
35

36 Whereas, Physicians and national organizations, including the National Child Traumatic Stress
37 Network, National Association of School Psychologists, and American Federation of Teachers,
38 express concern over the harmful effects that active shooter drills may have on the health and
39 wellbeing of children^{3,6,9}; and

1 Whereas, The National Association of School Psychologists and the National Association of
2 School Resource Officers acknowledge that drills have the power to empower and save lives,
3 but can cause harm to participants without proper caution¹⁰; and
4
5 Whereas, A study conducted on college students found that, though they felt more prepared
6 after watching a school shooting training video, they were also more afraid that one would
7 occur¹¹; and
8
9 Whereas, Schools often do not follow the guidelines for lockdown drills recommended by the
10 National Association of School Psychologists and the National Association of School Resource
11 Officers such as inclusion of mental healthcare professionals during and after drills¹²; and
12
13 Whereas, A study of student perceptions pre- and post-formal active shooter training, including
14 lockdown drills, found that despite students feeling more prepared for an emergency lockdown
15 situation, perceptions of safety in school were significantly decreased¹³; and
16
17 Whereas, The National Association of School Psychologists and the National Association of
18 School Resource Officers admit that, while research supports the effectiveness of lockdown
19 drills, research is still needed on the effectiveness of armed assailant drills¹⁰; therefore be it
20
21 RESOLVED, That our American Medical Association support that all school systems conduct
22 evidence-based active shooter drills in a trauma-informed manner that
23 a. is cognizant of children's physical and mental wellness,
24 b. considers prior experiences that might affect children's response to a simulation,
25 c. avoids creating additional traumatic experiences for children, and
26 d. provides support for students who may be adversely affected (Directive to Take Action); and
27 be it further
28
29 RESOLVED, That our AMA work with relevant stakeholders to raise awareness of ways to
30 conduct active shooter drills that are safe for children and age-appropriate. (Directive to Take
31 Action)

Fiscal Note: Minimal - less than \$1,000

Received: 06/10/2022

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RELEVANT AMA POLICY

Prevention of Firearm Accidents in Children H-145.990

Our AMA (1) supports increasing efforts to reduce pediatric firearm morbidity and mortality by encouraging its members to (a) inquire as to the presence of household firearms as a part of childproofing the home; (b) educate patients to the dangers of firearms to children; (c) encourage patients to educate their children and neighbors as to the dangers of firearms; and (d) routinely remind patients to obtain firearm safety locks, to store firearms under lock and key, and to store ammunition separately from firearms; (2) encourages state medical societies to work with other organizations to increase public education about firearm safety; (3) encourages organized medical staffs and other physician organizations, including state and local medical societies, to recommend programs for teaching firearm safety to children; and (4) supports enactment of Child Access Prevention laws that are consistent with AMA policy.

Res 165, I-89; Appended BOT Rep. 11, I-18

Prevention of Unintentional Shooting Deaths Among Children H-145.979

Our AMA supports legislation at the federal and state levels making gun owners legally responsible for injury or death caused by a child gaining unsupervised access to a gun, unless it can be shown that reasonable measures to prevent child access to the gun were taken by the gun owner, and that the specifics, including the nature of "reasonable measures," be determined by the individual constituencies affected by the law. Res 204, I-98; Reaffirmed: CSAPH Rep. 01, A-19

Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care H-145.975

1. Our AMA supports: a) federal and state research on firearm-related injuries and deaths; b) increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to inform state and federal health policy; c) encouraging physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety; d) the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes; e) encouraging local projects to facilitate the low-cost distribution of gun locks in homes; f) encouraging physicians to become involved in local firearm safety classes as a means of promoting injury prevention and the public health; and g) encouraging CME providers to consider, as appropriate, inclusion of presentations about the prevention of gun violence in national, state, and local continuing medical education programs.
2. Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of mental illness and concurrent substance use disorders, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior.
3. Our AMA (a) recognizes the role of firearms in suicides, (b) encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling, and (c) encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide.

Res 221, A-13; Reaffirmed: I-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 442
(A-22)

Introduced by: Medical Student Section

Subject: Opposing the Censorship of Sexuality and Gender Identity Discussions in Public Schools

Referred to: Reference Committee D

1 Whereas, Numerous bills were introduced in 14 state legislatures around the country between
2 2020-2021 seeking to remove books about sexual orientation and gender identity from the
3 country's public school curriculum¹; and

4
5 Whereas, Three states have passed bills in the last year that allow parents to opt students out
6 of any lessons or coursework that mention sexual orientation or gender identity, and the
7 Parental Rights in Education bill recently introduced in Tennessee would prohibit the discussion
8 of sexuality and gender identity in K-12 schools^{2,3}; and

9
10 Whereas, A 2019 national survey of LGBTQIA+ students found that 69% of respondents had
11 experienced verbal harassment at school based on their sexual orientation, 57% based on their
12 gender expression or outward appearance, and 54% based on their gender identity⁴; and

13
14 Whereas, A 2021 survey found that out of the nearly 35,000 LGBTQIA+ youth surveyed (ages
15 13–24 years) – more than half of whom identifying as transgender and nonbinary – 42%
16 seriously considered attempting suicide within the past year⁵; and

17
18 Whereas, A 2021 polling analysis revealed that ⅓ of LGBTQIA+ youth reported negative mental
19 health impacts stemming from recent debates about anti-trans legislation⁶; and

20
21 Whereas, A 2020 research report found that LGBTQIA+ youth who had at least one gender-
22 affirming space – such as a school, home or workplace – had 35% reduced odds of reporting a
23 suicide attempt in the past year⁷; and

24
25 Whereas, AMA policy H-60.927 recognizes that LGBTQIA+ youth face increased suicide risk
26 and calls for the AMA to partner with public and private organizations dedicated to public health
27 and policy to reduce said risk; and

28
29 Whereas, Restricting material and discussion around LGBTQIA+ topics promotes the
30 marginalization of LGBTQIA+ individuals and erasure of their experiences⁸; and

31
32 Whereas, Censoring information about LGBTQIA+ issues can further exacerbate the lack of
33 health literacy around gender-affirming care, especially among providers, fostering inappropriate
34 or inadequate care, discriminatory or invasive practices, and mistrust among patients⁹; and

35
36 Whereas, AMA policy H-160.931 supports the development of community resources and state
37 legislation that improves health literacy; and

1 Whereas, The American Psychiatric Association, the Florida chapter of the American Academy
2 of Pediatrics, and the American Academy of Child and Adolescent Psychiatry have each
3 publicly opposed the censorship of discussions of sexuality and gender identity in public
4 schools¹⁰⁻¹²; therefore be it

5
6 RESOLVED, That our American Medical Association oppose censorship of LGBTQIA+ topics
7 and opposes any policies that limit discussion or restrict mention of sexuality, sexual orientation,
8 and gender identity in schools or educational curricula (Directive to Take Action); and be it
9 further

10
11 RESOLVED, That our AMA support policies that ensure an inclusive, well-rounded educational
12 environment free from censorship of discussions surrounding sexual orientation, sexuality, and
13 gender identity in public schools. (Directive to Take Action)

Fiscal Note: Minimal - less than \$1,000

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RELEVANT AMA POLICY

Health Literacy H-160.931

Our AMA:

- (1) recognizes that limited patient literacy is a barrier to effective medical diagnosis and treatment;
- (2) encourages the development of literacy appropriate, culturally diverse health-related patient education materials for distribution in the outpatient and inpatient setting;
- (3) will work with members of the Federation and other relevant medical and nonmedical organizations to make the health care community aware that approximately one fourth of the adult population has limited literacy and difficulty understanding both oral and written health care information;
- (4) encourages the development of undergraduate, graduate, and continuing medical education programs that train physicians to communicate with patients who have limited literacy skills;

- (5) encourages all third party payers to compensate physicians for formal patient education programs directed at individuals with limited literacy skills;
- (6) encourages the US Department of Education to include questions regarding health status, health behaviors, and difficulties communicating with health care professionals in all future National Assessment of Adult Literacy studies;
- (7) encourages the allocation of federal and private funds for research on health literacy;
- (8) recommends all healthcare institutions adopt a health literacy policy with the primary goal of enhancing provider communication and educational approaches to the patient visit;
- (9) recommends all healthcare and pharmaceutical institutions adopt the USP prescription standards and provide prescription instructions in the patient's preferred language when available and appropriate; and
- (10) encourages the development of low-cost community- and health system resources, support state legislation and consider annual initiatives focused on improving health literacy.

CSA Rep. 1, A-98; Appended: Res. 415, I-99; Modified and Reaffirmed: CSAPH Rep. 1, A-09; Appended: Res. 718, A-13

Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations H-160.991

- 1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, transgender, queer/questioning, and other (LGBTQ) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBTQ patients; (iii) encouraging the development of educational programs in LGBTQ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBTQ people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBTQ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.
- 2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection screenings based on anatomy due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors.
- 3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBTQ health issues.
- 4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBTQ people.

CSA Rep. C, I-81; Reaffirmed: CLRPD Rep. F, I-91; CSA Rep. 8 - I-94; Appended: Res. 506, A-00; Modified and Reaffirmed: Res. 501, A-07; Modified: CSAPH Rep. 9, A-08; Reaffirmation A-12; Modified: Res. 08, A-16; Modified: Res. 903, I-17; Modified: Res. 904, I-17; Res. 16, A-18; Reaffirmed: CSAPH Rep. 01, I-18

Preventing Anti-Transgender Violence H-65.957

Our AMA will: (1) partner with other medical organizations and stakeholders to immediately increase efforts to educate the general public, legislators, and members of law enforcement using verified data related to the hate crimes against transgender individuals highlighting the disproportionate number of Black transgender women who have succumbed to violent deaths; (2) advocate for

federal, state, and local law enforcement agencies to consistently collect and report data on hate crimes, including victim demographics, to the FBI; for the federal government to provide incentives for such reporting; and for demographic data on an individual's birth sex and gender identity be incorporated into the National Crime Victimization Survey and the National Violent Death Reporting System, in order to quickly identify positive and negative trends so resources may be appropriately disseminated; (3) advocate for a central law enforcement database to collect data about reported hate crimes that correctly identifies an individual's birth sex and gender identity, in order to quickly identify positive and negative trends so resources may be appropriately disseminated; (4) advocate for stronger law enforcement policies regarding interactions with transgender individuals to prevent bias and mistreatment and increase community trust; and (5) advocate for local, state, and federal efforts that will increase access to mental health treatment and that will develop models designed to address the health disparities that LGBTQ individuals experience.

Res. 008, A-19

Clarification of Medical Necessity for Treatment of Gender Dysphoria H-185.927

Our AMA: (1) recognizes that medical and surgical treatments for gender dysphoria, as determined by shared decision making between the patient and physician, are medically necessary as outlined by generally-accepted standards of medical and surgical practice; (2) will advocate for federal, state, and local policies to provide medically necessary care for gender dysphoria; and (3) opposes the criminalization and otherwise undue restriction of evidence-based gender-affirming care.

Res. 05, A-16; Modified: Res. 015, A-21

Opposing Mandated Reporting of People Who Question Their Gender Identity H-65.959

Our AMA opposes mandated reporting of individuals who question or express interest in exploring their gender identity.

Res. 015, A-19

Affirming the Medical Spectrum of Gender H-65.962

Our AMA opposes any efforts to deny an individual's right to determine their stated sex marker or gender identity.

Res. 005, I-18

Access to Basic Human Services for Transgender Individuals H-65.964

Our AMA: (1) opposes policies preventing transgender individuals from accessing basic human services and public facilities in line with one's gender identity, including, but not limited to, the use of restrooms; and (2) will advocate for the creation of policies that promote social equality and safe access to basic human services and public facilities for transgender individuals according to one's gender identity.

Res. 010, A-17

Science, Technology, Engineering and Mathematics Education H-170.985

Our AMA is committed to working with other concerned organizations and agencies to improve science, technology, engineering and mathematics (STEM) education and literacy in the nation, and to increase interest in STEM on the part of the nation's youth, particularly underrepresented minorities.

Res. 2, A-88; Reaffirmed: Sunset Report, I-98; Modified and Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmed in lieu of Res. 514, A-09; Reaffirmed in lieu of Res. 524, A-09; Modified: Res. 516, A-14

Reducing Suicide Risk Among Lesbian, Gay, Bisexual, Transgender, and Questioning Youth Through Collaboration with Allied Organizations H-60.927

Our AMA will partner with public and private organizations dedicated to public health and public policy to reduce lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth suicide and improve health among LGBTQ youth.

Res. 402, A-12

Youth and Young Adult Suicide in the United States H-60.937

Our AMA:

- (1) Recognizes youth and young adult suicide as a serious health concern in the US;
- (2) Encourages the development and dissemination of educational resources and tools for physicians, especially those more likely to encounter youth or young adult patients, addressing effective suicide prevention, including screening tools, methods to identify risk factors and acuity, safety planning, and appropriate follow-up care including treatment and linkages to appropriate counseling resources;
- (3) Supports collaboration with federal agencies, relevant state and specialty medical societies, schools, public health agencies, community organizations, and other stakeholders to enhance awareness of the increase in youth and young adult suicide and to promote protective factors, raise awareness of risk factors, support evidence-based prevention strategies and interventions, encourage awareness of community mental health resources, and improve care for youth and young adults at risk of suicide;
- (4) Encourages efforts to provide youth and young adults better and more equitable access to treatment and care for depression, substance use disorder, and other disorders that contribute to suicide risk;
- (5) Encourages continued research to better understand suicide risk and effective prevention efforts in youth and young adults, especially in higher risk sub-populations such as Black, LGBTQ+, Hispanic/Latinx, Indigenous/Native Alaskan youth and young adult populations, and among youth and young adults with disabilities;
- (6) Supports the development of novel technologies and therapeutics, along with improved utilization of existing medications to address acute suicidality and underlying risk factors in youth and young adults;
- (7) Supports research to identify evidence-based universal and targeted suicide prevention programs for implementation in middle schools and high schools;
- (8) Will publicly call attention to the escalating crisis in children and adolescent mental health in this country in the wake of the COVID-19 pandemic;
- (9) Will advocate at the state and national level for policies to prioritize children's mental, emotional and behavioral health;
- (10) Will advocate for a comprehensive system of care including prevention, management and crisis care to address mental and behavioral health needs for infants, children and adolescents; and
- (11) Will advocate for a comprehensive approach to the child and adolescent mental and behavioral health crisis when such initiatives and opportunities are consistent with AMA policy.

Res. 424, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Reaffirmed in lieu of: Res. 001, I-16; Appended: CSAPH Rep. 3, A-21; Appended - BOT Action in response to referred for decision: CSAPH Rep. 3, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 443
(A-22)

Introduced by: Medical Student Section

Subject: Addressing the Longitudinal Healthcare Needs of American Indian Children in Foster Care

Referred to: Reference Committee D

1 Whereas, The Indian Child Welfare Act (ICWA) was enacted in 1978 to “protect the best interest
2 of American Indian and Alaska Native (AI/AN) children and to promote the stability and security
3 of Indian tribes and families by the establishment of minimum Federal standards for the removal
4 of Indian children and placement of such children in homes which will reflect the unique values
5 of [AI/AN] culture...”, and provides federal guidance to state legislatures on how these cases
6 should be handled¹; and

7
8 Whereas, The ICWA has been labeled the “gold standard” in child welfare policy and practice by
9 a coalition of 18 national child advocacy organizations¹⁻²; and

10
11 Whereas, The United States Supreme Court is currently in review of the Fifth Circuit Court of
12 Appeals’ decision regarding *Brackeen v. Haaland*, a case challenging the constitutionality of the
13 ICWA, prompting time-sensitive legislation³; and

14
15 Whereas, The definition of a AI/AN child is a politically-protected status as established by the
16 court case, *United States v. Antelope*, stating that “federal legislation with respect to Indian
17 tribes ... is not based upon impermissible racial classifications”, and therefore inapplicable to the
18 Equal Protection Act³; and

19
20 Whereas, Article II of the United Nations Convention on the Prevention and Punishment of the
21 Crime of Genocide, genocide includes “any of following acts committed with intent to destroy, in
22 whole or in part, a national, ethnical, racial or religious group, as such: [...] forcibly transferring
23 children of the group to another group”⁴; and

24
25 Whereas, AI/AN boarding schools of the 19th and 20th centuries forcibly removed AI/AN
26 children from their homes and communities under the pretense of education access, creating
27 centers of physical abuse, and assimilation, wherein the mission of these schools were to “kill
28 the Indian, save the man” and many of these children died from abuse or illness⁵; and

29
30 Whereas, Many of these AI/AN boarding school children have recently been discovered buried
31 in mass graves under these very institutions, and continue to be found after having never
32 returned to their families⁶; and

33
34 Whereas, AI/AN children raised in boarding schools lacked cultural ingratiation and knowledge
35 traditionally passed on to children by their return home, and composed entire generations
36 unfamiliar with their families, AI/AN communities, traditions, and language⁵⁻⁶; and

37
38 Whereas, 25-35% of AI/AN children prior to 1978 were removed from their homes, 85% of
39 whom were placed in care outside of their immediate family or tribal community²; and

1 Whereas, Due to historical subjugation, including forced removal, destruction of property and
2 resources, and genocide of AI/AN people, AI/AN communities suffer from access to basic
3 resources such as clean water or employment opportunities, prompting U.S. courts to remove
4 AI/AN children and place them into predominantly non-AI/AN homes that removed them from
5 their primary traditions, language, customs, and culture⁵⁻⁶; and
6
7 Whereas, The U.S. government has historically failed to recognize AI/AN definitions of child
8 care and child rearing as being the responsibility of extended family and community, wherein
9 the nuclear unit as defined by the U.S. government is a Western concept of kinship²; and
10
11 Whereas, While Tribes have an extended familial clan system beyond the traditional U.S.
12 extended family, allowing children to be housed or raised by clan relatives, the U.S. has failed to
13 recognize familial clan systems and removed children unnecessarily from the homes of their
14 families if a nuclear family member was not inherently present⁶; and
15
16 Whereas, Studies have demonstrated that children in kinship care have profound and enduring
17 benefits to economic and educational well-being⁷; and
18
19 Whereas, 92% of U.S. AI/AN indigenous languages are in danger of extinction, in addition to
20 cultural stories, traditions, and forms of cultural healing and medicine traditionally passed by
21 word of mouth to AI/AN children⁸; and
22
23 Whereas, Culturally- and trauma-informed care has been demonstrated to provide increased
24 quality of life outcomes for at-risk AI/AN youth⁹; and
25
26 Whereas, Not only are the tenets upheld by the ICWA important for AI/AN children, but they
27 improve the outcomes at a population health level among AI/AN communities²; and
28
29 Whereas, Restorative justice is necessary to promote cultural healing inside of AI/AN
30 communities in a manner led by community action and driven at a local tribal level; and
31
32 Whereas, Children who are protected under the ICWA will be placed in a home that reflects
33 their cultural values, with first priority being placement with extended family, followed by other
34 members of the child's tribe, then members of another federally-recognized tribe to foster
35 cultural identity as agreed upon by the state and Tribe^{2,10}; and
36
37 Whereas, The ICWA also aims to require the court to provide substantive evidence in favor of
38 the removal of children from their homes, which takes into consideration the fact that many
39 AI/AN families are disproportionately impacted by resource limitations and socioeconomic
40 disparities due to historical injustices, including, but not limited to, the taking of land, material
41 goods and livestock, generational wealth, and the significantly lacking employment
42 infrastructure in predominantly AI/AN communities¹¹⁻¹³; and
43
44 Whereas, Under the protection of the ICWA, AI/AN children who require foster care placements
45 are seen by an ICWA court in partnership with the state, which includes members of the judicial
46 system trained in ICWA cases, as well as representatives of the Tribes and preferred parental
47 involvement in the cases, all of which in concert lead to better outcomes for children who are
48 placed under the care of the ICWA³; and
49
50 Whereas, While AI/AN children are far less likely to be removed or adopted than before ICWA,
51 they are still four times more likely to be removed from their homes due to non-compliance with
52 ICWA¹; therefore be it
53

1
2 RESOLVED, The AMA recognize the Indian Child Welfare Act of 1978 as the gold standard in
3 child welfare legislation (New HOD Policy); and be it further
4
5 RESOLVED, The AMA support federal legislation preventing the removal of American Indian
6 and Alaska Native children from their homes by public and private agencies without cause (New
7 HOD Policy); and be it further
8
9 RESOLVED, The AMA work with local and state medical societies and other relevant
10 stakeholders to support legislation preventing the removal of American Indian and Alaska Native
11 children from their homes by public and private agencies without cause (Directive to Take
12 Action); and be it further
13
14 RESOLVED, The AMA support state and federal funding opportunities for American Indian and
15 Alaska Native child welfare systems. (New HOD Policy)

Fiscal Note: Modest - between \$1,000 - \$5,000

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RELEVANT AMA POLICY

Adoption H-420.973

It is the policy of the AMA to (1) support the provision of adoption information as an option to unintended pregnancies; and (2) support and encourage the counseling of women with unintended pregnancies as to the option of adoption.

Res. 146, A-90, Reaffirmed: Sunset Report, I-00, Reaffirmed: CSAPH Rep. 1, A-10, Reaffirmed: CSAPH Rep. 01, A-20

Improving Health Care of American Indians H-350.976

Our AMA recommends that: (1) All individuals, special interest groups, and levels of government recognize the American Indian people as full citizens of the U.S., entitled to the same equal rights and privileges as other U.S. citizens.

(2) The federal government provide sufficient funds to support needed health services for American Indians.

(3) State and local governments give special attention to the health and health-related needs of nonreservation American Indians in an effort to improve their quality of life.

(4) American Indian religions and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs.

(5) Our AMA recognize the "medicine man" as an integral and culturally necessary individual in delivering health care to American Indians.

(6) Strong emphasis be given to mental health programs for American Indians in an effort to reduce the high incidence of alcoholism, homicide, suicide, and accidents.

(7) A team approach drawing from traditional health providers supplemented by psychiatric social workers, health aides, visiting nurses, and health educators be utilized in solving these problems.

(8) Our AMA continue its liaison with the Indian Health Service and the National Indian Health Board and establish a liaison with the Association of American Indian Physicians.

(9) State and county medical associations establish liaisons with intertribal health councils in those states where American Indians reside.

(10) Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian health needs but opposes overemphasis on research for the sake of research, particularly if needed federal funds are diverted from direct services for American Indians.

(11) Our AMA strongly supports those bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations.

CLRPD Rep. 3, I-98; Reaffirmed: Res. 221, A-07; Reaffirmation A-12; Reaffirmed: Res. 233, A-13

Indian Health Service H-350.977

The policy of the AMA is to support efforts in Congress to enable the Indian Health Service to meet its obligation to bring American Indian health up to the general population level. The AMA specifically recommends: (1) Indian Population: (a) In current education programs, and in the expansion of educational activities suggested below, special consideration be given to involving the American Indian and Alaska native population in training for the various health professions, in the expectation that such professionals, if provided with adequate professional resources, facilities, and income, will be more likely to serve the tribal areas permanently; (b) Exploration with American Indian leaders of the possibility of increased numbers of nonfederal American Indian health centers, under tribal sponsorship, to expand the American Indian role in its own health care; (c) Increased involvement of private practitioners and facilities in American Indian care, through such mechanisms as agreements with tribal leaders or Indian Health Service contracts, as well as normal private practice relationships; and (d) Improvement in transportation to make access to existing private care easier for the American Indian population.

(2) Federal Facilities: Based on the distribution of the eligible population, transportation facilities and roads, and the availability of alternative nonfederal resources, the AMA recommends that those Indian Health Service facilities currently necessary for American Indian care be identified and that an immediate construction and modernization program be initiated to bring these facilities up to current standards of practice and accreditation.

(3) Manpower: (a) Compensation for Indian Health Service physicians be increased to a level

competitive with other Federal agencies and nongovernmental service; (b) Consideration should be given to increased compensation for service in remote areas; (c) In conjunction with improvement of Service facilities, efforts should be made to establish closer ties with teaching centers, thus increasing both the available manpower and the level of professional expertise available for consultation; (d) Allied health professional staffing of Service facilities should be maintained at a level appropriate to the special needs of the population served; (e) Continuing education opportunities should be provided for those health professionals serving these communities, and especially those in remote areas, and, increased peer contact, both to maintain the quality of care and to avert professional isolation; and (f) Consideration should be given to a federal statement of policy supporting continuation of the Public Health Service to reduce the great uncertainty now felt by many career officers of the corps.

(4) Medical Societies: In those states where Indian Health Service facilities are located, and in counties containing or adjacent to Service facilities, that the appropriate medical societies should explore the possibility of increased formal liaison with local Indian Health Service physicians. Increased support from organized medicine for improvement of health care provided under their direction, including professional consultation and involvement in society activities should be pursued.

(5) Our AMA also support the removal of any requirement for competitive bidding in the Indian Health Service that compromises proper care for the American Indian population.

CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmation A-12; Reaffirmed: Res. 233, A-13

American Indian / Alaska Native Adolescent Suicide D-350.988

Our AMA will: 1) provide active testimony in Congress for suicide prevention and intervention resources to be directed towards American Indian/Alaska Native communities; 2) encourage significant funding to be allocated to research the causes, prevention, and intervention regarding American Indian/Alaska Native adolescent suicide and make these findings widely available; and 3) lobby the Senate Committee on Indian Affairs on the important issue of American Indian/Alaska Native adolescent suicide.

Sub Res. 404, A-11; Reaffirmed: BOT Rep. 7, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 525
(A-22)

Introduced by: Medical Student Section

Subject: Reforming the FDA Accelerated Approval Process

Referred to: Reference Committee E

1 Whereas, The Food and Drug Administration (FDA)'s Accelerated Approval pathway is an
2 expedited approval pathway for pharmaceutical products created in 1992, in which
3 pharmaceutical products being developed for conditions where an unmet medical need exists
4 can be approved more rapidly through the use of a surrogate endpoint^{1,2}; and

5 Whereas, To qualify for use of the Accelerated Approval pathway, pharmaceutical products
6 must treat a serious condition, provide a meaningful improvement over available therapies, and
7 demonstrate an effect on either a surrogate endpoint (laboratory measurement, radiographic
8 image, physical sign, or other measure) that is reasonably likely to predict effect on irreversible
9 morbidity or mortality (IMM) or a clinical endpoint ("intermediate endpoint") that can be
10 measured earlier than IMM^{1,2}; and

11 Whereas, Drugs granted accelerated approvals must undergo post-marketing confirmatory trials
12 to be completed "with due diligence," which the FDA has interpreted to mean, "as early as
13 possible," but which carries no quantitative determination^{1,2}; and

14 Whereas, The FDA may withdraw approval of a drug approved under accelerated approval if
15 the product fails to verify predicted clinical benefit or if the applicant fails to conduct the post-
16 marketing trial with due diligence^{1,2}; and

17 Whereas, The use of accelerated approval has increased over time, with the mean annual
18 number of product-indication pairs using Accelerated Approval increasing from 4.7 per year
19 from 1992-2010 to 12.6 per year from 2011-2020, and with over 40% of cancer drugs being
20 used to treat solid tumors having been granted accelerated approval as of 2017^{3,4}; and

21 Whereas, Despite existing FDA guidance suggesting that post-marketing confirmatory trials
22 must be ongoing at the time of Accelerated Approval and the FDA's stated desire for sponsors
23 to complete trials "with due diligence," these studies are often not ongoing at the time of
24 Accelerated Approval, are slow to enroll, and take significant amounts of time to complete, with
25 50% of confirmatory trials still underway 3 years after Accelerated Approval⁵; and

26 Whereas, Notable recent examples of failures in the process of initiating and enrolling post-
27 marketing studies include that of Aducanumab, for which 9 years was granted to complete post-
28 marketing studies despite the post-marketing trial being scheduled to take place in the same
29 indication as the original trials (which took only 4 years to complete), and eteplirsen, for which a
30 post-marketing study was begun a full 5 years after accelerated approval was granted and is not
31 scheduled to be completed till 2026 (receiving direct FDA criticism in the process)^{6,7}; and

32 Whereas, Despite stated FDA guidance that post-marketing confirmation trials be designed
33 around endpoints such as IMM, post-marketing confirmation trials often are designed to report

1 benefit on the same surrogate endpoint as the original Accelerated Approval application, or a
2 different surrogate metric⁸; and

3
4 Whereas, For example, of 93 oncologic drug-indication pairs for which accelerated approval
5 was granted, only 20% reported improvements in overall survival, while the remaining trials
6 often use existing or new surrogate endpoints⁸; and

7
8 Whereas, Despite having statutory authority to remove drugs which fail to confirm clinical benefit
9 from the market, the FDA has ultimately exercised this authority cautiously, citing a variety of
10 factors including advocacy by manufacturers to retain the drug on the market when confronted
11 with a possible withdrawal and the uncertainty of benefit amongst professional physicians even
12 for drugs failing confirmatory studies⁹⁻¹²; and

13
14 Whereas, As a result of FDA reluctance to exercise its statutory authority, many drugs remain
15 marketed despite their failure in post-marketing studies, including one third of oncology agent-
16 indication combinations (6 out of a total of 18) that failed confirmatory studies⁹⁻¹²; and

17
18 Whereas, Even if indications are successfully removed from a drug's label following a negative
19 post-marketing trial result, a significant amount of time (median of 2 years for oncology agent-
20 indication combinations) often elapses from the announcement of negative post-marketing
21 results and official regulatory action, demonstrating the difficulty posed by indication withdrawal
22 under current FDA Accelerated Approval practices¹⁰⁻¹²; and

23
24 Whereas, Even when drug indications are successfully removed from a product's label, medical
25 practice guidelines continue to highly recommend use of these drugs; for example, half of the
26 18 oncology agent-indications failing post-marketing studies remain at the second-highest level
27 of recommendation by the National Comprehensive Cancer Network clinical guidelines¹⁰⁻¹²; and

28
29 Whereas, Drugs receiving accelerated approval account for significant and increasing levels of
30 total pharmaceutical expenditures, with Medicaid spending \$4.2-4.9 billion on accelerated
31 approval drugs in 2019 (6.4-9.1% of all Medicaid spending on pharmaceuticals) and Medicare
32 Part B spending \$9.1 billion on accelerated approval drugs in 2019 (a total of 16% of Medicare
33 Part B pharmaceutical spending), despite these drugs accounting for <1% of dispensed
34 prescriptions^{3,4}; and

35
36 Whereas, Citing the recent use of the Accelerated Approval pathway for Aducanumab
37 (Aduhelm) and an estimated \$7 - 37.4 billion total spending on the drug, the Center for Medicare
38 and Medicaid Services (CMS) announced a 14.5% premium rate hike, demonstrating the
39 possibility for severe budgetary strain and individual financial toxicity for drugs approved through
40 the Accelerated Approval pathway, particularly if use of accelerated approval continues to
41 proliferate^{13,14}; and

42
43 Whereas, While new spending on efficacious medicines is warranted and prices for FDA-
44 approved drugs (regardless of the regulatory pathway used) are set independently by
45 manufacturers, the outsized and growing spending on drugs granted Accelerated Approval, in
46 combination with documented evidence that Accelerated Approval evidentiary standards are
47 often weak, raises the concern that Accelerated Approval drugs are generating harmful
48 expenditures without corresponding benefits to patient health^{3,4,8}; and

49
50 Whereas, The current FDA Prescription Drug User Fee Act (PDUFA VI) expires in September
51 2022 and the United States House of Representatives and Senate have begun the process of
52 passing PDUFA VII to re-authorize the FDA^{15,16}; and

53 Whereas, Representatives in the U.S. House of Representatives and Senate often bundle other

1 FDA-related topics of interest into PDUFA reauthorization and have currently chosen to include
2 sections on Accelerated Approval reform in current PDUFA reauthorization efforts^{15,16};

3

4 Whereas, The House of Representatives Bill 7667 SEC. 804 (H.R. 7667 §804), passed by the
5 U.S. House of Representatives on June 9, 2022, proposes to reform the Accelerated Approval
6 pathway by statutorily enforcing several key requirements for all Accelerated Approvals¹⁷; and

7

8 Whereas, Specifically, under H.R. 7667 §804, 1) It will be required that post-marketing
9 confirmatory trials be ongoing at the time accelerated approval is granted; 2) the FDA is granted
10 authority to withdraw a product granted Accelerated Approval if the study sponsor fails to
11 complete post-marketing studies with due diligence, the drug fails to confirm effect on clinical
12 benefit, or the sponsor engages in misleading marketing efforts; 3) the process for withdrawal of
13 a drug is given greater clarity through the use of 'expedited procedures' to accelerate withdrawal
14 of products; 4) drug labeling for products approved via Accelerated Approval must clearly reflect
15 the fact that the drug was approved via the Accelerated Approval pathway and include
16 discussions of the uncertainty of benefit; and 5) sponsors are required to provide the Secretary
17 of Health and Human Services (HHS) with reports regarding their ongoing post-marketing
18 confirmatory studies¹⁷; and

19

20 Whereas, The U.S. Senate Bill titled, "FDALSA Act of 2022" also proposes to reform the
21 Accelerated Approval pathway, specifically in Section 506¹⁸; and

22

23 Whereas, Specifically, in addition to the proposals include in H.R. 7667 §804, under the
24 FDALSA Act of 2022 §506, the Senate proposes to create an inter-agency coordinating council
25 to review the use of the Accelerated Approval and also proposes legal penalties for sponsors
26 who fail to conduct post-marketing studies¹⁸; and

27

28 Whereas, Given the upcoming deadline for PDUFA reauthorization bills, which now include
29 Accelerated Approval riders, the window for the AMA to influence the future Accelerated
30 Approval regulatory pathway is open currently and will close by September 2022, necessitating
31 action¹⁵⁻¹⁸; and

32

33 Whereas, While existing AMA policy H-100.992 lends general support to existing FDA
34 procedures, including the use of multiple data sources (controlled trials, real-world-data, post-
35 marketing reports, and similar) and the ability to call upon standing advisory committees, no
36 current policy exists specifically describing the standards the FDA should follow with respect to
37 use of the Accelerated Approval pathway; therefore be it

38

39 RESOLVED, Our American Medical Association support mechanisms to address issues in the
40 Food & Drug Administration (FDA)'s Accelerated Approval process, including but not limited to:
41 efforts to ameliorate delays in post-marketing confirmatory study timelines, the creation of
42 expiration dates for accelerated approvals, protocols for the withdrawal of approvals when post-
43 marketing studies fail, justifications for the use of surrogate endpoints used to demonstrate
44 clinical benefit, and special considerations for certain diseases (New HOD Policy) ; and be it
45 further

46

47 RESOLVED, That our AMA support specific solutions to issues in the FDA's Accelerated
48 Approval process if backed by evidence that such solutions would not adversely impact the
49 likelihood of investment in novel drug development. (New HOD Policy)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 06/10/2022

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RELEVANT AMA POLICY

FDA H-100.992

1. Our AMA reaffirms its support for the principles that: (a) an FDA decision to approve a new drug, to withdraw a drug's approval, or to change the indications for use of a drug 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 unless the weight of the evidence from clinical trials, RWD fit for regulatory purpose, and postmarket reports shows that the drug is unsafe and/or ineffective for its labeled indications.
2. The AMA believes that social and economic concerns and disputes per se should not be permitted to play a significant part in the FDA's decision-making process in the course of FDA devising either general or product specific drug regulation.
3. It is the position of our AMA that the Food and Drug Administration should not permit political considerations or conflicts of interest to overrule scientific evidence in making policy decisions; and our AMA urges the current administration and all future administrations to consider our best and brightest scientists for positions on advisory committees and councils regardless of their political affiliation and voting history.

Res. 119, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmation A-06; Appended: Sub. Res. 509, A-06; Reaffirmation I-07; Reaffirmation I-09; Reaffirmation I-10; Modified: CSAPH Rep. 02, I-18; Modified: CSAPH Rep. 02, I-19; Reaffirmed: BOT Rep. 5, I-20

Drug Availability H-100.991

Our AMA urges HHS to consider all drugs approved by the FDA for marketing as eligible for reimbursement

Res. 79, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed and Modified: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 526
(A-22)

Introduced by: Medical Student Section

Subject: Adoption of Accessible Medical Diagnostic Equipment Standards

Referred to: Reference Committee E

1 Whereas, According to the Americans with Disabilities Act (ADA), a person with a disability is
2 defined as a “person with a physical or mental impairment that substantially limits one or more
3 major life activities, a person who has a history or record of such an impairment, or a person
4 who is perceived by others as having such an impairment”^{1,2}; and

5
6 Whereas, Similar to other marginalized minority groups, people with disabilities experience
7 barriers, including stigma and discrimination, that lead to health disparities³⁻¹²; and

8
9 Whereas, Approximately one in seven disabled adults has a mobility disability, defined a serious
10 difficulty walking or climbing stairs, which is the most common disability type¹³⁻¹⁵; and

11
12 Whereas, People with mobility disability encounter physical barriers in healthcare settings,
13 including inaccessible medical diagnostic equipment (MDE), such as examination tables,
14 examination chairs, weight scales, mammography equipment, and other diagnostic imaging
15 equipment^{3,5-7,9,16}; and

16
17 Whereas, The National Council on Disability, an independent federal advisory agency on
18 disability policy, published a comprehensive report in 2021 concluding that the MDE currently in
19 use is widely inaccessible to patients with mobility disability⁹; and

20
21 Whereas, A 2021 nationwide survey of 714 practicing U.S. physicians demonstrated that only
22 one-fifth of respondents consistently use accessible weight scales, and less than half
23 consistently use accessible exam tables or chairs for patients with significant mobility
24 disability¹⁶; and

25
26 Whereas, The lack of accessible MDE contributes to health disparities and allows for continued,
27 widespread discrimination of people with disabilities in healthcare settings^{3,5,6,9,17}; and

28
29 Whereas, Under the Rehabilitation Act, ADA, and Patient Protection and Affordable Care Act
30 (ACA), healthcare providers must ensure full and equal access to their healthcare services and
31 facilities; however, these regulations do not set specific standards for MDE^{1,2,18,19}; and

32
33 Whereas, In 2010, the ACA required the U.S. Access Board, an independent federal agency
34 that develops accessibility criteria for federally funded facilities, to issue accessibility standards
35 for MDE (MDE Standards)^{9,17}; and

36
37 Whereas, In 2017, the U.S. Access Board published MDE Standards that contain the minimum
38 technical criteria to ensure that MDE is accessible to patients with disabilities, but they are not
39 mandatory¹⁷; and

1 Whereas, Compliance with the MDE Standards only becomes mandatory when enforcing
2 agencies, such as the U.S. Department of Justice (DOJ) or Health and Human Services Office
3 of Civil Rights (HHS OCR), adopt the standards^{9,17}; and
4
5 Whereas, The only agency to voluntarily adopt the MDE Standards is the Veterans Health
6 Administration which, in 2017, required new equipment to meet the MDE Standards^{9,20}; and
7
8 Whereas, In 2018, the DOJ declined to adopt the MDE standards under the ADA because
9 implementation costs would exceed \$0.00, the limit imposed by Executive Order 13771 issued
10 by President Trump⁹; and
11
12 Whereas, In 2020, the HHS OCR declined to adopt the MDE standards under Section 1557 of
13 the ACA, stating that they were beyond the scope of the regulation⁹; and
14
15 Whereas, In 2021, Executive Order 13371 was revoked by President Biden, which facilitates
16 renewed efforts to adopt the MDE Standards by federal agencies⁹; and
17
18 Whereas, In January 2021, the HHS OCR initiated the regulatory process for inclusion of MDE
19 under its Section 504 of Rehabilitation, in which they requested information from stakeholders
20 including medical providers^{9,21}; and
21
22 Whereas, State governments, such as the Connecticut state government, proposed legislation
23 in 2022 that would voluntarily adopt the MDE standards, however this legislation was opposed
24 due to the current lack of federal guidance and rulemaking²²⁻²⁴; and
25
26 Whereas, Renewed efforts by the Biden administration to formally adopt the MDE Standards
27 requires timely and informative stakeholder input from governing bodies in medicine or risks
28 delaying federal rulemaking and deprioritizing physician and patient interests^{9,21}; and
29
30 Whereas, The DOJ and HHS OCR are likely to release their notice of proposed rulemaking and
31 advance notice of proposed rulemaking, respectively, within 6 months (Andres Gallegos, Esq.,
32 President of the National Council on Disability, email communication, June 10, 2022.); and
33
34 Whereas, The U.S. Access Board concluded that the potential benefits of the MDE standards
35 justify its potential costs after a multiyear process during which input was sought from diverse
36 stakeholders, including consumers, manufacturers, healthcare providers, and ergonomics
37 experts^{9,17}; and
38
39 Whereas, Currently, federal tax incentives are available to eligible businesses to offset costs, so
40 that individual physicians or small private practices who seek to increase the accessibility of
41 their MDE do not face undue financial hardship²⁵⁻²⁹; and
42
43 Whereas, The Disabled Access Credit allows for a credit of up to 50% of the amount of a
44 business' yearly eligible expenditures, including purchasing or modifying MDE, to offset costs
45 whereas the Architectural Barrier Removal Tax Deduction is a deduction of up to \$15,000 per
46 year associated with removing barriers to facilities, including medical practices²⁶⁻²⁸; and
47
48 Whereas, Both the Disabled Access Credit and Architectural Barrier Removal Tax Deduction
49 can be used together and in multiple tax years if the business is eligible²⁶⁻²⁸; and
50
51 Whereas, The cost of investing in accessible MDE is likely to be spread over multiple years and
52 balanced or exceeded by downstream savings as a result of enhanced safety in healthcare
53 facilities and access to preventative, primary, and specialty care^{9,17}; and

1 Whereas, While AMA policy H-90.971 encourages physicians to make their offices physically
2 accessible to people with disabilities in accordance with the ADA, it does not specify the need to
3 adopt enforceable MDE Standards at the federal level which are not yet covered by ADA; and
4
5 Whereas, While AMA policy H-425.970 advocates for equitable access to preventative
6 screenings for people with disabilities, it does not go further to recognize the widespread
7 discrimination of people with disabilities in many healthcare settings due to inaccessible MDE;
8 therefore be it
9
10 RESOLVED, That our American Medical Association support the enforcement of proposed
11 federal accessibility standards for medical diagnostic equipment, as well as tax incentives and
12 deductions that help physicians implement these standards. (New HOD Policy)

Fiscal Note: Minimal - less than \$1,000

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RELEVANT AMA POLICY

Medical Care of Persons with Developmental Disabilities H-90.968

1. Our AMA encourages: (a) clinicians to learn and appreciate variable presentations of complex functioning profiles in all persons with developmental disabilities; (b) medical schools and graduate medical education programs to acknowledge the benefits of education on how aspects in the social model of disability (e.g. ableism) can impact the physical and mental health of persons with Developmental Disabilities; (c) medical schools and graduate medical education programs to acknowledge the benefits of teaching about the nuances of uneven skill sets, often found in the functioning profiles of persons with developmental disabilities, to improve quality in clinical care; (d) the education of physicians on how to provide and/or advocate for quality, developmentally appropriate medical, social and living supports 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.

5. Our AMA recognizes the importance of managing the health of children and adults with developmental 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 developmental disabilities, as well as the consequences of poor health management on mental and physical health for people with developmental disabilities.
7. Our AMA encourages the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, and allopathic and osteopathic medical schools to develop and implement curriculum on the care and treatment of people with 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 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 education programs that focus on the care and treatment of people with 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.

CCB/CLRPD Rep. 3, A-14; Appended: Res. 306, A-14; Appended: Res. 315, A-17; Appended: Res. 304, A-18; Reaffirmed in lieu of the 1st Resolved: Res. 304, A-18

Promoting Health Awareness of Preventive Screenings in Individuals with Disabilities H-425.970

Our AMA will work closely with relevant stakeholders to advocate for equitable access to health promotion and preventive screenings for individuals with disabilities.

Res. 911, I-13

Reclassification of Complex Rehabilitation Technology H-330.871

Our AMA supports: (1) the reclassification of complex rehabilitation technology (CRT) as a separate, distinct, and adequately funded payment category to improve access to the most appropriate and necessary equipment to allow individuals with significant disabilities and chronic medical conditions to increase their independence, reduce their overall health care expenses and appropriately manage their medical needs; (2) state medical association and national medical specialty society efforts to accomplish adequately funded reclassification of CRT; and (3) upon reclassification of CRT as a distinct category, the development by the Centers for Medicare & Medicaid Services, with the advice of physicians with appropriate training and expertise, of appropriate, simplified and streamlined requirements specific to CRT that reduce the administrative burden on physicians.

CMS Rep. 04, A-19

Appropriate Reimbursement for Evaluation and Management Services for Patients with Severe Mobility-Related Impairments H-390.835

Our AMA supports: (1) additional reimbursement for evaluation and management services for patients who require additional time and specialized equipment during medical visits due to severe mobility-related impairments; (2) that no additional cost-sharing for the additional reimbursement will be passed on to patients with mobility disabilities, consistent with Federal Law; (3) that primary and specialty medical providers be educated regarding the care of patients with severely impaired mobility to improve access to care; and (4) additional funding for payment for services provided to patients with mobility related impairments that is not through a budget neutral adjustment to the physician fee schedule.

Res. 814, 1-17

Federal Legislation on Access to Community-Based Services for People with Disabilities H-290.970

Our AMA strongly supports reform of the Medicaid program established under title XIX of the Social Security Act (42 U.S.C. 1396) to provide services in the most appropriate settings based upon the individual's needs, and to provide equal access to community-based attendant services and supports.

Res. 917, I-07 Reaffirmed: BOT Rep. 22, A-17

Enhancing Accommodations for People with Disabilities, H-90.971

Our AMA encourages physicians to make their offices both physically and virtually accessible to patients with disabilities, consistent with the Americans with Disabilities Act (ADA) guidelines.
Res. 705, A-13

Preserving Protections of the Americans with Disabilities Act of 1990 D-90.992

1. Our AMA supports legislative changes to the Americans with Disabilities Act of 1990, to educate state and local government officials and property owners on strategies for promoting access to persons with a disability.
2. Our AMA opposes legislation amending the Americans with Disabilities Act of 1990, that would increase barriers for disabled persons attempting to file suit to challenge a violation of their civil rights.
3. Our AMA will develop educational tools and strategies to help physicians make their offices more accessible to persons with disabilities, consistent with the Americans With Disabilities Act as well as any applicable state laws.

Res. 220, I-17

Patient Advocacy H-140.997

Our AMA believes that physicians are the primary patient advocates, are not rationers of medical care, and will continue to utilize diagnostic and therapeutic measures and facilities in the best interest of the individual patient.

Res. 146, A-84 Reaffirmed: BOT Rep. I-93-25

Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: Rules and Cred. Cmt., I-97; Reaffirmed: CEJA Rep. 2, A-04 Reaffirmation A-05; Reaffirmed: CEJA Rep. 5, A-15

Children and Youth With Disabilities H-60.974

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

CSA Rep. J, I-91 Modified: Sunset Report, I-01

Modified: CSAPH Rep. 1, A-11 Reaffirmed: CSAPH Rep. 1, A-21

Support of Human Rights and Freedom H-65.965

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

CCB/CLRPD Rep. 3, A-14; Reaffirmed in lieu of: Res. 001, I-16; Reaffirmation: A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 621
(A-22)

Introduced by: American College of Obstetricians and Gynecologists

Subject: Establishing A Task Force to Preserve the Patient-Physician Relationship
When Evidence-Based, Appropriate Care Is Banned or Restricted

Referred to: Reference Committee F

1 Whereas, Absent federal protections, more than half the states are likely to ban abortion
2 services and training, target counseling, referrals, and triage, and profoundly shift the health
3 care practice and training landscape with broad consequences for management of induced,
4 spontaneous, and missed abortion, infertility treatment, and pregnancy complications; and
5

6 Whereas, In the wake of a leaked draft opinion in *Dobbs v. Jackson Women's Health*
7 *Organization*, physicians across specialties are grappling with unanswered questions about how
8 to navigate an upheaval of existing practice structures and norms and a radically altered legal
9 environment; and

10 Whereas, Such bans on abortion are a harbinger of what is to come--logically leading to
11 devastating strictures and prohibitions on necessary, evidence-based care, including counseling
12 for, management of, and referrals regarding gender affirming care, contraception/family
13 planning, in vitro fertilization, and pregnancy loss; and
14

15 Whereas, Our AMA has long been a trusted leader leveraging its policies and cross-specialty
16 expertise to equip physicians and practices with advocacy support and practice management
17 tools and convene task forces to act on pressing issues, challenges, and threats; therefore be it
18

19 RESOLVED, That our American Medical Association convene a task force of appropriate AMA
20 councils and interested state and medical specialty societies, in conjunction with the AMA
21 Center for Health Equity, and in consultation with relevant organizations, practices, government
22 bodies, and impacted communities (Directive to Take Action); and be it further
23

24 RESOLVED, That this task force guide organized medicine's response to bans and restrictions
25 on abortion, prepare for widespread criminalization of other evidence-based care, implement
26 relevant AMA policies, and identify and create implementation-focused practice and advocacy
27 resources on issues including but not limited to:
28

29 a) Health equity impact, including monitoring and evaluating the consequences of
30 abortion bans and restrictions for public health and the physician workforce and including
31 making actionable recommendations to mitigate harm, with a focus on the
32 disproportionate impact on under-resourced, marginalized, and minoritized communities,
33

34 b) Practice management, including developing recommendations and educational
35 materials for addressing reimbursement, uncompensated care, interstate licensure, and
36 provision of care, including telehealth and care provided across state lines;
37

1 c) Training, including collaborating with interested medical schools, residency and
2 fellowship programs, academic centers, and clinicians to mitigate radically diminished
3 training opportunities;

4

5 d) Privacy protections, including best practice support for maintaining medical records
6 privacy and confidentiality, including under HIPAA, for strengthening physician, patient,
7 and clinic security measures, and countering law enforcement reporting requirements;

8

9 e) Patient triage and care coordination, including identifying and publicizing resources for
10 physicians and patients to connect with referrals, practical support, and legal assistance;

11

12 f) Coordinating implementation of pertinent AMA policies, including any actions to protect
13 against civil, criminal, and professional liability and retaliation, including criminalizing and
14 penalizing physicians for referring patients to the care they need; and

15

16 g) Anticipation and preparation, including assessing information and resource gaps and
17 creating a blueprint for preventing or mitigating bans on other appropriate health care,
18 such as gender affirming care, contraceptive care, sterilization, infertility care, and
19 management of ectopic pregnancy and spontaneous pregnancy loss and pregnancy
20 complications. (Directive to Take Action)

Fiscal Note: Estimated cost to implement this resolution is \$30K.

Received: 05/27/22

RELEVANT AMA POLICY

Political Interference in the Patient-Physician Relationship H-140.835

Our AMA opposes any policies that interfere with the patient-physician relationship by giving probate, inheritance, a social security number, or other legal rights to an undelivered pregnancy, or imposing legislative barriers to medical decision-making by changes in tax codes or in definitions of beneficiaries.

Citation: Alt. Res. 007, I-17

Plan for Continued Progress Toward Health Equity H-180.944

Health equity, defined as optimal health for all, is a goal toward which our AMA will work by advocating for health care access, research, and data collection; promoting equity in care; increasing health workforce diversity; influencing determinants of health; and voicing and modeling commitment to health equity.

Citation: BOT Rep. 33, A-18; Reaffirmed: CMS Rep. 5, I-21

Government Interference in Patient Counseling H-373.995

1. Our AMA vigorously and actively defends the physician-patient-family relationship and actively opposes state and/or federal efforts to interfere in the content of communication in clinical care delivery between clinicians and patients.
2. Our AMA strongly condemns any interference by government or other third parties that compromise a physician's ability to use his or her medical judgment as to the information or treatment that is in the best interest of their patients.
3. Our AMA supports litigation that may be necessary to block the implementation of newly enacted state and/or federal laws that restrict the privacy of physician-patient-family relationships and/or that violate the First Amendment rights of physicians in their practice of the art and science of medicine.
4. Our AMA opposes any government regulation or legislative action on the content of the

individual clinical encounter between a patient and physician without a compelling and evidence-based benefit to the patient, a substantial public health justification, or both.

5. Our AMA will educate lawmakers and industry experts on the following principles endorsed by the American College of Physicians which should be considered when creating new health care policy that may impact the patient-physician relationship or what occurs during the patient-physician encounter:

- A. Is the content and information or care consistent with the best available medical evidence on clinical effectiveness and appropriateness and professional standards of care?
- B. Is the proposed law or regulation necessary to achieve public health objectives that directly affect the health of the individual patient, as well as population health, as supported by scientific evidence, and if so, are there no other reasonable ways to achieve the same objectives?
- C. Could the presumed basis for a governmental role be better addressed through advisory clinical guidelines developed by professional societies?
- D. Does the content and information or care allow for flexibility based on individual patient circumstances and on the most appropriate time, setting and means of delivering such information or care?
- E. Is the proposed law or regulation required to achieve a public policy goal - such as protecting public health or encouraging access to needed medical care - without preventing physicians from addressing the healthcare needs of individual patients during specific clinical encounters based on the patient's own circumstances, and with minimal interference to patient-physician relationships?
- F. Does the content and information to be provided facilitate shared decision-making between patients and their physicians, based on the best medical evidence, the physician's knowledge and clinical judgment, and patient values (beliefs and preferences), or would it undermine shared decision-making by specifying content that is forced upon patients and physicians without regard to the best medical evidence, the physician's clinical judgment and the patient's wishes?
- G. Is there a process for appeal to accommodate individual patients' circumstances?

6. Our AMA strongly opposes any attempt by local, state, or federal government to interfere with a physician's right to free speech as a means to improve the health and wellness of patients across the United States.

Citation: Res. 201, A-11; Reaffirmation: I-12; Appended: Res. 717, A-13; Reaffirmed in lieu of Res. 5, I-13; Appended: Res. 234, A-15; Reaffirmation: A-19

Freedom of Communication Between Physicians and Patients H-5.989

It is the policy of the AMA: (1) to strongly condemn any interference by the government or other third parties that causes a physician to compromise his or her medical judgment as to what information or treatment is in the best interest of the patient;

(2) working with other organizations as appropriate, to vigorously pursue legislative relief from regulations or statutes that prevent physicians from freely discussing with or providing information to patients about medical care and procedures or which interfere with the physician-patient relationship;

(3) to communicate to HHS its continued opposition to any regulation that proposes restrictions on physician-patient communications; and

(4) to inform the American public as to the dangers inherent in regulations or statutes restricting communication between physicians and their patients.

Citation: (Sub. Res. 213, A-91; Reaffirmed: Sub. Res. 232, I-91; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmed by Sub. Res. 133 and BOT Rep. 26, A-97; Reaffirmed by Sub. Res. 203 and 707, A-98; Reaffirmed: Res. 703, A-00; Reaffirmed in lieu of Res. 823, I-07; Reaffirmation I-09; Reaffirmation: I-12; Reaffirmed in lieu of Res. 5, I-13)

The Criminalization of Health Care Decision Making H-160.946

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

Citation: (Sub. Res. 202, A-95; Reaffirmed: Res. 227, I-98; Reaffirmed: BOT Rep. 2, A-07; Reaffirmation A-09; Reaffirmation: I-12)

Medical Training and Termination of Pregnancy H-295.923

1. Our AMA supports the education of medical students, residents and young physicians about the need for physicians who provide termination of pregnancy services, the medical and public health importance of access to safe termination of pregnancy, and the medical, ethical, legal and psychological principles associated with termination of pregnancy.
2. Our AMA supports the availability of abortion education and exposure to procedures for termination of pregnancy, including medication abortions, for medical students and resident/fellow physicians and opposes efforts to interfere with or restrict the availability of this education and training.
3. Our AMA encourages the Accreditation Council for Graduate Medical Education to consistently enforce compliance with the standardization of abortion training opportunities as per the requirements set forth by the Review Committee for Obstetrics and Gynecology and the American College of Obstetricians and Gynecologists' recommendations.

Citation: Res. 315, I-94; Reaffirmed: CME Rep. 2, A-04; Modified: CME Rep. 2, A-14; Modified: CME Rep. 1, A-15; Appended: Res. 957, I-17; Modified: Res. 309, I-21

Opposition to Criminalizing Health Care Decisions D-160.999

Our AMA will educate physicians regarding the continuing threat posed by the criminalization of healthcare decision-making and the existence of our model legislation "An Act to Prohibit the Criminalization of Healthcare Decision-Making."

Citation: (Res. 228, I-98; Reaffirmed: BOT Rep. 5, A-08; Reaffirmation: I-12)

Opposition to Criminalization of Medical Care Provided to Undocumented Immigrant Patients H-440.876

1. Our AMA: (a) opposes any policies, regulations or legislation that would criminalize or punish physicians and other health care providers for the act of giving medical care to patients who are undocumented immigrants; (b) opposes any policies, regulations, or legislation requiring physicians and other health care providers to collect and report data regarding an individual patient's legal resident status; and (c) opposes proof of citizenship as a condition of providing health care.
2. Our AMA will work with local and state medical societies to immediately, actively and publicly oppose any legislative proposals that would criminalize the provision of health care to undocumented residents.

Citation: (Res. 920, I-06; Reaffirmed and Appended: Res. 140, A-07; Modified: CCB/CLRPD Rep. 2, A-14)

Clarification of Medical Necessity for Treatment of Gender Dysphoria H-185.927

Our AMA: (1) recognizes that medical and surgical treatments for gender dysphoria, as determined by shared decision making between the patient and physician, are medically necessary as outlined by generally-accepted standards of medical and surgical practice; (2) will advocate for federal, state, and local policies to provide medically necessary care for gender

dysphoria; and (3) opposes the criminalization and otherwise undue restriction of evidence-based gender-affirming care.

Citation: Res. 05, A-16; Modified: Res. 015, A-21

Criminalization of Medical Judgment H-160.954

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

Citation: (Sub. Res. 223, I-93; Reaffirmed: Res. 227, I-98; Reaffirmed: Res. 237, A-99; Reaffirmed and Appended: Sub. Res. 215, I-99; Reaffirmation A-09; Reaffirmed: CEJA Rep. 8, A-09; Reaffirmation: I-12; Modified: Sub. Res. 716, A-13; Reaffirmed in lieu of Res. 605, I-13)

Patient Privacy and Confidentiality H-315.983

1. Our AMA affirms the following key principles that should be consistently implemented to evaluate any proposal regarding patient privacy and the confidentiality of medical information: (a) That there exists a basic right of patients to privacy of their medical information and records, and that this right should be explicitly acknowledged; (b) That patients' privacy should be honored unless waived by the patient in a meaningful way or in rare instances when strong countervailing interests in public health or safety justify invasions of patient privacy or breaches of confidentiality, and then only when such invasions or breaches are subject to stringent safeguards enforced by appropriate standards of accountability; (c) That patients' privacy should be honored in the context of gathering and disclosing information for clinical research and quality improvement activities, and that any necessary departures from the preferred practices of obtaining patients' informed consent and of de-identifying all data be strictly controlled; (d) That any information disclosed should be limited to that information, portion of the medical record, or abstract necessary to fulfill the immediate and specific purpose of disclosure; and (e) That the Health Insurance Portability and Accountability Act of 1996 (HIPAA) be the minimal standard for protecting clinician-patient privilege, regardless of where care is received.

2. Our AMA affirms: (a) that physicians and medical students who are patients are entitled to the same right to privacy and confidentiality of personal medical information and medical records as other patients, (b) that when patients exercise their right to keep their personal medical histories confidential, such action should not be regarded as fraudulent or inappropriate concealment, and (c) that physicians and medical students should not be required to report any aspects of their patients' medical history to governmental agencies or other entities, beyond that which would be required by law.

3. Employers and insurers should be barred from unconsented access to identifiable medical information lest knowledge of sensitive facts form the basis of adverse decisions against individuals. (a) Release forms that authorize access should be explicit about to whom access is being granted and for what purpose, and should be as narrowly tailored as possible. (b) Patients, physicians, and medical students should be educated about the consequences of signing overly-broad consent forms. (c) Employers and insurers should adopt explicit and public policies to assure the security and confidentiality of patients' medical information. (d) A patient's ability to join or a physician's participation in an insurance plan should not be contingent on signing a broad and indefinite consent for release and disclosure.

4. Whenever possible, medical records should be de-identified for purposes of use in connection with utilization review, panel credentialing, quality assurance, and peer review.

5. The fundamental values and duties that guide the safekeeping of medical information should remain constant in this era of computerization. Whether they are in computerized or paper form, it is critical that medical information be accurate, secure, and free from unauthorized access and improper use.

6. Our AMA recommends that the confidentiality of data collected by race and ethnicity as part of the medical record, be maintained.
7. Genetic information should be kept confidential and should not be disclosed to third parties without the explicit informed consent of the tested individual.
8. When breaches of confidentiality are compelled by concerns for public health and safety, those breaches must be as narrow in scope and content as possible, must contain the least identifiable and sensitive information possible, and must be disclosed to the fewest possible to achieve the necessary end.
9. Law enforcement agencies requesting private medical information should be given access to such information only through a court order. This court order for disclosure should be granted only if the law enforcement entity has shown, by clear and convincing evidence, that the information sought is necessary to a legitimate law enforcement inquiry; that the needs of the law enforcement authority cannot be satisfied by non-identifiable health information or by any other information; and that the law enforcement need for the information outweighs the privacy interest of the individual to whom the information pertains. These records should be subject to stringent security measures.
10. Our AMA must guard against the imposition of unduly restrictive barriers to patient records that would impede or prevent access to data needed for medical or public health research or quality improvement and accreditation activities. Whenever possible, de-identified data should be used for these purposes. In those contexts where personal identification is essential for the collation of data, review of identifiable data should not take place without an institutional review board (IRB) approved justification for the retention of identifiers and the consent of the patient. In those cases where obtaining patient consent for disclosure is impracticable, our AMA endorses the oversight and accountability provided by an IRB.
11. Marketing and commercial uses of identifiable patients' medical information may violate principles of informed consent and patient confidentiality. Patients divulge information to their physicians only for purposes of diagnosis and treatment. If other uses are to be made of the information, patients must first give their uncoerced permission after being fully informed about the purpose of such disclosures.
12. Our AMA, in collaboration with other professional organizations, patient advocacy groups and the public health community, should continue its advocacy for privacy and confidentiality regulations, including: (a) The establishment of rules allocating liability for disclosure of identifiable patient medical information between physicians and the health plans of which they are a part, and securing appropriate physicians' control over the disposition of information from their patients' medical records. (b) The establishment of rules to prevent disclosure of identifiable patient medical information for commercial and marketing purposes; and (c) The establishment of penalties for negligent or deliberate breach of confidentiality or violation of patient privacy rights.
13. Our AMA will pursue an aggressive agenda to educate patients, the public, physicians and policymakers at all levels of government about concerns and complexities of patient privacy and confidentiality in the variety of contexts mentioned.
14. Disclosure of personally identifiable patient information to public health physicians and departments is appropriate for the purpose of addressing public health emergencies or to comply with laws regarding public health reporting for the purpose of disease surveillance.
15. In the event of the sale or discontinuation of a medical practice, patients should be notified whenever possible and asked for authorization to transfer the medical record to a new physician or care provider. Only de-identified and/or aggregate data should be used for "business decisions," including sales, mergers, and similar business transactions when ownership or control of medical records changes hands.
16. The most appropriate jurisdiction for considering physician breaches of patient confidentiality is the relevant state medical practice act. Knowing and intentional breaches of patient confidentiality, particularly under false pretenses, for malicious harm, or for monetary

gain, represents a violation of the professional practice of medicine.

17. Our AMA Board of Trustees will actively monitor and support legislation at the federal level that will afford patients protection against discrimination on the basis of genetic testing.

18. Our AMA supports privacy standards that would require pharmacies to obtain a prior written and signed consent from patients to use their personal data for marketing purposes.

19. Our AMA supports privacy standards that require pharmacies and drug store chains to disclose the source of financial support for drug mailings or phone calls.

20. Our AMA supports privacy standards that would prohibit pharmacies from using prescription refill reminders or disease management programs as an opportunity for marketing purposes.

21. Our AMA will draft model state legislation requiring consent of all parties to the recording of a physician-patient conversation.

Citation: BOT Rep. 9, A-98; Reaffirmation I-98; Appended: Res. 4, and Reaffirmed: BOT Rep. 36, A-99; Appended: BOT Rep. 16 and Reaffirmed: CSA Rep. 13, I-99; Reaffirmation A-00; Reaffirmed: Res. 246 and 504 and Appended Res. 504 and 509, A-01; Reaffirmed: BOT Rep. 19, I-01; Appended: Res. 524, A-02; Reaffirmed: Sub. Res. 206, A-04; Reaffirmed: BOT Rep. 24, I-04; Reaffirmed: BOT Rep. 19, I-06; Reaffirmation A-07; Reaffirmed: BOT Rep. 19, A-07; Reaffirmed: CEJA Rep. 6, A-11; Reaffirmed in lieu of Res. 705, A-12; Reaffirmed: BOT Rep. 17, A-13; Modified: Res. 2, I-14; Reaffirmation: A-17; Modified: BOT Rep. 16, A-18; Appended: Res. 232, A-18; Reaffirmation: I-18; Reaffirmed: Res. 219, A-21; Reaffirmed: Res. 229, A-21; Reaffirmed: BOT Rep. 12, I-21

Public Funding of Abortion Services H-5.998

The AMA reaffirms its opposition to legislative proposals that utilize federal or state health care funding mechanisms to deny established and accepted medical care to any segment of the population.

Citation: (Sub. Res. 89, I-83; Reaffirmed: CLRPD Rep. 1, I-93 Reaffirmed: BOT Rep. 12, A-05; Reaffirmed: CMS Rep. 1, A-15)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 622
(A-22)

Introduced by: Young Physicians Section

Subject: HOD Modernization

Referred to: Reference Committee F

1 Whereas, The AMA has now hosted four special meetings of its House of Delegates; and

2 Whereas, Three of these meetings have included virtual policy-making processes; and

3 Whereas, Technology and the ability to communicate has adapted and grown rapidly during the
4 recent pandemic; and

5 Whereas, Changes in our communication platforms and processes may enable us to be more
6 efficient and streamline discussion, but still necessitate the important role of an in-person
7 deliberative process; therefore be it

8 RESOLVED, That our American Medical Association immediately convene a task force [The
9 House of Delegates (HOD) Modernization Task Force] representing HOD stakeholders,
10 including representatives from all AMA Sections, charged with analyzing lessons learned from
11 virtual meetings of our HOD to determine how future in-person meetings may be updated to
12 improve the efficiency and effectiveness of the HOD, while making efforts to maintain the central
13 tenets of our House, including equity, democracy, protecting minority voices, and recognizing
14 the importance of in-person deliberations (Directive to Take Action); and be it further

15 RESOLVED, That the Speakers issue updates on the HOD Modernization Task Force progress
16 and recommendations beginning at the 2022 Interim Meeting of the AMA House of Delegates
17 and each meeting thereafter until the Task Force has completed its work. (Directive to Take
18 Action)

Fiscal Note: Estimated cost to implement resolution is \$30,000.

Received: 06/10/22

RELEVANT AMA POLICY

[Special Committees of the House of Delegates. B-2.13.6](#)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 623
(A-22)

Introduced by: Organized Medical Staff Section

Subject: Virtual Attendance at AMA Meetings

Referred to: Reference Committee F

1 Whereas, The House of Delegates of the American Medical Association is the policy-making
2 instrument of the AMA and deliberations at its Sections contribute significantly to that process;
3 and

4
5 Whereas, The COVID-19 pandemic compelled communications among AMA delegates and
6 sections participants to discuss resolutions and policy issues be done through virtual means;
7 and

8
9 Whereas, There were concerns that strictly virtual interaction could dilute the sharing of ideas
10 and shaping of policy because of lack of face-to-face interaction; and

11
12 Whereas, Meetings through the time of the COVID-19 pandemic to date have been reasonably
13 successful, albeit at times cumbersome and somewhat restrictive of the number of policies
14 discussed; and

15
16 Whereas, Testimony and deliberation of proposed policies in the virtual Forum space has
17 expanded, with slow but ongoing acceptance and participation of members particularly of
18 sections, and is likely to continue to be an integral venue of sections, but to date do not include
19 the formal business meeting, including voting on section actions, in most instances; and

20
21 Whereas, The Centers for Medicare and Medicaid Services (CMS) acknowledged the necessity
22 and value of virtual medical interactions by virtue of an executive order allowing 100 percent of
23 reimbursement of virtual visits at the level of an in-office visit, and this has been continued into
24 2022 with expectation that some level of payment for virtual medical visits will become a part of
25 standard reimbursement policy by CMS and private insurers going forward, a measure of
26 society's acceptance of this form of communication; and

27
28 Whereas, Although patients' satisfaction with virtual visits is varied, a significant percentage are
29 supportive of the virtual alternative; and

30
31 Whereas, The vagaries and concerns related to the COVID-19 pandemic does not have a
32 defined ending and other similar health concerns may arise from time to time; and

33
34 Whereas, The cost of attending AMA meetings, both in expense and time, is significant and
35 likely serves as a barrier to participation of a significant number of potential
36 Delegates/Representatives; and

37
38 Whereas, The AMA seeks to maintain and enlarge its membership to ensure it maximizes its
39 representation of various medical interests, including maximizing equity, as well as thereby

1 fortifying its position and influence as the primary advocate for medical interests in the United
2 States and abroad; and

3
4 Whereas, Membership gaps such as physicians in mid-practice, as well as under-represented
5 section of society, in part result from conflicting demands such as time taken from family and
6 practice concerns, as well as economic burdens; and

7
8 Whereas, Some members with impairments/disabilities find it difficult to navigate AMA meetings
9 in person; and

10
11 Whereas, Despite anticipated logistical difficulties, the option to attend AMA meetings with full
12 participation, including testimony and voting, would be highly desirable to increase member
13 retention, attract new members, and increase member active participation; therefore be it

14
15 RESOLVED, That our American Medical Association expand the format of Section meetings to
16 include official participation via virtual, as well as in-person, attendance at Section Meetings,
17 with procedures to include voting as well as testimony and educational presentations, and
18 ensure equity and full access to meaningful interaction of those accredited but not physically
19 present starting at the Interim 2022 Meeting (Directive to Take Action); and be it further

20
21 RESOLVED, That our AMA study the experience of Sections that include virtual participation in
22 business meetings with voting privileges, with the goal of expanding House of Delegates
23 meetings to include virtual participation with those privileges as an option to in-person
24 attendance at its meeting and reference committees, and report back to the HOD by Interim
25 2023. (Directive to Take Action)

Fiscal Note: Indeterminate

Date received: 06/10/22

RELEVANT AMA POLICY

Meetings of the House of Delegates (B-2.12)

2.12.1 Regular Meetings of the House of Delegates. The House of Delegates shall meet twice annually, at an Annual Meeting and an Interim Meeting.

2.12.1.1 Business of Interim Meeting. The business of an Interim Meeting shall be focused on advocacy and legislation. Resolutions pertaining to ethics, and opinions and reports of the Council on Ethical and Judicial Affairs, may also be considered at an Interim Meeting. Other business requiring action prior to the following Annual Meeting may also be considered at an Interim Meeting. In addition, any other business may be considered at an Interim Meeting by majority vote of delegates present and voting.

2.12.2 Special Meetings of the House of Delegates. Special Meetings of the House of Delegates shall be called by the Speaker on written or electronic request by one-third of the members of the House of Delegates, or on request of a majority of the Board of Trustees. When a special meeting is called, the Executive Vice President of the AMA shall mail a notice to the last known address of each member of the House of Delegates at least 20 days before the special meeting is to be held. The notice shall specify the time and place of meeting and the purpose for which it is called, and the House of Delegates shall consider no business except that for which the meeting is called.

2.12.3 Locations. The House of Delegates shall meet in cities selected by the Board of Trustees.

2.12.3.1 Invitation from Constituent Association. A constituent association desiring a meeting within its borders shall submit an invitation in writing, together with significant data, to

the Board of Trustees. The dates and the city selected may be changed by action of the Board of Trustees at any time, but not later than 60 days prior to the dates selected for that meeting.

2.12.4 Meetings.

2.12.4.1 Open. The House of Delegates may meet in an open meeting to which any person may be admitted. By majority vote of delegates present and voting, an open meeting may be moved into either a closed or an executive meeting.

2.12.4.2 Closed. A closed meeting shall be restricted to members of the AMA, and to employees of the AMA and of organizations represented in the House of Delegates.

2.12.4.3 Executive. An executive meeting shall be limited to the members of the House of Delegates and to such employees of the AMA necessary for its functioning.

Business Meeting (B-7.0.6)

There shall be a Business Meeting of members of each Section. The Business Meeting shall be held on a day prior to each Annual and Interim Meeting of the House of Delegates.

7.0.6.1 Purpose. The purposes of the Business Meeting shall be:

7.0.6.1.1 To hear such reports as may be appropriate.

7.0.6.1.2 To consider other business and vote upon such matters as may properly come before the meeting.

7.0.6.1.3 To adopt resolutions for submission by the Section to the House of Delegates.

7.0.6.1.4 To hold elections.

7.0.6.2 Meeting Procedure.

7.0.6.2.1 The Business Meeting shall be open to all members of the AMA.

7.0.6.2.2 Only duly selected representatives who are AMA members shall have the right to vote at the Business Meeting.

7.0.6.2.3 The Business Meeting shall be conducted pursuant to rules of procedure adopted by the Governing Council. The rules of procedure may specify the rights and privileges of Section members, including any limitations on participation or vote.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 624
(A-22)

Introduced by: Organized Medical Staff Section

Subject: Creation of United Nations "Dr. Saul Hertz Theranostic Nuclear Medicine" International Day

Referred to: Reference Committee F

1 Whereas, the General Assembly of the United Nations advocates for proclaiming International
2 days of recognition to highlight specific values of worldwide human interest; and

4 Whereas, The United Nations General Assembly documents describe the purpose of
5 proclaiming "International Days" as follows: "International days are occasions to educate the
6 general public on issues of concern, to mobilize political will and resources to address global
7 problems, and to celebrate and reinforce achievements of humanity;" and

9 Whereas, Last year physicians and patients celebrated 80 years from the first recorded use of
10 radioiodine therapy to treat human disease; and

12 Whereas, Saul Hertz, MD (1905 – 1950) discovered the medical uses of radionuclides, and his
13 breakthrough work with radioactive iodine (RAI) created a dynamic paradigm change integrating
14 the sciences of physics, biology, physiology, and medicine; and

16 Whereas, Treatment of disease by radioactive iodine marks the initial use radionuclide targeted
17 cancer therapies, now known as "theranostic" therapy; and

19 Whereas, In early 1941, Dr. Hertz administered the first therapeutic treatment of cyclotron-
20 produced radioactive iodine at the Massachusetts General Hospital, which led to the first series
21 of 29 patients with hyperthyroidism being treated successfully with RAI; and

23 Whereas, This work generating and utilizing radioactive material for medical therapy leaves an
24 enduring legacy, impacting countless generations of patients, numerous institutions worldwide
25 and setting the cornerstone for the field of nuclear medicine, and has for all future generations
26 augmented and forever altered the approach to medical therapies, utilizing cell receptor biology;
27 and

29 Whereas, This novel work marks the advent of what we now recognize as modern medicine,
30 utilizing molecular medicine and the ever-evolving promise of targeted molecular therapies for
31 the treatment of human disease; and

33 Whereas, This resolution was held back during the last three meetings of the American Medical
34 Association due to the special meeting designation of these meetings and could not be
35 considered as part of a commemoration of the 80th anniversary of the first radioiodine therapy;
36 and

38 Whereas, To appropriately recognize and honor and celebrate this extraordinary
39 accomplishment of groundbreaking scientific and medical breakthrough 81 years later; and

1 Whereas, Antisemitic attitudes and policies during the 1940s and beyond, at his institution and
2 throughout the United States, were largely successful in allowing others to take credit for Saul
3 Hertz's ideas and work in creating this monumental medical advancement during his lifetime
4 and for much of the time since his death; and
5
6 Whereas, According to one expert, certain individuals misappropriated Dr. Hertz's work and
7 published it as their own: "Chapman and Evans had basically stolen his (Hertz's) work... the
8 most flagrant, unethical, academically reprehensible behavior...worst yet, Saul Hertz died... in
9 1950 and these two gentlemen (Chapman and Evans) spent a great deal of time and effort
10 rewriting history" (expert from Massachusetts General Hospital Chairman Emeritus, Department
11 of Radiology address, April 2016), and;
12
13 Whereas, Relatively recent validation of all the records and data created by his novel
14 discoveries kept secure by his daughter validates Dr. Hertz as the sole initiator of the concept of
15 targeted radioiodine therapy and inventor of radiotherapy dosimetry, marking the advent of
16 conceptual and practical "theranostics;" and
17
18 Whereas, Saul Hertz's daughter, Dr. Barbara Hertz, is alive today and can enjoy this honor of
19 her father's enduring work ad his living legacy; and
20
21 Whereas, The United States and the world are currently in a period of escalating attacks on
22 science and medicine; and
23
24 Whereas, The creation of the day by the United Nations honoring a monumental advance in
25 medical science can help sway the pervasive anti-science movement to take notice and rethink;
26 and
27
28 Whereas, This effort can provide a way for our House of Medicine during its advocacy for this
29 International Day of medical scientific achievement to champion the human benefits throughout
30 the world realized by basic concepts of science; therefore be it
31
32 RESOLVED, That our American Medical Association advocate and participate with the United
33 States Mission to the United Nations to create and introduce a United Nations General
34 Assembly Resolution for the creation of a new United Nations International Day of recognition,
35 marking March 31 as: "Dr. Saul Hertz Theranostic Nuclear Medicine Day," commemorating the
36 day the first patient was treated with therapeutic radionuclide therapy on that day in 1941,
37 marking the advent of theranostic medicine. (Directive to Take Action)

Fiscal Note: Minimal - less than \$1,000

Date received: 06/10/22

RELEVANT AMA POLICY

AMA Support for the United Nations Convention on The Rights of the Child (H-60.952)

Our AMA supports the United Nations Convention on the Rights of the Child and urges the Administration and Congress to support the Convention by ratifying it after considering any appropriate Reservations, Understandings, and Declarations.

Citation: BOT Rep. 44, A-96; Reaffirmed: Res. 2, I-00; Reaffirmed: CSAPH Rep. 1, A-10;
Reaffirmed: CSAPH Rep. 01, A-20

Elimination of Anti-Personnel Landmines (H-520.989)

Our AMA: (1) urges the US government to renounce its claimed exceptions to a ban on anti-personnel landmines; (2) encourages the US government and all members of the United Nations, as well as other interested charitable and medical organizations to contribute funds for the care, treatment and rehabilitation of landmine trauma victims; and (3) endorses a domestic and international ban on the manufacture, stockpiling, sale and use of anti-personnel landmines, and urges the President and the US Congress to work toward the achievement of this goal.

Citation: Res. 424, I-96; Res. 619, A-97; Res. 628, A-97; Reaffirmed: CSAPH Rep. 3, A-07;
Modified: SCAPH Rep. 01, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 625
(A-22)

Introduced by: Medical Student Section

Subject: AMA Funding of Political Candidates who Oppose Research-Backed Firearm Regulations

Referred to: Reference Committee F

1 Whereas, Given the 100,00 reported firearm injuries reported in the United States on average
2 each year and 45,200 reported firearm deaths in the United States in 2020 and the significant
3 financial burden that the gun violence epidemic poses on society, our AMA recognizes that gun
4 violence represents a public health crisis in our country (D-145.995)¹⁻³; and

5
6 Whereas, Laws that required a heightened showing of suitability for concealed carry, such as
7 universal background checks and “may issue” laws, and laws that prohibit gun possession by
8 people convicted of violent misdemeanors, have been found to be associated with lower firearm
9 homicide rates⁴; and

10
11 Whereas, Our AMA has adopted several policies demonstrating support for increased regulation
12 of firearm sales as well as research into the efficacy of different regulations (H-145.997, H-
13 145.975, H-145.972, H-145.996, H-145.985)⁵; and

14
15 Whereas, The Dickey Amendment currently prevents the Centers for Disease Control and
16 Prevention from using funding to advocate for and promote gun control, but does not place an
17 explicit ban on gun violence research⁷; and

18
19 Whereas, Our AMA political action committee (AMPAC) continues to make donations to
20 politicians who vote in opposition to evidence-based firearm regulation policies, donating
21 \$54,889 combined to 17 candidates in 2018 who were also financed by the National Rifle
22 Association (NRA) and received A-ratings from the NRA^{6,8-9}; and

23
24 Whereas, Political ratings are used to measure a politician’s alignment with the mission of the
25 NRA and overall support for firearm regulation^{9,10}; and

26
27 Whereas, 141 Congress members received donations from both physician organization political
28 action committees and the NRA PVF in 2018, and with one exception, sitting NRA-backed
29 congress members who received funds from physician organizations voted on policies not in
30 keeping with physician recommendations, including opposing legislation to require universal
31 background checks, and to prevent individuals prohibited from owning a firearm from utilizing
32 shooting ranges^{8,10}; and

33
34 Whereas, The NRA Institute for Legislative Action denies the existence of the “gun show
35 loophole,” opposes expanding firearm background check systems, and opposes firearm
36 registration, contradicting AMA policy supporting expansion of background checks and
37 registration of firearms (H-145.996)¹¹; and

38

1 Whereas, The AMA has called upon all candidates for public office to refuse contributions from
2 tobacco companies and their subsidiaries (G-640.020); therefore be it

3
4 RESOLVED, That our AMA amend policy G-640.020 as follows:

5
6 G-640.020 – POLITICAL ACTION COMMITTEES AND
7 CONTRIBUTIONS

8 Our AMA: (1) Believes that better-informed and more active citizens
9 will result in better legislators, better government, and better health
10 care; (2) Encourages AMA members to participate personally in the
11 campaign of their choice and strongly supports physician/family
12 leadership in the campaign process; (3) Opposes legislative
13 initiatives that improperly limit individual and collective participation
14 in the democratic process; (4) Supports AMPAC's policy to adhere
15 to a no Rigid Litmus Test policy in its assessment and support of
16 political candidates; (5) Encourages AMPAC to continue to
17 consider the legislative agenda of our AMA and the
18 recommendations of state medical PACs in its decisions; (6) Urges
19 members of the House to reaffirm their commitment to the growth
20 of AMPAC and the state medical PACs; (7) Will continue to work
21 through its constituent societies to achieve a 100 percent rate of
22 contribution to AMPAC by members; and (8) Calls upon all
23 candidates for public office to refuse contributions from tobacco
24 companies and their subsidiaries; and (9) Calls upon all candidates
25 for public office to refuse contributions from any organization that
26 opposes public health measures to reduce firearm violence. (Modify
27 Current HOD Policy)

28
Fiscal Note: Minimal - less than \$1,000

Received: 06/10/2022

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RELEVANT AMA POLICY

Gun Violence as a Public Health Crisis D-145.995

Our AMA: (1) will immediately make a public statement that gun violence represents a public health crisis which requires a comprehensive public health response and solution; and (2) will actively lobby Congress to lift the gun violence research ban.

Res. 1011, A-16; Reaffirmation: A-18; Reaffirmation: I-18

Political Action Committees and Contributions G-640.020

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.

BOT Rep. II and Res. 119; I-83, Res. 175, A-88; Reaffirmed: Sunset Report, I-98; Sub. Res. 610, A-99; Res. 610, I-00; Consolidated: CLRPD Rep. 3, I-01; Modified: CCB Rep. 2, A-11; Reaffirmed: Joint CCB/CLRPD Rep. 1, A-21

Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997

1. Our AMA recognizes that uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and deaths.

Therefore, the AMA:

(A) encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms; (B) urges that government agencies, the CDC in particular, enlarge their efforts in the study of firearm-related injuries and in the development of ways and means of reducing such injuries and deaths; (C) urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns; (D) urges the Congress to support recent legislative efforts to ban the manufacture and importation of nonmetallic, not readily detectable weapons, which also resemble toy guns; (E) encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms; (F) urges that a significant portion of any funds recovered from firearms manufacturers and dealers through legal proceedings be used for gun safety education and gun-violence prevention; and

(G) strongly urges US legislators to fund further research into the epidemiology of risks related to gun violence on a national level.

2. Our AMA will advocate for firearm safety features, including but not limited to mechanical or smart technology, to reduce accidental discharge of a firearm or misappropriation of the weapon by a non-registered user; and support legislation and regulation to standardize the use of these firearm safety features on weapons sold for non-military and non-peace officer use within the U.S.; with the aim of establishing manufacturer liability for the absence of safety features on newly manufactured firearms.

CSA Rep. A, I-87; Reaffirmed: BOT Rep. 50, I-93; Appended: Res. 403, I-99; Reaffirmation: A-07; Reaffirmation: A-13; Appended: Res. 921, I-13; Reaffirmed: CSAPH Rep. 04, A-18; Reaffirmation: A-18; Reaffirmation: I-18; Appended: Res. 405, A-19

Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care H-145.975

1. Our AMA supports: a) federal and state research on firearm-related injuries and deaths; b) increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to inform state and federal health policy; c) encouraging physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety; d) the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes; e) encouraging local projects to facilitate the low-cost distribution of gun locks in homes; f) encouraging physicians to become involved in local firearm safety classes as a means of promoting injury prevention and the public health; and g) encouraging CME providers to consider, as appropriate, inclusion of presentations about the prevention of gun violence in national, state, and local continuing medical education programs.

2. Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of mental illness and concurrent substance use disorders, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior.

3. Our AMA (a) recognizes the role of firearms in suicides, (b) encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling, and (c) encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide.

Sub. Res. 221, A-13; Appended: Res. 416, A-14; Reaffirmed: Res. 426, A-16; Reaffirmed: BOT Rep. 28, A-18; Reaffirmation: A-18; Modified: CSAPH Rep. 4, A-18; Reaffirmation: I-18; Reaffirmed: CSAPH Rep. 3, A-21

Firearms and High-Risk Individuals H-145.972

Our AMA supports: (1) the establishment of laws allowing family members, intimate partners, household members, and law enforcement personnel to petition a court for the removal of a firearm when there is a high or imminent risk for violence; (2) prohibiting persons who are under domestic violence restraining orders, convicted of misdemeanor domestic violence crimes or stalking, from possessing or purchasing firearms; (3) expanding domestic violence restraining orders to include dating partners; (4) requiring states to have protocols or processes in place for requiring the removal of firearms by prohibited persons; (5) requiring domestic violence restraining orders and gun violence restraining orders to be entered into the National Instant Criminal Background Check

System; and (6) efforts to ensure the public is aware of the existence of laws that allow for the removal of firearms from high-risk individuals.

CSAPH Rep. 4, A-18; Reaffirmed: BOT Rep. 11, I-18; Reaffirmed: CSAPH Rep. 3, I-21

Firearm Availability H-145.996

1. Our AMA: (a) advocates a waiting period and background check for all firearm purchasers; (b) encourages legislation that enforces a waiting period and background check for all firearm purchasers; and (c) urges legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic, ceramics, or other non-metallic materials that cannot be detected by airport and weapon detection devices.
2. Our AMA supports requiring the licensing/permitting of firearms-owners and purchasers, including the completion of a required safety course, and registration of all firearms.
3. Our AMA supports “gun violence restraining orders” for individuals arrested or convicted of domestic violence or stalking, and supports extreme risk protection orders, commonly known as “red-flag” laws, for individuals who have demonstrated significant signs of potential violence. In supporting restraining orders and “red-flag” laws, we also support the importance of due process so that individuals can petition for their rights to be restored.

Res. 140, I-87; Reaffirmed: BOT Rep. 8, I-93; Reaffirmed: BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Modified: BOT Rep. 12, A-16; Appended: Res. 433, A-18; Reaffirmation: I-18; Modified: BOT Rep 11, I-18

Ban on Handguns and Automatic Repeating Weapons H-145.985

It is the policy of the AMA to:

- (1) Support interventions pertaining to firearm control, especially those that occur early in the life of the weapon (e.g., at the time of manufacture or importation, as opposed to those involving possession or use). Such interventions should include but not be limited to:
 - (a) mandatory inclusion of safety devices on all firearms, whether manufactured or imported into the United States, including built-in locks, loading indicators, safety locks on triggers, and increases in the minimum pressure required to pull triggers;
 - (b) bans on the possession and use of firearms and ammunition by unsupervised youths under the age of 21;
 - (c) bans of sales of firearms and ammunition from licensed and unlicensed dealers to those under the age of 21 (excluding certain categories of individuals, such as military and law enforcement personnel);
 - (d) the imposition of significant licensing fees for firearms dealers;
 - (e) the imposition of federal and state surtaxes on manufacturers, dealers and purchasers of handguns and semiautomatic repeating weapons along with the ammunition used in such firearms, with the attending revenue earmarked as additional revenue for health and law enforcement activities that are directly related to the prevention and control of violence in U.S. society; and
 - (f) mandatory destruction of any weapons obtained in local buy-back programs.
- (2) Support legislation outlawing the Black Talon and other similarly constructed bullets.
- (3) Support the right of local jurisdictions to enact firearm regulations that are stricter than those that exist in state statutes and encourage state and local medical societies to evaluate and support local efforts to enact useful controls.
- (4) Oppose “concealed carry reciprocity” federal legislation that would require all states to recognize concealed carry firearm permits granted by other states and that would allow citizens with concealed gun carry permits in one state to carry guns across state lines into states that have stricter laws.

(5) Support the concept of gun buyback programs as well as research to determine the effectiveness of the programs in reducing firearm injuries and deaths.
BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmation A-14; Appended: Res. 427, A-18, Reaffirmation: A-18, Modified: Res. 244, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 728
(A-22)

Introduced by: Organized Medical Staff Section

Subject: Maintaining an Open and Equitable Hospital Work Environment for Specialists

Referred to: Reference Committee G

1 Whereas, AMA objectives include the betterment of patient care; and
2
3 Whereas, AMA objectives include the satisfaction and sustainability of physicians in the practice
4 of medicine; and
5
6 Whereas, Maintaining access to a larger number of specialty physicians in the inpatient setting
7 maintains and expands patient access to appropriate care as well as increases care integration;
8 and
9
10 Whereas, Assuring access to inpatient hospital consultations by independent physicians
11 promotes inclusive work environments and increases physicians' financial sustainability within
12 the healthcare environment as well as advancing professional growth and satisfaction; and
13
14 Whereas, AMA advocacy of increased physician engagement and diversity and increased
15 engagement and collaboration with key stakeholder groups demonstrates AMA dedication to
16 action in matters of practical import to the physician within the healthcare system; and
17
18 Whereas, The implementation of the position of inpatient hospital physician ("hospitalist")
19 programs was intended to streamline inpatient general management and was generally
20 accepted by physicians in outpatient general practice who concentrate on outpatient care; and
21
22 Whereas, Policy on this topic focuses on definition of the role of the hospitalist. Though it
23 speaks to teamwork and communication between hospitalist and outpatient general physicians,
24 existing policy does not directly address the dislocations of the community/independent
25 specialist by virtue of an expanding specialty hospitalist system, yet access to specialists is
26 imperative; and
27
28 Whereas, Specialty physicians in community/independent practice more often incorporate
29 consultations on hospitalized patients as part of a practice than general medicine physicians,
30 with economic benefit and an opportunity for gaining new patients for outpatient follow up which
31 also contributes to continuity of care; and
32
33 Whereas, Access of hospitalized patients to a variety of specialists in a field with different skills,
34 talents, and intangibles, in the opinion of many, benefits the general hospitalists as well as the
35 hospitalized patient and contributes to continuity of care into the outpatient setting; and
36
37 Whereas, Hospitals traditionally have required physicians on the medical staff to participate in
38 coverage to consult on hospitalized patients as a condition of having hospital privileges; and

1 Whereas, Introduction of specialty hospitalists, in many instances, severely constrains access to
2 inpatient consultation by community/independent specialists and limits access of patients to the
3 variety of independent specialists available. When this change is introduced unilaterally by the
4 hospital/healthcare organization, it is accompanied by preferential publicity and promotion of the
5 specialty hospitalist at the expense of the community/independent specialist, sometimes nearly
6 excluding them from practice in the hospital; and
7
8 Whereas, For a community/independent specialist, even limited coverage of inpatient care,
9 including telephone contacts for clinical advice, carries potential liability for which professional
10 liability insurance must still be procured; and
11
12 Whereas, Lower inpatient volume for the community/independent specialist may complicate
13 future reappointment to the medical staff, not the mention the economic loss to the physicians;
14 and
15
16 Whereas, Prejudicial financial arrangements for the specialty hospitalist compared with fee-for-
17 service opportunities without retainer for the community/independent specialist as the new
18 model may create a competitive advantage for the hospital system as well as the hospitalist;
19 therefore be it
20
21 RESOLVED, That our American Medical Association take the position that there should be
22 equal visibility of and access to inpatient consults for credentialed and privileged community
23 /independent specialty physicians as well as for hospital-employed specialty physicians (New
24 HOD Policy); and be it further
25
26 RESOLVED, That our AMA advocate that hospitals engage community/independent specialty
27 physicians available on the medical staff for observation, inpatient, and emergency department
28 coverage and that the parties negotiate mutually satisfactory payment terms and service
29 agreements for such service (Directive to Take Action).

Fiscal Note: Minimal - less than \$1,000

Date received: 06/10/22

RELEVANT AMA POLICY

Billing Procedures for Emergency Care (H-130.978)

(1) Our AMA urges physicians rendering emergency care to ensure that the services they provide are accurately and completely described and coded on the appropriate claim forms. (2) In the interest of high quality care, patients who seek medical attention on an emergency basis should have the benefit of an immediate evaluation of any indicated diagnostic studies. The physician who provides such evaluation is entitled to adequate compensation for his or her services. When such evaluations are provided as an integral part of and in conjunction with other routine services rendered by the emergency physician, ideally an inclusive charge, commensurate with the services provided, should be made. Where the carrier collapses or eliminates CPT-4 coding for payment purposes, the physician may be left with no realistic alternative other than to itemize. Such an itemized bill should not be higher than the amount which would be paid if the appropriate inclusive charge were recognized. The interpretation of diagnostic procedures by a consulting specialist, as a separate and independent service provided the emergency patient, is equally important to good patient care. Physicians who provide such interpretations are also entitled to adequate compensation for their services. (3) Our AMA encourages state and local organizations representing the specialty of emergency medicine to work with both private and public payers in their area to implement payment practices and coding procedures which assure that payment to physicians rendering emergency care adequately reflects the extent of services provided.

Citation: CMS Rep. J, I-86; Reaffirmed: Res. 118, I-95; Reaffirmed: A-00; Reaffirmed: BOT Rep. 6, I-01; Reaffirmed: CMS Rep. 7, A-11; Reaffirmed in lieu of Res. 808, I-15

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 729
(A-22)

Introduced by: Organized Medical Staff Section

Subject: Protecting Physician Wellbeing on Board Certification Applications

Referred to: Reference Committee G

1 Whereas, Burnout was an issue for physicians prior to the pandemic; and

2 Whereas, The reported rates of physician burnout have increased significantly to over 60
3 percent since the start of the pandemic; and

4 Whereas, Physicians are leaving the workforce due to professional and personal stressors and
5 burnout that have exacerbated during the pandemic; and

6 Whereas, This is worsening the already significant physician shortage; and

7 Whereas, Burnout can lead to mental health conditions, such as depression and anxiety; and

8 Whereas, Board certification applications typically include questions about specific mental or
9 physician health conditions and related treatments; and

10 Whereas, Physicians are reluctant to seek mental health care due to concerns about the impact
11 of this when applying for board certification; and

12 Whereas, The American Board of Medical Specialties is inclusive of 24 certifying or Member
13 Boards; and

14 Whereas, The goal of the American Board of Medical Specialties is "to assess and certify
15 doctors who demonstrate the clinical judgment, skills, and attitudes essential for the delivery of
16 excellent patient care;" and

17 Whereas, Physician reluctance to seek care does not only impact their wellbeing but can also
18 negatively impact "the delivery of excellent patient care" and patient outcomes; therefore be it

19 RESOLVED, That our American Medical Association work with the American Board of Medical
20 Specialties (ABMS), the American Osteopathic Association (AOA), and the National Board of
21 Physicians and Surgeons (NBPS) and their constituent boards to assure that physicians
22 wellbeing is a primary concern (Directive to Take Action); and be it further

23 RESOLVED, That our AMA advocate that the ABMS, AOA, and NBPS constituent boards' focus
24 on physician wellbeing be demonstrated by the removal of intrusive questions regarding
25 physician physical or mental health (including substance misuse) or related treatments on board
26 certification applications (Directive to Take Action); and be it further

1 RESOLVED, That our AMA advocate that any questions on ABMS, AOA, and NBPS constituent
2 board certification applications related to physician health be limited to only inquiries about
3 current impairment (Directive to Take Action).

Fiscal Note: Modest - between \$1,000 - \$5,000

Date received: 06/10/22

RELEVANT AMA POLICY

Medical Specialty Board Certification Standards (H-275.926)

Our AMA:

- (1) Opposes any action, regardless of intent, that appears likely to confuse the public about the unique credentials of American Board of Medical Specialties (ABMS) or American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) board certified physicians in any medical specialty, or take advantage of the prestige of any medical specialty for purposes contrary to the public good and safety.
- (2) Opposes any action, regardless of intent, by organizations providing board certification for non-physicians that appears likely to confuse the public about the unique credentials of medical specialty board certification or take advantage of the prestige of medical specialty board certification for purposes contrary to the public good and safety.
- (3) Continues to work with other medical organizations to educate the profession and the public about the ABMS and AOA-BOS board certification process. It is AMA policy that when the equivalency of board certification must be determined, accepted standards, such as those adopted by state medical boards or the Essentials for Approval of Examining Boards in Medical Specialties, be utilized for that determination.
- (4) Opposes discrimination against physicians based solely on lack of ABMS or equivalent AOA-BOS board certification, or where board certification is one of the criteria considered for purposes of measuring quality of care, determining eligibility to contract with managed care entities, eligibility to receive hospital staff or other clinical privileges, ascertaining competence to practice medicine, or for other purposes. Our AMA also opposes discrimination that may occur against physicians involved in the board certification process, including those who are in a clinical practice period for the specified minimum period of time that must be completed prior to taking the board certifying examination.
- (5) Advocates for nomenclature to better distinguish those physicians who are in the board certification pathway from those who are not.
- (6) Encourages member boards of the ABMS to adopt measures aimed at mitigating the financial burden on residents related to specialty board fees and fee procedures, including shorter preregistration periods, lower fees and easier payment terms.

Citation: Res. 318, A-07; Reaffirmed: A-11; Modified: CME Rep. 2, I-15; Modified: Res. 215, I-19

Discrimination Against Physicians in Treatment with Medication for Opioid Use Disorders (MOUD) (H-95.913)

1. Our AMA affirms: (a) that no physician or medical student should be presumed to be impaired by substance or illness solely because they are diagnosed with a substance use disorder; and (b) that no physician or medical student should be presumed impaired because they and their treating physician have chosen medication for opioid use disorder (MOUD) to address the substance use disorder, including but not limited to methadone and buprenorphine.
2. Our AMA strongly encourages the leadership of physician health and wellness programs, state medical boards, hospital and health system credentialing bodies, and employers to help end stigma and discrimination against physicians and medical students with substance use disorders and allow and encourage the usage of medication for opioid use disorder (MOUD),

including but not limited to methadone or buprenorphine, when clinically appropriate and as determined by the physician or medical student (as patient) and their treating physician, without penalty (such as restriction of privileges, licensure, ability to prescribe medications or other treatments, or other limits on their ability to practice medicine), solely because the physician's or medical student's treatment plan includes MOUD.

3. Our AMA will survey physician health programs and state medical boards and report back about the prevalence of MOUD among physicians under monitoring for OUD, types of MAT utilized, and practice limitations or other punitive measures, if any, imposed solely on the basis of medication choice.

Citation: Res. 001, A-21

Discrimination Against Physicians by Health Care Plans (H-285.985)

Our AMA: (1) will develop draft federal and model state legislation requiring managed care plans and third party payers to disclose to physicians and the public, the selection criteria used to select, retain, or exclude a physician from a managed care or other provider plans; (2) will request an advisory opinion from the Department of Justice on the application of the Americans with Disabilities Act of 1990 to selective contracting decisions made by managed care plans or other provider plans; (3) will support passage of federal legislation to clarify the Americans With Disabilities Act to assure that coverage for interpreters for the hearing impaired be provided for by all health benefit plans. Such legislation should also clarify that physicians practicing in an office setting should not incur the costs for qualified interpreters or auxiliary aids for patients with hearing loss unless the medical judgment of the treating physician reasonably supports such a need; (4) encourages state medical associations and national medical specialty societies to provide appropriate assistance to physicians at the local level who believe they may be treated unfairly by managed care plans, particularly with respect to selective contracting and credentialing decisions that may be due, in part, to a physician's history of substance abuse; and (5) urges managed care plans and third party payers to refer questions of physician substance abuse to state medical associations and/or county medical societies for review and recommendation as appropriate.

Citation: BOT Rep. 18, I-93; Appended by BOT Rep. 29, A-98; Reaffirmed: A-99; Reaffirmed: A-00; Reaffirmed: BOT Rep. 6, A-10; Reaffirmed in lieu of Res. 110, A-13

Self-Incriminating Questions on Applications for Licensure and Specialty Boards (H-275.945)

The AMA will: (1) encourage the Federation of State Medical Boards and its constituent members to develop uniform definitions and nomenclature for use in licensing and disciplinary proceedings to better facilitate the sharing of information; (2) seek clarification of the application of the Americans with Disabilities Act to the actions of medical licensing and medical specialty boards; and (3) until the applicability and scope of the Americans with Disabilities Act are clarified, will encourage the American Board of Medical Specialties and the Federation of State Medical Boards and their constituent members to advise physicians of the rationale behind inquiries on mental illness, substance abuse or physical disabilities in materials used in the licensure, reregistration, and certification processes when such questions are asked.

Citation: BOT Rep. 1, I-93; CME Rep. 10, I-94; Reaffirmed: CME Rep. 2, A-04; Reaffirmed: CME Rep. 2, A-14

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 730
(A-22)

Introduced by: Private Practice Physicians Section

Subject: Maintaining an Open and Equitable Hospital Work Environment for Specialists

Referred to: Reference Committee G

1 Whereas, AMA objectives include the betterment of patient care; and
2
3 Whereas, AMA objectives include the satisfaction and sustainability of physicians in the practice
4 of medicine; and
5
6 Whereas, Maintaining access to a larger number of specialty physicians in the inpatient setting
7 maintains and expands patient access to appropriate care as well as increases care integration;
8 and
9
10 Whereas, Assuring access to inpatient hospital consultations by independent physicians
11 promotes inclusive work environments and increases physicians' financial sustainability within
12 the healthcare environment as well as advancing professional growth and satisfaction; and
13
14 Whereas, AMA advocacy of increased physician engagement and diversity and increased
15 engagement and collaboration with key stakeholder groups demonstrates AMA dedication to
16 action in matters of practical import to the physician within the healthcare system; and
17
18 Whereas, The implementation of the position of inpatient hospital physician ("hospitalist")
19 programs was intended to streamline inpatient general management and was generally
20 accepted by physicians in outpatient general practice who concentrate on outpatient care; and
21
22 Whereas, Policy on this topic focuses on definition of the role of the hospitalist. Though it
23 speaks to teamwork and communication between hospitalist and outpatient general physicians,
24 existing policy does not directly address the dislocations of the community/independent
25 specialist by virtue of an expanding specialty hospitalist system, yet access to specialists is
26 imperative; and
27
28 Whereas, Specialty physicians in community/independent practice more often incorporate
29 consultations on hospitalized patients as part of a practice than general medicine physicians,
30 with economic benefit and an opportunity for gaining new patients for outpatient follow up which
31 also contributes to continuity of care; and
32
33 Whereas, Access of hospitalized patients to a variety of specialists in a field with different skills,
34 talents, and intangibles, in the opinion of many, benefits the general hospitalists as well as the
35 hospitalized patient and contributes to continuity of care into the outpatient setting; and
36
37 Whereas, Hospitals traditionally have required physicians on the medical staff to participate in
38 coverage to consult on hospitalized patients as a condition of having hospital privileges; and

1 Whereas, Introduction of specialty hospitalists, in many instances, severely constrains access to
2 inpatient consultation by community/independent specialists and limits access of patients to the
3 variety of independent specialists available. When this change is introduced unilaterally by the
4 hospital/healthcare organization, it is accompanied by preferential publicity and promotion of the
5 specialty hospitalist at the expense of the community/independent specialist, sometimes nearly
6 excluding them from practice in the hospital; and
7
8 Whereas, For a community/independent specialist, even limited coverage of inpatient care,
9 including telephone contacts for clinical advice, carries potential liability for which professional
10 liability insurance must still be procured; and
11
12 Whereas, Lower inpatient volume for the community/independent specialist may complicate
13 future reappointment to the medical staff, not the mention the economic loss to the physicians;
14 and
15
16 Whereas, Prejudicial financial arrangements for the specialty hospitalist compared with fee-for-
17 service opportunities without retainer for the community/independent specialist as the new
18 model may create a competitive advantage for the hospital system as well as the hospitalist;
19 therefore be it
20
21 RESOLVED, That our American Medical Association support equal promotion of, and access to
22 inpatient consults for, credentialed and privileged community /independent specialty physicians
23 on par with hospital-employed specialty physicians (New HOD Policy); and be it further
24
25 RESOLVED, That our AMA advocate that hospitals support having community/independent and
26 employed specialty physicians if credentialled available for observation, inpatient, and
27 emergency department coverage thus ensuring that physician referrals and consults be based
28 on physician and patient choice (Directive to Take Action).

Fiscal Note: Minimal - less than \$1,000

Date received: 06/10/22

RELEVANT AMA POLICY

Billing Procedures for Emergency Care (H-130.978)

(1) Our AMA urges physicians rendering emergency care to ensure that the services they provide are accurately and completely described and coded on the appropriate claim forms. (2) In the interest of high quality care, patients who seek medical attention on an emergency basis should have the benefit of an immediate evaluation of any indicated diagnostic studies. The physician who provides such evaluation is entitled to adequate compensation for his or her services. When such evaluations are provided as an integral part of and in conjunction with other routine services rendered by the emergency physician, ideally an inclusive charge, commensurate with the services provided, should be made. Where the carrier collapses or eliminates CPT-4 coding for payment purposes, the physician may be left with no realistic alternative other than to itemize. Such an itemized bill should not be higher than the amount which would be paid if the appropriate inclusive charge were recognized. The interpretation of diagnostic procedures by a consulting specialist, as a separate and independent service provided the emergency patient, is equally important to good patient care. Physicians who provide such interpretations are also entitled to adequate compensation for their services. (3) Our AMA encourages state and local organizations representing the specialty of emergency medicine to work with both private and public payers in their area to implement payment practices and coding procedures which assure that payment to physicians rendering emergency care adequately reflects the extent of services provided.

Citation: CMS Rep. J, I-86; Reaffirmed: Res. 118, I-95; Reaffirmed: A-00; Reaffirmed: BOT Rep. 6, I-01; Reaffirmed: CMS Rep. 7, A-11; Reaffirmed in lieu of Res. 808, I-15

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 731
(A-22)

Introduced by: Private Practice Physicians Section

Subject: Prior Authorization – Patient Autonomy

Referred to: Reference Committee G

1 Whereas, The AMA has previously affirmed that patient autonomy and choice are paramount;
2 and

4 Whereas, Treatment authorization requirements including prior authorizations impede patient
5 access to care; and

7 Whereas, Studies have shown that costs involved in prior authorizations provide perverse
8 disincentives and lead to sub-optimal healthcare outcomes, especially for marginalized and
9 economically vulnerable communities; and

10 Whereas, No one has a greater stake in getting prior authorization approved than the patient;
11 and

14 Whereas, Patients have real-time access to their full medical records as required by the 21st
15 Century Cures Act and the Health Insurance Portability and Accountability Act and as such
16 should be given access to an electronic prior authorization system by their health plans with the
17 ability to initiate and monitor the electronic prior authorization process; and

19 Whereas, Patient access to prior authorization empowers patients and puts them in control of
20 their healthcare, allowing patients to keep health plans and health providers accountable; and

22 Whereas, Patients have all the requisite information to submit prior authorization forms and
23 many patients are very informed about their medical condition and treatment choices and may
24 prefer doing their own prior authorizations, thus furthering patient autonomy and engaging
25 patients in their own care; and

27 Whereas, Because the health plan coverage is “owned” by the patient, the patient should have
28 unfettered access to prior electronic authorization and should have a choice whether to submit a
29 prior authorization independently or delegate the task to their physician; and

31 Whereas, Legally, physicians can only submit prior authorization requests with the patient's
32 consent; therefore be it

34 RESOLVED, That our American Medical Association will advocate that patients should be given
35 access to an electronic prior authorization system by their health plans with the ability to monitor
36 the electronic prior authorization process in any model legislation and as a basis for all
37 advocacy for prior authorization reforms (Directive to Take Action).

Fiscal Note: Modest - between \$1,000 - \$5,000

Date received: 06/10/22

RELEVANT AMA POLICY

Remuneration for Physician Services (H-385.951)

1. Our AMA actively supports payment to physicians by contractors and third party payers for physician time and efforts in providing case management and supervisory services, including but not limited to coordination of care and office staff time spent to comply with third party payer protocols.
2. It is AMA policy that insurers pay physicians fair compensation for work associated with prior authorizations, including pre-certifications and prior notifications, that reflects the actual time expended by physicians to comply with insurer requirements and that compensates physicians fully for the legal risks inherent in such work.
3. Our AMA urges insurers to adhere to the AMA's Health Insurer Code of Conduct Principles including specifically that requirements imposed on physicians to obtain prior authorizations, including pre-certifications and prior notifications, must be minimized and streamlined and health insurers must maintain sufficient staff to respond promptly.

Citation: Sub. Res. 814, A-96; Reaffirmed: A-02; Reaffirmed: I-08; Reaffirmed: I-09; Appended: Sub. Res. 126, A-10; Reaffirmed in lieu of: Res. 719, A-11; Reaffirmed in lieu of: Res. 721, A-11; Reaffirmed: A-11; Reaffirmed in lieu of Res. 822, I-11; Reaffirmed in lieu of: Res. 711, A-14; Reaffirmed: Res. 811, I-19

Prior Authorization Reform (D-320.982)

Our AMA will explore emerging technologies to automate the prior authorization process for medical services and evaluate their efficiency and scalability, while advocating for reduction in the overall volume of prior authorization requirements to ensure timely access to medically necessary care for patients and reduce practice administrative burdens.

Citation: Res. 704, A-19

11.2.4 Transparency in Health Care

Respect for patients' autonomy is a cornerstone of medical ethics. Patients must rely on their physicians to provide information that patients would reasonably want to know to make informed, well-considered decisions about their health care. Thus, physicians have an obligation to inform patients about all appropriate treatment options, the risks and benefits of alternatives, and other information that may be pertinent, including the existence of payment models, financial incentives; and formularies, guidelines or other tools that influence treatment recommendations and care. Restrictions on disclosure can impede communication between patient and physician and undermine trust, patient choice, and quality of care.

Although health plans and other entities may have primary responsibility to inform patient-members about plan provisions that will affect the availability of care, physicians share in this responsibility.

Individually, physicians should:

- (a) Disclose any financial and other factors that could affect the patient's care.
- (b) Disclose relevant treatment alternatives, including those that may not be covered under the patient's health plan.
- (c) Encourage patients to be aware of the provisions of their health plan.

Collectively, physicians should advocate that health plans with which they contract disclose to patient-members:

- (d) Plan provisions that limit care, such as formularies or constraints on referrals.
- (e) Plan provisions for obtaining desired care that would otherwise not be provided, such as provision for off-formulary prescribing.
- (f) Plan relationships with pharmacy benefit management organizations and other commercial entities that have an interest in physicians' treatment recommendations.

AMA Principles of Medical Ethics: I,II,III,V,VI

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.

Citation: Issued: 2016

Patient Information and Choice (H-373.998)

Our AMA supports the following principles:

1. Greater reliance on market forces, with patients empowered with understandable fee/price information and incentives to make prudent choices, and with the medical profession empowered to enforce ethical and clinical standards which continue to place patients' interests first, is clearly a more effective and preferable approach to cost containment than is a government-run, budget-driven, centrally controlled health care system.
2. Individuals should have freedom of choice of physician and/or system of health care delivery. Where the system of care places restrictions on patient choice, such restrictions must be clearly identified to the individual prior to their selection of that system.
3. In order to facilitate cost-conscious, informed market-based decision-making in health care, physicians, hospitals, pharmacies, durable medical equipment suppliers, and other health care providers should be required to make information readily available to consumers on fees/prices charged for frequently provided services, procedures, and products, prior to the provision of such services, procedures, and products. There should be a similar requirement that insurers make available in a standard format to enrollees and prospective enrollees information on the amount of payment provided toward each type of service identified as a covered benefit.
4. Federal and/or state legislation should authorize medical societies to operate programs for the review of patient complaints about fees, services, etc. Such programs would be specifically authorized to arbitrate a fee or portion thereof as appropriate and to mediate voluntary agreements, and could include the input of the state medical society and the AMA Council on Ethical and Judicial Affairs.
5. Physicians are the patient advocates in the current health system reform debate. Efforts should continue to seek development of a plan that will effectively provide universal access to an affordable and adequate spectrum of health care services, maintain the quality of such services, and preserve patients' freedom to select physicians and/or health plans of their choice.
6. Efforts should continue to vigorously pursue with Congress and the Administration the strengthening of our health care system for the benefit of all patients and physicians by advocating policies that put patients, and the patient/physician relationships, at the forefront.

Citation: BOT Rep. QQ, I-91; Reaffirmed: BOT Rep. TT, I-92; Reaffirmed: Ref. Cmte. A, A-93; Reaffirmed: BOT Rep. UU, A-93; Reaffirmed: CMS Rep. E, A-93; Reaffirmed: CMS Rep. G, A-93; Reaffirmed: Sub. Res. 701, A-93; Sub. Res. 125, A-93; Reaffirmed: A-93; Reaffirmed: BOT Rep. 25, I-93; Reaffirmed: BOT Rep. 40, I-93; Reaffirmed: CMS Rep. 5, I-93; Reaffirmed: CMS Rep. 10, I-93; Reaffirmed: Sub. Res. 107, I-93; Reaffirmed: BOT Rep. 46, A-94; Reaffirmed: Sub Res. 127, A-94; Reaffirmed: Sub. Res. 132, A-94; Reaffirmed: BOT Rep. 16, I-94 BOT Rep. 36, I-94; Reaffirmed: CMS Rep. 8, A-95; Reaffirmed: Sub. Res. 109, A-95; Reaffirmed: Sub. Res. 125, A-95; Reaffirmed: Sub Res. 107, I-95; Reaffirmed: Sub. Res. 109, I-95; Reaffirmed: RCC, A-96; Reaffirmed: A-96; Reaffirmed: I-96; Reaffirmed: A-97; Reaffirmed: RCC, I-97; Reaffirmed: CMS Rep. 3, I-97; Reaffirmed: I-98; Reaffirmed: CMS Rep. 9, A-98; Reaffirmed: A-99; Reaffirmed: A-00; Reaffirmed: I-00; Reaffirmed: A-04; Consolidated and Renumbered: CMS Rep. 7, I-05; Reaffirmed: A-07; Reaffirmed: A-08; Reaffirmed: CMS Rep. 4, A-09; Reaffirmed: CMS Rep. 3, I-09; Reaffirmed: I-14; Reaffirmed: CMS Rep. 4, A-15; Reaffirmed: A-17; Reaffirmed: Res. 108, A-17; Reaffirmed: A-19; Reaffirmed in lieu of: Res 112, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 732
(A-22)

Introduced by: Private Practice Physicians Section

Subject: Advocacy of Private Practice Options for Healthcare Operations in Large Corporations

Referred to: Reference Committee G

1 Whereas, Amazon has begun to develop primary care centers as part of a major internal
2 investment called Amazon Care¹ specifically targeting the largest workforce in America via on-
3 demand virtual primary care as well as in-person primary care clinics across their fulfillment
4 centers in partnership with Crossover Health² for their employees across the country; and
5
6 Whereas, Amazon's own business model that brought them success is actually based upon
7 giving diverse small businesses access to consumer sales and services globally; and
8
9 Whereas, When it came to the healthcare of their own employees, Amazon moved to enact a
10 wholly internal employment model rather than one that incorporated local healthcare small
11 businesses; and
12
13 Whereas, Amazon could have had a much more diverse, inclusive, and broad-focused
14 approach to the healthcare evolution of the care of their own employees with focused advocacy
15 and guidance from the AMA; and
16
17 Whereas, Several other large corporations like Walmart, CVS, Walgreens, Livongo, and other
18 Fortune 500 companies are expanding their corporate reach into the healthcare delivery system
19 in a shift for the entire healthcare industry; and
20
21 Whereas, These business line shifts represent major opportunities for the "House of Medicine"
22 to educate corporate America on the value of diverse models of care on the frontline and
23 promote better access to these models for patients; therefore be it
24
25 RESOLVED, That our American Medical Association study the best method to create pilot
26 programs which advance the advocacy of private practice and small business medicine within
27 the rapidly growing area of internal healthcare within Fortune 500 corporations in America with
28 a report back at Annual 2023 (Directive to Take Action); and be it further

¹ Amazon, "Amazon Care to launch across U.S. this summer, offering millions of individuals and families immediate access to high-quality medical care and advice—24 hours a day, 365 days a year;" March 17, 2021. Accessed 10/13/2021: <https://www.aboutamazon.com/news/workplace/amazon-care-to-launch-across-u-s-this-summer-offering-millions-of-individuals-and-families-immediate-access-to-high-quality-medical-care-and-advice-24-hours-a-day-365-days-a-year>

² Bowman, J. "Amazon has a new partner in its health care assault"; The Motley Fool; July 18, 2021; Accessed 10/13/21: <https://www.fool.com/investing/2020/07/18/amazon-has-a-new-partner-in-its-health-care-assault.aspx>

1 RESOLVED, That our AMA use proposals for the advocacy of small business medicine and
2 private practice models in healthcare as a pilot project in the development of advocacy
3 programs within major leading corporations like Amazon and Walmart which are currently
4 entering the healthcare service market with internalized models of healthcare in the complete
5 absence of more diverse private practice (small business) options (Directive to Take Action);
6 and be it further

7
8 RESOLVED, That our AMA prioritize advocacy efforts that emphasize small private practice
9 utilization within the investment and business efforts of Fortune 500 corporations that are
10 currently seeking to enter into the healthcare industry. (Directive to Take Action).

Fiscal Note: Indeterminate. Depends on nature of pilot program.

Date received: 06/10/22

RELEVANT AMA POLICY

Practicing Medicine by Non-Physicians (H-160.949)

Our AMA: (1) urges all people, including physicians and patients, to consider the consequences of any health care plan that places any patient care at risk by substitution of a non-physician in the diagnosis, treatment, education, direction and medical procedures where clear-cut documentation of assured quality has not been carried out, and where such alters the traditional pattern of practice in which the physician directs and supervises the care given; (2) continues to work with constituent societies to educate the public regarding the differences in the scopes of practice and education of physicians and non-physician health care workers; (3) continues to actively oppose legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision; (4) continues to encourage state medical societies to oppose state legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision; (5) through legislative and regulatory efforts, vigorously support and advocate for the requirement of appropriate physician supervision of non-physician clinical staff in all areas of medicine; and (6) opposes special licensing pathways for "assistant physicians" (i.e., those who are not currently enrolled in an Accreditation Council for Graduate Medical Education training program, or have not completed at least one year of accredited graduate medical education in the U.S.). Citation: Res. 317, I-94; Modified: Res. 501, A-97; Appended: Res. 321, I-98; Reaffirmed: A-99; Appended: Res. 240, Reaffirmed: Res. 708 and reaffirmation, A-00; Reaffirmed: CME Rep. 1, I-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: Res. 208, I-10; Reaffirmed: Res. 334, A-11; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed: Res. 107, A-14; Appended: Res. 342, A-14; Modified: CME Rep. 2, A-21

Support for Physician Led, Team Based Care (D-35.985)

Our AMA:

1. Reaffirms, will proactively advance at the federal and state level, and will encourage state and national medical specialty societies to promote policies H-35.970, H-35.973, H-35.974, H-35.988, H-35.989, H-35.992, H-35.993, H-160.919, H-160.929, H-160.947, H-160.949, H-160.950, H-360.987, H 405.969 and D-35.988.
2. Will identify and review available data to analyze the effects on patients? access to care in the opt-out states (states whose governor has opted out of the federal Medicare physician supervision requirements for anesthesia services) to determine whether there has been any increased access to care in those states.

3. Will identify and review available data to analyze the type and complexity of care provided by all non-physician providers, including CRNAs in the opt-out states (states whose governor has opted out of the federal Medicare physician supervision requirements for anesthesia services), compared to the type and complexity of care provided by physicians and/or the anesthesia care team.
4. Will advocate to policymakers, insurers and other groups, as appropriate, that they should consider the available data to best determine how non-physicians can serve as a complement to address the nation's primary care workforce needs.
5. Will continue to recognize non-physician providers as valuable components of the physician-led health care team.
6. Will continue to advocate that physicians are best qualified by their education and training to lead the health care team.
7. Will call upon the Robert Wood Johnson Foundation to publicly announce that the report entitled, "Common Ground: An Agreement between Nurse and Physician Leaders on Interprofessional Collaboration for the Future of Patient Care" was premature; was not released officially; was not signed; and was not adopted by the participants.

Citation: BOT Rep. 9, I-11; Reaffirmed: CMS Rep. 1, A-12; Reaffirmed: CMS Rep. 07, A-17; Reaffirmed: CMS Rep. 10, A-19; Reaffirmed: CMS Rep. 6, A-21