Abridged Handbook Document is currently laid out for letter-sized paper; change as desired.

Note: this table includes only the recommendations from reports and the resolve statements from resolutions. The table can be sorted in Word using either the “committee” column or the “item” column (or both). Alternatively, the table can be copied to a spreadsheet and manipulated there. The table includes all items of business excepting informational reports. Only the primary sponsor, usually the submitter, is listed for resolutions.

| **Cmte\*** | **Item** | **Sponsor†** | **Title** | **Recommendations or Resolves** |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| .Con | BOT 01 | n/a | Opposition to Requirements for Gender-Based Treatments for Athletes | 1. That our American Medical Association (AMA) oppose mandatory testing, medical treatment or surgery for transgender athletes and athletes with Differences of Sex Development (DSD), and affirm that these athletes be permitted to compete in alignment with their identity; (New HOD Policy)  2. That our AMA oppose the use of specific hormonal guidelines to determine gender classification for athletic competitions. (New HOD Policy)  3. That our AMA oppose physician participation in any practices intended to officially certify or confirm an athlete’s gender for the purposes of satisfying third party requirements. (New HOD Policy) |
| .Con | BOT 03 | n/a | Delegate Apportionment and Pending Members | Your Board of Trustees recommends that Policy G-600.016 be rescinded and the remainder of the report filed. |
| .Con | BOT 04 | n/a | Preserving Access to Reproductive Health Services | The Board recommends that the following recommendations be adopted and that the remainder of the report be filed.  1. That Policy H-5.993, “Right to Privacy in Termination of Pregnancy” be amended by addition and deletion as follows:  The AMA reaffirms existing policy that (1) abortion is the practice of medicine and requires the personal performance or supervision by an appropriately licensed physician ~~a medical procedure and should be performed only by a duly licensed physician~~ in conformance with standards of good medical practice and the laws of the state; ~~and~~ (2) no physician or other professional personnel shall be required to perform an act violative of good medical judgment or personally held moral principles. In these circumstances ~~good medical practice requires only that the~~ a physician or other professional may withdraw from the case so long as the withdrawal is consistent with good medical practice and ethical guidance on the exercise of conscience;~~.~~ (3) ~~T~~the AMA further supports the position that the ~~early~~ termination of pregnancy is a medical matter between the patient and the physician, subject to the physician's clinical judgment, the patient's informed consent, and the ability to perform the procedure safely ~~availability of appropriate facilities~~. (Modify Current HOD Policy)  2. That Policies H-5.995, “Abortion,” and Policy H-5.983, “Pregnancy Termination,” be rescinded. (Rescind HOD Policy)  3. That Policy H-5.990, “Policy on Abortion,” be amended by addition as follows:  The issue of personal support of or opposition to abortion is a matter for members of the AMA to decide individually, based on personal values or beliefs. The AMA will take no action which may be construed as an attempt to alter or influence the personal views of individual physicians regarding abortion procedures. (Modify HOD Policy)  4. That Policy H-5.982, “Late-Term Pregnancy Termination Techniques,” be amended by addition and deletion as follows:  (1) The term “partial birth abortion” is not a medical term. The AMA will use the term “intact dilatation and extraction” (or intact D&X) to refer to a specific procedure comprised of the following elements: deliberate dilatation of the cervix, usually over a sequence of days; instrumental or manual conversion of the fetus to a footling breech; breech extraction of the body excepting the head; and partial evacuation of the intracranial contents of the fetus to effect vaginal delivery of a dead but otherwise intact fetus. This procedure is distinct from dilatation and evacuation (D&E) procedures more commonly used to induce abortion after the first trimester. Because 'partial birth abortion' is not a medical term it will not be used by the AMA. (2) According to the scientific literature, there does not appear to be any identified situation in which intact D&X is the only appropriate procedure to induce abortion, and ethical concerns have been raised about intact D&X. The AMA recommends that the procedure not be used unless alternative procedures pose materially greater risk to the woman. The physician must, however, retain the discretion to make that judgment, acting within standards of good medical practice and in the best interest of the patient. (3) The viability of the fetus and the time when viability is achieved may vary with each pregnancy. ~~In the second trimester w~~When viability may be in question, it is the physician who should determine the viability of a specific fetus, using the latest available diagnostic technology. (4) ~~In recognition of the constitutional principles regarding the right to an abortion articulated by the Supreme Court in Roe v. Wade, and~~ In keeping with the science and values of medicine, the AMA recommends that abortions not be performed in the third trimester except in cases of serious fetal anomalies incompatible with life. Although third-trimester abortions can be performed to preserve the life or health of the mother, they are, in fact, generally not necessary for those purposes. Except in extraordinary circumstances, maternal health factors which demand termination of the pregnancy can be accommodated without sacrifice of the fetus, and the near certainty of the independent viability of the fetus argues for ending the pregnancy by appropriate delivery. (Modify Current HOD Policy)  5. Policy D-5.999, “Preserving Access to Reproductive Health Services,” be amended by deletion as follows:  Our AMA: (1) recognizes that healthcare, including reproductive health services like contraception and abortion, is a human right; (2) opposes limitations on access to evidence-based reproductive health services, including fertility treatments, contraception, and abortion; (3) will work with interested state medical societies and medical specialty societies to vigorously advocate for broad, equitable access to reproductive health services, including fertility treatments, contraception, and abortion; (4) supports shared decision-making between patients and their physicians regarding reproductive healthcare; (5) opposes any effort to undermine the basic medical principle that clinical assessments, such as viability of the pregnancy and safety of the pregnant person, are determinations to be made only by healthcare professionals with their patients; (6) opposes the imposition of criminal and civil penalties or other retaliatory efforts against patients, patient advocates, physicians, other healthcare workers, and health systems for receiving, assisting in, referring patients to, or providing reproductive health services; (7) will advocate for legal protections for patients who cross state lines to receive reproductive health services, including contraception and abortion, or who receive medications for contraception and abortion from across state lines, and legal protections for those that provide, support, or refer patients to these services~~; and (8) will review the AMA policy compendium and recommend policies which should be amended or rescinded to reflect these core values, with report back at the 2022 Interim Meeting~~. (Modify Current HOD Policy) |
| .Con | BOT 05 | n/a | Towards Diversity and Inclusion: A Global Non-discrimination Policy Statement and Benchmark for our AMA | • That our AMA reaffirm its commitment to complying with all applicable laws, rules or regulations against discrimination on the basis of protected characteristics, including Title VII of the Civil Rights Act, The Age Discrimination in Employment Act, and the Americans with Disabilities Act, among other federal, state and local laws. (New HOD Policy)  • That our AMA reaffirm Policy H-65.965, “Support of Human Rights and Freedom,” as an overarching non-discrimination policy for the Association. (Reaffirm HOD Policy)  • That our AMA reaffirm Policy H-65.988, “Organizations Which Discriminate,” Policy G-630.040, “Principles on Corporate Relationships,” and Policy H-65.950, “Terms and Language in Policies Adopted to Protect Populations from Discrimination and Harassment.” (Reaffirm HOD Policy)  • That our AMA provide updates on its comprehensive diversity and inclusion strategy as part of the annual Board report to the AMA House of Delegates on health equity. (Directive to Take Action) |
| .Con | BOT 12 | n/a | Terms and Language in Policies Adopted to Protect Populations from Discrimination and Harassment | That our AMA amend Policy H-65.950 by addition to read as follows:  Our AMA recognizes broad and evolving protected personal characteristics spanning identity, origin, and status that include those outlined by regulatory authorities overlapping with those prioritized by AMA. To prevent misunderstandings and facilitate collaboration to move medicine forward, AMA ~~recommends~~ acknowledges preferred terminology for protected personal characteristics outlined in the actual sources used in the 2021 AMA Strategic Plan to Embed Racial Justice and Advance Health Equity and the AMA-AAMC Advancing Health Equity such as the CDC’s Health Equity Guiding Principles for Inclusive Communication ~~to~~ that may be used in AMA policies and position statements. (Modify Current HOD Policy) |
| .Con | CCB 01 | n/a | Updated Bylaws: Delegate Apportionment and Pending Members | The Council on Constitution and Bylaws recommends that the following amendments to the AMA Bylaws be adopted and that the remainder of this report be filed. Adoption requires the affirmative vote of two-thirds of the members of the House of Delegates present and voting.  **2.1 Constituent Associations.** Each recognized constituent association granted representation in the House of Delegates is entitled to delegate representation based on the number of seats allocated to it by apportionment, and such additional delegate seats as may be provided under Bylaw 2.1.~~1.~~2. Only one constituent association from each U.S. state, commonwealth, territory, or possession shall be granted representation in the House of Delegates.  **2.1.1 Apportionment.** The apportionment of delegates from each constituent association is one delegate for each 1,000, or fraction thereof, active constituent and active direct members of the AMA within the jurisdiction of each constituent association, as recorded by the AMA as of December 31 of each year.  **2.1.1.1** ~~The December 31 count will include pending members for purposes of apportionment; however, pending members shall not be recounted the following year absent membership renewal.~~ For 2023 only, the apportionment shall include the greatest of the following numbers: the number of delegates apportioned at the rate of 1 per 1000, or fraction thereof, AMA members consistent with Bylaw 2.1.1; the number of delegates apportioned for 2022 so long as that figure is not greater than 2 more than the number apportioned at the rate of 1 per 1000, or fraction thereof, AMA members; or for societies that would lose more than 5 delegates from their 2022 apportionment, the number of delegates apportioned at the rate of 1 per 1000, or fraction thereof, AMA members plus 5. Bylaw 2.1.1.1 will sunset as of December 31, 2023 ~~the close of business of the 2022 Interim Meeting unless the House of Delegates acts to retain it~~.  **2.1.1.2 Effective Date.** Such apportionment shall take effect on January 1 of the following year and shall remain effective for one year.  **2.1.1.2.1 Retention of Delegate.** If the membership information as recorded by the AMA as of December 31 warrants a decrease in the number of delegates representing a constituent association, the constituent association shall be permitted to retain the same number of delegates, without decrease, for one additional year, if it promptly files with the AMA a written plan of intensified AMA membership development activities among its members. At the end of the one year grace period, any applicable decrease will be implemented.  **2.1.1.2.1.1**~~A constituent association that shows a membership loss for 2020 and/or 2021 shall be granted an additional one year grace period beyond the one year grace period set forth in 2.1.1.2.1 without a decrease in the number of delegates. This Bylaw will sunset at the close of the 2022 Interim Meeting.~~ A constituent society may not benefit from both this provision and 2.1.1.1. Bylaw 2.1.1.2.1.1 will sunset as of December 31, 2023.  \*\*\*  **2.2 National Medical Specialty Societies.** The number of delegates representing national medical specialty societies shall equal the number of delegates representing the constituent societies.Each national medical specialty society granted representation in the House of Delegates is entitled to delegate representation based on the number of seats allocated to it by apportionment, and such additional delegate seat as may be provided under Bylaw 2.2.2. The total number of delegates apportioned to national medical specialty societies under Bylaw 2.2.1 shall be adjusted to be equal to the total number of delegates apportioned to constituent societies under sections 2.1.1 and 2.1.1.~~1~~2.1 using methods specified in AMA policy. (Modify Bylaws) |
| .Con | CEJA 01 | n/a | Amendment to Opinion 4.2.7, “Abortion” | With all of the foregoing considerations in mind, the Council on Ethical and Judicial Affairs recommends that Opinion 4.2.7, “Abortion,” be amended as follows and the remainder of this report be filed:  Abortion is a safe and common medical procedure, about which thoughtful individuals hold diverging, yet equally deeply held and well-considered perspectives. Like all health care decisions, a decision to terminate a pregnancy should be made privately within the relationship of trust between patient and physician in keeping with the patient’s unique values and needs and the physician’s best professional judgment.  The *Principles of Medical Ethics* of the AMA ~~do not prohibit a physician from performing an abortion~~ permit physicians to perform abortions in keeping with good medical practice ~~under circumstances that do not violate the law~~.  (Modify HOD/CEJA Policy) |
| .Con | CEJA 02 | n/a | Amendment to Opinion 10.8, “Collaborative Care” | In light of the foregoing, the Council on Ethical and Judicial Affairs recommends that Opinion 10.8, “Collaborative Care,” be amended as follows and the remainder of this report be filed:  In health care, teams that collaborate effectively can enhance the quality of care for individual patients. By being prudent stewards and delivering care efficiently, teams also have the potential to expand access to care for populations of patients. Such teams are defined by their dedication to providing patient-centered care, ~~protecting the integrity of the patient-physician relationship,~~ sharing mutual respect and trust, communicating effectively, sharing accountability and responsibility, and upholding common ethical values as team members.  Health care teams often include members of multiple health professions, including physicians, nurse practitioners, physician assistants, pharmacists, physical therapists, and care managers among others. To foster the trust essential to healing relationships between patients and physicians or nonphysician practitioners, all members of the team should be candid about their professional credentials, their experience, and the role they will play in the patient’s care.  An effective team requires the vision and direction of an effective leader. In medicine, this means having a clinical leader who will ensure that the team as a whole functions effectively and facilitates decision-making. Physicians are uniquely situated to serve as clinical leaders. By virtue of their thorough and diverse training, experience, and knowledge, physicians have a distinctive appreciation of the breadth of health issues and treatments that enables them to synthesize the diverse professional perspectives and recommendations of the team into an appropriate, coherent plan of care for the patient.  As clinical leaders within health care teams, physicians individually should:   1. Model ethical leadership by: 2. Understanding the range of their own and other team members' skills and expertise and roles in the patient's care 3. Clearly articulating individual responsibilities and accountability 4. Encouraging insights from other members and being open to adopting them and 5. Mastering broad teamwork skills   (b) Promote core team values of honesty, discipline, creativity, humility and curiosity and commitment to continuous improvement.  (c) Help clarify expectations to support systematic, transparent decision making.  (d) Encourage open discussion of ethical and clinical concerns and foster a team culture in which each member’s opinion is heard and considered and team members share accountability for decisions and outcomes.  (e) Communicate appropriately with the patient and family, ~~and~~ respecting the~~ir~~ unique relationship of patient and family as members of the team.  (f) Assure that all team members are describing their profession and role.  As leaders within health care institutions, physicians individually and collectively should:  (~~f~~g) Advocate for the resources and support health care teams need to collaborate effectively in providing high-quality care for the patients they serve, including education about the principles of effective teamwork and training to build teamwork skills.  (~~g~~h)Encourage their institutions to identify and constructively address barriers to effective collaboration.  (~~hi~~) Promote the development and use of institutional policies and procedures, such as an institutional ethics committee or similar resource, to address constructively conflicts within teams that adversely affect patient care.  (j) Promote a culture of respect, collegiality and transparency among all health care personnel. (Modify HOD/CEJA Policy) |
| .Con | CEJA 03 | n/a | Pandemic Ethics and the Duty of Care | In light of these considerations, the Council on Ethical and Judicial Affairs recommends that Opinion 8.3, “Physician Responsibility in Disaster Response and Preparedness,” be amended by addition and deletion as follows and the remainder of this report be filed:  8.3 Physician Responsibility in Disaster Response and Preparedness  Whether at the national, regional, or local level, responses to disasters require extensive involvement from physicians individually and collectively. Because of their commitment to care for the sick and injured, individual physicians have an obligation to provide urgent medical care during disasters. This obligation holds even in the face of greater than usual risks to physicians’ own safety, health, or life.  ~~However, the physician workforce is not an unlimited resource. Therefore, when providing care in a disaster with its inherent dangers, physicians also have an obligation to evaluate the risks of providing care to individual patients versus the need to be available to provide care in the future.~~  The duty to treat is foundational to the profession of medicine but is not absolute. The health care work force is not an unlimited resource and must be preserved to ensure that care is available in the future. For their part, physicians have a responsibility to protect themselves, as well as a duty of solidarity to colleagues to share risks and burdens in a public health crisis. So too, health care institutions have responsibilities to support and protect health care professionals and to apportion the risks and benefits of providing care as equitably as possible.  Many physicians owe competing duties of care as medical professionals and as individuals outside their professional roles. In a public health crisis, institutions should provide support to enable physicians to meet compelling personal obligations without undermining the fundamental obligation to patient welfare. In exceptional circumstances, when arrangements to allow the physician to honor both obligations are not feasible, it may be ethically acceptable for a physician to limit participating in care, provided that the institution has made available another mechanism for meeting patients’ needs. Institutions should strive to be flexible in supporting physicians in efforts to address such conflicts. The more immediately relevant a physician’s clinical expertise is to the urgent needs of the moment and the less that alternative care mechanisms are available, the stronger the professional obligation to provide care despite competing obligations.  With respect to disaster, whether natural or manmade, individual physicians should:  (a) Take appropriate advance measures, including acquiring and maintaining appropriate knowledge and skills to ensure they are able to provide medical services when needed.  Collectively, physicians should:  (b) Provide medical expertise and work with others to develop public health policies that:  (i) Are designed to improve the effectiveness and availability of medical services during a disaster  (ii) Are based on sound science  (iii) Are based on respect for patients  (c) Advocate for and participate in ethically sound research to inform policy decisions.  (Modify HOD/CEJA Policy) |
| .Con | Res. 001 | Young Physicians Section | Updating Physician Job Description for Disability Insurance | RESOLVED, That our American Medical Association study the most effective approach to developing specialty-specific job descriptions that reflect the true physical and cognitive demands of each given specialty for use in the Occupational Information System under development by the Social Security Administration so as to ensure that physician disability policies are robust and protective if a coverage trigger occurs. (Directive to Take Action) |
| .Con | Res. 002 | Resident and Fellow Section | Assessing the Humanitarian Impact of Sanctions | RESOLVED, That our American Medical Association recognize that economic sanctions can negatively impact health and exacerbate humanitarian crises (New HOD Policy); and be it further  RESOLVED, That our AMA support efforts to study the humanitarian impact of economic sanctions imposed by the United States. (New HOD Policy) |
| .Con | Res. 003 | Medical Student Section | Indigenous Data Sovereignty | RESOLVED, That our American Medical Association recognize that American Indian and Alaska Native Tribes and Villages are sovereign governments that should be consulted before the conduct of research specific to their members, lands, and properties (New HOD Policy); and be it further  RESOLVED, That our AMA support that American Indian and Alaska Native (AI/AN) Tribes and Villages’ Institutional Review Boards and research departments retain the right to oversee and regulate the collection, ownership, and management of research data generated by their members, and that individual members of AI/AN Tribes and Villages retain their autonomy and privacy regarding research data shared with researchers, AI/AN Tribes and Villages, and governments, consistent with existing protections under 45 CFR 46 (New HOD Policy); and it be further  RESOLVED, That our AMA encourage the use and regular review of data-sharing agreements for all studies between academic medical centers and American Indian and Alaska Native Tribes and Villages (New HOD Policy); and be it further  RESOLVED, That our AMA encourage the National Institutes of Health and other stakeholders to provide flexible funding to American Indian and Alaska Native Tribes and Villages for research efforts, including the creation and maintenance of Institutional Review Boards (IRBs). (New HOD Policy) |
| .Con | Res. 004 | Medical Student Section | Supporting Intimate Partner and Sexual Violence Safe Leave | RESOLVED, That our American Medical Association recognize the positive impact of paid safe leave on public health outcomes and support legislation that offers paid and unpaid safe leave (New HOD Policy); and be it further  RESOLVED, That our AMA amend policy H-420.979, “AMA Statement on Family and Medical Leave,” to promote inclusivity by addition to read as follows:  AMA Statement on Family and Medical Leave, H-420.979  Our AMA supports policies that provide employees with reasonable job security and continued availability of health plan benefits in the event leave by an employee becomes necessary due to documented medical conditions and/or concerns for safety. Such policies should provide for reasonable periods of paid or unpaid: (1) medical leave for the employee, including pregnancy; (2) maternity leave for the employee-mother; (3) leave if medically appropriate to care for a member of the employee's immediate family, i.e., a spouse or children; and (4) leave for adoption or for foster care leading to adoption; and (5) safe leave provisions for those experiencing any instances of violence, including but not limited to intimate partner violence, sexual violence or coercion, and stalking. Such periods of leave may differ with respect to each of the foregoing classifications, and may vary with reasonable categories of employers. Such policies should encourage voluntary programs by employers and may provide for appropriate legislation (with or without financial assistance from government). Any legislative proposals will be reviewed through the Association's normal legislative process for appropriateness, taking into consideration all elements therein, including classifications of employees and employers, reasons for the leave, periods of leave recognized (whether paid or unpaid), obligations on return from leave, and other factors involved in order to achieve reasonable objectives recognizing the legitimate needs of employees and employers. (Modify Current HOD Policy) |
| .Con | Res. 005 | Medical Student Section | Strengthening Interview Guidelines for American Indian and Alaska Native Medical School, Residency, and Fellowship Applicants | RESOLVED, That our American Medical Association work with the Accreditation Council for Graduate Medical Education, the National Residency Matching Program, the Association of American Medical Colleges, and other interested parties to eliminate questioning about or discrimination based on American Indian and Alaska Native blood quantum during the medical school, residency, and fellowship application process. (Directive to Take Action) |
| .Con | Res. 006 | Medical Student Section | Assessing the Humanitarian Impact of Sanctions | RESOLVED, That our American Medical Association recognize that economic sanctions can negatively impact health and exacerbate humanitarian crises (New HOD Policy); and be it further  RESOLVED, That our AMA support legislative and regulatory efforts to study the humanitarian impact of economic sanctions imposed by the United States. (New HOD Policy) |
| .Con | Res. 007 | International Medical Graduates Section | Consent for Sexual and Reproductive Healthcare | RESOLVED, That our American Medical Association work with state and county medical societies to advocate for legislation and legal protections: 1) allowing minors (age 12 or above) to consent for sexual and reproductive health care; 2) allowing minors to consent for prenatal care and delivery services; and 3) protecting physician autonomy to provide sexual and reproductive health care with minor consent, without parental consent. (Directive to Take Action) |
| .Con | Res. 008 | Colorado | Support for Physicians Practicing Evidence-Based Medicine in a  Post Dobbs Era | RESOLVED, That our American Medical Association Task Force developed under HOD Policy G-605.009, “Establishing A Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted,” provide policy and strategies to support physicians individually and through their medical organizations when they are required by medical and ethical standards of care to act against state and federal laws (Directive to Take Action); and be it further  RESOLVED, That our AMA work to provide support, including legal support through the AMA Litigation Center, as may be appropriate, to physicians that are targeted for practicing in accordance with accepted standards of medical care and medical ethics in the face of legal constraint or any other disciplinary action; and be it further  RESOLVED, That our AMA advocate for affirmative protections for “conscientious provision” of care in accordance with accepted standards of medical care and medical ethics in hostile environments on par with protection of “conscientious objection.” (Directive to Take Action) |
| .Con | Res. 009 | Mississippi | Medical Decision-Making Autonomy of the Attending Physician | RESOLVED, That our American Medical Association advocate that no matter what may change in regard to a physician’s employment or job status, that there is a sacred relationship between an attending physician and his/her patient that leads the patient’s attending physician to hold the ultimate authority in the medical decision-making that affects that patient, and be it further  RESOLVED, That our AMA advocate strongly that if there is a unique circumstance that puts the attending physician’s care into question by a hospital administrator of any sort such as listed above but certainly not limited to that list– physician or not- in the event of a disagreement between an administrator and the attending physician regarding a decision one would call a mere judgment call, the onus would be on the administrator to prove to an ethics committee why the attending physician is wrong prior to anyone having the authority to overturn or overrule the order of the physician attending the patient directly (Directive to Take Action); and be it further  RESOLVED, That our AMA reaffirm that the responsibility for the care of the individual patient lies with a prudent and responsible attending physician, and that his/her decisions should not easily be overturned unless there has been an egregious and dangerous judgment error made, and this would still call for an ethics committee consult in that instance (Reaffirm HOD Policy); and be it further  RESOLVED, That our AMA aggressively pursue any encroachment of administrators upon the medical decision making of attending physicians that is not in the best interest of patients as strongly as possible, for there is no more sacred relationship than that of a doctor and his/her patient, and as listed above, first, we do no harm. (Directive to Take Action) |
| .Con | Res. 010 | Medical Student Section | Amending AMA Bylaw 2.12.2, Special Meetings of the House of Delegates | RESOLVED, That our American Medical Association update its Special Meeting procedures by updating the Special Meetings Bylaws as follows:   1. Specification that the processes used to determine which items of business meet or do not meet the purpose for which the Special Meeting is called shall be published online and electronically sent to all members of the House of Delegates prior to the initiation of the Special Meeting. 2. Specification concerning the processes for how formal feedback may be submitted and reviewed prior to, during, and after the conclusion of the Special Meeting. 3. Description of how a Special Meeting report, detailing the processes that were used in the meeting, along with a summary of the concerns and suggestions submitted by the formal feedback mechanism, shall be produced by the Speakers and Board of Trustees following each Special Meeting that occurs. 4. Description of how, after each Special Meeting, a committee that is representative of House membership shall be formed for the purpose of (a) reviewing the Special Meeting and (b) proposing any improvements to the processes for future Special Meetings. (Modify Bylaws) |
| .Con | Res. 011 | Washington | Advocating for the Informed Consent for Access to Transgender Health Care | RESOLVED, That our American Medical Association advocate and encourage the adoption of an informed consent model when determining coverage for transgender health care services. (Directive to Take Action) |
| .Con | Res. 012 | Medical Student Section | Guidelines on Chaperones for Sensitive Exams | RESOLVED, That our American Medical Association ask the Council on Ethical and Judicial Affairs to consider amending E-1.2.4, “Use of Chaperones in Code of Medical Ethics,” to ensure that it is most in line with the current best practices and potentially considers the following topics: a) opt-out chaperones for breast, genital, and rectal exams; b) documentation surrounding the use or not-use of chaperones; c) use of chaperones for patients without capacity; d) asking patients’ consent regarding the gender of the chaperons and attempting to accommodate that preference as able. (Directive to Take Action) |
| .Con | Res. 013 | Medical Student Section | Hospital Bans on Trial of Labor After Cesarean | RESOLVED, That our American Medical Association encourage hospitals that can provide basic maternal care as defined by the American College of Obstetrics and Gynecology not to prohibit trial of labor after cesarean (TOLAC) (New HOD Policy); and be it further  RESOLVED, That our AMA encourage hospitals that do not have resources to perform TOLAC to assist in the transfer of care of patients who desire TOLAC to a hospital that is equipped to perform TOLAC. (New HOD Policy) |
| .Con | Res. 014 | Medical Student Section | Gender-Neutral Language in AMA Policy | RESOLVED, That our American Medical Association (1) revise all relevant policies to utilize gender-neutral pronouns and other non-gendered language in place of gendered language where such text inappropriately appears, and (2) utilize gender-neutral pronouns and other non-gendered language in future policies where gendered language does not specifically need to be used. (Directive to Take Action) |
| .Con | Res. 015 | Washington | Restricting Derogatory and Stigmatizing Language of ICD-10 Codes | Resolved**,** That our American Medical Association collaborate with the World Health Organization to implement destigmatizing terminology in ICD-10 that will cover gender-affirming health care services as well as human immunodeficiency virus pre-exposure prophylaxis services and medications. (Directive to Take Action) |
| B | Res. 201 | American Association of Clinical Urologists | Physician Reimbursement for Interpreter Services | RESOLVED, That our American Medical Association prioritize physician reimbursement for interpreter services and advocate for legislative and/or regulatory changes to federal health care programs such as Medicare, Medicare Advantage plans, Tricare, Veterans Administration, etc., for payment for such services (Directive to Take Action); and be it further  RESOLVED, That our AMA develop model state legislation for physician reimbursement for interpreter services for commercial health plans, worker compensation plans, Medicaid, Medicaid managed care plans, etc., for payment for such services. (Directive to Take Action) |
| B | Res. 202 | Young Physicians Section | Advocating for State GME Funding | RESOLVED, That our American Medical Association publicize best practice examples of state-funded Graduate Medical Education positions and develop model state legislation where appropriate. (Directive to Take Action) |
| B | Res. 203 | Missouri | International Medical Graduate Employment | RESOLVED, That our American Medical Association support federal legislation that reduces the paperwork burden on hiring of International Medical Graduates in rural communities. (New HOD Policy) |
| B | Res. 204 | Missouri | Elimination of Seasonal Time Change | RESOLVED, That our American Medical Association work with state medical associations to enact state legislation in support of remaining in the Standard Time Zone year-round (Directive to Take Action); and be it further  RESOLVED, That our AMA urge Congress to repeal the federal law establishing the annual advancement of time known as “Daylight Saving Time” and leave the U.S. on standard time year-round. (Directive to Take Action) |
| B | Res. 205 | Missouri | Waiver of Due Process Clauses | RESOLVED, That our American Medical Association support legislation that bans the use of “Waiver of Due Process” provisions within employment contracts and declares such current provisions to be declared void. (New HOD Policy) |
| B | Res. 206 | Resident and Fellow Section | The Shortage of Bedside Nurses and Intersection with Concerns in Nurse Practitioner Training | RESOLVED, That our American Medical Association study, and encourage relevant advocacy organizations to study, the links between the bedside nursing shortage, expansion of nurse practitioner programs, and the impact of this connection on patient health outcomes (Directive to Take Action); and be it further  RESOLVED, That our AMA reaffirm existing policies H-160.947, Physician Assistants and Nurse Practitioners, and H-35.996, Status and Utilization of New or Expanding Health Professionals in Hospitals. (Reaffirm HOD Policy) |
| B | Res. 207 | Resident and Fellow Section | Preserving Physician Leadership in Patient Care | RESOLVED, That our American Medical Association create a national targeted ad campaign to educate the public about the training pathway of physicians compared to non-physician providers (Directive to Take Action); and be it further  RESOLVED, That our AMA reaffirm our opposition to physicians being referred to as “providers” in healthcare settings (New HOD Policy); and be it further  RESOLVED, That our AMA conduct a review of the AMA policy compendium and replace conflicting policies referring to physicians as “providers” with the term “physician” when appropriate and report back at the 2023 Annual Meeting. (Directive to Take Action) |
| B | Res. 208 | Resident and Fellow Section | Comparing Student Debt, Earnings, Work Hours, and Career Satisfaction Metrics in Physicians v. Other Health Professionals | RESOLVED, That our American Medical Association’s advocacy efforts be informed by the fact that student debt burden is higher for physicians when compared to physician assistants and nurse practitioners (Directive to Take Action); and be it further  RESOLVED, That our AMA work with relevant stakeholders to study: (a) how total career earnings of physicians compare to those physician assistants and nurse practitioners in order to specifically discern if there is a financial disincentive to becoming a physician, considering the relatively high student debt burden and work hours of physicians; (b) if resident physicians provide a net financial benefit for hospitals and healthcare institutions; (c) best practices for increasing resident physician compensation so that their services may be more equitably reflected in their earnings; and (d) burnout metrics using a standardized system to compare differences among physicians, physician assistants and nurse practitioners (Directive to Take Action); and be it further  RESOLVED, That our AMA recognize that burnout-centered metrics do not fully characterize work-life balance, particularly for individuals with varying socioeconomic, racial and/or sexual minoritized backgrounds (New HOD Policy); and be it further  RESOLVED, That our AMA seek to publish its findings in a peer-reviewed medical journal. (Directive to Take Action) |
| B | Res. 209 | Resident and Fellow Section | Comprehensive Solutions for Medical School Graduates Who Are Unmatched or Did Not Complete Training | RESOLVED, That our American Medical Association work with US Centers for Medicare and Medicaid Services and other relevant stakeholders to create a commission to estimate future physician workforce needs and suggest re-allocation of available residency funding and available first-year positions accordingly (Directive to Take Action); and be it further  RESOLVED, That our AMA work with relevant stakeholders to study the possibility of alternative pathways to ACGME certification of training, ABMS board certification, and medical practice for unmatched medical school graduates. (Directive to Take Action) |
| B | Res. 210 | Resident and Fellow Section | Elimination of Seasonal Time Changes and Establishment of Permanent Standard Time | RESOLVED, That our American Medical Association support the elimination of seasonal time changes (New HOD Policy); and be it further  RESOLVED, That our AMA support the adoption of year-round standard time. (New HOD Policy) |
| B | Res. 211 | Resident and Fellow Section | Illicit Drug Use Harm Reduction Strategies | RESOLVED, That our American Medical Association amend current policy D-95.987, “Prevention of Drug-Related Overdose,” by addition to read as follows:  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.  5. Our AMA will implement an education program for patients with substance use disorder and their family/caregivers to increase understanding of the increased risk of adverse outcomes associated with having a substance use disorder and a serious respiratory illness such as COVID-19.  6. Our AMA supports efforts to increase access to fentanyl test strips and other drug checking supplies for purposes of harm reduction. (Modify Current HOD Policy) |
| B | Res. 212 | Medical Student Section | SNAP Expansion for DACA Recipients | RESOLVED, That our American Medical Association actively support expansion of SNAP to Deferred Action Childhood Arrivals (DACA) recipients who would otherwise qualify. (Directive to Take Action) |
| B | Res. 213 | New York | Hazard Pay During a Disaster Emergency | RESOLVED, That our American Medical Association work with the federation of medicine to advocate for state or federal programs that would provide hazard pay bonuses to physicians and other healthcare staff delivering care during a state or federal disaster emergency. (Directive to Take Action) |
| B | Res. 214 | Georgia | Universal Good Samaritan Statute | RESOLVED, That our American Medical Association help protect patients in need of emergency care and protect physicians and other responders by advocating for a national “universal” Good Samaritan Statute (Directive to Take Action); and be it further  RESOLVED, That our AMA advocate for the unification of the disparate statutes by creation of a national standard via either federal legislation or through policy directed by the Department of Health and Human Services [HHS] to specify terms that would protect rescuers from legal repercussion as long as the act by the rescuer meets the specified universal minimal standard of conduct and the good faith requirement, regardless of the event location; thus, effectively eliminating variations in the state statutes to facilitate the intent of the Good Samaritan statutes removing barriers that could impede the prompt rendering of emergency care. (Directive to Take Action) |
| B | Res. 215 | International Medical Graduates Section | Eliminating Practice Barriers for Immigrant Physicians During Public Health Emergencies | RESOLVED, That our American Medical Association advise the state medical boards and other stakeholders to allow physicians in the health professional shortage areas to have temporary access to all unique and expedited licensing options, both inside and outside of the state of their practice during public health emergencies, to facilitate workforce utilization at the time of critical shortage (Directive to Take Action); and be it further  RESOLVED, That our AMA advocate at the state and national level and advise the Department of Labor and the Department of Homeland Security to allow temporary provisions for such licensing inclusions for the physicians on a Visa during public health emergencies. (Directive to Take Action) |
| B | Res. 216 | American Society of Addiction Medicine | Expanding Parity Protections and Coverage of Mental Health and Substance Use Disorder Care in Medicare | RESOLVED, That our American Medical Association amend policy H-185.974, “Parity for Mental Illness, Alcoholism, and Related Disorders in Medical Benefits Programs,” by addition and deletion to read as follows:  **Parity for Mental ~~Illness~~ Health~~, Alcoholism,~~ and ~~Related~~ Substance Use Disorders in Health Insurance ~~Medical Benefits~~ Programs H-185.974**  1. Our AMA supports parity of coverage for mental ~~illness, alcoholism,~~ health~~,~~ and substance use~~, and eating~~ disorders.  2. Our AMA supports federal legislation, standards, policies, and funding that expand the parity and non-discrimination protections of the Paul Wellstone and Peter Domenici Mental Health Parity and Addiction Equity Act of 2008 to Medicare (Parts A, B, C, and D).  3. Our AMA supports federal legislation, standards, policies, and funding that require Medicare coverage (Parts A, B, C, and D) of all levels of mental health and substance use disorder care, consistent with nationally recognized medical professional organization level of care criteria for mental health or substance use disorders. (Modify Current HOD Policy) |
| B | Res. 217 | Mississippi | Restrictions on the Ownership of Hospitals by Physicians | RESOLVED, That our American Medical Association advocate to alleviate any restriction upon physicians from owning, constructing and/or expanding any hospital facility type - in the name of patient safety, fiscal responsibility, transparency and in acknowledgment of physicians everywhere who have given of themselves valiantly in the name of patient care. (Directive to Take Action) |
| B | Res. 218 | Mississippi | Screening and Approval Process for the Over-the-Counter Sale of Substances with Potential for Recreational Use and Abuse | RESOLVED, That our American Medical Association advocate for the implementation of a national impact on substance abuse by working on model state legislation for state level screening and approval programs to fall under the authority of the State Health Officer which would bestow the authority on his/her office to approve or deny the over-the-counter availability and/or sales of any substance with the potential to be recreationally used and/or abused based on anecdotal, scientific or any other relevant and available evidence to help determine such approval or denial. An appeals process, should one be necessary, would be available by way of appeal to the Board of Health directly by the manufacturer or distributor of such substance that was denied by the State Health Officer initially (Directive to Take Action); and be it further  RESOLVED, That our AMA work with stakeholders to create a public education campaign regarding these unregulated substances. (Directive to Take Action) |
| B | Res. 219 | Mississippi | Hold Accountable the Regulatory Bodies, Hospital Systems, Staffing Organizations, Medical Staff Groups, and Individual Physicians Supporting Systems of Care Promoting Direct Supervision of Emergency Departments by Nurse Practitioners | RESOLVED, That, in accordance with Centers for Medicare & Medical Services regulations and standards of practice for emergency medicine as defined by ACEP and AAEM, our American Medical Association hold accountable the regulatory bodies, hospital systems, staffing organizations, medical staff groups, and individual physicians supporting systems of care that promote direct supervision of emergency departments by nurse practitioners. (New HOD Policy) |
| B | Res. 220 | Mississippi | Extend Telemedicine to Out of State Enrolled College Students to Avoid Emergency Room and Inpatient Psychiatric Hospitalizations when in Crisis | RESOLVED, That our American Medical Association work with state medical associations, the American Psychiatric Association, the American Osteopathic Association, and the Federation of State Medical Boards to advocate to Congress that legislation be introduced and passed to extend telemedicine coverage for out of state enrolled college and graduate-level students with an established physician-patient relationship to avoid emergency room and inpatient psychiatric hospitalizations. (Directive to Take Action) |
| B | Res. 221 | Medical Student Section | Development and Implementation of Recommendations for Responsible Media Coverage of Opioid Overdoses | RESOLVED, That our American Medical Association encourage the Centers for Disease Control and Prevention, in collaboration with other public and private organizations, to develop recommendations or best practices for media coverage and portrayal of opioid overdoses. (New HOD Policy) |
| B | Res. 222 | Washington | Allocate Opioid Funds to Train More Addiction Treatment Physicians | RESOLVED, That our American Medical Association amend Policy H-95.918, “Holding the Pharmaceutical Industry Accountable for Opioid-Related Costs,” by addition to read as follows:  Our AMA will advocate that any monies paid to the states, received as a result of a settlement or judgment, or other financial arrangement or agreement as a result of litigation against pharmaceutical manufacturers, distributors, or other entities alleged to have engaged in unethical and deceptive misbranding, marketing, and advocacy of opioids, be used exclusively for research, education, prevention, and treatment of overdose, opioid use disorder, and pain, as well as expanding physician training opportunities to provide clinical experience in the treatment of opioid use disorders. (Modify Current HOD Policy) |
| B | Res. 223 | Association for Clinical Oncology | Criminalization of Pregnancy Loss as the Result of Cancer Treatment | RESOLVED, That our American Medical Association advocate that pregnancy loss as a result of medically necessary treatment for cancer shall not be criminalized for physicians or patients (Directive to Take Action); and  RESOLVED, That our AMA advocate that physicians should not be held civilly liable for pregnancy loss as a result of treatment for cancer. (Directive to Take Action) |
| B | Res. 224 | Association for Clinical Oncology | Fertility Preservation | RESOLVED, That our American Medical Association advocate for state legislation requiring payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed treating physician (Directive to Take Action); and be it further  RESOLVED, That our AMA advocate that “fertility preservation therapy services” should include cryopreservation of embryos, sperm, and oocytes (Directive to Take Action); and be it further  RESOLVED, That our AMA advocate against the prosecution of physicians for eliminating or transporting unused embryos created during and subsequent to the fertility preservation process. (Directive to Take Action) |
| B | Res. 225 | Medical Student Section | Drug Policy Reform | RESOLVED, That our American Medical Association advocate for federal and state reclassification of drug possession offenses as civil infractions and the corresponding reduction of sentences and penalties for individuals currently incarcerated, monitored, or penalized for previous drug-related felonies (Directive to Take Action); and be it further  RESOLVED, That our AMA support federal and state efforts to expunge criminal records for drug possession upon completion of a sentence or penalty at no cost to the individual (New HOD Policy); and be it further  RESOLVED, That our AMA support federal and state efforts to eliminate incarceration-based penalties for persons under parole, probation, pre-trial, or other criminal supervision for drug possession. (New HOD Policy) |
| B | Res. 226 | Medical Student Section | Support for Mental Health Courts | RESOLVED, That AMA Policy H-100.955, Support for Drug Courts, be amended by addition and deletion to read as follows:  **Support for Mental Health ~~Drug~~ Courts, H-100.955**  Our AMA: (1) supports the establishment and use of mental health ~~drug~~ courts, including drug courts and sobriety courts, as an effective method of intervention for individuals with mental illness involved in the justice system within a comprehensive system of community-based services and supports ~~addictive disease who are convicted of nonviolent crimes~~; (2) encourages legislators to establish mental health ~~drug~~ courts at the state and local level in the United States; and (3) encourages mental health ~~drug~~ courts to rely upon evidence-based models of care for those who the judge or court determine would benefit from intervention rather than incarceration. (Modify Current HOD Policy) |
| B | Res. 227 | Women Physicians Section | Access to Methotrexate Based on Clinical Decisions | RESOLVED, That our American Medical Association work to create a formal process to review pharmaceutical practices related to refusal of methotrexate and other drugs on the basis that it could be used off-label for pregnancy termination (Directive to Take Action); and be it further  RESOLVED, That our AMA work to provide educational guidance on state-specific laws that have impacted the distribution of methotrexate given post Dobbs vs. Jackson Women’s Health Organization restrictions. (Directive to Take Action) |
| C | CME 01 | n/a | The Impact of Private Equity on Medical Training | The Council on Medical Education therefore recommends that the following recommendations be adopted, and the remainder of this report be filed. That our AMA:   1. Affirm that an institution or medical education training program academic mission should not be compromised by a clinical training site’s fiduciary responsibilities to an external corporate or for-profit entity. (New HOD Policy) 2. Encourage GME training institutions, programs, and relevant stakeholders to:    1. demonstrate transparency on mergers and closures, especially as it relates to private equity acquisition of GME programs and institutions, and demonstrate institutional accountability to their trainees by making this information available to current and prospective trainees;    2. uphold comprehensive policies which protect trainees, including those who are not funded by Medicare dollars, to ensure the obligatory transfer of funds after institution closure;    3. empower designated institutional officials (DIOs) to be involved in institutional decision-making to advance such transparency and accountability in protection of their residents, fellows, and physician faculty;    4. develop educational materials that can help trainees better understand the business of medicine, especially at the practice, institution, and corporate levels;    5. develop policies highlighting the procedures and responsibilities of sponsoring institutions regarding the unanticipated catastrophic loss of faculty or clinical training sites and make these policies available to current and prospective GME learners. (Directive to Take Action) 3. Encourage necessary changes in Public Service Loan Forgiveness Program (PSLF) to allow medical students and physicians to enroll in the program even if they receive some or all of their training at a for-profit or governmental institution. (Directive to Take Action) 4. Support publicly funded independent research on the impact that private equity has on graduate medical education. (New HOD Policy) 5. Encourage physician associations, boards, and societies to draft policy or release their own issue statements on private equity to heighten awareness among the physician community. (Directive to Take Action) 6. Encourage physicians who are contemplating corporate investor partnerships to consider the ongoing education and welfare for trainee physicians who train under physicians in that practice, including the financial implications of existing funding that is used to support that training. (Directive to Take Action) 7. Amend Policy D-310.948 “Protection of Resident and Fellow Training in the Case of Hospital or Training Program Closure” by addition to read as follows:   Our AMA: (6) will continue to work with ACGME, interested specialty societies, and others to monitor issues, collect data, and share information related to training programs run by corporate and nonprofit entities and their effect on medical education. (Modify HOD Policy)   1. Reaffirm the following policies:    * H-310.904 “Graduate Medical Education and the Corporate Practice of Medicine”    * H-310.943 “Closing of Residency Programs”    * H-310.929 “Principles for Graduate Medical Education"    * H-215.981 “Corporate Practice of Medicine” (Reaffirm HOD policy) 2. Rescind AMA Policy D-310.947 as having been accomplished by this report. (Rescind HOD policy) |
| C | CME 02 | n/a | Mitigating Demographic and Socioeconomic Inequities in the Residency and Fellowship Selection Process | The Council on Medical Education therefore recommends that the following recommendations be adopted and the remainder of this report be filed:   1. That our AMA encourage medical schools, medical honor societies, and residency/fellowship programs to work toward ethical, equitable, and transparent recruiting processes, which are made available to all applicants. (New HOD Policy) 2. That AMA Policy D-200.985, “Strategies for Enhancing Diversity in the Physician Workforce,” be amended by addition and deletion, to read as follows:   Our AMA will recommend that medical school admissions committees and residency/fellowship programs use holistic assessments of ~~admission~~ applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education with the goal of improving health care for all communities. (Modify Current HOD Policy)   1. That our AMA advocate for residency and fellowship programs to avoid using objective criteria available in the Electronic Residency Application Service (ERAS) application process as the sole determinant for deciding which applicants to offer interviews. (Directive to Take Action) 2. That our AMA advocate to remove membership in medical honor societies as a mandated field of entry on the Electronic Residency Application Service (ERAS)—thereby limiting its use as an automated screening mechanism—and encourage applicants to share this information within other aspects of the ERAS application. (Directive to Take Action) 3. That our AMA advocate for and support innovation in the undergraduate medical education to graduate medical education transition, especially focusing on the efforts of the Accelerating Change in Medical Education initiative, to include pilot efforts to optimize the residency/fellowship application and matching process. (New HOD Policy) 4. That our AMA monitor use of novel online assessments for sampling personal characteristics for the purpose of medical school admissions or residency/fellowship selection and consider their impact on equity and diversity of the physician workforce.. (New HOD Policy) 5. That AMA Policy D-295.963(5), “Continued Support for Diversity in Medical Education,” be rescinded, as having been fulfilled through this report:   Our AMA will: … ~~work with appropriate stakeholders to study reforms to mitigate demographic and socioeconomic inequities in the residency and fellowship selection process, including but not limited to the selection and reporting of honor society membership and the use of standardized tools to rank applicants, with report back to the House of Delegates~~. (Rescind HOD Policy) |
| C | Res. 301 | Resident and Fellow Section | Increasing Musculoskeletal Education in Primary Care Specialties and Medical School Education Through Inclusion of Osteopathic Manual Therapy Education | RESOLVED, That our American Medical Association continue to support equal treatment of osteopathic students, trainees and physicians in the residency application cycle and workplace through continued education on the training of osteopathic physicians (New HOD Policy); and be it further  RESOLVED, That our AMA encourage education on the benefits of evidence-based Osteopathic Manual Therapy for musculoskeletal conditions in medical education of allopathic students and in primary care residencies. (New HOD Policy) |
| C | Res. 302 | Medical Student Section | Expanding Employee Leave to Include Miscarriage and Stillbirth | RESOLVED, That our American Medical Association amend Policy H-405.960, “Policies for Parental, Family, and Medical Necessity Leave,” by addition and deletion to read as follows:  Policies for Parental, Family and Medical Necessity Leave H-405.960  AMA adopts as policy the following guidelines for, and encourages the implementation of, Parental, Family and Medical Necessity Leave for Medical Students and Physicians:  1. Our AMA urges medical schools, residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement.  2. Recommended components of parental leave policies for medical students and physicians include: (a) duration of leave allowed before and after delivery; (b) category of leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for continuation of insurance benefits during leave, and who pays the premium; (e) whether sick leave and vacation time may be accrued from year to year or used in advance; (f) how much time must be made up in order to be considered board eligible; (g) whether make-up time will be paid; (h) whether schedule accommodations are allowed; ~~and~~ (i) leave policy for adoption; and (j) leave policy for miscarriage or stillbirth.  3. AMA policy is expanded to include physicians in practice, reading as follows: (a) residency program directors and group practice administrators should review federal law concerning maternity leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled; (b) staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other physicians' workloads, particularly in residency programs; and (c) physicians should be able to return to their practices or training programs after taking parental leave without the loss of status.  4. Our AMA encourages medical schools, residency programs, specialty boards, and medical group practices to incorporate into their parental leave policies a six-week minimum leave allowance, with the understanding that no parent should be required to take a minimum leave.  5. Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave.  6. Medical students and physicians who are unable to work because of pregnancy, childbirth, and other related medical conditions should be entitled to such leave and other benefits on the same basis as other physicians who are temporarily unable to work for other medical reasons.  7. Residency programs should develop written policies on parental leave, family leave, and medical leave for physicians. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) duration of leave allowed after miscarriage or stillbirth ; ~~(c)~~(d) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); ~~(d)~~(e) whether leave is paid or unpaid; ~~(e)~~(f) whether provision is made for continuation of insurance benefits during leave and who pays for premiums; ~~(f)~~(g) whether sick leave and vacation time may be accrued from year to year or used in advance; ~~(g)~~(h) extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; ~~(h)~~(i) how time can be made up in order for a resident physician to be considered board eligible; ~~(i)~~(j) what period of leave would result in a resident physician being required to complete an extra or delayed year of training; ~~(j)~~(k) whether time spent in making up a leave will be paid; and ~~(k)~~(l) whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling.  8. Our AMA endorses the concept of equal parental leave for birth, stillbirth, miscarriage, and adoption as a benefit for resident physicians, medical students, and physicians in practice regardless of gender or gender identity.  9. Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs.  10. Physicians should be able to return to their practices or training programs after taking parental leave, family leave, or medical leave without the loss of status.  11. Residency program directors must assist residents in identifying their specific requirements (for example, the number of months to be made up) because of leave for eligibility for board certification and must notify residents on leave if they are in danger of falling below minimal requirements for board eligibility. Program directors must give these residents a complete list of requirements to be completed in order to retain board eligibility.  12. Our AMA encourages flexibility in residency training programs, incorporating parental leave and alternative schedules for pregnant house staff.  13. In order to accommodate leave protected by the federal Family and Medical Leave Act, our AMA encourages all specialties within the American Board of Medical Specialties to allow graduating residents to extend training up to 12 weeks after the traditional residency completion date while still maintaining board eligibility in that year.  14. These policies as above should be freely available online and in writing to all applicants to medical school, residency or fellowship. (Modify Current HOD Policy); and be it further  RESOLVED, That due to the prevalence of miscarriage and stillbirth and the need for physical and psychological healing afterwards, our AMA amend Policy H-420.979 “AMA Statement on Family and Medical Leave,” by addition to read as follows:  AMA Statement on Family and Medical Leave H-420.979  Our AMA supports policies that provide employees with reasonable job security and continued availability of health plan benefits in the event leave by an employee becomes necessary due to documented medical conditions. Such policies should provide for reasonable periods of paid or unpaid:  (1) medical leave for the employee, including pregnancy~~;~~, miscarriage, and stillbirth;  (2) maternity leave for the employee-mother;  (3) leave if medically appropriate to care for a member of the employee's immediate family, i.e., a spouse or children; and  (4) leave for adoption or for foster care leading to adoption. Such periods of leave may differ with respect to each of the foregoing classifications, and may vary with reasonable categories of employers. Such policies should encourage voluntary programs by employers and may provide for appropriate legislation (with or without financial assistance from government). Any legislative proposals will be reviewed through the Association's normal legislative process for appropriateness, taking into consideration all elements therein, including classifications of employees and employers, reasons for the leave, periods of leave recognized (whether paid or unpaid), obligations on return from leave, and other factors involved in order to achieve reasonable objectives recognizing the legitimate needs of employees and employers. (Modify Current HOD Policy) |
| C | Res. 303 | Medical Student Section | Medical Student Leave Policy | RESOLVED, That our American Medical Association amend policy H-405.960 “Policies for Parental, Family and Medical Necessity Leave” by addition and deletion to read as follows:  Policies for Parental, Family and Medical Necessity Leave, H-405.960  AMA adopts as policy the following guidelines for, and encourages the implementation of, Parental, Family and Medical Necessity Leave for Medical Students and Physicians:  1. Our AMA urges ~~medical schools,~~ residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement.  2. Recommended components of parental leave policies for ~~medical students and~~ physicians include: (a) duration of leave allowed before and after delivery; (b) category of leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for continuation of insurance benefits during leave, and who pays the premium; (e) whether sick leave and vacation time may be accrued from year to year or used in advance; (f) how much time must be made up in order to be considered board eligible; (g) whether make-up time will be paid; (h) whether schedule accommodations are allowed; and (i) leave policy for adoption.  3. AMA policy is expanded to include physicians in practice, reading as follows: (a) residency program directors and group practice administrators should review federal law concerning maternity leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled; (b) staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other physicians' workloads, particularly in residency programs; and (c) physicians should be able to return to their practices or training programs after taking parental leave without the loss of status.  4. Our AMA encourages medical schools, residency programs, specialty boards, and medical group practices to incorporate into their parental leave policies a six-week minimum leave allowance, with the understanding that no parent should be required to take a minimum leave.  5. Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave.  6. Medical students and physicians who are unable to work because of pregnancy, childbirth, and other related medical conditions should be entitled to such leave and other benefits on the same basis as other physicians who are temporarily unable to work for other medical reasons.  7. Residency programs should develop written policies on parental leave, family leave, and medical leave for physicians. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); (d) whether leave is paid or unpaid; (e) whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (f) whether sick leave and vacation time may be accrued from year to year or used in advance; (g) extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (h) how time can be made up in order for a resident physician to be considered board eligible; (i) what period of leave would result in a resident physician being required to complete an extra or delayed year of training; (j) whether time spent in making up a leave will be paid; and (k) whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling.  8. Medical schools should develop written policies on parental leave, family leave, and medical leave for medical students. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) extended leave for medical students with extraordinary and long-term personal or family medical tragedies, without loss of previously accepted medical school seats, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (d) how time can be made up in order for a medical students to be eligible for graduation without delays; (e) what period of leave would result in a medical student being required to complete an extra or delayed year of training; and (f) whether schedule accommodations are allowed, such as modified rotation schedules, no night duties, and flexibility with academic testing schedules.  ~~8.~~ 9.Our AMA endorses the concept of equal parental leave for birth and adoption as a benefit for resident physicians, medical students, and physicians in practice regardless of gender or gender identity.  ~~9.~~ 10. Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs.  ~~10.~~ 11. Physicians should be able to return to their practices or training programs after taking parental leave, family leave, or medical leave without the loss of status.  ~~11.~~ 12. Residency program directors must assist residents in identifying their specific requirements (for example, the number of months to be made up) because of leave for eligibility for board certification and must notify residents on leave if they are in danger of falling below minimal requirements for board eligibility. Program directors must give these residents a complete list of requirements to be completed in order to retain board eligibility.  ~~12.~~ 13. Our AMA encourages flexibility in residency training programs and medical schools incorporating parental leave and alternative schedules for pregnant trainees ~~house staff~~.  ~~13.~~ 14. In order to accommodate leave protected by the federal Family and Medical Leave Act, our AMA encourages all specialties within the American Board of Medical Specialties to allow graduating residents to extend training up to 12 weeks after the traditional residency completion date while still maintaining board eligibility in that year.  ~~14.~~ 15. These policies as above should be freely available online and in writing to all current trainees and applicants to medical school, residency or fellowship. (Modify Current HOD Policy) |
| C | Res. 304 | New York | Protecting State Medical Licensing Boards from External Political Influence | RESOLVED, That our American Medical Association work with the Federation of State Medical Boards and other interested parties to minimize external interference with the independent functioning of state medical disciplinary and licensing boards. (Directive to Take Action) |
| C | Res. 305 | Illinois | Encouraging Medical Schools to Sponsor Pipeline Programs to Medicine for Underrepresented Groups | RESOLVED, That our American Medical Association urge medical schools to develop or expand the reach of existing pipeline programs for underrepresented middle school, high school and college aged students to motivate them to pursue and prepare them for a career in medicine (New HOD Policy); and be it further  RESOLVED, That our AMA encourage collegiate programs to establish criteria by which completion of such programs will secure an interview for admission to the sponsoring medical school (New HOD Policy); and be it further  RESOLVED, That our AMA recommend that medical school pipeline programs for underrepresented students be free-of-charge or provide financial support with need-based scholarships and grants (New HOD Policy); and be it further  RESOLVED, That our AMA encourage all physicians to actively participate in programs and mentorship opportunities that help expose underrepresented students to potential careers in medicine. (New HOD Policy) |
| C | Res. 306 | New York | Increased Credit for Continuing Medical Education Preparation | RESOLVED, That our American Medical Association collaborate with the Accreditation Council on Continuing Medical Education (ACCME), to allow physicians to claim an amount of Category 1 CME credits that more accurately reflects the hours they spend on preparing and presenting CME programs to a maximum of four (4) Category 1 CME hours. (Directive to Take Action) |
| C | Res. 307 | Arkansas | Fair Compensation of Residents and Fellows | RESOLVED, That our American Medical Association advocate for increasing the Resident and Fellow salary substantially (by at least 50% of current levels or better), along with all benefits including retirement benefits with institutional match as available to institutional administration, and peg yearly salary increase thereafter to COLA (Directive to Take Action); and be it further  RESOLVED, That our AMA advocate for enhanced and uniform payment per resident and fellow for all educational and training institutions across the country (Directive to Take Action); and be it further  RESOLVED, That our AMA amend the Residents and Fellows Bill of Rights: H-310.912 (last modified 2022) accordingly. (Modify Current HOD Policy) |
| C | Res. 308 | American College of Radiology | Paid Family/Medical Leave in Medicine | RESOLVED, That our American Medical Association policy H-405.960 “Policies for Parental Family and Medical Necessity Leave” be amended by addition and deletion to read as follows:  AMA adopts as policy the following guidelines for, and encourages the implementation of, Parental, Family and Medical Necessity Leave for Medical Students and Physicians:  1. Our AMA urges medical schools, residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement.  2. Recommended components of parental leave policies for medical students and physicians include: (a) duration of leave allowed before and after delivery; (b) category of leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for continuation of insurance benefits during leave, and who pays the premium; (e) whether sick leave and vacation time may be accrued from year to year or used in advance; (f) how much time must be made up in order to be considered board eligible; (g) whether make-up time will be paid; (h) whether schedule accommodations are allowed; and (i) leave policy for adoption.  3. AMA policy is expanded to include physicians in practice, reading as follows: (a) residency program directors and group practice administrators should review federal law concerning maternity leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled; (b) staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other physicians' workloads, particularly in residency programs; and (c) physicians should be able to return to their practices or training programs after taking parental leave without the loss of status.  4. Our AMA encourages medical schools, residency programs, specialty boards, and medical group practices to incorporate into their parental, family, and medical necessity leave policies a ~~six~~ twelve-week minimum leave allowance, with the understanding that no ~~parent~~ individual should be required to take a minimum leave.  5. Our AMA recommends that medical practices, departments and training programs strive to provide 12 weeks of paid parental, family and medical necessity leave in a 12-month period for their attending and trainee physicians as needed.  ~~5~~6. Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave.  ~~6~~7. Medical students and physicians who are unable to work because of pregnancy, childbirth, and other related medical conditions should be entitled to such leave and other benefits on the same basis as other physicians who are temporarily unable to work for other medical reasons.  ~~7~~8. Residency programs should develop written policies on parental leave, family leave, and medical leave for physicians. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); (d) whether leave is paid or unpaid; (e) whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (f) whether sick leave and vacation time may be accrued from year to year or used in advance; (g) extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (h) how time can be made up in order for a resident physician to be considered board eligible; (i) what period of leave would result in a resident physician being required to complete an extra or delayed year of training; (j) whether time spent in making up a leave will be paid; and (k) whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling.  ~~8~~9. Our AMA endorses the concept of equal parental leave for birth and adoption as a benefit for resident physicians, medical students, and physicians in practice regardless of gender or gender identity.  ~~9~~10. Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs.  ~~10~~11. Physicians should be able to return to their practices or training programs after taking parental leave, family leave, or medical leave without the loss of status.  ~~11~~12. Residency program directors must assist residents in identifying their specific requirements (for example, the number of months to be made up) because of leave for eligibility for board certification and must notify residents on leave if they are in danger of falling below minimal requirements for board eligibility. Program directors must give these residents a complete list of requirements to be completed in order to retain board eligibility.  ~~12~~13. Our AMA encourages flexibility in residency training programs, incorporating parental leave and alternative schedules for pregnant house staff.  ~~13~~14. In order to accommodate leave protected by the federal Family and Medical Leave Act, our AMA encourages all specialties within the American Board of Medical Specialties to allow graduating residents to extend training up to 12 weeks after the traditional residency completion date while still maintaining board eligibility in that year.  ~~14~~15. These policies as above should be freely available online and in writing to all applicants to medical school, residency or fellowship. (Modify Current HOD Policy) |
| C | Res. 309 | Resident and Fellow Section | Bereavement Leave for Medical Students and Physicians | RESOLVED, That our American Medical Association support bereavement leave for medical students and physicians:  1. Our AMA urges medical schools, residency and fellowship training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of bereavement leave policies as part of the physician's standard benefit agreement.  2. Recommended components of bereavement leave policies for medical students and physicians include:  a. whether cases requiring extensive travel qualify for additional days of leave and, if so, how many days;  b. policy and duration of leave for an event impacting pregnancy or fertility including pregnancy loss, an unsuccessful round of intrauterine insemination or of an assisted reproductive technology procedure, a failed adoption arrangement, a failed surrogacy arrangement, or an event that impacts pregnancy or fertility;  c. whether leave is paid or unpaid;  d. whether obligations and time must be made up; and  e. whether make-up time will be paid.  3. Our AMA encourages medical schools, residency and fellowship programs, specialty boards, specialty societies and medical group practices to incorporate into their bereavement leave policies a three-day minimum leave, with the understanding that no physician or medical student should be required to take a minimum leave.  4. Medical students and physicians who are unable to work beyond the defined bereavement leave period because of physical or psychological stress, medical complications of pregnancy loss, or another related reason should refer to their institution’s sick leave policy, family and medical leave policy, and other benefits on the same basis as other physicians who are temporarily unable to work for other reasons.  5. Our AMA supports the concept of equal bereavement leave for pregnancy loss and other such events impacting fertility in a physician or their partner as a benefit for medical students and physicians regardless of gender or gender identity.  6. Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs.  7. These guidelines as above should be freely available online and in writing to all applicants to medical school, residency, or fellowship. (Directive to Take Action) |
| C | Res. 310 | Michigan | Enforce AMA Principles on Continuing Board Certification | RESOLVED, That our American Medical Association continue to actively work to enforce current AMA Principles on Continuing Board Certification (Directive to Take Action); and be it further  RESOLVED, That our AMA publicly report their work on enforcing AMA Principles on Continuing Board Certification at the Annual and Interim meetings of the AMA House of Delegates. (Directive to Take Action) |
| C | Res. 311 | Medical Student Section | Supporting a Hybrid Residency and Fellowship Interview Process | RESOLVED, That our American Medical Association support incorporating virtual interviews as a component to the residency and fellowship interview process as a means to increase interviewing efficiency (New HOD Policy); and be it further  RESOLVED, That our AMA work with appropriate stakeholders, such as the Association of American Medical Colleges and the Accreditation Council for Graduate Medical Education, to study interviewee and program perspectives on incorporating videoconferencing as an adjunct to residency and fellowship interviews, in order to guide the development of protocols for expansion of hybrid residency and fellowship interviews. (Directive to Take Action) |
| C | Res. 312 | Medical Student Section | Reporting of Residency Demographic Data | RESOLVED, That our American Medical Association work with appropriate stakeholders to encourage that residency programs annually publish and share with FREIDA and other appropriate stakeholders, (a) demographic data, including but not limited to the composition of their program over the last 5 years by age, gender identity, URM status, and LGBTQIA+ status; (b) parental and family leave policies; and (c) the number and/or proportion of residents who have utilized parental or family leave in the past 5 years (Directive to Take Action); and be it further  RESOLVED, That our AMA encourage the Accreditation Council for Graduate Medical Education and other relevant stakeholders to annually collect data on pregnancy, childbirth, and parenthood from all accredited US residency programs and publish this data with disaggregation by gender identity and specialty. (New HOD Policy) |
| C | Res. 313 | Oklahoma | Request a two-year delay in ACCME Changes to State Medical Society Recognition Program | RESOLVED, That our American Medical Association collaborate with Accreditation Council for Continuing Medical Education (ACCME) with a goal to secure a two-year delay in the implementation of any changes to the state medical society accreditor program. During that time, AMA, ACCME and state medical societies will work collaboratively to study the impact and unintended consequences of the proposed action and to create a plan that is in the best interests of all parties, including the continuing medical education providers currently accredited by state medical societies. (Directive to Take Action) |
| C | Res. 314 | Michigan | Balancing Supply and Demand for Physicians by 2030 | RESOLVED, That our American Medical Association take action on all fronts to advocate for and implement remedies that will rebalance the supply and demand equation for primary care physicians by 2030 (Directive to Take Action); and be it further  RESOLVED, That our AMA reaffirm AMA Policies H-200.954, H-200.955, H-200.972, H‑465.988, and D-305.958. (Reaffirm HOD Policy) |
| C | Res. 315 | Michigan | Bedside Nursing and Health Care Staff Shortages | RESOLVED, That our AMA amend AMA policy D-360.998, “The Growing Nursing Shortage in the United States” by addition to read as follows:  Our AMA: (1) recognizes the important role nurses and other allied health professionals play in providing quality care to patients, and participate in activities with state medical associations, county medical societies, and other local health care agencies to enhance the recruitment and retention of qualified individuals to the nursing profession and the allied health fields;  (2) encourages physicians to be aware of and work to improve workplace conditions that impair the professional relationship between physicians and nurses in the collaborative care of patients;  (3) encourages hospitals and other health care facilities to collect and analyze data on the relationship between staffing levels, nursing interventions, and patient outcomes, and to use this data in the quality assurance process;  (4) will work with nursing, hospital, and other appropriate organizations to enhance the recruitment and retention of qualified individuals to the nursing and other allied health professions;  (5) will work with nursing, hospital, and other appropriate organizations to seek to remove administrative burdens, e.g., excessive paperwork, to improve efficiencies in nursing and promote better patient care~~.~~;  (6) will approach appropriate stakeholders such as the American Hospital Association to collaborate on the identification of and advocacy for short- and long-term strategies and solutions to address nursing and other health care staff shortages in order to promote a stable work force and career longevity.(Modify Current HOD Policy) |
| F | BOT 02 | n/a | Further Action to Respond to the Gun Violence Public Health Crisis | Our AMA will make readily accessible on the AMA website the comprehensive summary of AMA policies, plans, current activities, and progress regarding the public health crisis of firearm violence. (New HOD Policy) |
| F | BOT 07 | n/a | Transparency of Resolution Fiscal Notes | Your Board of Trustees recommends that Resolution 608 not be adopted and the remainder of the report be filed. |
| F | BOT 08 | n/a | The Resolution Committee as a Standing Committee of the House | That the Board of Trustees prepare a report for consideration at the 2023 Annual Meeting recommending a trial of a resolution committee, including the make-up and operation of the committee and create measures of fairness and effectiveness of the trial. (Directive to Take Action) |
| F | BOT 09 | n/a | Employed Physicians | 1. That our AMA adopt the following definition of “employed physician”:  An employed physician is any non-resident, non-fellow physician who maintains a contractual relationship to provide medical services with an entity from which the physician receives a W-2 to report their income, and in which the physician does not have a controlling interest, either individually or as part of a collective. (New HOD Policy)  2. That our AMA re-examine the representation of employed physicians within the organization and report back at the 2024 Annual Meeting. (Directive to Take Action) |
| F | CLRPD 01 | n/a | Senior Physicians Section Five-Year Review | The Council on Long Range Planning and Development recommends that our American Medical Association renew delineated section status for the Senior Physicians Section through 2027 with the next review no later than the 2027 Interim Meeting and that the remainder of this report be filed. (Directive to Take Action) |
| F | HOD Comp  Report | n/a | Report of the House Of Delegates Committee on the Compensation of the Officers | RECOMMENDATIONS   1. That there be no changes to the Officers’ compensation for the period beginning July 1, 2022 through June 30, 2023. (Directive to Take Action.) 2. That the remainder of the report be filed. |
| F | Res. 601 | Louisiana | AMA Withdraw its Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity | RESOLVED, That our American Medical Association withdraw its Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity (Equity Strategic Plan) and rewrite the recommendations for correcting its past support for racially discriminating behavior with removal of the inflammatory rhetoric. (Directive to Take Action) |
| F | Res. 602 | Alabama | Finding Cities for Future AMA Conventions/Meetings | RESOLVED, That our American Medical Association amend Policy G-630.140, “Lodging, Meeting Venues, and Social Functions,” by addition and deletion to read as follows:  AMA policy on lodging and accommodations includes the following:  1. Our AMA supports choosing hotels for its meetings, conferences, and conventions based on size, service, location, cost, and similar factors.  2. Our AMA shall attempt, when allocating meeting space, to locate the Section Assembly Meetings in the House of Delegates Meeting hotel or in a hotel in close proximity.  3. All meetings and conferences organized and/or primarily sponsored by our AMA will be held in a town, city, county, or state that has regulation or ~~enacted comprehensive~~ legislation requiring smoke-free worksites and public places (including restaurants and bars), unless intended or existing contracts or special circumstances justify an exception to this policy, and our AMA encourages state and local medical societies, national medical specialty societies, and other health organizations to adopt a similar policy.  4. It is the policy of our AMA not to ~~hold meetings organized and/or primarily sponsored by our AMA, in cities, counties, or states, or~~ pay member, officer or employee dues in any club, restaurant, or other institution, that has exclusionary policies, including, but not limited to, policies based on, race, color, religion, national origin, ethnic origin, language, creed, sex, sexual orientation, gender, gender identity and gender expression, disability, or age unless intended or existing contracts or special circumstances justify an exception to this policy.  5. Our AMA staff will work with facilities where AMA meetings are held to designate an area for breastfeeding and breast pumping.  6. All future AMA meetings will be structured to provide accommodations for members and invited attendees who are able to physically attend, but who need assistance in order to meaningfully participate.  7. Our AMA will revisit our criteria for selection of hotels and other venues in order to facilitate maximum participation by members and invited attendees with disabilities.  8. Our AMA will report back to the HOD by no later than the 2023 Annual Meeting with a plan on how to maximize meeting participation for members and invited attendees with disabilities. (Modify Current HOD Policy) |
| F | Res. 603 | American Academy of Physical Medicine and Rehabilitation | AMA House of Delegates Resolution Process Review | RESOLVED, That our American Medical Association review the entire process of resolution submission including re-evaluating the definitions of “on time,” late, and emergency resolutions and current exceptions with a report back at the Interim 2023 meeting (Directive to Take Action); and be it further  RESOLVED, That the review committee consider changing the policy so that all on time resolutions must be submitted to the HOD by the same deadlines so that the only resolutions in the Saturday/Sunday tote would be emergency and late resolutions to be voted on for acceptance by the HOD (Directive to Take Action); and be it further  RESOLVED, That the review committee consider changing the rule so that all sections of the AMA will submit their “on time” resolutions by the same deadlines as the rest of the HOD, with only emergency resolutions to be submitted after Section meetings during the week before the annual or interim meetings (Directive to Take Action); and be it further  RESOLVED, That our AMA facilitate virtual meetings of the sections prior to the resolution deadline so that all resolutions can be submitted, reviewed, and discussed prior to the deadline. (Directive to Take Action) |
| F | Res. 604 | Resident and Fellow Section | Solicitation Using the AMA Brand | RESOLVED, That our American Medical Association study the use of AMA branded solicitation material mailed to physicians, the impact it has on the perception of our AMA by current and potential physician members, and the merits of continuing to use these materials in future communications (Directive to Take Action); and be it further  RESOLVED, That our AMA study our membership on the preferred method to receive third party solicitation material (mail, phone, email, social media) and provide a method to opt-out of certain methods if not desired. (Directive to Take Action) |
| F | Res. 605 | Melissa Garretson, MD, Delegate | Decreasing Political Advantage Within AMA Elections | RESOLVED, That our American Medical Association amend operating procedures and bylaws as needed to assure that any currently seated member of an appointed or elected council who announces and seeks another elected or appointed office prior to completion of said member’s current term shall be deemed to have resigned from the member’s current council/board term effective upon completion of the Annual Meeting of the House of Delegates at which the member has run for another office. (New HOD Policy) |
| F | Res. 606 | Oklahoma | Patient-Centered Health Equity Strategic Plan and Sustainable Funding | RESOLVED, Our American Medical Association HOD reaffirm policy H-180.944, “Plan for Continued Progress Toward Health Equity,” and aggressively advocate for Health Equity as defined as optimal health for all which should be the goal toward which our AMA will work by advocating for health care access, promoting equity in care, increasing health workforce diversity, influencing determinants of health, and voicing and modeling commitment to health equity (Reaffirm HOD Policy); and be it further  RESOLVED, That our AMA Center for Health Equity’s future strategic plan should include advocacy planning and be presented to the AMA HOD for consideration with the opportunity for it to be more widely understood, strengthened, and supported by the HOD (Directive to Take Action); and be it further  RESOLVED, As the AMA Center for Health Equity develops its next strategic plan, it shall actively engage our AMA Board of Trustees in the strategic planning process, and ensure a more patient-centered strategic plan for health equity advocacy that is consistent with the intent of AMA policies, including H-180.944,“ Plan for Continued Progress Toward Health Equity,” and D-180.981, “Plan for Continued Progress Toward Health Equity,” and report the strategic plan to the HOD at the 2024 Annual Meeting prior to publicly releasing the plan to the press (Directive to Take Action); and be it further  RESOLVED, That our AMA, in a collaboration with interested stakeholders, actively advocate for sustainable funding from Congress to increase health equity efforts of identifying and reducing health disparities including but not limited to funding of the Health Resources and Services Administration through U.S. Department of Health and Human Services and our AMA Health Equity Center. (Directive to Take Action) |
| F | Res. 607 | Texas | Accountability for Election Rules Violations | RESOLVED, That our American Medical Association empower the Election Committee to develop a list of appropriate penalties for candidates and caucus/delegation/section leadership who violate election rules (Directive to Take Action); and be it further  RESOLVED, That the Election Committee define potential election rule violations as minor (oversight or misinterpretation of rules), moderate (more serious and more likely to affect the outcome of an election), and severe (intentional violation with high likelihood of affecting the outcome of an election) and assign appropriate penalties or actions to remedy the situation and/or report the violation to the House of Delegates (Directive to Take Action); and be it further  RESOLVED, That any candidate who is deemed to have violated the vote trading election rule be disqualified from the current race as well as any future races at the AMA for a period not less than 2 years, upon the recommendation of the Election Committee and approval of the full House of Delegates (Directive to Take Action); and be it further  RESOLVED, That any caucus/delegation/section leadership that is found to have engaged in vote trading shall not be allowed to sponsor any candidates for a period not less than 2 years (Directive to Take Action); and be it further  RESOLVED, That anyone who is deemed by the Election Committee to have knowingly and egregiously violated the vote trading rule be referred to the Council on Ethical and Judicial Affairs for potential ethics violations. (Directive to Take Action) |
| F | Res. 608 | Medical Student Section | Encouraging Collaboration Between Physicians and Industry in AI  (Augmented Intelligence) Development | RESOLVED, That our American Medical Association augment the existing Physician Innovation Network (PIN) through the creation of advisors to specifically link physician members of AMA and its associated specialty societies with companies or individuals working on augmented intelligence (AI) research and development, focusing on:  (1) Expanding recruitment among AMA physician members,  (2) Advising AMA physician members who are interested in healthcare innovation/AI without knowledge of proper channels to pursue their ideas,  (3) Increasing outreach from AMA to industry leaders and companies to both further promote the PIN and to understand the needs of specific companies,  (4) Facilitating communication between companies and physicians with similar interests,  (5) Matching physicians to projects early in their design and testing stages,  (6) Decreasing the time and workload spent by individual physicians on finding projects themselves,  (7) Above all, boosting physician-centered innovation in the field of AI research and development (Directive to Take Action); and be it further  RESOLVED, That our AMA support selection of PIN advisors through an application process where candidates are screened by PIN leadership for interpersonal skills, problem solving, networking abilities, objective decision making, and familiarity with industry. (Directive to Take Action) |
| J | CMS 01 | n/a | Incentives to Encourage Efficient Use of Emergency Departments | The Council on Medical Service recommends that the following be adopted and the remainder of the report be filed:   1. That our American Medical Association (AMA) support continued monitoring, by the Centers for Medicare & Medicaid Services and other stakeholders, of strategies and best practices for reducing non-emergency emergency department (ED) use among Medicaid/Children’s Health Insurance Program (CHIP) enrollees, including frequent ED users. (New HOD Policy) 2. That our AMA support state efforts to encourage appropriate emergency department (ED) use among Medicaid/CHIP enrollees that are consistent with the standards and safeguards outlined in AMA policy on ED services. (New HOD Policy) 3. That our AMA reaffirm Policy H-130.970, which supports the prudent layperson standard and directs the AMA to work with state insurance regulators, insurers, and other stakeholders to halt the implementation of policies that violate the prudent layperson standard of determining when to seek emergency care. (Reaffirm HOD Policy) 4. That our AMA reaffirm Policy H-290.985, which advocates that numerous criteria be used in Medicaid managed care monitoring and oversight, including that enrollees are educated about appropriate use of services, including ED services; plans are responsive to cultural, language and transportation barriers to access; off-hours, walk-in primary care is available; and intensive case management is provided to high utilizers. (Reaffirm HOD Policy) 5. That our AMA reaffirm Policy H-290.976, which affirms the AMA’s commitment to advocating that Medicaid should pay physicians at minimum 100 percent of Medicare rates. (Reaffirm HOD Policy) 6. That our AMA rescind Policy D-130.959, which called for the development of this report. (Rescind HOD Policy) |
| J | CMS 02 | n/a | Corporate Practice of Medicine (Resolution 721-A-22) | The Council on Medical Service recommends that the following be adopted in lieu of Resolution 721-A-22, and the remainder of the report be filed:   1. That our American Medical Association (AMA) acknowledge that the corporate practice of medicine has the potential to erode the patient-physician relationship. (New HOD Policy) 2. That our AMA acknowledge that the corporate practice of medicine may create a conflict of interest between profit and best practices in residency and fellowship training. (New HOD Policy) 3. That our AMA amend Policy H-160.891 by addition of two new clauses, as follows:   j. Each individual physician should have the ultimate decision for medical judgment in patient care and medical care processes, including the use of mandated patient care algorithms or supervision of non-physician practitioners.  k. Physicians should retain primary and final responsibility for structured medical education inclusive of undergraduate and graduate medical education including the structure of the program, program curriculum, selection of faculty and trainees, as well as educational and disciplinary issues related to these programs. (Modify Current HOD Policy) |
| J | Res. 801 | Young Physicians Section | Parity in Military Reproductive Health Insurance Coverage for All Service Members and Veterans | RESOLVED, That our American Medical Association support expansion of reproductive health insurance coverage to all active-duty service members and veterans eligible for medical care regardless of marital status, gender or sexual orientation. (New HOD Policy) |
| J | Res. 802 | New York | FAIR Health Database | RESOLVED, That our American Medical Association advocate to FAIR Health to ensure the continued identification of the frequency by which a particular CPT code is used. (New HOD Policy) |
| J | Res. 803 | New York | Patient Centered Medical Home – Administrative Burdens | RESOLVED, That our American Medical Association seek regulations which would reduce the increasing strain that Patient Centered Medical Home (PCMH) metrics are placing on physicians and patient care. (Directive to Take Action) |
| J | Res. 804 | New York | Centers for Medicare & Medicaid Innovation Projects | RESOLVED, That our American Medical Association advocate against mandatory participation in Centers for Medicare and Medicaid Innovation (CMMI) demonstration projects, and advocate for CMMI instead to focus on the development of voluntary pilot projects (Directive to Take Action); and be it further  RESOLVED, That our AMA advocate to ensure that any CMMI project that requires physician and/or patient participation be required to be approved by Congress. (Directive to Take Action) |
| J | Res. 805 | Utah | COVID Vaccine Administration Fee | RESOLVED, That American Medical Association policy D-440.981, “Appropriate Reimbursements and Carve-outs for Vaccines,” be amended by addition to read as follows:  **Appropriate Reimbursements and Carve-outs for Vaccines D-440.981**  Our AMA will: (1) continue to work with the Centers for Medicare and Medicaid Services (CMS) and provide comment on the Medicare Program payment policy for vaccine services; (2) continue to pursue adequate reimbursement for vaccines and their administration from all public and private payers, including federal funds to reimburse for administration of the COVID-19 vaccine to uninsured patients; (3) encourage health plans to recognize that physicians incur costs associated with the procurement, storage and administration of vaccines that may be beyond the average wholesale price of any one particular vaccine; (4) seek legislation mandating that health insurance companies in applicable states either adequately pay for vaccines recommended by the Advisory Committee on Immunization Practices, or clearly state in large bold font in their notices to patients and businesses that they do not follow the federal advisory body on vaccine recommendations, the Advisory Committee on Immunization Practices; and (5) advocate that a physician’s office can bill Medicare for all vaccines administered to Medicare beneficiaries and that the patient shall only pay the applicable copay to prevent fragmentation of care. (Modify Current HOD Policy) |
| J | Res. 806 | Georgia | Healthcare Marketplace Plan Selection | RESOLVED, That our American Medical Association advocate for patients to have expanded plan options on the Healthcare Marketplace beyond the current options based solely on the zip code of their primary residence or where their physician practices, including the interstate portability of plans. (Directive to Take Action) |
| J | Res. 807 | Georgia | Medicare Advantage Record Requests | RESOLVED, That our American Medical Association advocate for the relevant agencies and stakeholders to prevent Medicare Advantage plans from requesting records from practices solely to data mine for more funds and limit requests to 2% of plan participants, and otherwise advocate that the plan will reimburse the practices for their efforts in obtaining additional requested information. (Directive to Take Action) |
| J | Res. 808 | Georgia | Reinstatement of Consultation Codes | RESOLVED, That our American Medical Association proactively engage and advocate with any commercial insurance company that discontinues payment for consultation codes or that is proposing to or considering eliminating payment for such codes, requesting that the company reconsider the policy change. (Directive to Take Action) |
| J | Res. 809 | Senior Physician Section | Uniformity and Enforcement of Medicare Advantage Plans and Regulations | RESOLVED, That our American Medical Association advocate for better enforcement of Medicare Advantage regulations to hold the Centers for Medicare & Medicaid Services (CMS) accountable for presenting transparency of minimum standards and to determine if those standards are being met for senior physicians and their patients (Reaffirm HOD Policy); and be it further  RESOLVED, That our AMA advocate that Medicare Advantage plans be required to post all components of Medicare covered in all plans across the US on their website along with additional benefits provided (Directive to Take Action); and be it further  RESOLVED, That our AMA advocate that CMS provide an accurate, up-to-date list of physicians and the plans with which they may or may not be accepting as well as if the practice is no longer participating, continuing on with current patients, or taking new patients for plans that they are contracted for under Medicare Advantage. (Directive to Take Action) |
| J | Res. 810 | Senior Physician Section | Medicare Drug Pricing and Pharmacy Costs | RESOLVED, That our American Medical Association advocate for immediate, timely and transparent negotiations for how Medicare drug prices are set to be incorporated into law (Directive to Take Action); and be it further  RESOLVED, That our AMA advocate to eliminate loopholes such as new usage for current medications (commonly known as patent evergreening) (Directive to Take Action); and be it further  RESOLVED, That our AMA advocate for a ban on direct-to-consumer advertising for prescription drugs by no later than five years, in 2027. (Reaffirm HOD Policy) |
| J | Res. 811 | Senior Physician Section | Covering Vaccinations for Seniors through Medicare Part B | RESOLVED, That our American Medical Association advocate that Medicare Part B cover the full cost of all vaccinations administered to Medicare patients that are recommended by the Advisory Committee on Immunization Practices (ACIP), the US Preventive Services Task Force (USPSTF), or based on prevailing preventive clinical health guidelines. (Directive to Take Action) |
| J | Res. 812 | Resident and Fellow Section | Implant-Associated Anaplastic Large Cell Lymphoma | RESOLVED, That our American Medical Association support appropriate coverage of cancer diagnosis, treating surgery and other systemic treatment options for implant-associated anaplastic large cell lymphoma. (New HOD Policy) |
| J | Res. 813 | New England | Amending Policy on a Public Option to Maximize AMA Advocacy | RESOLVED, That our American Medical Association amend Policy H-165.823, “Options to Maximize Coverage under the AMA Proposal for Reform”, by addition and deletion to read as follows:  1. Our AMA will advocate ~~that any~~for a public option to expand health insurance coverage ~~must~~that meets the following standards:  a. The primary goals of establishing a public option are to maximize patient choice of health plan and maximize health plan marketplace competition.  b. Eligibility for premium tax credit and cost-sharing assistance to purchase the public option is restricted to individuals without access to affordable employer-sponsored coverage that meets standards for minimum value of benefits.  c. Physician payments under the public option are established through meaningful negotiations and contracts. Physician payments under the public option must be higher than prevailing Medicare rates and at rates sufficient to sustain the costs of medical practice.  d. Physicians have the freedom to choose whether to participate in the public option. Public option proposals should not require provider participation and/or tie physician participation in Medicare, Medicaid and/or any commercial product to participation in the public option.  e. The public option is financially self-sustaining and has uniform solvency requirements.  f. The public option does not receive advantageous government subsidies in comparison to those provided to other health plans.  g. The public option shall be made available to uninsured individuals who fall into the “coverage gap” in states that do not expand Medicaid – having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credits – at no or nominal cost. (Modify Current HOD Policy) |
| J | Res. 814 | American College of Cardiology | Socioeconomics of CT Coronary Calcium: Is it Scored or Ignored? | RESOLVED, That our American Medical Association seek national and/or state legislation and/or a national coverage determination (NCD) to include coronary artery calcium scoring (CACS) for patients who meet the screening criteria set forth by the American College of Cardiology/American Heart Association 2019 Primary Prevention Guidelines, as a first-dollar covered preventive service, consistent with the current policy in the state of Texas (Directive to Take Action); and be it further  RESOLVED, That our AMA collaborate with the appropriate stakeholders to propose that hospitals strongly consider a no cost/nominal cost option for CACS in appropriate patients who are unable to afford this test, as a means to enhance disease detection, disease modification and management. (Directive to Take Action) |
| J | Res. 815 | Medical Student Section | Opposition to Debt Litigation Against Patients | RESOLVED, That our American Medical Association oppose the practice of health care organizations pursuing litigation against patients due to medical debt, and encourages health care organizations to consider the relative financial benefit of collecting medical debt to their revenue, against the detrimental cost to a patient’s well-being (New HOD Policy); and be it further  RESOLVED, That our AMA encourage health care organizations to manage medical debt with patients directly and consider several options, including discounts, payment plans with flexibility and extensions as needed, or forgiveness of debt altogether, before resorting to third-party debt collectors or any punitive actions (New HOD Policy); and be it further  RESOLVED, That our AMA encourage health care organizations to consider the American Hospital Association Patient Billing Guidelines when faced with patients struggling to finance their medical bills. (New HOD Policy) |
| J | Res. 816 | Medical Student Section | Medicaid and CHIP Coverage for Glucose Monitoring Devices for Patients with Diabetes | RESOLVED, That our American Medical Association advocate for broadening the classification criteria of Durable Medical Equipment to include all clinically effective and cost-saving diabetic glucose monitors (Directive to Take Action); and be it further  RESOLVED, That our AMA amend AMA Policy H-330.885, “Medicare Coverage of Continuous Glucose Monitoring Devices for Patients with Insulin-Dependent Diabetes,” by addition and deletion to read as follows:  **~~Medicare~~ Public Insurance Coverage of Continuous Glucose Monitoring Devices for Patients with Insulin-Dependent Diabetes H-330.885**  Our AMA supports efforts to achieve ~~Medicare~~ coverage of continuous and flash glucose monitoring systems for all patients with ~~insulin-dependent~~ diabetes by all public insurance programs. (Modify Current HOD Policy) |
| J | Res. 817 | Medical Student Section | Promoting Oral Anticancer Drug Parity | RESOLVED, That our American Medical Association amend policy H-55.986, “Home Chemotherapy and Antibiotic Infusions,” by addition and deletion to read as follows:  H-55.986 - HOME CHEMOTHERAPY AND ANTIBIOTIC INFUSIONS  Our AMA: (1) endorses the use of home medications to include those orally-administered, injections and/or infusions of FDA approved drugs and group C drugs (including chemotherapy and/or antibiotic therapy) for appropriate patients under physicians' recommendation and supervision; (2) only considers extension of the use of home infusions for biologic agents, immune modulating therapy, and anti-cancer therapy as allowed under the public health emergency when circumstances are present such that the benefits to the patient outweigh the potential risks; (3) encourages CMS and/or other insurers to provide adequate reimbursement and liability protections for such treatment; (4) supports educating legislators and administrators about the risks and benefits of such home infused antibiotics and supportive care treatments in terms of cost saving, increased quality of life and decreased morbidity, and about the need to ensure patient and provider safety when considering home infusions for such treatment as biologic, immune modulating, and anti-cancer therapy; (5) advocates for appropriate reimbursement policies for home infusions; and (6) opposes any requirement by insurers for home administration of drugs, if in the treating physician’s clinical judgment it is not appropriate, or the precautions necessary to protect medical staff, patients and caregivers from adverse events associated with drug infusion and disposal are not in place; this includes withholding of payment or prior authorization requirements for other settings~~.~~; and (7) advocates for patient cost-sharing parity between office- and home-administered anticancer drugs. (Modify Current HOD Policy) |
| J | Res. 818 | American Academy of Pediatrics | Pediatric Obesity Treatment Insurance Coverage | RESOLVED, That our American Medical Association immediately call for full public health insurance coverage of pediatric evidence-based anti-obesity treatment, including comprehensive life-style therapy, anti-obesity medications and metabolic and bariatric surgery (Directive to Take Action); and be it further  RESOLVED, That our AMA work with all interested parties to lobby the legislative and executive branches of government to affect public health insurance coverage and payment for the full spectrum of evidence-based pediatric anti-obesity therapy. (Directive to Take Action) |
| J | Res. 819 | American College of Preventive Medicine | Advocating for the Implementation of Updated U.S. Preventive Services Task Force Recommendations for Colorectal Cancer Screening Among Primary Care Physicians and Major Payors by the AMA | RESOLVED, That our American Medical Association advocate that payors, health systems, and clinicians adopt the updated U.S. Preventive Services Task Force Recommendation to initiate routine preventive screening for colorectal cancer at age 45; and to coordinate with like-minded professional organizations to enhance physician education and awareness of this essential recommendation. (Directive to Take Action) |
| J | Res. 820 | American College of Rheumatology | Third-Party Pharmacy Benefit Administrators | 1. RESOLVED, That our American Medical Association recommend that third-party pharmacy benefit administrators that contract to manage the specialty pharmacy portion of drug formularies be included in existing pharmacy benefit manager (PBM) regulatory frameworks and statutes, and be subject to the same licensing, registration, and transparency reporting requirements (New HOD Policy); and be it further   RESOLVED, That our AMA advocate that third-party pharmacy benefit administrators be included in future PBM oversight efforts at the state and federal levels. (Directive to Take Action) |
| K | CSAPH 01 | NA | Drug Shortages: 2022 Update | RECOMMENDATIONS The Council on Science and Public Health recommends that the following be adopted and the remainder of the report be filed.  1. Policy H-100.956, “National Drug Shortages” be amended by addition to read as follows:   1. Our AMA considers drug shortages to be an urgent public health crisis, and recent shortages have had a dramatic and negative impact on the delivery and safety of appropriate health care to patients. 2. Our AMA supports recommendations that have been developed by multiple stakeholders to improve manufacturing quality systems, identify efficiencies in regulatory review that can mitigate drug shortages, and explore measures designed to drive greater investment in production capacity for products that are in short supply, and will work in a collaborative fashion with these and other stakeholders to implement these recommendations in an urgent fashion. 3. Our AMA supports authorizing the Secretary of the U.S. Department of Health and Human Services (DHHS) to expedite facility inspections and the review of manufacturing changes, drug applications and supplements that would help mitigate or prevent a drug shortage. 4. Our AMA will advocate that the US Food and Drug Administration (FDA) and/or Congress require drug manufacturers to establish a plan for continuity of supply of vital and life-sustaining medications and vaccines to avoid production shortages whenever possible. This plan should include establishing the necessary resiliency and redundancy in manufacturing capability to minimize disruptions of supplies in foreseeable circumstances including the possibility of a disaster affecting a plant. 5. The Council on Science and Public Health shall continue to evaluate the drug shortage issue, including the impact of group purchasing organizations and pharmacy benefit managers on drug shortages, and report back at least annually to the House of Delegates on progress made in addressing drug shortages. 6. Our AMA urges continued analysis of the root causes of drug shortages that includes consideration of federal actions, evaluation of manufacturer, Group Purchasing Organization (GPO), pharmacy benefit managers, and distributor practices, contracting practices by market participants on competition, access to drugs, pricing, and analysis of economic drivers, and supports efforts by the Federal Trade Commission to oversee and regulate such forces. 7. Our AMA urges regulatory relief designed to improve the availability of prescription drugs by ensuring that such products are not removed from the market or caused to stop production due to compliance issues unless such removal is clearly required for significant and obvious safety reasons. 8. Our AMA supports the view that wholesalers should routinely institute an allocation system that attempts to fairly distribute drugs in short supply based on remaining inventory and considering the customer's purchase history. 9. Our AMA will collaborate with medical specialty society partners and other stakeholders in identifying and supporting legislative remedies to allow for more reasonable and sustainable payment rates for prescription drugs. 10. Our AMA urges that during the evaluation of potential mergers and acquisitions involving pharmaceutical manufacturers, the Federal Trade Commission consult with the FDA to determine whether such an activity has the potential to worsen drug shortages. 11. Our AMA urges the FDA to require manufacturers to provide greater transparency regarding the pharmaceutical product supply chain, including production locations of drugs, and provide more detailed information regarding the causes and anticipated duration of drug shortages. 12. Our AMA supports the collection and standardization of pharmaceutical supply chain data in order to determine the data indicators to identify potential supply chain issues, such as drug shortages. 13. Our AMA encourages global implementation of guidelines related to pharmaceutical product supply chains, quality systems, and management of product lifecycles, as well as expansion of global reporting requirements for indicators of drug shortages. 14. Our AMA urges drug manufacturers to accelerate the adoption of advanced manufacturing technologies such as continuous pharmaceutical manufacturing. 15. Our AMA supports the concept of creating a rating system to provide information about the quality management maturity, resiliency and redundancy, and shortage mitigation plans, of pharmaceutical manufacturing facilities to increase visibility and transparency and provide incentive to manufacturers. Additionally, our AMA encourages GPOs and purchasers to contractually require manufacturers to disclose their quality rating, when available, on product labeling. 16. Our AMA encourages electronic health records (EHR) vendors to make changes to their systems to ease the burden of making drug product changes. 17. Our AMA urges the FDA to evaluate and provide current information regarding the quality of outsourcer compounding facilities. 18. Our AMA urges DHHS and the U.S. Department of Homeland Security (DHS) to examine and consider drug shortages as a national security initiative and include vital drug production sites in the critical infrastructure plan. 19. Our AMA urges the Drug Enforcement Administration and other federal agencies to regularly communicate and consult with the FDA regarding regulatory actions which may impact the manufacturing, sourcing, and distribution of drugs and their ingredients. (Modify Current HOD Policy)   2. That Policy H-440.847, “Pandemic Preparedness,” which addresses the adequacy of the Strategic National Stockpile, be reaffirmed. (Reaffirm HOD Policy) |
| K | CSAPH 02 | NA | Climate Change and Human Health | RECOMMENDATIONS  The Council on Science and Public Health recommends that the following be adopted and the remainder of the report be filed.  1. That Policy D-135.966, “Declaring Climate Change a Public Health Crisis” be amended by addition to read as follows:  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 a 50 percent reduction in emissions by 2030 and 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 consider signing on to the Department of Health and Human Services Health Care Pledge or making a similar commitment to lower its own greenhouse gas emissions. 4. Our AMA encourages the health sector to lead by example in committing to carbon neutrality by 2050. 5. 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. (Modify Current HOD Policy)  2. That Policy H-135.938, “Global Climate Change and Human Health” be amended by addition and deletion to read as follows:  Our AMA: 1. Supports ~~the findings of the Intergovernmental Panel on Climate Change's fourth assessment report and concurs with the~~ scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes have adversely affected the physical and mental health of people. ~~will create conditions that affect public health, with~~ We recognize that minoritized and marginalized populations, children, the elderly, rural communities, and those who are economically disadvantaged will suffer disproportionate ~~impacts~~ harms from of climate change ~~on vulnerable populations, including children, the elderly, and the poor~~.  2. Supports educating the medical community on the ~~potential~~ adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies.  3. (a) Recognizes the importance of physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and (b) recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes.  4. Encourages physicians to assist in educating patients and the public ­on the physical and mental health effects of climate change and on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability. 5. Encourages physicians to work with ~~local and state~~ health departments to strengthen the public health infrastructure to ensure that the ~~global~~ health effects of climate change can be anticipated and responded to more efficiently, and that adaptation interventions are equitable and prioritize the needs of the populations most at risk~~, and that the AMA's Center for Public Health Preparedness and Disaster Response assist in this effort~~. 6. Supports epidemiological, translational, clinical and basic science research necessary for evidence-based global climate change policy decisions related to health care and treatment. 7. Encourages physicians to assess for environmental determinants of health in patient history-taking and encourages the incorporation of assessment for environmental determinants of health in patient history-taking into physician training. (Modify Current HOD Policy)  3. That Policy D-150.978, “Sustainable Food” be reaffirmed.  Our AMA: (1) supports practices and policies in medical schools, hospitals, and other health care facilities that support and model a healthy and ecologically sustainable food system, which provides food and beverages of naturally high nutritional quality; (2) encourages the development of a healthier food system through tax incentive programs, community-level initiatives and federal legislation; and (3) will consider working with other health care and public health organizations to educate the health care community and the public about the importance of healthy and ecologically sustainable food systems. (Reaffirm HOD Policy)  4. That Policy H-135.977, “Global Climate Change - The "Greenhouse Effect"” be rescinded. ~~Our AMA: (1) endorses the need for additional research on atmospheric monitoring and climate simulation models as a means of reducing some of the present uncertainties in climate forecasting; (2) urges Congress to adopt a comprehensive, integrated natural resource and energy utilization policy that will promote more efficient fuel use and energy production; (3) endorses increased recognition of the importance of nuclear energy's role in the production of electricity; (4) encourages research and development programs for improving the utilization efficiency and reducing the pollution of fossil fuels; and (5) encourages humanitarian measures to limit the burgeoning increase in world population.~~ (Rescind HOD Policy) |
| K | Res. 901 | Medical Student Section | Opposing the Use of Vulnerable Incarcerated People in Response to Public Health Emergencies | RESOLVED, That our American Medical Association oppose the use of forced or coercive labor practices for incarcerated populations (New HOD Policy); and be it further  RESOLVED, That our AMA support that any labor performed by incarcerated individuals or other captive populations should include adequate workplace safety and fairness standards similar to those outside of carceral institutions and support their reintegration into the workforce after incarceration. (New HOD Policy) |
| K | Res. 902 | Medical Student Section | Reducing the Burden of Incarceration on Public Health | RESOLVED, That our American Medical Association support efforts to reduce the negative health impacts of incarceration, such as: (1) implementation and incentivization of adequate funding and resources towards indigent defense systems; (2) implementation of practices that promote access to stable employment and laws that ensure employment non-discrimination for workers with previous non-felony criminal records; and (3) housing support for formerly incarcerated people, including programs that facilitate access to immediate housing after release from carceral settings (New HOD Policy); and be it further  RESOLVED, That our AMA partner with the American Public Health Association and other stakeholders to urge Congress, the Department of Justice, and the Department of Health and Human Services to minimize the negative health effects of incarceration by supporting programs that facilitate employment and housing opportunities for formerly incarcerated individuals as well as research into alternatives to incarceration. (Directive to Take Action) |
| K | Res. 903 | Medical Student Section | Supporting Further Study of Kratom | RESOLVED, That our AMA amend policy H-95.934 by addition and deletion to read as follows:  Kratom and its Growing Use Within the United States, H-95.934  Our AMA: supports ~~legislative or regulatory~~ ~~efforts to~~ ~~prohibit the sale or distribution of Kratom in the United States which do not inhibit proper scientific research~~ efforts to further study the clinical uses, benefits, and potential harms of Kratom, and oppose efforts that may restrict research. (Modify Current HOD Policy) |
| K | Res. 904 | International Medical Graduates Section | Immigration Status is a Public Health Issue | RESOLVED, That our American Medical Association declare that immigration status is a public health issue that requires a comprehensive public health response and solution (Directive to Take Action); and be it further  RESOLVED, That our AMA recognize interpersonal, institutional, structural, and systemic factors that negatively affect immigrants’ health (New HOD Policy); and be it  RESOLVED, That our AMA promote the development and implementation of educational resources for healthcare professionals to better understand health and healthcare challenges specific for the immigrant population (Directive to Take Action); and be it further  RESOLVED, That our AMA support the development and implementation of public health policies and programs that aim to improve access to healthcare and minimize systemic health barriers for immigrant communities. (New HOD Policy) |
| K | Res. 905 | Illinois | Minimal Age of Juvenile Justice Jurisdiction in the United States | RESOLVED, That our American Medical Association create a policy to establish minimal age of 10 years for juvenile justice jurisdiction in the United States (New HOD Policy); and be it further  RESOLVED, That our AMA introduce legislation to establish minimal age of 10 for juvenile justice jurisdiction in the United States. (Directive to Take Action) |
| K | Res. 906 | New York | Requirement for COVID-19 Vaccination in Public Schools Once Fully FDA-Authorized | RESOLVED, That our American Medical Association encourage states to make COVID-19 vaccination a requirement for school attendance for children and college/university students once the FDA grants full approval for COVID-19 vaccination for all relevant age groups. (New HOD Policy) |
| K | Res. 907 | American Academy of Physical Medicine and Rehabilitation | A National Strategy for Collaborative Engagement, Study, and Solutions to Reduce the Role of Illegal Firearms in Firearm Related Injury | RESOLVED, That our American Medical Association support research looking at the major sources of illegal gun supply, as well as possible methods of decreasing the proliferation of illegal firearms in the United States (New HOD Policy); and be it further  RESOLVED, That our AMA work with key stakeholders including, but not limited to, firearm manufacturers, firearm advocacy groups, law enforcement agencies, public health agencies, firearm injury victims advocacy groups19, healthcare providers, and state and federal government agencies to study and develop evidence-informed public health recommendations to mitigate the effects of violence committed with illegal firearms (Directive to Take Action); and be it further  RESOLVED, That our AMA convene national public forums including, but not limited to, online venues, national radio, and televised/streamed in-person town halls, that bring together key stakeholders and members of the general public to focus on finding common ground, non-partisan measures to mitigate the effects of illegal firearms in our firearm injury public health crisis (Directive to Take Action); and be it further  RESOLVED, That our AMA reaffirm House policies H-145.975, H-145.984, H-145.997, D-145.994, and D-145.999 calling for increased funding for national firearm violence research. (Reaffirm HOD Policy) |
| K | Res. 908 | Senior Physician Section | Older Adults and the 988 Suicide and Crisis Lifeline | RESOLVED, That our American Medical Association, with other interested organizations, develop model legislation for use by states who wish to pursue funding for the 988 Suicide and Crisis Lifeline (Directive to Take Action); and be it further  RESOLVED, That our AMA advocate that the Department of Health and Human Services (HHS) prioritize education and outreach activities for use of the 988 Suicide and Crisis Lifeline to those who are at highest risk for suicide completion with a special emphasis on those over age 65. (Directive to Take Action) |
| K | Res. 909 | Senior Physician Section | Decreasing Gun Violence and Suicide in Seniors | RESOLVED, That our American Medical Association and other organizations develop and disseminate a formal educational program to enable clinicians to effectively and efficiently address suicides with an emphasis on seniors and firearms (Directive to Take Action); and be it further  RESOLVED, That our AMA develop with other interested organizations a toolkit for clinicians to use addressing Extreme Risk Protection Orders in their individual states (Directive to Take Action); and be it further  RESOLVED, That our AMA partner with other groups interested in firearm safety to raise public awareness of magnitude and interventions available regarding senior suicides and firearms. (Directive to Take Action) |
| K | Res. 910 | Resident and Fellow Section | Gonad Shields: Regulatory and Legislation Advocacy to Oppose Routine Use | RESOLVED, That our American Medical Association oppose mandatory use of gonad shields in medical imaging considering the risks far outweigh the benefits (New HOD Policy); and be it further  RESOLVED, That our AMA advocate that the U.S. Food and Drug Administration amend the code of federal regulations to oppose the routine use of gonad shields in medical imaging (Directive to Take Action); and be it further  RESOLVED, That our AMA, in conjunction with state medical societies, support model state and national legislation to oppose or repeal mandatory use of gonad shields in medical imaging (New HOD Policy) |
| K | Res. 911 | Society for Cardiovascular Angiography & Interventions | Critical Need for National Emergency Cardiac Care (ECC) System to Ensure Individualized, State-Wide, Care for ST Segment Elevation Myocardial Infarction (STEMI), Cardiogenic Shock (CS) and Out-of-Hospital Cardiac Arrest (OHCA), and to Reduce Disparities in Health Care for Patients with Cardiac Emergencies | RESOLVED, That our American Medical Association encourage each state to standardize pre-hospital and inpatient care for cardiac emergencies, with individualized systems of Emergency Cardiac Care (ECC), specific for each state, to improve care and enhance survival for all patients, especially for those citizens who receive sociodemographically disparate care, when they present with cardiac emergencies (STEMI, STEMI-CS and OHCA) (New HOD Policy); and be it therefore,  RESOLVED, That our AMA encourage states to designate hospitals as ECC Centers based on their individual capabilities to provide ECC, much like the designations and systems of care for Stroke and Trauma Centers. (New HOD Policy) |
| K | Res. 912 | Medical Student Section | Reevaluating the Food and Drug Administration's Citizen Petition Process | RESOLVED, That our American Medical Association support the research of anti-competitive practices on the Food and Drug Administration's (FDA) citizen petitions process (New HOD Policy); and be it further  RESOLVED, That our AMA advocate for further public transparency by the FDA in the content of each petition, the relationship between citizen petitions and decisions to delay generic approval, and the time and resources expended on petition reviews. (Directive to Take Action) |
| K | Res. 913 | Medical Student Section | Supporting and Funding Sobering Centers | RESOLVED, That our American Medical Association recognize the utility, cost effectiveness, and racial justice impact of sobering centers (New HOD Policy); and be it further  RESOLVED, That our AMA support the maintenance and expansion of sobering centers (New HOD Policy); and be it further  RESOLVED, That our AMA support ongoing research of the sobering center public health model (New HOD Policy); and be it further  RESOLVED, That our AMA support the use of state and national funding for the development and maintenance of sobering centers. (New HOD Policy) |
| K | Res. 914 | Washington | Greenhouse Gas Emissions from Health Care | RESOLVED, That our American Medical Association advocate for reducing greenhouse gas emissions from health care as well as strategies for increasing the resilience of our health system to the adverse impacts of climate change (Directive to Take Action); and be it further   1. RESOLVED, That our AMA study the climate effects of metered-dose inhalers, options for reducing hydrofluorocarbon use in the medical sector, and strategies for encouraging the development of alternative inhalers with equal efficacy and less adverse effect on our climate. (Directive to Take Action) |
| K | Res. 915 | Washington | Pulse Oximetry in Patients with Pigmented Skin | 1. RESOLVED, That our American Medical Association make recommendations to the US Food and Drug Administration that will ensure pulse oximeters provide accurate and reliable readings for patients with diverse degrees of skin pigmentation. (Directive to Take Action) |
| K | Res. 916 | Medical Student Section | Non-Cervical HPV Associated Cancer Prevention | RESOLVED, That our American Medical Association amend policy H-440.872, “HPV Vaccine and Cervical Cancer Prevention Worldwide,” by addition and deletion to read as follows:  **HPV Vaccine and ~~Cervical~~ Cancer Prevention Worldwide, H-440.872**   1. Our AMA (a) urges physicians to educate themselves and their patients about HPV and associated diseases, HPV vaccination, as well as routine ~~cervical~~ cancer screening for those at risk; and (b) encourages the development and funding of programs targeted at HPV vaccine introduction and cervical cancer screening in countries without organized cervical cancer screening programs. 2. Our AMA will intensify efforts to improve awareness and understanding about HPV and associated diseases, in all individuals regardless of sex, such as, but not limited to, cervical cancer, head and neck cancer, anal cancer, and penile cancer, the availability and efficacy of HPV vaccinations, and the need for routine cervical cancer screening in the general public. 3. Our AMA: 4. encourages the integration of HPV vaccination and routine cervical cancer screening into all appropriate health care settings and visits ~~for adolescents and young adults~~, 5. supports the availability of the HPV vaccine and routine cervical cancer screening to appropriate patient groups that benefit most from preventive measures, including but not limited to low-income and pre-sexually active populations, 6. recommends HPV vaccination for all groups for whom the federal Advisory Committee on Immunization Practices recommends HPV vaccination. 7. Our AMA encourage appropriate stakeholders to investigate means to increase HPV vaccination rates by: 8. facilitating administration of HPV vaccinations in community-based settings including school settings, and 9. supporting state mandates for HPV vaccination for school attendance. (Modify Current HOD Policy); and be it further   RESOLVED, That our AMA support legislation and funding for research aimed towards discovering screening methodology and early detection methods for other non-cervical HPV associated cancers. (New HOD Policy) |
| K | Res. 917 | Society of American Gastrointestinal and Endoscopic Surgeons | Care for Children with Obesity | RESOLVED, That our American Medical Association actively support the education of physicians on the morbidity of childhood obesity, the existence of effective treatment for this condition, and the importance of patients obtaining bariatric care as early as possible (Directive to Take Action); and be it furtherRESOLVED, That our AMA support the development of multidisciplinary care programs for children with obesity, inclusive of bariatric surgery care, access to medications, nutrition, and mental health support (Directive to Take Action); and be it further   1. RESOLVED, That our AMA actively work to remove barriers to bariatric surgery, access to medications, nutrition, and mental health support for the treatment of obesity in children. (Directive to Take Action) |
| K | Res. 918 | Medical Student Section | Opposition to Alcohol Industry Marketing Self-Regulation | RESOLVED, That our American Medical Association amend policy H-30.940, “Labeling Advertising, and Promotion of Alcoholic Beverages,” by addition and deletion to read as follows:  **H-30.940, Labeling, Advertising, and Promotion of Alcoholic Beverages**  (1.) (a) Supports accurate and appropriate labeling disclosing the alcohol content of all beverages, including so-called "nonalcoholic" beer and other substances as well, including over-the-counter and prescription medications, with removal of "nonalcoholic" from the label of any substance containing any alcohol; (b) supports efforts to educate the public and consumers about the alcohol content of so-called "nonalcoholic" beverages and other substances, including medications, especially as related to consumption by minors; (c) urges the Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF) and other appropriate federal regulatory agencies to continue to reject proposals by the alcoholic beverage industry for authorization to place beneficial health claims for its products on container labels; and (d) urges the development of federal legislation to require nutritional labels on alcoholic beverages in accordance with the Nutritional Labeling and Education Act.  (2.) (a) Expresses its strong disapproval of any consumption of "nonalcoholic beer" by persons under 21 years of age, which creates an image of drinking alcoholic beverages and thereby may encourage the illegal underaged use of alcohol; (b) recommends that health education labels be used on all alcoholic beverage containers and in all alcoholic beverage advertising (with the messages focusing on the hazards of alcohol consumption by specific population groups especially at risk, such as pregnant women, as well as the dangers of irresponsible use to all sectors of the populace); and (c) recommends that the alcohol beverage industry be encouraged to accurately label all product containers as to ingredients, preservatives, and ethanol content (by percent, rather than by proof).  (3.) Actively supports and will work for a total statutory prohibition of advertising of all alcoholic beverages except for inside retail or wholesale outlets. Pursuant to that goal, our AMA (a) supports federal and/or state oversight for all forms of alcohol advertising ~~in lieu of the alcohol industry’s current practice of self-regulated advertising and marketing~~; ~~(a)~~(b) supports continued research, educational, and promotional activities dealing with issues of alcohol advertising and health education to provide more definitive evidence on whether, and in what manner, advertising contributes to alcohol abuse; ~~(b)~~(c) opposes ~~the use of the radio and television~~ any form of advertising which links alcoholic products to agents of socialization in order to promote drinking; ~~(c)~~(d) will work with state and local medical societies to support the elimination of advertising of alcoholic beverages from all mass transit systems; ~~(d)~~(e) urges college and university authorities to bar alcoholic beverage companies from sponsoring athletic events, music concerts, cultural events, and parties on school campuses, and from advertising their products or their logo in school publications; and ~~(e)~~(f) urges its constituent state associations to support state legislation to bar the promotion of alcoholic beverage consumption on school campuses and in advertising in school publications.   1. (4.) (a) Urges producers and distributors of alcoholic beverages to discontinue all advertising directed toward youth, including ~~such as~~ promotions on high school and college campuses; (b) urges advertisers and broadcasters to cooperate in eliminating television program content that depicts the irresponsible use of alcohol without showing its adverse consequences (examples of such use include driving after drinking, drinking while pregnant, or drinking to enhance performance or win social acceptance); (e) supports continued warnings against the irresponsible use of alcohol and challenges the liquor, beer, and wine trade groups to include in their advertising specific warnings against driving after drinking; and (f) commends those automobile and alcoholic beverage companies that have advertised against driving while under the influence of alcohol. (Modify Current HOD Policy) |
| K | Res. 919 | Medical Student Section | Decreasing Youth Access to E-cigarettes | RESOLVED, That our American Medical Association support the inclusion of disposable and tank-based e-cigarettes in the language and implementation of any restrictions that are applied by the Food and Drug Administration or other bodies to cartridge-based e-cigarettes (New HOD Policy); and be it further  RESOLVED, That AMA policy H-495.986, “Tobacco Product Sales and Distribution,” be amended by addition to read as follows:  **Tobacco Product Sales and Distribution, H-495.986**  Our AMA:  (1) recognizes the use of e-cigarettes and vaping as an urgent public health epidemic and will actively work with the Food and Drug Administration and other relevant stakeholders to counteract the marketing and use of addictive e-cigarette and vaping devices, including but not limited to bans and strict restrictions on marketing to minors under the age of 21;  (2) encourages the passage of laws, ordinances and regulations that would set the minimum age for purchasing tobacco products, including electronic nicotine delivery systems (ENDS) and e-cigarettes, at 21 years, and urges strict enforcement of laws prohibiting the sale of tobacco products to minors;  (3) supports the development of model legislation regarding enforcement of laws restricting children's access to tobacco, including but not limited to attention to the following issues: (a) provision for licensure to sell tobacco and for the revocation thereof; (b) appropriate civil or criminal penalties (e.g., fines, prison terms, license revocation) to deter violation of laws restricting children's access to and possession of tobacco; (c) requirements for merchants to post notices warning minors against attempting to purchase tobacco and to obtain proof of age for would-be purchasers; (d) measures to facilitate enforcement; (e) banning out-of-package cigarette sales ("loosies"); and (f) requiring tobacco purchasers and vendors to be of legal smoking age;  (4) requests that states adequately fund the enforcement of the laws related to tobacco sales to minors;  (5) opposes the use of vending machines to distribute tobacco products and supports ordinances and legislation to ban the use of vending machines for distribution of tobacco products;  (6) seeks a ban on the production, distribution, and sale of candy products that depict or resemble tobacco products;  (7) opposes the distribution of free tobacco products by any means and supports the enactment of legislation prohibiting the disbursement of samples of tobacco and tobacco products by mail;  (8) (a) publicly commends (and so urges local medical societies) pharmacies and pharmacy owners who have chosen not to sell tobacco products, and asks its members to encourage patients to seek out and patronize pharmacies that do not sell tobacco products; (b) encourages other pharmacists and pharmacy owners individually and through their professional associations to remove such products from their stores; (c) urges the American Pharmacists Association, the National Association of Retail Druggists, and other pharmaceutical associations to adopt a position calling for their members to remove tobacco products from their stores; and (d) encourages state medical associations to develop lists of pharmacies that have voluntarily banned the sale of tobacco for distribution to their members; and  (9) opposes the sale of tobacco at any facility where health services are provided; and  (10) supports that the sale of tobacco products be restricted to tobacco specialty stores.  (11) supports measures that prevent retailers from opening new tobacco specialty stores in proximity to elementary schools, middle schools, and high schools; and   1. (12) support measures that decrease the overall density of tobacco specialty stores, including but not limited to, preventing retailers from opening new tobacco specialty stores in proximity to existing tobacco specialty stores. (Modify Current HOD Policy) |
| K | Res. 920 | Medical Student Section | Mitigating Environmental Contributors to Disease and Sustainability of AMA National Meetings | RESOLVED, That our American Medical Association amend Policy D-135.997, “Research into the Environmental Contributors to Disease,” by addition and deletion to read as follows:  **~~Research into the~~ Environmental Contributors to Disease and Advocating for Environmental Justice D-135.997**  Our AMA will (1) advocate for greater public and private funding for research into the environmental causes of disease, and urge the National Academy of Sciences to undertake an authoritative analysis of environmental causes of disease; (2) ask the steering committee of the Medicine and Public Health Initiative Coalition to consider environmental contributors to disease and environmental racism as ~~a~~ priority public health issues; (3) encourage federal, state, and local agencies to address and remediate environmental injustice, environmental racism, and all other environmental conditions that are adversely impacting health, especially in marginalized communities; and (4) lobby Congress to support ongoing initiatives that include reproductive health outcomes and development particularly in minority populations in Environmental Protection Agency Environmental Justice policies (Modify Current HOD Policy); and be it further  RESOLVED, That our AMA commit to reaching net zero emissions for its business operations by 2030, and remain net zero or net negative, as defined by a carbon neutral certifying organization (Directive to Take Action); and be it further  RESOLVED, That our AMA create educational programs for and encourage the United States healthcare system, including but not limited to hospitals, clinics, ambulatory care centers, and healthcare professionals, to decrease emissions to half of 2010 levels by 2030 and become net zero by 2050, and remain net zero or negative, as defined by a carbon neutral certifying organization (Directive to Take Action); and be it further  RESOLVED, That our AMA report the progress on implementing this resolution at each Annual Meeting hereafter. (Directive to Take Action) |
| K | Res. 921 | American Academy of Pediatrics | Firearm Injury and Death Research and Prevention | RESOLVED, That our American Medical Association and all interested medical societies advocate for a comprehensive national-level data system for firearm injuries and deaths including real-time surveillance and continued improvements to the quality and comparability of currently collected data (Directive to Take Action); and be it further  RESOLVED, That our AMA advocate for repeal of the 2003 Tiahrt amendment which prohibits the release of firearm tracing data for research (Directive to Take Action); and be it further   1. RESOLVED, That our AMA advocate for additional federal budgetary funding for expanded firearm injury and death prevention research at all appropriate federal agencies in order to better understand the risk and protective factors for firearm injuries and to develop evidence-based interventions at the individual, house-hold, community, state, and federal levels to decrease firearm injuries and deaths. (Directive to Take Action) |
| K | Res. 922 | American Academy of Pediatrics | Firearm Safety and Technology | 1. RESOLVED, That our American Medical Association solicit technology company interest in and advocate for the design of affordable personalized “smart” gun and safety technology which allow only authorized users to pull the trigger on the firearm. (Directive to Take Action) |
| K | Res. 923 | American Academy of Pediatrics | Physician Education and Intervention to Improve Patient Firearm Safety | RESOLVED, That our American Medical Association and all interested medical societies educate physicians about firearm epidemiology, anticipatory guidance, and lethal means screening for and exploring potential restrictions to access to high-lethality means of suicide such as firearms. Health care clinicians, including trainees, should be provided training on the importance of anticipatory guidance and lethal means counseling to decrease firearm injuries and deaths and be provided training introducing evidence-based techniques, skills and strategies for having these discussions with patients and families (Directive to Take Action); and be it further  RESOLVED, That our AMA and all interested medical societies educate physicians about lethal means counseling in health care settings and intervention options to remove lethal means, either permanently or temporarily from the home (Directive to Take Action); and be it further  RESOLVED, That our AMA and all interested medical societies advocate for policies that support the provision of funding for physicians to provide affordable rapid-access safe storage devices to patients with firearms in the home (Directive to Take Action); and be it further   1. RESOLVED, That our AMA and all interested medical societies educate the public about: (1) best practices for firearm storage safety; (2) misconceptions families have regarding child response to encountering a gun in the home; and (3) he need to ask other families with whom the child interacts regarding the presence and storage of guns in other homes the child may enter. (Directive to Take Action) |
| K | Res. 924 | Association for Clinical Oncology | Domestic Production of Personal Protective Equipment | RESOLVED, That our American Medical Association support state and federal incentives to locate the manufacturing of goods used in healthcare and healthcare facilities in the United States (New HOD Policy); and be it furtherRESOLVED, That our AMA support the efforts of the Administration and CMS to encourage the purchase of domestically produced personal protective equipment (New HOD Policy); and be it further   1. RESOLVED, That our AMA reaffirm policy H-440.847, “Pandemic Preparedness.” (Reaffirm HOD Policy) |
| K | Res. 925 | American College of Preventive Medicine | Incorporation of Social Determinants of Health Concepts into Climate Change Work of the AMA | 1. RESOLVED, That our American Medical Association consider climate change, and the environmental impacts thereof, as social determinants of health and modifiers of other social determinants of health in its work on systems level, “novel, comprehensive, and economically sensitive approaches to mitigating climate change”. (New HOD Policy) |
| K | Res. 926 | Michigan | Limit the Pornography Viewing by Minors Over the Internet | RESOLVED, That our American Medical Association amend existing policy H-60.934, “Internet Pornography Protecting Children and Youth Who Use the Internet and Social Media,” by addition to read as follows:  Our AMA:  (1) Recognizes the positive role of the Internet in providing health information to children and youth.  (2) Recognizes the negative role of the Internet in connecting children and youth to predators and exposing them to pornography.  (3) Supports federal legislation that restricts Internet access to pornographic materials in designated public institutions where children and youth may use the Internet.  (4) Encourages physicians to continue efforts to raise parent/guardian awareness about the importance of educating their children about safe Internet and social media use.  (5) Supports school-based media literacy programs that teach effective thinking, learning, and safety skills related to Internet and social media use.   1. 6) Actively support legislation that would strengthen child-centric content protection by internet service providers and/or search engines in order to limit the access of pornography to minors on the internet and mobile applications**.** (Modify Existing Policy) |
| K | Res. 927 | Michigan | Off-Label Policy | RESOLVED, That our American Medical Association amend Policy H-120.988, “Patient Access to Treatments Prescribed by Their Physicians,” by addition to read as follows:  1. Our AMA confirms its strong support for the autonomous clinical decision-making authority of a physician and that a physician may lawfully use an FDA approved drug product or medical device for an off-label indication when such use is based upon sound scientific evidence or sound medical opinion; and affirms the position that, when the prescription of a drug or use of a device represents safe and effective therapy, third party payers, including Medicare, should consider the intervention as clinically appropriate medical care, irrespective of labeling, should fulfill their obligation to their beneficiaries by covering such therapy, and be required to cover appropriate 'off-label' uses of drugs on their formulary.  2. Our AMA strongly supports the important need for physicians to have access to accurate and unbiased information about off-label uses of drugs and devices, while ensuring that manufacturer-sponsored promotions remain under FDA regulation.  3. Our AMA supports the dissemination of generally available information about off-label uses by manufacturers to physicians. Such information should be independently derived, peer reviewed, scientifically sound, and truthful and not misleading. The information should be provided in its entirety, not be edited or altered by the manufacturer, and be clearly distinguished and not appended to manufacturer-sponsored materials. Such information may comprise journal articles, books, book chapters, or clinical practice guidelines. Books or book chapters should not focus on any particular drug. Dissemination of information by manufacturers to physicians about off-label uses should be accompanied by the approved product labeling and disclosures regarding the lack of FDA approval for such uses, and disclosure of the source of any financial support or author financial conflicts.  4. Physicians have the responsibility to interpret and put into context information received from any source, including pharmaceutical manufacturers, before making clinical decisions (e.g., prescribing a drug for an off-label use).  5. Our AMA strongly supports the addition to FDA-approved labeling those uses of drugs for which safety and efficacy have been demonstrated.  6. Our AMA supports the continued authorization, implementation, and coordination of the Best Pharmaceuticals for Children Act and the Pediatric Research Equity Act.   1. 7. Our AMA supports physician autonomy with regard to deciding appropriate dosing.(Modify Current Policy) |
| K | Res. 928 | Medical Student Section | Expanding Transplant Evaluation Criteria to Include Patients that May Not Satisfy Center-Specific Alcohol Sobriety Requirements | 1. RESOLVED, That our American Medical Association encourage transplant centers to expand potential recipient evaluation criteria to include patients that may not satisfy center-specific alcohol sobriety requirements on a case-by-case basis, using medically appropriate criteria supportable by peer-reviewed and published research. (New HOD Policy) |
| K | Res. 929 | Medical Student Section | Opposing the Marketing of Pharmaceuticals to Parties Responsible for Captive Populations | RESOLVED, That our American Medical Association oppose the practice of pharmaceutical marketing towards those who make decisions for captive populations, including, but not limited to, doctors working in a correctional capacity, judges, wardens, sheriffs, correctional officers,Immigration and Customs Enforcement, and other detention administrators (New HOD Policy); and be it further  RESOLVED, That our AMA advocate for the inclusion of physicians in the selection of medications available to vulnerable populations such as incarcerated individuals (Directive to Take Action); and be it further  RESOLVED, That our AMA support and work with state medical societies to support measures to increase transparency in medication procurement, including but not limited to: (1) requiring those responsible for medical procurement to report gifts from pharmaceutical companies over a minimum amount; and (2) centralizing formulary choices in a physician-led office, agency, or commission following the principles of a sound formulary. (New HOD Policy) |
| K | Res. 930 | Medical Student Section | Addressing Longitudinal Health Care Needs of Children in Foster Care | RESOLVED, That our American Medical Association support the construction of computerized health information systems to enhance information exchange between both tribal and non-tribal child welfare agencies and healthcare professionals (New HOD Policy); and be it further  RESOLVED, That our AMA promote existing pediatric medical homes which provide continuity of care to children in foster care (New HOD Policy); and be it further  RESOLVED, That our AMA advocate for the designation of medical providers, teams, and/or committees to longitudinally follow children in foster care (Directive to Take Action); and be it further  RESOLVED, That our AMA support the appointment of a pediatrician in each state with experience in child welfare to the position of state medical director of foster care health case management in accordance with AAP guidelines to ensure standards of care are met (New HOD Policy); and be it further   1. RESOLVED, That the AMA support the longitudinal stability and care of American Indian and Alaska Native children in foster care by promoting the Indian Child Welfare Act. (New HOD Policy) |
| K | Res. 931 | Medical Student Section | Amending H-160.903 Eradicating Homelessness to Include Support for Street Medicine Programs | RESOLVED, That our American Medical Association encourage medical schools to implement Street Medicine programs and/or promote student-led Street Medicine programs (New HOD Policy); and be it further  RESOLVED, That our AMA recognizes and supports the use of Street Medicine programs by amending policy H-160.903 Eradicating Homelessness via addition and deletion as follows.  **Eradicating Homelessness, H-160.903** Our AMA:  (1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services;  (2) recognizes that stable, affordable housing as a first priority, without mandated therapy or services compliance, is effective in improving housing stability and quality of life among individuals who are chronically-homeless;  (3) recognizes adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address this societal problem on a long-term basis;  (4) supports the use of street medicine programs, which travel to individuals who are unhoused or unsheltered and provide healthcare and social services, as well as funds, including Medicaid and other public insurance reimbursement, for their maintenance;  ~~(4~~5) recognizes the need for an effective, evidence-based national plan to eradicate homelessness;  (~~5~~6) encourages the National Health Care for the Homeless Council to study the funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons;  (~~6~~7) will partner with relevant stakeholders to educate physicians about the unique healthcare and social needs of homeless patients and the importance of holistic, cost-effective, evidence-based discharge planning, and physicians’ role therein, in addressing these needs;  (~~7~~8) encourages the development of holistic, cost-effective, evidence-based discharge plans for homeless patients who present to the emergency department but are not admitted to the hospital;  (~~8~~9) encourages the collaborative efforts of communities, physicians, hospitals, health systems, insurers, social service organizations, government, and other stakeholders to develop comprehensive homelessness policies and plans that address the healthcare and social needs of homeless patients;  (~~9~~10) (a) supports laws protecting the civil and human rights of individuals experiencing homelessness, and (b) opposes laws and policies that criminalize individuals experiencing homelessness for carrying out life-sustaining activities conducted in public spaces that would otherwise be considered non-criminal activity (i.e., eating, sitting, or sleeping) when there is no alternative private space available; and  (~~10~~11) recognizes that stable, affordable housing is essential to the health of individuals, families, and communities, and supports policies that preserve and expand affordable housing across all neighborhoods; ~~and~~  (~~11~~12) (a) supports training to understand the needs of housing insecure individuals for those who encounter this vulnerable population through their professional duties; (b) supports the establishment of multidisciplinary mobile homeless outreach teams trained in issues specific to housing insecure individuals; and (c) will make available existing educational resources from federal agencies and other stakeholders related to the needs of housing-insecure individuals; and   1. (13) supports federal and state efforts to enact just cause eviction statutes and examine and restructure punitive eviction practices; instate inflation-based rent control; guarantee tenants’ right to counsel in housing disputes and improve affordability of legal fees; and create national, state, and/or local rental registries. (Modify Current HOD Policy) |
| K | Res. 932 | Medical Student Section | Increase Employment Services Funding for People with Disabilities | 1. RESOLVED, That our American Medical Association support increased resources for employment services to reduce health disparities for people with disabilities. (New HOD Policy) |
| K | Res. 933 | Medical Student Section | Reducing Disparities in HIV Incidence through Pre-Exposure Prophylaxis (PrEP) for HIV | 1. RESOLVED, That our American Medical Association amend Policy H-20.895 “Pre‑Exposure Prophylaxis (PrEP) for HIV” by addition to read as follows:   **Pre-Exposure Prophylaxis (PrEP) for HIV, H-20.895**   1. Our AMA will educate physicians, physicians-in-training, and the public about the effective use of pre-exposure prophylaxis for HIV and the US PrEP Clinical Practice Guidelines. 2. Our AMA supports the coverage of PrEP in all clinically appropriate circumstances. 3. Our AMA supports the removal of insurance barriers for PrEP such as prior authorization, mandatory consultation with an infectious disease specialist and other barriers that are not clinically relevant. 4. Our AMA advocates that individuals not be denied any insurance on the basis of PrEP use. 5. Our AMA encourages the discussion of and education about PrEP during routine sexual health counseling, regardless of a patient’s current reported sexual behaviors. (Modify Current HOD Policy) |
| K | Res. 934 | Medical Student Section | Denouncing the Use of Solitary Confinement in Correctional Facilities and Detention Centers | RESOLVED, That our American Medical Association policy H-430.983, “Reducing the Use of Restrictive Housing in Prisoners with Mental Illness,” be amended by addition and deletion to read as follows:  **~~Reducing~~ Opposing the Use of Restrictive Housing ~~in~~ for Prisoners ~~with Mental Illness~~ H-430.983**   1. Our AMA will: (1) ~~support limiting~~ oppose the use of solitary confinement of any length~~, with rare exceptions,~~ for incarcerated persons ~~with mental illness~~, in ~~adult~~ correctional facilities and detention centers, except for medical isolation or to protect individuals who are actively being harmed or will be immediately harmed by a physically violent individual, in which cases confinement may be used for as short a time as possible; ~~and~~ (2) while solitary confinement practices are still in place, support efforts to ensure that the mental and physical health of all individuals placed in solitary confinement are regularly monitored by health professionals; and (3) encourage appropriate stakeholders to develop and implement safe, humane, and ethical alternatives to solitary confinement for incarcerated persons in all correctional facilities.~~; and (3) encourage appropriate stakeholders to develop and implement alternatives to solitary confinement for incarcerated persons in all correctional facilities.~~ (Modify Current HOD Policy) |
| K | Res. 935 | Medical Student Section | Government Manufacturing of Generic Drugs to Address Market Failures | 1. RESOLVED, That our American Medical Association support the formation of a non-profit government manufacturer of pharmaceuticals to produce small-market generic drugs. (New HOD Policy) |
| K | Res. 936 | Medical Student Section | Promoting the Use of Multi-Use Devices and Sustainable Practices in the Operating Room | 1. RESOLVED, That our American Medical Association advocate for research into and development of intended multi-use operating room equipment and attire over devices, equipment and attire labeled for “single-use” with verified similar safety and efficacy profiles. (Directive to Take Action) |