Your Reference Committee recommends the following consent calendar for acceptance:

**RECOMMENDED FOR ADOPTION**

1. Resolution 005 - Inclusive Language for Immigrants in Relevant Past and Future AMA Policies
2. Resolution 022 - Supporting Efforts to Strengthen Competition in U.S. Healthcare Provider Markets
3. Resolution 055 - Carbon Pricing to Address Climate Change
4. MSS COLA MIC Report A - IMG Exemptions from Immigration Caps on IMG-Specific Immigration categories for Green Cards and VISAs
5. MSS CME CGPH Report A - Advocating for the Inclusion of Weight Bias Training for Medical Students
6. MSS MIC CEQM Report A - Immigration Status in Medicaid & CHIP
7. MSS WIM COLA Report A - Improving Safety of Planned Home Births through Midwifery Licensing and Regulation

**RECOMMENDED FOR ADOPTION AS AMENDED**

8. Resolution 001 - Establishment of a Standing Committee Task Force
9. Resolution 006 - Supporting Diversity, Equity, & Inclusion Offices and Initiatives at United States Medical Schools to Enhance Longitudinal Community Engagement
10. Resolution 008 - Opposing Pay-to-Stay Incarceration Fees
11. Resolution 013 - Wearable Devices to Protect High-Exposure Occupations
12. Resolution 034 - Improving Nonprofit Hospital Charity Care Policies
13. Resolution 037 - Improving Medicaid and CHIP Access and Affordability
14. Resolution 040 - Provision of Continuation of Health Insurance Benefits for Medical Students Taking a Leave of Absence
15. Resolution 041 - Opposition to Restrictions on United States Foreign Aid Allocation for Reproductive Healthcare
16. Resolution 046 - Dedicated Interfaith Prayer and Reflection Spaces in Medical Schools and Healthcare Facilities
17. Resolution 047 - Federal Medical Assistance Percentage Extension for Urban Indian Organizations
18. Resolution 048 - Expanding AMA's Position on Healthcare Reform Options
19. Resolution 052 - Increasing Access to Colorectal Cancer Screening for American Indian / Alaska Native Populations
20. Resolution 054 - Reconsideration of Medical Aid in Dying
21. Resolution 057 - Inappropriate Use of Health Records in Criminal Proceedings
22. Resolution 058 - A Public Health-Centered Criminal Justice System
23. Resolution 060 - Addressing Phone and Email Scams Related to Healthcare Insurance
24. Resolution 067 - Generative Augmented Intelligence as a Threat to Scientific Publications
25. Resolution 068 - Improving Hazardous Chemical Transport Regulations for Public Health Protections
26. Resolution 070 - Protecting the Health of Incarcerated Individuals by Opposing for-profit Prisons
27. Resolution 074 - Allowing Exemptions to Mandatory Student Health Insurance Plans
28. Resolution 075 - Support Development of Sickle Cell Disease Comprehensive Care Centers
29. Resolution 084 – Improving Pharmaceutical Access and Affordability
30. Resolution 090 - Improving Access to Forensic Medical Evaluations and Legal Representation for Asylum Seekers
31. GC Report A – Sunset Report
32. GC Report B – Resolution Task Force Report
33. MSS Delegate Report A - Status of Pending MSS-authored Resolutions to the HOD
34. Internal Operating Procedures & Election Task Force Report
35. MSS CDA WIM CBH Report A - Condemnation of Non-Therapeutic Sterilization for Contraception of Women with Disabilities without Informed Patient Consent
36. MSS CEQM COLRP Report A - Expanding and Reclassifying Emergency Medical Services

RECOMMENDED FOR ADOPTION IN LIEU OF

37. Resolution 010 - Addressing Overconsumption of Poor-Nutritional-Quality Foods
38. Resolution 011 - Protecting Access to Gender-Affirming Care
39. Resolution 017 - Strengthening the Supplemental Nutrition Assistance Program
40. Resolution 038 - High Risk HPV Subtypes in American Indian and Alaska Native Populations
41. Resolution 061 - Encouraging Wayfinding Research in Healthcare Facilities
42. Resolution 085 - Addressing the Economic Impacts of Industry Involvement in Medical Device Procurement
43. Resolution 056 - Expanding the Use of Medical Interpreters
44. Resolution 080 - Medical Second Language Training & Certification for Physicians and Trainees

RECOMMENDED FOR REFERRAL

45. Resolution 015 - Opposing Private Equity Acquisitions of Healthcare Practices
45. Resolution 024 - Supporting Academic Medical-Legal Partnerships to Address Social Determinants of Health
46. Resolution 028 - The Use of Language Interpreters in Medical and Clinical Research
47. Resolution 030 - Advocating for Methadone Maintenance Therapy Dispensation in Community Pharmacy Settings
48. Resolution 033 - Racial Misclassification
49. Resolution 035 - Indian Health Service Pharmaceutical Coverage
50. Resolution 043 - Support for Increased Diversity in Genetic Research
51. Resolution 049 - Addressing Gender-Based Disparities on Health-Related Consumer Goods (The Pink Tax)
52. Resolution 063 - Access to Health-Supporting Civil Legal Aid Services as a Social Determinant of Health
53. Resolution 065 - Addressing the Health Impacts of Discrimination and Rejection on LGBTQ Youth in Foster Care
54. Resolution 066 - Supporting Policies which Increase Biosimilar Penetration
55. Resolution 078 - Coverage for Care Provided After Sexual Assault
56. Resolution 083 - Indian Water Rights
57. Resolution 091 - Humanitarian Efforts to Resettle Refugees

RECOMMENDED FOR NOT ADOPTION

58. Resolution 002 - Free, Individualized Therapy for Medical Students
59. Resolution 003 - Addressing Self-discharge Against Medical Advice
60. Resolution 004 – Amending D-90.990 “Evaluate Barriers to Medical Education for Trainees with Disabilities” to Reflect Updated Approaches and LCME/COCA Requirements
61. Resolution 007 - The Stigma Surrounding “Noncompliant” Language in Patient Charting
62. Resolution 009 - Treating Traumatic Injury Survivorship as a Chronic Condition
63. Resolution 019 - Support for Diversity and Development of Formal Clinical Criteria for Hair Curl Pattern
64. Resolution 021 - Inclusion of Harm Reduction Curricula in Undergraduate Medical Education
65. Resolution 025 - Access to Restoration of Rights for People with Disabilities
66. Resolution 026 - Promoting the Implementation of Environmental Justice within Medical Curriculum
67. Resolution 029 - Addressing Augmented Intelligence in Medical Education
68. Resolution 031 - Encouraging the Transition from Artificial Turf to Natural Grass Surfaces for Athletic Use
69. Resolution 032 - Addressing Increasing Microplastics Pollution in Water and the Health Effects of Plastic on Human Health
70. Resolution 042 - Advocacy for Researching the Benefits and Cost-efficacy of Patient Navigation Programs Outside the Realm of Oncology

71. Resolution 044 - Improving Medigap Protections

72. Resolution 050 - Utilizing Social Workers to Address and Prevent Gun Violence

73. Resolution 051 - Support for Persons with Skin-related Disorders and Disabilities

74. Resolution 053 - Support for Efforts to Maintain Construction/Building Safety Standards

75. Resolution 059 - Addressing Misinformation with Augmented Intelligence

76. Resolution 062 - Comprehensive Reproductive Health Education in the Preclinical Undergraduate Medical Education Curriculum

77. Resolution 071 - Increasing Education About and Access to Supported Decision-Making Agreements (SDMAs)

78. Resolution 072 - Improving Usability of Electronic Health Records for Transgender and Gender Diverse Patients

79. Resolution 077 - Supplemental Breast Cancer Screening for People with Dense Breast Tissue

80. Resolution 079 - Expanding Access to Hemorrhage Control Kits

81. Resolution 081 - Patient Protections for Implantable Medical Devices and Prosthetics

82. Resolution 082 - Supporting Food is Medicine Programs

83. Resolution 086 – Improving Access to Pediatric Care to Address American Indian / Alaska Native Infant Mortality

84. Resolution 087 - Sleep Physiology and Wellness in Medical Education

85. Resolution 089 - Promoting Mobile Mammography Units in Medically Underserved Regions

86. MSS COLA LGBTQ Report A - Pharmacy Access to Human Immunodeficiency Virus (HIV) Pre-Exposure Prophylaxis (PrEP) & Post-Exposure Prophylaxis (PEP)

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

87. Resolution 012 - Access to Torture Documentation for Asylum Seekers

88. Resolution 014 - Strategies to Mitigate Child Abuse and Neglect

89. Resolution 016 - Support a Surgeon General Warning for Processed Meat

90. Resolution 018 - Advocacy for Secondary Victims of Family Violence

91. Resolution 020 - Approaches to Reduce Interventions in Childbirth


93. Resolution 027 - Mitigating Drunk Driving Injuries and Fatalities Through Alternative Transportation Programs

94. Resolution 036 - Call for Minimum Standard Subway Ventilation Standards
95. Resolution 039 - Support for Research on the Efficacy of Workplace Suicide Prevention Interventions

96. Resolution 045 - Addressing Transparency of Funds of Crisis Pregnancy Centers


99. Resolution 073 - American Indian and Alaska Native Language Revitalization and Elder Care

100. Resolution 076 - Community-Based Pregnancy Support for Refugee and Asylum-Seeking Women

101. Resolution 088 - Family and Intimate Partner Violence and Abuse

102. MSS LGBTQ WIM CME Report A - Accuracy and Awareness for Sex Representation in Medical Textbooks

103. MSS MIC CGPH Report A - Mental Health Reform in Prisons
RECOMMENDED FOR ADOPTION

1) RESOLUTION 005 - INCLUSIVE LANGUAGE FOR IMMIGRANTS IN RELEVANT PAST AND FUTURE AMA POLICIES

RECOMMENDATION:

Resolution 005 be adopted.

RESOLVED, That our AMA will utilize the terms "documented," "undocumented," "immigrant," and/or "noncitizen" in all future policies and publications when broadly addressing the United States immigrant population; and be it further

RESOLVED, That our AMA will revise all relevant and active policies to utilize the term "documented/undocumented immigrant" in place of the terms "legal/illegal immigrant" where such text appears; and be it further

RESOLVED, That our AMA will revise all relevant and active policies to utilize the term "immigrant/noncitizen" in place of the term "alien" where such text appears.

VRC testimony was very supportive. Your Reference Committee agrees with testimony that the resolution is inclusive and there is precedence to implement the asks of this resolution. We discussed the importance of having AMA Policy that is non-threatening and that uses appropriate, current terminology. Your Reference Committee recommends Resolution 005 be adopted.

2) RESOLUTION 022 - SUPPORTING EFFORTS TO STRENGTHEN COMPETITION IN U.S. HEALTHCARE PROVIDER MARKETS

RECOMMENDATION:

Resolution 022 be adopted.

RESOLVED, That our AMA oppose not-for-profit firm immunity from Federal Trade Commission competition policy enforcement in the healthcare sector, which represent the majority of U.S. hospitals; and be it further

RESOLVED, That our AMA advocate to adequately resource competition policy authorities such as the Federal Trade Commission and Department of Justice Antitrust Division to perform oversight of healthcare markets; and be it further
RESOLVED, That our AMA support lowering the transaction value threshold for merger reporting in healthcare sectors to ensure that vertical acquisitions in healthcare do not evade antitrust scrutiny; and be it further

RESOLVED, That our AMA support healthcare-specific advocacy efforts which will strengthen antitrust enforcement in the healthcare sector through multiple mechanisms, which may include but not be limited to a) Simplifying the evidentiary burden on plaintiffs and shifting the evidentiary burden to defendants and b) Encouraging the FTC to leverage its authority under Section 7 of the Clayton Act to increase the frequency of retroactive challenges to healthcare mergers.

VRC testimony was supportive. Your Reference Committee agrees with testimony that the resolution clearly proves that consolidation in healthcare markets has a negative impact on patients. The resolution’s goal to increase competition in healthcare markets will help address high costs for consumers, access to care, and choice of providers. We agree that a strong stance on this issue will help the MSS monitor upcoming the Council on Medical Service Report 8. Your Reference Committee recommends Resolution 022 be adopted.

(3) RESOLUTION 055 - CARBON PRICING TO ADDRESS CLIMATE CHANGE

RECOMMENDATION:

Resolution 055 be adopted.

RESOLVED, That our AMA amend D-135.966 by addition and deletion to read as follows:

Declaring Climate Change a Public Health Crisis D-135.966

Our AMA:
1. Our AMA declares climate change a public health crisis that threatens the health and well-being of all individuals.
2. Our AMA will protect patients by advocating for policies that: (a) limit global warming to no more than 1.5 degrees Celsius, (b) reduce US greenhouse gas emissions aimed at carbon neutrality by 2050, and (c) support rapid implementation and incentivization of clean energy solutions and significant investments in climate resilience through a climate justice lens.
3. Our AMA will advocate for federal and state carbon pricing systems and for US support of international carbon pricing.
4. Our AMA will work with the World Medical Association and interested countries’ medical associations on international carbon pricing and other ways to address climate change.
53. Our AMA will develop a strategic plan for how we will enact our climate change policies including advocacy priorities and strategies to decarbonize physician practices and the health sector with report back to the House of Delegates at the 2023 Annual Meeting.

VRC testimony was very supportive. Your Reference Committee agrees with testimony that this resolution is well-written and timely. We believe the resolution is feasible and has a strong evidentiary basis. Your Reference Committee recommends Resolution 055 be adopted.

(4) MSS COLA MIC REPORT A - IMG EXEMPTIONS FROM IMMIGRATION CAPS ON IMG-SPECIFIC IMMIGRATION CATEGORIES FOR GREEN CARDS AND VISAS

RECOMMENDATION:

The Recommendations of MSS COLA MIC Report A be adopted.

Your Committee on Legislation and Advocacy and Minority Issues Committee recommend that the following recommendation be adopted as amended by addition and deletion and the remainder of the report be filed:

RESOLVED, Our AMA-MSS support measures that ease the implementation of a healthcare worker VISA category specifically for IMGS and IMSSs, which could ease post-VISA foreign residence requirements and allow for appropriate VISA travel guidelines to continue patient care; and be it further

RESOLVED, Our AMA-MSS support the creation of broad and accessible IMG specific bridge programs between education-based and employment-based VISAs to increase the capability for retention of J-1 VISA recipients who complete medical training in the US to continue practicing in the US; and be it further

RESOLVED, Our AMA-MSS support the implementation of profession-specific or education level exemptions for residents and physicians from the annual caps for EB-1,2 green cards and H-1B temporary work VISAs in order to decrease barriers of preventing non-citizen International Medical Graduates from practicing in the U.S.
VRC testimony was limited. Your Reference Committee agrees with testimony to support the report’s internal recommendations as this will allow the MSS to support future international medical graduate initiatives. Your Reference Committee recommends MSS COLA MIC Report A be adopted and the remainder of the report be filed.

(5) MSS CME CGPH REPORT A - ADVOCATING FOR THE INCLUSION OF WEIGHT BIAS TRAINING FOR MEDICAL STUDENTS

RECOMMENDATION:

The Recommendations of MSS CME CGPH Report A be adopted.

Your Committee on Medical Education recommends that the proposed recommendations not be adopted and the remainder of the report be filed.

1. RESOLVED, Our AMA recognizes the negative effects of weight bias on patients and physicians and be committed to addressing it alongside other forms of bias; further be it

2. RESOLVED, Our AMA supports the inclusion of weight bias education for medical students as part of the anti-bias training curricula, while working with relevant stakeholders; further be it

3. RESOLVED, To support weight-inclusive health policy, our AMA amends Policy H440.821, “Person-First Language for Obesity”

Person-First Language for Obesity to Decrease Weight Bias, H-440.821
Our AMA: (1) encourages the use of person-first language (patients with obesity, patients affected by obesity) in all discussions, resolutions and reports regarding obesity; (2) encourages the use of preferred terms in discussions, resolutions and reports regarding patients affected by obesity including weight and unhealthy weight, and discourage the use of stigmatizing terms including obese, morbidly obese, and fat; (3) encourages healthcare providers to use evidence-based interventions when discussing health and disease with patients; and (4) will educate health care providers on the importance of person-first language for treating patients with obesity, including the harmful effects of weight bias and other similar assumptions; equipping their health care facilities with proper sized furniture, medical equipment and gowns for patients with obesity; and having patients weighed respectfully.

VRC testimony was limited. Your Reference Committee agrees the referred resolution should not be adopted due to lack of specific evidence for improved clinical outcomes and novelty concerns. We further find that the AMA has existing policy addressing
implicit and explicit bias and former proposed amendments to H-440.821 would not meaningfully change our advocacy. Your Reference Committee recommends the Recommendations of MSS CME CGPH Report A be adopted and the remainder of the report be filed.

(6) MSS MIC CEQM REPORT A - IMMIGRATION STATUS IN MEDICAID & CHIP

RECOMMENDATION:

The Recommendations of MSS MIC CEQM Report A be adopted.

Your Minority Issues Committee and Committee on Economics and Quality in Medicine recommends that the following Resolved clauses be adopted in lieu and the remainder of this report be filed:

RESOLVED, That our AMA advocates for the removal of eligibility criteria based on immigration status from Medicaid and CHIP.

VRC testimony was limited and in support. Your Reference Committee agrees with testimony that this report is well-written and timely. We agree that the ask of this report is significant and encompasses a critical expansion that will enable coverage of those who are undocumented. Your Reference Committee recommends the Recommendations of MSS MIC CEQM Report A be adopted and the remainder of the report be filed.

(7) MSS WIM COLA REPORT A - IMPROVING SAFETY OF PLANNED HOME BIRTHS THROUGH MIDWIFERY LICENSING AND REGULATION

RECOMMENDATION:

The Recommendations of MSS WIM COLA Report A be adopted.

Your Committee on Legislation and Advocacy and Women in Medicine Committee recommend that the proposed resolution not be adopted and the remainder of the report be filed.

VRC testimony was limited. Your Reference Committee agrees with testimony that there is not enough evidence to support the asks of Resolution 019. We agree with concerns that the resolution as written opposes the American College of Obstetrics and Gynecology’s recommendations on midwifery and does not address concerns of scope creep. Your Reference Committee recommends the Recommendations of MSS WIM COLA Report A be adopted and the remainder of the report be filed.
RECOMMENDED FOR ADOPTION AS AMENDED

(8) RESOLUTION 001 - ESTABLISHMENT OF A STANDING COMMITTEE TASK FORCE

RECOMMENDATION A:

The second Resolve of Resolution 001 be amended by addition:

RESOLVED, The Standing Committee Task Force will be chaired by the MSS Governing Council Vice Chair and Chair, who will both be non-voting members of the Task Force, and include opportunities for input from standing committees; and be it further

RECOMMENDATION B:

Resolution 001 be amended by the addition of a new Resolve:

RESOLVED, The Standing Committee Task Force will reevaluate the role of the House of Delegates Coordinating Committee (HCC) Standing Committee, in conjunction with the Section Delegates and the MSS Governing Council, in the Resolution Review process and provide recommendations on the role of HCC with a report due back at I-23, with the HCC continuing their duties until this time.

RECOMMENDATION C:

Resolution 001 be adopted as amended.

RESOLVED, Following the conclusion of the A-23 meeting, the AMA-MSS Governing Council will assemble a Standing Committee Task Force to evaluate and provide recommendations on structure and operations of our MSS Standing Committees; and be it further

RESOLVED, The Standing Committee Task Force will be chaired by the Vice Chair and include opportunities for input from standing committees; and be it further

RESOLVED, The Standing Committee Task Force will submit an update on their progress to the assembly at I-23, and a completed report with their findings at A-24.

VRC testimony was supportive. Your Reference Committee agrees with testimony supporting the need to clarify the structure, function, formation, and dissolution of MSS Standing Committees. Your Reference Committee also agrees with testimony that the MSS Chair should be added as a co-chair of The Standing Committee Task Force and...
both chairs will be nonvoting members. The amendment aligns the structure of the task force with previous task forces such as the Internal Operating Procedures & Election Task Force. We discussed the addition of a fourth resolved clause focused on the role of HCC due in part to other proposed amendments made to the role of HCC by GC Report B: Resolution Task Force. Further, we support the goals of the proposed Standing Committee Task Force. Your Reference Committee recommends Resolution 001 be adopted as amended.

(9) RESOLUTION 006 - SUPPORTING DIVERSITY, EQUITY, & INCLUSION OFFICES AND INITIATIVES AT UNITED STATES MEDICAL SCHOOLS TO ENHANCE LONGITUDINAL COMMUNITY ENGAGEMENT

RECOMMENDATION A:

The first Resolve of Resolution 006 be amended by addition:

RESOLVED, That our AMA-MSS recognize the negative consequences that Minority Tax has on medical faculty and trainees; and be it further

RECOMMENDATION B:

The second Resolve of Resolution 006 be amended by addition and deletion:

RESOLVED, That our AMA-MSS will support collaboration with the AAMC, LCME, and relevant stakeholders to encourage academic institutions to increase incentives for utilize DEI activities and community engagement by considering involvement in these activities as valuable institution-building contributions when determining as criteria for faculty and staff promotion and tenure; and be it further

RECOMMENDATION C:

The third Resolve of Resolution 006 be amended by addition and deletion:

RESOLVED Our AMA-MSS will support the AMA amending D-295.963 “Continued Support for Diversity in Medical Education” by addition and deletion as follows:

Continued Support for Diversity in Medical Education D-295.963 Our AMA will: (1) publicly state and reaffirm its stance on support for diversity in medical education and acknowledge the incorporation of Diversity, Equity, and Inclusion DEI efforts as a vital aspect of medical training; (2) request that the Liaison Committee on Medical Education regularly share statistics related to compliance with accreditation standards IS-16 and MS-8 with medical schools
and with other stakeholder groups; (3) work with appropriate stakeholders to commission and enact the recommendations of a forward-looking, cross-continuum, external study of 21st century medical education focused on reimagining the future of health equity and racial justice in medical education, improving the diversity of the health workforce, and ameliorating inequitable outcomes among minoritized and marginalized patient populations; and (4) advocate for funding to support the creation and sustainability of Historically Black College and University (HBCU), Hispanic-Serving Institution (HSI), and Tribal College and University (TCU) affiliated medical schools and residency programs, with the goal of achieving a physician workforce that is proportional to the racial, ethnic, and gender composition of the United States population; (5) directly oppose any local, state, or federal actions that aim to limit diversity, equity, and inclusion initiatives, curriculum requirements, or funding in medical education; and (6) support the provision of advocate for resources to establish and maintain DEI offices at medical schools that are staff-managed and student- and physician-guided as well as committed to longitudinal community engagement.

RECOMMENDATION D:

Resolution 006 be adopted as amended.

RESOLVED, That our AMA recognize the negative consequences that Minority Tax has on medical faculty and trainees; and be it further

RESOLVED, That our AMA will collaborate with the AAMC, LCME, and relevant stakeholders to encourage academic institutions to utilize DEI activities and community engagement as criteria for faculty and staff promotion and tenure; and be it further

RESOLVED Our AMA will amend D-295.963 Continued Support for Diversity in Medical Education by addition and deletion as follows:

Continued Support for Diversity in Medical Education D-295.963

Our AMA will: (1) publicly state and reaffirm its stance on support for diversity in medical education and acknowledge the incorporation of DEI efforts as a vital aspect of medical training; (2) request that the Liaison Committee on Medical Education regularly share statistics related to compliance with accreditation standards IS-16 and MS-8 with medical schools and with other stakeholder groups; (3) work with appropriate stakeholders to commission and enact the recommendations of a forward-looking, cross-continuum, external study of 21st century medical education focused on
reimagining the future of health equity and racial justice in medical education, improving the diversity of the health workforce, and ameliorating inequitable outcomes among minoritized and marginalized patient populations; and (4) advocate for funding to support the creation and sustainability of Historically Black College and University (HBCU), Hispanic-Serving Institution (HSI), and Tribal College and University (TCU) affiliated medical schools and residency programs, with the goal of achieving a physician workforce that is proportional to the racial, ethnic, and gender composition of the United States population; (5) directly oppose any local, state, or federal actions that aim to limit diversity, equity, and inclusion initiatives, curriculum requirements, or funding in medical education; and (6) advocate for resources to establish and maintain DEI offices at medical schools that are staff-managed and student- and physician-guided as well as committed to longitudinal community engagement.

VRC testimony was very supportive. Your Reference Committee agrees with amendments to clarify the language in the resolution, as well as amendments to make the resolution internal. Resolution 006 as amended will allow for the MSS to support and testify on a similar resolution proffered by the Minority Affairs Section (MAS) at the Annual 2023 Meeting of the AMA House of Delegates. Your Reference Committee recommends Resolution 006 be adopted as amended.

(10) RESOLUTION 008 - OPPOSING PAY-TO-STAY INCARCERATION FEES

RECOMMENDATION A:

The first Resolve of Resolution 008 be amended by addition and deletion:

RESOLVED, That our AMA, in partnership collaborate with relevant stakeholders, oppose charging fees charged to incarcerated individuals for room and board, and support advocate for federal and state efforts to repeal statutes and ordinances which permit inmates to be charged for room and board.

RECOMMENDATION B:

Resolution 008 be adopted as amended.

RESOLVED, That our AMA, in partnership with relevant stakeholders, oppose charging incarcerated individuals for room and board, and support federal and state efforts to repeal statutes and ordinances which permit inmates to be charged for room and board.
VRC testimony was supportive. Your Reference Committee agrees with testimony to strengthen the resolution with clarifying amendments to make the ask more actionable. Your Reference Committee recommends Resolution 008 be adopted as amended.

(11) RESOLUTION 013 - WEARABLE DEVICES TO PROTECT HIGH-EXPOSURE OCCUPATIONS

RECOMMENDATION A:

The first Resolve of Resolution 013 be amended by deletion:

RESOLVED, That our AMA-MSS collaborates with relevant stakeholders, such as NIOSH and NBIB, to advocate for studying the efficacy of implementing physiologic monitoring through IoTs in the form of non-obstructive wearable devices; and be it further

RECOMMENDATION B:

The second Resolve of Resolution 013 be amended by addition and deletion:

RESOLVED, That our AMA-MSS supports the development of wearable devices that utilize physiologic monitoring to promote and improve to expand capabilities for improving reliability and safety of users for individuals in high-exposure occupations.

RECOMMENDATION C:

Resolution 013 be adopted as amended.

RESOLVED, That our AMA-MSS collaborates with relevant stakeholders, such as NIOSH and NBIB, to advocate for studying the efficacy of implementing physiologic monitoring through IoTs in the form of non-obstructive wearable devices; and be it further

RESOLVED, That our AMA-MSS supports the development of wearable devices to expand capabilities for improving reliability and safety of users in high-exposure occupations.

VRC testimony was supportive with amendments. Your Reference Committee agrees with concerns that the first Resolve is not feasible as the MSS does not have the ability to work with external partners, only the AMA, and therefore recommends the first resolved clause to be struck. We further note that the AMA is not a research organization, and AMA support for a research study is minimally impactful. Additionally, we agree with testimony to amend the second Resolve to align with the intent of the resolution to support the development of
wearable devices to improve health outcomes. Adopting this resolution as internal policy will allow our MSS to meaningfully engage in discussion on this issue. Your Reference Committee recommends Resolution 013 be adopted as amended.

(12) RESOLUTION 034 - IMPROVING NONPROFIT HOSPITAL CHARITY CARE POLICIES

RECOMMENDATION A:

The first Resolve of Resolution 034 be amended by addition and deletion:

RESOLVED, That our AMA advocate for legislation and regulations support efforts that require nonprofit hospitals to notify and screen all patients, in a format reasonably appropriate to the abilities and understanding of the patient, for financial assistance according to their own eligibility criteria prior to billing; and be it further

RECOMMENDATION B:

The second Resolve of Resolution 034 be amended by addition and deletion:

RESOLVED, That our AMA support efforts to establish regulatory standards for nonprofit hospital financial assistance eligibility taking cost of living and other geographic factors into consideration; and be it further

RECOMMENDATION C:

The third Resolve of Resolution 034 be amended by deletion:

RESOLVED, That our AMA support efforts to establish a reasonable timeframe allowing patients can apply retroactively for nonprofit hospitals financial assistance; and be it further

RECOMMENDATION D:

The fourth Resolve of Resolution 034 be amended by deletion:

RESOLVED, That our AMA encourage research to identify nonprofit hospital noncompliance, defined as billing practices not in accordance with their own financial assistance policies; and be it further

RECOMMENDATION E:
Resolution 034 be adopted as amended.

RESOLVED, That our AMA support efforts that require nonprofit hospitals to notify and screen all patients, in a format reasonably appropriate to the abilities and understanding of the patient, for financial assistance according to their own eligibility criteria prior to billing; and be it further

RESOLVED, That our AMA support efforts to establish standards for nonprofit hospital financial assistance eligibility taking cost of living and other geographic factors into consideration; and be it further

RESOLVED, That our AMA support efforts to establish a reasonable timeframe allowing patients can apply retroactively for nonprofit hospitals financial assistance; and be it further

RESOLVED, That our AMA encourage research to identify nonprofit hospital noncompliance, defined as billing practices not in accordance with their own financial assistance policies; and be it further

RESOLVED, That our AMA encourages Centers for Medicare and Medicaid Services (CMS) to publish the charity-care-to-expense ratio and the charity-care-to-benefit ratio for hospitals listed in Medicare Cost Reports to improve transparency and compliance of charitable care and community benefit activities.

VRC testimony was supportive with amendments. Your Reference Committee agrees with testimony to amend the resolution and make the asks more actionable. We agree that amendments to the first and second Resolves increase the strength and feasibility of the ask. Resolve three does not have enough support from the whereas clauses and the fourth Resolve calls for research that already exists. Your Reference Committee recommends Resolution 034 be adopted as amended.

(13) RESOLUTION 037 - IMPROVING MEDICAID AND CHIP ACCESS AND AFFORDABILITY

RECOMMENDATION A:

The first Resolve of Resolution 037 be amended by deletion:

RESOLVED, That our AMA oppose premiums, copayments, and other cost sharing methods for Medicaid and Children’s Health Insurance Program (CHIP), including Section 1115 waiver applications that would allow states to charge premiums or copayments to Medicaid beneficiaries below 150% of the Federal Poverty Level; and be it further

RECOMMENDATION B:
The second Resolve of Resolution 037 be amended by addition:

RESOLVED, That our AMA amend policy H-290.982 “Transforming Medicaid and Long-Term Care and Improving Access to Care for the Uninsured” by deletion as follows:

Transforming Medicaid and Long-Term Care and Improving Access to Care for the Uninsured H-290.982
(10) supports modest co-pays or income-adjusted premium shares for non-emergent, non-preventive services as a means of expanding access to coverage for currently uninsured individuals; and be it further

RECOMMENDATION C:

The third Resolve of Resolution 037 be amended by addition and deletion:

RESOLVED, That our AMA encourage The Centers for Medicaid and Medicare Services CMS to amend existing Section 1115 waivers to disallowing states the ability to charge premiums to Medicaid beneficiaries below 150% of the Federal Poverty Level.

RECOMMENDATION D:

Resolution 037 be adopted as amended.

RESOLVED, That our AMA oppose premiums, copayments, and other cost sharing methods for Medicaid and Children’s Health Insurance Program (CHIP), including Section 1115 waiver applications that would allow states to charge premiums or copayments to Medicaid beneficiaries below 150% of the Federal Poverty Level; and be it further

RESOLVED, That our AMA amend H-290.982 by deletion as follows:

(10) supports modest co-pays or income-adjusted premium shares for non-emergent, non-preventive services as a means of expanding access to coverage for currently uninsured individuals; and be it further

RESOLVED, That our AMA encourage CMS to amend existing Section 1115 waivers disallowing states to charge premiums to Medicaid beneficiaries below 150% of the Federal Poverty Level.

VRC testimony was supportive. Your Reference Committee agrees with testimony to amend the first and third Resolves to oppose premiums for all Medicaid beneficiaries as
opposed to restricting to those below 150% of the Federal Poverty Level. We agree that
the amendments proposed clarify the intent and increase the impact of the resolution’s
asks. Your Reference Committee recommends Resolution 037 be adopted as amended.

(14) RESOLUTION 040 - PROVISION OF CONTINUATION OF HEALTH
INSURANCE BENEFITS FOR MEDICAL STUDENTS TAKING A LEAVE OF
ABSENCE

RECOMMENDATION A:

The first Resolve of Resolution 040 be amended by addition and deletion:

RESOLVED, Our AMA-MSS supports work with relevant stakeholders to
support the continuation of comprehensive medical insurance benefits for
students taking a leave of absence; and be it further

RECOMMENDATION B:

The second Resolve of Resolution 040 be amended by addition and
deletion:

RESOLVED, Our AMA-MSS advocate for support encouraging medical
schools to develop written policies regarding whether
provisions are made for the continuation of insurance benefits during
leaves of absence.

RECOMMENDATION C:

Resolution 040 be adopted as amended.

RESOLVED, That our AMA work with relevant stakeholders to support continuation of
comprehensive medical insurance benefits for students taking a leave of absence; and be it further
RESOLVED, That our AMA-MSS advocate for medical schools to develop written policies
regarding whether provisions are made for continuation of insurance benefits during leave.

VRC testimony was very supportive. Your Reference Committee supports the spirit of
Resolution 040 and agrees with testimony to amend this resolution to support an
upcoming Council on Medical Education Report to be discussed at the Interim 2023
Meeting of the AMA House of Delegates. We recommend making the first Resolve internal
and amending the second Resolve to clarify the asks and allow our MSS to engage in
productive discussion on this issue. Your Reference Committee recommends Resolution
040 be adopted as amended.
RESOLUTION 041 - OPPOSITION TO RESTRICTIONS ON UNITED STATES FOREIGN AID ALLOCATION FOR REPRODUCTIVE HEALTHCARE

RECOMMENDATION A:

The first Resolve of Resolution 041 be amended by deletion:

RESOLVED, That our AMA oppose restrictions on U.S. funding to non-governmental organizations which provide reproductive health care internationally, including but not limited to contraception and abortion care; and it be further

RECOMMENDATION B:

Resolution 041 be adopted as amended.

RESOLVED, That our AMA oppose restrictions on U.S. funding to non-governmental organizations which provide reproductive health care internationally, including but not limited to contraception and abortion care; and it be further

RESOLVED, That our AMA supports global humanitarian assistance for maternal healthcare and comprehensive reproductive health services, including but not limited to contraception and abortion care.

VRC testimony was supportive. Your Reference Committee agrees with testimony that the first Resolve is outside of the AMA’s scope. We believe that the second Resolve will provide opportunities to support humanitarian efforts for strengthening international reproductive healthcare. Your Reference Committee recommends Resolution 041 be adopted as amended.

RESOLUTION 046 - DEDICATED INTERFAITH PRAYER AND REFLECTION SPACES IN MEDICAL SCHOOLS AND HEALTHCARE FACILITIES

RECOMMENDATION A:

The first Resolve of Resolution 046 be amended by addition and deletion:

RESOLVED, That the AMA-MSS support advocate for the creation and upkeep of dedicated interfaith prayer spaces and spaces for ritual purification in medical schools and healthcare facilities.

RECOMMENDATION B:
Resolution 046 be adopted as amended.

RESOLVED, That the AMA advocate for the creation and upkeep of dedicated interfaith prayer spaces and spaces for ritual purification in medical schools and healthcare facilities.

VRC testimony was supportive of the spirit of the resolution. Your Reference Committee agrees with testimony to make the resolution internal because of existing AMA policy on spirituality. Further, we had concerns with the actionability and impact of this resolution and favored an internal MSS position. Your Reference Committee and VRC were in support of the spirit of this resolution and would favor enhanced local advocacy via hospital and school-specific changes to provide better evidence for these spaces and an understanding of the cost-to-benefit analysis of this approach. Your Reference Committee recommends Resolution 046 be adopted as amended.

(17) RESOLUTION 047 - FEDERAL MEDICAL ASSISTANCE PERCENTAGE EXTENSION FOR URBAN INDIAN ORGANIZATIONS

RECOMMENDATION A:

The first Resolve of Resolution 047 be amended by addition and deletion:

RESOLVED, Our AMA will advocate to for amendments to the Social Security Act that permanently increase the Federal Medical Assistance Percentage (FMAP) to 100% for medical services which are received at or through an Urban Indian Organization that has a grant or contract with the Indian Health Service; and be it further

RECOMMENDATION B:

The second Resolve of Resolution 047 be amended by addition and deletion:

RESOLVED, Our AMA will work with state medical societies to encourage state and federal governments to reinvest Medicaid savings from 100% Federal Medical Assistance Percentage (FMAP) into tribally-driven health improvement programs.

RECOMMENDATION C:

Resolution 047 be adopted as amended.
RESOLVED, That our AMA will advocate for amendments to the Social Security Act that permanently increase the Federal Medical Assistance Percentage (FMAP) to 100% for medical services which are received at or through an Urban Indian Organization that has a grant or contract with the Indian Health Service; and be it further

RESOLVED, That our AMA will work with state medical societies to encourage state governments to reinvest Medicaid savings from 100% FMAP into tribally-driven health improvement programs.

VRC testimony was supportive with amendments. Your Reference Committee agrees with testimony to amend the resolution to expand the permanent Federal Medical Assistance Percentage (FMAP) and strengthen the language. We agree with the amendment in the first Resolve to strike the reference to the Social Security Act to broaden the ask and increase flexibility to achieve 100% FMAP. Additionally, we agree with amendments in the second Resolve to increase feasibility and include encouragement of the federal government in this effort. Your Reference Committee recommends Resolution 047 be adopted as amended.

(18) RESOLUTION 048 - EXPANDING AMA’S POSITION ON HEALTHCARE REFORM OPTIONS

RECOMMENDATION A:

The first Resolve of Resolution 048 be amended by addition and deletion:

RESOLVED, That our AMA adopts a neutral stance regarding **single payer health insurance healthcare reform**, and instead will evaluate single payer proposals by the extent to which they align with the AMA’s policy on healthcare reform.

RECOMMENDATION B:

Resolution 048 be adopted as amended.

RESOLVED, That our AMA adopts a neutral stance regarding single-payer health insurance.

VRC testimony was very supportive. Your Reference Committee agrees with testimony that the resolution should be amended as taking a neutral stance on single-payer health insurance will limit the AMA’s ability to engage with policy related to insurance coverage. Your Reference Committee recommends amending the language to ensure the AMA will still be able to be involved in conversations related to insurance. Your Reference Committee recommends that Resolution 048 be adopted as amended.
RESOLUTION 052 - INCREASING ACCESS TO COLORECTAL CANCER SCREENING FOR AMERICAN INDIAN / ALASKA NATIVE POPULATIONS

RECOMMENDATION A:

The first Resolve of Resolution 052 be amended by addition and deletion:

RESOLVED, Our AMA will: (1) advocate provide testimony in Congress for colorectal cancer prevention and intervention resources, including tribal technical assistance, to be directed to Indian Health Service, Tribal Health Programs, and Urban Indian Health Programs until colorectal Government Performance and Results Act (GPRA) screening measures are met to improve colorectal cancer screening rates in AI/AN populations; (2) encourage funding to be allocated to research the causes, prevention, and intervention regarding American Indian and Alaska Native colorectal cancer disparities and make these findings widely available; and (3) encourage funding of establish partnerships with tribal organizations to conduct this research in a manner respecting Indigenous data sovereignty; and (4) lobby the Senate Committee on Indian Affairs and House Subcommittee for Indigenous Peoples of the United States in favor of funding the aforementioned research on the important issue of American Indian and Alaska Native colorectal cancer disparities.

RECOMMENDATION B:

Policies D-55.998, D-350.990, and H-55.981 be reaffirmed in lieu of the second and third Resolves of Resolution 052.

RECOMMENDATION C:

Resolution 052 be adopted as amended.

RESOLVED, That our AMA will: (1) provide testimony in Congress for colorectal cancer prevention and intervention resources, including tribal technical assistance, to be directed to Indian Health Service, Tribal Health Programs, and Urban Indian Health Programs until colorectal Government Performance and Results Act (GPRA) screening measures are met; (2) encourage funding to be allocated to research the causes, prevention, and intervention regarding American Indian and Alaska Native colorectal cancer disparities and make these findings widely available; (3) establish partnerships with tribal organizations to conduct this research in a manner respecting Indigenous data sovereignty; and (4) lobby the Senate Committee on Indian Affairs and House Subcommittee for Indigenous Peoples of the United States in favor of funding the
RESOLVED, That our AMA will coordinate with interested national medical specialty societies, state medical associations, area Indian health boards, and relevant tribal advisory organizations to enhance physician education and awareness of the increased risk and need of screening for colorectal cancer among AI/AN patients, especially for those younger than age 50; and be it further

RESOLVED, That our AMA will work with relevant stakeholders to encourage distribution of colorectal cancer screening materials by rural and urban Indian health clinics and the Indian Health Service in an effective manner via culturally and linguistically competent resources, patient teaching time and culturally adapted follow-up interventions.

Encourage Appropriate Colorectal Cancer Screening D-55.998
Our AMA, in conjunction with interested organizations and societies, will support educational and public awareness programs to assure that physicians actively encourage their patients to be screened for colon cancer and precursor lesions, and to improve patient awareness of appropriate guidelines, particularly within minority populations and for all high risk groups. Res. 510, A-03; Modified: CSAPH Rep. 1, A-13.

Collaboration with the National Medical Association to Address Health Disparities D-350.990
Our American Medical Association will continue to work with the National Medical Association on issues of common concern, that include opportunities to increase underrepresented minorities in the health care professional pipeline including leadership roles and will continue to support efforts to increase the cultural competence of clinicians, and reduce health disparities. BOT Action in response to referred for decision Res. 606, A-09; Modified: CSAPH Rep. 01, A-19.

Carcinoma of the Colon and Rectum H-55.981
Our AMA supports: (1) Recognizing colon cancer as a leading cause of cancer deaths in the United States and encouraging appropriate screening programs to detect colorectal cancer. (2)
Persons at increased risk for CRC (family history of CRC, previous adenomatous polyps, inflammatory bowel disease, previous resection of CRC, genetic syndromes) receiving more intensive screening efforts. (3) Physicians becoming aware of genetic alterations that influence the development of CRC, and of diagnostic and screening tests that are available in this area. (4) Physicians engaging their patients in shared decision-making, including consideration of both clinical and financial patient impacts, to determine at what age to begin screening for colorectal cancer and which screening method (or sequence of methods) is most appropriate. Sub. Res. 513, I-95; Appended: CSA Rep. 7, I-98; Reaffirmed: CSAPH Rep. 2, A-08; Modified: CMS/CSAPH Joint Rep. 01, A-18.

(20) RESOLUTION 054 - RECONSIDERATION OF MEDICAL AID IN DYING

RECOMMENDATION A:

The first Resolve of Resolution 054 be amended by addition:

RESOLVED, That our AMA-MSS support access to medical aid in dying (MAID) for adults with terminal illness and preserved decision-making capacity, including those who cannot self-administer medications; and be it further

RECOMMENDATION B:

The second Resolve of Resolution 054 be amended by deletion:

RESOLVED, That our AMA-MSS support access to euthanasia for adults with terminal illness and preserved decision-making capacity who cannot self-administer medications; and be it further

RECOMMENDATION C:

The third Resolve of Resolution 054 be amended by addition and deletion:

RESOLVED, That our AMA-MSS support health coverage that comprehensively and equitably funds all medically appropriate end-of-life care legal in a jurisdiction (including palliative and hospice care, continuation of nonfutile care until death, medical aid in dying MAID, and euthanasia) to remove financial barriers to patient autonomy; and be it further

RECOMMENDATION D:
The sixth Resolve of Resolution 054 be amended by addition and deletion:

RESOLVED, That our AMA oppose criminalization of physicians, and other health professionals who engage in medical aid in dying or euthanasia at a patient’s request and with their informed consent, and oppose civil or criminal legal action against patients who engage or attempt to engage in medical aid in dying; and be it further

RECOMMENDATION E:

The seventh Resolve of Resolution 054 be amended by deletion:

RESOLVED, That our AMA oppose civil or criminal legal action against patients who request or attempt to engage in medical aid in dying or euthanasia; and be it further

RECOMMENDATION F:

Resolution 054 be amended by addition of a new Resolve:

RESOLVED, That our AMA study changing our existing position on medical aid in dying, including reviewing government data, health services research, and clinical practices in domestic and international jurisdictions where it is legal.

RECOMMENDATION G:

The ninth Resolve of Resolution 054 be amended by addition and deletion:

RESOLVED, That our AMA rescind H-270.965, “Physician-Assisted Suicide,” and H-140.952 “Physician Assisted Suicide”, regarding advocacy opposing legalization of physician-assisted suicide and euthanasia.; and be it further

RECOMMENDATION H:

Resolution 054 be amended by addition of a new Resolve:

RESOLVED, That our AMA amend H-140.966 “Decisions Near the End of Life H-140.966” by deletion as follows:

(4) Physicians must not perform euthanasia or participate in assisted suicide. A more careful examination of the issue is
necessary. Support, comfort, respect for patient autonomy, good communication, and adequate pain control may decrease dramatically the public demand for euthanasia and assisted suicide. In certain carefully defined circumstances, it would be humane to recognize that death is certain and suffering is great. However, the societal risks of involving physicians in medical interventions to cause patients’ deaths is too great to condone euthanasia or physician-assisted suicide at this time.

RECOMMENDATION I:
Resolutions 054 be adopted as amended.

RESOLVED, That our AMA-MSS support access to medical aid in dying (MAID) for adults with terminal illness and preserved decision-making capacity; and be it further

RESOLVED, That our AMA-MSS support access to euthanasia for adults with terminal illness and preserved decision-making capacity who cannot self-administer medications; and be it further

RESOLVED, That our AMA-MSS support health coverage that comprehensively and equitably funds all medically appropriate end-of-life care legal in a jurisdiction (including palliative and hospice care, continuation of nonfutile care until death, MAID, and euthanasia) to remove financial barriers to patient autonomy; and be it further

RESOLVED, That our AMA-MSS amend 140.034MSS, “Physician Aid-in-Dying,” by addition and deletion to read as follows; and be it further

140.034MSS Physician Medical Aid-In-Dying Protections & Terminology
AMA-MSS (1) supports protections for physicians and other health professionals who participate in physician medical aid in dying and (2) encourages use of the term “physician medical aid in dying” instead of “physician-assisted suicide.”

RESOLVED, That our AMA-MSS rescind 140.026MSS, “Assisted Suicide,” as it is superseded by this resolution; and be it further

RESOLVED, That our AMA oppose criminalization of physicians or other health professionals who engage in medical aid in dying or euthanasia at a patient’s request and with their informed consent; and be it further

RESOLVED, That our AMA oppose civil or criminal legal action against patients who request or attempt to engage in medical aid in dying or euthanasia; and be it further
RESOLVED, That our AMA use the term “medical aid in dying” instead of the term “physician-assisted suicide” and accordingly amend HOD policies and directives, excluding Code of Medical Ethics opinions; and be it further


VRC testimony was very supportive with amendments. Your Reference Committee agrees that this is a well-written resolution with sound evidence, and notes that this is a timely and important topic with large support from the greater MSS Delegation. We discussed the history of consideration of Medical Aid in Dying in the AMA House of Delegates, most recently five years ago, and the potential for individuals and state and specialty delegations to have moved their position in the interim. Your Reference Committee agrees with testimony to combine some resolve clauses and rescind additional policies in order to make the resolution stronger and more comprehensive. We have identified additional policies that will need to be rescinded in light of this resolution. Additionally, we agree with testimony that “euthanasia” should be removed from all external asks because it is not the resolution’s intent to conflate euthanasia and medical aid in dying. We agree that the MSS will need to adopt sufficient internal policy, guided by sound evidence and testimony, to aid our MSS Delegation in future discussions. Your Reference Committee agrees with author testimony to add a new ninth Resolve to address the AMA’s position on medical aid in dying. Your Reference Committee recommends Resolution 054 be adopted as amended.

(21) RESOLUTION 057 - INAPPROPRIATE USE OF HEALTH RECORDS IN CRIMINAL PROCEEDINGS

RECOMMENDATION A:

The first Resolve of Resolution 057 be amended by deletion:

RESOLVED, That our AMA oppose the automatic inclusion of health records without informed consent to lengthen parole board portfolio packets and adversely influence parole decisions due to documentation volume; and be it further

RECOMMENDATION B:

The second Resolve of Resolution 057 be amended by deletion:

RESOLVED, that our AMA support the inclusion of physician oversight in decisions to include health records in parole portfolio application packets; and be it further

RECOMMENDATION C:
The third Resolve of Resolution 057 be amended by addition and deletion:

RESOLVED, That our AMA encourage collaboration with relevant stakeholders, including the American Bar Association, state and county medical societies, The American College of Correctional Physicians, and other interested stakeholders on efforts to preserve patients' rights to privacy regarding medical care while incarcerated while ensuring appropriate use of medical records in parole and other legal proceedings to protect incarcerated individuals from punitive actions related to their medical care, improve adequate review of health history to determine relevance of inclusion in parole portfolio application packets, preventing unforeseen consequences arising from unnecessary health record inclusion.

RECOMMENDATION D:

Resolution 057 be adopted as amended.

RESOLVED, That our AMA oppose the automatic inclusion of health records without informed consent to lengthen parole board portfolio packets and adversely influence parole decisions due to documentation volume; and be it further

RESOLVED, That our AMA support the inclusion of physician oversight in decisions to include health records in parole portfolio application packets; and be it further

RESOLVED, That our AMA collaborate with the American Bar Association, state and county medical societies, and other interested stakeholders on efforts to improve adequate review of health history to determine relevance of inclusion in parole portfolio application packets, preventing unforeseen consequences arising from unnecessary health record inclusion.

VRC testimony was supportive with amendments. Your Reference Committee agrees with testimony that the first and second Resolves are not sufficiently supported by the whereas clauses. We agree with amendments from the American College of Correctional Physicians to collaborate with relevant stakeholders to determine if inclusion of medical records is appropriate in parole and other legal proceedings. The House Coordination Committee slated the first and third Resolves as reaffirmation of H-315.983. The Reference Committee believes that the third Resolve as amended is novel and will promote collaborative efforts. Your Reference Committee recommends Resolution 057 be adopted as amended.

(22) RESOLUTION 058 - A PUBLIC HEALTH-CENTERED CRIMINAL JUSTICE SYSTEM

RECOMMENDATION A:
The first Resolve of Resolution 058 be amended by addition and deletion:

RESOLVED, That our AMA support efforts legislation that reduces the negative health impacts of incarceration by:

1. advocating for decreasing the magnitude of penalties, including the length of prison sentences, to create a criminal justice model focused on citizen safety and improved public health outcomes and rehabilitative practices rather than retribution,
2. advocating for legislation and regulations that reduce the number of people placed in prison conditions, such as preventing people who were formerly incarcerated from being sent back to prison for minor parole violations or technicalities without justifiable cause, and
3. supporting the continual review of sentences for people at various time points of their sentence to enable early release of people who are incarcerated but unlikely to pose a risk to society; and be it further

RECOMMENDATION B:

The second Resolve of Resolution 058 be amended by addition and deletion:

RESOLVED, That our AMA works with state medical societies to advocate for (1) recognize the inefficacy of mandatory minimums and three-strike rules and the negative consequences of resultant longer prison sentences to the health of incarcerated individuals, and (2) support legislation that reduces or eliminates mandatory minimums and three-strike rules.

RECOMMENDATION C:

Resolution 058 be adopted as amended.

RESOLVED, That our AMA support efforts that reduce the negative health impacts of incarceration by:

(1) advocating for decreasing the magnitude of penalties, including the length of prison sentences, to create a criminal justice model focused on citizen safety rather than retribution,
(2) advocating for legislation and regulations that reduce the number of people placed in prison conditions, such as preventing people who were formerly incarcerated from being sent back to prison for minor parole violations or technicalities, and
(3) supporting the continual review of sentences for people at various time points of their sentence to enable early release of people who are incarcerated but unlikely to pose a risk to society; and be it further

RESOLVED, That our AMA works with state medical societies to advocate for legislation that reduces or eliminates mandatory minimums and three-strike rules.

VRC testimony was supportive. Your Reference Committee agrees with testimony that this resolution is well-written, well-researched, and will have strong impact on a topic which is of high priority to our Medical Student Section. We agree with amendments to clarify and bolster the impact of this resolution. We appreciate the clear, evidence-based argument made between healthcare and criminal justice. We discussed use of “legislation” specifically versus “efforts” and favored “legislation” for more tangible outcomes in support of incarcerated individuals. Your Reference Committee recommends Resolution 058 be adopted as amended.

(23) RESOLUTION 060 - ADDRESSING PHONE AND EMAIL SCAMS RELATED TO HEALTHCARE INSURANCE

RECOMMENDATION A:

The first Resolve of Resolution 060 be amended by addition and deletion:

RESOLVED, That our AMA encourage relevant stakeholders to educate patients and physicians on the dangers of healthcare-related insurance scams, including and how to avoid and report them such scams.

RECOMMENDATION B:

The second Resolve of Resolution 060 be amended by deletion:

RESOLVED, That our AMA provide educational resources to physicians on the dangers of healthcare insurance scams and how to avoid them, and encourage them to distribute these resources to their patients; and be it further

RECOMMENDATION C:

The third Resolve of Resolution 060 be amended by deletion:

RESOLVED, That our AMA encourage hospitals to provide information or resources to patients about healthcare insurance scams.

RECOMMENDATION D:
Resolution 060 be adopted as amended.

RESOLVED, That our AMA encourage stakeholders to educate patients on the dangers of healthcare insurance scams and how to report such scams; and be it further

RESOLVED, That our AMA provide educational resources to physicians on the dangers of healthcare insurance scams and how to avoid them, and encourage them to distribute these resources to their patients; and be it further

RESOLVED, That our AMA encourage hospitals to provide information or resources to patients about healthcare insurance scams.

VRC testimony was supportive with amendments. Your Reference Committee agrees with testimony that the three resolves can be consolidated into a single resolve clause. We amended the first resolve clause to target patients and physicians in avoiding and reporting fraud, with “relevant stakeholders” encompassing hospital systems, and expanded the scope from health insurance scams to healthcare-related scams. The Reference Committee recommends Resolution 060 be adopted as amended.

(24) RESOLUTION 067 - GENERATIVE AUGMENTED INTELLIGENCE AS A THREAT TO SCIENTIFIC PUBLICATIONS

RECOMMENDATION A:

The first Resolve of Resolution 067 be amended by addition and deletion:

RESOLVED, That our AMA support publishing groups and scientific journals to establish guidelines to regulate the use of augmented intelligence in scientific publications that include detailing the use of augmented intelligence in the methods, exclusion of augmented intelligence systems as authors, and the responsibility of authors to validate the veracity of any text generated by augmented intelligence in their regulation of generative augmented intelligence written contributions to publications; and be it further

RECOMMENDATION B:

The second Resolve of Resolution 067 be amended by addition and deletion:

RESOLVED, That our AMA work with relevant stakeholders to raise awareness of concerns about augmented intelligence utilization in the research and publication process research institutions without adequate human supervision and diligence; and be it further.
RECOMMENDATION C:

Resolution 067 be **amended by addition of a new Resolve:**

**RESOLVED, That our AMA encourage augmented intelligence developers to prioritize facts and avoid the generation of fraudulent information in the design and implementation of generative augmented intelligence; and be it further**

RECOMMENDATION D:

Resolution 067 be **amended by addition of a new Resolve:**

**RESOLVED, That our AMA-MSS immediately forward this resolution to the American Medical Association House of Delegates for consideration at the A-23 Meeting.**

RECOMMENDATION E:

Resolution 067 be **adopted as amended.**

**RESOLVED, That our AMA support publishing groups and scientific journals in their regulation of generative augmented intelligence written contributions to publications; and be it further**

**RESOLVED, That our AMA work with relevant stakeholders to raise awareness of concerns about augmented intelligence utilization in research institutions without adequate human supervision and diligence; and be it further**

**RESOLVED, That our AMA amend by addition H-460.972, “Fraud and Misrepresentation in Science”, to read as follows:**

**Fraud and Misrepresentation in Science H-460.972**

The AMA: (1) supports the promotion of structured discussions of ethics that include research, clinical practice, and basic human values within all medical school curricula and fellowship training programs; (2) supports the promotion, through AMA publications and other vehicles, of (a) a clear understanding of the scientific process, possible sources of error, and the difference between intentional and unintentional scientific misrepresentation, and (b) multidisciplinary discussions to formulate a standardized definition of scientific fraud and misrepresentation that elaborates on
unacceptable behavior; (3) supports the promotion of discussions on the peer review process and the role of the physician investigator; (4) supports the development of specific standardized guidelines dealing with the disposition of primary research data, generative augmented intelligence in research and scientific publications, authorship responsibilities, supervision of research trainees, role of institutional standards, and potential sanctions for individuals proved guilty of scientific misconduct; (5) supports the sharing of information about scientific misconduct among institutions, funding agencies, professional societies, and biomedical research journals; and (6) will educate, at appropriate intervals, physicians and physicians-in-training about the currently defined difference between being an "author" and being a "contributor" as defined by the Uniform Requirements for Manuscripts of the International Committee of Medical Journal Editors, as well as the varied potential for industry bias between these terms.

VRC testimony was supportive with amendments. Your Reference Committee agrees with testimony that the first Resolve was too vague to be impactful as originally written and have added amendments to address what will be regulated by journals based on the whereas clauses and VRC testimony. We further agree with the amendment to not only address the impacts of augmented intelligence on research with journal guidelines but also by encouraging augmented intelligence developers to prioritize factuality in the creation of these systems. While we agree that augmented intelligence in scientific writing and publication is a relatively new field, we believe it is critical to act quickly while the field is in its nascency and policy can help direct its future direction. We therefore recommend adding an immediate forwarding clause so our AMA can act now rather than wait until the next AMA Meeting of the House of Delegates. Your Reference Committee recommends Resolution 067 be adopted as amended.

(25) RESOLUTION 068 - IMPROVING HAZARDOUS CHEMICAL TRANSPORT REGULATIONS FOR PUBLIC HEALTH PROTECTIONS

RECOMMENDATION A:

The first Resolve of Resolution 068 be amended by deletion:

RESOLVED, That our AMA supports the implementation of a registry system for hazardous chemical transportation across all modalities with this system being made accessible to emergency responders as a means to protect public health; and be it further
RECOMMENDATION B:

The second Resolve of Resolution 068 be amended by addition and deletion:

RESOLVED, Our AMA amend H-135.993 “Transportation and Storage of Hazardous Materials” by addition and deletion as follows:

H-135.993 Transportation and Storage of Regulating Hazardous Materials to Protect Public Health

Our AMA (1) requests governmental agencies to develop adequate systems, which include instruction for detoxification or neutralization in event of emergencies, for continuous monitoring of transportation and storage of hazardous materials, and (2) advocates for the re-evaluation of transport regulations of hazardous chemicals to prevent public health emergencies; (2) advocates for regulations that govern the transportation of hazardous materials to prioritize public health and safety over cost or other considerations, (3) supports efforts to hold companies that are responsible for chemical spills liable for the cost of healthcare incurred by people exposed to hazardous chemicals, and (4) supports the creation of a registry for people affected by hazardous chemical exposures in order to monitor the health effects of these exposures, with cohort reports released as appropriate; and be it further

RECOMMENDATION C:

The third Resolve of Resolution 068 be amended by deletion:

RESOLVED, That our AMA supports the creation of a registry for people affected by hazardous chemical exposures in order to monitor the health effects of these exposures, with cohort reports released as appropriate; and be it further

RECOMMENDATION D:

Resolution 068 be adopted as amended.

RESOLVED, That our AMA supports the implementation of a registry system for hazardous chemical transportation across all modalities with this system being made accessible to emergency responders as a means to protect public health; and be it further
RESOLVED, That our AMA amend H-135.993 “Transportation and Storage of Hazardous Materials” by addition to read as follows:

H-135.993 Transportation and Storage of Hazardous Materials
Our AMA (1) requests governmental agencies to develop adequate systems, which include instruction for detoxification or neutralization in event of emergencies, for continuous monitoring of transportation and storage of hazardous materials, and (2) advocates for the re-evaluation of transport regulations of hazardous chemicals to prevent public health emergencies; and be it further

RESOLVED, That our AMA supports the creation of a registry for people affected by hazardous chemical exposures in order to monitor the health effects of these exposures, with cohort reports released as appropriate; and be it further

RESOLVED, That our AMA-MSS immediately forward this resolution in its entirety to the 2023 Annual Meeting of the AMA House of Delegates.

VRC testimony was supportive with amendments. Your Reference Committee agrees with testimony that the amendments consolidate and strengthen the resolution. We agree that the first Resolve is reaffirmation and the third Resolve can be incorporated into existing policy H-135.993. We discussed the timeliness of this issue and support immediate forwarding to the 2023 AMA Meeting of the House of Delegates. Your Reference Committee recommends Resolution 068 be adopted as amended.

(26) RESOLUTION 070 - PROTECTING THE HEALTH OF INCARCERATED INDIVIDUALS BY OPPOSING FOR-PROFIT PRISONS

RECOMMENDATION A:

The second Resolve of Resolution 070 be amended by addition and deletion:

RESOLVED, That our AMA advocate for for-profit prisons, public prisons with privatized medical services, and detention centers to be held to the same standards as prisons with public medical services their public counterparts, especially with respect to their oversight and reporting of health-related outcomes, and quality of healthcare until we move away from the use of for-profit prisons.

RECOMMENDATION B:
Resolution 070 be adopted as amended.

RESOLVED, That our AMA advocate against the use of for-profit prisons; and be it further
RESOLVED, That our AMA advocate for for-profit prisons to be held to the same
standards as their public counterparts with respect to their oversight and reporting of
health-related outcomes, until we move away from the use of for-profit prisons.

VRC testimony was supportive with amendments. Your Reference Committee agrees with
testimony that amendments to the second Resolve would ensure that the quality of
healthcare provided by for-profit prisons is the same quality as the care provided by their
public counterparts. Additionally, the amendments would clarify the Resolve clause’s
intent as many public prisons engage in contracts with private, for-profit entities to provide
medical services within public prisons. Your Reference Committee recommends
Resolution 070 be adopted as amended.

(27) RESOLUTION 074 - ALLOWING EXEMPTIONS TO MANDATORY STUDENT
HEALTH INSURANCE PLANS

RECOMMENDATION A:

The first Resolve of Resolution 074 be amended by addition:

RESOLVED, That our AMA work with relevant stakeholders to urge medical
schools to allow students and their families who qualify for and enroll in
other health insurance with equal or greater coverage, including Medicaid,
Children’s Health Insurance Program (CHIP), or an Affordable Care Act
(ACA) Marketplace health insurance plans, to be exempt from otherwise
mandatory student health insurance plans.

RECOMMENDATION B:

Resolution 074 be adopted as amended.

RESOLVED, That our AMA work with relevant stakeholders to urge medical schools to
allow students and their families who qualify for other health insurance with equal or
greater coverage, including Medicaid, Children’s Health Insurance Program (CHIP), or an
Affordable Care Act (ACA) Marketplace health insurance plans, to be exempt from
otherwise mandatory student health insurance plans.

VRC testimony was mainly supportive. Your Reference Committee agrees with testimony
to clarify the policy by addition of a three-word amendment. We agree that the amendment
clarifies that students must be eligible and enroll in other insurance plans to be exempt
from mandatory student health insurance plans. Your Reference Committee recommends
Resolution 074 be adopted as amended.

(28) RESOLUTION 075 - SUPPORT DEVELOPMENT OF SICKLE CELL DISEASE
COMPREHENSIVE CARE CENTERS

RECOMMENDATION A:

The first Resolve of Resolution 075 be amended by deletion:

RESOLVED, That our AMA supports the establishment of comprehensive
sickle cell treatment care centers to address critical care gaps that patients
with sickle cell disease (SCD) face and improve both the quality of care and
life for patients affected by SCD.

RECOMMENDATION B:

Resolution 075 be amended by addition of a new Resolve:

RESOLVED, That our AMA amend H-350.973 “Sickle Cell Center” by
addition to read as follows:

Sickle Cell Center H-350.973
(9) supports expanding the health care and research
workforce taking care of patients with sickle cell disease; and
(10) collaborate with relevant stakeholders to advocate for
improving access to comprehensive, quality, and preventive
care for individuals with sickle cell disease, to address
crucial care gaps that patients with sickle cell disease face
and improve both the quality of care and life for patients
affected by sickle cell disease.

RECOMMENDATION C:

Resolution 075 be adopted as amended.

RESOLVED, That our AMA supports the establishment of comprehensive sickle cell
treatment care centers to address critical care gaps that patients with sickle cell disease
(SCD) face and improve both the quality of care and life for patients affected by SCD.

VRC testimony supports the spirit of the resolution. The Reference Committee agrees with
testimony from the American Society of Hematology (ASH) that the resolution as written
is too narrow in scope. There are multiple bills coming through Congress focused on
various aspects of sickle cell disease treatment. Amendments were proffered to broaden
the language and expand future access to the treatment of sickle cell disease. We
discussed incorporation of the ASH’s amendment into existing AMA policy H-350.973. The
proposed amendment will lead to a more comprehensive and impactful ask. Your
Reference Committee recommends Resolution 075 be adopted as amended.

(29) RESOLUTION 084 - IMPROVING PHARMACEUTICAL ACCESS AND
AFFORDABILITY

RECOMMENDATION A:

The first Resolve of Resolution 084 be amended by addition and deletion:

RESOLVED, That our AMA advocates for decreasing supports lowering
out-of-pocket maximums for prescription drugs including immunotherapy
treatments, and for medical insurance benefits in insurance plans including
but not limited to ERISA plans, other forms of employer-sponsored
insurance, plans offered on the ACA marketplace, TRICARE, and ACA and
any other public or private insurance programs to decrease the
perpetuation of racial and ethnic health disparities; and be it further

RECOMMENDATION B:

The second Resolve of Resolution 084 be amended by addition and
deletion:

RESOLVED, That our AMA advocates for implementing an initial out-of-
pocket maximum for oppose Direct Member Reimbursement plans, where
patients pay the full retail costs of a prescription drug that they may then
be reimbursed for, due to their potential to expose patients to significant
out-of-pocket costs policies under commercial insurance pharmaceutical
plans.

RECOMMENDATION C:

Resolution 084 be adopted as amended.

RESOLVED, That our AMA advocates for decreasing out-of-pocket maximums for
prescription drugs including immunotherapy treatments, and for medical insurance
benefits including but not limited to ERISA, TRICARE, and ACA to decrease the
perpetuation of racial and ethnic health disparities; and be it further
RESOLVED, That our AMA advocates for implementing an initial out-of-pocket maximum for Direct Member Reimbursement policies under commercial insurance pharmaceutical plans.

VRC testimony was supportive with amendments. Your Reference Committee agrees with testimony to amend both resolve clauses to improve the specificity and clarity. We agree with amendments to the first Resolve to eliminate the confusing distinction between prescription drug and medical benefits and expand on the list of insurance sources. We also agree with the amendment to clarify the second Resolve and directly oppose Direct Member Reimbursement. Your Reference Committee recommends Resolution 084 be adopted as amended.

(30) RESOLUTION 090 - IMPROVING ACCESS TO FORENSIC MEDICAL EVALUATIONS AND LEGAL REPRESENTATION FOR ASYLUM SEEKERS

RECOMMENDATION A:

The second Resolve of Resolution 090 be amended by addition and deletion:

RESOLVED, Our AMA supports state funding of legal representation for people seeking legal asylum encourages individual and collective physician collaboration with legal organizations to increase access to medical and psychiatric forensic evaluations and legal representation for asylum seekers; and be it further

RECOMMENDATION B:

The third Resolve of Resolution 090 be amended by deletion:

RESOLVED, Our AMA supports further study of the mental and medical health outcomes of asylees pre- and post-asylum determination with relevant stakeholders including but not limited to the American Psychiatric Association, American Academy of Child and Adolescent Psychiatry, American Academy of Pediatrics, American College of Legal Medicine, and American Academy of Psychiatry and the Law.

RECOMMENDATION C:

Resolution 090 be adopted as amended.

RESOLVED, That our AMA supports efforts to train and recruit physicians to conduct medical and psychiatric forensic evaluations for all asylum seekers through existing
training resources, including, but not limited to, the Asylum Medicine Training Initiative;
and be it further

RESOLVED, That our AMA encourages individual and collective physician collaboration
with legal organizations to increase access to medical and psychiatric forensic evaluations
and legal representation for asylum seekers; and be it further

RESOLVED, That our AMA supports further study of the mental and medical health
outcomes of asylees pre- and post-asylum determination with relevant stakeholders
including but not limited to the American Psychiatric Association, American Academy of
Child and Adolescent Psychiatry, American Academy of Pediatrics, American College of
Legal Medicine, and American Academy of Psychiatry and the Law.

VRC testimony was supportive with amendments. Your Reference Committee agrees with
testimony to amend the second Resolve by clarifying the action requested. Your
Reference Committee agrees with testimony to strike the third Resolve as there is already
evidence that being granted asylum can have a positive impact on medical and mental
health of asylees as outlined by authors in the resolution and thus further study would not
significantly change the AMA’s advocacy on this topic. Removing the ask for research
strengthens the resolution and focuses the action. Your Reference Committee
recommends Resolution 090 be adopted as amended.

(31) GC REPORT A – SUNSET REPORT

RECOMMENDATION A:

Appendix A, Item 7 be amended by addition:

95.007MSS Increased Advocacy for Needle Exchange Programs: AMA-MSS
(1) supports physicians referring their patients to needle exchange
programs; (2) supports legislation providing funding for needle exchange
programs for persons who inject drugs; and (3) supports state legislation
modifying drug paraphernalia laws so that injection drug users can
purchase and possess needles and syringes without a prescription and
needle exchange program employees are protected from prosecution for
disseminating syringes.

RECOMMENDATION B:

Appendix A, item 13 be amended by addition and deletion:
135.014MSS Updating Energy Policy and Extraction Regulations to Promote Public Health and Sustainability: AMA-MSS (1) supports the continued development, promotion, and widespread implementation of alternative renewable energy sources in lieu of carbon-based fossil fuels; (2) does not support substitution of natural gas in lieu of other carbon-based fossil fuels; and (3) supports the implementation of buffer zones between oil and gas development sites and residences, schools, hospitals, and religious institutions. AMA-MSS (1) supports federal legislation and regulations that meaningfully reduce the following four major power plant emissions: mercury, carbon dioxide, sulfur dioxide and nitrogen oxide; (2) supports efforts to limit carbon dioxide emissions through the reduction of the burning of coal in the nation’s power generating plants, efforts to improve the efficiency of power plants, and continued development, promotion, and widespread implementation of alternative renewable energy sources in lieu of carbon-based fossil fuels; and (3) support the implementation of buffer zones between oil and gas development sites and residences, schools, hospitals, and religious institutions.

RECOMMENDATION C:
Appendix A, Item 15 be amended by deletion:

150.039MSS Food Advertising Targeted to Black and Latino Minority and Low Income Youth Contributes to Health Disparities.

RECOMMENDATION D:
Appendix A, Item 28 be amended by addition and deletion:

310.054MSS Preventing Resident Physician Suicide Mental Health

RECOMMENDATION E:
Appendix A, Item 95 be amended by addition and deletion:

AMA-MSS will ask the AMA to oppose the use of legacy status in medical school admissions and to support mechanisms to eliminate its inclusion from the application process such as by encouraging the AAMC, AACOM, LCME, and the AACOM to remove any questions on secondary applications pertaining to legacy status. AMA-MSS will ask the AMA to 1.) recognize that legacy admissions are rooted in discriminatory practices; 2.) oppose the use of legacy status as a screening tool for medical school admissions;
and 3.) study the prevalence and impact of legacy status in medical school admissions.

RECOMMENDATION F:
The Recommendations of GC Report A be adopted as amended.

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

1. That the policies specified for retention in Appendix 1 of this report be retained as official, active policies of the AMA-MSS.

2. The Governing Council’s review of the Statements of Support will be addressed in the upcoming Resolution Task Force at A-23.

3. That AMA MSS policy 170.016MSS be rescinded.

4. That the AMA MSS policy 630.044MSS be amended by addition and deletion as follows:

630.044MSS Sunset Mechanism for AMA-MSS Policy
AMA-MSS will establish and use a sunset mechanism for AMA-MSS policy with a five year time horizon whereby a policy will remain viable for five years unless action is taken by the Assembly to reestablish or refer it. The implementation of a sunset mechanism for AMA-MSS policy shall follow the following procedures: (1) review of policies will be the ultimate responsibility of the Governing Council, whereby the report is authored by the Chair of the Governing Council with initial policy recommendations being solicited from relevant Standing Committees as appropriate; (2) The Governing Council will provide Standing Committees clear guidance regarding criteria for recommendations of retention, retention with amendments, or sunset; (3) policy recommendations will be reported to the AMA-MSS Assembly at each Interim Annual Meeting on the five or five and one-half year anniversary of a policy's adoption, with a brief rationale accompanying each recommendation; (4) a consent calendar format will be used by the Assembly in considering the policies encompassed within the report; and (5) a vote will not be necessary on policies recommended for rescission as they will automatically expire under the auspices of the sunset
VRC testimony was in support of changing language of Appendix A, Item 95 to reflect recent transmittal language related to the same policy. Your Reference Committee appreciates this thorough report and broadly agrees with proposals to update the language of the Sunset policy to reflect changes in timing of the report to be submitted and changes to the policy compendium put forward. We discussed revision of several policies for retention with amendment to the original language, as it was more expansive and would better support future resolutions put forward by the AMA-MSS, updating titles of policies that were changed, and incorporating suggested amendments noted in VRC testimony. We propose changing language of Appendix A, Item 95 to reflect recent transmittal language related to the same policy given that this new language encompasses the most recent goals of AMA-MSS members; amend the titles of Appendix A, Items 15 and 28 to reflect changes initially missed; and retain the original language of Appendix A, Items 7 and 13 to better reflect the tenets of the asks from the AMA-MSS of the AMA to act on as they are more expansive and better reflect the intent/tenets proposed in those policies. Your Reference Committee recommends the Recommendations of GC Report A be adopted as amended and the remainder of the report be filed.

(32) GC REPORT B – REPORT OF THE 2023 RESOLUTION TASK FORCE

RECOMMENDATION A:

Recommendation one, point two be amended by addition and deletion:

2. The draft resolution review process should include opportunities for participation by MSS Caucus members; MSS members on AMA Councils; appropriate MSS region officers; MSS standing committees; other MSS members with significant HOD experience; and MSS members who liaise with other AMA Sections and groups, specialty societies, professional interest medical associations, medical student organizations (including identity-based groups), and medical education bodies.

RECOMMENDATION B:

Recommendation one, point four be amended by addition and deletion:

4. No Resolutions submitted by the correct deadline in the correct format as determined by the MSS Section Delegates prior to start of the policy cycle may not be rejected for submission for consideration by the MSS
Assembly based on their content after organizational review for legal issues.

RECOMMENDATION C:

Recommendation one, point five be amended by addition and deletion:

5. Per the MSS Internal Operating Procedures (IOPs), submitted resolutions will be sent to the MSS Reference Committee, which will make recommendations to the Assembly for disposition of its items of business. The Reference Committee Report will use a consent calendar format. In order for an item to be heard by the MSS Assembly, it must be extracted from the Reference Committee Consent Calendar. The Order of Business for each MSS Assembly meeting will follow the order listed in the MSS Reference Committee report for that meeting. Items of business will be categorized by Reference Committee recommendations for “adoption,” “adoption as amended,” “adoption in lieu of,” “referral,” “MSS action item,” “not adoption,” “reaffirmation in lieu of,” etc. The order of items in each category will be determined by the Reference Committee randomized. The MSS Reference Committee must include a meaningful rationale for their recommendations made on each item of business. The timeline and procedure for extracting items from the Reference Committee Report will be set by the MSS Section Delegates in conjunction with the MSS Speaker, MSS Vice Speaker, and Reference Committee Chair(s).

RECOMMENDATION D:

Recommendation one, point six be amended by addition and deletion:

6. The AMA-MSS Internal Operating Procedures (IOPs) and Digest of Actions will be made available on the AMA-MSS Web site, with updates made prior to the beginning of the Policy Cycle for within two months of each Annual and Interim Meeting of the Assembly.

RECOMMENDATION E:

The seventh resolved clause be amended by addition:

RESOLVED, That our AMA-MSS will investigate strategies for (a) preserving institutional memory, which would document the results of MSS resolutions and actions taken by the AMA in response to policies passed by the AMA HOD and (b) reporting this information to the original resolution authors and MSS assembly.
RECOMMENDATION F:

MSS GC Report B be **amended by addition of a new Resolve:***

RESOLVED, That these changes, and the AMA-MSS resolutions process as a whole, be re-evaluated in an AMA-MSS Governing Council report to be presented 3 years after the adoption of these recommendations.

RECOMMENDATION G:

The Recommendations of GC Report B be **adopted as amended.***

Your AMA-MSS Governing Council and Resolution Task Force recommend that the following recommendations be adopted and the remainder of the report be filed:

RESOLVED, That our AMA-MSS adopt the following as our MSS Policy Process:

1. The MSS Section Delegates will ensure that all items of business submitted for consideration to each MSS Assembly meeting undergo a comprehensive review process evaluating their impact, feasibility, timeliness, and evidence basis.

2. The review process should include opportunities for participation by MSS Caucus members; MSS members on AMA Councils; appropriate MSS region officers; MSS committees; other MSS members with significant HOD experience; and MSS members who liaise with other AMA Sections and groups, specialty societies, professional interest medical associations, medical student organizations (including identity-based groups), and medical education bodies.

3. The MSS Section Delegates will decide the timeline for the policy cycle preceding each MSS Assembly and will design the criteria used to review items of business.

4. No resolutions submitted by the correct deadline in the correct format may be rejected for submission for consideration by the MSS Assembly based on their content.

5. Per the MSS IOPs, submitted resolutions will be sent to the MSS Reference Committee, which will make recommendations to the Assembly for disposition of its items of business. The Reference Committee Report will use a consent calendar format. In order for an item to be heard by the MSS Assembly, it must be extracted from the Reference Committee Consent Calendar. The Order of Business for each MSS Assembly meeting will follow the order listed in the MSS Reference Committee report for that meeting. Items of business will be categorized by Reference Committee recommendations for “adoption,” “adoption as amended,” “adoption in lieu of,” “referral,” “not adoption,” “reaffirmation in lieu of,” etc. The order of items in each category will be randomized. The MSS Reference Committee must include a meaningful rationale for their recommendations made on each item of business. The
timeline and procedure for extracting items from the Reference Committee Report will be set by the MSS Section Delegates.

6. The AMA-MSS Internal Operating Procedures and Digest of Actions will be made available on the AMA-MSS Web site, with updates made within two months of each Annual and Interim Meeting of the Assembly.

7. A resolution template will be made publicly available to assist resolution authors in formatting their resolutions.

; and be it further

RESOLVED, That our AMA-MSS adopt the following as Additional MSS Caucus Operations:

1. The MSS Section Delegates have the ability to nominate existing policies in the MSS Digest of Actions to the queue to be transmitted to a future HOD meeting, based on strategic considerations. These nominations must be approved by a majority vote of the MSS Caucus.

2. The MSS Caucus can co-sponsor resolutions in the name of the MSS with another HOD delegation.
    a. Co-sponsoring a resolution authored by another delegation must be approved by a ⅔ vote of the MSS Caucus.
    b. The MSS Section Delegates have the authority to add other delegations as co-sponsors of MSS-authored resolutions.

; and be it further

RESOLVED, That our AMA-MSS amend 645.031MSS, “Policy-making Procedures,” by addition and deletion as follows:

<table>
<thead>
<tr>
<th>645.031MSS</th>
<th>MSS Action Items</th>
<th>Policy-making Procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. A minimum of 90 days before the start of a national MSS meeting, the MSS Delegate and Alternate Delegate, with input from other members of the MSS caucus to the AMA House of Delegates, release a list of several suggested resolution topics based on perceived gaps in the MSS Digest of Actions.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. A list of all GCMSS Action Items received during the period between MSS national meetings will be included in the Meeting Handbook as official MSS Actions, along with their implementation status. Additionally, the MSS should create an opportunity for the Governing Council to discuss GCMSS Action Item implementation status with interested students. Additionally, the MSS should create an opportunity for the Governing Council to discuss GC Action Item implementation status with interested students.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. That Reference Committees be encouraged to recommend GC Action Items in future report reasoning.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. All authored resolutions are submitted to the region of the resolution’s primary author for rough draft scoring using the</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
MSS Scoring Rubric. Following the draft submission deadline, regional delegates and alternate delegates will be assigned specific resolutions, for which they score and subsequently contact the particular resolution’s author to offer feedback and suggestions prior to the MSS final resolution deadline.

5. All resolutions submitted for MSS consideration by the resolution deadline will be scored blindly by the MSS House Coordinating Committee and the Regional and Alternate Delegates from the 6 regions where the primary author’s school is not located, with each resolution’s average ranking subsequently being released to the author.

6. Our MSS will release detailed resolution formatting rules and an easy to use template for resolution drafting, available on the MSS Resolution Resources page. Resolutions not meeting the formatting guidelines will be returned to the submitting author and not be accepted until properly formatted within the established deadlines.

; and be it further

RESOLVED, That our AMA-MSS reaffirm 630.007MSS and 630.025MSS; and be it further

RESOLVED, That our AMA-MSS rescind 630.008MSS, 630.016MSS, 630.037MSS, 630.051MSS, 630.055MSS, 630.074MSS, 630.075MSS, 645.023MSS, 645.032MSS, and 645.034MSS; and be it further

RESOLVED, That our AMA-MSS rescind all statements of formal support for AMA policies listed in the section “AMA-MSS Statements of Support for HOD Policies” of the MSS Digest of Policy Actions; and be it further

RESOLVED, That our AMA-MSS will investigate strategies for (a) preserving institutional memory, which would document the results of MSS resolutions and actions taken by the AMA in response to policies passed by the AMA HOD and (b) reporting this information to the MSS.

VRC testimony was absent. Your Reference Committee appreciates this thorough report and broadly agrees with proposals by the Task Force which serve, in part, to reduce redundant internal operating policy and remove policy which is no longer relevant for the functioning of our section. We propose clarifying amendments, grammatical amendments, and amendments which better outline functions of certain MSS roles. We discussed resolved clause one point 2 and preferred to clarify that feedback from the aforementioned members is particularly sought during the draft review phase while general MSS members still have opportunities for participation at other times. We discussed use and highlighting of MSS Action Items as a recommendation by the Reference Committee. Location of “MSS action item” was determined by discussion aligning MSS AI with actions we can take to promote MSS member ideas, much like our “adoption,” “adoption as amended,” “adoption in lieu of,” and “referral.” We discussed several possible mechanisms for determining the order of MSS Assembly business, considering how to prioritize items
important to our section, reasonably add work to existing roles, utilize the wisdom of members with House of Delegates experience, and promote collaborative discussion in this process. We discussed the possibility of continuing MSS Caucus member review, having our seven Region Delegation Chairs determine order, having our Section Delegate and Alternate Delegate decide order, having a random order, and having your Reference Committee determine the order of items in each category. Understanding that items extracted from the Reference Committee Report but not discussed revert to a position or not adopt, we thoroughly considered each possibility. Ultimately, we determined that randomization of item order would not allow prioritization of key items for our section. Due to extensive review of each resolution and its corresponding testimony, we decided that the Reference Committee taking on the responsibility of determining order of items in each category does not overburden any MSS individual or committee while retaining multiple voices and opinions in discussion. We further note that any member still retains the ability to motion on MSS Assembly floor to extract an item to move it forward or backward in discussion, retaining broad representation of our MSS members voices and priorities each Meeting. On resolved clause one point six, we determined that two months was too prescriptive, noting the difference in policy cycle lengths between the Annual and Interim MSS Assembly meetings and preferred a broader timeline for updates, still to occur before our MSS Policy Cycles originates. We also discussed resolved clause three, amending 645.031MSS “MSS Action Items,” and look forward to the role of the proposed MSS Task Force on MSS Standing Committees may or may not seek to implement MSS Action Items in the purview of Standing Committees where it may be indicated. Your Reference Committee agrees with reaffirmation and rescission of the mentioned policies and their justifications, noting that relevant portions were added to new resolved clauses of this report where appropriate. On resolved clause seven, we discussed that AMA members may have graduated out of the MSS by the time their original resolutions are heard by the AMA House of Delegates. We hope adding “original resolution authors” may encourage closed loop communication that allows authors to know the results of their work and be proud of the results. Finally, with the magnitude of these changes, we would like the Governing Council to re-evaluate the status of these recommendations in three years, a time that standard four-year medical students will be able to see the results of. Your Reference Committee recommends the Recommendations of GC Report B: Resolution Task Force be adopted as amended and the remainder of the report be filed.

(33) MSS DELEGATE REPORT A – STATUS OF PENDING MSS-AUTHORED RESOLUTIONS TO THE HOD

RECOMMENDATION A:

The First Recommendation be amended by deletion:

Your Section Delegates recommend that the following resolutions be discharged from the transmittal queue:
1. 132 Updating AMA Bylaw 2.12.2, Special Meetings of the House of Delegates
2. 37 Amending G-630.140, Lodging, Meeting Venues, and Social Functions
3. 127 Supporting Daylight Saving Time as the New, Permanent Standard Time
4. 143 Amending Policy on a Public Option to Maximize AMA Advocacy

RECOMMENDATION B:

The Recommendations of MSS Delegate Report A be adopted as amended.

Your Section Delegates recommend that the following resolutions be discharged from the transmittal queue:

1. 132 Updating AMA Bylaw 2.12.2, Special Meetings of the House of Delegates
2. 37 Amending G-630.140, Lodging, Meeting Venues, and Social Functions
3. 127 Supporting Daylight Saving Time as the New, Permanent Standard Time
4. 143 Amending Policy on a Public Option to Maximize AMA Advocacy

Your Section Delegates recommend the transmittal of the following resolutions due to the mismatch of final resolved clauses sent at the I-22 meeting:

1. 53 Supporting the Use of Gender-Neutral Language
2. 73 Environmental Sustainability of AMA National Meetings
3. 152 Amending H-160.903, Eradicating Homelessness, to Reduce Evictions

Your Section Delegates further recommend that the following resolutions be combined:

1. 148 The Importance of Keeping Health Information Technology (HIT) Advancements Age-Friendly to 174 Accessible Electronic Charting Software and Alternative Access to Health Information for Visually Impaired Patients (New Title: Increasing Usability of Health Information Technology (HIT))
2. 160 Support of Research on Vision Screenings and Visual Aids for Adults Covered by Medicaid; 130 Establishing Comprehensive Dental Benefits Under State Medicaid Programs; 223 Medicaid Hearing Coverage (New Title: Medicaid Benefit Expansion)
3. 109 Support Harm Reduction Efforts through Decriminalization of Possessing of Non-Prescribed Buprenorphine; 245 Advocating for Access to Safer Smoking Kits as Part of Harm Reduction Services (New Title: Supporting Harm Reduction)
4. 257 Expansion of Medicaid Coverage of HPV Screening (CEQM WIM Report A); 222 Preventing Human Papillomavirus (HPV) Infection and HPV-Associated Cancers in People Who Are Incarcerated (New Title: Additional Interventions to Prevent Human Papillomavirus (HPV) infection and HPV-Associated Cancers)
5. 202 Access to Naloxone for Vulnerable and Underserved Populations; 229 Naloxone Alternatives or Adjuncts to Combat Synthetic Opioid-Induced Respiratory Depression (New Title: Improving Access to Opioid Antagonists for Vulnerable and Underserved Populations)
Your Section Delegates further recommend the following resolutions be amended as indicated:

1. Mitigating Environmental Contributors to Disease and Sustainability of AMA National Meetings
2. Hospital Bans on TOLAC
3. New Policies To Respond To The Gun Violence Public Health Crisis
4. Environmental Health Equity In Federally Subsidized Housing

Your Section Delegates further recommend that the following resolutions be held in the queue for the duration of the current meeting due to other ongoing movement on related items:

1. Support of Research on Vision Screenings and Visual Aids for Adults Covered by Medicaid; Establishing Comprehensive Dental Benefits Under State Medicaid Programs; Medicaid Hearing Coverage
2. Abolishment of the Resolution Committee

VRC testimony is absent. Your Reference Committee applauds our Section Delegates for their work condensing resolutions and discharging items based on actions taken by the MSS at the AMA House of Delegates. While we agree with discharging MSS Transmittals 132, 127, and 143 based on recent actions of the House of Delegates, we think it is prudent to maintain MSS Transmittal 37 in the queue at this time. The scope of the upcoming report on national meeting locations is much broader and not necessarily inclusive of MSS Transmittal 37. It will likely be necessary for the MSS to take specific actions on the resulting report to include MSS Transmittal 37 in the recommendations. Further, depending on the report recommendations it may be more prudent to send MSS Transmittal 37 as an independent resolution at a meeting after the recommendations of the pending report are decided. Therefore, to stay in concordance with past transmittal discharge procedures, your Reference Committee believes MSS Transmittal 37 should not be discharged until the proposal it proffers is enacted or substantially debated by the House of Delegates. Your Reference Committee recommends the Recommendations of MSS Delegate Report A: Status of Pending MSS-Aauthored Resolutions to the HOD be adopted as amended and the remainder of the report be filed.

(34) INTERNAL OPERATING PROCEDURES & ELECTION TASK FORCE REPORT

RECOMMENDATION A:

IOPETF Report A Section 6.3 be amended by addition and deletion to read as follows:

6.3. Nominations. Nominations for Governing Council (GC), Medical Student Trustee, and other elections positions shall be received in advance of their respective Annual Meeting (in advance of the Interim Meeting for the
Chair elect and Medical Student Trustee), pursuant to the rules of the MSS. Further nominations may be made from the floor of the Assembly Meeting at a time determined by the Governing Council GC.

RECOMMENDATION B:

IOPETF Report A Section 6.5.12.2 be amended by addition, deletion, and rearrangement (subpoints 6.5.12.2.1 and 6.5.12.2.2) to read as follows:

6.5.123.2 Investigation & Decision Process In the event of an alleged infraction, the Speaker and Vice Speaker shall be the lead investigators of any alleged infraction in conjunction with support from the Rules Committee as directed. The Speaker or Acting Speaker shall ultimately be responsible for a decision. No person who is a candidate for the same or paired position in the same election as the candidate being investigated for alleged infractions may participate in any part of the investigation of those alleged infractions. The candidate is required to participate in the investigation. The Speaker and the Vice Speaker shall have the discretion to delegate any portion of the investigation to the Rules Committee. The extent of delegation can vary depending on the circumstances and the Speakers' judgment. The final authority in making a decision regarding the matter shall rest in with the Speaker and Vice Speaker. For a reported infraction to be substantiated, both the Speaker and Vice Speaker must be in agreement. To arrive at a decision, the Speaker and Vice Speaker may involve the Rules Committee as they see fit. No individual who is a candidate for the same position or a related position as the candidate under investigation shall participate in any aspect of the investigation.

6.5.123.2.1. In the event where either the Speaker or Vice Speaker are a candidate for the election being investigated, the MSS Chair will designate one member of the Rules Committee as an investigator to examine the alleged infraction in tandem with the remaining Speaker or Vice Speaker. Both investigators must agree for a reported infraction to be substantiated.

6.5.123.2.2. In the event where both the Speakers and Vice Speaker are candidates for the election being investigated, the MSS Chair will designate two members of the Rules Committee as the investigators to examine the alleged infraction. Both investigators must agree for a reported infraction to be substantiated.
6.5.12.2.3. The investigators are required to include the candidate in the investigation.

RECOMMENDATION C:

IOPETF Report A Section 6.5.12.3.4 be amended by addition, deletion, and rearrangement to read as follows:

6.5.12.3.4. Upon each substantiated infraction of the Campaign Rules, the candidate shall be given an official warning letter written notice from the Speakers investigators with the final decision authority.

Following this, the lead investigator(s) shall report substantiated infractions to the Assembly but shall not make any recommendation to the Assembly.

RECOMMENDATION D:

IOPETF Report A Section 6.5.12.5 be amended by addition and deletion to read as follows:

6.5.12.5. Appeals Process. Appeals occur after a determination of whether an infraction is substantiated or after a determination of whether a candidate should be disqualified. Appeals focus on the process of the investigation or determination. Should a candidate feel that due process was not followed in either of these cases and that an appeal is warranted, they must submit this in writing to the Chair of the MSSGC within twenty-four (24) hours of being notified of the result and before the start of balloting. The GC, excluding investigators members (Section 6.5.12.2) and candidates for the election being investigated, shall promptly convene to review the appeal and determine whether the previous decision should be reversed prior to the start of balloting to the close of the House of Delegates. Region Chairs and Acting Chairs shall be offered the opportunity to provide comments on whether the appeal is justified. Whenever possible, an appeal should be completed reviewed prior to the results of the investigation being released to the Assembly.

RECOMMENDATION E:

IOPETF Report be adopted as amended.

Your Internal Operating Procedures and Election Task Force recommend adoption of the report recommendations.
VRC testimony was limited. Your Reference Committee agreed with testimony offering amendments to the appeals process to create an environment which is fair to all candidates, for clarification of timing of appeals before balloting is to occur and allowing Regional Chairs to be included in the appeals process. Your Reference Committee was concerned about concentration of infraction decision making authority in a single individual and therefore recommends amendments making it necessary for both the Speaker and Vice Speaker to decide an infraction has occurred in order for it to be substantiated. We believe this diffusion of power adds a critical check on the infraction determination process, will improve fair consideration, and is in line with the spirit of the VRC amendments that were reviewed by AMA Council members. Your Reference Committee acknowledges the significant time and months spent by the Task Force, MSS Speakers, and members of the AMA Council on Constitution and Bylaws in order to refine these changes and improve our Section’s elections. Your Reference Committee recommends the Internal Operating Procedures & Election Task Force Report to be adopted as amended, and for the remainder of the report to be filed.

(35) MSS CDA WIM CBH REPORT A - CONDEMNATION OF NON-THERAPEUTIC STERILIZATION FOR CONTRACEPTION OF WOMEN WITH DISABILITIES WITHOUT INFORMED PATIENT CONSENT

RECOMMENDATION A:

The Recommendations of MSS CDA WIM CBH Report A be amended by addition and deletion:

RESOLVED, That our AMA-MSS advocate for and actively support national legislation that bans guardians or petitioners from attaining a sterilization deemed non-therapeutic (i.e. for menstrual control or pregnancy prevention) for their disabled patients with disabilities or vulnerable circumstances in their care.

RECOMMENDATION B:

The Recommendations of MSS CDA WIM CBH Report A be adopted as amended.

Your CDA, WIM, and CBH recommend that the following be amended by addition and deletion and the remainder of this report be filed:

RESOLVED, That our AMA advocate for and actively support national legislation that bans guardians or petitioners from attaining a sterilization deemed non-therapeutic (i.e. for menstrual control or pregnancy prevention) for their disabled patients with disabilities or vulnerable circumstances in their care.
pregnancy prevention) for their disabled patients with disabilities or vulnerable circumstances in their care.

VRC testimony was limited. Your Reference Committee recommends amending the recommendation to internal policy. The internal amendment will allow the MSS to support broadening of language to oppose any forced sterilization and recognize the unique need of people with disabilities concerning sterilization. Your Reference Committee recommends the Recommendations of MSS CDA WIM CBH be adopted as amended and the remainder of the report filed.

(36) MSS CEQM COLRP REPORT A - EXPANDING AND RECLASSIFYING EMERGENCY MEDICAL SERVICES

RECOMMENDATION A:

The first Recommendation of MSS CEQM COLRP Report A be amended by deletion:

RESOLVED, Our AMA recognizes the impact of health care services provisioned by emergency medical service (EMS) providers on patient health outcomes; and be it further

RECOMMENDATION B:

The second Recommendation of MSS CEQM COLRP Report A be amended by addition and deletion:

RESOLVED, Our AMA-MSS supports state and federal classification and establishment of EMS as an essential service.; and be it further

RECOMMENDATION C:

The third Recommendation of MSS CEQM COLRP Report A be amended by deletion:

RESOLVED, That our AMA amend H-130.971 by addition:

The Future of Emergency and Trauma Care D-130.971
Our AMA will: (1) expand the dialogue among relevant specialty societies to gather data and identify best practices for the staffing, delivery, and financing of emergency/trauma services and Emergency Medical Services (EMS) systems, including mechanisms for the effective regionalization of care and use of information technology, teleradiology and other
advanced technologies to improve the efficiency of care;
(2) with the advice of specific specialty societies,
advocate for the creation and funding of additional residency training positions in specialties that provide emergency and trauma care and for financial incentive programs, such as loan repayment programs, to attract physicians to these specialties;
(3) continue to advocate for the following: a. Insurer payment to physicians who have delivered EMTALA-mandated, emergency care, regardless of in-network or out-of-network patient status, b. Financial support for providing EMTALA-mandated care to uninsured patients, c. Bonus payments to physicians who provide emergency/trauma services to patients from physician shortage areas, regardless of the site of service, d. Federal and state liability protections for physicians providing EMTALA-mandated care;
(4) disseminate these recommendations immediately to all stakeholders including but not limited to Graduate Medical Education Program Directors for appropriate action/implementation;
(5) support demonstration programs to evaluate the expansion of liability protections under the Federal Tort Claims Act for EMTALA-related care;
(6) support the extension of the Federal Tort Claims Act (FTCA) to all Emergency Medical Treatment and Labor Act (EMTALA) mandated care if an evaluation of a demonstration program, as called for in AMA Policy D-130.971(5), shows evidence that physicians would benefit by such extension; and
(7) if an evaluation of a demonstration program, as called for in AMA Policy D-130.971(5), shows evidence that physicians would benefit by extension of the FTCA, our AMA will conduct a legislative campaign, coordinated with national specialty societies, targeted toward extending FTCA protections to all EMTALA-mandated care, and the AMA will assign high priority to this effort.

RECOMMENDATION D:

The Recommendations of MSS CEQM COLRP Report A be adopted as amended.

Your Committee on Economics and Quality of Medicine and Committee on Long Range Planning recommends that the following recommendations are adopted and the remainder of this report is filed:
1) Your committees recommend that “The Growing Nursing Shortage in the United States D-360.998” be reaffirmed in lieu of the following:

RESOLVED, Our AMA recognizes the impact of health care services provisioned by emergency medical service (EMS) providers on patient health outcomes; and be it further

2) Your committees recommend that the following be adopted:

RESOLVED, Our AMA supports state and federal classification and establishment of EMS as an essential service; and be it further

3) Your committees recommend amendment to existing policy “The Future of Emergency and Trauma Care D-130.971” in lieu of the proposed third resolved clause:

The Future of Emergency and Trauma Care D-130.971
Our AMA will: (1) expand the dialogue among relevant specialty societies to gather data and identify best practices for the staffing, delivery, and financing of emergency/trauma services and Emergency Medical Services (EMS) systems, including mechanisms for the effective regionalization of care and use of information technology, teleradiology and other advanced technologies to improve the efficiency of care; (2) with the advice of specific specialty societies, advocate for the creation and funding of additional residency training positions in specialties that provide emergency and trauma care and for financial incentive programs, such as loan repayment programs, to attract physicians to these specialties; (3) continue to advocate for the following: a. Insurer payment to physicians who have delivered EMTALA-mandated, emergency care, regardless of in-network or out-of-network patient status, b. Financial support for providing EMTALA-mandated care to uninsured patients, c. Bonus payments to physicians who provide emergency/trauma services to patients from physician shortage areas, regardless of the site of service, d. Federal and state liability protections for physicians providing EMTALA-mandated care; (4) disseminate these recommendations immediately to all stakeholders including but not limited to Graduate Medical
Education Program Directors for appropriate action/implementation;
(5) support demonstration programs to evaluate the expansion of liability protections under the Federal Tort Claims Act for EMTALA-related care;
(6) support the extension of the Federal Tort Claims Act (FTCA) to all Emergency Medical Treatment and Labor Act (EMTALA) mandated care if an evaluation of a demonstration program, as called for in AMA Policy D-130.971(5), shows evidence that physicians would benefit by such extension; and
(7) if an evaluation of a demonstration program, as called for in AMA Policy D-130.971(5), shows evidence that physicians would benefit by extension of the FTCA, our AMA will conduct a legislative campaign, coordinated with national specialty societies, targeted toward extending FTCA protections to all EMTALA-mandated care, and the AMA will assign high priority to this effort.

VRC testimony was limited. Your Reference Committee agrees with amendments to make the recommendations internal due to an upcoming resolution to be considered at Annual 2023 Meeting of the House of Delegates from the American College of Emergency Physicians with the same spirit as these recommendations. We agree that amending to an internal stance will allow the MSS to support the upcoming resolution. Your Reference Committee recommends the Recommendations of MSS CEQM COLRP Report A be adopted as amended and the remainder of the report be filed.
RECOMMENDED FOR ADOPTION IN LIEU OF

(37) RESOLUTION 010 - ADDRESSING OVERCONSUMPTION OF POOR-
NUTRITIONAL-QUALITY FOODS

RECOMMENDATION A:

Alternate Resolution 010 be adopted in lieu of Resolution 010.

RESOLVED, Our AMA-MSS supports: (a) the development of front-of-
package warning labels for foods that are high in added sugars, sodium,
saturated fats, and calories based on the established recommended daily
values; (b) limiting the amount of added sugars, sodium, saturated fats,
and calories permitted in a food product containing front-of-package health
or nutrient content claims; and (c) including warnings about increased
health risks on packaging of foods that are high in added sugars, sodium,
saturated fats, and calories based on the established recommended daily
values.

RESOLVED, That our AMA amend policy D-150.974 “Support for Nutrition Label Revision
and FDA Review of Added Sugars” by addition and deletion to read as follows:

Support for Nutrition Label Revision and FDA Review of Added
Sugars D-150.974

1. Our AMA will issue a statement of support for the newly proposed
nutrition labeling by the Food and Drug Administration (FDA) during
the public comment period.

2. Our AMA will recommend that the FDA further establish a
recommended daily value (%DV) for the new added sugars listing
on the revised nutrition labels based on previous recommendations
from the WHO and AHA.

3. Our AMA will encourage further research into studies of sugars
as addictive through epidemiological, observational, and clinical
studies in humans.

4. Our AMA encourages the FDA to: (a) develop front-of-package
warning labels for foods that are high in added sugars, sodium,
saturated fats, and calories based on the established
recommended daily values; and (b) include language in warnings
about increased risk for diabetes, cardiovascular disease, and
cancer, limit the amount of added sugars permitted in a food
product containing front-of-package health or nutrient content
claims.
VRC testimony was supportive with amendments. Your Reference Committee agrees with testimony that labeling foods is quite difficult, expresses concerns about feasibility of implementation, and is within the FDA’s purview. We agree that the asks of this resolution will not meaningfully change AMA advocacy efforts, and we recommend amendments to make this resolution internal. We agree that clause 4(b) of D-150.974 was struck without sufficient evidence from the whereas clauses and further clarified the resolution by amending to internal support. Your Reference Committee recommends Alternate Resolution 010 be adopted in lieu of Resolution 010.

(38) RESOLUTION 011 - PROTECTING ACCESS TO GENDER-AFFIRMING CARE

RECOMMENDATION A:

Alternate Resolution 011 be adopted in lieu of Resolution 011.

RESOLVED, That our AMA-MSS oppose any and all criminal and other legal penalties against patients seeking gender-affirming care and against parents and guardians who support minors seeking and receiving gender-affirming care; including the penalties of loss of custody and the inappropriate characterization of gender-affirming care as child abuse; and advocate for protections from violence, criminal or other legal penalties, adverse medical licensing actions, and liability, including responsibility for future medical costs, for (a) healthcare facilities that provide gender-affirming care; (b) physicians and other healthcare providers who provide gender-affirming care; and (c) patients seeking and receiving gender-affirming care; and be it further

RESOLVED, That our AMA-MSS support the AMA working with state and specialty societies and other interested organizations to advocate against state and federal legislation that would prohibit or limit gender-affirming care; and be it further

RESOLVED, That our AMA-MSS support the AMA working with other interested organizations to communicate with the Federation of State Medical Boards about the importance of preserving gender-affirming care despite government intrusions.

RESOLVED, That our AMA amend H-185.927 “Clarification of Medical Necessity for Treatment of Gender Dysphoria” by addition and deletion as follows; and be it further

Clarification of Medical Necessity for Treatment of Gender Dysphoria, H-185.927
Our AMA (1) recognizes that medical and surgical treatments for gender dysphoria and gender incongruence, 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 gender incongruence; and (3) opposes the criminalization and otherwise undue restriction of evidence-based gender-affirming care; and (4) supports federal, state, and local policies that protect and increase access to gender-affirming care.

RESOLVED, That our AMA opposes any and all criminal and other legal penalties against parents and guardians who support minors seeking and receiving gender-affirming care, including designation as child abuse and alterations to custody status; and be it further

RESOLVED, That our AMA advocate for protections from violence and criminal or other legal penalties for a) healthcare facilities that provide gender-affirming care; b) physicians and other healthcare providers who provide gender-affirming care; and c) patients seeking and receiving gender-affirming care.

VRC testimony was mixed between support and reaffirmation. Your Reference Committee agrees with testimony from the GLMA: Health Professionals Advancing LGBTQ Equality to amend the first Resolve to be more inclusive. The MSS Caucus has agreed to co-sponsor a resolution along with The Endocrine Society that has been forwarded to the Annual 2023 Meeting of the AMA House of Delegates. The Reference Committee agrees with amendments to make the second and third Resolves internal policy to support upcoming AMA efforts on this issue. Your Reference Committee recommends Alternate Resolution 011 be adopted in lieu of Resolution 011.

(39) RESOLUTION 017 - STRENGTHENING THE SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM

RECOMMENDATION A:

Alternate Resolution 017 be adopted in lieu of Resolution 017.

RESOLVED, That our AMA-MSS amend Pending MSS Transmittal 192, which is set for transmission to the Annual 2023 Meeting of the AMA House of Delegates, by addition to read as follows:

Our AMA actively support elimination of the five-year SNAP waiting period for otherwise qualifying immigrants and expansion of SNAP
to otherwise qualifying Deferred Action Childhood Arrivals (DACA) recipients;

Our AMA support increases and oppose decreases in funding, eligibility, benefit generosity, and purchasing power incentives in the Supplemental Nutrition Assistance Program (SNAP); and

Our AMA support expanding SNAP to U.S. territories that currently receive capped block grants for nutrition assistance.

RESOLVED, That our AMA oppose efforts to curtail Supplemental Nutrition Assistance Program benefit allotments and overall program funding; and be it further

RESOLVED, That our AMA support efforts to expand Supplemental Nutrition Assistance Program eligibility and outreach among students of higher education; and be it further

RESOLVED, That our AMA support measures to expand the Supplemental Nutrition Assistance Program to US territories that presently receive nutrition assistance funding via a capped block grant structure; and be it further

RESOLVED, That our AMA support the elimination of the current five-year Supplemental Nutrition Assistance Program eligibility waiting period for all otherwise qualified documented immigrants; and be it further

RESOLVED, That our AMA support measures to classify hot and prepared foods as items eligible for purchase using Supplemental Nutrition Assistance Program benefits; and be it further

RESOLVED, That our AMA collaborate with relevant stakeholders to advocate for increased funding for nutrition assistance programs, including but not limited to SNAP or SNAP incentive programs, in an effort to increase the individual purchasing power of recipients; and be it further

RESOLVED, That our AMA amend policy H-150.925 “Food Environments and Challenges Accessing Healthy Food” by addition to read the following;

Food Environments and Challenges Accessing Healthy Food

H-150.925

Our AMA (1) encourages the U.S. Department of Agriculture and appropriate stakeholders to study the national prevalence, impact, and solutions to challenges accessing healthy affordable food, including, but not limited to, food environments like food mirages, food swamps, and food deserts; (2) recognizes that food access
inequalities are a major contributor to health inequities, disproportionately affecting marginalized communities and people of color; (3) supports policy promoting community-based initiatives that empower resident businesses, create economic opportunities, and support sustainable local food supply chains to increase access to affordable healthy food; and (4) will advocate for CMS and other relevant agencies to develop, test, and then implement evidence-based innovative models to address food insecurity, such as food delivery, food subscription services, community supported agriculture, and transportation services to supermarkets, food banks and pantries, and local farmers markets for healthy food options.

RESOLVED, That our AMA-MSS append this resolution to Pending Transmittal 192, “SNAP Expansion for DACA Recipients,” which is set for transmission to the Annual 2023 Meeting of the House of Delegates.

VRC testimony was supportive with amendments. Your Reference Committee agrees with testimony that this resolution is very timely and should be amended to consolidate the ask. We agree with amendments to amend current MSS Transmittal 192 and clarify the asks of the resolution while preserving original language. Amending the MSS transmittal will allow for the MSS to address the reduction of Supplemental Nutrition Assistance Program (SNAP) in the wake of the “ending” of the COVID benefit expansion. Your Reference Committee recommends Alternate Resolution 017 be adopted in lieu of Resolution 017.

(40) RESOLUTION 038 - HIGH RISK HPV SUBTYPES IN AMERICAN INDIAN AND ALASKA NATIVE POPULATIONS

RECOMMENDATION A:

Alternate Resolution 038 be adopted in lieu of Resolution 038.

TITLE: High Risk HPV Subtypes in Vulnerable Populations

RESOLVED, That our AMA amend H-440.872 “HPV Vaccine and Cervical Cancer Prevention Worldwide” by addition as follows:

HPV Vaccine and Cervical Cancer Prevention Worldwide H440.872
7. Our AMA advocate that racial, ethnic, socioeconomic, and geographic differences in high-risk HPV subtype prevalence be taken into account during the development, clinical testing, and strategic distribution of next-generation HPV vaccines.
RESOLVED, That our AMA recognizes that there is a high-quality evidence gap for the screening, management, prevention, and treatment of American Indian and Alaska Native women with high-risk HPV infections; and be it further

RESOLVED, That our AMA will advocate to federal agencies to conduct epidemiological surveys of high-risk HPV subtypes most prevalent among American Indian and Alaska Native women.

VRC testimony was supportive with amendments. Your Reference Committee agrees with testimony that reformulating the HPV vaccine to achieve broader coverage of high-risk strains in the AI/AN population would improve health outcomes. We have broadened the language to focus on many types of vulnerable populations including “racial, ethnic, socioeconomic, and geographic differences in high-risk HPV” and formatted the new Resolve as an amendment to current AMA policy “HPV Vaccine and Cervical Cancer Prevention Worldwide” (H-440.872). Your Reference Committee recommends Alternate Resolution 038 be adopted in lieu of Resolution 038.

(41) RESOLUTION 061 - ENCOURAGING WAYFINDING RESEARCH IN HEALTHCARE FACILITIES

RECOMMENDATION A:

Alternate Resolution 061 be adopted in lieu of Resolution 061.

RESOLVED, That our AMA-MSS support the use of wayfinding and patient-centered considerations in healthcare facility design.

RESOLVED, That our AMA encourage stakeholders to educate patients on the dangers of healthcare insurance scams and how to report such scams; and be it further

RESOLVED, That our AMA provide educational resources to physicians on the dangers of healthcare insurance scams and how to avoid them, and encourage them to distribute these resources to their patients; and be it further

RESOLVED, That our AMA encourage hospitals to provide information or resources to patients about healthcare insurance scams.

VRC testimony was supportive of the spirit of the resolution. Your Reference Committee agrees with concerns that the resolution would not significantly impact AMA’s advocacy efforts. We agree that amendments to consolidate and redirect the ask within the AMA’s scope will improve the resolution’s feasibility. Amending the policy to an internal resolve clause allows the MSS to support the spirit of the resolution. Your Reference Committee recommends Alternate Resolution 061 be adopted in lieu of Resolution 061.
RESOLUTION 085 - ADDRESSING THE ECONOMIC IMPACTS OF INDUSTRY INVOLVEMENT IN MEDICAL DEVICE PROCUREMENT

RECOMMENDATION A:

Alternate Resolution 085 be adopted in lieu of Resolution 085.

RESOLVED, That our AMA-MSS supports strengthening the rigor of the Food and Drug Administration 510(k) exemption process for medical device approvals by requiring that 510(k) exceptions may not be predicated on a device that has been voluntarily recalled.

RESOLVED, That our Council on Ethical and Judicial Affairs consider the impact that industry representative presence in the operating room or catheterization lab has on increased costs and waste; and be it further

RESOLVED, That our AMA urge congress to pass legislation to update the medical device approval process to strengthen the rigor of the 510(k) exemption process to include:

a) The requirement for clinical trials in human subjects
b) Demonstrated improved therapeutic benefit to patients over the predicate devices on which the exemption is based
c) Extension of the requirement that an exemption may not be predicated on a device that has been recalled to include voluntary recalls

VRC testimony was supportive of the spirit. Your Reference Committee agrees with testimony that the resolution should be amended as new internal policy. The asks of the resolution will be addressed in a Council on Science and Public Health report at the Annual 2023 Meeting of the AMA House of Delegates that outlines the study of MSS transmittal 270.040MSS. By amending the resolution to an internal ask, the MSS can take a stance on the upcoming CSAPH report. Your Reference Committee recommends Alternate Resolution 085 be adopted in lieu of Resolution 085.

(43) RESOLUTION 056 - EXPANDING THE USE OF MEDICAL INTERPRETERS
RESOLUTION 080 - MEDICAL SECOND LANGUAGE TRAINING & CERTIFICATION FOR PHYSICIANS AND TRAINEES

RECOMMENDATION:

Alternate Resolution 056 be adopted in lieu of Resolution 056 and Resolution 080.
RESOLVED, That our AMA amend H-160.924 “Use of Language Interpreters in the Context of the Patient-Physician Relationship” by addition and deletion to read as follows:

Use of Language Interpreters in the Context of the Patient-Physician Relationship H-160.924

1. AMA policy is that: (1) further research is necessary on how the use of interpreters—both those who are trained and those who are not—impacts patient care; (b) treating physicians shall respect and assist the patients’ choices whether to involve capable family members or friends to provide language assistance that is culturally sensitive and competent, with or without an interpreter who is competent and culturally sensitive; (c) physicians continue to be resourceful in their use of other appropriate means that can help facilitate communication—including print materials, digital and other electronic or telecommunication services with the understanding, however, of these tools’ limitations—to aid Limited English Proficiency (LEP) patients’ involvement in meaningful decisions about their care; (d) patients have expanded access to documentation and communications available in their preferred language, including appointment reminder calls/messages, post-appointment summaries, and electronic medical records, through access to trained interpreter and translator services; (de) physicians cannot be expected to provide and fund these translation services for their patients, as the Department of Health and Human Services’ policy guidance currently requires; when trained medical interpreters are needed, the costs of their services shall be paid directly to the interpreters by patients and/or third party payers and physicians shall not be required to participate in payment arrangements.

2. Our AMA recognizes the importance of using medical interpreters as a means of improving quality of care provided to patients with LEP including patients with sensory impairments.

3. Our AMA promote opportunities for physicians, trainees, and medical staff to receive medical interpreter training.
Resolution 056 – Expanding the Use of Medical Interpreters

RESOLVED, That our AMA supports the expansion of interpreter services to include providing appointment reminder calls/messages, post-appointment summaries, electronic medical records, and any other documentation or communication in the patient’s preferred language by professional medical translators; and be it further

RESOLVED, That our AMA advocates on a national level for the incorporation of these expanded interpreter services and supports an increase in hospital reimbursement of interpretation costs by the Centers for Medicare and Medicaid Services to ensure access to quality interpretation services for all patients.

Resolution 080 - Medical Second Language Training & Certification for Physicians and Trainees

RESOLVED, That our AMA encourage hospital systems, clinics, residency programs, and medical schools to promote and incentivize opportunities for physicians, staff, and trainees to receive medical interpreter training and certification.

VRC testimony was mixed. Your Reference Committees agrees with testimony to improve patient access to trained interpreters and promote opportunities for physicians, trainees, and medical staff to receive interpreter training. We agree with consolidation of related asks to decrease the number of items transmitted to the House of Delegates by our section. We agree that amendments to current policy H-160.924 cover the asks of Resolution 056 and 080. Your Reference Committee recommends Alternate Resolution 056 be adopted in lieu of Resolution 056 and Resolution 080.
RECOMMENDED FOR REFERRAL

(44) RESOLUTION 015 - OPPOSING PRIVATE EQUITY ACQUISITIONS OF HEALTHCARE PRACTICES

RECOMMENDATION:

Resolution 015 be referred.

RESOLVED, That our AMA-MSS recognizes that acquisition of healthcare practices by PE firms often has detrimental consequences for patients and providers; and be it further
RESOLVED, That our AMA-MSS opposes the acquisition of healthcare practices by PE firms due to their detrimental effects on healthcare access, patient outcomes, and increased financial burden on the health care system.

VRC testimony was mixed. Your Reference Committee agrees with testimony that there is not enough evidence outrightly oppose private equity acquisition of healthcare practices. The Council on Medical Service is doing a series of reports related to health care consolidation and a study will enable the MSS to establish a position on this specific component of that topic that will be useful going forward. We recommend that these HOD reports be considered along with further study from the MSS. Your Reference Committee recommends Resolution 015 be referred.

(45) RESOLUTION 024 - SUPPORTING ACADEMIC MEDICAL-LEGAL PARTNERSHIPS TO ADDRESS SOCIAL DETERMINANTS OF HEALTH

RECOMMENDATION:

Resolution 024 be referred.

RESOLVED, That our AMA will inform physicians and medical students of the impact of unmet legal needs on the health of patients, particularly with respect to social determinants of health; and be it further
RESOLVED, That our AMA will support the education of medical students and physicians about the value of Medical-Legal Partnerships in addressing patients’ unmet legal needs, and ways to screen for these needs; and be it further
RESOLVED, That our AMA will support further research into how to improve Academic Medical-Legal Partnerships’ impact on addressing social determinants of health; and be it further
RESOLVED, That our AMA will support the establishment and expansion of Academic Medical-Legal Partnerships and greater incorporation of civil legal needs as Social Determinants of Health into medical school curricula, similar to the Health Justice Alliance at Georgetown University.

VRC testimony was mixed. Resolution 024 and 063 address very similar topics. We agree that these two resolutions would be best combined and referred to study to 1.) address evaluating the impact of recognizing civil legal aid services as a social determinant of health, 2.) determine the work that other medical education stakeholders, such as The American Association of Medical Colleges, have done on medical-legal education and related topics, and 3.) clarify the AMA’s role in addressing this issue. We agree that referral will provide improved language and a clear path forward for AMA advocacy. Your Reference Committee recommends Resolution 024 and 063 be referred.

(46) RESOLUTION 028 - THE USE OF LANGUAGE INTERPRETERS IN MEDICAL AND CLINICAL RESEARCH

RECOMMENDATION A:

Resolution 028 be referred.

RESOLVED, That our AMA supports the use of language interpreters in research participation to promote equitable data collection and outcomes; and be it further

RESOLVED, That our AMA encourages research institutions to budget for the use of language interpreters in medical and clinical research proposals; and be it further

RESOLVED, That our AMA collaborates with the American Society for Physicians in Clinical Research to encourage relevant stakeholders to develop guidelines for the appropriate implementation of language interpreters in medical and clinical research.

VRC testimony was mixed between general support, support with amendments, and reaffirmation. Your Reference Committee supports the spirit of the resolution and agrees with concerns regarding the downstream consequences of expanding interpreter and translation services in clinical/medical research. We recommend amendments to strike the second and third Resolves and make the intent of the resolution actionable via a new Resolve to read as follows: make the intent of the resolution actionable via a new Resolve to read as follows:

RESOLVED, That our AMA encourages all Institutional and Research Review Boards to develop and publish transparent guidance on the enrollment of medical and clinical research participants with Limited English Proficiency.

Additionally, we recommend amendments to the first Resolve to read as follows:
RESOLVED, Our AMA supports the use of language interpreters and translators in clinical and medical research participation to promote equitable data collection and outcomes; and be it further.

The Reference Committee recommends the following questions for study: 1.) What potential training is required to provide specific research study interpretation and translation services? 2.) Do programs need to invest not just in the cost of medical interpreter services, but in training to meaningfully communicate information from clinical studies? 3.) What is the role of IRB and institutional guidelines in accomplishing the asks of this resolution? 4.) How can this item be strengthened with other possible mechanisms to increase equity in medical studies with greater inclusion of Limited English Proficiency individuals? Your Reference Committee recommends Resolution 028 be referred.

(47) RESOLUTION 030 - ADVOCATING FOR METHADONE MAINTENANCE THERAPY DISPENSATION IN COMMUNITY PHARMACY SETTINGS

RECOMMENDATION:

Resolution 030 be referred.

RESOLVED, That our AMA support the ability of OTP clinicians, physicians holding board certification in addiction medicine or addiction psychiatry, and other appropriately trained physicians such as primary care physicians to prescribe methadone for opioid use disorder that can be dispensed through a pharmacy for individuals for unsupervised use; and be it further

RESOLVED, That our AMA amend Policy D-95.961 by addition and deletion to read as follows:

Enabling Methadone Treatment of Opioid Use Disorder in Primary Care Settings D-95.961

Our AMA: (1) will research current best practices and support pilot programs and other evidence-based efforts to expand and integrate primary care services for patients receiving methadone maintenance treatment; (2) supports further research to help define the population of patients who may be safely treated with advocate for the provision of methadone maintenance treatment via office-based treatment, including primary care; and (3) urges all payers, including health insurance companies, pharmacy benefit management companies, and state and federal agencies, to reduce prior authorization and other administrative burdens and to enhance the provision of primary care, counseling, and other medically necessary services for patients being treated with methadone maintenance treatment; and (4) will advocate for methadone maintenance therapy doses to be dispensed in a community pharmacy setting for patients who are receiving
methadone maintenance therapy treatment at a licensed Opioid Treatment Program.

VRC testimony was mainly in opposition to the resolution as written. Your Reference Committee agrees with testimony that study would help refine language and bolster the asks with evidence before bringing this resolution forward to the House of Delegates. We agree with testimony to strike the first Resolve and recommend referring the second resolve clause to study. Your Reference Committee recommends Resolution 030 be referred.

(48) RESOLUTION 033 - RACIAL MISCLASSIFICATION

RECOMMENDATION:

Resolution 033 be referred.

RESOLVED, Our AMA amend Improving Death Certification Accuracy and Completion H-85.953 by addition as follows:

Improving Death Certification Accuracy and Completion H-85.953

1. Our AMA: (a) acknowledges that the reporting of vital events is an integral part of patient care; (b) urges physicians to ensure completion of all state vital records carefully and thoroughly with special attention to the use of standard nomenclature, using legible writing and accurate diagnoses; and (c) supports notifying state medical societies and state departments of vital statistics of this policy and encouraging their assistance and cooperation in implementing it.

2. Our AMA also: (a) supports the position that efforts to improve cause of death statistics are indicated and necessary; (b) endorses the concept that educational efforts to improve death certificates should be focused on physicians, particularly those who take care of patients in facilities where patients are likely to die, namely in acute hospitals, nursing homes and hospices; and (c) supports the concept that training sessions in completion of death certificates should be (i) included in hospital house staff orientation sessions and clinical pathologic conferences; (ii) integrated into continuing medical education presentations; (iii) mandatory in mortality conferences; and (iv) included as part of in-service training programs for nursing homes, hospices and geriatric physicians.
3. Our AMA further: (a) promotes and encourages the use of ICD codes among physicians as they complete medical claims, hospital discharge summaries, death certificates, and other documents; (b) supports cooperating with the National Center for Health Statistics (NCHS) in monitoring the four existing models for collecting tobacco-use data; (c) urges the NCHS to identify appropriate definitions, categories, and methods of collecting risk-factor data, including quantification of exposure, for inclusion on the U.S. Standard Certificates, and that subsequent data be appropriately disseminated; and (d) continues to encourage all physicians to report tobacco use, exposure to environmental tobacco smoke, and other risk factors using the current standard death certificate format.

4. Our AMA further: (a) supports HIPAA-compliant data linkages between Native Hawaiian and Tribal Registries, population-based and hospital-based clinical trial and disease registries, and local, state, tribal, and federal vital statistics databases aimed at minimizing racial misclassification.

VRC testimony was mixed between support and referral. Your Reference Committee agrees with testimony that insufficient evidence was provided in the resolution to support data linkages between vital statistics databases and tribal registries/hospital-based databases. Your Reference Committee agrees that this resolution covers an important topic and recommends referral to ensure the ask is comprehensive. Your Reference Committee recommends the following questions be addressed by the MSS committees:

1.) How would the AMA support creating a HIPAA-compliant data linkage system with reservations that do not have HIPAA laws? 2.) What are the effects of creating a data linkage system? 3.) Are there any unintended consequences? Your Reference Committee recommends Resolution 033 be referred.

(49) RESOLUTION 035 - INDIAN HEALTH SERVICE PHARMACEUTICAL COVERAGE

RECOMMENDATION:

Resolution 035 be referred.

RESOLVED, That our AMA will advocate to the U.S. Department of Health and Human Services that essential FDA-approved pharmaceuticals mandated for coverage by Medicare, Medicaid, Tricare, and the Children’s Health Insurance Program programs should also be covered by the Indian Health Service.
RESOLVED, That our AMA will work with the Indian Health Service and appropriate agencies and organizations to ensure that their National Core Formulary includes at least two standard-of-care drugs proven to be equally effective in each therapeutic category or pharmacologic class, if available, to be used by the physician in deciding the best treatment options for their patients, including:

i. antidepressants;
ii. antipsychotics;
iii. anticonvulsants;
iv. immunosuppressants for treatment of transplant rejection;
v. antiretrovirals;
vi. antineoplastics;

VRC testimony was mixed. Your Reference Committee agrees with testimony in support of the resolution’s spirit yet shares concerns about feasibility and specific language proposed. We recommend that the committees studying this resolution address the following questions: 1.) Does medication covered by all three insurance programs need to be covered by IHS or all medications covered by any of those programs? 2.) Is it necessary and feasible to include both Resolve 1 and 2 or would Resolve 2 be sufficient, as Resolve 2 mirrors AMA policy for Medicare Part D? 3.) Does this introduce an added financial burden to AI/AN communities? Your Reference Committee recommends Resolution 035 be referred.

(50) RESOLUTION 043 - SUPPORT FOR INCREASED DIVERSITY IN GENETIC RESEARCH

RECOMMENDATION:

Resolution 043 be referred.

RESOLVED, That our AMA support the diversification of genetic research to include subjects from multiple genetic ancestries; and be it further

RESOLVED, That our AMA support the recruitment of individuals from underrepresented genetic ancestry groups for participation in genetic research studies, especially those regarding genetic risk; and be it further

RESOLVED, That our AMA encourage the NIH to increase funding for outreach and recruitment of members of underrepresented genetic ancestry groups and the sharing of such deidentified genetic data with the scientific community; and be it further

RESOLVED, That our AMA promotes public education regarding PRSs and genetic research participation in order to aid in the recruitment of diverse ancestry cohorts for future genetic studies; and be it further
RESOLVED, That the AMA amend Policy H-460.909, “Comparative Effectiveness Research,” by addition and deletion to read as follows:

**Comparative Effectiveness Research H-460.909**

The following Principles for Creating a Centralized Comparative Effectiveness Research Entity are the official policy of our AMA:

**PRINCIPLES FOR CREATING A CENTRALIZED COMPARATIVE EFFECTIVENESS RESEARCH ENTITY:**

A. **Value.** Value can be thought of as the best balance between benefits and costs, and better value as improved clinical outcomes, quality, and/or patient satisfaction per dollar spent. Improving value in the US health care system will require both clinical and cost information. Quality comparative clinical effectiveness research (CER) will improve health care value by enhancing physician clinical judgment and fostering the delivery of patient-centered care.

B. **Independence.** A federally sponsored CER entity should be an objective, independent authority that produces valid, scientifically rigorous research.

C. **Stable Funding.** The entity should have secure and sufficient funding in order to maintain the necessary infrastructure and resources to produce quality CER. Funding source(s) must safeguard the independence of a federally sponsored CER entity.

D. **Rigorous Scientifically Sound Methodology.** CER should be conducted using rigorous scientific methods to ensure that conclusions from such research are evidence-based and valid for the population studied. The primary responsibility for the conduct of CER and selection of CER methodologies must rest with physicians and researchers.

E. **Transparent Process.** The processes for setting research priorities, establishing accepted methodologies, selecting researchers or research organizations, and disseminating findings must be transparent and provide physicians and researchers a central and significant role.

F. **Significant Patient and Physician Oversight Role.** The oversight body of the CER entity must provide patients, physicians (MD, DO), including clinical practice physicians, and independent scientific researchers with substantial representation and a central decision-making role(s). Both physicians and patients are uniquely motivated to provide/receive quality care while maximizing value.

G. **Conflicts of Interest Disclosed and Minimized.** All conflicts of interest must be disclosed and safeguards developed to minimize
actual, potential and perceived conflicts of interest to ensure that
stakeholders with such conflicts of interest do not undermine the
integrity and legitimacy of the research findings and conclusions.
H. Scope of Research. CER should include long term and short
term assessments of diagnostic and treatment modalities for a
given disease or condition in a defined population of patients.
Diagnostic and treatment modalities should include drugs,
biologics, imaging and laboratory tests, medical devices, health
services, or combinations. It should not be limited to new
treatments. In addition, the findings should be re-evaluated
periodically, as needed, based on the development of new
alternatives and the emergence of new safety or efficacy data.
The priority areas of CER should be on high volume, high cost
diagnosis, treatment, and health services for which there is
significant variation in practice. Research priorities and
methodology should factor in any systematic variations in disease
prevalence or response across groups by race, ethnicity, genetic
ancestry, gender, age, geography, and economic status; and be it
further
I. Dissemination of Research. The CER entity must work with
health care professionals and health care professional
organizations to effectively disseminate the results in a timely
manner by significantly expanding dissemination capacity and
intensifying efforts to communicate to physicians utilizing a variety
of strategies and methods. All research findings must be readily
and easily accessible to physicians as well as the public without
limits imposed by the federally supported CER entity. The highest
priority should be placed on targeting health care professionals
and their organizations to ensure rapid dissemination to those who
develop diagnostic and treatment plans.
J. Coverage and Payment. The CER entity must not have a role in
making or recommending coverage or payment decisions for
payers.
K. Patient Variation and Physician Discretion. Physician discretion
in the treatment of individual patients remains central to the
practice of medicine. CER evidence cannot adequately address
the wide array of patients with their unique clinical characteristics,
co-morbidities and certain genetic characteristics. In addition,
patient autonomy and choice may play a significant role in both
CER findings and diagnostic/treatment planning in the clinical
setting. As a result, sufficient information should be made
available on the limitations and exceptions of CER studies so that
physicians who are making individualized treatment plans will be
able to differentiate patients to whom the study findings apply from those for whom the study is not representative.

VRC testimony was mixed. Your Reference Committee agrees with testimony that the resolution is not reaffirmation of existing policies H-460.909, D-350.981, and H-460.911. The House Coordination Committee slated Resolution 043 as reaffirmation of current policy that supports diversity in clinical research, but we agree that the resolution focuses specifically on genetic ancestry which is distinct from race and includes not only clinical research but also basic science research. However, your Reference Committee has concerns about the impact of this resolution as many initiatives including the NIH All of Us Project are collecting genetic and health data with an emphasis on including individuals that have historically not been included in this type of research. The Reference Committee questions the impact of AMA action in this realm and whether the proposals including “outreach” and “public education” are the most efficacious method to improve genetic ancestry representation in research. Referral of this item would allow our MSS to gather more research and find the best solution to the problem. Your Reference Committee recommends Resolution 043 be referred.

RESOLUTION 049 - ADDRESSING GENDER-BASED DISPARITIES ON HEALTH-RELATED CONSUMER GOODS (THE PINK TAX)

RECOMMENDATION:

Resolution 049 be referred.

RESOLVED, That our AMA recognizes the existence of a gender-based disparity in health-related consumer goods; and be it further

RESOLVED, That our AMA will work with state medical societies to raise awareness of substantially similar health-related products that are priced differently based on the gender of the consumers and advocate for further regional study of this disparity.

VRC testimony was mixed. Your Reference Committee agrees with testimony that the evidence presented to support the gender-based disparity in healthcare goods is insufficient and outdated. Your Reference Committee recommends referral to strengthen the evidence for gender-based disparities specifically in healthcare goods, the effect of this disparity on health outcomes, and further clarify the AMA’s role in addressing this issue. We recommend that our MSS standing committees study the following questions 1.) Is this resolution feasible? 2.) Are the asks of this resolution within the scope of the AMA? Your Reference Committee recommends Resolution 049 be referred.

RESOLUTION 063 - ACCESS TO HEALTH-SUPPORTING CIVIL LEGAL AID SERVICES AS A SOCIAL DETERMINANT OF HEALTH
RECOMMENDATION:

Resolution 063 be referred.

RESOLVED, That our AMA recognize health-promoting civil legal services include but are not limited to legal services that support access to healthcare, safe housing and work environments, safeguards against financial exploitation, and assistance with family issues such as protection from abusive relationships, child support, and custody; and be it further

RESOLVED, That our AMA recognize access to health-promoting civil legal aid services as a social determinant of health.

VRC testimony was mixed. Resolution 024 and 063 address very similar topics. We agree that these two resolutions would be best combined and referred to study to 1.) address evaluating the impact of recognizing civil legal aid services as a social determinant of health, 2.) determine the work that other medical education stakeholders, such as The American Association of Medical Colleges, have done on medical-legal education and related topics, and 3.) clarify the AMA's role in addressing this issue. We agree that referral will provide improved language and a clear path forward for AMA advocacy. Your Reference Committee recommends Resolution 024 and 063 be referred.

(53)  RESOLUTION 065 - ADDRESSING THE HEALTH IMPACTS OF DISCRIMINATION AND REJECTION ON LGBTQ YOUTH IN FOSTER CARE

RECOMMENDATION:

Resolution 065 be referred.

RESOLVED, That our AMA recognizes that LGBTQ youth are disproportionately represented in foster care systems where they are vulnerable to unique forms of maltreatment that both cause and exacerbate disparities in physical health, mental health, and overall well-being outcomes; and be it further

RESOLVED, That our AMA supports federal and state legislation that establishes nondiscrimination protections within the foster care system on the basis of sexual orientation and gender identity; and be it further

RESOLVED, That our AMA supports efforts by the Department of Health and Human Services and other appropriate stakeholders to establish reporting requirements and necessary privacy protections for the collection of sexual orientation and gender identity data in the Foster Care Analysis and Reporting System; and be it further
RESOLVED, That our AMA encourages child welfare agencies to implement practices, policies, and regulations that: (a) provide training to child welfare professionals, social workers, and foster caregivers on how to establish safe, stable, and affirming care placements for LGBTQ youth; (b) adopt programs to prevent and reduce violence against LGBTQ youth in foster care; (c) improve recruitment and tracking of foster families that are affirming of LGBTQ youth; and (d) allow gender diverse youth to be placed in residential foster homes that best align with their gender identity.

VRC testimony was mainly supportive with amendments. Your Reference Committee agrees that this issue needs to be addressed, but we have concerns about the practical implication of nondiscrimination protections. We recommend that this resolution be referred to address the following questions: 1.) If a parent is considered discriminatory what are the practical implications? Does that mean they no longer are able to receive any foster children, thus putting more pressure on a system that is already without enough foster parents? 2.) Is this currently feasible? Your Reference Committee recommends Resolution 065 be referred.

RESOLUTION 066 - SUPPORTING POLICIES WHICH INCREASE BIOSIMILAR PENETRATION

RECOMMENDATION:

Resolution 066 be referred.

RESOLVED, That our AMA encourage the Centers for Medicare and Medicaid Services (CMS) to implement systems for economically encouraging the uptake of biosimilars by physicians, including but not limited to setting rewards for volume targets and via shared savings programs; and be it further

RESOLVED, That our AMA encourage the Food and Drug Administration (FDA) to consider modifying its guidelines for the biosimilar ‘interchangeability’ designation; and be it further

RESOLVED, That our AMA encourage the Federal Trade Commission (FTC) and Department of Justice (DOJ) Antitrust Division to closely scrutinize long-term exclusive contracts signed between biologics originators and PBMs to ensure they do not impede biosimilar development and uptake.
VRC testimony was mainly in opposition. Your Reference Committee agrees with testimony that the resolution lacks evidence and has questionable feasibility. We recommend referral of this resolution to study the following questions: 1.) What are the ethical impacts of incentivizing physicians for utilization of these products? 2.) Is there enough evidence to go against current AMA policy H-125.976 on the need for switching trials? 3.) Is “consider modifying” a strong and clear enough directive to enable the AMA to engage on interchangability guidelines? 4.) Is the third resolve a good use of AMA resources? Your Reference Committee recommends Resolution 066 be referred.

(55) RESOLUTION 078 - COVERAGE FOR CARE PROVIDED AFTER SEXUAL ASSAULT

RECOMMENDATION:

Resolution 078 be referred.

RESOLVED, That AMA policy H-80.999 “Sexual Assault Survivors” be amended by addition to include coverage for additional services following a sexual assault to reduce patient costs, as follows:

- Sexual Assault Survivors H-80.999
  1. Our AMA supports the preparation and dissemination of information and best practices intended to maintain and improve the skills needed by all practicing physicians involved in providing care to sexual assault survivors.
  2. Our AMA advocates for the legal protection of sexual assault survivors’ rights and work with state medical societies to ensure that each state implements these rights, which include but are not limited to, the right to: (a) receive a medical forensic examination free of charge, which includes but is not limited to HIV/STD testing and treatment, pregnancy testing and prevention, drug testing, treatment of injuries, and collection of forensic evidence; (b) preservation of a sexual assault evidence collection kit for at least the maximum applicable statute of limitation; (c) notification of any intended disposal of a sexual assault evidence kit with the opportunity to be granted further preservation; (d) be informed of these rights and the policies governing the sexual assault evidence kit; and (e) access to emergency contraception information and treatment for pregnancy prevention.
  3. Our AMA will support efforts to cover the cost of all medical care involved in the immediate management of all patients presenting after a sexual assault, regardless of insurance status.
4. Our AMA will collaborate with relevant stakeholders to develop recommendations for implementing best practices in the treatment of sexual assault survivors, including through engagement with the joint working group established for this purpose under the Survivor's Bill of Rights Act of 2016.

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

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

VRC testimony was in opposition. Your Reference Committee agrees with testimony that resolution is well-intended, but the asks are not feasible. We appreciate that Illinois has adopted legislation on this issue and believe it could potentially be used as a model to strengthen future language. We agree that the resolution would be strengthened through further study and would urge the committees to address the following questions: 1.) Is this resolution feasible? 2.) How would the costs of this medical care be covered? 3.) What is the evidence for adding “drug testing” in clause 2? Your Reference Committee recommends Resolution 078 be referred.

(56) RESOLUTION 083 - INDIAN WATER RIGHTS

RECOMMENDATION:

Resolution 083 be referred.

Resolved, That our AMA:

(1) Recognizes access to water as a public health crisis in American Indian and Alaska Native reservations and villages;

(2) Will make it an organizational priority to work with relevant American Indian and Alaska Native stakeholder organizations, Tribal governmental leaders, and Tribal federal relations staff to secure additional resources for American Indian and Alaska Native sanitation, water treatment, and environmental support and health services;

(3) Will work with state medical societies and associations and American Indian and Alaska Native Tribes and Villages to support Indian Water Rights litigation and federal Indian Water Rights legislation.

VRC testimony was supportive. Your Reference Committee agrees with support for the spirit of the resolution, but we noted that some whereas clauses lack credible evidence.
In order to bolster these asks, we recommend this resolution be referred for study to find credible sources, specifically documenting these issues in broader areas and areas not initially supported in the whereas clauses (i.e. more than CO, AK, and NM), and compile more information to justify the resolve clauses. Your Reference Committee recommends Resolution 083 be referred.

(57) RESOLUTION 091 - HUMANITARIAN EFFORTS TO RESETTLE REFUGEES

RECOMMENDATION:

Resolution 091 be referred.

RESOLVED, That our AMA support increases and oppose decreases to the annual refugee admissions cap in the United States.

VRC testimony was supportive. Your Reference Committee agrees that evidence provided by the Whereas clauses is unclear and appears to conflict with the asks of the Resolve. We recommend this resolution be studied thoroughly with strong, clear evidence to substantiate the asks. Your Reference Committee recommends Resolution 091 be referred.
RECOMMENDED FOR NOT ADOPTION

(58) RESOLUTION 002 - FREE, INDIVIDUALIZED THERAPY FOR MEDICAL STUDENTS

RECOMMENDATION:

Resolution 002 not be adopted.

RESOLVED, That our AMA will work with the Council on Medical Education to support options for medical schools to provide free, individualized therapy to medical students as a means to improve their mental and emotional well-being.

VRC testimony was mixed. Your Reference Committee agrees with concerns that the resolution could have unintended risks of increasing the cost of medical school tuition and burden on medical students. We agree that the amendments proposed would move the resolution to be reaffirmation of H-345.973 and H-295.898. The Reference Committee agrees with testimony that the resolution did not adequately support the need for free mental health services over affordable mental health services. Your Reference Committee agrees that medical schools should not limit the options available to students, including outside sources of mental healthcare and school-provided mental healthcare. Your Reference Committee has also noted that asking our AMA to work with the Council on Medical Education is not a feasible or actionable ask. Your Reference Committee recommends Resolution 002 not be adopted.

(59) RESOLUTION 003 - ADDRESSING SELF-DISCHARGE AGAINST MEDICAL ADVICE

RECOMMENDATION:

Resolution 003 not be adopted.

RESOLVED, That our AMA supports research and early identification of patients vulnerable to self-discharge against medical advice and promote interventions that ameliorate such disparities; and be it further

RESOLVED, That our AMA study the ethics of nonmaleficence, liability, and justice regarding discharge against medical advice.

VRC testimony was in opposition. Your Reference Committee agrees with the concerns of impact, feasibility, and the possible stigmatization of patients who choose to discharge against medical advice. We agree with testimony that the first resolve is not impactful, and the second resolve is outside the scope of the AMA. The Reference Committee recommends Resolution 003 not be adopted.
(60) RESOLUTION 004 - AMENDING D-90.990 “EVALUATE BARRIERS TO MEDICAL EDUCATION FOR TRAINEES WITH DISABILITIES” TO REFLECT UPDATED APPROACHES AND LCME/COCA REQUIREMENTS

RECOMMENDATION:

Resolution 004 not be adopted.

RESOLVED, That our AMA amends by addition and deletion D-90.990 “Evaluate Barriers to Medical Education for Trainees with Disabilities” to read as follows:

Evaluate Barriers to Medical Education for Trainees with Disabilities D-90.990

1. Our AMA urges that the Liaison Committee of Medical Education, Commission on Osteopathic College Accreditation, and other relevant stakeholders require all medical schools and graduate medical education (GME) institutions and programs to create, review, and revise technical standards, concentrating on replacing “organic” standards with “functional” standards or “competency-based” standards that emphasize abilities rather than limitations, and that those institutions also disseminate these standards and information on how to request accommodations for disabilities in a prominent and easily found location on their websites.

2. Our AMA urges all medical schools and GME institutions to: a) make available to students and trainees a designated, qualified person or committee trained in the application of the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act of 1973, and available support services; b) encourage students and trainees to avail themselves of any needed support services; and c) foster a supportive and inclusive environment where students and trainees with disabilities feel comfortable accessing support services.

3. Our AMA encourages the National Board of Medical Examiners (NBME), National Board of Osteopathic Medical Examiners (NBOME), and member boards of the American Board of Medical Specialties and the American Osteopathic Association to evaluate and enhance their processes for reviewing requests for accommodations from applicants with disabilities in order to reduce delays in completion of licensing and initial board certification examinations. This should include an assessment of the experience of those applicants and the development of a transparent communication process that keeps applicants informed about the expected timeline to address their requests.
These processes should require neither proof of accommodation nor proof of poor academic performance prior to the time at which a need for accommodation was requested.

4. Our AMA encourages research and broad dissemination of results in the area of disabilities accommodation in the medical environment that includes: the efficacy of established accommodations; innovative accommodation models that either reduce barriers or provide educational approaches to facilitate the avoidance of barriers; impact of disabled learners and physicians on the delivery of health care to patients with disabilities; and research on the safety of established and potential accommodations for use in clinical programs and practice.

5. Our AMA will collaborate with the NBME and the NBOME to facilitate a timely accommodations application.

6. Our AMA recommends adherence to the ADA recommendations in section 36.309 that requires the documentation requested by a testing entity to evaluate a request for testing accommodations be both reasonable and limited to only the information needed to determine the nature of an examinee’s disability and their need for the requested testing accommodations, as noted by the Civil Rights Division of the Department of Justice in their 2014 interpretation of this ADA provision.

7. Our AMA will collaborate with key stakeholders to raise awareness regarding the process for applying and preparing for examinations, inclusive of requests for accommodations.

VRC testimony was mixed. Your Reference Committee agrees with testimony that the proposed amendments to existing policy do not significantly change AMA’s advocacy. Specifically, the update to “competency-based standards” is not a substantial change to D-90.990 from an advocacy perspective. Your Reference Committee agrees with concerns that educational accreditation bodies do not institute technical standards. Your Reference Committee recommends Resolution 004 not be adopted.

(61) RESOLUTION 007 - THE STIGMA SURROUNDING “NONCOMPLIANT” LANGUAGE IN PATIENT CHARTING

RECOMMENDATION:

Resolution 007 not be adopted.

RESOLVED, That the AMA study whether the addition of a qualifying “due to” clause after including the terms “noncompliant” or “nonadherent” in a patient chart is effective in reducing bias and stigmatization of patients; and be it further
1 RESOLVED, That the AMA encourage the use of “I” statements and motivational
2 interviewing by providers with patients labeled as “noncompliant” or “nonadherent” to
3 identify potential barriers in their access to healthcare.

4 VRC testimony was in opposition. Your Reference Committee agrees with testimony that
5 the first resolve is too prescriptive and outside the scope of the AMA. Your Reference
6 Committee also notes that the AMA is not a research organization and asking the AMA to
7 study the ask is not actionable. The second resolve is covered by existing policy H-30.942
8 and we agree with testimony that this ask is not feasible or actionable as written. Your
9 Reference Committee recommends Resolution 007 not be adopted.

10 (62) RESOLUTION 009 - TREATING TRAUMATIC INJURY SURVIVORSHIP AS A
11 CHRONIC CONDITION

12 RECOMMENDATION:

13 Resolution 009 not be adopted.

14 RESOLVED, That our AMA-MSS recognizes (1) the impact of traumatic injury
15 survivorship on our healthcare and social resources; (2) the chronicity of comprehensive
16 rehabilitation following traumatic injury; and be it further

17 RESOLVED, That our AMA supports efforts to increase access to comprehensive care
18 and improved quality of life strategies and interventions for traumatic injury survivors
19 including, but not limited to, resilience screenings, multidisciplinary clinics, and
20 appropriate long term care plans.

21 VRC testimony was opposed to the resolution as written. Your Reference Committee
22 agrees with testimony that the AMA has extensive policy addressing chronic pain
23 management, traumatic injury, and disability covering the asks of this resolution. We agree
24 that the second Resolve would not have a significant impact on AMA's advocacy efforts
25 as specialty societies are working to address the issue. The Reference Committee
26 reviewed amendments proffered and concluded that amendments do not increase the
27 novelty of the ask. Your Reference Committee recommends Resolution 009 not be
28 adopted.

29 (63) RESOLUTION 019 - SUPPORT FOR DIVERSITY AND DEVELOPMENT OF
30 FORMAL CLINICAL CRITERIA FOR HAIR CURL PATTERN

31 RECOMMENDATION:

32 Resolution 019 not be adopted.
RESOLVED, That our AMA support hair diversity as a relevant factor in providing culturally competent dermatological care and education; and be it further

RESOLVED, That our AMA support relevant medical societies’ efforts to develop formal clinical criteria in identifying hair types to improve medical education and patient care.

VRC testimony was mainly in opposition. Your Reference Committee agrees with testimony that the authors did not provide enough evidence to show a clear link between misclassification of hair curl patterns to adverse health effects. We agree with the spirit of resolution but have concerns about the resolution’s evidentiary basis. Your Reference Committee recommends Resolution 019 not be adopted.

(64) RESOLUTION 021 - INCLUSION OF HARM REDUCTION CURRICULA IN UNDERGRADUATE MEDICAL EDUCATION

RECOMMENDATION:

Resolution 021 not be adopted.

RESOLVED, That our AMA promote the inclusion of Harm Reduction education within current UME curricula as a key component to developing a physician workforce that are confident in their ability to work with patients experiencing substance misuse in a humane and compassionate manner; and be it further

RESOLVED, That our AMA will work with relevant stakeholders to encourage medical schools to incorporate Harm Reduction education as part of their current UME curricula, acknowledging that appropriate knowledge, skills, and attitudes regarding substance use disorders can improve patient outcomes and reduce public health burden; and be it further

RESOLVED, That our AMA encourages the development of a curriculum inventory and database in Harm Reduction practices and philosophy for use by medical schools in UME; and be it further

RESOLVED, That our AMA supports the development of national standards for Harm Reduction training in the UME curricula; and be it further

RESOLVED, That our AMA amend Policy D-95.987 by addition to read as follows:

Prevention of Drug-Related Overdose, D-95.987

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

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

3. Our AMA will support the development and implementation of appropriate education programs for persons receiving treatment for a SUD or in recovery from a SUD and their friends/families that address Harm Reduction measures.

4. Our AMA will advocate for and encourage state and county medical societies to advocate for Harm Reduction policies that provide civil and criminal immunity for the possession, distribution, and use of “drug paraphernalia” designed for Harm Reduction from drug use, including but not limited to drug contamination testing and injection drug preparation, use, and disposal supplies.

VRC testimony was mixed. Your Reference Committee agrees with testimony that the resolution is covered under current policy D-160.981 and D-95.987. Additionally, we agree with testimony that there is a lack of evidence for the deficiency of harm reduction education in undergraduate medical education and this resolution will not significantly impact current AMA efforts. Your Reference Committee recommends Resolution 021 not be adopted.

(65) RESOLUTION 025 - ACCESS TO RESTORATION OF RIGHTS FOR PEOPLE WITH DISABILITIES

RECOMMENDATION:

Resolution 025 not be adopted.

RESOLVED, That our AMA amend MSS Transmittal 233 by addition to read as follows:

RESOLVED, That our AMA support federal and state efforts to collect anonymized data on guardianships and conservatorships to assess the effects on medical decision making and rates of abuse; and be it further

RESOLVED, That our AMA study the impact of less restrictive alternatives to guardianships and conservatorships including supported decision making on medical decision making, health outcomes, and quality of life; and be it further

RESOLVED, That our AMA
RESOLVED, That our AMA support notification of conservatees of their option to pursue Restoration of Rights and allow for informal requests for restoration to increase access to these options.

VRC testimony was mixed. The Reference Committee agrees with concerns surrounding the resolution's lack of evidence and novelty. The notification of an informal request for rights restoration is not proven to solve the problem. Your Reference Committee recommends Resolution 025 not be adopted.

(66) RESOLUTION 026 - PROMOTING THE IMPLEMENTATION OF ENVIRONMENTAL JUSTICE WITHIN MEDICAL CURRICULUM

RECOMMENDATION:

Resolution 026 not be adopted.

RESOLVED, That our American Medical Association strongly encourage the implementation of environmental justice into medical curriculum, during both preclinical and clinical training.

VRC testimony supports the spirit of the resolution. Your Reference Committee agrees with testimony that the resolution asks are sufficiently addressed in MSS Transmittal 238. Your Reference Committee agrees with testimony that there is not sufficient evidence to support the effectiveness of environmental justice training in undergraduate medical education. Your Reference Committee recommends Resolution 026 not be adopted.

(67) RESOLUTION 029 – ADDRESSING AUGMENTED INTELLIGENCE IN MEDICAL EDUCATION

RECOMMENDATION:

Resolution 029 not be adopted.

RESOLVED, That our AMA amend the existing policy H-295.857 Augmented Intelligence (AI) in Medical Education by addition and deletion as follows:

**Augmented Intelligence in Medical Education H-295.857**

Our AMA encourages:

(1) accrediting and licensing bodies to study how AI should be most appropriately addressed in accrediting and licensing standards;

(2) medical specialty societies and boards to consider production of specialty-specific educational modules related to AI;
(3) research regarding the effectiveness of AI instruction in medical education on learning and clinical outcomes;
(3) research regarding the effectiveness of AI-delivered medical education on learning and clinical outcomes;
(4) research regarding how to effectively integrate education over the integration of AI into medicine;
(4)(5) institutions and programs to be deliberative in the determination of when AI-assisted technologies should be taught, including consideration of established evidence-based treatments, and including consideration regarding what other curricula may need to be eliminated in order to accommodate new training modules;
(5)(6) stakeholders to provide educational materials to help learners guard against inadvertent dissemination of bias that may be inherent in AI systems;
(6) the study of how differences in institutional access to AI may impact disparities in education for students at schools with fewer resources and less access to AI technologies;
(7) the study of disparities regarding access to and education on AI in medicine;
(7)(8) enhanced training across the continuum of medical education regarding assessment, understanding, and application of data in the care of patients;
(8) the study of how disparities in AI educational resources may impact health care disparities for patients in communities with fewer resources and less access to AI technologies;
(9) the study of how AI may perpetuate or affect disparities in health care;
(8)(10) institutional leaders and academic deans to proactively accelerate the inclusion of non-clinicians, such as data scientists and engineers, as well as AI-educated physicians, onto their faculty rosters in order to assist learners in their understanding and use of AI; and
(9)(11) close collaboration with and oversight by practicing physicians in the development of AI applications.;
(12) institutions and programs to be deliberative in developing comprehensive learning objectives and educational opportunities regarding augmented intelligence integrated curriculum;
(13) institutional leaders and academic deans hold students and educators participating in AI integrated curriculum accountable to meeting the conditions for professionalism in health care systems; and
(14) institutions and programs consider how the integration of Al will affect the workload of medical educators.

VRC testimony was mixed. Your Reference Committee agrees with concerns that the proposed amendments largely re-word the existing policy without changing the content. Additionally, we agree with testimony that the author’s amendments are covered by existing policy and would not significantly impact AMA’s advocacy efforts. Your Reference Committee recommends Resolution 029 not be adopted.

(68) RESOLUTION 031 - ENCOURAGING THE TRANSITION FROM ARTIFICIAL TURF TO NATURAL GRASS SURFACES FOR ATHLETIC USE

RECOMMENDATION:

Resolution 031 not be adopted.

RESOLVED, That our AMA recognizes that the installation and maintenance of artificial turf is more environmentally detrimental than natural grass fields; and be it further

RESOLVED, That our AMA recognizes that those participating in athletic activities on artificial turf are at an increased risk of injury compared to those performing the same activities on well-maintained natural grass.

VRC testimony was mixed. Your Reference Committee agrees with testimony that the resolution is outside of the scope of the AMA. We agree with the spirit of the resolution, but the AMA is not the appropriate body to address this issue. Your Reference Committee recommends Resolution 031 not be adopted.

(69) RESOLUTION 032 - ADDRESSING INCREASING MICROPLASTICS POLLUTION IN WATER AND THE HEALTH EFFECTS OF PLASTIC ON HUMAN HEALTH

RECOMMENDATION:

Resolution 032 not be adopted.

RESOLVED, That our AMA support efforts by the US Environmental Protection Agency to encourage relevant stakeholders to research efforts to reduce microplastic pollution, including but not limited to wastewater treatment plants and laundry machine removal filters; and be it further

RESOLVED, That our AMA-MSS amend pending transmittal “Research Plastic Use in Medicine” by addition and deletion as follows:

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 research into the reduction of single-use plastic in medicine; (15) encourages research on the effects of microplastics on human health; (16) encourages research into the reduction methods of microplastic pollution (17) encourages physician educators in medical schools, residency programs, and continuing medical education sessions to devote more attention to environmental health issues; (18) will strengthen its liaison with appropriate environmental health agencies, including the National Institute of Environmental Health Sciences (NIEHS); (19) encourages expanded funding for environmental research by the federal government; and (20) encourages family planning through national and international support.
VRC testimony was opposed to the resolution as written. Your Reference Committee agrees with testimony that MSS Transmittal 230 covers the asks of the resolution and the proposed amendments will not significantly change AMA advocacy. The AMA is also not a research organization and AMA advocacy to encourage research is minimally impactful. Additionally, the MSS transmitted Resolution 936 on single-use plastics to the Interim 2022 Meeting of the AMA House of Delegates and a report is due back at the Interim 2023 Meeting. We find that our current internal policies will allow the MSS to engage in productive discussion once the Report is released. Your Reference Committee recommends Resolution 032 not be adopted.

(70) RESOLUTION 042 - ADVOCACY FOR RESEARCHING THE BENEFITS AND COST-EFFICACY OF PATIENT NAVIGATION PROGRAMS OUTSIDE THE REALM OF ONCOLOGY

RECOMMENDATION:

Resolution 042 not be adopted.

RESOLVED, That our AMA supports research into the benefits of patient navigation in other clinical specialties outside of oncology; and be it further

RESOLVED, That our AMA supports research into the cost-efficacy of patient navigation programs in other fields outside of oncology to better understand if patient navigation is cost-effective for hospitals to implement.

VRC testimony was mixed. Your Reference Committee questions the need for further research into these programs since this resolution is already well cited. We also agree that the AMA has existing policy on expanding patient navigation programs H-373.994, and this resolution does not add feasible asks. Your Reference Committee recommends Resolution 042 not be adopted.

(71) RESOLUTION 044 - IMPROVING MEDIGAP PROTECTIONS

RECOMMENDATION:

Resolution 044 not be adopted.

RESOLVED, That our AMA advocates for annual Medigap open enrollment periods and guaranteed lifetime enrollment eligibility for those enrolled in Medicare; and be it further

RESOLVED, That our AMA advocates that Medigap insurers offer lifetime Community Rated policies to protect against premium adjustments for age and health-related changes amongst Medicare enrollees.

VRC testimony was mixed. Your Reference Committee agrees with testimony that the first Resolve is reaffirmation of H-165.856 and the second Resolve is in direct conflict with
existing policy and has unintended consequences. Further, the second Resolved clause
is unsupported by the Whereas clauses and the evidence is insufficient. Your Reference
Committee recommends Resolution 044 not be adopted.

(72) RESOLUTION 050 - UTILIZING SOCIAL WORKERS TO ADDRESS AND
PREVENT GUN VIOLENCE

RECOMMENDATION:

Resolution 050 not be adopted.

RESOLVED, That our AMA recognize the importance of social workers in hospital-based
violence intervention programs and support more extensive research on the importance
of having them as a core resource of hospital-based violence intervention programs.

VRC testimony was opposed to the resolution as written. Your Reference Committee
agrees with testimony that the intent of this resolution is covered by existing policy and the
asks will not impact AMA’s advocacy efforts. The AMA has recently instituted a Gun
Violence Task Force as a result of a previously-authored MSS resolution and thus, this
issue is covered under current policy and efforts. Your Reference Committee recommends
Resolution 050 not be adopted.

(73) RESOLUTION 051 - SUPPORT FOR PERSONS WITH SKIN-RELATED
DISORDERS AND DISABILITIES

RECOMMENDATION:

Resolution 051 not be adopted.

RESOLVED, That our AMA encourages physicians, health and human professionals,
and other relevant agencies that involve persons with dermatologic conditions to
recognize the unique burdens of dermatologic disorders due to the visibility of skin
lesions, psychiatric and psychological comorbidities, and chronic, refractory disease
course; and be it further

RESOLVED, That our AMA supports the inclusion of mental health screenings and
increased accessibility to mental health treatment services, given the psychiatric and
psychological comorbidities of dermatologic disabilities; and be it further

RESOLVED, That our AMA will work with the American Academy of Dermatology,
Society for Investigative Dermatology, American Society of Dermatopathology, and
public health organizations to improve awareness of cutaneous disability assessments
as well as dermatologic disabilities, especially in under-resourced patients.

VRC testimony was mixed. Your Reference Committee agrees with testimony that the first
and second Resolves are reaffirmation of current policies supporting those with
disabilities, and the third Resolve will not elicit significant advocacy efforts from the AMA. We agree that the asks of this resolution are covered by current efforts from specialty societies. Your Reference Committee recommends that Resolution 051 not be adopted.

(74) RESOLUTION 053 - SUPPORT FOR EFFORTS TO MAINTAIN CONSTRUCTION/BUILDING SAFETY STANDARDS

RECOMMENDATION:

Resolution 053 not be adopted.

RESOLVED, That our AMA encourages construction industry employees to receive training in building safety, and establishing better reporting channels and mechanisms in collaboration with Occupational Safety and Health Administration (OSHA) to reduce the mortality due to preventable deaths.

VRC testimony was mainly in opposition. Your Reference Committee agrees with concerns that current Occupational Safety and Health Administration (OSHA) safety mechanisms were not mentioned as there is extensive regulation on construction standards/regulation by OSHA on this issue. We agree that the asks of this resolution are outside the scope of the AMA and will not change advocacy efforts. Your Reference Committee recommends Resolution 053 not be adopted.

(75) RESOLUTION 059 - ADDRESSING MISINFORMATION WITH AUGMENTED INTELLIGENCE

RECOMMENDATION:

Resolution 059 not be adopted.

RESOLVED, That our AMA support research into the use of Augmented Intelligence-powered chatbots to address online medical misinformation; and be it further

RESOLVED, That our AMA supports research into the use of Augmented Intelligence to detect misinformation-spreading bots and general misinformation online.

VRC testimony was mixed. Your Reference Committee agrees with concerns arising from the changing nature of the field and the limited impact the resolution is likely to have by only supporting studies. The authors have proposed amendments to make the policy internal. However, these amendments also change the policy from supporting research to supporting the use of AI chatbots, which seems beyond the scope of the evidence and current capabilities of this technology. We agree with testimony that the technology is not fully developed and may have unintended consequences. Chatbots cited in the whereas clauses mainly focused on COVID-19, while the resolve clauses call for use of augmented intelligence chatbots for all medical misinformation. Further, the authors mention a Colorado COVID-19 chatbot with an accuracy rate of 91.1% which is a concerningly low
RESOLUTION 059 - REDUCING MISINFORMATION

Your Reference Committee recommends Resolution 059 not be adopted.

RESOLUTION 062 - COMPREHENSIVE REPRODUCTIVE HEALTH EDUCATION IN THE PRECLINICAL UNDERGRADUATE MEDICAL EDUCATION CURRICULUM

RECOMMENDATION:

Resolution 062 not be adopted.

RESOLVED, That our AMA amends policy H-295.923 Medical Training and Termination of Pregnancy by addition and deletion as follows:

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 will advocate for the availability of abortion education and clinical exposure to medication and procedural abortion for medical students and resident/fellow physicians and opposes efforts to interfere with or restrict the availability of this education and training--by collaborating with relevant stakeholders.

3. Our AMA will collaborate with relevant stakeholders to define comprehensive reproductive health, with explicit mention of termination of pregnancy, and include comprehensive reproductive health as a required curriculum topic or subtopic in preclinical undergraduate medical education.

4. In the event that medication and procedural abortion are limited or illegal in a home institution, our AMA will support pathways for medical students and resident/fellow physicians to receive this training at another location.

5. Our AMA will advocate for funding for institutions that provide clinical training on reproductive health services, including medication and procedural abortion, to medical students and resident/fellow physicians from other programs, so that they can expand their capacity to accept out-of-state medical students and resident/fellow physicians seeking this training.

6. 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 relevant Residency Review Committees.

VRC testimony was mixed. Your Reference Committee agrees with testimony that the action requested is outside of the scope of the AMA. Current initiatives by several key
stakeholders address the resolution’s asks and further AMA policy would likely not meaningfully change our organizations advocacy efforts in this area. The Association of Professors of Gynecology & Obstetrics are in support of comprehensive reproductive care education in clerkship training already. While advocating for curriculum changes are largely outside the scope of the AMA past precedent for AMA support of medical education curriculum was discussed. Your Reference Committee finds that the precedent is more generalized for broader topics of public health-related topics and general healthcare funding knowledge. We consider support of reproduction-specific curriculum to be a significant departure from past AMA policy precedent. Your Reference Committee recommends Resolution 062 not be adopted.

(77) RESOLUTION 071 – INCREASING EDUCATION ABOUT AND ACCESS TO SUPPORTED DECISION-MAKING AGREEMENTS (SDMAs)

RECOMMENDATION:

Resolution 071 not be adopted.

RESOLVED, That our AMA advocates for the use of supported decision-making agreements (SDMAs) as an alternative to guardianship; and be it further

RESOLVED, That our AMA encourages schools to promote the full range of decision-making options for students with disabilities, including supported decision-making agreements; and be it further

RESOLVED, That our AMA will collaborate with the American Academy of Pediatrics to increase provider and trainee knowledge on the use of supported decision-making when caring for individuals with disabilities.

VRC testimony was opposed to the resolution as written. Your Reference Committee agrees with concerns regarding evidence and feasibility. We believe that MSS Transmittal 233, “Conservatorship and Guardianship Reform,” conflicts with the resolution because the transmittal calls for a study on supported decision-making as an alternative to guardianship. We find that the first proposed resolved clause is broadly covered by AMA Code of Medical Ethics Opinions on Consent, Communication 2.1.2 "Decisions for Adult Patients Who Lack Capacity," and we felt that resolved clause two was a specific use of resolved clause one. We were further concerned with the AMA’s scope and that school and legal focused advocacy for minors is not an appropriate focus for our healthcare organization. Your Reference Committee recommends Resolution 071 not be adopted.

(78) RESOLUTION 072 – IMPROVING USABILITY OF ELECTRONIC HEALTH RECORDS FOR TRANSGENDER AND GENDER DIVERSE PATIENTS
RECOMMENDATION:

Resolution 072 not be adopted.

RESOLVED, That our AMA will amend policy H-315.967 “Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation” by addition and deletion to read as follows:

Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation, H-315.967

Our AMA: (1) supports the voluntary inclusion of a patient's biological sex, current clinical sex, sex assigned at birth, current gender identity, legal sex on identification documents, sexual orientation, preferred gender pronoun(s), preferred chosen name, and clinically relevant, sex specific anatomy in medical documentation, and related forms, including in electronic health records, in a culturally-sensitive and voluntary manner, with efforts to improve visibility and awareness of transgender and gender diverse patients' chosen name and pronouns in all relevant EHR screens and to de-emphasize or conceal legal name except when required for insurance and billing purposes; (2) Will advocate for the inclusion of an organ inventory encompassing medical transition history and a list of current present organs in EHRs, with efforts to link organ-specific examinations and cancer screenings to the current organ inventory rather than sex or gender identity; (23) Will advocate for collection of patient data in medical documentation and in medical research studies, according to current best practices, that is inclusive of sexual orientation, gender identity, and other sexual and gender minority traits for the purposes of research into patient and population health; (34) Will research the problems related to the handling of sex and gender within health information technology (HIT) products and how to best work with vendors so their HIT products treat patients equally and appropriately, regardless of sexual or gender identity; (45) Will investigate the use of personal health records to reduce physician burden in maintaining accurate patient information instead of having to query each patient regarding sexual orientation and gender identity at each encounter; and (56) Will advocate for the incorporation of recommended best practices into electronic health records and other HIT products at no additional cost to physicians automatically.

; and be it further
RESOLVED, That our AMA advocates for increased education and training on usage of gender identity and related transgender-inclusive functions in electronic healthcare records within healthcare institutions; and be it further

RESOLVED, That our AMA advocates for easy transferability of transgender-inclusive functions between different electronic healthcare record systems and that this transfer capability is included in the healthcare institutions’ training and education for staff; and be it further

RESOLVED, That this resolution be immediately forwarded to the AMA House of Delegates.

VRC testimony was mixed and supportive of the spirit of the resolution. Your Reference Committee agrees with testimony that the asks of the second and third Resolves are covered under existing policy and the first Resolve is not actionable. Your Reference Committee notes that the current policy being amended was presented to the AMA several years ago by the MSS. At the time "clinically relevant, sex specific anatomy in medical documentation, and related forms, including in electronic health records" was interpreted as an organ inventory. We agree that the additions to this existing policy will not meaningfully change AMA advocacy and neither will further amendments. Your Reference Committee recommends Resolution 072 not be adopted.

(79) RESOLUTION 077 – SUPPLEMENTAL BREAST CANCER SCREENING FOR PEOPLE WITH DENSE BREAST TISSUE

RECOMMENDATION:

Resolution 077 not be adopted.

RESOLVED, That our AMA encourage the development of patient education materials regarding breast density, including the increased risk of missing breast cancer on screening mammography and appropriate supplemental screening; and be it further

RESOLVED, That our AMA supports education for healthcare professionals, both in training and in practice, regarding breast cancer screening guidelines for individuals with dense breasts; and be it further

RESOLVED, That our AMA amend policy H-525.977 Breast Density Notification by addition as follows:

Breast Density Notification, H-525.977

1. Our AMA supports the inclusion of breast tissue density information in the mammography report when appropriate and
education of patients about the clinical relevance of such information, but opposes state requirements for mandatory notification of breast tissue density to patients.

2. Our AMA encourages research on the benefits and harms of adjunctive screening for breast cancer for women identified to have dense breasts on an otherwise negative screening mammogram, in order to guide appropriate and evidence-based care and insurance coverage of the service.

3. Our AMA supports insurance coverage for and adequate access to supplemental screening recommended for patients with “dense breast” tissue following a discussion between the patient and their physician which integrates secondary risk characteristics.

4. Our AMA recognizes that dense breast tissue is one of many secondary risk characteristics for breast cancer; and be it further

RESOLVED, That our AMA amend policy H-525.993 Screening Mammography by addition as follows:

Screening Mammography, H-525.993

Our AMA:

a. recognizes the mortality reduction benefit of screening mammography and adjunctive screening methods and supports its use as a tool to detect breast cancer.

b. recognizes that as with all medical screening procedures there are small, but not inconsequential associated risks including false positive and false negative results and overdiagnosis.

c. favors participation in and support of the efforts of professional, voluntary, and government organizations to educate physicians and the public regarding the value of screening mammography and adjunctive screening methods in reducing breast cancer mortality, as well as its limitations.

d. advocates remaining alert to new epidemiological findings regarding screening mammography and encourages the periodic reconsideration of these recommendations as more epidemiological data become available.

e. believes that beginning at the age of 40 years, all women should be eligible for screening mammography.

f. encourages physicians to regularly discuss with their individual patients the benefits and risks of screening mammography, and whether screening is appropriate for each clinical situation given that the balance of benefits and risks will be viewed differently by each patient.
g. encourages physicians to inquire about and update each patient’s family history to detect red flags for hereditary cancer and to consider other risk factors for breast cancer, so that recommendations for screening will be appropriate.

h. encourages physicians and patients to consider supplemental screening modalities, such as screening MRI and breast ultrasound, for patients with dense breast tissue.

i. supports insurance coverage for screening mammography.

j. supports seeking common recommendations with other organizations, informed and respectful dialogue as guideline-making groups address the similarities and differences among their respective recommendations, and adherence to standards that ensure guidelines are unbiased, valid and trustworthy.

k. reiterates its longstanding position that all medical care decisions should occur only after thoughtful deliberation between patients and physicians.

VRC testimony was mixed. Your Reference Committee agrees with testimony that the first Resolve is reaffirmation of H-525.977 and the second Resolve is reaffirmation of H-525.993. The third Resolve would not significantly impact the AMA’s advocacy efforts. The American College of Obstetricians and Gynecologists has practice guidelines for screening mammography and the fourth Resolve conflicts with them. We agree with testimony that the resolution is not actionable. Your Reference Committee recommends Resolution 077 not be adopted.

(80) RESOLUTION 079 – EXPANDING ACCESS TO HEMORRHAGE CONTROL KITS

RECOMMENDATION:

Resolution 079 not be adopted.

RESOLVED, That our AMA amend the existing policy H-130.935 “Support for Hemorrhage Control Training” to promote inclusivity by addition as follows:

Support for Hemorrhage Control Training, H-130.935
1. Our AMA encourages state medical and specialty societies to promote the training of both lay public and professional responders in essential techniques of bleeding control.
2. Our AMA encourages, through state medical and specialty societies, the inclusion of hemorrhage control kits (including pressure bandages, hemostatic dressings, tourniquets and gloves) for all first responders.
3. Our AMA supports the increased availability of bleeding control supplies with adequate and relevant training in public and private schools, places of employment, and public buildings.

4. Our AMA supports the increased availability of bleeding control supplies through a capacity-based approach in large private recreational spaces, including but not limited to entertainment venues, stadiums, and parks, implemented with collaboration from local, community, and state-level stakeholders.

5. Our AMA supports, through local, community, and state-level stakeholders, the implementation of cost-reduction measures including but not limited to price locks and loaner kit programs to increase the affordability and accessibility of bleeding control supplies by the lay public.

VRC testimony was mixed. Your Reference Committee agrees with testimony that the amendment to clause three is not impactful, the amendment by addition of clause four is covered by current language, and clause five has a weak evidentiary basis. Additionally, The American College of Surgeons has made this issue a priority and has an active “Stop the Bleed” campaign. Your Reference Committee feels that the proposed amendments to existing policy are unlikely to meaningfully change AMA advocacy efforts or contribute to ongoing campaigns by other medical organizations. Your Reference Committee recommends Resolution 079 not be adopted.

(81) RESOLUTION 081 – PATIENT PROTECTIONS FOR IMPLANTABLE MEDICAL DEVICES AND PROSTHETICS

RECOMMENDATION:

Resolution 081 not be adopted.

RESOLVED, That our AMA supports legislation requiring companies to inform patients of business decisions or news that could negatively affect the function, maintenance, and monitoring of their medical devices or prosthesis in a timely manner; and be it further

RESOLVED, That our AMA supports legislation that requires that companies producing implantable devices and prosthetics designate a surrogate in the event a company fails or is unable to provide the necessary monitoring and maintenance services; and be it further

RESOLVED, That our AMA supports legislation requiring transparency for expected medical device and prosthetic repair and maintenance services and their subsequent costs prior to the implantation of a device; and be it further

RESOLVED, That our AMA supports legislation encouraging payers to cover the costs of device maintenance, required upgrades, and remote monitoring of implantable medical devices and prosthesis; and be it further
RESOLVED, That our AMA opposes planned obsolescence, throttling of effectiveness, unnecessary monitoring fees, and all other types of predatory subscription based models for the use of all prosthetics and implantable medical devices; and be it further

RESOLVED, That our AMA amends Resolution D-480.991 “Access to Medical Care” by addition to read as follows:

**D-480.991 Access to Medical Care**

Our AMA shall work with the Centers for Medicare and Medicaid Services to maximize access to the devices and procedures available to Medicare patients by ensuring reimbursement at least covers the cost of said device or procedure as well as its expected maintenance, support, and monitoring fees.

VRC testimony was opposed to the resolution as written. Your Reference Committee agrees with testimony Resolves 1 and 2 are not feasible; Additionally, there lacks evidence that patients are losing or struggling to access device maintenance after a company is unable to do so and lacks evidence supporting the designation of surrogates.

Resolves 3, 4, and 6 are reaffirmation of existing policy; and Resolve 5 does not have a strong evidentiary basis. Our AMA has policy on device transparency D155.987 and coverage for devices H-480.943 and D-480.991; therefore, resolves 3, 4 and 6 will not meaningfully change AMA advocacy efforts. We agree with VRC testimony that there lacks evidence for planned obsolescence, throttling effectiveness, and unnecessary monitoring fees for prosthetics and implantable medical devices and therefore will not well received in the HOD.

Your Reference Committee recommends Resolution 081 not be adopted.

(82) **RESOLUTION 082 – SUPPORTING FOOD IS MEDICINE PROGRAMS**

**RECOMMENDATION:**

Resolution 082 not be adopted.

RESOLVED, That our AMA acknowledges the rising challenge of chronic diseases in the United States, and how nutritional interventions integrated into clinical care can greatly benefit patients with complex, severe, or chronic illnesses; and be it further

RESOLVED, That our AMA supports further research through larger-scale studies that investigate the cost-effectiveness of coverage, delivery, and efficacy of Food is Medicine interventions.
VRC testimony was in opposition to the resolution as written. Your Reference Committee agrees with testimony that recognizing the burden of chronic health conditions and supporting research into nutrition will not lead to substantial AMA advocacy efforts as our AMA has significant policy on improving access to healthy foods to fight chronic disease and improve public health. We agree that the resolution is well-written, but none of the amendments proffered increase the impact or actionability of the resolution and note that a resolution introduced for the 2023 AMA Annual Meeting addresses largely overlapping asks of this resolution. Further, the AMA is not a research organization and AMA support for research is minimally impactful. Your Reference Committee recommends Resolution 082 not be adopted.

(83) RESOLUTION 086 – IMPROVING ACCESS TO PEDIATRIC CARE TO ADDRESS AMERICAN INDIAN / ALASKA NATIVE INFANT MORTALITY

RECOMMENDATION:

Resolution 086 not be adopted.

RESOLVED, The AMA will collaborate with the American Academy of Pediatrics in their efforts to increase the use of evidence-based supports for AI/AN parents and young children by promoting the use of home visiting models, high-quality child care, and comprehensive pediatric care; and be it further

RESOLVED, The AMA will collaborate with the Indian Health Service, Center for Medicare and Medicaid Services, Tribal authorities, state public health agencies, and relevant community organizations to increase the distribution of appropriate American Indian and Alaska Native (AI/AN) infant health and safe parenting materials in the spirit of self-determination to reduce infant mortality and improve overall health outcomes of AI/AN children.

VRC testimony was mixed. The House Coordination Committee placed Resolution 086 on the reaffirmation calendar due to its overlap with D-245.994, H-245.998, H-245.992, H-245.986, and H-350.976. Your Reference Committee agrees with testimony that the first resolve details existing efforts and will not impact AMA efforts. Policy H-350.976 covers the second resolve by supporting innovations to the betterment of AI/AN health needs. The Reference Committee recommends Resolution 086 not be adopted.

(84) RESOLUTION 087 – SLEEP PHYSIOLOGY AND WELLNESS IN MEDICAL EDUCATION

RECOMMENDATION:
Resolution 087 not be adopted.

RESOLVED, That our AMA recognizes sleep as foundational to health and well-being; and be it further

RESOLVED, That our AMA supports curriculum coverage of sleep physiology to include the interaction between circadian rhythm and sleep-wake homeostatic drive; and be it further

RESOLVED, That our AMA encourages wellness resources to include strategies for medical trainees to improve their quality and quantity of sleep.

VRC testimony was mixed between opposition and reaffirmation. Your Reference Committee agrees with the House Coordination Committee that the first and second Resolves are reaffirmation of existing policies H-295.894 and H-60.930. Furthermore, we agree that resolution is not actionable because the first Resolve is a statement of fact and the third Resolve is not evidence-based and is not actionable. Your Reference Committee also notes that the third Resolved clause was not supported by evidence demonstrating that wellness resources which include strategies to improve sleep are an effective means of increasing sleep quantity and quality. Your Reference Committee recommends Resolution 087 not be adopted.

(85) RESOLUTION 089 – PROMOTING MOBILE MAMMOGRAPHY UNITS IN MEDICALLY UNDERSERVED REGIONS

RECOMMENDATION:

Resolution 089 not be adopted.

RESOLVED, That our AMA promote mobile mammography units to screen eligible individuals for breast cancer in under-resourced regions, including but not limited to rural areas, medically underserved areas, and regions with limited mammography facilities, in order to address socioeconomic and geographic disparities in breast cancer screening; and be it further

RESOLVED, That our AMA encourage the identification of optimal locations for mobile mammography units to increase access to breast cancer screening in under-resourced regions.

VRC testimony was in opposition to the resolution. Your Reference Committee agrees with testimony that the resolution does not clearly quantify the problem and prove that mobile mammography units are an evidence-based, cost-effective solution. We agree that there is not enough data on mobile mammography units to support the asks of the resolution. The Reference Committee reviewed amendments proffered to R2 and concluded that the amendments were neither well-supported nor feasible. There was also
discussion of specialty societies that may be more well-equipped to bring this topic forward. Your Reference Committee recommends Resolution 089 not be adopted.

(86) MSS COLA LGBTQ REPORT A - PHARMACY ACCESS TO HUMAN IMMUNODEFICIENCY VIRUS (HIV) PRE-EXPOSURE PROPHYLAXIS (PREP) & POST-EXPOSURE PROPHYLAXIS (PEP)

RECOMMENDATION:

MSS COLA LGBTQ Report A not be adopted.

Your Committee on Legislation and Advocacy and Committee on LGBTQ+ Affairs recommend that the following recommendation be adopted as amended by addition and deletion and the remainder of the report be filed:

RESOLVED, That our AMA support federal and state efforts to make HIV Pre-Exposure Prophylaxis (PrEP) and Post-Exposure Prophylaxis (PEP) prescribable by pharmacists through the establishment of Collaborative Practice Agreements with physicians, with evidence of a recent negative HIV test in accordance with best practice guidelines, including efforts to make rapid HIV tests available and affordable to patients requesting PrEP; and be it further

RESOLVED, That our AMA support federal and state efforts to make HIV Post-Exposure Prophylaxis (PEP)-prescribable by pharmacists.

VRC testimony was limited. Your Reference Committee agrees with testimony that the report lacks evidence to prove that the implementation of Collaborative Practice Agreements (CPAs) will improve accessibility to PrEP/PEP and patient outcomes. The report did not sufficiently address concerns of physician liability, feasibility, or administrative burden. Your Reference Committee noted several statistics lacking appropriate citations. Your Reference Committee believes this report will raise many concerns from AMA physicians of implications on expanding pharmacist scope of practice, including downstream effects on microbial resistance and patient follow-up. Your Reference Committee recommends MSS COLA LBGTQ Report A not be adopted.
RECOMMENDED FOR REAFFIRMATION IN LIEU OF

(87)  RESOLUTION 012 - ACCESS TO TORTURE DOCUMENTATION FOR
      ASYLUM SEEKERS

RECOMMENDATION:

Policy H-65.981 be reaffirmed in lieu of Resolution 012.

RESOLVED, That our AMA work with interested specialty, state, and county medical
societies and professional organizations and relevant US departments such as the United
States Department of Health and Human Services Office of Refugee Resettlement to
ensure that all asylum seekers can access screenings for torture and forensic medical and
psychological evaluations free of charge by clinicians with relevant expertise in
documenting experiences of torture in ways that identify the best approaches for medical
intervention, including helping aid victims maintain legal residency status and avoid re-
traumatization.

VRC testimony was mixed. Your Reference Committee agrees with testimony that
supports the spirit of the resolution; however, the asks of the resolution are already
covered under existing policy H-65.981 which “urges appropriate support for victims of
torture.” We find that existing AMA policy is sufficiently broad for the AMA to act on this
issue already without adoption of new policy, which could result in limiting the ways in
which the AMA could act on this specific case in this future Your Reference Committee
recommends Policy H-65.981 be reaffirmed in lieu of Resolution 012.

Human Rights and Health Professionals H-65.981
The AMA opposes torture in any country for any reason; urges
appropriate support for victims of torture; condemns the
persecution of physicians and other health care personnel who treat
torture victims. Sub. Res. 615, A-97; Reaffirmed: Sub. Res. 12, A-
04; Reaffirmed: Sub. Res. 10, A-05; Reaffirmed: CEJA Rep. 5, A-
15.

(88)  RESOLUTION 014 - STRATEGIES TO MITIGATE CHILD ABUSE AND
      NEGLECT

RECOMMENDATION:

Policy H-515.965 be reaffirmed in lieu of Resolution 014.

RESOLVED, That our AMA promotes implementation of child abuse mitigation strategies;
and be it further
RESOLVED, That our AMA encourage further studies into strategies to mitigate child abuse and neglect, including but not limited to crisis nurseries.

VRC testimony was in support of reaffirmation. Your Reference Committee agrees with testimony from the House Coordination Committee that the resolution is covered under existing policy H-515.965. We agree that the resolution is vague and contradictory; the AMA has extensive policy on family and intimate partner violence and the asks of the resolution will not meaningfully impact our advocacy efforts. Your Reference Committee recommends Policy H-515.965 be reaffirmed in lieu of Resolution 014.

**Family and Intimate Partner Violence H-515.965**

(1) Our AMA believes that all forms of family and intimate partner violence (IPV) are major public health issues and urges the profession, both individually and collectively, to work with other interested parties to prevent such violence and to address the needs of survivors. Physicians have a major role in lessening the prevalence, scope and severity of child maltreatment, intimate partner violence, and elder abuse, all of which fall under the rubric of family violence. To suppor physicians in practice, our AMA will continue to campaign against family violence and remains open to working with all interested parties to address violence in US society.

(2) Our AMA believes that all physicians should be trained in issues of family and intimate partner violence through undergraduate and graduate medical education as well as continuing professional development. The AMA, working with state, county and specialty medical societies as well as academic medical centers and other appropriate groups such as the Association of American Medical Colleges, should develop and disseminate model curricula on violence for incorporation into undergraduate and graduate medical education, and all parties should work for the rapid distribution and adoption of such curricula. These curricula should include coverage of the diagnosis, treatment, and reporting of child maltreatment, intimate partner violence, and elder abuse and provide training on interviewing techniques, risk assessment, safety planning, and procedures for linking with resources to assist survivors. Our AMA supports the inclusion of questions on family violence issues on licensure and certification tests.

(3) The prevalence of family violence is sufficiently high and its ongoing character is such that physicians, particularly physicians providing primary care, will encounter survivors on a regular basis. Persons in clinical settings are more likely to have experienced intimate partner and family violence than non-clinical populations. Thus, to improve clinical services as well as the public health, our AMA encourages physicians to: (a) Routinely inquire about the family violence histories of their patients as this knowledge is essential for effective diagnosis and care; (b) Upon identifying patients currently experiencing abuse or threats from intimates, assess and discuss safety issues with the patient before he or she leaves the office, working with the patient to develop a safety or exit
plan for use in an emergency situation and making appropriate referrals to address intervention and safety needs as a matter of course; (c) After diagnosing a violence-related problem, refer patients to appropriate medical or health care professionals and/or community-based trauma-specific resources as soon as possible; (d) Have written lists of resources available for survivors of violence, providing information on such matters as emergency shelter, medical assistance, mental health services, protective services and legal aid; (e) Screen patients for psychiatric sequelae of violence and make appropriate referrals for these conditions upon identifying a history of family or other interpersonal violence; (f) Become aware of local resources and referral sources that have expertise in dealing with trauma from IPV; (g) Be alert to men presenting with injuries suffered as a result of intimate violence because these men may require intervention as either survivors or abusers themselves; (h) Give due validation to the experience of IPV and of observed symptomatology as possible sequelae; (i) Record a patient's IPV history, observed traumata potentially linked to IPV, and referrals made; (j) Become involved in appropriate local programs designed to prevent violence and its effects at the community level.

(4) Within the larger community, our AMA:
(a) Urges hospitals, community mental health agencies, and other helping professions to develop appropriate interventions for all survivors of intimate violence. Such interventions might include individual and group counseling efforts, support groups, and shelters.
(b) Believes it is critically important that programs be available for survivors and perpetrators of intimate violence.
(c) Believes that state and county medical societies should convene or join state and local health departments, criminal justice and social service agencies, and local school boards to collaborate in the development and support of violence control and prevention activities.

(5) With respect to issues of reporting, our AMA strongly supports mandatory reporting of suspected or actual child maltreatment and urges state societies to support legislation mandating physician reporting of elderly abuse in states where such legislation does not currently exist. At the same time, our AMA oppose the adoption of mandatory reporting laws for physicians treating competent, non-elderly adult survivors of intimate partner violence if the required reports identify survivors. Such laws violate basic tenets of medical ethics. If and where mandatory reporting statutes dealing with competent adults are adopted, the AMA believes the laws must incorporate provisions that: (a) do not require the inclusion of survivors’ identities; (b) allow competent adult survivors to opt out of the reporting system if identifiers are required; (c) provide that reports be made to public health agencies for surveillance purposes only; (d) contain a sunset mechanism; and (e) evaluate the efficacy of those laws. State societies are encouraged to ensure that all mandatory reporting laws contain adequate protections for the
(6) Substance abuse and family violence are clearly connected. For this reason, our AMA believes that:
(a) Given the association between alcohol and family violence, physicians should be alert for the presence of one behavior given a diagnosis of the other. Thus, a physician with patients with alcohol problems should screen for family violence, while physicians with patients presenting with problems of physical or sexual abuse should screen for alcohol use.
(b) Physicians should avoid the assumption that if they treat the problem of alcohol or substance use and abuse they also will be treating and possibly preventing family violence.
(c) Physicians should be alert to the association, especially among female patients, between current alcohol or drug problems and a history of physical, emotional, or sexual abuse. The association is strong enough to warrant complete screening for past or present physical, emotional, or sexual abuse among patients who present with alcohol or drug problems.
(d) Physicians should be informed about the possible pharmacological link between amphetamine use and human violent behavior. The suggestive evidence about barbiturates and amphetamines and violence should be followed up with more research on the possible causal connection between these drugs and violent behavior.
(e) The notion that alcohol and controlled drugs cause violent behavior is pervasive among physicians and other health care providers. Training programs for physicians should be developed that are based on empirical data and sound theoretical formulations about the relationships among alcohol, drug use, and violence. CSA Rep. 7, I-00Reaffirmed: CSAPH Rep. 2, I-09Modified: CSAPH Rep. 01, A-19.

RESOLUTION 016 - SUPPORT A SURGEON GENERAL WARNING FOR PROCESSED MEAT

RECOMMENDATION:

Policy H-150.922 be reaffirmed in lieu of Resolution 016.

RESOLVED, That our AMA will support the issuance of a United States Surgeon General warning on processed meat considered to be carcinogenic, detailing the positive correlation between processed meat consumption and the incidence of gastrointestinal cancers, including colorectal cancer.

VRC testimony was mixed. Your Reference Committee agrees with testimony that the asks of this resolution are covered under existing policy and would not add anything novel.
Specifically, H-150.922 calls for “public awareness of the risks of processed meat consumption” which is broadly inclusive of a Surgeon General warning. Your Reference Committee recommends that Policy H-150.922 be reaffirmed in lieu of Resolution 016.

**Reduction in Consumption of Processed Meats H-150.922**

Our AMA supports: (1) reduction of processed meat consumption, especially for patients diagnosed or at risk for cardiovascular disease, type 2 diabetes, and cancer; (2) initiatives to reduce processed meats consumed in public schools, hospitals, food markets and restaurants while promoting healthy alternatives such as a whole foods and plant-based nutrition; (3) public awareness of the risks of processed meat consumption; and (4) educational programs for health care professionals on the risks of processed meat consumption and the benefits of healthy alternatives. Res. 406, A-19.

**RESOLUTION 018 - ADVOCACY FOR SECONDARY VICTIMS OF FAMILY VIOLENCE**

**RECOMMENDATION:**


RESOLVED, That our AMA support for the expansion of current family and domestic violence laws to include protections for secondary victims; and be it further

RESOLVED, That our AMA amend H-185.976 by addition to read as follows:

**Insurance Discrimination Against Victims of Domestic Violence H-185.976**

Our AMA: (1) opposes the denial of insurance coverage to all primary and secondary victims of domestic violence and abuse and seeks federal legislation to prohibit such discrimination; and (2) advocates for equitable coverage and appropriate reimbursement for all health care, including mental health care, related to family and intimate partner violence; and be it further

RESOLVED, That our AMA amend H-515.965 by addition to read as follows:

**Family and Intimate Partner Violence H-515.965**

(2) Our AMA believes that all physicians should be trained in issues of family and intimate partner violence through undergraduate and
graduate medical education as well as continuing professional
development. The AMA, working with state, county and specialty
medical societies as well as academic medical centers and other
appropriate groups such as the Association of American Medical
Colleges, should develop and disseminate model curricula on
violence for incorporation into undergraduate and graduate medical
education, and all parties should work for the rapid distribution and
adoption of such curricula. These curricula should include coverage
of the diagnosis, treatment, and reporting of child maltreatment,
inmate partner violence, secondary victims of trauma, and elder
abuse and. Furthermore, these curricula should provide training on
interviewing techniques, risk assessment, safety planning, and
procedures for linking with resources to assist survivors and
secondary victims. Our AMA supports the inclusion of questions on
family violence issues on licensure and certification tests; and be it
further

RESOLVED, That our AMA amend H-295.912 by addition to read as
follows:

Education of Medical Students and Residents about Domestic
Violence Screening H-295.912
The AMA will continue its support for the education of medical
students and residents on domestic violence by advocating that
medical schools and graduate medical education programs
educate students and resident physicians to sensitively inquire
about family abuse with all patients, when appropriate and as part
of a comprehensive history and physical examination, and provide
information about the available community resources for the
management of the patient and any secondary victims.

VRC testimony was mixed. Your Reference Committee agrees with testimony that existing
AMA policy covers the asks of this resolution broadly as secondary victims are considered
victims of domestic and intimate partner violence. Your Reference Committee thus does
not find the Resolved clauses to be novel or leading to new advocacy efforts. Your
Reference Committee recommends that Policies H-515.965, H-185.976, H-515.952 be
reaffirmed in lieu of Resolution 018.

Family and Intimate Partner Violence H-515.965
(1) Our AMA believes that all forms of family and intimate partner
violence (IPV) are major public health issues and urges the
profession, both individually and collectively, to work with other
interested parties to prevent such violence and to address the
needs of survivors. Physicians have a major role in lessening the
prevalence, scope and severity of child maltreatment, intimate
partner violence, and elder abuse, all of which fall under the rubric
of family violence. To support physicians in practice, our AMA will
continue to campaign against family violence and remains open to
working with all interested parties to address violence in US society.
(2) Our AMA believes that all physicians should be trained in issues
of family and intimate partner violence through undergraduate and
graduate medical education as well as continuing professional
development. The AMA, working with state, county and specialty
medical societies as well as academic medical centers and other
appropriate groups such as the Association of American Medical
Colleges, should develop and disseminate model curricula on
violence for incorporation into undergraduate and graduate medical
education, and all parties should work for the rapid distribution and
adoption of such curricula. These curricula should include coverage
of the diagnosis, treatment, and reporting of child maltreatment,
intimate partner violence, and elder abuse and provide training on
interviewing techniques, risk assessment, safety planning, and
procedures for linking with resources to assist survivors. Our AMA
supports the inclusion of questions on family violence issues on
licensure and certification tests.
(3) The prevalence of family violence is sufficiently high and its
ongoing character is such that physicians, particularly physicians
providing primary care, will encounter survivors on a regular basis.
Persons in clinical settings are more likely to have experienced
intimate partner and family violence than non-clinical populations.
Thus, to improve clinical services as well as the public health, our
AMA encourages physicians to: (a) Routinely inquire about the
family violence histories of their patients as this knowledge is
essential for effective diagnosis and care; (b) Upon identifying
patients currently experiencing abuse or threats from intimates,
assess and discuss safety issues with the patient before he or she
leaves the office, working with the patient to develop a safety or exit
plan for use in an emergency situation and making appropriate
referrals to address intervention and safety needs as a matter of
course; (c) After diagnosing a violence-related problem, refer
patients to appropriate medical or health care professionals and/or
community-based trauma-specific resources as soon as possible;
(d) Have written lists of resources available for survivors of violence,
providing information on such matters as emergency shelter,
medical assistance, mental health services, protective services and
legal aid; (e) Screen patients for psychiatric sequelae of violence
and make appropriate referrals for these conditions upon identifying a history of family or other interpersonal violence; (f) Become aware of local resources and referral sources that have expertise in dealing with trauma from IPV; (g) Be alert to men presenting with injuries suffered as a result of intimate violence because these men may require intervention as either survivors or abusers themselves; (h) Give due validation to the experience of IPV and of observed symptomatology as possible sequelae; (i) Record a patient's IPV history, observed traumata potentially linked to IPV, and referrals made; (j) Become involved in appropriate local programs designed to prevent violence and its effects at the community level.

(4) Within the larger community, our AMA:
(a) Urges hospitals, community mental health agencies, and other helping professions to develop appropriate interventions for all survivors of intimate violence. Such interventions might include individual and group counseling efforts, support groups, and shelters.
(b) Believes it is critically important that programs be available for survivors and perpetrators of intimate violence.
(c) Believes that state and county medical societies should convene or join state and local health departments, criminal justice and social service agencies, and local school boards to collaborate in the development and support of violence control and prevention activities.

(5) With respect to issues of reporting, our AMA strongly supports mandatory reporting of suspected or actual child maltreatment and urges state societies to support legislation mandating physician reporting of elderly abuse in states where such legislation does not currently exist. At the same time, our AMA oppose the adoption of mandatory reporting laws for physicians treating competent, non-elderly adult survivors of intimate partner violence if the required reports identify survivors. Such laws violate basic tenets of medical ethics. If and where mandatory reporting statutes dealing with competent adults are adopted, the AMA believes the laws must incorporate provisions that: (a) do not require the inclusion of survivors’ identities; (b) allow competent adult survivors to opt out of the reporting system if identifiers are required; (c) provide that reports be made to public health agencies for surveillance purposes only; (d) contain a sunset mechanism; and (e) evaluate the efficacy of those laws. State societies are encouraged to ensure that all mandatory reporting laws contain adequate protections for the reporting physician and to educate physicians on the particulars of the laws in their states.
(6) Substance abuse and family violence are clearly connected. For this reason, our AMA believes that:
(a) Given the association between alcohol and family violence, physicians should be alert for the presence of one behavior given a diagnosis of the other. Thus, a physician with patients with alcohol problems should screen for family violence, while physicians with patients presenting with problems of physical or sexual abuse should screen for alcohol use.
(b) Physicians should avoid the assumption that if they treat the problem of alcohol or substance use and abuse they also will be treating and possibly preventing family violence.
(c) Physicians should be alert to the association, especially among female patients, between current alcohol or drug problems and a history of physical, emotional, or sexual abuse. The association is strong enough to warrant complete screening for past or present physical, emotional, or sexual abuse among patients who present with alcohol or drug problems.
(d) Physicians should be informed about the possible pharmacological link between amphetamine use and human violent behavior. The suggestive evidence about barbiturates and amphetamines and violence should be followed up with more research on the possible causal connection between these drugs and violent behavior.
(e) The notion that alcohol and controlled drugs cause violent behavior is pervasive among physicians and other health care providers. Training programs for physicians should be developed that are based on empirical data and sound theoretical formulations about the relationships among alcohol, drug use, and violence.

Insurance Discrimination Against Victims of Domestic Violence H-185.976
Our AMA: (1) opposes the denial of insurance coverage to victims of domestic violence and abuse and seeks federal legislation to prohibit such discrimination; and (2) advocates for equitable coverage and appropriate reimbursement for all health care, including mental health care, related to family and intimate partner violence. Res. 814, I-94; Appended: Res. 419, I-00; Reaffirmation A-09; Reaffirmed: CMS Rep. 01, A-19.

Adverse Childhood Experiences and Trauma-Informed Care H-515.952
1. Our AMA recognizes trauma-informed care as a practice that recognizes the widespread impact of trauma on patients, identifies the signs and symptoms of trauma, and treats patients by fully integrating knowledge about trauma into policies, procedures, and practices and seeking to avoid re-traumatization.

2. **Our AMA supports:**
   a. evidence-based primary prevention strategies for Adverse Childhood Experiences (ACEs);
   b. evidence-based trauma-informed care in all medical settings that focuses on the prevention of poor health and life outcomes after ACEs or other trauma at any time in life occurs;
   c. efforts for data collection, research, and evaluation of cost-effective ACEs screening tools without additional burden for physicians.
   d. efforts to educate physicians about the facilitators, barriers and best practices for providers implementing ACEs screening and trauma-informed care approaches into a clinical setting; and
   e. funding for schools, behavioral and mental health services, professional groups, community, and government agencies to support patients with ACEs or trauma at any time in life; and
   f. increased screening for ACEs in medical settings, in recognition of the intersectionality of ACEs with significant increased risk for suicide, negative substance use-related outcomes including overdose, and a multitude of downstream negative health outcomes.

3. **Our AMA supports the inclusion of ACEs and trauma-informed care into undergraduate and graduate medical education curricula.**

(91) **RESOLUTION 020 - APPROACHES TO REDUCE INTERVENTIONS IN CHILDBIRTH**

**RECOMMENDATION:**

Policy H-185.917 be **reaffirmed in lieu of Resolution 020.**

RESOLVED, That our AMA amend policy H-185.917, “Reducing Inequities and Improving Access to Insurance for Maternal Health Care,” by addition as follows:

**Reducing Inequities and Improving Access to Insurance for Maternal Health Care, H-185.917**
1. Our AMA acknowledges that structural racism and bias negatively impact the ability to provide optimal health care, including maternity care, for people of color.

2. Our AMA encourages physicians to raise awareness among colleagues, residents and fellows, staff, and hospital administrators about the prevalence of racial and ethnic inequities and the effect on health outcomes, work to eliminate these inequities, and promote an environment of trust.

3. Our AMA encourages physicians to pursue educational opportunities focused on embedding equitable, patient-centered care for patients who are pregnant and/or within 12 months postpartum into their clinical practices and encourages physician leaders of health care teams to support similar appropriate professional education for all members of their teams.

4. Our AMA will continue to monitor and promote ongoing research regarding the impacts of societal (e.g., racism or unaffordable health insurance), geographical, facility-level (e.g., hospital quality), clinician-level (e.g., implicit bias), and patient-level (e.g., comorbidities, chronic stress or lack of transportation) barriers to optimal care that contribute to adverse and disparate maternal health outcomes, as well as research testing the effectiveness of interventions to address each of these barriers.

5. Our AMA will promote the adoption of federal standards for clinician collection of patient-identified race and ethnicity information in clinical and administrative data to better identify inequities. The federal data collection standards should be: (a) informed by research (including real-world testing of technical standards and standardized definitions of race and ethnicity terms to ensure that the data collected accurately reflect diverse populations and highlight, rather than obscure, critical distinctions that may exist within broad racial or ethnic categories), (b) carefully crafted in conjunction with clinician and patient input to protect patient privacy and provide non-discrimination protections, and (c) lead to the dissemination of best practices to guide respectful and non-coercive collection of accurate, standardized data relevant to maternal health outcomes.

6. Our AMA supports the development of a standardized definition of maternal mortality and the allocation of resources to states and Tribes to collect and analyze maternal mortality data (i.e., Maternal Mortality Review Committees and vital statistics) to enable stakeholders to better understand the underlying causes of maternal deaths and to inform evidence-based policies to improve maternal health outcomes and promote health equity.
7. Our AMA encourages hospitals, health systems, and state medical associations and national medical specialty societies to collaborate with non-clinical community organizations with close ties to minoritized and other at-risk populations to identify opportunities to best support pregnant persons and new families.

8. Our AMA encourages the development and funding of resources and outreach initiatives to help pregnant individuals, their families, their communities, and their workplaces to recognize the value of comprehensive prepregnancy, prenatal, peripartum, and postpartum care. These resources and initiatives should encourage patients to pursue both physical and behavioral health care, strive to reduce barriers to pursuing care, and highlight care that is available at little or no cost to the patient.

9. Our AMA supports adequate payment from all payers for the full spectrum of evidence-based prepregnancy, prenatal, peripartum, and postpartum physical and behavioral health care.

10. Our AMA encourages hospitals, health systems, and states to participate in maternal safety and quality improvement initiatives such as the Alliance for Innovation on Maternal Health program and state perinatal quality collaboratives.

11. Our AMA will advocate for increased access to risk-appropriate care by encouraging hospitals, health systems, and states to adopt verified, evidence-based levels of maternal care, including low-intervention, patient-centered approaches for the intrapartum management of low-risk women in spontaneous labor; and be it further

RESOLVED, That our AMA supports interprofessional approaches to expose medical trainees to low-intervention childbirth.

VRC testimony was mixed. Your Reference Committee agrees with the House Coordination Committee that Resolution 020 is reaffirmation of existing policy H-185.917. While we support the spirit of the resolution, policy H-185.917 advocates for evidence-based maternal care. If the asks of this resolution are evidence-based, then they are covered by this existing AMA policy. Alternatively, if they are not evidence-based, your Reference Committee would be concerned that they may not be appropriate recommendations. Taken this together, your Reference Committee recommends Policy H-185.917 be reaffirmed in lieu of Resolution 020.

Reducing Inequities and Improving Access to Insurance for Maternal Health Care H-185.917
1. Our AMA acknowledges that structural racism and bias negatively impact the ability to provide optimal health care, including maternity care, for people of color.

2. Our AMA encourages physicians to raise awareness among colleagues, residents and fellows, staff, and hospital administrators about the prevalence of racial and ethnic inequities and the effect on health outcomes, work to eliminate these inequities, and promote an environment of trust.

3. Our AMA encourages physicians to pursue educational opportunities focused on embedding equitable, patient-centered care for patients who are pregnant and/or within 12 months postpartum into their clinical practices and encourages physician leaders of health care teams to support similar appropriate professional education for all members of their teams.

4. Our AMA will continue to monitor and promote ongoing research regarding the impacts of societal (e.g., racism or unaffordable health insurance), geographical, facility-level (e.g., hospital quality), clinician-level (e.g., implicit bias), and patient-level (e.g., comorbidities, chronic stress or lack of transportation) barriers to optimal care that contribute to adverse and disparate maternal health outcomes, as well as research testing the effectiveness of interventions to address each of these barriers.

5. Our AMA will promote the adoption of federal standards for clinician collection of patient-identified race and ethnicity information in clinical and administrative data to better identify inequities. The federal data collection standards should be: (a) informed by research (including real-world testing of technical standards and standardized definitions of race and ethnicity terms to ensure that the data collected accurately reflect diverse populations and highlight, rather than obscure, critical distinctions that may exist within broad racial or ethnic categories), (b) carefully crafted in conjunction with clinician and patient input to protect patient privacy and provide non-discrimination protections, and (c) lead to the dissemination of best practices to guide respectful and non-coercive collection of accurate, standardized data relevant to maternal health outcomes.

6. Our AMA supports the development of a standardized definition of maternal mortality and the allocation of resources to states and Tribes to collect and analyze maternal mortality data (i.e., Maternal Mortality Review Committees and vital statistics) to enable stakeholders to better understand the underlying causes of maternal deaths and to inform evidence-based policies to improve maternal health outcomes and promote health equity.
7. Our AMA encourages hospitals, health systems, and state medical associations and national medical specialty societies to collaborate with non-clinical community organizations with close ties to minoritized and other at-risk populations to identify opportunities to best support pregnant persons and new families.

8. Our AMA encourages the development and funding of resources and outreach initiatives to help pregnant individuals, their families, their communities, and their workplaces to recognize the value of comprehensive prepregnancy, prenatal, peripartum, and postpartum care. These resources and initiatives should encourage patients to pursue both physical and behavioral health care, strive to reduce barriers to pursuing care, and highlight care that is available at little or no cost to the patient.

9. Our AMA supports adequate payment from all payers for the full spectrum of evidence-based prepregnancy, prenatal, peripartum, and postpartum physical and behavioral health care.

10. Our AMA encourages hospitals, health systems, and states to participate in maternal safety and quality improvement initiatives such as the Alliance for Innovation on Maternal Health program and state perinatal quality collaboratives.

11. Our AMA will advocate for increased access to risk-appropriate care by encouraging hospitals, health systems, and states to adopt verified, evidence-based levels of maternal care. Joint CMS/CSAPH Rep. 1, I-21.

(92) RESOLUTION 023 - ADVOCATING FOR COLLABORATION WITH PRIVATE INSURERS TO PROVIDE COVERAGE OF CLINICALLY VALIDATED SELF-MEASURED BLOOD MONITORING (SMBP) DEVICES AND DEVELOP PHYSICIAN COMPENSATION MODELS FOR SMBP RELATED CARE

RECOMMENDATION:


RESOLVED, That our AMA collaborates with private insurers to increase coverage of clinically validated self-measured blood pressure monitoring (SMBP) devices for patients with diagnosed hypertension in an effort to improve the management of hypertension; and be it further,

RESOLVED, That our AMA collaborates with private insurers to develop comprehensive insurer compensation models for physicians who spend time educating patients, and
managing patient hypertension with self-measured blood pressure monitoring (SMBP) devices.

VRC testimony was mixed. Your Reference Committee agrees with the House Coordination Committee’s decision to place Resolution 023 on the reaffirmation calendar. The AMA issued a joint statement with the American Heart Association in 2020 about self-measured blood pressure monitoring at home and additionally instituted an AMA M.A.P. BP program. We agree that this resolution is already covered under existing policy and AMA efforts. Your Reference Committee recommends that Policies D-480.991, H-185.951, and H-425.998 be reaffirmed in lieu of Resolution 023.

**Access to Medical Care D-480.991**

Our AMA shall work with the Centers for Medicare and Medicaid Services to maximize access to the devices and procedures available to Medicare patients by ensuring reimbursement at least covers the cost of said device or procedure. Res. 130, A-02; Reaffirmation A-04; Reaffirmed: CMS Rep. 1, A-14.

**Home Anti-Coagulation Monitoring H-185.951**

1. Our AMA encourages all third party payers to extend coverage and reimbursement for home monitors and supplies for home self-monitoring of anti-coagulation for all medically appropriate conditions.
2. Our AMA (a) supports the appropriate use of home self-monitoring of oral anticoagulation therapy and (b) will continue to monitor safety and effectiveness data, in particular cost-effectiveness data, specific to the United States on home management of oral anticoagulation therapy.
3. Our AMA will request a change in Centers for Medicare & Medicaid Services' regulations to allow a nurse, under physician supervision, to visit a patient who cannot travel, has no family who can reliably test, or is unable to test on his/her own to obtain and perform a protime/INR without restrictions. Res. 825, I-05; Modified and Reaffirmed: CSAPH Rep. 9, A-07; Appended: Res. 709, A-14.

**Pharmacist in Hypertension Screening H-425.998**

1. Physicians should encourage the establishment of adequate training programs in blood pressure measurement, under the supervision of qualified physicians or other qualified personnel, for pharmacists and other non-physicians in order to assure adequate personnel for hypertension screening programs.
2. The medical profession should participate in the development of programs which assure an adequate system for monitoring blood pressure measurement and referring patients when indicated to physicians.
3. Community programs should be established to educate the public on the importance of participation in screening programs and adherence to subsequently prescribed courses of therapy, with
periodic blood pressure measurement and evaluation of the
effectiveness of the therapeutic regimen by licensed physicians.

(4) The particular program to be implemented in any community
should receive the full support of the medical profession and be built
upon the existing community facilities and health personnel
resources, taking into consideration applicable state legal
restriction or requirements. BOT Rep. Q, A-77; Reaffirmed: CLRPD
Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed:

(93) RESOLUTION 027 - MITIGATING DRUNK DRIVING INJURIES AND
FATALITIES THROUGH ALTERNATIVE TRANSPORTATION PROGRAMS

RECOMMENDATION:

Policy H-425.993 be reaffirmed in lieu of Resolution 027.

RESOLVED, That our AMA amend Policy H-30.936 “Prevention of Impaired Driving” by
addition to read as follows; and be it further

Prevention of Impaired Driving, H-30.936

Legislation: Our AMA: (1) supports the development of model
legislation which would provide for school education programs to
teach adolescents about the dangers of drinking and driving and
which would mandate the following penalties when a driver under
age 21 drives with any blood alcohol level (except for minimal blood
alcohol levels, such as less than .02 percent, only from medications
or religious practices): (a) for the first offense - mandatory
revocation of the driver's license for one year and (b) for the second
offense - mandatory revocation of the driver's license for two years
or until age 21, whichever is greater; (2) urges state medical
associations to seek enactment of the legislation in their
legislatures; (3) urges all states to pass legislation mandating all
drivers convicted of first and multiple DUI offenses be screened for
alcoholism and provided with referral and treatment when indicated;
(4) urges adoption by all states of legislation calling for
administrative suspension or revocation of driver licenses after
conviction for driving under the influence, and mandatory
revocation after a specified number of repeat offenses; and (5)
encourages passage of state traffic safety legislation that mandates
screening for substance use disorder for all DUI offenders, with
those who are identified with substance use disorder being strongly
couraged and assisted in obtaining treatment from qualified
physicians and through state and medically certified facilities; and
(6) encourages government officials to establish, expand, and
continue maintenance of affordable, accessible, barrier-free, reliable, and preferably clean-energy public transportation to provide alternative transportation options for intoxicated drivers.

RESOLVED, That our AMA supports efforts towards increasing social acceptance, public awareness, accessibility, and safety of alternative transportation programs.

VRC testimony was in opposition to the resolution as written. Your Reference Committee agrees with testimony that the asks of this resolution are covered under existing policy. We agree that the evidence for alternative programs is mixed and not as strong as the resolution demonstrates. Your Reference Committee recommends Policy H-425.993 be reaffirmed in lieu of Resolution 027.

**Health Promotion and Disease Prevention H-425.993**

The AMA (1) reaffirms its current policy pertaining to the health hazards of tobacco, alcohol, accidental injuries, unhealthy lifestyles, and all forms of preventable illness; (2) advocates intensified leadership to promote better health through prevention; (3) believes that preventable illness is a major deterrent to good health and accounts for a major portion of our country's total health care expenditures; (4) actively supports appropriate scientific, educational and legislative activities that have as their goals: (a) prevention of smoking and its associated health hazards; (b) avoidance of alcohol abuse, particularly that which leads to accidental injury and death; (c) reduction of death and injury from vehicular and other accidents; and (d) encouragement of healthful lifestyles and personal living habits; (5) advocates that health be considered one of the goals in transportation planning and policy development including but not limited to the establishment, expansion, and continued maintenance of affordable, accessible, barrier-free, reliable, and preferably clean-energy public transportation; and (6) strongly emphasizes the important opportunity for savings in health care expenditures through prevention. Presidential Address, A-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CSA Rep. 8, A-03; Reaffirmed: BOT Rep. 8, I-06; Reaffirmed: CSAPH Rep. 01, A-16; Modified: Res. 923, I-19.

(94) **RESOLUTION 036 - CALL FOR MINIMUM STANDARD SUBWAY VENTILATION STANDARDS**

**RECOMMENDATION:**

Policy H-135.998 be **reaffirmed in lieu of Resolution 036**.

RESOLVED, That our AMA will support further research on safe levels of particulate matter in subway systems; and be it further
RESOLVED, That our AMA supports the development of minimum ventilation standards for subway cars and tunnels in conjunction with relevant stakeholders such as the Centers for Disease Control and Prevention, the Environmental Protection Agency, The National Institute for Occupational Safety and Health, and the Occupational Safety and Health Administration.

VRC testimony was mixed. Your Reference Committee agrees with testimony that existing policy H-135.998 covers the asks of the resolution to address air pollution for subway cars and tunnels. H-135.998 specifically includes “particulates” as addressed in this resolution and calls for the “Maximum feasible reduction of all forms of air pollution” which would include air pollution both outdoors and in facilities including subway tunnels. Your Reference Committee recommends Policy H-135.998 be reaffirmed in lieu of Resolution 036.

AMA Position on Air Pollution H-135.998

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

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

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

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


(95) RESOLUTION 039 - SUPPORT FOR RESEARCH ON THE EFFICACY OF WORKPLACE SUICIDE PREVENTION INTERVENTIONS

RECOMMENDATION:

Policy D-345.974 be reaffirmed in lieu of Resolution 039.

RESOLVED, That our AMA support research on the efficacy of workplace suicide prevention programs in occupations with access to lethal means and higher rates of burnout to reduce workplace suicide in the USA.
VRC testimony was mixed. Your Reference Committee agrees with testimony that the asks of the resolution are covered under existing policy D-345.974. This policy specifically calls for the AMA to “prioritize education and outreach to those populations at highest risk for suicide attempts, suicide completions, and self-injurious behavior.” People in occupations with access to lethal means are included within the highest risk population referenced in current AMA policy. In fact, current AMA policy is stronger than the proposed resolution as it promotes education rather than supporting only research on this topic. Your Reference Committee recommends Policy D-345.974 be reaffirmed in lieu of Resolution 039.

Awareness Campaign for 988 National Suicide Prevention Lifeline D-345.974

Our AMA will: (1) utilize their existing communications channels to educate the physician community and the public on the new 9-8-8 National Suicide Prevention Lifeline program; (2) work with the Federation and other stakeholders to advocate for adequate federal and state funding for the 9-8-8 system, including the development of model legislation; and (3) collaborate with the Substance Abuse and Mental Health Services Administration, the 9-8-8 partner community, and other interested stakeholders, to strengthen suicide prevention and mental health crisis services that prioritize education and outreach to those populations at highest risk for suicide attempts, suicide completions, and self-injurious behavior. Res. 423, A-22; Modified: Res. 908, I-22.

(96) RESOLUTION 045 - ADDRESSING TRANSPARENCY OF FUNDS OF CRISIS PREGNANCY CENTERS

RECOMMENDATION:

Policy H-420.954 be reaffirmed in lieu of Resolution 045.

RESOLVED, That our AMA advocates that Crisis Pregnancy Centers clearly and transparently disclose their current sources of private, state, and federal funding, as well as any changes to said funding; and be it further

RESOLVED, That our AMA advocates that Crisis Pregnancy Centers that do not adhere to policy H-420.954 and the currently proposed funding disclosure should lose eligibility for state and federal funding; and be it further

RESOLVED, That our AMA advocates supporting funding for legitimate reproductive health clinics and not Crisis Pregnancy Centers.

VRC testimony was supportive of reaffirmation. Your Reference Committee agrees with the House Coordination Committee that Policy H-420.954 covers the asks of this resolution. H-420.95 contains language about effective oversight and transparency in
funding and sponsorship relationships of reproductive health clinics, which adequately addresses the asks of the first and second Resolves. The policy also urges public funding of reproductive health clinics that follow specific guidelines consistent with the third Resolve. Your Reference Committee recommends Policy H-420.954 be reaffirmed in lieu of Resolution 045.

Truth and Transparency in Pregnancy Counseling Centers H-420.954

1. It is AMA’s position that any entity that represents itself as offering health-related services should uphold the standards of truthfulness, transparency, and confidentiality that govern health care professionals.

2. Our AMA urges the development of effective oversight for entities offering pregnancy-related health services and counseling.

3. Our AMA advocates that any entity offering crisis pregnancy services a. truthfully describe the services they offer or for which they refer—including prenatal care, family planning, termination, or adoption services—in communications on site and in their advertising, and before any services are provided to an individual patient; and b. be transparent with respect to their funding and sponsorship relationships.

4. Our AMA advocates that any entity licensed to provide medical or health services to pregnant women a. ensure that care is provided by appropriately qualified, licensed personnel; and b. abide by federal health information privacy laws.

5. Our AMA urges that public funding only support programs that provide complete, non-directive, medically accurate health information to support patients’ informed, voluntary decisions.


(97) RESOLUTION 064 - EXPANDING AUTOMATED EXTERNAL DEFIBRILLATOR PLACEMENT IN K-12 SCHOOLS, HEALTH CLUBS, AND GYM/RECREATIONAL EXERCISE FACILITIES

RECOMMENDATION:

Policy H-130.938 be reaffirmed in lieu of Resolution 064.

RESOLVED, That our AMA amend D-470.992 by addition and deletion to read as follows:

Implementation of Automated External Defibrillators in K-12 High-Schools, and College Sports Programs, Health Clubs, and Gym/Recreational Exercise Facilities to be Amended, D-470.992

Our AMA supports state legislation and/or state educational policies encouraging: (1) each K-12 high school, and college that
participates in interscholastic and/or intercollegiate athletic programs to have an automated external defibrillator and trained personnel on its premises and locations of events; and (2) health clubs and gyms/recreational exercise facilities have automated external defibrillators at all locations; and (2)(3) athletic coaches, sports medicine personnel, and student athletes to be trained and certified in cardiovascular-pulmonary resuscitation (CPR), automated external defibrillators (AED), basic life support, and recognizing the signs of sudden cardiac arrest; and (4) research efforts will be directed to identify gaps in public AED accessibility to guide optimal placement.

VRC testimony was mixed and mainly in support of reaffirmation. Your Reference Committee agrees with testimony that the asks of this resolution are covered by existing AMA policy and MSS Transmittal 191 “Increasing the Availability of Automated External Defibrillators”. We agree that widespread placement of automated external defibrillators is supported by current AMA policy and the asks of the resolution would not meaningfully change AMA advocacy on this issue. Your Reference Committee recommends Policy H-130.938 be reaffirmed in lieu of Resolution 064.

Cardiopulmonary Resuscitation (CPR) and Defibrillators H-130.938

Our AMA:
(1) supports publicizing the importance of teaching CPR, including the use of automated external defibrillation;
(2) strongly recommends the incorporation of CPR classes as a voluntary part of secondary school programs;
(3) encourages the American public to become trained in CPR and the use of automated external defibrillators;
(4) advocates the widespread placement of automated external defibrillators, including on all grade K-12 school campuses and locations at which school events are held;
(5) encourages all grade K-12 schools to develop an emergency action plan for sudden cardiac events;
(6) supports increasing government and industry funding for the purchase of automated external defibrillator devices;
(7) endorses increased funding for cardiopulmonary resuscitation and defibrillation training of community organization and school personnel;
(8) supports the development and use of universal connectivity for all defibrillators;
(9) supports legislation that would encourage high school students be trained in cardiopulmonary resuscitation and automated external defibrillator use;
(10) will update its policy on cardiopulmonary resuscitation and automated external defibrillators (AEDs) by endorsing efforts to promote the importance of AED use and public awareness of AED locations, by using solutions such as integrating AED sites into
widely accessible mobile maps and applications;  
(11) urges AED vendors to remove labeling from AED stations that  
stipulate that only trained medical professionals can use the  
defibrillators; and  
(12) supports consistent and uniform legislation across states for  
the legal protection of those who use AEDs in the course of  
attempting to aid a sudden cardiac arrest victim. CCB/CLRPD Rep.  
3, A-14; Appended: Res. 211, I-14; Modified: Res. 919, I-15;  
Appended: Res. 211, I-18.

(98) RESOLUTION 069 - ADDRESSING BARRIERS TO MEDICATION FOR  
ADDITION TREATMENT PRESCRIPTION AND ACCESS FOLLOWING THE  
DRUG ADDICTION TREATMENT ACT-WAIVER REMOVAL

RECOMMENDATION:

Policy D-95.968 be reaffirmed in lieu of Resolution 069.

RESOLVED, That our AMA support research involving both socioeconomic and provider- 
based barriers to implementation of medication for addiction treatment (MAT) for opioid  
use disorder (OUD) in light of removal of the Drug Addiction Treatment Act-waiver  
requirement.

VRC testimony was mixed. Your Reference Committee agrees with the House  
Coordination Committee that this resolution is reaffirmation of policy D-95.968, clause two.  
The resolution is not actionable because it asks for the AMA to support research. We  
recommend Policy D-95.968 be reaffirmed in lieu of Resolution 069.

Support the Elimination of Barriers to Medication-Assisted  
Treatment for Substance Use Disorder D-95.968

1. Our AMA will: (a) advocate for legislation that eliminates barriers  
to, increases funding for, and requires access to all appropriate  
FDA-approved medications or therapies used by licensed drug  
treatment clinics or facilities; and (b) develop a public awareness  
campaign to increase awareness that medical treatment of  
substance use disorder with medication-assisted treatment is a  
first-line treatment for this chronic medical disease.

2. Our AMA supports further research into how primary care  
practices can implement medication-assisted treatment (MAT) into  
their practices and disseminate such research in coordination with  
primary care specialties.

3. The AMA Opioid Task Force will increase its evidence-based  
educational resources focused on methadone maintenance therapy  
(MMT) and publicize those resources to the Federation. Res. 222,  
RESOLUTION 073 - AMERICAN INDIAN AND ALASKA NATIVE LANGUAGE REVITALIZATION AND ELDER CARE

RECOMMENDATION:

Policies H-350.976 and H-350.977 be reaffirmed in lieu of Resolution 073.

RESOLVED, That our AMA will study the 2022 White House Office of Science and Technology Policy Guidance for Federal Departments and Agencies on Indigenous Knowledge and support convention of healthcare organizations, tribal leaders, and tribal-serving organizations with focuses on, but not limited to:

a. Integrating Indigenous knowledge and cultural competence into health care services delivery for American Indian and Alaska Native patients living in rural, urban, and tribal areas
b. Identifying best practices for American Indian and Alaska Native elder health care, especially on language-concordant health care services
c. Assess the historical and ongoing economic impact of tribal set-asides in healthcare funding and funding opportunities for tribes in HRSA, IHS, and CMS grantmaking; and be it further

RESOLVED, That our AMA recognizes that access to language concordant services for AI/AN patients will require targeted investment as Indigenous languages in North America are threatened due to a complex history of removal and assimilation by state and federal actors; and be it further

RESOLVED, That our AMA will partner with stakeholder organizations to encourage advance care planning for American Indian and Alaska Native elders with incorporation of patients’ cultural values and priorities; and be it further

RESOLVED, That our AMA will support federal-tribal funding opportunities for American Indian and Alaska Native language revitalization efforts, especially those that increase health information resources and access to language-concordant health care services for American Indian and Alaska Native elders living on or near tribal lands.

VRC testimony was mixed. Your Reference Committee agrees with testimony that the asks of this resolution are covered by current policy and there is no evidence that existing policy is insufficient. Your Reference Committee recommends Policies H-350.976 and H-350.977 be reaffirmed in lieu of Resolution 073.

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 culturallynecessary 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.


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.

RESOLUTION 076 - COMMUNITY-BASED PREGNANCY SUPPORT FOR REFUGEE AND ASYLUM-SEEKING WOMEN

RECOMMENDATION:
Policy H-185.917 be reaffirmed in lieu of Resolution 076.

RESOLVED, That our AMA supports increased research funding evaluating the efficacy and impact of community-based support programs on large-scale birth and post-pregnancy outcomes for vulnerable populations.

VRC testimony was mixed. Your Reference Committee agrees with testimony that existing policy supports research and creation of programs mentioned in the resolution. We agree with the House Coordination Committee’s recommendation of reaffirmation of current policy H-185.917 Clauses 4, 7, and 8. Your Reference Committee recommends Policy H-185.917 be reaffirmed in lieu of Resolution 076.

Reducing Inequities and Improving Access to Insurance for Maternal Health Care H-185.917

1. Our AMA acknowledges that structural racism and bias negatively impact the ability to provide optimal health care, including maternity care, for people of color.
2. Our AMA encourages physicians to raise awareness among colleagues, residents and fellows, staff, and hospital administrators about the prevalence of racial and ethnic inequities and the effect on health outcomes, work to eliminate these inequities, and promote an environment of trust.
3. Our AMA encourages physicians to pursue educational opportunities focused on embedding equitable, patient-centered care for patients who are pregnant and/or within 12 months postpartum into their clinical practices and encourages physician leaders of health care teams to support similar appropriate professional education for all members of their teams.
4. Our AMA will continue to monitor and promote ongoing research regarding the impacts of societal (e.g., racism or unaffordable health insurance), geographical, facility-level (e.g., hospital quality), clinician-level (e.g., implicit bias), and patient-level (e.g., comorbidities, chronic stress or lack of transportation) barriers to optimal care that contribute to adverse and disparate maternal health outcomes, as well as research testing the effectiveness of interventions to address each of these barriers.
5. Our AMA will promote the adoption of federal standards for clinician collection of patient-identified race and ethnicity information in clinical and administrative data to better identify inequities. The federal data collection standards should be: (a) informed by research (including real-world testing of technical standards and standardized definitions of race and ethnicity terms to ensure that the data collected accurately reflect diverse populations and highlight, rather than obscure, critical distinctions that may exist within broad racial or ethnic categories), (b) carefully crafted in conjunction with clinician and patient input to protect patient privacy and provide non-discrimination protections, and (c) lead to the dissemination of best practices to guide respectful and
non-coercive collection of accurate, standardized data relevant to maternal health outcomes.

6. Our AMA supports the development of a standardized definition of maternal mortality and the allocation of resources to states and Tribes to collect and analyze maternal mortality data (i.e., Maternal Mortality Review Committees and vital statistics) to enable stakeholders to better understand the underlying causes of maternal deaths and to inform evidence-based policies to improve maternal health outcomes and promote health equity.

7. Our AMA encourages hospitals, health systems, and state medical associations and national medical specialty societies to collaborate with non-clinical community organizations with close ties to minoritized and other at-risk populations to identify opportunities to best support pregnant persons and new families.

8. Our AMA encourages the development and funding of resources and outreach initiatives to help pregnant individuals, their families, their communities, and their workplaces to recognize the value of comprehensive prepregnancy, prenatal, peripartum, and postpartum care. These resources and initiatives should encourage patients to pursue both physical and behavioral health care, strive to reduce barriers to pursuing care, and highlight care that is available at little or no cost to the patient.

9. Our AMA supports adequate payment from all payers for the full spectrum of evidence-based prepregnancy, prenatal, peripartum, and postpartum physical and behavioral health care.

10. Our AMA encourages hospitals, health systems, and states to participate in maternal safety and quality improvement initiatives such as the Alliance for Innovation on Maternal Health program and state perinatal quality collaboratives.

11. Our AMA will advocate for increased access to risk-appropriate care by encouraging hospitals, health systems, and states to adopt verified, evidence-based levels of maternal care. Joint CMS/CSAPH Rep. 1, I-21.

(101) RESOLUTION 088 - FAMILY AND INTIMATE PARTNER VIOLENCE AND ABUSE

RECOMMENDATION:

Policy H-515.965 be reaffirmed in lieu of Resolution 088.

RESOLVED, That our AMA amends Family and Intimate Partner Violence, H-515.965 by addition and deletion to include explicit mentions to emotional abuse as a form of intimate partner violence (IPV), the explicit identification, diagnosis, and treatment of perpetrators of IPV, including primary prevention strategies, and further research on emotional abuse, and IPV primary prevention strategies, as follows:
(1) Our AMA believes that all forms of family and intimate partner violence (IPV) including emotional abuse, sexual abuse, and physical abuse, are major public health issues and urges the profession, both individually and collectively, to work with other interested parties to prevent such violence and abuse and to address the needs of survivors. Physicians have a major role in lessening the prevalence, scope and severity of child maltreatment, intimate partner violence, and elder abuse, all of which fall under the rubric of family violence. To support physicians in practice, our AMA will continue to campaign against family violence and abuse, and remains open to working with all interested parties to address violence and abuse in US society.

(2) Our AMA believes that all physicians should be trained in issues of family and intimate partner violence through undergraduate and graduate medical education as well as continuing professional development. The AMA, working with state, county and specialty medical societies as well as academic medical centers and other appropriate groups such as the Association of American Medical Colleges, should develop and disseminate model curricula on violence abuse including emotional, sexual, and physical abuse for incorporation into undergraduate and graduate medical education, and all parties should work for the rapid distribution and adoption of such curricula. These curricula should include coverage of the diagnosis, treatment, and reporting of child maltreatment, intimate partner abuse and violence, and elder abuse, and provide training on interviewing techniques, risk assessment for those at risk of perpetrating or experiencing IPV, relationship health education for all patients, safety planning for those at risk of violence, the intersection of IPV risk factors with marginalized identity, and procedures to connect for linking with resources to assist survivors and abusers with resources appropriate to each. Our AMA supports the inclusion of questions on family violence issues, including all forms of abuse, on licensure and certification tests.

(3) The prevalence of family violence and abuse is sufficiently high and its ongoing character is such that physicians, particularly physicians providing primary care, will encounter survivors and perpetrators on a regular basis. Persons in clinical settings are more likely to have experienced intimate partner and family violence than non-clinical populations. Thus, to improve clinical services as well as the public health, our AMA encourages physicians to: (a) Routinely inquire about the relationship health and family violence abuse histories of their patients as this knowledge is essential for effective diagnosis and care; (b) Upon identifying patients currently
(1) Experiencing abuse or threats from intimate partners, assess and discuss safety issues with the patient before he or she leaves the office, working with the patient to develop a safety or exit plan for use in an emergency situation and making appropriate referrals to address intervention and safety needs as a matter of course; 

(c) Upon identifying patients at risk of perpetrating violence or abuse towards intimate partners, educate the patient on healthy relationships and the lifelong impacts that these behaviors can have on those around them, and refer and strongly encourage the patient to join community primary prevention programs; 

(cd) After diagnosing an abuseviolence-related problem, ensure to educate the patient about the spectrum of abuse including emotional abuse, and refer patients to appropriate medical or health care professionals and/or community-based trauma-specificinformed resources as soon as possible; 

(de) HaveKeep and maintain written lists of resources available for survivors of violence_and abuse, providing information on such matters as emergency shelter, medical assistance, mental health services, protective services and legal aid, as well as resources to educate and empower survivors; 

(ef) Screen patients for psychiatric sequelae of trauma caused by violence or abuse and make appropriate referrals for these conditions upon identifying a history of family or other interpersonal violence and abuse; 

(fg) Become aware ofSeek out local resources and referral sources that have expertise in dealing with trauma from IPV; 

(gh) Be alert to men presenting with injuries suffered as a result of intimate violence because these men may require intervention as either survivors or abusers themselves; 

(hi) Give due validation to the experience of IPV and of observed symptomatology as possible sequelae; 

(jj) Record a patient's IPV history, observed trauma potentially linked to IPV, and referrals made; 

(4) Within the larger community, our AMA: 

(a) Urges hospitals, community mental health agencies, and other helping professions to develop appropriate interventions for all survivors of intimate partner violence and preventative health education for all patients at risk of perpetrating violence and abuse. Such interventions might include individual and group counseling efforts, support groups, and shelters. 

(b) Believes it is critically important that programs be available for survivors and perpetrators of intimate violence. 

(c) Believes that state and county medical societies should convene or join state and local health departments, criminal justice and
social service agencies, and local school boards to collaborate in the development and support of violence control and prevention activities. (d) Believes it is critically important to recognize emotional abuse as a more pervasive and common form of IPV than physical or sexual abuse, and to promote research to better understand emotional abuse, its prevention, and its impacts on the mental health of patients. (e) Believes it is critically important to pursue research to deepen our understanding of the psychological and behavioral risk factors and sequelae associated with perpetration of violence and abuse in addition to primary prevention already mentioned in policy.

VRC testimony was opposed to the resolution as written. Your Reference Committee agrees with testimony that Resolution 088 is reaffirmation of existing policy H-515.965 as emotional abuse is widely known to be a type of intimate partner violence. Your Reference Committee feels this resolution would not lead to meaningful change in AMA’s advocacy efforts and recommends Policy H-515.965 be reaffirmed in lieu of Resolution 088.

**Family and Intimate Partner Violence H-515.965**

(1) Our AMA believes that all forms of family and intimate partner violence (IPV) are major public health issues and urges the profession, both individually and collectively, to work with other interested parties to prevent such violence and to address the needs of survivors. Physicians have a major role in lessening the prevalence, scope and severity of child maltreatment, intimate partner violence, and elder abuse, all of which fall under the rubric of family violence. To support physicians in practice, our AMA will continue to campaign against family violence and remains open to working with all interested parties to address violence in US society.

(2) Our AMA believes that all physicians should be trained in issues of family and intimate partner violence through undergraduate and graduate medical education as well as continuing professional development. The AMA, working with state, county and specialty medical societies as well as academic medical centers and other appropriate groups such as the Association of American Medical Colleges, should develop and disseminate model curricula on violence for incorporation into undergraduate and graduate medical education, and all parties should work for the rapid distribution and adoption of such curricula. These curricula should include coverage of the diagnosis, treatment, and reporting of child maltreatment, intimate partner violence, and elder abuse and provide training on interviewing techniques, risk assessment, safety planning, and procedures for linking with resources to assist survivors. Our AMA
supports the inclusion of questions on family violence issues on licensure and certification tests.

(3) The prevalence of family violence is sufficiently high and its ongoing character is such that physicians, particularly physicians providing primary care, will encounter survivors on a regular basis. Persons in clinical settings are more likely to have experienced intimate partner and family violence than non-clinical populations. Thus, to improve clinical services as well as the public health, our AMA encourages physicians to: (a) Routinely inquire about the family violence histories of their patients as this knowledge is essential for effective diagnosis and care; (b) Upon identifying patients currently experiencing abuse or threats from intimates, assess and discuss safety issues with the patient before he or she leaves the office, working with the patient to develop a safety or exit plan for use in an emergency situation and making appropriate referrals to address intervention and safety needs as a matter of course; (c) After diagnosing a violence-related problem, refer patients to appropriate medical or health care professionals and/or community-based trauma-specific resources as soon as possible; (d) Have written lists of resources available for survivors of violence, providing information on such matters as emergency shelter, medical assistance, mental health services, protective services and legal aid; (e) Screen patients for psychiatric sequelae of violence and make appropriate referrals for these conditions upon identifying a history of family or other interpersonal violence; (f) Become aware of local resources and referral sources that have expertise in dealing with trauma from IPV; (g) Be alert to men presenting with injuries suffered as a result of intimate violence because these men may require intervention as either survivors or abusers themselves; (h) Give due validation to the experience of IPV and of observed symptomatology as possible sequelae; (i) Record a patient's IPV history, observed traumata potentially linked to IPV, and referrals made; (j) Become involved in appropriate local programs designed to prevent violence and its effects at the community level.

(4) Within the larger community, our AMA: (a) Urges hospitals, community mental health agencies, and other helping professions to develop appropriate interventions for all survivors of intimate violence. Such interventions might include individual and group counseling efforts, support groups, and shelters. (b) Believes it is critically important that programs be available for survivors and perpetrators of intimate violence. (c) Believes that state and county medical societies should convene or
join state and local health departments, criminal justice and social
service agencies, and local school boards to collaborate in the
development and support of violence control and prevention
activities. (5) With respect to issues of reporting, our AMA strongly
supports mandatory reporting of suspected or actual child
maltreatment and urges state societies to support legislation
mandating physician reporting of elderly abuse in states where such
legislation does not currently exist. At the same time, our AMA
oppose the adoption of mandatory reporting laws for physicians
treating competent, non-elderly adult survivors of intimate partner
violence if the required reports identify
survivors. Such laws violate basic tenets of medical ethics. If and
where mandatory reporting statutes dealing with competent adults
are adopted, the AMA believes the laws must incorporate
provisions that: (a) do not require the inclusion of
survivors’ identities; (b) allow competent adult survivors to opt out
of the reporting that reports be made to public health agencies
for surveillance purposes only; (d) contain a sunset mechanism;
and (e) evaluate the efficacy of those laws. State societies are
encouraged to ensure that all mandatory reporting laws contain
adequate protections for the reporting physician and to educate
physicians on the particulars of the laws in their states.
(6) Substance abuse and family violence are clearly connected. For
this reason, our AMA believes that:
(a) Given the association between alcohol and family violence,
physicians should be alert for the presence of one behavior given a
diagnosis of the other. Thus, a physician with patients with alcohol
problems should screen for family violence, while physicians with
patients presenting with problems of physical or sexual abuse
should screen for alcohol use. (b) Physicians should avoid the
assumption that if they treat the problem of alcohol or substance
use and abuse they also will be treating and possibly preventing
family violence. (c) Physicians should be alert to the association,
especially among female patients, between current alcohol or drug
problems and a history of physical, emotional, or sexual abuse. The
association is strong enough to warrant complete screening for past
or present physical, emotional, or sexual abuse among patients
who present with alcohol or drug problems. (d) Physicians should
be informed about the possible pharmacological link between
amphetamine use and human violent behavior. The suggestive
evidence about barbiturates and amphetamines and violence
should be followed up with more research on the possible causal
connection between these drugs and violent behavior. (e) The
notion that alcohol and controlled drugs cause violent behavior is pervasive among physicians and other health care providers. Training programs for physicians should be developed that are based on empirical data and sound theoretical formulations about the relationships among alcohol, drug use, and violence. CSA Rep. 7, I-00 Reaffirmed: CSAPH Rep. 2, I-09 Modified: CSAPH Rep. 01, A-19.

(102) MSS LGBTQ WIM CME REPORT A - ACCURACY AND AWARENESS FOR SEX REPRESENTATION IN MEDICAL TEXTBOOKS

RECOMMENDATION:

Policies D-295.312, D-295.310, and H-160.991 be reaffirmed in lieu of MSS LGBTQ WIM CME Report A.

The Committee on LGBTQ Affairs, Committee on Women in Medicine, and Committee on Medical Education recommend that the following is adopted as amended by addition and deletion and the remainder of this report be filed.

RESOLVED, Our AMA supports increased female sex, intersex, and transgender representation in representation of variation in genital anatomy within medical textbooks education resources, including but not limited to anatomical images showing variations in sex characteristics as well as genital diversity across the spectrum of gender affirming care specific and nonspecific content; and be it further RESOLVED, Our AMA recognizes the need for an accurate depiction of female sex supports increased representation and accuracy of vulvar and clitoral anatomy in medical education resources, including, but not limited to, depictions of variation in length, morphology, and neuro-vasculature of the clitoris and vulva length, morphology, nerves, and vasculature, and variations in medical textbooks, as well as an increase in number of clitoral and vulvar anatomic images; and be it further RESOLVED, Our AMA supports increased representation of gender diverse individuals and people with variation in sex characteristics in the full spectrum of medical education materials, including but not limited to case-based discussions, clinical skills sessions, and board-style questions.

VRC testimony was limited and mixed. Your Reference Committee agrees with testimony that policies D-295.312, D-295.310, and H-160.991 cover the recommendations of this report. We support the spirit of the resolution, but the proposed amendments to the referred resolution will not result in actionable policy. Your Reference Committee
Medical Spectrum of Gender D-295.312

Given the medical spectrum of gender identity and sex, our AMA: (1) will work with appropriate medical organizations and community based organizations to inform and educate the medical community and the public on the medical spectrum of gender identity; (2) will educate state and federal policymakers and legislators on and advocate for policies addressing the medical spectrum of gender identity to ensure access to quality health care; and (3) affirms that an individual’s genotypic sex, phenotypic sex, sexual orientation, gender and gender identity are not always aligned or indicative of the other, and that gender for many individuals may differ from the sex assigned at birth. Res. 003, A-17; Modified: Res. 005, I-18.

Sex and Gender Based Medicine in Clinical Education D-295.310

1. Our AMA will collaborate with Accreditation Council for Graduate Medical Education, Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, Association of American Medical Colleges, and Accreditation Council for Continuing Medical Education to disseminate the work produced by medical schools participating in the Accelerating Change in Medical Education consortium and distribute pertinent information and a comprehensive bibliography about the influence that sex and gender have upon clinical medicine.
2. Our AMA will work collaboratively with the Liaison Committee on Medical Education and other interested organizations for the inclusion of sex- and gender-based differences within the curricular content for medical school accreditation. Res. 958, I-17; Appended: Res. 306, A-18.

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.


(103) MSS MIC CGPH REPORT A - MENTAL HEALTH REFORM IN PRISONS
RECOMMENDATION:

Policy D-430.997 be reaffirmed in lieu of MSS MIC CGPH Report A.

Your Minority Issues Committee and Committee on Global and Public Health recommend adoption of the following recommendations in lieu of the proposed Resolve clause and the remainder of this report be filed:

RESOLVED, That our AMA supports conducting mental health screening, with validated measures, of all individuals entering or reentering the prison system in order to improve diversion practices as well as treatment access; and be it further

RESOLVED, That our AMA advocates for the continuation of mental health care for individuals post-incarceration and the assessment of mental health needs by screening individuals upon release; and be it further

RESOLVED, That our AMA supports continued research into other methods, including but not limited to universalized method and implementation of effective screening to identify mental health needs of incarcerated and post-incarcerated individuals.

VRC testimony was limited. Your Reference Committee agrees that National Commission on Correctional Health Care (NCCHC) guidelines are used as evidence to support the need for mental health screenings in prisons and existing policy D-430.997 already explicitly supports the NCCHC guidance including on mental health services. Further, this Report states “Subject-matter experts have been advocating for mental health screening in prisons and jails for decades.” It is clear that the need for mental health resources in prisons and jails continues to exist; However, it is unclear that these proposed additions to AMA Policy would alter AMA advocacy in this area or that further AMA advocacy would significantly benefit initiatives by other invested federal organizations. Your Reference Committee recommends that Policy D-430.997 be reaffirmed in lieu of MSS MIC CGPH Report A.

Support for Health Care Services to Incarcerated Persons D-430.997

Our AMA will:

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